#UCmgmt

Application to Practice:

Translating the New UC Guidelines for the Optimal Management of Your Patients

Saturday, October 26, 2019

Dinner: 5:30 pm | Symposium: 6:00 pm

This event is neither sponsored by nor endorsed by ACG

Provided by: CME Outfitters

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Learning Objective 1

Apply recent UC guidelines and evidence for advanced therapies to select the right treatment for the right patient.

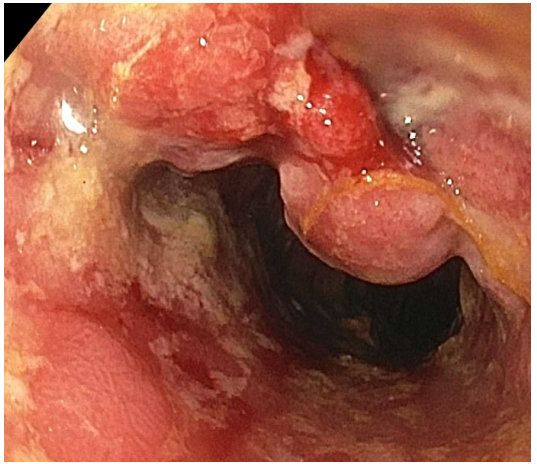
Case 1: Andrew

- 23-year-old male college student presents with the following symptoms for the past 6 weeks:
  - Weight loss (5 pounds)
  - Diarrhea (3 x daily; with nocturnal frequency 1x)
  - Urgency and cramping prior to stools; otherwise no abdominal pain
  - Rectal bleeding with about ½ of stools
- Thinks symptoms were present previously but worse over the past 6 weeks due to stress (exams)
- What else would you like to know?

Case 1: Andrew

- Abdominal exam is benign
- Rectal exam with anal canal tenderness, no perianal fistula
- No extraintestinal manifestations
- Further lab workup:
  - Hemoglobin 10.6 g/dL
  - Albumin 3.2 g/dL
  - CRP 15 mg/L (normal: < 5 mg/L)
  - *Clostridioides difficile* negative

Colonoscopy:
Mayo 3 Pancolitis



CRP = C-reactive protein.

CLINICAL GUIDELINES

ACG Clinical Guideline: Ulcerative Colitis in Adults

David T. Rubin, MD, FACG[1], Ashwin N. Ananthakrishnan, MD, MPH[2], Corey A. Siegel, MD, MS[3], Bryan G. Sauer, MD, MSc (Clin Res), FACG (GRADE Methodologist)[4] and Millie D. Long, MD, MPH, FACG[5]

Ulcerative colitis (UC) is an idiopathic inflammatory disorder. These guidelines indicate the preferred approach to the management of adults with UC and represent the official practice recommendations of the American College of Gastroenterology. The scientific evidence for these guidelines was evaluated using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) process. In instances where the evidence was not appropriate for GRADE, but there was consensus of significant clinical merit, "key concept" statements were developed using expert consensus. These guidelines are meant to be broadly applicable and should be viewed as the preferred, but not only, approach to clinical scenarios.

Am J Gastroenterol 2019;114:384–413. https://doi.org/10.14309/ajg.0000000000000152; published online February 22, 2019

ACG = American College of Gastroenterology.

New to 2019 UC Guidelines

- Differentiated activity from severity
- ACG Disease Activity Index
- Mildly vs. moderately-to-severely active disease
- Treatment of hospitalized patients
- Updated colorectal cancer prevention guidelines
- 48 GRADE Recommendations
- 54 key concept statements

GRADE = Grading of Recommendations Assessment, Development and Evaluation.

New ACG Ulcerative Colitis (UC) Activity Index

	Remission	Mild	Moderate-Severe	Fulminant
Stools (#/day)	Formed stools	< 4	> 6	> 10
Blood in stools	None	Intermittent	Frequent	Continuous
Urgency	None	Mild, occasional	Often	Continuous
Hemoglobin	Normal	Normal	< 75% of normal	Transfusion required
ESR	< 30	< 30	> 30	> 30
CRP (mg/L)	Normal	Elevated	Elevated	Elevated
Fecal calprotectin (µg/g)	< 150-200	> 150-200	> 150-200	> 150-200
Endoscopy (Mayo subscore)	0-1	1	2-3	3
UCEIS	0-1	2-4	5-8	7-8

ESR = erythrocyte sedimentation rate; UCEIS = Ulcerative Colitis Endoscopic Index of Severity.

Rubin DT, et al. *Am J Gastroenterol.* 2019;114(3):384-413.

Poor Prognostic Factors in Ulcerative Colitis Disease Severity

Poor Prognostic Factors
Age < 40 at diagnosis
Extensive colitis
Severe endoscopic disease (Mayo endoscopic subscore 3, UCEIS ≥ 7)
Hospitalization for colitis
Elevated CRP
Low serum albumin

Rubin DT, et al. *Am J Gastroenterol.* 2019;114(3):384-413.

Updated Goals of Management of UC

- Diagnosis including extent of disease and biopsy
- Movement to separate activity and severity
- Induction of clinical response/remission and mucosal healing
- Maintenance therapy identified based on induction therapy and prognosis
- Screen and treat for anxiety/depressive disorders
- Prevention of complications (cancer, hospitalization, infections, other drug-related)
- Organ-selective before systemic treatments

ACTIVITY: How sick the patient is NOW
SEVERITY: Includes elements of PROGNOSIS

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Learning Objective 2

Select robust objective treatment targets for patients with UC, with the goal of achieving deep remission and mucosal healing.

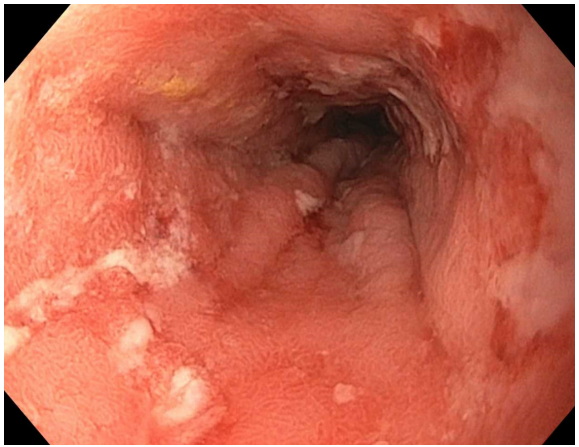
Case 2: Sonja

- 54-year-old woman with history of UC rectosigmoiditis for 4 years who presents to your clinic as she recently moved to your area
- At diagnosis she had Mayo 2 inflammation in the recto-sigmoid
- On oral and topical mesalamine from diagnosis
- She has required 3 tapers of prednisone since this time for increased bowel movement frequency and urgency, typically about once annually
- Currently has 4 bowel movements/day with mild urgency, occasional blood
- What else would you like to know?

