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Where Conventional IBD Therapies Fall Short

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Dr. Dolinger:
Hello. I'm Dr. Michael Dolinger, I'm delighted to be here, and here with me today is Dr. Ugo Iroku. While conventional therapies remain widely used in IBD, they were developed for a different treatment era. As our goals now emphasize mucosal healing and long-term disease control, their limitations, particularly in moderate to severe disease, have become increasingly apparent. Let's break down where these approaches fall short.

Dr. Iroku, why don't you talk about how you utilize these "conventional therapies"—corticosteroids, mesalamine, and immunomodulators—in your practice, and where you see their use today and their limitations.

Dr Iroku:
Thank you so much for having me on, and thanks for that question, Michael. When it comes to corticosteroids, we know that we commonly use them in our patients who are in the middle of an IBD flare, either with their ulcerative colitis or Crohn's.

Their use historically dates back to the 1940s, 1950s, and essentially, they're taking advantage of the stress response that our HPA axis that we all learned about in med school where cortisol needs to act in multiple organs. So very ubiquitously located, these receptors—glucocorticoid receptors—that allow for actions of cortisol. With our prednisone converted to prednisolone, it's able to bind on those glucocorticoid receptors, make their way to the nucleus, and affect cell transcription, and ultimately cause a downgrading of inflammatory proteins and then upgrading of anti-inflammatory proteins.

What that means is that you have a rapid improvement of symptoms and a rapid downgrading of inflammation. The problem is the very thing that makes it great—it's found everywhere. And so not only is it affecting inflammation on the gut, it's also affecting blood pressure, blood sugar, insomnia, cataracts, et cetera, et cetera, could be producing a cascade of side effects that are unintended with the treatments. And so we know over the course of time, prolonged steroid use, although it can work in the short term with rapidly improving symptoms, long term just produces a number of side effects that just are not amenable to modern-day care.

And this brings us to our immunomodulators. Very helpful in the sense that they are purine analogs—that is to say they mimic the building blocks used in the DNA for transcription of proteins that are involved in inflammatory responses of the human gut. The problem with that is that they are a very slow process. This action of causing apoptosis of your lymphocytes takes weeks and even months to play itself out overtime, and so it's not the best option to use for induction of improvement in our ulcerative colitis or Crohn's patients.

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These days we have medical therapies that work much quicker.

And that brings us to our mesalamine-based options. They also try to decrease the amount of inflammation found in the human gut, but they do that in a topical manner. Even though they might be ingested or used in a parental form, they bathe the mucosa of the gut and downgrade inflammatory responses, including the COX-2 responses, decreasing the likelihood of ongoing inflammation and irritation in our ulcerative colitis patients. However, it's a very topical response, not superficial enough for the transmural inflammation seen in severe ulcerative colitis or in our Crohn's disease patients. And so it's able to produce some improvement, but not sufficiently enough for severe cases or for some categories of our IBD patients.

And so these are all medications that had great application in the 1940s, 50s, 60s, in our mildly affected patients and perhaps for short periods of time, but they are not long-term great medications for our more severe patients.

Dr. Dolinger:
Wow. That is well said and remarkably similar to how I view the use of these therapies in today's IBD care. I think of steroids, as you said, a medicine that really dampens the immune system broadly and allows patients to feel better but is a little bit dangerous, and we don't want that on long term because it has too many side effects.

And then when it comes to immunomodulators, they were effective for a portion of patients, but now we have more effective therapies, more targeted therapies, and safer therapies that I think have more of a role in IBD care today—biologic therapies in ulcerative colitis and Crohn's disease, especially moderate to severe cases.

And then with mesalamine, I agree. I think for those mild cases where it bathes the topical mucosa, it's an excellent starting therapy. But for the majority of cases, to prevent the progression of disease, they really need targeted immune therapies that go after the causes of IBD that's driving systemic inflammation, and that goes beyond the inner lining, that mucosa.

And with that, I think it's a wrap. Thank you so much for joining us, and I hope you stay for the next episode.

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