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

Tailoring Treatment: Can You Select the Best Therapy?

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Dr. Rubin:
This is CE on ReachMD, and I'm Dr. David Rubin.

Ms. Hodnick:
And I'm Brooke Hodnick. Let's kick it off today by talking about your approach to individualizing treatment in inflammatory bowel disease. I think new providers and even the seasoned providers out there struggle with what to use and when to use certain therapies. Dr. Rubin, I would love for you to start with the basic principles you follow when tackling therapy selection.

Dr. Rubin:
Thanks, Brooke. Well, I think this is a really important question and one of the most challenging things that our colleagues face. So the first point is to make sure everyone understands our goal, which is remission. And I define remission to patients as being you feel perfect and it lasts forever. And then, of course, we get into details. That means no pain. It means normal stool frequency, no bleeding or urgency. And then paying attention to other things, like mental health, ability to work and take care of your family, or whatever else is important to you.

Remember that ultimately, at the end of the day, it's about quality of life, and that also includes being able to eat what you enjoy. So I try to clarify that as my first goal for patients.

The separate thing we need to remember is that up to 40% of people will have comorbid other inflammatory conditions or coexisting other problems that we should try to address when we're treating their IBD.

Ms. Hodnick:
Great. Given the evolution of treatment sequencing from the step-up approach to the top-down and treat-to-target methods, where do you start when initiating an advanced therapy in the newly diagnosed patient?

Dr. Rubin:
I think it's really important that people understand that we have some very effective therapies in our patients with Crohn's and UC, but they're only effective if we use them. And one of the points about all of this is to be comfortable using these drugs in the people who need them.

Who needs them? Well, most patients who are diagnosed with symptomatic Crohn's are going to fall into the category of moderate to severe Crohn's. So that means getting people on therapy early is going to be the best way to get them well.

And we've also learned in many studies, including a more recent one that was just published in the last year, that when you treat people early, that means getting them right on the drug as soon as they're diagnosed, you have a much greater likelihood of achieving remission. In fact, in that same study, 80% of patients achieved symptomatic response when they were treated within the first few weeks of being diagnosed with their Crohn's.

So the concept of top-down just means getting people the appropriate therapy as early as possible. And I think that's a super important point to keep in mind. Don't be shy, and don't think that giving repeated courses of steroids is the way to get people well. You need to get people on therapies that have been shown to induce steroid-free, stable remission and that prevent recurrence or progression, which is a key message when you're talking to people about managing these diseases.

We have an entire group of biological therapies. Biologics means that this is a protein made by living cells. That's all it means. And sometimes people get scared by the term, but they should understand that. And those classes of therapies include basically 3 classes: anti-TNF agents, anti-IL-23 agents, and anti-integrin therapies, and there's really only one right now, vedolizumab.

So of the IL-23 therapies, we have 3 new ones that are more selective because they target a specific protein called p19 and work really well. And in head-to-head trials against ustekinumab, which is our old friend, the first IL-23 inhibitor, they seem to work even better.

So how do you choose between these? Well, it depends on what your patient is presenting with, and it depends on whether they have any comorbid problems, and it also has to do with understanding both the efficacy and safety of these different options.

Ms. Hodnick:
It's all great information. And again, thank you for that reminder of repeating our use of steroids as well.

Well, we've talked quite a bit about biologics, but the small molecules have also become part of the conversation in the treatment-naïve setting or in early IBD management. Where do they fit in? And what clinical or patient-specific factors guide your decision to consider a small molecule?

Dr. Rubin:
Well, thanks. I consider the small molecules arriving in the world of IBD as one of the revolutions of treatment management in our field. And the reason for that is not just because they're oral, and that means they're convenient, but also because in an inflamed bowel, we've had challenges giving monoclonal antibodies, which can leak through that inflamed gut. So by giving a small molecule, it gets absorbed in the small intestine, and then we don't have to worry about that problem. So that's the first thing to keep in mind.

We have 2 classes that have been approved, the S1P receptor modulators, which are available for ulcerative colitis, and the JAK inhibitors, specifically tofacitinib and upadacitinib, also available for ulcerative colitis, but upadacitinib is also available for Crohn's disease.

And knowing how to use these and which patients to treat is a very important point. Generally speaking, any one of them can be used for moderate to severe ulcerative colitis, have a fairly rapid onset, and are well tolerated. The JAK inhibitors offer you an additional benefit, because they treat inflammatory joint problems. So if you have a patient with Crohn's or UC who has the inflamed gut and an inflamed joint, you can give upadacitinib and feel very comfortable and confident that it's going to work rapidly. And you can avoid steroids, because they work so fast.

The one thing to remember is we can't have patients who are pregnant or who are planning imminent pregnancy on any of these new small molecules. We just haven't studied them enough yet.

Ms. Hodnick:
Thank you, Dr. Rubin. Well, this has been a great micro discussion. Our time is up. Thanks for listening.

Announcer:
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