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/goals-of-managing-ibd-treating-to-target/12352/

Released: 03/17/2021
Valid until: 03/17/2022
Time needed to complete: 15 minutes

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

Goals of Managing IBD – Treating to Target

Announcer:
Welcome to CME on ReachMD. This activity, entitled “Goals of Managing IBD – Treating to Target” is provided by Prova Education.

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

Dr. Nandi:
Treat to target. That is the current standard, but understanding precisely what those targets are and how we achieve them is critical. But where do we begin, and how do we truly define therapeutic success?

Welcome to our discussion on the Goals of Managing IBD – Treating to Target. I’m Dr. Neil Nandi, and joining me today on the program is Dr. Miguel Regueiro, chair of the Division of Gastroenterology, Hepatology, and Nutrition at the Cleveland Clinic, and also champion of multidisciplinary care.

Welcome to the program, Dr. Regueiro.

Dr. Regueiro:
Thanks, Neil. I’m glad to be here.

Dr. Nandi:
We’re pleased to have you, as well. Now often, we begin these types of discussions on therapeutic success by reviewing meaningful endpoints, such as clinical and mucosal remission. But today, I’d like us to begin by reviewing equally meaningful outcomes from the patient perspective. Specifically, what are patient-reported outcomes? How do we define remission from their point of view?

Dr. Regueiro:
Yeah, so, you know, that’s an excellent question, Neil, and when we sit with our patient in the clinic and discuss outcomes, obviously one of the most important things for the patient is they want to feel better. So while we focus on mucosal healing and hard endpoints and objective data in our clinical trials, patient-reported outcomes are really how does the patient feel? So for example, for Crohn’s PRO-2 of diarrhea and pain, I think that’s really useful. For ulcerative colitis, bleeding and diarrhea. But then other symptoms – urgency, fatigue, quality of life. Quality of life is a big factor. How does it affect their school, their work, their lives? These are really, from my perspective, what the patient is most interested in. Yes, they understand mucosal healing is important, but especially in that first conversation, we really need to focus on the patient’s symptoms.

Dr. Nandi:
On that note, the definitions of clinical success have really evolved significantly over the last 10 to 15 years. We still recognize the importance of clinical response and clinical remission, but we also recognize a primary endpoint of mucosal remission. This is important because there are many times that our patients in the endoscopy suite show active mucosal disease, but the patient has no symptoms. Miguel, can you please elaborate more on each of these specific endpoints? And what endpoint should our frontline GIs really strive for? How should they approach the conversation and management of a patient with what some may call “silent disease activity”?

Dr. Regueiro:
So I think this is a key point that we've moved towards in our treat-to-target paradigm. So just to put this into perspective, many of our trials now define endpoints by clinical response, clinical remission, steroid-free remission, and then also objective endpoints such as mucosal healing, and this is true for both Crohn's and ulcerative colitis. And while the scoring scales might be different for each, these are really the parameters by which we measure outcomes and ultimately what the FDA uses to approve a medication for Crohn's or ulcerative colitis.

Now, your aspects of this clinically silent disease, this is where this treat-to-target becomes so important because we have many of our patients, especially with Crohn's disease, who may have silent disease or asymptomatic disease. And our group had actually researched this a while back, and there are some patients who have ileal Crohn's or right-sided colon Crohn's that essentially don't feel this. And when we do a colonoscopy or we do imaging, we see very significant active inflammation. Sometimes it's hard to convince the patient, who feels entirely well, that they either need to escalate or optimize therapy or even change therapy given the fact that their symptoms are so controlled. This is where, I think, the importance is from a clinician explaining to the patient that this disease burden, this ongoing inflammation, can lead to future surgery, hospitalizations, potentially cancer, and that this is an important aspect of care, that we need to heal the mucosa. We need to improve these objective findings but not lose sight of the patient's perspective in that shared decision, where the patient needs to be involved in the conversation and understand why this is such an important outcome. So that's a really excellent question that I think captures our care of IBD today.

Dr. Nandi:
Absolutely. And I think what you just said there really highlights how important it is that clinicians, when they're sitting down with their patients, explain that mucosal remission and endpoints are not only about short-term quality of life and control of symptoms, but long-term – whether they're symptomatic or not, like you mentioned – complications of active disease and scarring or fistula or cancer. You know, one phrase I use with my own patients is, "We want you to look as good on the inside as you feel on the outside," hoping to impress upon them how important it is for these mucosal assessments we put them through.

