was high heterogeneity among the studies (OR 0.25, 95% CI 0.10-0.64, \( P = 0.003; \) \( I^2 = 61\%\), \( P \) for heterogeneity = 0.02; Figure 1A). Since the heterogeneity was high, sensitivity analysis was performed by sequential omission of individual studies. When we pooled the OR by excluding the study by Lutz et al,\(^2\) the heterogeneity became clearly insignificant and the estimated effect did change a lot (OR 0.18, 95% CI 0.10-0.33, \( P < 0.0001; \) \( I^2 = 0\%\), \( P \) for heterogeneity = 0.86; Figure 1B). After comparison, we found that participants’ disease in Lutz’s study was more serious and the duration of follow-up (only 4 weeks) was much shorter than others. These factors may contribute to the high heterogeneity between studies.

In addition, the overall safety of rifaximin was high with no serious adverse events reported in these studies. Gastrointestinal symptoms (nausea, vomiting and abdominal cramps) were the most common adverse effects.

In conclusion, we appreciate Goel et al for their systemic review and meta-analysis. Our analysis with larger sample size also shows that compared with no antibiotics use, rifaximin can significantly reduce the risk of SBP in cirrhotic patients and could play a preventative role.

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LINKED CONTENT

This article is linked to Goel et al paper. To view this article visit https://doi.org/10.1111/apt.14361.

REFERENCES


Letter: what gastroenterologists should know about VSL#3

EDITORS.
I read with interest the review by McIlroy et al.\(^1\) about the therapeutic approaches focused on the modulation of microbiome in inflammatory bowel diseases, probiotics and prebiotics included.

The eight strain high concentration probiotic formulation that I invented (US patent no. 5,716,615) is formulated to deliver a certain enzymatic, biochemical and immunological activity to humans through oral consumption. This formulation (now called the De Simone Formulation) has been the subject of over 60 clinical trials while sold under the trademark VSL#3 (own by Actial Srl, Italy). It must be clarified that currently my formulation is no longer available under the brand VSL#3 and therefore it is not the formulation distributed today by Ferring in Europe and Canada. It is not sufficiently accurate for McIlroy et al to describe the formulation with “the most available evidence to date” as
"a probiotic mix of 4 lactobacilli, 3 bifidobacteria and a Streptococcus."
The specific strains present in the formulation previously studied and endorsed by the Gastroenterology Associations for pouchitis and IBD should be stated: that is, Lactobacillus paracasei DSM 24734, Lactobacillus plantarum DSM 24730, Lactobacillus acidophilus DSM 24735, Lactobacillus delbrueckii subspecies bulgaricus DSM 24734, Bifidobacterium longum DSM 24736, Bifidibacterium infantis DSM 24737, Bifidobacterium breve DSM 24732 e Streptococcus thermophilus DSM 24731. In this same journal, Derwa et al.2 clearly stated "the bacterial composition of this product has recently been altered in the United Kingdom and Holland which may limit the applicability of these findings in IBD populations in these countries." Moreover, several peer reviewed publications raised concerns regarding the strain composition, efficacy and safety of the new formulation promoted under the trademark VSL#3.3-6 As a medical doctor and inventor of the formulation, I believe this should be known to doctors and patients.

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REFERENCES


LETTER TO THE EDITORS

Letter: nutritional benefits of rifaximin in cirrhotic patients

EDITORS,

We read with interest the article by Kang et al who reported the impact of rifaximin (RFX) treatment on overall survival in cirrhosis. Through decrease in the occurrence of portal hypertension complications such as hepatic encephalopathy (HE) recurrence, spontaneous bacterial peritonitis and variceal bleeding, rifaximin treatment was significantly associated with a lower risk of death among cirrhotic patients experiencing HE.1

Nutritional status has been recently identified as an independent predictor of survival in cirrhotic patients.2 Thus, loss of skeletal muscle mass assessed using measurement of psoas muscle area (PMA),3 has been associated with a poorer prognosis in cirrhotic patients waiting for liver transplantation (LT), and with an increased risk of complications after LT.4,5 To investigate the impact of RFX treatment on nutritional status, we conducted a retrospective study on a cohort of cirrhotic patients who received RFX for secondary prophylaxis of HE. Among the 86 patients who received RFX between June 2015 and October 2016, a total of 10 cirrhotic patients who were treated with RFX for more than 3 months, and with available CT scan before and after at least 3 months post-RFX were included in the study. All these 10 patients had been evaluated for transjugular intrahepatic portosystemic shunt (TIPSS). Five of them underwent TIPSS placement and developed post-TIPSS HE, and TIPSS was contraindicated in the remaining five patients because of pre-existing HE. The characteristics of these patients are reported in Table 1.

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