Reviewer’s report

Title: Colectomy rate in steroid-refractory colitis initially responsive to cyclosporin: A long-term retrospective cohort study

Version: 1 Date: 18 September 2006

Reviewer: Severine Vermeire

Reviewer’s report:

General
In this study by Actis et al, the authors report the results of a retrospective cohort study on the colectomy and relapse rate in patients with steroid-refractory colitis treated with cyclosporin. A total of 61 patients were reviewed, treated between 1991 and 1998. There were 63% of patients who responded short term. 1 patient died. The colectomy rate at one year was 39% and at 7 years 65%.

Although this is a retrospective cohort study, and similar studies with larger sample sizes have been published, the study is well done, and includes a relatively large cohort of patients (n=61) with a follow up of 7 years. Although initial response rates are a bit at the low site, the colectomy rates both short and long term confirm previous studies.

I have the following specific questions however that need to be answered:

Major:
1. Authors should include one table with the baseline demographic and clinical variables of these patients: mean age, gender, disease duration, disease location, treatment at start of CyA (5-ASA, Azathioprine, steroids, ...)
2. Figure 1 is not adding anything new to literature and is misleading in a way. It has been known that CyA is an effective therapy to be used short term for 3-4 months, but that, unless long-term therapy with immunomodulators is started, patients will almost inevitably relapse and put at risk for colectomy. However, the critical question is if, in a patients already on AZA who comes in with steroid refractory disease, giving CyA is effective yes/no or is merely "buying" time (since these patients are at high risk for colectomy anyway). Therefore figure 1 should show all patients and stratified for previous AZA use or not
3. Trough levels of CyA were kept remarkably low in some patients (range from 60-24). It is generally recommended to keep levels around 200 (range 150-250). Were the patients with low levels, the ones that did not respond? The authors should show a table or a paragraph with differences in clinical characteristics and CyA trough levels (mean) between initial responders and non-responders
4. Patients included between 1991-1996 were treated with IV CyA and thereafter, from 1996 with oral cyA. Although the authors state that this difference in way of administration was not reflecting less severe patients since they exhibited the same frequency of left-sided disease, this reviewer does not agree: location of disease is not a marker of severity of disease? What was the mean Rachmilewitz score (or other score, but authors use Rachmilewitz in their manuscript) in both groups (treated orally and IV)? Second, what is the colectomy rate and relapse rate for patients treated between 1991-1996 and those treated after 1996?
5. Discussion last sentence: “alternatives to cyclosporine for the management of severe refractory UC “ must be considered with caution is overstated. Since in this cohort only 11% of UC patients were on azathioprine at entry, this is really not a refractory cohort, but rather a “steroid-refractory” cohort. If this is really a refractory cohort, how to explain that only 11% of patients were on azathioprine before?

Minor:
1. Title: responsive tocyclosporin should be to cyclosporine
2. How many patients could actually stop steroids?
3. What were the reasons for the 4 drop outs?

What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable
Statistical review: No

Declaration of competing interests:
I declare that I have no competing interests