Dear Editor,

We thank Nunn and Tweed for their response to our paper published in the July edition of The International Journal of Tuberculosis and Lung Disease.[1] The authors raise a valid point regarding the potential difficulty of patient identification and accrual if running a trial comparing different treatment regimens in patients with rifampicin (RIF) monoresistant tuberculosis disease. The advent of Xpert MTB/RIF may also make country-specific estimation of the burden of non-multidrug resistant (MDR) RIF resistant disease increasingly difficult- a critical figure in the planning of such studies- as MDR and non-MDR RIF resistance is often reported as a composite value.[2]

An up-to-date systematic review of the literature for non-RIF containing regimens utilised in drug sensitive patients would undoubtedly be beneficial. Indeed, this would require similar search terms to those employed by our original study (as drug resistance terms were not included);[1;3] we would welcome members of the research community building upon this work.

We also agree that a role for RIF in the treatment of RIF resistant disease cannot be ruled out and will likely depend upon phenotypic levels of resistance. A systematic review and meta-regression of trial data by Menzies *et al*. published in 2009 examined the influence of different baseline drug resistance patterns (including non-MDR isoniazid resistance, but not RIF resistance) and RIF duration on rates of treatment failure, relapse and acquisition of additional drug resistance.[4] It would be informative to undertake something similar for non-MDR RIF resistant tuberculosis using trial and observational data to evaluate the role of RIF in more detail.

Yours faithfully,

Helen R. Stagg[a]
Ross J. Harris[b]
Marc C. Lipman[a,c]
on behalf of the authors

[a] University College London, United Kingdom
[b] Public Health England, United Kingdom
[c] Royal Free London National Health Service Foundation Trust, United Kingdom

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