



A CASEWISE™ INITIATIVE

MISSION: ~~IMPOSSIBLE~~

*MATCHING TREATMENT GOALS
OF PATIENTS AND PROVIDERS
IN IBD IN CLINICAL PRACTICE*

Supported by an educational grant from Johnson & Johnson.



In support of improving patient care, CME Outfitters LLC is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

ACTIVITY CREDIT TYPES

Physicians (ACCME)

CME Outfitters LLC designates this live activity for a maximum of 2.0 *AMA PRA Category 1 Credit(s)*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This activity is designated for 2.0 contact hours.

Nurses (ANCC)

Note to Nurse Practitioners: The content of this CNE activity pertains to Pharmacology.

California Residents: Provider approved by the California Board of Registered Nursing, Provider # CEP 15510, for 2.0 Contact Hours.



CME Outfitters LLC has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for 2.0 AAPA Category 1 CME credits. PAs should only claim credit commensurate with the extent of their participation.



Through an agreement between the Accreditation Council for Continuing Medical Education and the Royal College of Physicians and Surgeons of Canada, medical practitioners participating in the Royal College MOC Program may record completion of accredited activities registered under the ACCME's "CME in Support of MOC" program in Section 3 of the Royal College's MOC Program.

Completion of this accredited CME activity meets the expectations of an Accredited Safety or Quality Improvement Program (IA_PSPA_28) for the Merit-based Incentive Payment Program (MIPS). Clinicians should submit their improvement activities by attestation via the CMS Quality Payment Program website.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 2.0 MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit.

This activity may include discussions of products or devices that are not currently labeled for use by the U.S. Food and Drug Administration (FDA).

The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational uses (any uses not approved by the FDA) of products or devices.

To Ask a Question

To submit a question, please go to the *Ask Question* tab at the bottom of the screen.



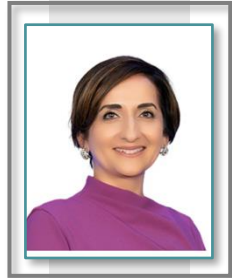
Miguel Regueiro, MD *(moderator)*

Chief, Digestive Disease Institute

Cleveland Clinic

Professor, Department of Medicine

Cleveland Clinic Lerner College of Medicine of Case Western Reserve University
Cleveland, Ohio



Anita Afzali, MD, MPH, MHCM, FACG, AGAF

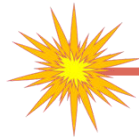
Professor of Medicine

Interim Chair, Department of Internal Medicine

University of Cincinnati College of Medicine

Cincinnati, Ohio

FACULTY





Edward L. Barnes, MD, MPH

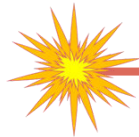
Associate Professor of Medicine
University of North Carolina–Chapel Hill
Chapel Hill, North Carolina



Angelina Collins, MSN, ANP-BC

Nurse Practitioner
Inflammatory Bowel Disease Center
UC San Diego Health
La Jolla, California

FACULTY





Jessica R. Allegretti, MD, MPH, FACG, AGAF

Medical Director, Infusion Services
Director, Crohn's and Colitis Center
Division of Gastroenterology, Hepatology and Endoscopy
Brigham and Women's Hospital
Associate Professor of Medicine, Harvard Medical School



Edward V. Loftus, Jr., MD

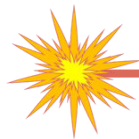
Maxine and Jack Zarrow Family Professor of Gastroenterology
Mayo Clinic College of Medicine and Science
Rochester, Minnesota



Millie D. Long, MD, MPH

Professor of Medicine
Chief, Division of Gastroenterology and Hepatology
University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

CONTRIBUTING KOLs





Natalie Hayden

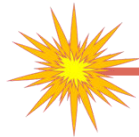
Patient Advocate
Founder, Lights, Camera, Crohn's



Kaylaa' White

Writer
IBD Patient Advocate
National Council of College Leaders and Social Media Ambassador
Crohn's and Colitis Foundation
COGI Ambassador

PATIENT ADVOCATES



Disclosures

FACULTY

Miguel Regueiro, MD—reports the following financial relationships:

Advisory board—AbbVie Inc., Amgen Inc., Boehringer Ingelheim Pharmaceuticals Inc., (BIPI), Bristol Myers Squibb Company, Celgene Corporation, Genentech Inc., Gilead Sciences Inc., Janssen Pharmaceuticals Inc., Lilly, Organon, Pfizer Inc., Prometheus Laboratories, Salix Pharmaceuticals, Takeda Pharmaceutical Company Limited, and UCB Inc.

Consultant—AbbVie Inc., Amgen Inc., Boehringer Ingelheim Pharmaceuticals Inc., (BIPI), Bristol Myers Squibb Company, Celgene Corporation, Genentech Inc., Gilead Sciences Inc., Janssen Pharmaceuticals Inc., Lilly, Organon, Pfizer Inc., Prometheus Laboratories, Salix Pharmaceuticals, Takeda Pharmaceutical Company Limited, and UCB Inc.

Anita Afzali, MD, MPH, MHCM, FAGG, AGAF—reports the following financial relationships:

Advisory board—AbbVie Inc., Johnson & Johnson, Lilly, Pfizer Inc., and Takeda Pharmaceutical Company Limited

Consultant—AbbVie Inc., Johnson & Johnson, Lilly, Pfizer Inc., Sanofi, and Takeda Pharmaceutical Company Limited

Grants—AbbVie Inc., Celltrion USA Inc., Johnson & Johnson, Lilly, Pfizer Inc., and Takeda Pharmaceutical Company Limited

Speakers bureau—AbbVie Inc., Johnson & Johnson, Pfizer Inc, Takeda Pharmaceutical Company Limited

Other financial or material support—co-founder, board member of Scrubs & Heels Foundation

Edward L. Barnes, MD, MPH—reports the following financial relationships:

Advisory board—AbbVie Inc., Lilly, Pfizer Inc., and Sanofi

Consultant—Boomerang Medical, Takeda Pharmaceutical Company Limited, and Target RWE

Research support—Bausch Health Companies Inc./Salix Pharmaceuticals and Lilly

Angelina Collins, MSN, ANP-BC—reports the following financial relationships:

Advisory board—AbbVie Inc., Cristcot, Johnson & Johnson, Lilly, and Takeda Pharmaceutical Company Limited

Consultant—AbbVie Inc., Cristcot, Johnson & Johnson, Lilly, and Takeda Pharmaceutical Company Limited

Speakers bureau—AbbVie Inc., Cristcot, Johnson & Johnson, Lilly, and Takeda Pharmaceutical Company Limited

All identified conflicts of interest have been mitigated.

Disclosures

CONTRIBUTING KEY OPINION LEADERS

Jessica R. Allegratti, MD, MPH, FACG, AGAF—reports the following financial relationships:

Consultant—AbbVie Inc., Bristol Myer Squibb Company, Celltrion USA Inc., CUROGEN, Ferring Pharmaceuticals, Genentech Inc., GSK, Janssen Pharmaceuticals Inc., Merck & Co. Inc., Metagen Biologics, Pfizer Inc., Roivant Sciences Ltd., Seres Therapeutics, Shattuck Labs Inc., TRXbio Co. Ltd, Vedanta Biosciences Inc., and Xencor

Speakers bureau—AbbVie Inc. and Janssen Pharmaceuticals Inc.

Edward V. Loftus, Jr., MD—reports the following financial relationships:

Consultant—AbbVie Inc., Abivax, Astellas Pharma Inc., Avalo Therapeutics Inc., Biocon Limited, Bristol Myers Squibb Company, Celltrion USA Inc., Genentech Inc., Gilead Sciences Inc., Iota Biosciences, Iterative Health, Lilly, Janssen Pharmaceuticals Inc., Merck & Co. Inc., Morphic Therapeutic, Ono Pharma USA Inc., Spyre Therapeutics Inc., Takeda Pharmaceutical Company Limited, and TR1X Bio

Research support—AbbVie Inc., Gilead Sciences Inc., Janssen Pharmaceuticals Inc., and TR1X Bio

Stock shareholder (directly purchased)—Exact Sciences Corporation and Moderna Inc.

Millie D. Long, MD, MPH—reports the following financial relationships:

Consultant—AbbVie Inc., Bristol Myers Squibb Company, Celltrion Inc., Genentech Inc., Intercept Pharmaceuticals Inc., Janssen Pharmaceuticals Inc., Lilly, Merck & Co. Inc., Pfizer Inc., Prometheus Laboratories, Roche, Roivant Sciences Ltd., Spyre Therapeutics Inc., Sanofi, Takeda Pharmaceutical Company Limited, and Target RWE

Research support—Celltrion Inc., Lilly, Pfizer Inc., and Takeda Pharmaceutical Company Limited

PATIENT ADVOCATES

Natalie Hayden—reports no financial relationships to disclose

Kaylaa' White—reports the following financial relationships:

Social media ambassador—Coloplast

PEER REVIEWERS

Thai Nguyen, MD, MHA—no disclosures to report

Shirley Michelle Franks, MSN, APRN, FNP-BC—no disclosures to report

The following CMEO staff have no financial relationships to disclose:

Leah Zadrozny, DVM, PhD (planning committee)

Nichole Lain (planning committee)

Scott J. Hershman, MD, FACEHP, CHCP (planning committee)

Sandra Caballero, PharmD (planning committee)

Sharon Tordoff (planning committee)

All identified conflicts of interest have been mitigated.

LEARNING OBJECTIVES

1

Integrate the latest data and guideline recommendations for IL-23 inhibitors into clinical practice as part of treatment selection for patients with IBD

2

Develop treatment plans utilizing effective communication and SDM strategies that factor in patient needs, preferences, QoL considerations, and treatment goals to optimize adherence and long-term outcomes

LEARNING OBJECTIVES

3 Evaluate the latest clinical trial efficacy and safety data for recently approved IL-23 therapies in IBD

4 Utilize the latest clinical evidence in real-world patient scenarios

From Treat-to-Target to Precision Care

What Guides IBD Decisions Today?

