

Correspondence

Should clinicians use omalizumab for the treatment of nasal polyps?

To the Editor:

We read with interest the article entitled “Omalizumab is effective in allergic and nonallergic patients with nasal polyps and asthma” by Gevaert et al¹ and the accompanying editorial by Kern.² The study provides excellent clinical and biomarker data in a small group of patients, strongly implicating that IgE plays a role in the pathophysiology of nasal polyps in asthmatic individuals with and without positive skin test results.

Our major concern is the clinical implication that this study provides a rationale to treat polyp patients with anti-IgE, a concept that is promoted in Kern’s editorial. While we strongly agree with the urgent need for additional effective treatments in cases of refractory nasal polyps, the design of Gevaert et al’s study is insufficient to draw such clinical conclusions. The primary reason is that neither of their study groups (placebo or anti-IgE) received any treatment for nasal polyps during the clinical trial (information not readily accessible in the article or discussed). Defining the enrolled patients as refractory to treatment, and then withdrawing all antipolyp therapy before initiating the trial, does not prove that anti-IgE therapy provides superior clinical benefit over standard therapy.

Gevaert et al’s study contrasts with our negative study in a similar group of patients who were aggressively treated with medical therapies including intranasal steroids, leukotriene modifiers, and saline irrigations, and, when indicated, short courses of prednisone and antibiotics.³ In our randomized, placebo-controlled, double-blind study, anti-IgE therapy did not add to the clinical benefit of medical management. Our study is far from being a definitive negative trial given its limited power due to a similarly small sample size, but it did highlight one important point: showing a difference between standard (if mostly ineffective) clinical regimens and novel treatments such as anti-IgE is a difficult challenge for clinical researchers in this field.

Thus, we believe that the results of Gevaert et al’s study show a role for IgE in nasal polyp patients with asthma. However, we feel that this study merely suggests the need for a clinical trial that looks specifically at the clinical relevance of this therapy compared with current clinical therapy. In such a trial, patients refractory to standard therapy would be kept on it and then randomized to placebo or anti-IgE therapy. We worry that clinicians will use this study to justify the use of anti-IgE therapy in the management of nasal polyps. Unfortunately, because of the design of the trial, its results offer no information on whether anti-IgE is better than the arsenal of therapies currently available to them.

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