Case 2: Sonja

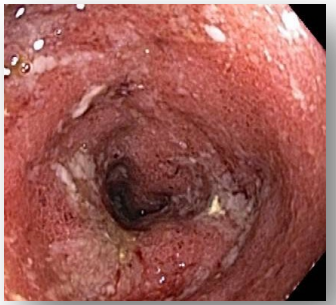
- Abdominal exam is benign
- Rectal exam is benign
- No extraintestinal manifestations
- Blood work is essentially normal
  - Hemoglobin 13.1 g/dL
  - Albumin 3.8 g/dL
  - CRP 5.0 mg/L
- Stool markers
  - Fecal calprotectin 270 µg/g
  - *Clostrioides difficile* negative

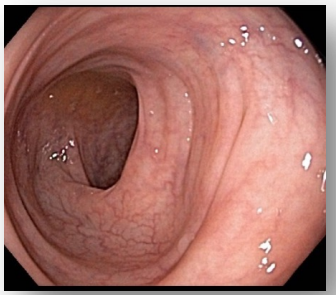
Colonoscopy:
Mayo 2 pancolitis



Mucosal Healing as a Target

- Treat to achieve mucosal healing (increases sustained steroid-free remission, prevents hospitalizations/surgery)[1,2]
- Fecal calprotectin as surrogate for endoscopy when endoscopy not feasible to assess for mucosal healing and disease activity[1,2]
- Histological healing is distinct from endoscopic mucosal healing[3] and **is not yet a target**
  - "Histological remission" = absence of neutrophils





1. Rubin DT, et al. *Am J Gastroenterol*. 2019;114(3):384-413. 2. Wei CS, et al. *Intest Res.* 2017;15(3):266-284.
3. Magro F, et al. *J Crohns Colitis*. 2017;11(6):649-670.

Mild-to-Moderate UC: ACG and AGA Recommendations 2019

Condition	ACG Recommendation	AGA Recommendation
Extensive mild-moderate UC	Oral 5-aminosalicylic acid (5-ASA)	Mesalamine or diazo-bonded 5-ASA
Left-sided mild-moderate UC	Rectal 5-ASA (induction) + oral 5-ASA	Rectal mesalamine + oral 5-ASA
Mild-moderate UC w/suboptimal response to 5-ASA	Budesonide MMX	Oral prednisone or budesonide MMX
Mild-moderate UC (any extent)	Low-dose 5-ASA over high dose	Standard-dose oral mesalamine or diazo-bonded 5-ASA over budesonide
Mild-moderate proctitis	Rectal 5-ASA	Mesalamine enema
Opinion on systemic steroids	Recommendation against systemic steroids	Not addressed

Rubin DT, et al. *Am J Gastroenterol*. 2019;114(3):384-413. Ko CW, et al. *Gastroenterology*. 2019;156(3):748-764.

Induction of Remission: Moderate-Severe UC

- UC failing to respond to **5-ASA** therapy → **oral systemic corticosteroids**[1-4]
- Moderate UC → **oral budesonide MMX**[1]
- Moderate-severe UC of any extent → **oral systemic corticosteroids**[1,3,4]
- **Anti–tumor necrosis factor (TNF)** therapy using **adalimumab**, **golimumab**, or **infliximab**[1,3]
- **Infliximab** in combination with a **thiopurine**[1-4]
- **Vedolizumab**[1-3]
- **Tofacitinib**[1] 10 mg PO twice a day (BID) x 8 weeks (+ 8 weeks)
- If failed **anti-TNF** → **vedolizumab**[1-4] *or* **tofacitinib**[1]
- **Recommend against** monotherapy with **thiopurines** *or* **methotrexate**[1,3]

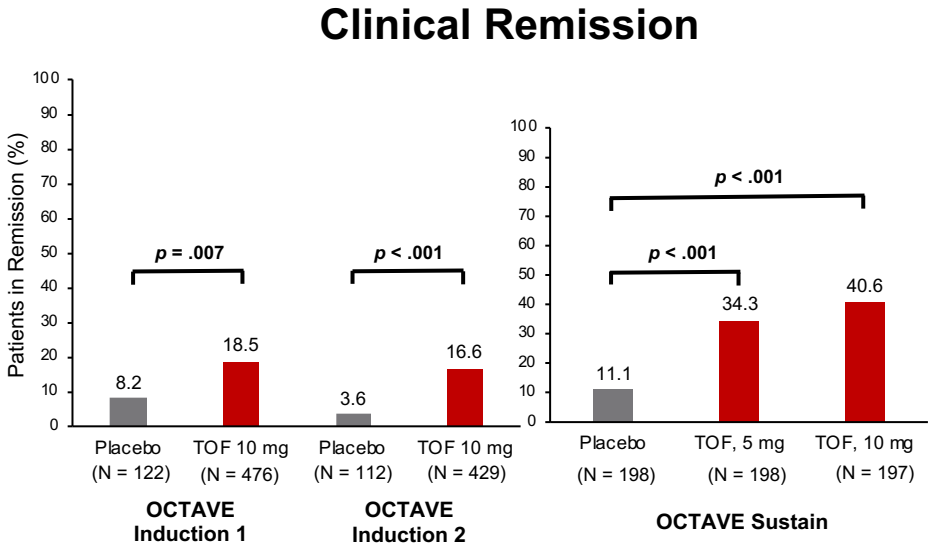
1. Rubin DT, et al. *Am J Gastroenterol*. 2019;114:384-413. 2. Hardbord M, et al. *J Crohns Colitis*. 2017;11(7):769-784.
3. Bressler B, et al. *Gastroenterology*. 2015;148(5):1035-1058.e3. 4. Coi CH, et al. *Intest Res*. 2017;15(1):7-37.