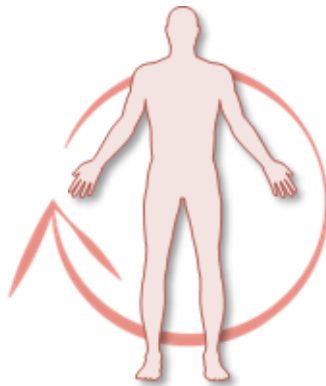
ULCERATIVE COLITIS (UC)

DISEASE CHARACTERISTICS

- IBD severity
- Disease behavior/complications
- Early vs late disease
- Extraintestinal manifestations
- Associated IMID

PATIENT CHARACTERISTICS

- Age
- Comorbidities
- Pregnancy/fertility
- Prior malignancy
- Infection risk
- Biologic naïve vs biologic exposure
- Treatment preferences
- Administrative route



CROHN'S DISEASE (CD)

ACCESS

- Insurance coverage
- Cost

EFFICACY

- Available evidence
- Onset of action
- Durability of response
- PK/therapeutic drug monitoring
- Combination vs monotherapy
- Positioning and sequencing

SAFETY

- Disease severity
- Drug-specific concerns

Why Target the IL-23/Th17 Axis in IBD

- IL-23 is a key driver of pathogenic Th17 responses in both UC and CD
- IL-23 promotes
 - Chronic intestinal inflammation
 - Resistance to anti-TNF therapy
 - Persistence to pathogenic immune memory
- Selective IL-23p19 inhibition
 - Suppresses pathogenic inflammation
 - Preserves protective IL-17 gut immunity
 - Offers mechanistic rationale for durable remission

Pivotal and Supportive Regulatory Trials for FDA-approved IL-23p19 Inhibitors

COMMAND
SC maintenance

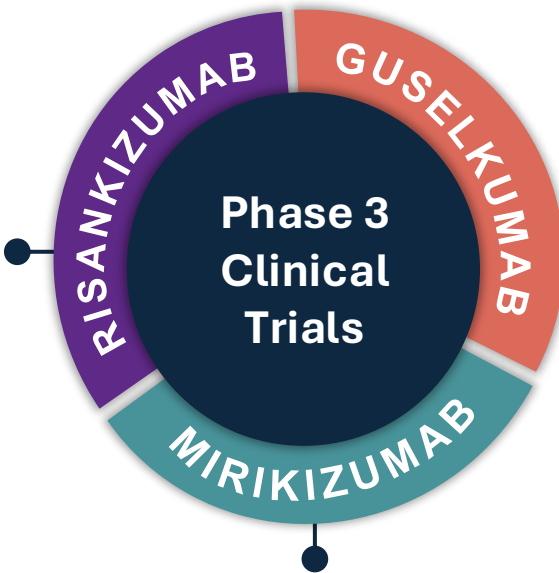
INSPIRE
IV maintenance

ADVANCE
IV induction

MOTIVATE
IV induction

SEQUENCE
IV induction
SC maintenance

FORTIFY
SC maintenance



QUASAR
IV induction
and SC maintenance

ASTRO
SC induction
and maintenance

GALAXI 1/2/3
IV induction
and SC maintenance

GRAVITI
SC induction
and maintenance

LUCENT-1
IV induction

LUCENT-2
SC maintenance

VIVID-1
IV induction
and SC maintenance

ULCERATIVE COLITIS
CHROHN'S DISEASE

The Evolving Landscape of IL-12/23 and IL-23p19 Inhibitors in IBD

Therapeutic	FDA Indications	Route/Regimen (<i>induction</i> → <i>maintenance</i>)	Key Efficacy Snapshot
Guselkumab* (IL-23p19)	UC and CD	<ul style="list-style-type: none"> UC + CD induction: 200 mg IV or 400 mg SC (two 200 mg injections at week 0, 4, 8) UC + CD maintenance: 100 mg SC q8w or 200 mg SC q4w 	<ul style="list-style-type: none"> UC induction (week 12): CR 23% vs 8% placebo (QUASAR) UC maintenance (week 44): CR 45%–50% vs 19% placebo (QUASAR) CD induction (week 12): CR 56.1% vs 21.4% placebo (GRAVITI) CD maintenance (week 48): CR 60%–66.1% vs 17.1% placebo (GRAVITI)
Mirikizumab (IL-23p19)	UC and CD	<ul style="list-style-type: none"> UC: 300 mg IV (week 0, 4, 8) → 200 mg SC q4w (starting week 12) CD: 900 mg IV (week 0, 4, 8) → 300 mg SC q4w (starting week 12) 	<ul style="list-style-type: none"> UC induction (week 12): CR 24.2% vs 13.3% placebo (LUCENT-1) UC maintenance (week 40): CR 49.9% vs 25.1% placebo (LUCENT-2) CD induction (week 12): endoscopic response 32% vs 11% placebo (VIVID-1) CD maintenance (week 52): CR 53% vs 36% placebo; endoscopic response 46% vs 23% (VIVID-1)

*Fully subcutaneous option for induction through maintenance. Agents listed in alphabetical order.

CR, clinical remission; FDA, U.S. Food and Drug Administration; IV, intravenous; q#w, every # weeks; SC, subcutaneous.

Hart A, et al. *Gastroenterology*. 2025;169(2):308–325. Loftus EV Jr, et al. *JAMA*. 2024;332(11):881–897.

Sands BE, et al. *N Engl J Med*. 2019;381(13):1201–1214. Feagan BG, et al. *N Engl J Med*. 2016 Nov 17;375(20):1946–1960.

Guselkumab [package insert]. Revised September 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761061s026lbl.pdf.

Mirikizumab-mrkz [package insert]. Revised November 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761279s005lbl.pdf

Risankizumab-rzaa [package insert]. Revised September 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761105s039,761262s011lbl.pdf

Ustekinumab [package insert]. Revised November 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/125261s171,761044s019lbl.pdf#page=36.

The Evolving Landscape of IL-12/23 and IL-23p19 Inhibitors in IBD (cont.)

Therapeutic	FDA Indications	Route/Regimen (<i>induction</i> → <i>maintenance</i>)	Key Efficacy Snapshot
Risankizumab (IL-23p19)	UC and CD	<ul style="list-style-type: none"> UC: 1,200 mg IV (week 0, 4, 8) → 180 mg or 360 mg SC q8w CD: 600 mg IV (week 0, 4, 8) → 180 mg or 360 mg SC q8w 	<ul style="list-style-type: none"> UC induction (week 12): CR 20.3% vs 6.2% placebo (INSPIRE) UC maintenance (week 52): CR 40.2% / 37.6% vs 25.1% placebo (COMMAND) CD induction (week 12): CR 45% vs 25% placebo (ADVANCE); 42% vs 20% placebo (MOTIVATE) CD maintenance (week 52): CR 57%–61% vs 46% placebo; endoscopic response 48%–50% vs 22% (FORTIFY)
Ustekinumab (IL-12/23p40)	UC & CD	<ul style="list-style-type: none"> UC & CD: weight-based induction IV → 90 mg SC q8w (starting week 8) 	<ul style="list-style-type: none"> UC induction (week 8): CR 15.5%–15.6% vs 5.3% placebo (UNIFI) UC maintenance (week 44): CR 38%–44% vs 24% placebo (UNIFI) CD induction (week 8): CR 21%–40% vs 7%–20% placebo (UNITI-1/UNITI-2) CD maintenance (week 44): CR 53% vs 36% placebo (IM-UNITI)

*Fully subcutaneous option for induction through maintenance. Agents listed in alphabetical order.

Hart A, et al. *Gastroenterology*. 2025;169(2):308–325. Loftus EV Jr, et al. *JAMA*. 2024;332(11):881–897.

Sands BE, et al. *N Engl J Med*. 2019;381(13):1201–1214. Feagan BG, et al. *N Engl J Med*. 2016 Nov 17;375(20):1946–1960.

Guselkumab [package insert]. Revised September 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761061s026lbl.pdf.

Mirikizumab-mrkz [package insert]. Revised November 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761279s005lbl.pdf

Risankizumab-rzaa [package insert]. Revised September 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761105s039,761262s011lbl.pdf

Ustekinumab [package insert]. Revised November 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/125261s171,761044s019lbl.pdf#page=36.

Safety Overview: UC (Adults)

Outcome	Guselkumab	Mirikizumab	Risankizumab	Ustekinumab
Serious infections	Low; similar to placebo in UC trials	Low; similar to placebo in UC trials	Low; similar to placebo in UC trials	Low; similar to placebo in UC trials
Most common AEs	URTI ~10%, injection-site reactions ~7%–8%, headache ~5%–6%, arthralgia ~5%, fatigue ~3%–4%, diarrhea ~4%	URTI ~14%, injection-site reactions ~9%, headache ~8%, arthralgia ~7%, fatigue ~5%, diarrhea ~5%, rash ~5%	Arthralgia ~5%–10%, injection-site reactions ~3%, headache ~5%, pyrexia ~4%–5%, rash ~4%	Nasopharyngitis ~20%–25%, headache ~10%, abdominal pain ~7%, fatigue ~4%–5%, diarrhea ~4%
Monitoring	TB screening; avoid live vaccines	TB screening; avoid live vaccines	TB screening; avoid live vaccines; baseline liver enzymes and bilirubin required	TB screening; avoid live vaccines; malignancy risk per label
IBD-specific label note	Hepatotoxicity warning/precaution included for UC/CD	No UC-specific label warnings	Hepatotoxicity reported → obtain baseline LFTs	No UC-specific lab requirement

AEs, adverse events; LFTs, liver function tests; TB, tuberculosis; URTI, upper respiratory tract infection.

Guselkumab [package insert]. Revised September 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761061s026lbl.pdf.

Mirikizumab-mrkz [package insert]. Revised November 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761279s005lbl.pdf

Risankizumab-rzaa [package insert]. Revised September 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761105s039,761262s0111lbl.pdf.

Ustekinumab [package insert]. Revised November 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/125261s171,761044s019lbl.pdf#page=36.

