Editorial: safety and tolerability of rifaximin for IBS – more information is required; authors' reply

P. Schoenfeld* & M. Pimentel†

*Division of Gastroenterology, University of Michigan School of Medicine, Ann Arbor, MI, USA.
†Division of Gastroenterology, Cedars-Sinai Medical Center, Los Angeles, CA, USA.
E-mail: pschoenf@umich.edu

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We appreciate the comments of Cai and Yang, but we respectfully disagree with several of their criticisms.[1, 2] First, this study was not a systematic review. It is a pooled analysis of individual patient data and data on safety for each dose of medication are provided. Nevertheless, there is no difference in safety or tolerability regardless of dose. This is unsurprising as less than 1% of rifaximin is absorbed.

Second, the appropriate dose of rifaximin for treatment of nonconstipation predominant irritable bowel syndrome (non-C IBS) is clear. Based on the data in over 1600 patients in two phase 3 randomised controlled trials (RCTs), rifaximin 550 mg t.d.s. for 14 days is the recommended dose.[3] The third RCT discussed in our study is a phase 2 dose-ranging study to identify the ideal dose for treatment of non-C IBS.[4]

Third, it is true that the incremental benefit of rifaximin over placebo for improvement in global IBS symptoms is 9% (40.7% vs. 31.7%). However, in rigorously designed RCTs, IBS treatments with proven efficacy for global IBS symptoms consistently show benefits of approximately 10% over placebo.[5] Further data are needed about long-term management with rifaximin. This is being studied in an RCT of over 1000 patients and data will be available later in 2014.

Finally, there is controversy about the diagnosis of small intestinal bacterial overgrowth (SIBO) with breath testing. However, the patients in these RCTs did not undergo breath testing and the decision to treat was based solely on the presence of non-C IBS symptoms. We therefore do not think that criticisms about breath testing apply. In fact, the impact of rifaximin may not be limited to treatment of SIBO. Rifaximin may alter the interaction between bacterial flora and the immune system in the colonic mucosa, and this is being explored in the Target 3 study.

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Editorial: IDASPHERE phase I trial for chemoembolisation of HCC

G. H. Lee & S. G. Lim

Department of Gastroenterology and Hepatology, National University Hospital, Singapore.
E-mail: mdclimsg@nus.edu.sg

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Transarterial chemoembolisation (TACE) is considered the standard treatment for intermediate-stage (BCLC stage B) hepatocellular carcinoma (HCC).[1] A meta-analysis revealed highly variable objective response rates between 16% and 61%, which did not always translate into improved survival.[2] TACE was also not a well-defined and homogenous technique across different units.

Embolisation material has evolved over time. Microspheres allowed occlusion of target vessels at a desired point by selecting an appropriate particle size, compared with conventional particulate agents, such as gelatin sponge or polyvinyl alcohol particles.[3] Drug-eluting beads (DEB) have been recently developed, which can