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Reply

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The letter by Özsoylu emphasizes the good results of high-dose methylprednisolone (MP) administered to patients with aplastic anaemia (AA) following hepatitis. In his original paper [1], only 7 out of 28 patients had severe AA according to the criteria of the International Aplastic Anemia Study Group [2]. Although 2 of his 3 patients with AA following hepatitis showed a good response to the above-mentioned treatment, the degree of severity of AA in such patients was not specified and, moreover, a relapse was observed at 19 months in 1 of them. (In his letter the author states that there were 3 responders out of 4 treated patients. However, in his own original paper there were only 2 responders out of 3 patients.)

The purpose of our report [3] was merely to describe the first well-established case of AA following hepatitis A, without making any discussion about the merits of the different available treatments. It is well known that currently in young people with an HLA-compatible donor the best treatment for severe AA is bone marrow transplantation [4]. Otherwise, immuno-suppressive treatment should be administered. We are not aware of any randomized trial comparing MP versus antithymocyte globulin (ATG). In a non-randomized study of the European Group of Bone Marrow Transplant [5] analysing the influence of immuno-suppression on the survival of patients with severe AA, no statistical differences were found between ATG and high-dose MP. According to these results, we chose ATG to treat our patient's AA, and low-dose MP was added to prevent the adverse reactions of ATG, but not as a treatment for the AA. Although we appreciate the interesting comments by Dr. Özsoylu, it seems clear enough from the available data that there is no convincing evidence of any superiority of MP over ATG in this clinical setting.

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