Safety Overview: CD (Adults)

Outcome	Guselkumab	Mirikizumab	Risankizumab	Ustekinumab
Serious infections	Low; similar to placebo in CD trials	Low; similar to placebo in CD trials	Low; generally similar to placebo in CD trials	Low; similar to placebo in CD trials
Most common AEs	URTI ~30%–38%, abdominal pain ~12%–14%, headache ~6%–8%, injection-site reactions ~3%–4%, arthralgia ~4%–5%, diarrhea ~3%–5%	URTI ~28%, injection-site reactions ~10%, diarrhea ~9%, abdominal pain ~7%, fatigue ~6%, headache ~6%	URTI ~10%–11%, headache ~6%–7%, arthralgia ~5%, injection-site reactions ~4%–6%, anemia ~4%–5%	Nasopharyngitis ~11%, injection-site erythema ~5%, bronchitis ~5%, pruritus ~4%, UTI ~4%, sinusitis ~3%
Monitoring	TB screening; avoid live vaccines	TB screening; avoid live vaccines	TB screening; avoid live vaccines; baseline liver enzymes and bilirubin required	TB screening; avoid live vaccines
IBD-specific label note	SC induction is FDA approved for CD	No CD-specific label warnings	Hepatotoxicity reported → obtain baseline LFTs	No CD-specific lab requirement

UTI, urinary tract infection.

Guselkumab [package insert]. Revised September 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761061s026lbl.pdf.

Mirikizumab-mrkz [package insert]. Revised November 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761279s005lbl.pdf

Risankizumab-rzaa [package insert]. Revised September 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/761105s039,761262s011lbl.pdf

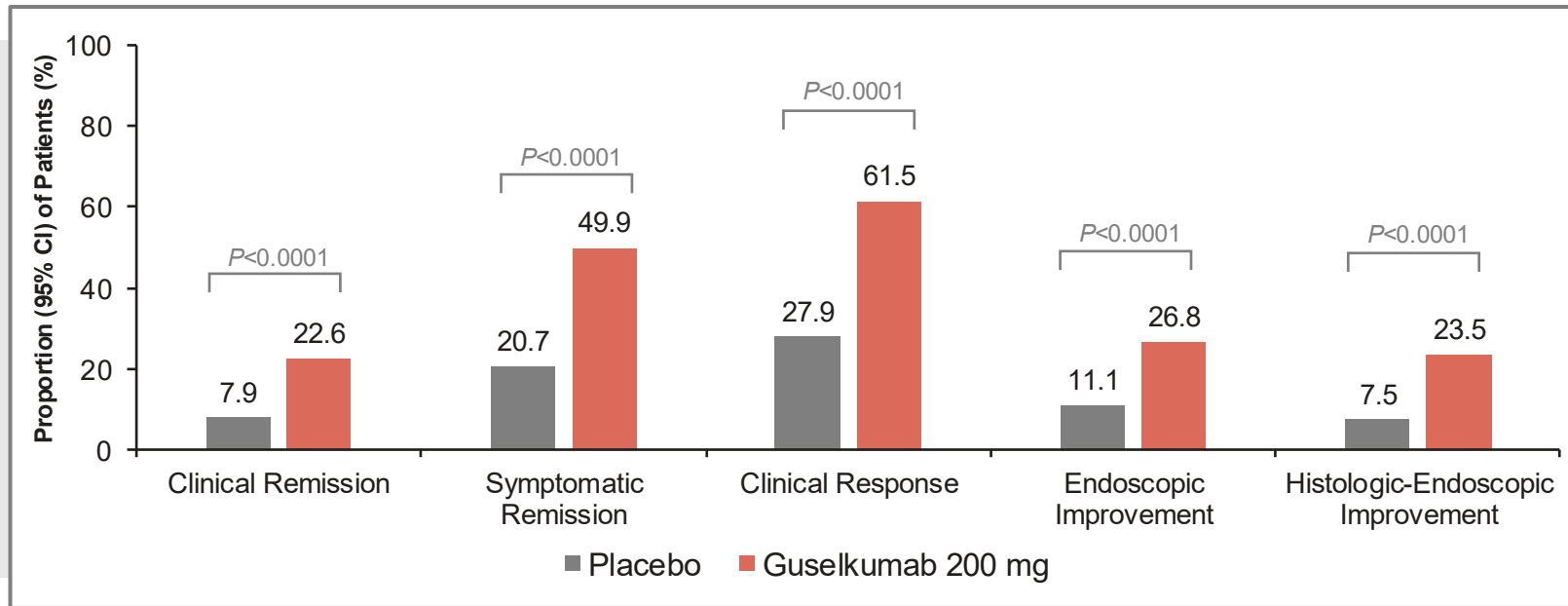
Ustekinumab [package insert]. Revised November 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/125261s171,761044s019lbl.pdf#page=36.

Pivotal UC Efficacy: IL-23p19 Inhibitors

Clinical Remission and Endoscopic Improvement

Guselkumab Induction in UC

QUASAR Phase 3 Week 12 Endpoints



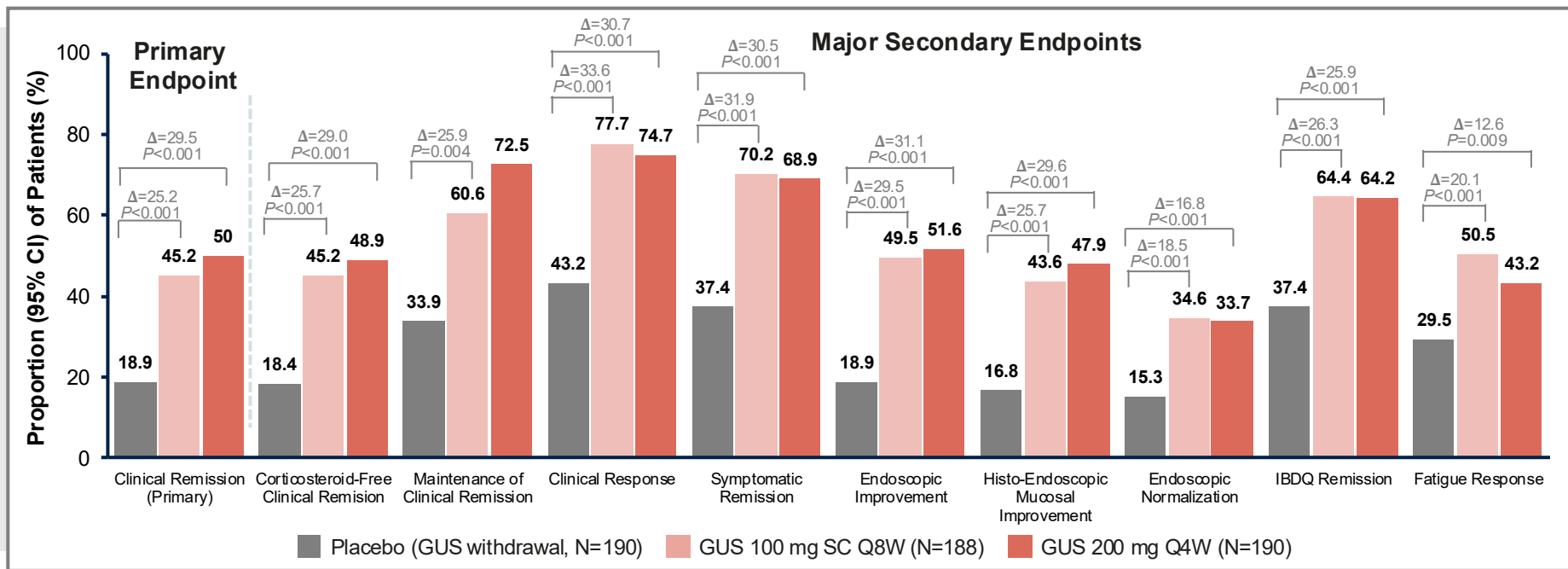
Clinical remission defined as a Mayo SFS of 0 or 1 with no increase from baseline, an RBS of 0, and a MES of 0 or 1 with no friability.

MES, Mayo endoscopic subscore; RBS, rectal bleeding subscore; SFS, stool frequency subscore.

Rubin DT, et al. *Lancet*. 2025;405(10472):33–49.

Guselkumab Maintenance in UC

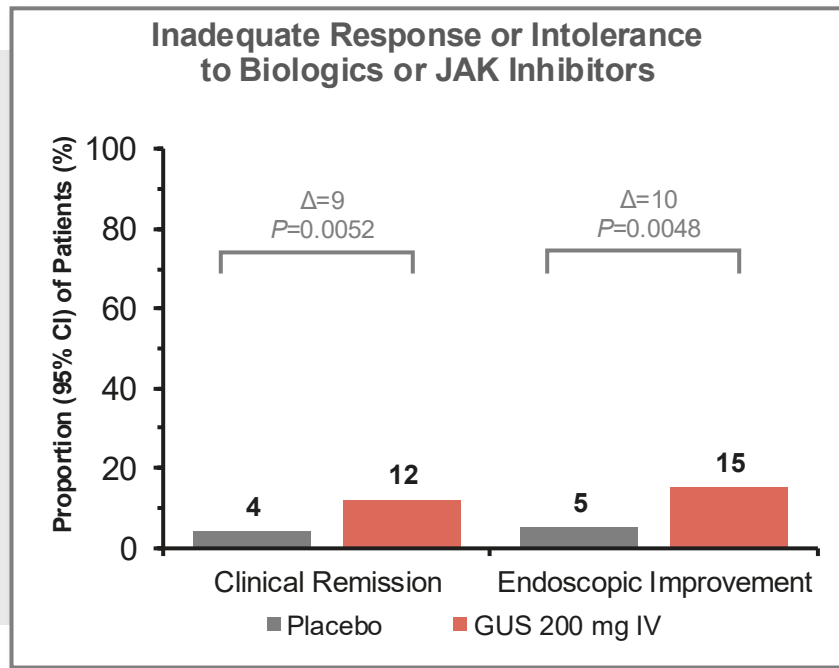
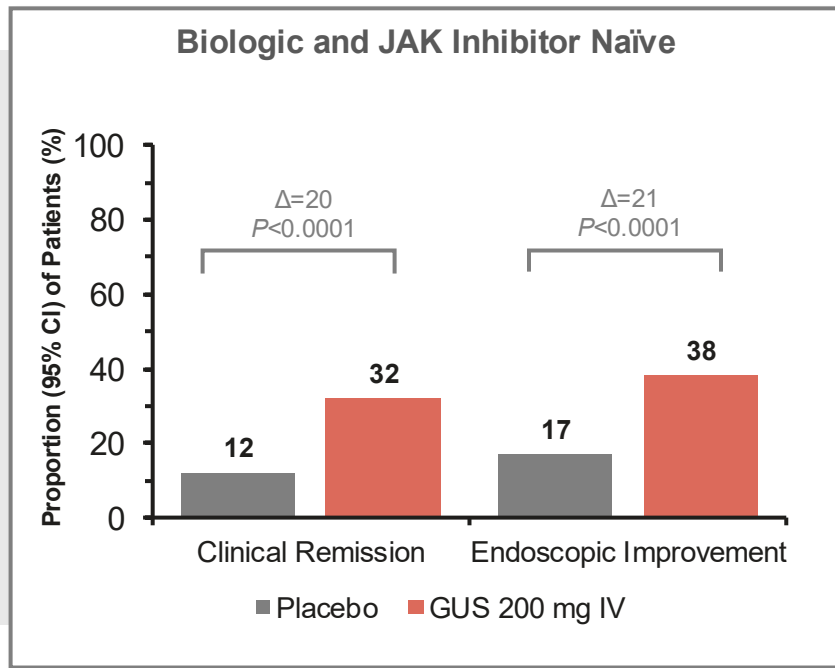
QUASAR Phase 3 Week 44 Endpoints after Induction



