

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.comhttps://crohnscolitisprofessional.org/clinical-topics/symptoms-diagnosis/overview-medications-used-ibd-management/11721/>

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An Overview of Medications Used in IBD Management

Ms. Perkovich:

Hi, I'm Ashley Perkovich. I'm a nurse practitioner from the University of Chicago Medicine, and I'm going to give an overview on medications used in inflammatory bowel diseases.

IBD is a chronic disease that requires medication compliance to keep the disease in remission, prevent complications, such as structural damage to the bowels, and patient education is very important for these issues. Medications used in inflammatory bowel disease are over-the-counter medications, antibiotics, mesalamines, corticosteroids, immunomodulators, biologics and JAK inhibitors. Over-the-counter medications are used to address symptoms only. These include antidiarrheal agents, laxatives, and pain relievers. It's important to note that NSAIDs, such as ibuprofen, may cause or worsen GI irritation, so Tylenol-based products are definitely preferred.

Antibiotics are effective in managing pouchitis in patients with perianal fistulas and abscesses and in some patients with inflammatory Crohn's disease. However, antibiotics are generally not useful in ulcerative colitis. There are some risks associated with antibiotics, such as bacterial resistance. Also, sometimes antibiotics will give patients side effects of abdominal cramping and diarrhea, and it also poses a risk for *Clostridium difficile*.

Mesalamines, also known as 5-ASAs, are useful in preventing relapses and maintaining remission. They are generally well tolerated with only about 3% of patients having an allergy or an intolerance to these medications. Mesalamines are formulated to release medication to specific areas of the bowel, and they are most effective in treating ulcerative colitis, but not so much in Crohn's disease. However, sometimes they're used off-label.

Corticosteroids are effective in inducing a remission. However, it's very important that you're not using these frequently in patients as they have many side effects including infection, sleep disturbance, mood swings, weight gain, growth delay and bone loss, just to name a few. Often times when patients require corticosteroids for an extended period of time, they often need to taper the medication so that they don't have withdrawal symptoms. And a clinical tip is to always use budesonide first, whenever possible, opposed to systemic steroids.

Immunomodulators, such as azathioprine, mercaptopurine and methotrexate, are used to quiet down the immune system. These are used for maintenance of remission. However, these medications generally take a while to work, so they're usually used along with another medication, often times a steroid, to get patients into remission. There are some risks associated with immunomodulators, such as a low white blood cell count, changes in liver function tests, infection, and also a rare risk of lymphoma, so these medications require very close monitoring of labs while initiating and also maintaining therapy. These medications, azathioprine and mercaptopurine, can also be individualized by checking a TPMT prior to starting, and thiopurine metabolites once they're on a dose to see if it's the correct dose for them. Methotrexate is a little bit different, and it's dosed once weekly instead of a daily medicine as azathioprine and mercaptopurine.

Biologics are indicated for moderate-to-severe disease. These are designer drugs made to specifically block inflammation or stimulate anti-inflammatory processes. Sixty to 80% of patients respond to biologics within a few doses. There are some risks, though. All biologics currently approved for ulcerative colitis and Crohn's disease are given by infusion or injection, so injection site reaction is a risk as well as a risk for infection.

Biosimilars are something new in the field of IBD. These are biologics that are highly similar to the reference product with no clinically meaningful difference in terms of safety profile, purity and potency but are often more cost effective.

Next, we have JAK inhibitors. These are chemically active substances that are broken down in the GI tract after ingestion and are directly absorbed into the bloodstream via the intestinal wall. This class of medication works to easily block multiple pathways of inflammation directly at the site. In addition, due to the small size of these chemically active substances, they can be transported to nearly any site in the body through the bloodstream, including to the immune system.

Tofacitinib is a newly approved medication for the treatment of ulcerative colitis as it targets a very specific molecule in the inflammatory process.

Research advances have contributed to breakthroughs in the development of newer medical options for the treatment of IBD. Further developments may lead to expanding how currently approved medications are used in other diseases, including Crohn's disease and ulcerative colitis.

Personalized medicine is a broad concept that includes the right drug, the right dose, the right patient, the right route and the right time. Personalized medicine also utilizes biologic markers that predict response to treatment and patient involvement and decision-making and self-management. Personalized medicine also uses therapeutic drug monitoring, which is dose adjustment and titration based on serum drug concentrations, antibodies and enzyme activity. In my practice, I like to send a biologic marker, such as a CRP or fecal calprotectin, prior to starting therapy and 3 to 6 months after they've been on therapy to compare the efficacy of the therapy itself.

So, goals of medical therapy and IBD are to definitely, and number one, limit steroid exposure, limit narcotic use. It's also important to recognize when your patient is not responding to therapy, which is why I check those biomarkers before starting therapy and then routinely thereafter. When they're not responding, it's important to change therapy or escalate as appropriate. Also, make sure to remember that you're dose-optimizing your medications before switching therapies. As I mentioned, when using azathioprine or 6-mercaptopurine, you can check a thiopurine metabolite level to see if that dose is right for your patient. And also, remember to treat to target. Symptom relief is important, but it doesn't always correlate with inflammation activity. So, the treat-to-target concept uses serial objective evaluations of inflammation including biochemical, radiological and endoscopic. A clinical, endoscopic and histologic remission is a deep remission, which is our goal for patients.

So, to summarize, first you want to get your patient into remission, so to induce that remission you're going to turn off that inflammation, get your patient feeling well and normalize their labs. Next, you want to maintain that remission, and this does not include steroids. You want to make sure that you're getting stable disease control by optimizing their therapy. Next, you want to monitor their disease and prevent relapses and flares and prevent other things, such as infections and cancer.

The Crohn's and Colitis Foundation has many resources on their website for providers and patients. Please check out crohnscolitisfoundation.org for these resources.