Letters to the Editor

Author's answer: Biosimilar therapy for inflammatory bowel disease

Key words: Inflammatory bowel disease. Biosimilar. EMA. SEPD.

Dear Editor,

We are sincerely grateful to the authors of the letter to the editor "Biosimilar therapy for inflammatory bowel disease" (1) for the attention they paid to the joint positioning paper published by Sociedad Española de Patología Digestiva (SEPD) and Sociedad Española de Farmacología (SEF) approximately one year ago (2).

We are glad they endorse the positioning's primary conclusions, particularly regarding the importance of non-interchangeability, and the need for specific product identification and medical indication, which should always govern the use of this kind of therapies. Especially because these necessary conditions were not so clear at the time of writing and publication. Of course, we are willing to comment on the apparent discrepancy they point out, regarding the fact that approval by the European Medicines Agency (EMA) should be guarantee enough to accept extrapolated indications.

First and foremost, the fact that this is a *post-hoc* criticism should be highlighted. When the joint positioning statement by SEPD and SEF was published, the EMA had taken no stand yet, hence a negative judgment cannot be attributed to us on the authority of this agency or the evidence that eventually led them to accept that biological comparability between original monoclonal antibodies and biosimilars suffices to authorize such extrapolation. Our task force is presently working on an updated positioning statement that will shortly be submitted to *Revista Española*

de Enfermedades Digestivas (REED) precisely to discuss such evidence, hence we consider that the appraisals by Avendaño et al. have the advantage of betting on a sure thing that to us was merely a potential scenario depending on then inexorable evidence. We simply voiced our confidence in the EMA and AEMPMS, and strongly advocated that these agencies are precisely the best guarantee available, even though, indeed, we eventually suggested that approval based on clinical outcomes for rheumatoid arthritis will not necessarily warrant the final effectiveness of these biosimilar complexes in inflammatory bowel disease (IBD). To be fair, the opinion expressed by Avendaño et al. should have joined in an evolutionary manner this scientific debate as a new contribution discussing new evidence rather than sheer criticism to a previous paper that simply could not include them.

Nevertheless, without going into further details regarding the solidity of EMA's argumentations, which will no doubt be discussed in our upcoming review, this being why we invite Avendaño et al. to postpone their scientific debate on our assessment until it does take place, we do deem it relevant to highlight the importance of not shutting just down the need for submitting clinical evidence before enshrining the use of any drug, an aspect on which, again, we are sure to agree with our questioners. Even if we endorse that pharmacological reasons exist to accept a relevant biosimilarity that would overlap the new drug's spectrum of use on the original's, we clearly want to be cautious on this subject –and we all seemingly agree on this point– by ensuring close pharmacovigilance, indispensable traceability and non-interchangeability, and stringent clinical criteria regarding indication. That is, even if the drug receives approval, it will not replace the originals as their equivalent, which it is not, but will be added to the armamentarium as a biosimilar. This clearly implies that providing clinical evidence is necessary to claim sometime in the future that biosimilars indeed fulfil our present expectations. Thus, in our opinion, clinical research on monoclonal antibody biosimilars is an essential requirement as regards their indication for IBD. Whether regulations place this before or after authorization is a different story. To this day, we clinicians used to discuss clinical evidence for any new drug before authorization regarding each and every indication. The advent of generics forced us to accept and understand that an equivalent drug is by definition a

drug that is identical to the original one, and that no new clinical research but only regulatory warranties applied. However, we all agree that monoclonal antibody biosimilars represent a new frontier. Hence our prudence and above all our desire that their use be discussed in the scientific setting of clinical research with accessible publications rather than just in the previous stage of an agency judgment, no matter how solid or rigorous it may be. On the frontier of the foreseeable incorporation of biosimilars to the therapeutic armamentarium for IBD, we all –and most particularly clinicians– are responsible for the assessment of these new products' real effectiveness, not just their safety.

Federico Argüelles-Arias, Manuel Barreiro-de-Acosta,
Fernando Carballo, Joaquín Hinojosa and Teresa Tejerina

*Grupo de Trabajo Multidisciplinar en Biosimilares y
Enfermedad Inflamatoria Intestinal de la Sociedad Española
de Patología Digestiva y de la Sociedad Española
de Farmacología*

References

1. Avendaño-Solá C, Panés J, Calvo G. Biosimilar therapy for inflammatory bowel disease. *Rev Esp Enferm Dig* 2014;106:65-6
2. Argüelles-Arias F, Barreiro-de-Acosta M, Carballo F, Hinojosa J, Tejerina T. Joint position statement by Spanish Society of Gastroenterology and Spanish Society of Pharmacology on biosimilar therapy for inflammatory bowel disease. *Rev Esp Enferm Dig* 2013;105:37-43.