Primary analysis population: randomized patients with an MMS of 5–9 at induction who received at least one maintenance study treatment dose.

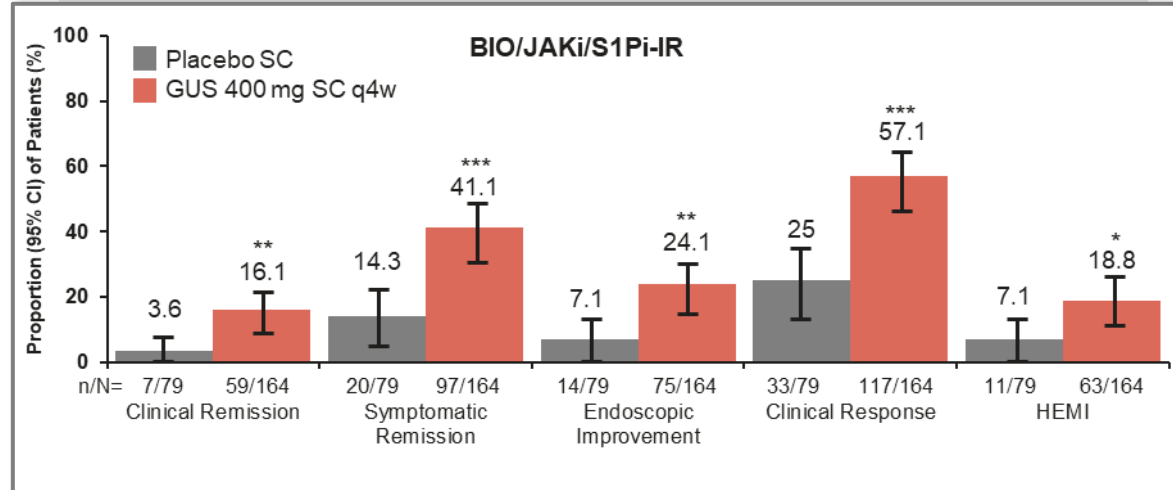
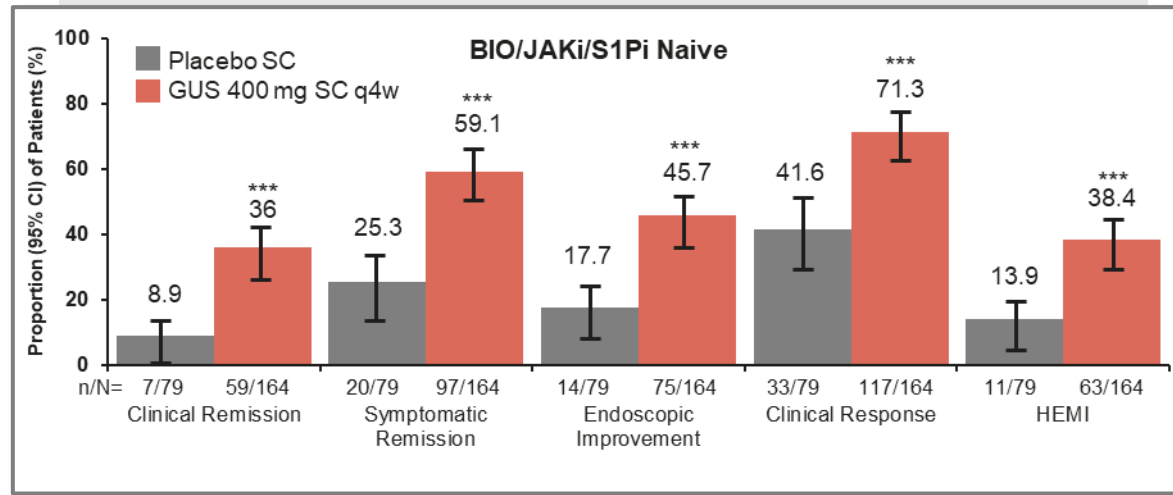
GUS, guselkumab; IBDQ, IBD questionnaire.
Rubin DT, et al. *Lancet*. 2025;405(10472):33–49.

Guselkumab in Previously Treated Patients with UC at Week 44: QUASAR



SC Guselkumab Induction in UC

ASTRO Phase 3 at Week 12



*Nominal $P < 0.05$; **Nominal $P < 0.01$; ***Nominal $P < 0.001$.

Clinical remission: Mayo SFS 0/1 and not increased from BL, a Mayo RBS=0, and MES 0/1 with no friability.

Symptomatic remission: SFS 0/1 and not increased from BL and RBS=0.

Endoscopic improvement: MES 0/1 with no friability.

Clinical response: $\geq 30\%$ and ≥ 2 -point decrease from BL in Modified Mayo Score with ≥ 1 -point decrease from BL in RBS or RBS 0/1.

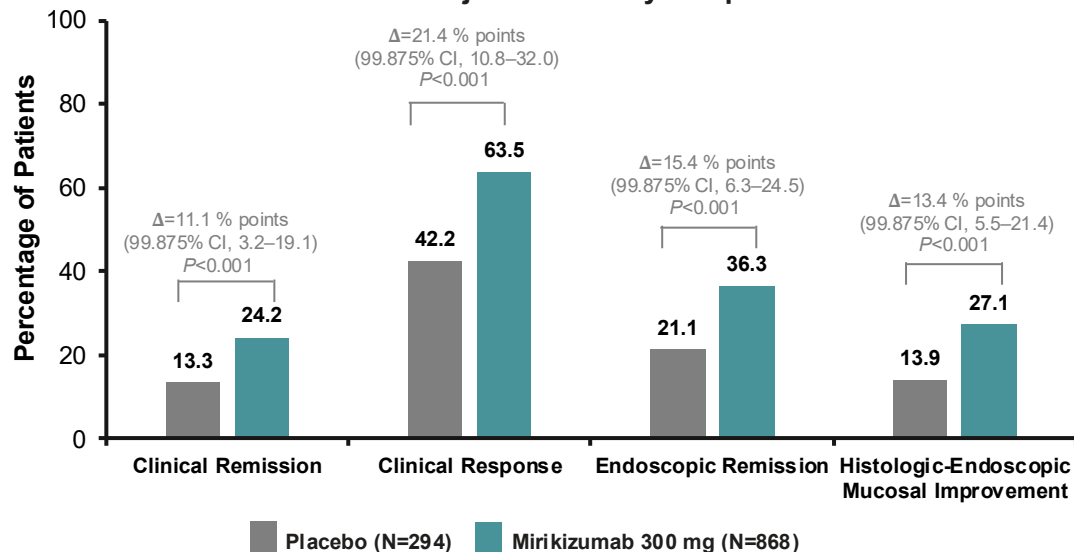
HEMI: histologic improvement (neutrophil infiltration in $< 5\%$ of crypts, no crypt destruction, and no erosions, ulcerations, or granulation tissue per Geboes grading system) and endoscopic improvement.

CI, confidence interval; HEMI, histo-endoscopic mucosal improvement; S1Pi, sphingosine 1-phosphate inhibitor; S1Pi-IR, sphingosine 1-phosphate inhibitor–inadequate response.