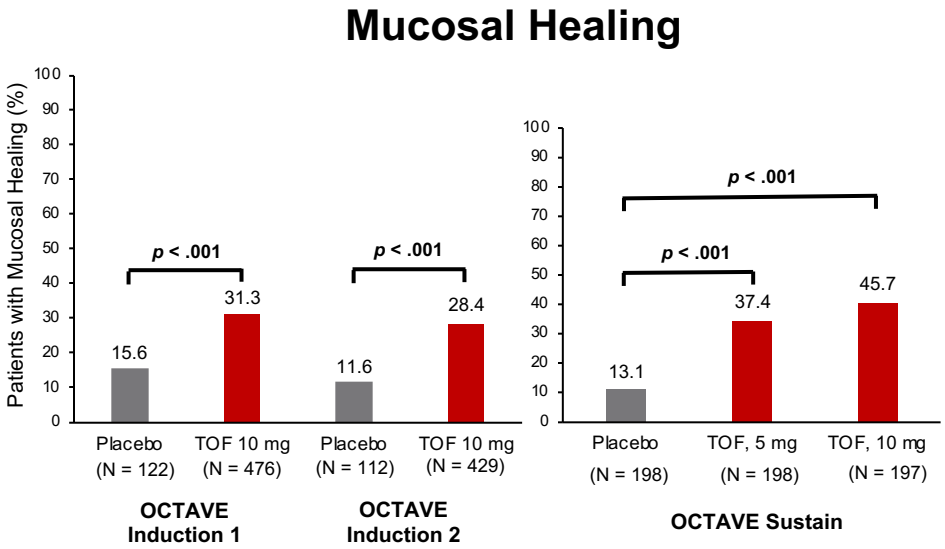
Maintenance of Remission: Moderate-Severe UC

- **Recommend against** systemic steroids[1,3,5]
- Thiopurines[1-5]
- **Recommend against** using methotrexate[1-3]
- Anti-TNF therapy using adalimumab, golimumab or infliximab[1-5]
- Vedolizumab[1,4]
- Tofacitinib[1] 5 mg PO BID or 10 mg PO BID

1. Rubin DT, et al. *Am J Gastroenterol*. 2019;114:384-413. 2. Hardbord M, et al. *J Crohns Colitis*. 2017;11(7):769-784.
3. Bressler B, et al. *Gastroenterology*. 2015;148(5):1035-1058.e3. 4. Coi CH, et al. *Intest Res*. 2017;15(1):7-37.
5. Wei CS, et al. *Intest Res.* 2017;15(3):266-284.

Tofacitinib (JAK1/3) for UC Maintenance: Week 52 (OCTAVE)





TOF = tofacitinib.

Sandborn W, et al. *N Engl J Med*. 2017;376(18):1723-1736.

Tofacitinib (JAK1/3): Pulmonary Embolism and Mortality Interim Report

- Phase IV rheumatoid arthritis study
- ≥ 1 cardiovascular risk factors
- ↑ in pulmonary embolism / mortality[1]
- Only at 10 mg BID
- Mechanism unclear
- Not seen in any phase II or phase III trials[2]
- Recent European Medicines Agency (EMA) advice[3]
- Label change; tofacitinib after anti-TNF[4]

FDA In Brief: FDA responds to safety signal reported in required postmarketing trial for Xeljanz

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Restrictions in use of Xeljanz while EMA reviews risk of blood clots in lungs

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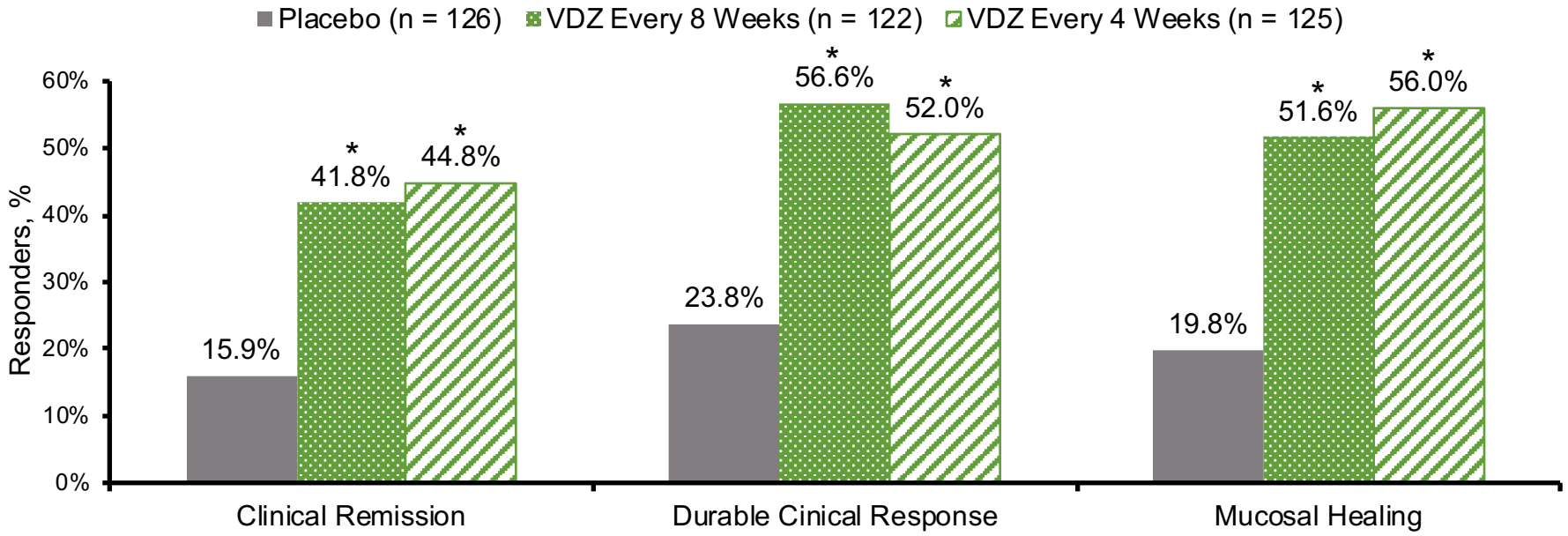
Press release 17/05/2019

FDA approves Boxed Warning about increased risk of blood clots and death with higher dose of arthritis and ulcerative colitis medicine tofacitinib (Xeljanz, Xeljanz XR)

FDA Drug Safety Communication

1. U.S. Food and Drug Administration (FDA). 2019. https://www.fda.gov/news-events/fda-brief/fda-brief-fda-responds-safety-signal-reported-required-postmarketing-trial-xeljanz. 2. Mease PJ, et al. *Arthritis Rheumatol.* 2017;69(Suppl 10). https://acrabstracts.org/abstract/secukinumab-demonstrates-consistent-safety-over-long-term-exposure-in-patients-with-psoriatic-arthritis-and-moderate-to-severe-plaque-psoriasis-updated-pooled-safety-analyses/. 3. European Medicines Agency. *Restrictions in use of Xeljanz while EMA reviews risk of blood clots in lungs*. 2019. https://www.ema.europa.eu/en/news/restrictions-use-xeljanz-while-ema-reviews-risk-blood-clots-lungs. 4. FDA. https://www.fda.gov/drugs/drug-safety-and-availability/fda-approves-boxed-warning-about-increased-risk-blood-clots-and-death-higher-dose-arthritis-and.

