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Author's Reply

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To begin, we would like to express our deepest appreciation for your attention as well as for your insightful comments regarding the study we published in the April 2014 issue of *Intestinal Research*.[1]

In that study, we investigated the rate of post-operative endoscopic recurrence (PER) using colonoscopy or capsule endoscopy in patients with CD who had underwent various operations including ileocolonic resection. When defining PER as a Rutgeerts' score[2] ≥i-1, cumulative recurrence rates were 33.3%, 42.9%, and 66.1% at 6, 12, and 24 months, respectively.

As pointed out by Dr. Kotze[3], the Rutgeerts' score has not been sufficiently validated for patients who had surgeries other than ileocolonic resection. In addition, PER has been defined by a Rutgeerts' score ≥i-2 in most of the studies conducted in Western countries, as the risk of clinical recurrence is higher in patients with score ≥i-2 compared to those with no recurrence (i-0) or i-1. However, the main purpose of our study was to assess how frequently 'new endoscopic lesions' developed after bowel resection, as the association between PER severity and subsequent clinical recurrence has not been fully elucidated. In our study, therefore, we defined PER as a Rutgeerts' score ≥i-1, which indicated a 'new lesion' (at least 1 aphthous ulcer) on endoscopy.

According to data presented by Kotze PG et al at the 2014 European Crohn´s and Colitis Organisation congress, the PER rates in Brazil, Japan, and Italy were 32%, 38%, and 14%, respectively, for the 12 months follow-up period after surgeries.[4] In our study, the PER rate at 1 year after bowel resection was 42.9%, a higher rate than that observed for Brazil, Italy, or even Japan. As mentioned by Dr. Kotze, such differences may have been attributable, at least in part, to their active strategies for post-operative prevention of recurrences. According to a risk-stratified strategy to prevent post-operative recurrence of CD, determining patient risk factors, identifying PER by performing colonoscopy 6–12 months after surgery, and promptly introducing preventive medications are recommended.[5] In Western countries and Japan, the introduction of biologic agents for preventing PER in high-risk CD patients is more accepted, even when considering issues of safety and cost.[6] Collectively, these data suggest that more vigilant monitoring should be performed and proper prophylactic therapy administered for PER prevention in Korean patients with CD.

Despite our study's small sample size and relatively short follow-up period, the results should be considered as significant because ours was the first study to investigate PER in Korean patients with CD. In future studies with larger sample sizes, we intend to investigate the impact of PER severity on clinical recurrences, as well as on re-operation rates.

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