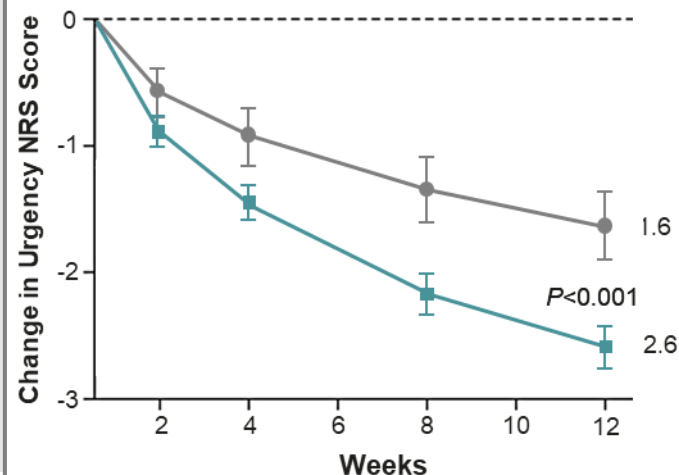
Mirikizumab Induction in UC

LUCENT-1

Primary Endpoint of Clinical Remission and Three Major Secondary Endpoints



Change in Bowel Urgency from Baseline

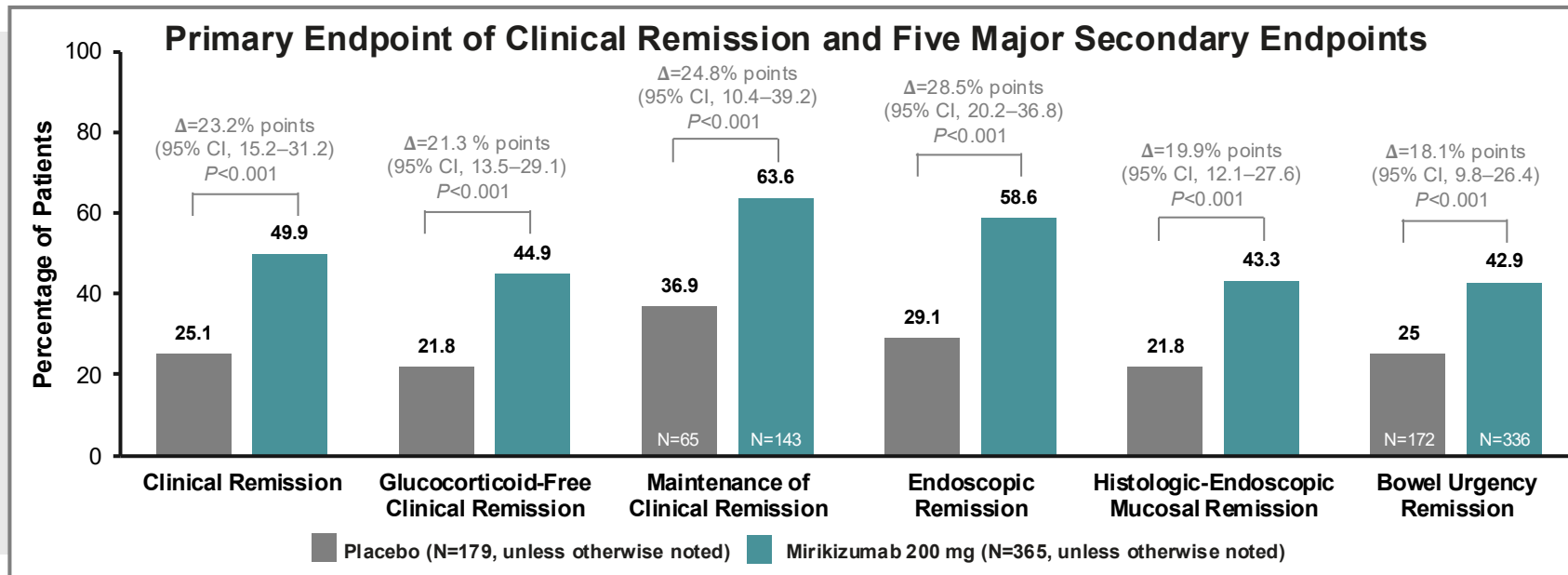


NRS, numeric rating scale.

D'Haens G, et al. *N Engl J Med.* 2023;388(26):2444–2455.

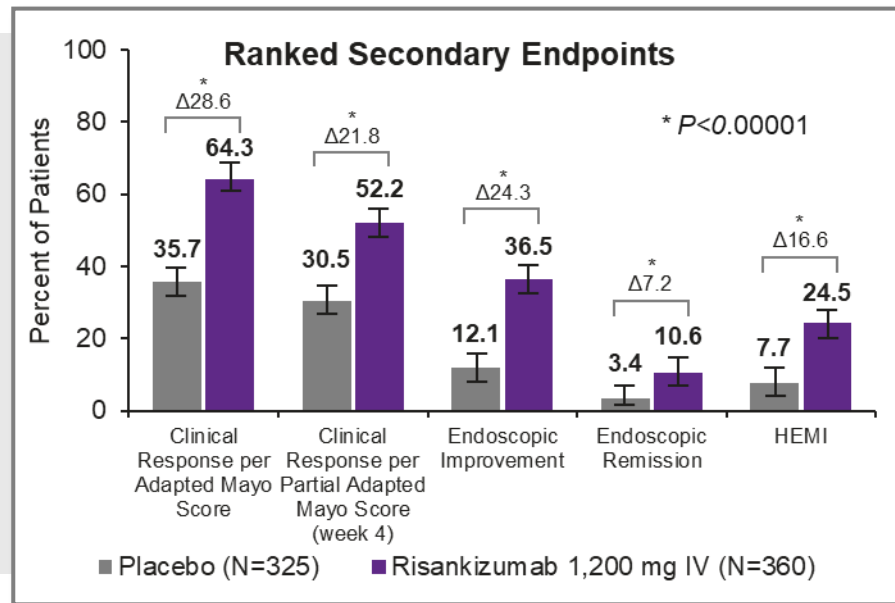
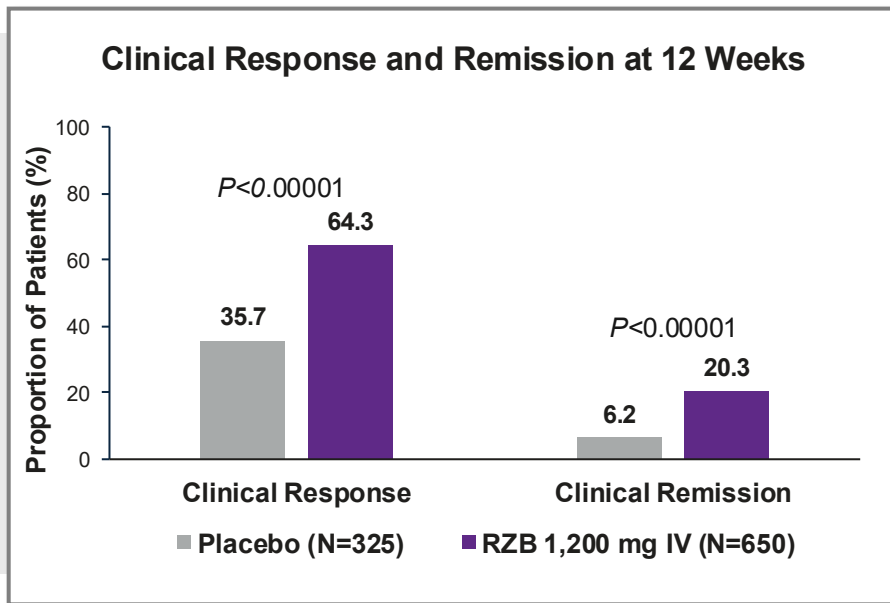
Mirikizumab Maintenance in UC

LUCENT-2 Week 40 Endpoints after Induction



Risankizumab Induction in UC

INSPIRE



*P<0.00001 vs placebo.

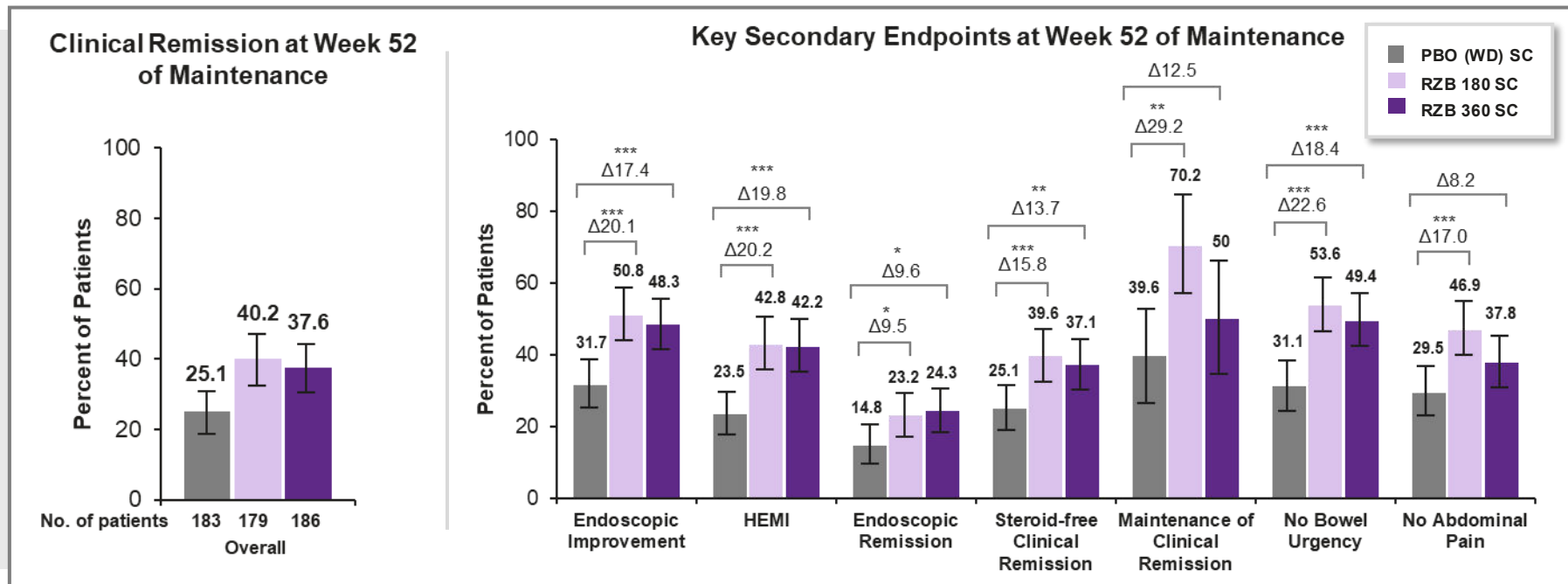
Clinical remission per Adapted Mayo Score is defined as stool frequency subscore (SFS) ≤1 and not greater than baseline, rectal bleeding subscore (RBS) of 0 and ES ≤1 without friability. Clinical response is defined as a decrease from baseline in the Adapted Mayo Score ≥2 points and ≥30% from baseline, plus a decrease in RBS ≥1 or an absolute RBS ≤1.

RZB, risankizumab.

Louis E, et al. *Am J Gastroenterol.* 2023;118(10S):S624–S625.