Vedolizumab: Maintenance of Remission in UC (GEMINI I) at Week 52



Durable clinical response = clinical response (reduction in Mayo score of at least 3 points + > 30% decrease from baseline + at least 1 point decrease in rectal bleeding) at weeks 6 and 52.

Clinical remission = Mayo score $\leq$2 and no subscore higher than 1. Mucosal healing = Mayo endoscopic subscore of 0 or 1.

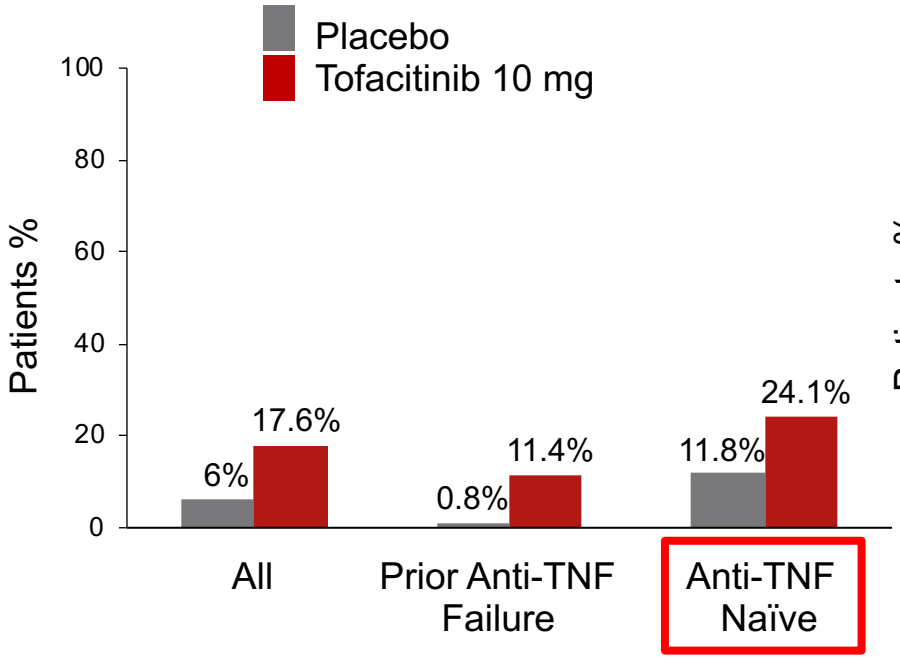
*$p < .001$.

VDZ = vedolizumab.

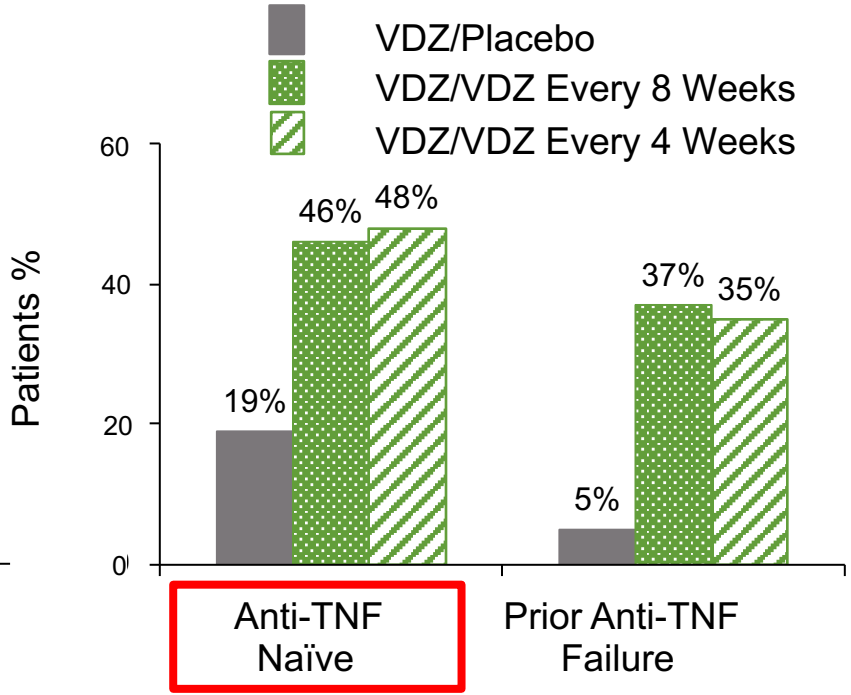
Feagan BG, et al. *N Engl J Med*. 2013;369:699-710.

TNF-Naïve Patients Respond Better to Tofacitinib or Vedolizumab vs. Those Who Have Failed a TNF

Clinical Remission Tofacitinib in UC[1]



Clinical Remission Vedolizumab in UC[2]

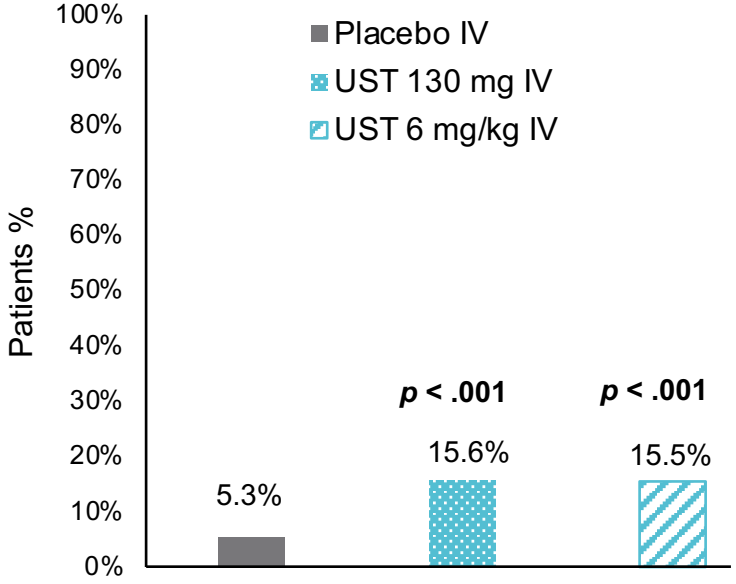


1. Gastrointestinal Drugs Advisory Committee (GIDAC). *tofacitinib for Treatment of Moderate to Severe Ulcerative Colitis*. 2018. https://www.fda.gov/media/112149/download
2. Feagan BG, et al. *N Engl J Med*. 2013;369(8):699-710.

