

**Authors' reply to the comment  
"High-dose, high-frequency  
infliximab: A novel treatment  
paradigm for hidradenitis  
suppurativa"**



*To the Editor:* We appreciate the interest of Adelman et al<sup>1</sup> in our recent study regarding the efficacy of high-dose, high-frequency infliximab (IFX) in the treatment of moderate to severe hidradenitis suppurativa (HS).<sup>2</sup> We agree with the importance of highlighting potential differences in cross-institutional experiences so that we may learn from these past cases and optimize patient outcomes moving forward. In our prospective study, we demonstrate that initiating patients on IFX 7.5 mg/kg every 4 weeks, with possible dose-escalation to 10 mg/kg, improves disease and pain control in patients with moderate to severe HS.

A retrospective study by Adelman et al<sup>1</sup> found that a greater proportion of patients (10 of 51) experienced "infusion-related reactions"; however, the dose and frequency of IFX in these patients remains unclear. Another important factor to consider would be how long the patients were on IFX before developing symptoms and whether they had any lapses (or "drug holidays") in their treatments. Further characterization of this cohort may provide important context, given the greater risk of developing severe infusion reactions to IFX in the presence of anti-IFX antibodies.<sup>3</sup> Luber et al<sup>4</sup> also describe the increased risk of infusion reactions after the development of anti-IFX antibodies. Given the 9.5-day half-life of IFX, one hypothesis may be that longer treatment intervals lead to lower drug troughs, thereby increasing the risk of developing anti-IFX antibodies.<sup>5</sup>

Adelman et al<sup>1</sup> reported adverse infusion reactions, including hives, palpitations, rigors, anaphylaxis, and most often, shortness of breath. In their commentary, they suggest these symptoms may be attributed to immunoglobulin E-mediated or mast cell histamine release. As part of our infusion center protocol, all of our patients are pretreated with a low dose of diphenhydramine and acetaminophen before IFX. Pretreatment with diphenhydramine may prevent such reactions, and providers should consider adding this to the prophylactic management of IFX infusion reactions.

We agree with the authors that more prospective studies are needed with long-term follow-up to properly assess the relative risks and benefits of this treatment in HS. Limitations of our study include a relatively short interval of prospective follow-up.

Long-term prospective studies of our population may provide greater information regarding the durability of high-dose, high-frequency IFX efficacy and the risk of developing adverse reactions in the future.

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*Funding sources:* Dr Johnston was supported by Einstein's Medical Scientist Training Program, National Institutes of Health, National Institute of General Medical Sciences grant T32 GM007288.

*IRB approval status:* Reviewed and approved by the Albert Einstein College of Medicine/Montefiore Medical Center Institutional Review Board.

*Reprints not available from the authors.*

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**Conflicts of interest**

Dr Cohen discloses the following conflicts of interest: principal investigator and advisory board for AbbVie, Inc, and advisory board for Verrica Pharmaceuticals. Drs Ghias, Johnston, Kutner, Micheletti, and Hosgood have no conflicts of interest to declare.

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<https://doi.org/10.1016/j.jaad.2020.11.041>