Risankizumab Maintenance in UC

COMMAND Week 52 Endpoints



* $P \leq 0.05$; ** $P \leq 0.01$; *** $P \leq 0.001$ vs PBO (WD) SC.

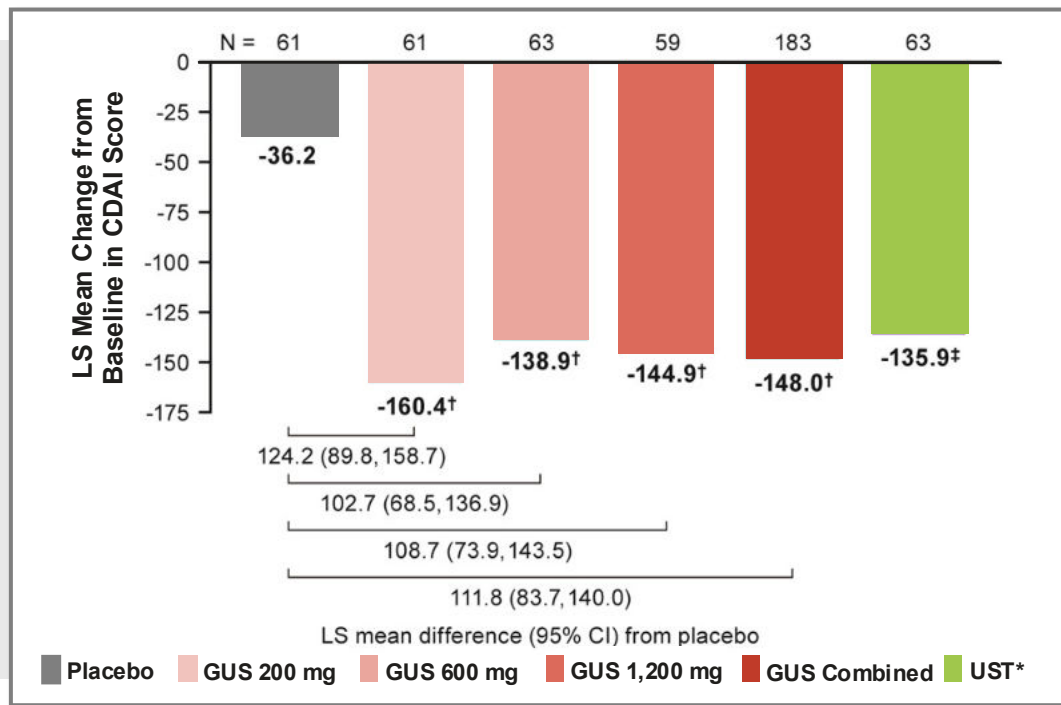
HEMI, histo-endoscopic mucosal improvement; IR, inadequate response; PBO, placebo; WD, withdrawal.
 Louis E, et al. *J Crohns Colitis*. 2024;18(Suppl 1):i10–i12.

Pivotal CD Efficacy: IL-23p19 Inhibitors

Clinical Remission and Endoscopic Improvement

GALAXI-1

Guselkumab Induction in CD



Primary Endpoint

- Change from baseline in CDAI score at week 12
- GALAXI-1 is a DBPC trial
- Randomized patients 1:1:1:1:1 to
 - 3 different doses of IV GUS given at weeks 0, 4, and 8
 - IV UST at week 8
 - Placebo
- UST was a reference arm
- N=309

*UST 6 mg/kg IV → 90 mg SC; [†] <0.05 for GUS vs placebo; [‡]Nominal <0.05 from post hoc analysis of UST vs placebo.

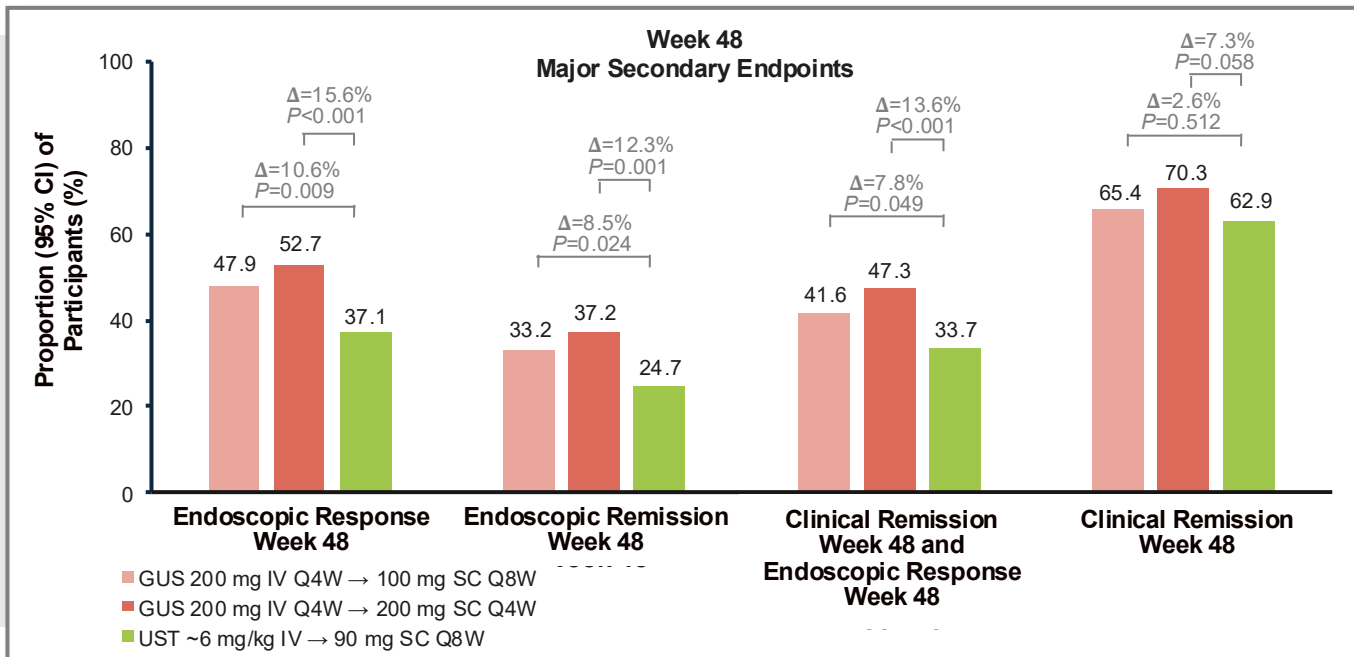
CDAI, Crohn's disease activity index; DBPC, double-blind placebo controlled; LS, least squares; UST, ustekinumab.

Sandborn W, et al. *Gastroenterology*. 2022;162(6):1650–1664.

GALAXI 2 and 3

Guselkumab Maintenance in CD

GALAXI 2 and 3 are identical 48-week, randomized, double-blind, double-dummy, placebo, and active-comparator (UST) treat-through trials assessing the efficacy and safety of GUS in patients with moderately to severely active CD



Clinical response: ≥100-point reduction from baseline in CDAI or CDAI <150

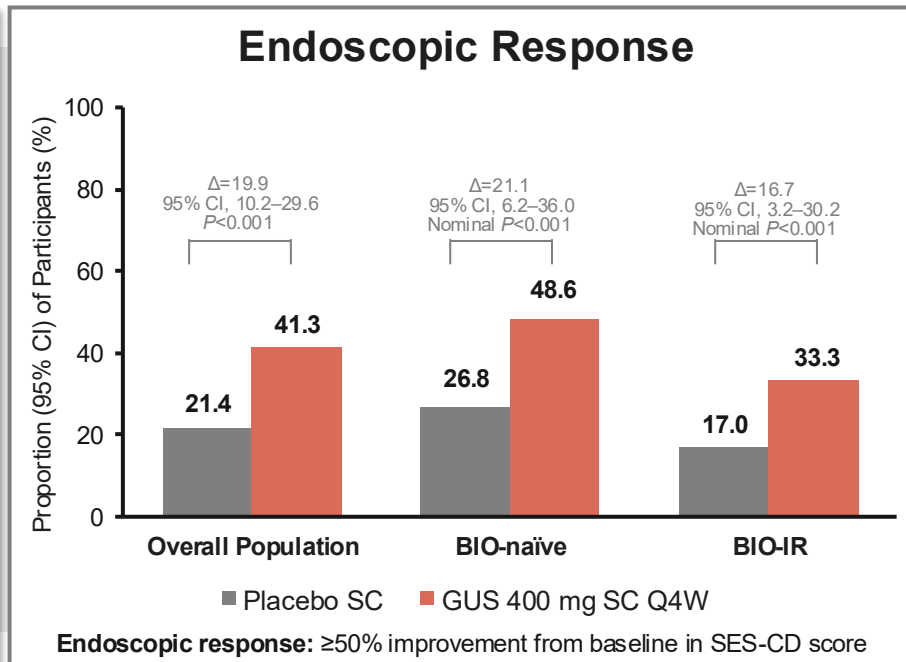
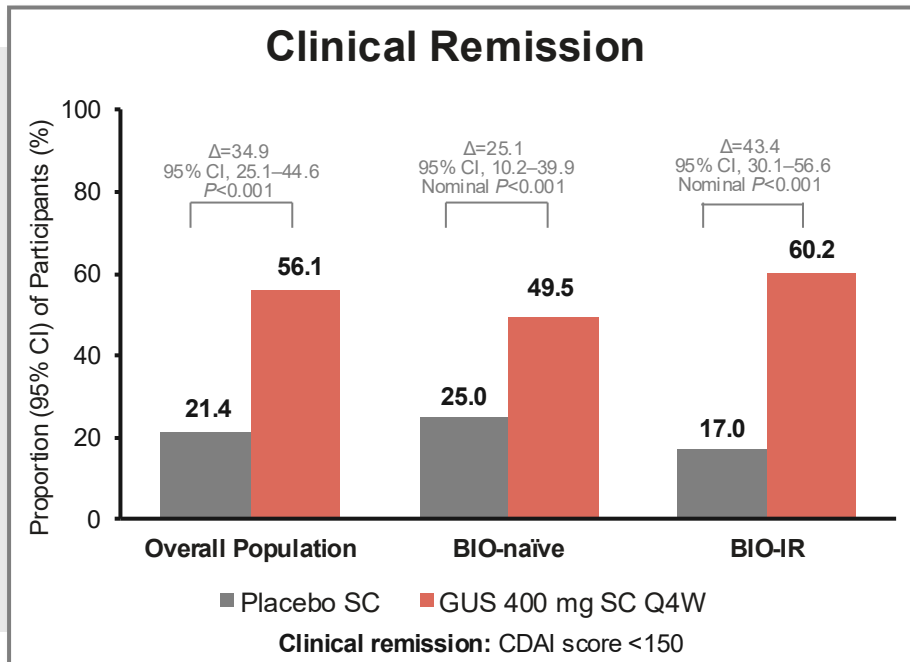
Endoscopic response: ≥50% improvement from baseline in SES-CD or SES-CD ≤2