Ustekinumab for Induction and Maintenance in Moderate-Severe UC (UNIFI)

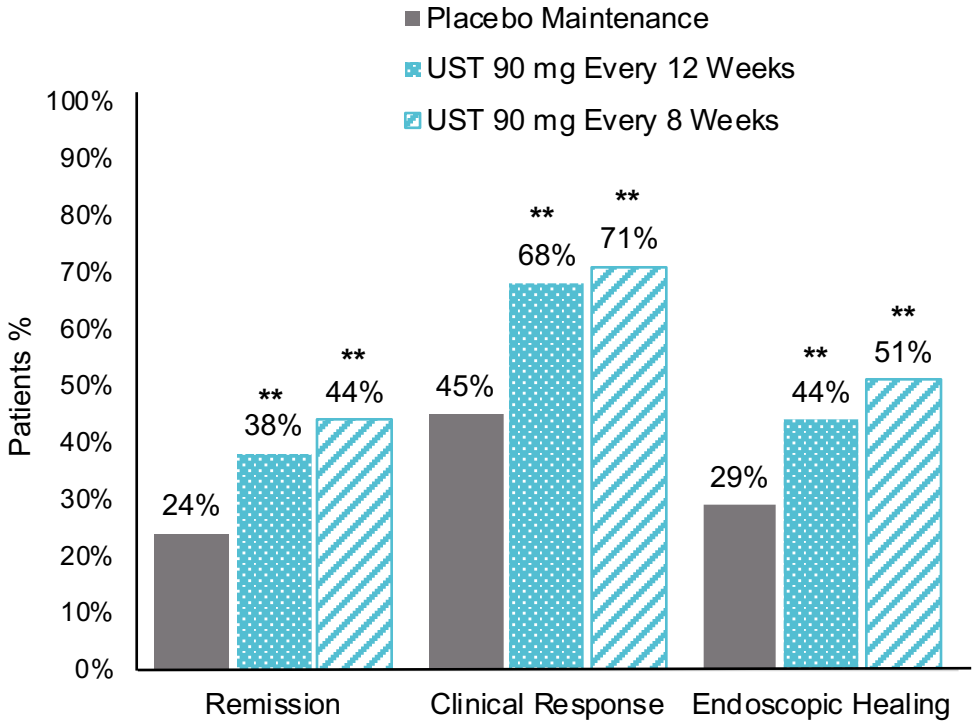
Induction (N = 961)[1]

Primary Endpoint: Clinical Remission Week 8



Maintenance (N = 397)[2]

Clinical and Endoscopic Outcomes at Week 52



**$p < 01$.
Clinical Remission: Mayo Score ≤ 2 with no individual subscore.
Endoscopic healing: Mayo endoscopic subscore 0 or 1.

1. Sands BE, et al. Presented at ACG 2018. Abstract 54A.
2. Sandborn WJ, et al. Presented at ECCO 2019. OP37.

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Learning Objective 3

Evaluate comparative effectiveness data from real-world experience and clinical trials of advanced UC treatments.

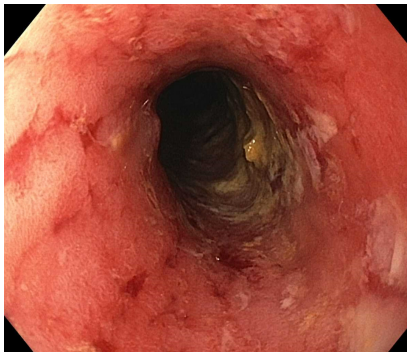
Case 3: Justine

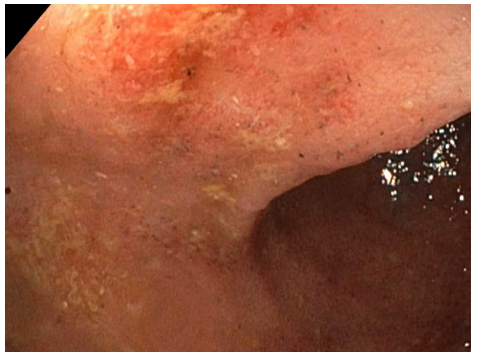
- 70-year-old woman with ulcerative colitis (rectosigmoiditis) diagnosed during hospitalization 6 months ago; initiated on infliximab monotherapy
- Initially with clinical response, able to leave the hospital, but with inability to taper off of prednisone (now on 10 mg daily)
- Infliximab level of 8; no antibodies
- Currently with 5 bowel movements a day, + urgency, unable to go to church due to concerns of incontinence, intermittent blood in her stool
- Weight has been stable; although 10 pounds lower than prior to her diagnosis
- What else would you like to know?

