

**Campylobacter concisus**: a New Character in the Crohn’s Disease Story?

I read with extreme interest the article by Zhang et al. (7) about a high prevalence of *Campylobacter concisus* DNA as well as of immunoglobulin G antibodies to *C. concisus* in children with Crohn’s disease. The role of bacteria in the pathogenesis of inflammatory bowel disease is well recognized, but an individual responsible microorganism had not been singled out so far (3). The finding that this particular bacterium, already pinpointed as an emerging pathogen in enteric infections (4), may have a pathogenic role in Crohn’s disease provides further evidence of the possible therapeutic role of antibiotics and probiotics for that disorder (3).

In this respect, rifaximin, a nonadsorbable antibiotic endowed with strong activity against *Campylobacter* species (2) and devoid of systemic side effects, appears to be a very promising agent.

The results of both open-label (6) and double-blind, placebo-controlled (5) studies have suggested that rifaximin can be effective for active Crohn’s disease, although very high doses, up to 1,600 mg daily, may be necessary (5). A case series has recently reported that a short-term rifaximin course followed by long-term administration of probiotics can induce and maintain remission of Crohn’s disease (1).

Similarly, my coworkers and I observed that in patients intolerant to mesalamine and for whom immunosuppressants were not indicated, a 3-month combined therapy with rifaximin at 400 mg in the evening and *Saccharomyces boulardii* at 500 mg in the morning was able to effectively prevent clinical relapses (M. Guslandi, A. Celli, and P. A. Testoni, unpublished results).

Obviously, further studies are needed to confirm and expand the data from Zhang et al. before it can be claimed that *C. concisus* represents for Crohn’s disease what *Helicobacter pylori* (formerly known as *Campylobacter pylori*, incidentally) is for peptic ulcer disease. Nevertheless, I believe that the identification of this new pathogen constitutes an important step in the understanding of the mechanisms involved in Crohn’s disease and of a more suitable therapeutic approach.

**REFERENCES**


**Authors’ Reply**

We would like to thank Dr. Mario Guslandi for his comments on our study “Detection and Isolation of *Campylobacter* Species Other Than *C. jejuni* from Children with Crohn’s Disease” (1). As pointed out by Dr. Guslandi, our findings of a significantly higher prevalence of *Campylobacter concisus* in intestinal biopsy specimens from children with Crohn’s disease (CD) than in controls are indeed interesting results. However, while this study provides important preliminary data regarding a possible role for *C. concisus* in CD, it does not, as yet, prove a causative role for *C. concisus* in CD. Further studies are clearly required.

In his letter, Dr. Guslandi presents some interesting data showing that rifaximin is beneficial in the treatment of CD and suggests that this efficacy may relate to the eradication of *Campylobacter* species. While this may be possible, given that rifaximin is a broad-spectrum antimicrobial agent, it can also target a range of other susceptible intestinal bacteria in addition to *Campylobacter* species.

To prove a causative role for *C. concisus*, a well-designed clinical trial that examines not only clinical outcomes but also the effects of rifaximin on the intestinal flora, including *C. concisus*, is required.

**REFERENCE**
