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Comments on Quality of Life in Patients With Definite Chronic Pancreatitis: A Nationwide Longitudinal Cohort Study

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We read with great interest the recently published study on "Quality of life in patients with definite chronic pancreatitis: a nationwide longitudinal cohort study" (1). The study is valuable, yet we found some points requiring further clarification.

First, common complications in patients with long-standing chronic pancreatitis (CP) include pancreatic pseudocysts, common bile duct stricture, and pancreatic stones, and the 10-year incidence of these complications after onset of CP are 13.5%, 12.4%, and 59.7%, respectively, according to our previous published cohort studies. These complications act as important covariates to affect physical (PCS) and mental (MCS) component summary scales because of the complications-related symptoms including abdominal pain, fever, jaundice, or upper gastrointestinal hemorrhage. Frequent hospital visits caused by these complications can increase patients' financial burden, which in turn has a significant impact on patients' quality of life. Moreover, pancreatic cancer is a severe complication of CP with the cumulative risk of 1.8% at 10 years and 4% at 20 years after diagnosis of CP (2). Patients with pancreatic cancer have poor quality of life because of the series of cancer-related conditions including dyscrasia and psychosocial impact. A case-control study noted that geriatric patients with pancreatic cancer have a poorer PCS scale (36.3 vs 29.3) and MCS scale (49.9 vs 44.8) compared with controls without cancer (3). Thus, it is better to include these CP-related complications in the univariate and multivariate analyses.

Second, patients with pancreatic cancer who have been misdiagnosed to have CP should be excluded from this study. According to previous research, approximately 5% of patients with pancreatic cancer were initially misdiagnosed to have CP within 2 years (4), and some studies have set the time interval between the diagnosis of CP and pancreatic cancer at more than 5 years to further reduce the misdiagnosis. Pancreatic cancer within 2 years after the diagnosis of CP was not exhibited in this study or was excluded from this study, causing bias to the PCS and MCS scales. Therefore, excluding patients diagnosed to have pancreatic cancer during the first 2 years of follow-up would help purify the study group.

Third, only assessing pancreatic interventions performed ≤6 months before follow-up may have influenced the results. Many research studies have confirmed the long-term efficacy of interventions for CP. For example, a randomized clinical trial reported that the PCS and MCS scales increased from 31 to 36 and 36 to 41, respectively, at the 18-month follow-up after endoscopic therapy, and these scales were 35–39 and 38 to 44, respectively, in the surgery group (5). Thus, we think it is necessary to collect the interventions patients received during the whole time interval between every follow-up. In addition, we advise that the item "endoscopic treatment/surgery ≤ 6 months prior to the follow-up questionnaire" in univariate and multivariate analyses could be replaced by "endoscopic treatment/surgery during follow-up."

In summary, this research is valuable and has important implications for guiding clinical practice while further works including variables' inclusion and patients' exclusion could be made to perfect the results.

CONFLICTS OF INTEREST

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Response to Yi et al

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We thank Drs. Jin-Hiu Yi and colleagues for their knowledgeable comments on our article (1,2). We agree that chronic

pancreatitis–related complications such as pancreatic pseudocysts, common bile duct strictures, and pancreatic strictures and stones are important covariates of both physical and mental quality of life. These disease-related complications frequently lead to chronic abdominal pain, hospital readmissions, and pancreatic invasive interventions. We hypothesized that the consequences, rather than the development of the disease-related complications, impair the quality of life in patients with complicated chronic pancreatitis. Based on this, the choice was made to focus our analyses on complication-related symptoms and their treatment and to not include morphological complications as separate variables in our multivariate model.

One concern of Drs. Jin-Hiu Yi and colleagues was that misclassifying patients with pancreatic cancer as patients with chronic pancreatitis may have influenced our results. In our study, strict inclusion criteria were handled, and only those patients with a diagnosis of definite chronic pancreatitis according to the M-ANNHEIM criteria were included. The M-ANNHEIM criteria are based on end-stage features of chronic pancreatitis, such as ductal abnormalities and pancreatic calcifications, which both are a result of long-lasting inflammation (3). We are of the opinion that by using these criteria the risk for misdiagnosing patients with pancreatic cancer as chronic pancreatitis is minimal. Furthermore, most patients were followed for a longer period of time, and therefore, an incorrect initial diagnosis of chronic pancreatitis will be of no concern in this study. It is indeed true that we cannot rule out that there are some patients who may develop an underlying pancreatic cancer during follow-up, which is a possible complication of chronic pancreatitis after all.

A question was raised pertaining the impact of invasive interventions on the quality of life during follow-up. This could not be investigated because these data were not available for the whole follow-up period. Quality-of-life data after follow-up interventions were only available when these interventions were performed within 6 months before the patients' specific follow-up time point. For this reason, we were not able to perform additional subgroup analyses to explore the effect of interventions during follow-up on mental and quality-of-life scores over time. In patients who underwent invasive interventions before inclusion, physical quality of life significantly improved over time, showing a similar trend as for the overall population. Pancreatic interventions when performed 6 months before the follow-up questionnaire proved not to be significantly correlated with changes in quality of life. We therefore believe that stratification for follow-up interventions would probably have no significant impact on our findings.

CONFLICTS OF INTEREST

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Identifying Phenotypic Determinants of Infliximab Target Concentrations in Inflammatory Bowel Disease: Toward Personalized Evidence-Based Dosing Regimens

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We read with great interest the article by Yarur et al (1). In a prospective, cross-sectional study, predominantly overweight (average body mass index 27.8 kg/m^2 [SD: 6.4]) patients with inflammatory bowel disease on infliximab (IFX) maintenance therapy were enrolled. This study demonstrated that patients within the highest two % quartiles of visceral adipose tissue (VAT) burden required considerably higher IFX exposure to achieve higher target concentrations, associated with higher steroid-free deep remission and endoscopic remission rates. Importantly, these results have several implications: (i) They discourage traditional typical bodyweight-based dosing because IFX pharmacokinetics (PK) seems to be rather driven by other size descriptors than typical bodyweight, (ii) they emphasize the need for testing VAT as a potential covariate