Case 3: Justine

- Abdominal exam is benign
- Rectal exam benign
- No extraintestinal manifestations
- Further lab workup:
  - Hemoglobin 12.1 g/dL
  - Albumin 2.7 g/dL
  - CRP 22 mg/L (normal: < 5 mg/L)
  - *Clostridioides difficile* negative

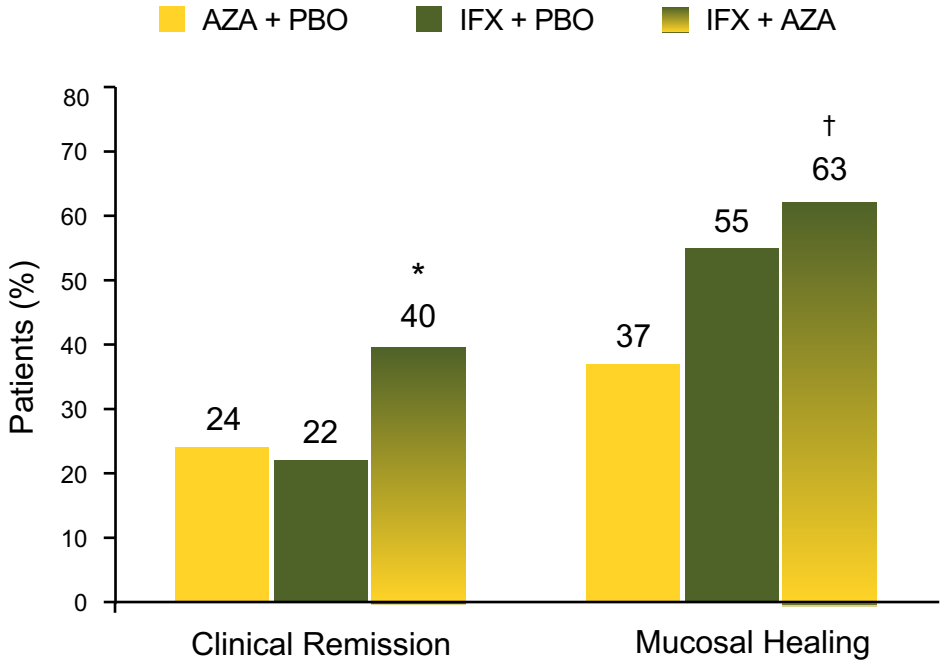
Flex sig: Mayo 3 to sigmoid;
Mayo 2 to extent of exam





Infliximab (TNF) + Azathioprine vs. Monotherapy: Week 16 (UC SUCCESS)

- N = 239
- Randomized, double-blind trial in anti-TNF-naïve patients with moderate-to-severe UC
- Primary endpoint: corticosteroid-free clinical remission at week 16

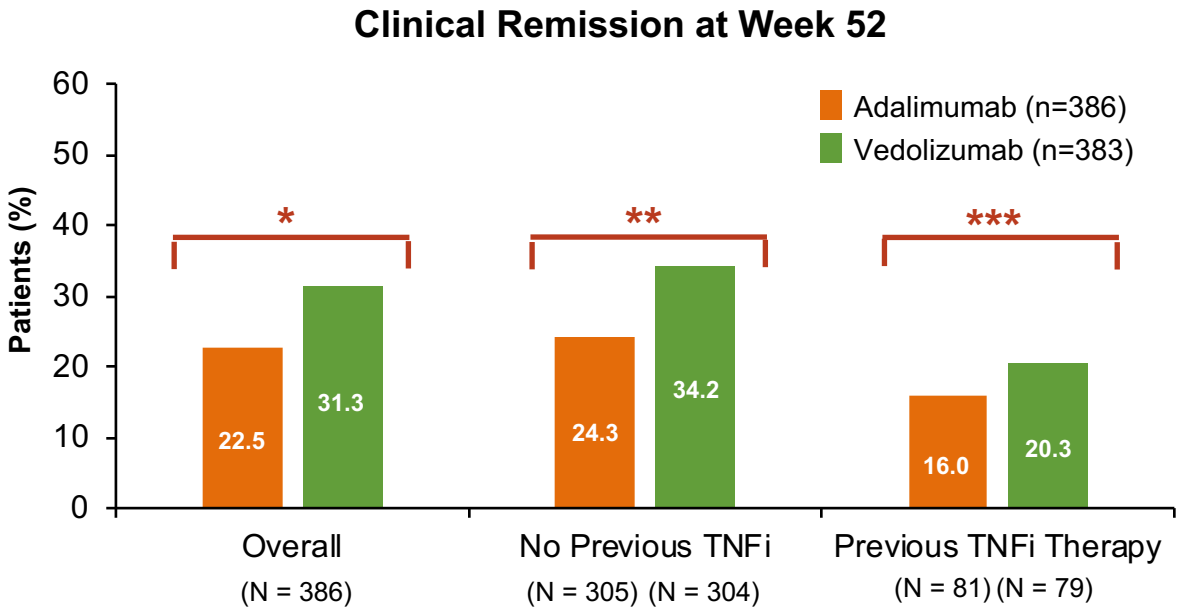


*$p < .05$ compared to AZA and IFX monotherapy; †$p < .05$ compared to azathioprine.
AZA = azathioprine; IFX = infliximab; PBO = placebo.

Panaccione R, et al. *Gastroenterology*. 2014;146(2):392-400.e3.

Vedolizumab (Integrin) vs. Adalimumab (TNF): Week 52 (VARSITY)

- N = 769
- Phase IIIb, double-blind, double-dummy, multi-center, active-controlled trials for patients with moderately to severely active UC who failed conventional therapies
- Primary endpoint: clinical remission at week 52



*Difference, 8.8 percentage points (95% CI, 2.5-15.0); $p = 0.006$.
**Difference, 9.9 percentage points (95% CI, 2.8-17.1).
***Difference, 4.2 percentage points (95% CI, 27.8-16.2).

Sands BE, et al. *N Engl J Med*. 2019;381:1215-1226.

SERENE Trial: High- vs. Standard-Dose Adalimumab

- Phase III double-blind randomized, controlled trial
- Higher induction regimen (HIR): 160 mg at weeks 0, 1, 2, and 3 followed by 40 mg at weeks 4 and 6 vs. standard
- Outcomes at week 8: clinical remission (primary), endoscopic improvement (Mayo score 0 or 1), fecal calprotectin, Inflammatory Bowel Disease Questionnaire (IBDQ), clinical response, endoscopic remission (Mayo 0)
- Clinical remission rate at week 8: HIR 13.3% vs. 10.9% standard, $p = 0.273$

Panes J, et al. United European Gastroenterology Week; 2019. Abstract OP216.

