

Authors' reply

We thank Parameswaran et al for their interest and cogent comments^[1] on our article on belatacept. We have already mentioned in our paper^[2] that a major limitation of belatacept is its intravenous route of administration. In developing countries like India patients invariably end up making frequent visits to the hospital to receive medication. A once monthly injection of belatacept should rather reduce the frequency of his/her hospital visits and ensure better compliance. We do agree with him that tacrolimus would have been a better comparator in the trial as it is the first-line drug for maintenance immunosuppression in postrenal transplant patients. However considering the fact that tacrolimus was not approved for coadministration with mycophenolate mofetil at the time of commencement of the BENEFIT trial in 2008 by the US FDA,^[3] cyclosporine was preferred instead. Tacrolimus being a CYP3A4 substrate is known to have drug interactions with several drugs. The incidence of nephrotoxicity matches with that of cyclosporine, and there is an increased frequency of insulin-dependent diabetes mellitus.^[4,5] These disadvantages of tacrolimus may be circumvented to a certain extent with belatacept. A study is now underway that compares

belatacept over tacrolimus or cyclosporine.^[6] The results of this study would be able to answer the question of belatacept's superiority over tacrolimus.

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