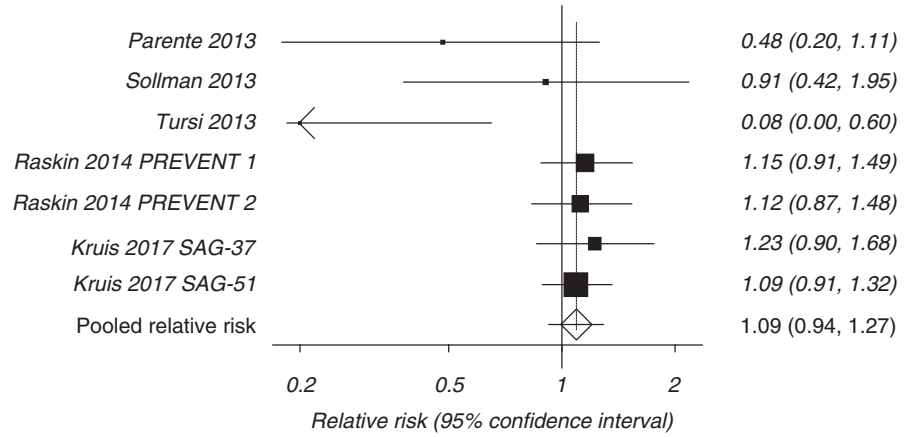

FIGURE 1 Forest plot of randomised controlled trials of mesalazine in the prevention of recurrent acute diverticulitis. Cochran Q=7.76 (df=6) P=.26; I^2 (inconsistency)=22.7%

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Editorial: mesalazine to prevent recurrent acute diverticulitis—the final nail in the coffin. Authors' reply

We thank Drs Gracie and Ford for their editorial[1] on our study.[2] We fully agree that the use of mesalazine for preventing recurrence of true diverticulitis cannot be recommended. Although this issue is now solved, the treatment dilemma of the many patients with pain in the left lower quadrant of the abdomen associated with diverticula remains.

General excision of the sigmoid colon of diverticulitis patients does not seem a viable alternative, as persistent symptoms remain in a significant group of patients.[3] However, a recent meta-analysis of patient-reported outcomes suggested that elective surgery on well-defined patients might be more beneficial than conservative treatment.[4] In addition, well-characterised patients with "smoldering" diverticulitis seem to benefit from surgical procedures.[5]

With regard to conservative management, a placebo-controlled study has shown therapeutic effects on abdominal pain in acute uncomplicated diverticular disease (DD)[6] and a systematic review described symptomatic control by mesalazine in symptomatic uncomplicated DD (SUDD),[7] a subgroup of chronic DD, which seems to be closely related to irritable bowel syndrome.[8] Here, a final high-quality trial is urgently needed to clarify the effects of mesalazine in the treatment of SUDD.

Another subgroup of DD/diverticulitis is segmental colitis-associated DD (SCAD),[9] which is poorly studied. No formal trials are existing, but many doctors treat their patients with mesalazine.

What can we conclude from this short overview? High-quality protocols for controlled trials in DD/diverticulitis have to consider modern classification.[10] For inclusion, study patients need to be strictly classified with adequate procedures. Before we quash old drugs used for many years by many doctors around the world such as mesalazine, we should focus efforts to improve our treatment strategies in DD/diverticulitis not only by testing new drugs but also by re-evaluating old compounds using strictly-defined patient populations.

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Editorial: different tests for different drugs in Crohn's disease, or different tests for different people?

It is well demonstrated that tight disease control leads to superior clinical and endoscopic outcomes in Crohn's disease.[1-3] However, as one strives toward the new goals of normalisation of inflammatory biomarkers and attaining mucosal healing, the utility of therapeutic drug monitoring (TDM) in achieving these goals is less clear. While there appears to be a clear exposure-response relationship for individuals treated with infliximab, the association between circulating drug and outcomes is less well defined and somewhat contradictory for adalimumab, despite the two drugs belonging to the same class.[4-6]

Conducting well designed studies in the area of TDM is challenging. Debate has ensued regarding the influence of interpatient variability on drug levels. Drug levels may vary in an individual over time which may not be addressed by cross-sectional study designs, while disease activity may not be as reliably reported in retrospective studies. Further, population based pharmacokinetic analyses may not be relevant for the individual.

Ward et al. investigated the association between anti-TNF drug levels and clinical outcomes in Crohn's disease, and probed factors