SERENE Trial: High- vs. Standard-Dose Adalimumab (continued)

Endpoints (Week 8), n (%)	Adalimumab HIR (n = 512)	Adalimumab SIR (n = 340)	*p* Value
1. Endoscopic improvement* (endoscopic subscore of 0 or 1)	159 (31.1)	92 (27.1)	.182
2. Fecal calprotectin < 150 mg/kg	115 (22.5)	67 (19.8)	.283
3. IBDQ response (increase of IBDQ ≥ 16 from baseline)	342 (66.8)	207 (60.9)	.063
4. Clinical response per full Mayo Score*†	241 (47.1)	136 (40.0)	.034‡
5. Endoscopic remission* (endoscopic subscore of 0)	67 (13.1)	34 (10.0)	.162

*Endoscopy scored via a central reading protocol.
†Clinical response per full Mayo Score: Decrease from baseline in the full Mayo Score ≥ 3 points and ≥ 30% from baseline, plus a decrease in rectal bleeding score (RBS) ≥ 1 or an absolute RBS ≤ 1.
‡Nominal *p* value < .05.
SIR = standard induction dosing regimen.

Panes J, et al. OP216, United European Gastroenterology Week. Abstract.

Network Meta-analysis of Pharmacological Agents in UC

Induction of Clinical Remission						
Induction of Mucosal Healing	Tofacitinib 10 mg BID	0.50 (0.14-1.79)	0.78 (0.31-1.96)	1.22 (0.52-2.86)	0.52 (0.23-1.20)	**2.15 (1.08-4.28)**
	0.70 (0.31-1.55)	Vedolizumab	1.55 (0.46-5.24)	2.41 (0.75-7.79)	1.04 (0.33-3.31)	**4.26 (1.47-12.32)**
	1.17 (0.64-2.12)	1.67 (0.83-3.38)	Golimumab	1.55 (0.73-3.33)	0.67 (0.31-1.43)	**2.75 (1.51-4.98)**
	1.28 (0.72-2.29)	1.84 (0.92-3.66)	1.10 (0.71-1.71)	Adalimumab	**0.43 (0.22-0.85)**	**1.77 (1.08-2.90)**
	0.60 (0.34-1.11)	0.88 (0.43-1.77)	**0.52 (0.33-0.83)**	**0.48 (0.31-0.74)**	Infliximab	**4.10 (2.58-6.52)**
	2.03 (1.23-3.34)	**2.91 (1.56-5.42)**	**1.74 (1.25-2.41)**	**1.58 (1.18-2.13)**	**3.32 (2.39-4.60)**	Placebo
Rank:	3	2	4	5	1	

Effectiveness in maintaining remission: No significant difference among all agents in responders (but comparison problematic due to different trial designs).

<u>Comparative efficacy of drugs in inducing mucosal healing:</u>

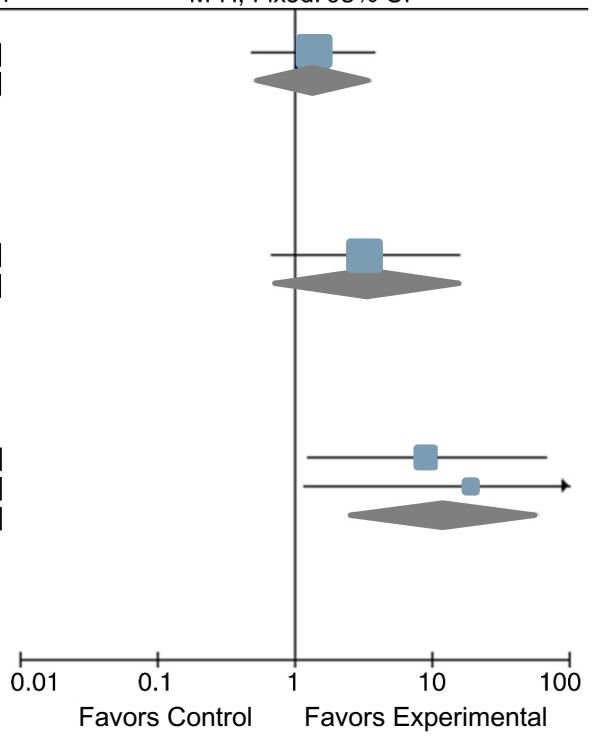
Infliximab (59%) > vedolizumab (56%) > tofacitinib (47%) > golimumab (43%) > adalimumab (41%) > placebo (30%)

Singh S, et al. *Aliment Pharmacol Ther.* 2018;47(2):162-175.

Network Meta-analysis of Pharmacological Agents in UC (continued)

Comparative Efficacy of Second-Line Therapy (Prior Anti-TNF exposure) in Inducing Clinical Remission

Study or subgroup	Experimental Events	Experimental Total	Control Events	Control Total	Weight	Odds ratio M-H, Fixed. 95% CI
2.3.1 Adalimumab vs. Placebo						
Sandborn ULTRA 2 2012	9	98	7	101	100.0%	1.36 [0.49, 3.80]
Subtotal (95% CI)		98		101	100.0%	1.36 [0.49, 3.80]
Total events	9		7			
Heterogeneity. Not applicable						
Test for overall effect: Z = 0.58 (*P* = .56)						
2.3.2 Vedolizumab vs. Placebo						
Feagan GEMINI 2013	8	82	2	63	100.0%	3.30 [0.68, 16.11]
Subtotal (95% CI)		82		63	100.0%	3.30 [0.68, 16.11]
Total events	8		2			
Heterogeneity. Not applicable						
Test for overall effect: Z = 1.47 (*P* =.14)						
2.3.3 Tofacitinib vs. Placebo						
Sandborn OCTAVE 1 2016	32	254	1	65	67.3%	9.23 [1.24, 68.83]
Sandborn OCTAVE 2 2016	28	234	0	70	32.7%	19.46 [1.17, 322.92]
Subtotal (95% CI)		488		135	100.0%	12.57 [2.46, 64.12]
Total events	60		1			
Heterogeneity. $Chi^2 = 0.18$, df = 1 (*P* = .67); $I^2 = 0\%$						
Test for overall effect: Z = 3.04 (*P* = .002)						



Singh S, et al. *Aliment Pharmacol Ther.* 2018;47(2):162-175.