Clinical remission: CDAI <150

Endoscopic remission: SES-CD ≤4 and a ≥2-point reduction from baseline and no subscore greater than 1 in any individual component

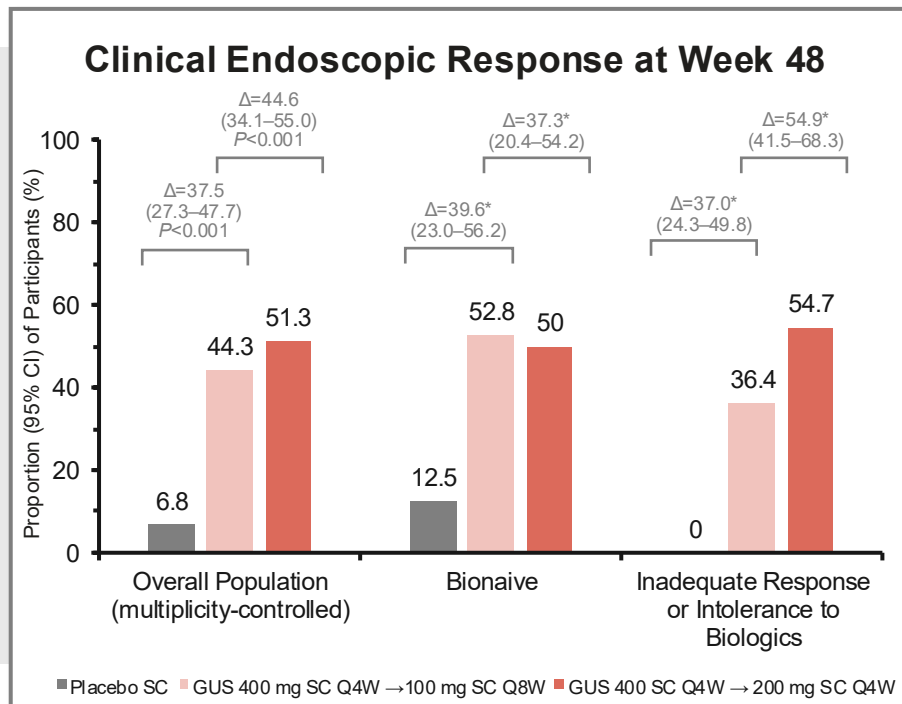
GRAVITI

Subcutaneous Guselkumab in CD at Week 12



GRAVITI

Subcutaneous Guselkumab in CD at Week 48

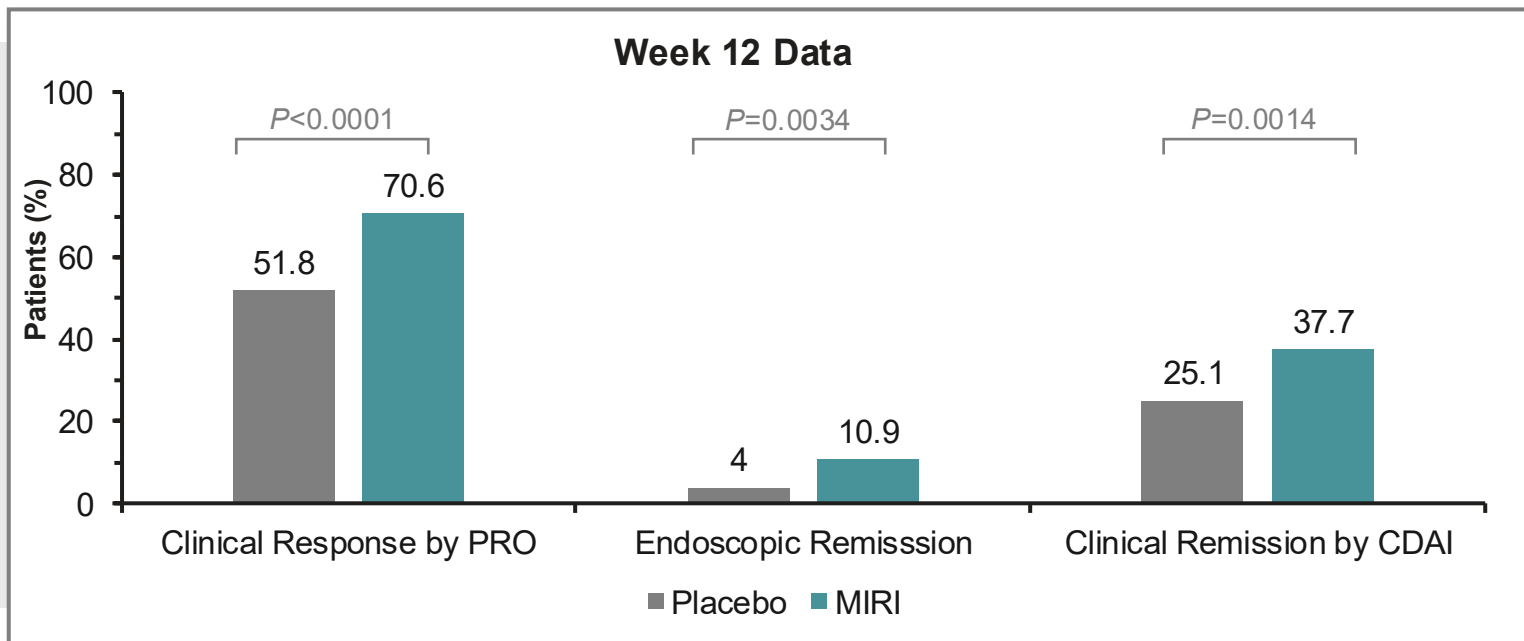


*Nominal p-value<0.05

Hart A, et al. *Gastroenterology*. 2025;169(2):308-325.

VIVID-1

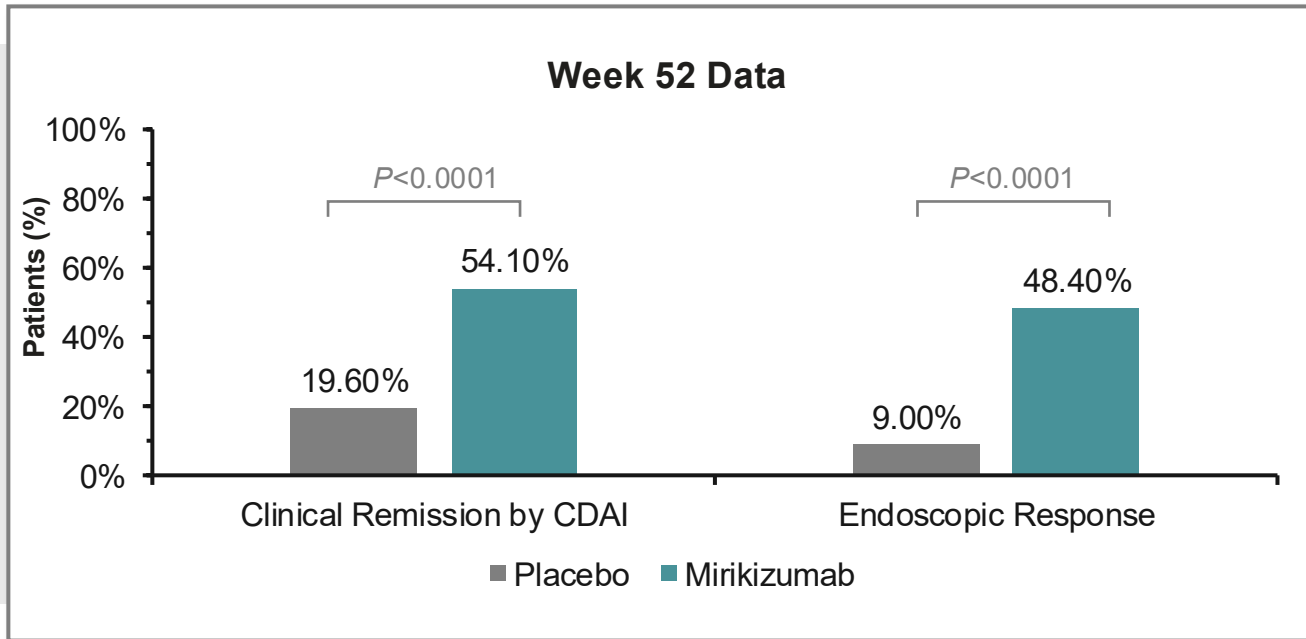
Mirikizumab Induction in CD



MIRI, mirikizumab; PRO, patient reported outcomes.
Ferrante M, et al. *Lancet*. 2024;404(10470):2423–2436.