Dr. Regueiro:
Yeah, I completely agree.

Dr. Nandi:
For those just joining us, this is CME on ReachMD. I'm Dr. Neil Nandi, and I'm here today with Dr. Miguel Regueiro. We're discussing strategies for achieving complete remission for patients with inflammatory bowel disease.

Miguel, managing IBD can be tricky given the number of potential therapies and the complexity of using some of these agents. Both the American Gastroenterological Association and the American College of Gastroenterology have recently updated their guidelines. Can you please provide us some brief overview of the major practice highlights from the updated UC and Crohn's guidelines? And how can GI specialists begin to best apply some of the highlights or algorithms to clinical practice?

Dr. Regueiro:
I think the guidelines are obviously very important, but we need to apply them in a practical sense to our patient who's sitting before us in the office. And I'll be honest, sometimes there's a disconnect between the two. But just on a high level from the AGA and ACG guidelines, there have been a number of agents, and I think we're lucky now to have more agents and in the future even more expanding agents. But for example, for Crohn's disease, the positioning of anti-TNFs, IL-12/23, the integrin receptor antagonists – I think these are the key features to these guidelines. As far as ulcerative colitis, we have actually now 4 classes of medications, so the anti-TNF, IL-12/23, the integrin receptor antagonist, and then now the newest on the block, which isn't really that new anymore, the JAK inhibitors – the janus kinase inhibitors. And in the future, there will be more.

I think the guidelines are nice in that they take key important features for Crohn's and ulcerative colitis and say, "What's the high risk for progression of disease?" So to your point a minute ago as far as objective findings, so for example, deep ulcers in the colon or in the ileum for either Crohn's or ulcerative colitis would really prompt us to use these agents earlier in treatment. So all the medicines I mentioned a minute ago, the classes of medicines for Crohn's and ulcerative colitis. And then there are another number of predictors of more severe disease. So I think the guidelines are a good frame. And now it's our job, as a physician sitting with our patient, to tease out which the best treatment is for that patient based on a number of factors that might have to do with their own lifestyle, preferences, and shared decision.

Dr. Nandi:
You know, with ulcerative colitis, the extent of disease is the changing variable from patient to patient, certainly mucosal severity. In Crohn's, there is definitely different phenotypes, right? Some are inflammatory, some are fibrostenotic and stricturizing, some are penetrating fistulizing disease. Does the phenotype of Crohn's at all affect your choice of treatment?

Dr. Regueiro:
Certainly, it does. So, for example, I think there are certain predictors of more severe and aggressive disease that can lead to surgery, hospitalization, poor quality of life. And some of these, Neil, to your point about phenotypes, are do they have multiple segments of disease involved? So not just the ileum, but ileum and colon? Upper GI tract Crohn's disease is especially severe, so stomach, duodenum. When they have ulcers, the esophagus. And we put perianal Crohn's disease almost in its own category, so fistula, strictures. Those types of phenotypes are important for us in understanding the behavior of the disease. These would be aspects that would lead us to more adequate or aggressive therapy early. I think the patient that has just a single segment of Crohn's that's very mild – which is probably, in my opinion, only about 20% to 25% of the patients. 75% to 80% of the patients with Crohn's will present with those more severe predictors of progressive disease and really have earned themselves that early aggressive biologic therapy. We can't overlook that, and I'm glad you asked that because I think that's so vitally important.

Dr. Nandi:
In 2021, we're always looking for fancy markers, or, you know, we were talking a lot about personalized therapy and predictive therapies, but some of the most simple clinical markers of aggressive disease are right under our noses, right? And you highlighted them: duration of disease, severity of disease such as deep mucosal ulcers, extent of the disease, how uncontrolled the disease has been, and certainly others that we recognize – if they've had a history of surgical intervention or corticosteroid dependence. So I think those simple clinical pearls from the basic history that we get should be low threshold for a clinician to start a biologic.

So, you know, earlier we talked a little bit about suboptimal healing. So what are the strategies that you may employ in clinical practice or that you interpret from guidelines about what to do about patients with incomplete healing? How do you become more aggressive with therapy? Can you?