Network Meta-analysis of Pharmacological Agents in UC (continued)

Risk of Serious Adverse Events						
Risk of Infections	Tofacitinib 5 mg BID	1.60 (0.50-5.15)	0.47 (0.16-1.42)	0.69 (0.27-1.77)	1.03 (0.40-2.65)	0.76 (0.32-1.77)
	0.69 (0.84-3.41)	Vedolizumab	**0.29 (0.10-0.86)**	0.43 (0.17-1.06)	0.64 (0.26-1.59)	0.47 (0.21-1.06)
	0.94 (0.51-1.74)	0.56 (0.28-1.12)	Golimumab	1.46 (0.64-3.32)	2.18 (0.96-4.95)	1.61 (0.80-3.26)
	1.42 (0.84-2.41)	0.84 (0.45-1.57)	1.51 (0.89-2.56)	Adalimumab	1.49 (0.83-2.69)	1.10 (0.73-1.67)
	1.34 (0.77-2.34)	0.80 (0.42-1.52)	1.43 (0.82-2.48)	0.94 (0.60-1.49)	Infliximab	0.74 (0.49-1.12)
	1.75 (1.13-2.70)	1.03 (0.60-1.79)	**1.85 (1.20-2.86)**	1.23 (0.91-1.65)	1.30 (0.92-1.83)	Placebo

Safety: Vedolizumab > anti-TNF monotherapy > tofacitinib, thiopurine monotherapy, anti-TNF combination therapy

Singh S, et al. *Aliment Pharmacol Ther.* 2018;47(2):162-175.

Individualized Therapy of Moderate-Severe UC: Sub-Populations

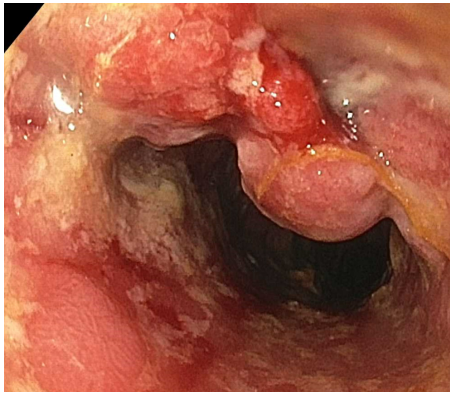
- **Age > 65:** Vedolizumab, ustekinumab
- **Inpatient:** Infliximab (induction and maintenance), cyclosporine (induction followed by vedolizumab or azathioprine maintenance)
- **Significant cancer history, lymphoma:** Vedolizumab, ustekinumab
- **Pregnancy:** Anti-TNF, azathioprine, vedolizumab, ustekinumab
- **Steroid responsive mild-moderate disease:** Thiopurine
- **Extraintestinal manifestations such as arthritis:** Anti-TNF, tofacitinib
- **Previous anti-TNF failure:** Tofacitinib or vedolizumab or ustekinumab

Rubin DT, et al. *Am J Gastroenterol.* 2019;114(3):384-413.

Let’s go back to our patients…

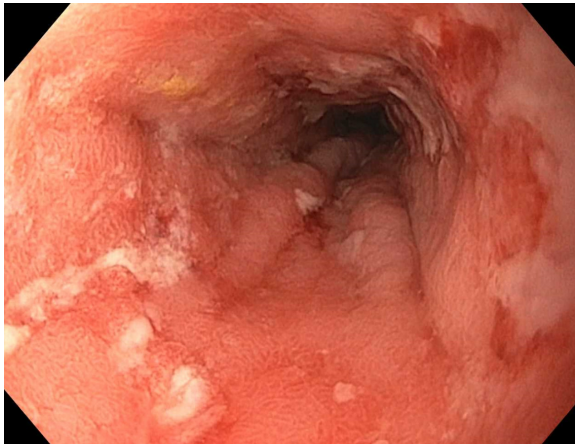
Case 1: Andrew

- Past 6 weeks:
  - Weight loss (5 pounds)
  - Diarrhea (3 x daily; with nocturnal frequency 1x)
  - Urgency and cramping prior to stools; otherwise no abdominal pain
  - Rectal bleeding with about ½ of stools
- Further lab workup:
  - Hemoglobin 10.6 g/dL
  - Albumin 3.2 g/dL
  - CRP 15 mg/L (normal: < 5 mg/L)
  - *Clostridioides difficile* negative
- Colonoscopy
  - Mayo 3
  - Pancolitis



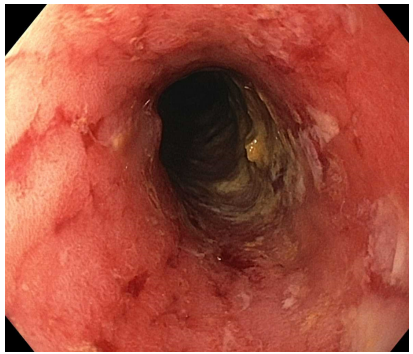
Case 2: Sonja

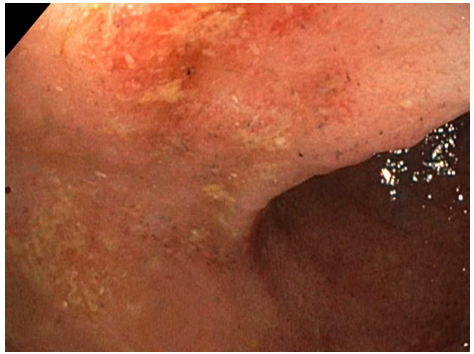
- History of UC rectosigmoiditis for last 4 years
- Four BMs/day with mild urgency, occasional blood
- Further lab workup:
  - Albumin 3.8 g/dL
  - CRP 5.0 mg/L
  - Fecal calprotectin 270 µg/g
  - *Clostridioides difficile* negative
- Colonoscopy:
  - Mayo 2
  - Pancolitis



Case 3: Justine

- UC (rectosigmoiditis) diagnosed during hospitalization 6 months ago, initiated on infliximab monotherapy
- Currently five BMs/day, + urgency, unable to go to church due to concerns of incontinence, intermittent blood in her stool
- Further lab workup:
  - Hemoglobin 12.1 g/dL
  - Albumin 2.7 g/dL
  - CRP 22 mg/L (normal: < 5 mg/L)
  - *Clostridioides difficile* negative
- Flexible sigmoidoscopy:
  - Mayo 3 to sigmoid
  - Mayo 2 to extent of exam





SMART Goals

Specific, Measurable, Attainable, Relevant, Timely

- Differentiate **activity** from **severity** in UC
- Management involves successful induction of clinical and **endoscopic remission** AND steroid-free maintenance strategy
- Choose therapy based on:
  - Activity, severity, extent of inflammation, and prognostic factors
  - Include oral, topical (rectal), systemic therapies, and surgery
  - Comparative effectiveness

#UCmgmt

Questions & Answers

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Thank You

Don’t forget to complete the evaluation and collect your credit.