We are grateful for the comments of Stagno et al.1 on potential toxicities of infliximab in patients with hematologic malignancies.

We agree that the occurrence of secondary malignancies could be a potential concern for infliximab use in patients with low-risk MDS, although none of the 43 patients included in our study developed a secondary malignancy.2 Similarly, none of the 37 patients with low-risk MDS treated with infliximab (5 or 10 mg/kg i.v. every 4 weeks for 4 cycles) by Raza et al. developed a secondary hematologic malignancy.3 Development of secondary malignancies is associated with many conditions characterized by chronic inflammation, auto-immunity and immune suppression even before the introduction of potent immunomodulators, such as infliximab.4

We share the concern of Stagno et al. about the high incidence of grade 3-5 infections in our study (30%).1 Interestingly, grade 3-5 infections tended to be more frequent (41%) in patients randomized in the 3 mg/kg arm than in those randomized in the 5 mg/kg arm (19%).2 Such a high incidence of infection was not observed in the Raza et al. study in which only one of 37 patients (3%) experienced a grade 3 infection.3

While the results of our study suggest that infliximab alone does not have sufficient activity in unselected patients with early MDS, we agree with Stagno et al.1 that a combination of infliximab with other MDS active agents might offer interesting possibilities. Scott et al. have observed a high durable response rate in MDS patients treated with a combination of azacitidine and TNF-α blockade with etanercept, with a relatively low toxicity profile.5 Similarly, a recent phase II study has shown encouraging results with a combination of anti-thymocyte globulin and etanercept in patients with low- or intermediate 1 risk MDS.6

Finally, we agree with Stagno et al.1 that any further trial assessing infliximab in MDS patients should assess potential toxicities associated with this drug, and in particular, severe infections.

References