Dr. Regueiro:
Yeah, so I think this is pretty common. How do you optimize? One is, I think, if we get it right in induction. And what I mean by that is if we really heal the mucosa early, if we really heal that disease and inflammatory burden early with aggressive treatment. And the inductive course is so important. That actually, to me, will predict long-term success. But to your point – and I think secondly – to your point, what about the patient that maybe goes through induction or is on a therapy and they either have kind of smoldering symptoms – they're not really perfect, they're still affecting their quality of life – or you do imaging or a colonoscopy and you find that they still have active inflammation and active disease and they may be on a biologic therapy. I think then we get into how do we optimize? And I think in the anti-TNFs – and I'll say specifically with infliximab and adalimumab, there's now this concept of therapeutic drug monitoring. That means that if you have a patient who has active inflammation or ongoing symptoms that are related to active inflammation, that's when I'm checking drug levels. And proactively, often I'll check them after my induction course, and I'll want them at a certain level, and we maybe can get into some of the specifics, but we want the level at what we would consider adequate. And if they're not, I'm more likely to escalate therapy – increase the dose or shorten the interval. Similarly, if they have ongoing active inflammation and they're on that treatment, I'll check a level. And if it's sub-adequate, then I would actually increase the dose or shorten the interval. I'll tell you, Neil, for ustekinumab and vedolizumab, I'll be honest in saying that right now, I don't use therapeutic drug monitoring as much, but I will certainly optimize the treatment. And in both of those, I will shorten the interval of treatment if I see there's active, ongoing inflammation.

And then the final point that I want to make in your question is we should also not burn through our biologics or our therapies too quickly. I would much rather optimize a treatment and really try to get them under control with that agent before moving on to the next. I think we're seeing way too often we move from one treatment to the next too early, without giving it a true chance, and this is where we run into a problem, where people burn through the therapies.

Dr. Nandi:
I think that last point's really important. You're absolutely right. And if we don't do that, then what gets imprinted into the chart is that they were drug X failure, which may not have been true if we didn't push it, if we didn't maximize or optimize that medicine. So, you know, adopting these guidelines can be impacted by quite a lot of different factors. Choosing the right medicine really can be dependent upon patient preference, the route of delivery, and definitely, of course, we have to consider insurance coverage.

Dr. Regueiro:
But beyond that, I think then it gets into efficacy, safety, personal experience, guidelines, and then also route of administration. And actually, Neil, just before you go on, you did mention insurance earlier, and I didn't want to brush over that too much because that's a real-world question. And I think for those out there, probably know this, but the Crohn's and Colitis Foundation has a wonderful resource for physicians and providers in terms of letters of appeal, how we can help hopefully navigate this a bit better. We understand the time that this takes to do these appeals, but using resources like the CCF – Crohn's Colitis Foundation – has been, in my practice, very helpful as well.

Dr. Nandi:
And those are all free for download and customization at the CCF, or Crohn's and Colitis Foundation's website. And of course, the ACG and AGA guidelines also provide more meat and substance to supplement your letters of appeal.

Miguel, before we wrap up, do you have any last take-home messages to share with our audience?

Dr. Regueiro:
I think a couple take-home messages are obviously understand your patient. That's what's going to be most important in these decisions. The second take-home that we'd talked about is probably about 50% of ulcerative colitis is severe from the onset; 75%, 80% of Crohn's is severe. Don't wait on more aggressive and adequate therapy. Start it early. I think induction is so important. And then my final point is monitor along the way – that treat-to-target concept you mentioned up front. If a patient's not improving or if they have active disease, don't necessarily switch to another agent until you really make sure it's failing. Really optimize, and that can include therapeutic drug monitoring and just increasing the dose or decreasing the interval as well.

Dr. Nandi:
This is practical, hard-hitting, and just awesome advice to apply to our patients today. Folks, that's all the time we have for today. I want to thank our digital audience for listening in, and I want to sincerely thank Dr. Miguel Regueiro for sharing his valuable insights. Thank you for all that you do for our IBD patients, clinicians, and greater IBD community. It's truly amazing, and it was great fun speaking with you today.

Dr. Regueiro:
Thanks, Neil. As always, I appreciate it.

Announcer:
You have been listening to CME on ReachMD. This activity is provided by Prova Education.

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