Response to: ’Comment on: ‘Successful remission with tofacitinib in a patient with refractory Takayasu arteritis complicated by ulcerative colitis’ by Kuwabara et al’ by Rios Rodriguez et al

We thank Rios Rodriguez et al for sharing their interesting case with us. Both of us reported that tofacitinib, a janus kinase (JAK) inhibitor, showed a favourable therapeutic effect in each patient with Takayasu arteritis (TAK) complicated by ulcerative colitis1 or psoriatic arthritis.2 These complications are in the same spectrum as spondyloarthritis, in which IL-23/Th17 axis plays an important pathophysiological role and the effectiveness of JAK inhibitors was demonstrated by randomised control studies.3 As Rios Rodriguez et al mentioned, some population of TAK has the overlapped features with spondyloarthritis.4 It is not unexpected if JAK inhibitors are effective in the population of TAK. But, it is unclear if JAK inhibitors are broadly useful in patients with TAK due to the heterogeneity of the disease. Th1/Th17-mediated autoimmunity is thought to be the main pathogenesis of TAK, whereas B cells and granulocytes also contribute to the development of vascular inflammation in TAK.5 Rituximab may be more feasible for B cell-dominant TAK,6 and tumour necrosis factor-α inhibitors may be suitable for granulocyte-dominant TAK.7 We believe that a large-scale randomised control trial should be conducted to clarify whether JAK inhibitors are effective in the whole population of TAK. JAK inhibitors have been tested in many clinical trials as a promising drug for various rheumatic diseases.8 If the indications for JAK inhibitors are expanded including TAK, we have to pay close attention to the safety as well as the efficacy in clinical practice. We and Rios Rodriguez et al described successful implementation of JAK inhibition therapy in patients with TAK.

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