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Defining Success in IBD: Treat-to-Target

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Ms. Dudley-Brown:
The treat-to-target approach has fundamentally changed how we manage inflammatory bowel disease. Rather than focusing solely on symptom control, the goal is to achieve objective markers of disease control in order to alter the long-term course of disease. So before we talk about specific therapies, let's outline the key treatment targets that guide modern IBD management.

Hello. I'm Sharon Dudley-Brown. I'm a Nurse Practitioner at Johns Hopkins University in the IBD Center. Here with me today are Dr. Odufalu and Dr. Iroku.

Dr. Odufalu, can you walk us through how you apply a treat-to-target strategy in your clinical practice for patients with IBD?

Dr. Odufalu:
Of course, Sharon. So STRIDE-II stands for Selecting Therapeutic Targets in Inflammatory Bowel Disease. This is an update on the STRIDE-I guidelines by the International Organization of IBD. And this update is a consensus guidance on a systematic review of several data in management of IBD.

And so in the short term, the treat-to-target guidelines look at getting patients into symptomatic response and to symptomatic remission, and we want to achieve those goals early on. We know that this improves overall quality of life and can give an indicator that your therapies are working.

Dr. Iroku, how do you incorporate treat-to-target in getting to intermediate and long-term?

Dr. Iroku:
Yeah, and so I think, of course, with our short-term targets we're answering the patient's need, which is that they want to begin to feel better. And so there might be a sense that they're having less bowel movements, a sense that there's less bleeding, a sense that there's less pain, et cetera, et cetera.

When it comes to intermediate targets—and that's a couple of months into therapy, likely beyond your induction phase and into your maintenance phase of therapy. We're expecting symptomatic remission. And so that's a sense that we're not seeing blood in the stool, that their bowel movements are largely back to normal, that there's been a resolution of pain. And so that subjective marker is one

important factor that we want to reach as an intermediate target.

But not just that. We're aware that with Crohn's disease and with ulcerative colitis it's also important that we have objective markers normalized as well. And there are 2 biological markers that we look at in particular. One is CRP serum levels, and the other is our fecal calprotectin levels. And so what are those? Those are both just markers of the evidence of inflammation in the blood and in the gut. And so oftentimes we'll see CRP track with Crohn's patients and fecal calprotectin levels track with ulcerative colitis patients. Not every patient may have these, but when they do have it, these are very important noninvasive markers that we can use to determine that the overall inflammation in the gut is being resolved with our therapy. And so that's a target that should be reached, and if it isn't reached it's a warning that we might have to adjust our therapy to get our treatment under better control.

And what are some of our long-term targets? Well, that's when we start bringing in our endoscopic reassessment and making sure we have healing. We want to have a sense that there's normalization of the tissue visually in the gut—less ulcerations, less friability, and less alteration of vascularity, in addition to the clinical signs improving as well. And we also want to, beyond just the endoscope, look at the patient and make sure that the patient's doing better. They're having a normalization of their quality of life and an absence of disability. And for our pediatric patients as well, there is a normalization of their growth curve.

Dr. Odufalu:
Alright. Thank you for that in-depth explanation, Dr. Iroku. I'd like to pose a common clinical scenario with respect to treat-to-target. So say you have a patient who you start on a new therapy, and they are telling you that they feel better. However, when you look at their objective markers of inflammation, their CRP remains elevated, their fecal calprotectin remains elevated, and you do a colonoscopy; and there's still moderate to severe inflammation throughout the colon. How does that align with treat-to-target? And how do we shift gears?

Dr. Iroku:
Great question. And so this allows us an opportunity, again, to dive into some of the details with treat-to-target. And so if you see on the screen here, we have our goal C-reactive protein level improvement. We want it normalized at <5 mcg/L. And for our fecal calprotectin levels, we would like to have a sense that there's less inflammation, with normalization to numbers <150 units.

And so for ulcerative colitis, when we take a look and we do our colonoscopy, we want a sense of normalization of their Mayo Endoscopic Subscore. And when we take biopsies, we expect to see histologic remission, a sense that there's less neutrophils infiltrating the tissue of the gut, which represents a normalization of their scoring.

For Crohn's disease, we can follow a number of scoring systems, including the Simple Endoscopic Score for Crohn's Disease. And again, we expect to see endoscopic remission, <2 in the scoring, or an absence of ulceration.

And so when we're not seeing these improvements, when we're not seeing these objective markers reached, we know from studies that there is a high likelihood that our patients will have a symptomatic flare in the years to come. So it's important to make our adjustments. Sometimes that means dose adjustment, increasing the frequency of dosing. Sometimes that means dose escalation, increasing the amount of medication given at a particular time. Sometimes that means adding in a second therapy in appropriate settings. But whatever it is, it's a marker that we have to adjust our therapy now.

Ms. Dudley-Brown:
Well, this has been a great micro discussion. Thank you, Dr. Odufalu and Dr. Iroku. Our time is up. Thanks for listening.

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