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SCIENTIFIC LETTER

Duration of sustained remission after treatment by induction with exclusive enteral nutrition and azathioprine in patients with Crohn's disease☆,☆☆

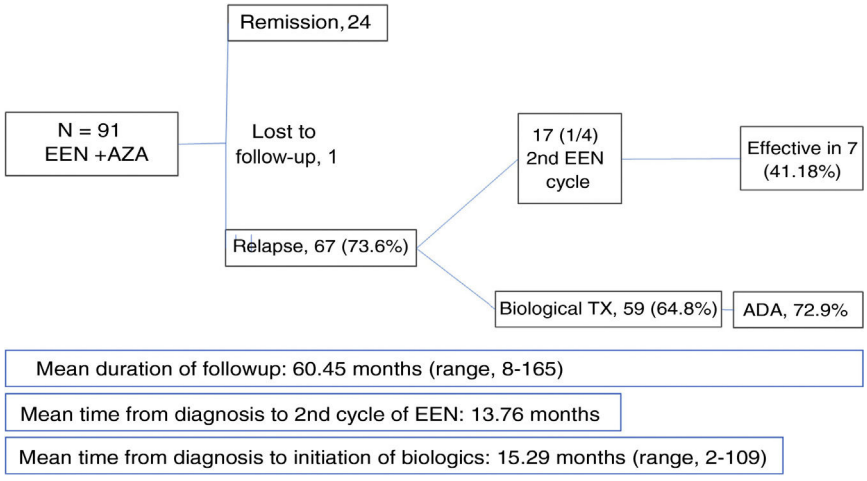
Duración de la remisión sostenida tras el tratamiento de inducción con nutrición enteral exclusiva y azatioprina en pacientes con enfermedad de Crohn

Dear Editor:

Numerous studies have evinced the efficacy of exclusive enteral nutrition (EEN) to induce remission in paediatric-onset Crohn's disease (POCD).[1–4] The guidelines of the European Crohn's and Colitis Organization and the European Society of Pediatric Gastroenterology, Hepatology and Nutrition (ECCO-ESPGHAN) recommend the use of EEN combined with early initiation of immunosuppression in patients with mild to moderate forms of disease.[5] However, there are no data on the long-term efficacy of this strategy in preventing or postponing the use of biological therapy.

Thus, to determine the proportion of our patients with POCD that require initiation of anti-tumour necrosis factor (TNF) therapy after achieving clinical remission with the aforementioned approach, we conducted the observational retrospective study presented in this article.

We reviewed the medical records of patients with POCD that were diagnosed in our unit between 2003 and 2017 and achieved clinical remission at onset with a combination of EEN and thiopurine drug therapy (azathioprine, mercaptopurine). We collected demographic, clinical and outcome



Abbreviations: ADA, adalimumab; AZA, azathioprine; EEN, exclusive enteral nutrition

Figure 1 Study results.

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☆☆ Previous presentation: This study was presented and received the award to the best brief oral communication in Gastroenterology/Nutrition at the XXVI Congress of the Sociedad Española de Gastroenterología, Hepatología y Nutrición Pediátrica; May 16–18, 2019; Santander, Spain.

data for these patients until February 2019 or their transition to the adult care unit.

We included 91 patients (68.1% male; mean age at onset, 12.29 years, median age, 13 years; age range, 8 months–17 years) (Fig. 1). The mean duration of follow-up of patients in our unit was 60.45 months (range, 8–165 months). During this time, 66 of the 91 patients (72.53%) relapsed. The strategy used to manage the relapse in 17 patients (25.76%) was a second cycle of EEN, which was effective in 7 of them (41.18%). The mean time elapsed from diagnosis to the second cycle of EEN was 13.76 months (maximum, 110 months). During the follow-up, 65.6% of the patients required escalation of treatment to anti-TNF therapy due to failure of maintenance with thiopurines, with a mean time elapsed from onset to initiation of anti-TNF therapy of 15.29 months (median, 9 months). Of all patients that required biological therapy, 72.9% started with adalimumab (ADA). After a period of combined treatment (anti-TNF and thiopurines), the immunosuppressive treatment was discontinued in 42.2% of patients once they exhibited sustained clinical and endoscopic remission, thus switching to anti-TNF as monotherapy.

Despite the limitations intrinsic in the retrospective design of the study, the results obtained in a large sample of patients ($n = 91$ patients) show that although EEN is an effective approach for induction of remission in POCD, a successful-enough approach has yet to be established for subsequent maintenance to prevent the need of biological therapy in the medium term in a significant proportion of patients. Such an approach should involve more strict criteria for the definition of remission and a thorough evaluation of the latter so enable the establishment of more appropriate maintenance therapy.

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Conflicts of interest

The authors have no conflicts of interest to declare.

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Disopyramide as coadjuvant treatment in obstructive hypertrophic cardiomyopathy☆

Disopiramida como tratamiento coadyuvante en miocardiopatía hipertrófica obstructiva

To the editor

The role of left ventricular outflow tract obstruction (LVOTO) in obstructive hypertrophic cardiomyopathy (OHCM) in the paediatric population has yet to be clarified, but it is believed to be a risk modifier or minor risk factor for sudden death, and its management and control of the associated symptoms are among the main goals of treatment in these patients.[1] Treatment of LVOTO is recommended in all symptomatic patients and also in asymptomatic patients with a resting peak gradient (PG) greater than 25 mmHg, with the goal of maintaining it below 50 mmHg.[1] Some of the treatment options include surgical septal myectomy and percutaneous alcohol septal ablation, but there is limited experience with these interventions in paediatric patients, and pharmacotherapy is the first step of treatment.[2] Beta blockers are the first-line therapeutic agents, administered at minimum doses equivalent to 6 mg/kg/day of propranolol.[2] However, these drugs are frequently contraindicated, cause side effects or are not effective at the maximum tolerated dose, which requires switching treatment or adding second-line drugs. Although calcium channel blockers are the first alternative used in adults, their use in paediatric OHCM is limited, especially in infants aged

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