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Editorial

Siltuximab from Clinical Trial to Real Life

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I am writing to express my appreciation for the ongoing discourse regarding treatment options for Castleman [1,2] disease with Siltuximab. The evidence supporting Siltuximab's efficacy is compelling, demonstrating substantial improvements in both clinical symptoms and quality of life for patients with multicentric Castleman disease. This evidence is based on the C0328T0) and the CNTO328MCD2001 study showing that the 34% of the patients achieve a tumoral response and an improvement of the symptomatology. Even though Castleman´s disease is a rare condition we have two patients treated with

Siltuximab

The first one was a 56-year-old man with pathological cervical and supraclavicular lymphadenopathy with airway compromise and a diagnosis of multicentric [3,4]. Castleman´s disease with plasmatic cell producers of IgG4 without organic failure and without relevant alterations in the hemogram the HHV-8 serology was negative [5]. It was treated with Rituximab + prednisone in first line and was changed to siltuximab (24 doses) and the best response achieve was a stability and must be changed due to a discreet progression. The second one was 62-year-old women in study for constitutional syndrome, normocytic anaemia and unspecific polyclonal gammopathy with a diagnosis of Castleman´s disease rich plasmatic cell variant, HVV-8 negative and a renal failure as an organic symptom secondary to a renal amyloidosis that is a secondary pathology with some reported in the bibliography.

Siltixumab was initiated and after 6 cycles of the patient was reevaluated with a creatinine in 6.65 mg/dL and a proteinuria in nephrotic range and haemodialysis was initiated 3 times per week. Even though two clinical studies endorse the efficacy of siltuximab in Castleman´s disease our limited experience is not as encouraging as the one in clinical trials. In the first patient the clinical was scarce but the radiological improvement was none, in the second one the clinical objective was to avoid haemodialysis and was a failure.

Furthermore, I urge the medical community to continue exploring Siltuximab given the heterogeneity of Castleman disease, it is essential to identify which subsets of patients might obtain the most benefit from this therapy. In conclusion, Siltuximab represents a significant advancement in the management of Castleman disease, yet further research is necessary to optimize treatment strategies. I look forward to seeing more studies that will illuminate the full potential of this promising agent.

Thank you for considering my thoughts on this important topic.

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