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Indications for Liver Transplant and AASLD Guidelines

To the Editor:

We read with great interest the recently updated AASLD Practice Guidelines published in the March issue of HEPATOLOGY titled "Evaluation for Liver Transplantation in Adults."[1] We commend Dr. Martin and colleagues for undertaking an extensive review of the literature. We think it important for your readers to be aware that, among the indications for liver transplant, other rare disorders should be included. Specifically, we write about growing interest in and a growing body of literature indicating that liver transplantation is curative for severe, unremitting acute intermittent porphyria (AIP).[2,3] This was first described in 2004 and, thus far, most cases have been done in Europe.[4] Recently, the first liver transplantation for AIP in the United States was performed with excellent success and prompt cure at Mt. Sinai Medical Center, NYC (Liu et al., pers. commun.).

It is also worth reminding readers that erythropoietic protoporphyria (EPP) with pigmentary cirrhosis is a well-established indication for liver or combined liver/bone marrow transplantation. Numerous case reports and publications in various peer-reviewed journals attest to the role of liver or combined liver/bone marrow transplantation in patients with chronic liver disease secondary to EPP.[5,6] In fact, among the porphyrias, chronic liver disease in EPP is probably the best established indication for liver transplant.

We recently published a review article assessing the role of liver transplantation in porphyria.[7] Because of the growing influence of AASLD guidelines for clinical practice and decisions regarding reimbursement, etc., we hope that the AASLD guidelines will soon be amended to take into account liver transplantation for carefully selected patients with porphyrias.

MANISH THAPAR, M.D.[1]
HERBERT L. BONKOVSKY, M.D.[2]
[1]*Department of Medicine*
Drexel University College of Medicine
Philadelphia, PA
[2]*Department of Medicine*
Carolinas HealthCare System and University of NC School of Medicine
Charlotte, NC

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Association Between Response to Pegylated Interferon/Ribavirin Therapy and Ribavirin Levels

To the Editor:

We read with great interest the article by Holmes et al.[1] published in HEPATOLOGY. The researchers conclude that inosine triphosphatase (ITPase) deficiency protects against ribavirin (RBV)-induced anemia, but that it is not associated with sustained virological response (SVR) to pegylated interferon (Peg-IFN)-α-2a/RBV therapy in HCV genotype 1 (HCV-1)-infected patients from the CHARIOT study.

Rapid virological response (RVR) has been considered the most important predictor for SVR, and an abbreviated treatment regimen was encouraged in patients with RVR and a low viral load.[2,3] We wonder whether RVR (32.8%) had any effect on the result of the association between SVR and hemoglobin decline or upon RBV pharmacokinetics in the study by Holmes et al.[1] It is known that plasma RBV levels at week 8, rather than the actual hemoglobin levels or ITPase deficiency in patients with HCV-1[1] and genotype 2/3 infection,[1,4] have been associated with SVR. Since the very important role of the genetic variation in interleukin (IL)28B on predicting response to Peg-IFN-based therapies either without[3,5,6] or with new direct antiviral agents[7] has been recognized, it seems also necessary to take the IL28B genotype into consideration in elucidating the influence of RBV levels on SVR in HCV-1 patients, without otherwise detracting from the results by Holmes et al.[1]

CHIA-YEN DAI, M.D., PH.D.[1,2,3]
MING-LUNG YU, M.D., PH.D.[1,2,3]
WAN-LONG CHUANG, M.D., PH.D.[1,2]
[1]*Hepatobiliary Division*
Department of Internal Medicine
Kaohsiung Medical University Hospital
Kaohsiung Medical University
Kaohsiung, Taiwan
[2]*Hepatitis Center*
Kaohsiung Medical University Hospital
Kaohsiung Medical University
Kaohsiung, Taiwan
[3]*Center for Health Management*
Kaohsiung Medical University Hospital
Kaohsiung Medical University
Kaohsiung, Taiwan