Reply to "Anti-IL5/IL5R switching between biologics in patients with severe eosinophilic asthma"

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Reply to "Anti-IL5/IL5R switching between biologics in patients with severe eosinophilic asthma"

To the Editor:

Yılmaz et al[1] are right that there is no consensus on the criteria for defining super-responders to biologics in asthma. We chose a super-response definition excluding any residual disease manifestation such as markers of inflammation (eg, chronic oral corticosteroid use and exacerbations), airflow limitation, or asthma symptoms, because this determines disease burden and prognosis. Our response definition therefore reflects complete remission under treatment, which we believe should be the ultimate treatment goal in all patients with severe asthma.[2] However, the examples the authors described aptly illustrate the shortcomings of the definition we used in our study.[3] We fully agree that response criteria should be standardized once sufficient clinical experience with the asthma biologics has been obtained.

With regard to control criteria of sinonasal comorbidities such as nasal polyps and chronic rhinosinusitis, we relied on the findings of nasal endoscopy in combination with the subjective absence of symptoms. We should have stated this more clearly in the article.

The comment by Yılmaz et al about an improved response after switching from one anti-IL-5 to another anti-IL-5 biological agent is important. Indeed, many partial responders (but none of the nonresponders) showed further improvement after switching to another anti-IL-5 biologic, and 4 patients subsequently became super-responders. We have written a separate article on outcomes after switching between asthma biologics that will be published shortly in this journal.[4]

Yılmaz et al rightly state that nasal polyposis is a predictor of a good response to anti-IL-5 with regard to asthma symptoms. However, regarding sinonasal manifestations, anti-IL-5 therapy failed to completely eliminate nasal polyps in our patients, so we could not label them as super-responders according to our definition.

Finally, regarding the adverse effects of anti-IL-5 biologics, 3 of our patients discontinued therapy because of migraine, severe dermatitis, and colon cancer, respectively.

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House dust mite liquid SLIT effective in atopic dermatitis even with suboptimal dosing

To the Editor:

We have read the article by Langer et al[1] on sublingual immunotherapy (SLIT) with a house dust mite (HDM) extract for atopic dermatitis (AD) with great interest and would like to congratulate our Brazilian colleagues for having been able to conduct a double-blind, placebo-controlled trial under the not always favorable local circumstances and with budget limitations. The study is of even greater importance because it managed to show statistically significant differences in favor of the active treatment group, even with a suboptimal SLIT administration schedule, as the investigators comment.

By taking a closer look at how the study was conducted, the patients characterized, and the liquid SLIT administered, we would like to make some comments, because we consider that the SLIT schedule could be improved and would like other readers to realize how an optimal liquid SLIT schedule with HDM allergen could look like.