Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/beyond-one-size-fits-all-individualizing-first-line-ibd-treatment/60776/

Released: 06/02/2026
Valid until: 06/30/2027
Time needed to complete: 2h 08m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Beyond One-Size-Fits-All: Individualizing First-Line IBD Treatment

Announcer:
You're listening to GLC on ReachMD. This activity is provided by Global Learning Collaborative and is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Dolinger:
When initiating therapy in IBD, clinicians aren't choosing from a single algorithm, we're choosing the most effective therapy only; they're navigating disease severity, comorbidities, safety considerations, access issues, and patient preferences, often without clear comparative or predictive data to guide them. In the next few minutes, we'll unpack how clinicians can navigate these competing factors to make more confident first-line treatment decisions.

I'm Dr. Michael Dolinger, and here today with me is Dr. Damie Odufalu.

Damie, when you're selecting an initial therapy for IBD, what are some key factors that you take into consideration?

Dr. Odufalu:
Hi Mike. Thanks for that question. And answering that is a real challenge, especially with this expanding landscape of new and effective IBD therapies for both Crohn's disease and ulcerative colitis. For me, I think it's really understanding at the onset what the patient's disease severity, phenotype, and distribution is when I meet them in consultation, as well as in follow-up.

In Crohn's disease, I like to categorize patients into low risk and high risk. Specifically are what's their age at diagnosis? Do they have signs and features of aggressive disease, specifically stricturing? Complications with abscess? Are they hospitalized? Has their disease presentation progressed rapidly since the onset of symptoms? And then in UC, categorizing again in low risk and high risk, are they at high risk for colectomy? Are they at high risk for malignancy with long-term symptoms and long-term evidence of inflammation on their colonoscopy? And so when I meet patients, I like to discuss with them what their disease severity is and what their risk of progression is.

And then I like to discuss with them what treatment options are available to them. I'll talk to them about specifically why I think one therapy will work better for their specific phenotype and distribution. And then I like to go over the comorbidities, as well as the mechanism of action with how these medications are administered.

Sometimes it's not just their disease, but also the patient lifestyle. And so is there needle phobia? Are the patients pregnant or lactating? Are they planning to become pregnant right away? These are all things that I like to understand at the onset when we're discussing and choosing a treatment, and then I think that helps me choose the right therapy for them.

I also want to understand what their concurrent diagnoses are. So specifically, do they have other comorbidities that may benefit from certain treatments? Or do they have other comorbidities which may make our certain treatment therapy contraindicated or more worrisome?

So addressing all of these things is a challenge, but that's why my longest visit is generally the first one, and hopefully we can lay out the

© 2026 ReachMD

framework about what we're choosing.

And then lastly understanding what their prior therapies are if they are bio-experienced. We know that a patient's best biologic is often their first biologic that we choose, and so I like to discuss with them at the onset so we can get them into remission quickly.

Dr. Dolinger:
That's great. The way you say it, is very similar to how I treat IBD and manage it as well.

Dr. Odufalu:
Excellent. It is a challenge.

But I have a question for you. So with multiple advanced therapies available but limited head-to-head data, how do you think about therapeutic positioning when starting a treatment for patients?

Dr. Dolinger:
Yeah, I think you summarized it so well with it starts with that shared decision-making model where you take individual patient preferences and see really in that first visit or when you're deciding on a therapy what they prioritize. Is it safety? Is it efficacy? Is it feeling better quickly? Is it the long-term durability of a therapy? Is it avoiding complications? Do they have another family member with IBD or another autoimmune disease who's been exposed to a therapy, and do they have preconceived notions about what therapies and how we treat IBD? Unearthing that in that shared-understanding model is really critical to guiding your patient to the right therapy for them.

In 2026 and beyond, we have so many therapeutic options that it really is individualized, and you have the ability to individualize treatment for your patient-specific needs, and there's often multiple therapies that would suffice for each individual patient. And as clinicians, we don't always get it right, so getting them on a therapy that we think may be effective early and is safe is critical.

And when you're guiding them in that discussion, you then factor in the disease-severity variables and the disease-activity variables. And the way I think about it is, who are my patients who are at the risk of disease progression? Those are in the most severe category. Example: pancolitis, Mayo 3, deep ulcers on endoscopy, Crohn's disease with transmural disease, stricturing complications, as you described earlier. And as you parse out who is in that severe group and who needs this aggressive therapeutic approach, you also understand there's a mild group who may benefit from natural approaches, diet therapy, combination strategies around their treatment, maybe around symptoms, and they're less likely to go on to maybe have surgery, hospitalizations, and steroid use.

And you really then take their activity variables, their CRP, their fecal calprotectin, and their symptoms, and combine it with their risk of progression. And when we really think about it in young women, we're thinking about fertility and their family planning. We're thinking about long-term cancer risks in patients, and we're all factoring this into the initial discussion. It makes it take hours. It can't be done quickly when you do it right for patients.

Dr. Odufalu:
Yeah Mike, thanks for that discussion. And thanks for even touching on diet, especially in more mild and moderate cases. I think that's something that we don't have all the information on, but that also is a big part of my practice and discussion with patients because patients also want to be proactive with what they are doing in their lifestyle to get better as well. So thanks for sharing that.

Well, I think we nailed it. Thanks so much, and we'll see you next time.

Announcer:
You have been listening to GLC on ReachMD. This activity is provided by Global Learning Collaborative and is part of our MinuteCE curriculum.

To receive your free CE credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.

© 2026 ReachMD