

## Answer to the letter AL amyloidosis: an epidemiological and clinical challenge

To the Editor:

The interest in our paper and the letter by Jimenez-Zepeda is acknowledged. We feel obliged to make the following statements in response to his comments:

Second-generation studies to search for immunoglobulins free light chains (FLC) are currently unavailable in Mexico. We have just reviewed our experience with total light chain measurements and found that its sensitivity is not better than that of serum immunofixation (Zamora-Ortiz G, Velázquez-Sánchez-de-Cima S, Hernández-Reyes J, Ruiz-Argüelles A, Ruiz-Delgado GJ, Ruiz-Argüelles GJ. Is the serum light chain quantification more sensitive than immunofixation in the diagnosis and follow up of patients with multiple myeloma? Submitted). It is obvious that we did not use second generation FLC assays.

Reference number 2 in the paper clearly states that: "in the city of Puebla, in a group of 272 individuals aged above 70 years and living in three retirement houses, we found two persons with monoclonal gammopathy of undetermined significance, this representing 0.7%, a figure well below that informed in Caucasians, which is 3%". This epidemiological figure, together with the information contained in references 2 to 6 of our paper support the idea of a genetic predisposition of monoclonal gammopathies, which has been widely studied and published.

We did not employ laser micro dissection/mass spectrometry testing to define the diagnosis of

amyloidosis as my friends and colleagues from Mayo Clinic do. Accordingly, we clearly state in the manuscript that: "...*this condition is probably under-diagnosed in México...*"

In a retrospective study it is difficult to analyze response assessment and several lines of therapy. However, we do indicate that: "Of the 23 patients, 17 were followed for more than three months (90 to 5190 days, median 1830 days. Of these, 8 patients were treated with M / P, 12 were treated with thal/dex and 5 were given an autologous peripheral blood stem cell allograft after being given thal/dex."

As far as bone lesions is concerned, the text clearly indicates that: "On X ray-films, 12/17 patients (71%) had an abnormal skeletal survey: Overt osteolytic lesions in three cases, osteosclerotic lesions in three and only osteoporosis in six cases". Osteoporosis is not specific of multiple myeloma.

The overall survival analysis of the patients was done using the well known method of Kaplan and Meier, which censors individuals lost to follow up as alive when last seen. Accordingly, if 5/17 individuals have died (29%), the remaining patients were censored as alive. In addition, in the text, similar to Jimenez-Zepeda, we state that: "The high number of patients lost to follow up (7/17 = 41%) mainly for economical reasons is concerning and makes the survival analysis rather questionable."

We do hope that these explanations make clear some points and add to the information provided by our study, which, as indicated in the text, is the first one dealing with the salient features of this disease in México.

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*Recibido el 16 de mayo de 2013.*  
*Aceptado el 25 de junio de 2013.*