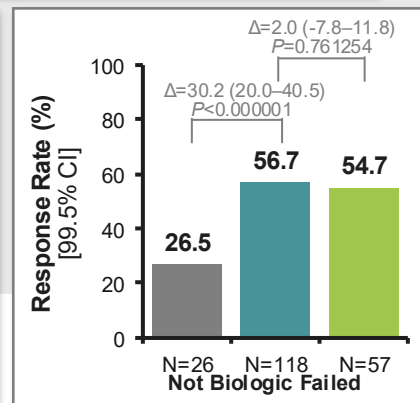
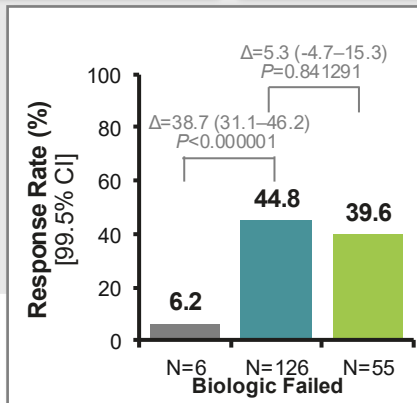
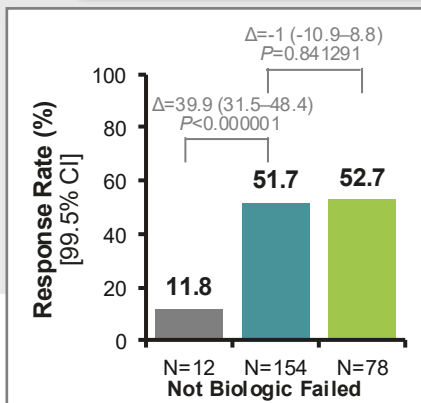
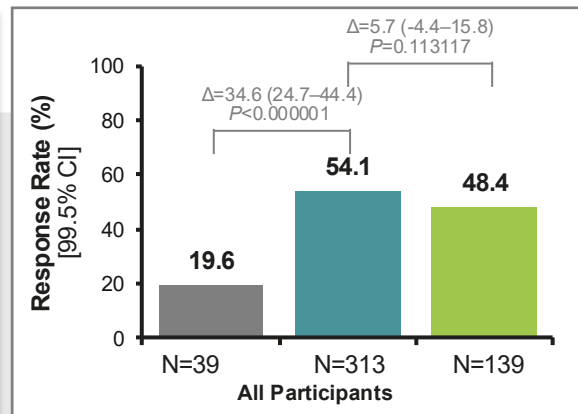
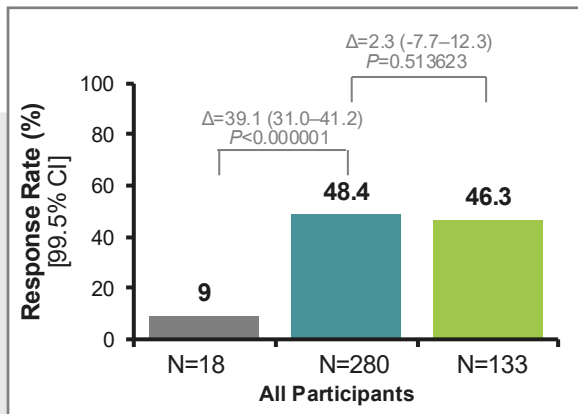
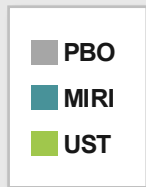
VIVID-1

Mirikizumab Maintenance in CD



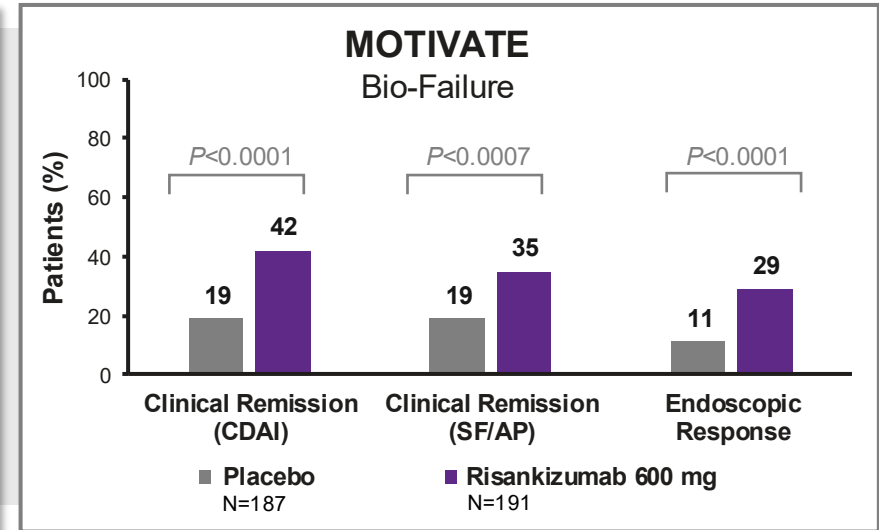
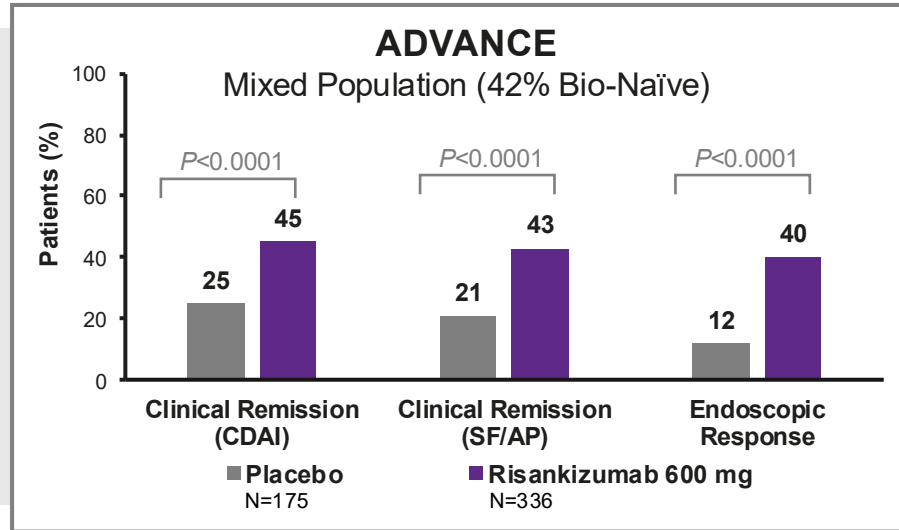
VIVID-1 Secondary Endpoints

Mirikizumab vs Ustekinumab in Moderate-to-Severe CD



ADVANCE and MOTIVATE

Risankizumab Induction in CD



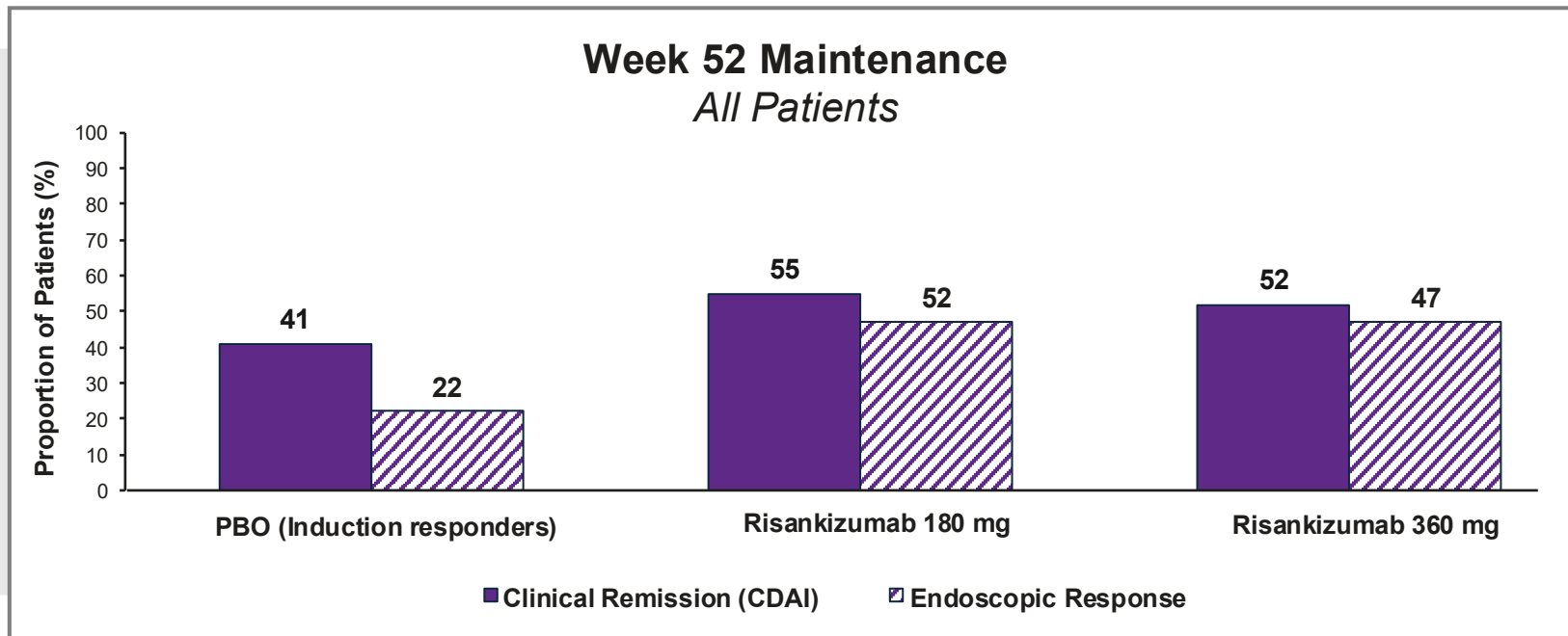
Clinical responders defined as $\geq 30\%$ decrease in average daily stool frequency or abdominal pain score (APS) and not worse than baseline; endoscopic response defined as $>50\%$ decline in simple endoscopic score (SES-CD) vs baseline by central reviewer (or in patients with SES-CD of 4 at baseline, ≥ 2 -point decrease vs baseline); CDAI clinical remission, a CDAI of < 150 .

CDAI, Crohn's disease activity index; SF/AP, stool frequency/abdominal pain.

D'Haens G, et al. *Lancet*. 2022;399(10340):2015–2030. Ferrante M, et al. *Lancet*. 2022;399(10340):2031–2046.

FORTIFY

Risankizumab Maintenance in CD

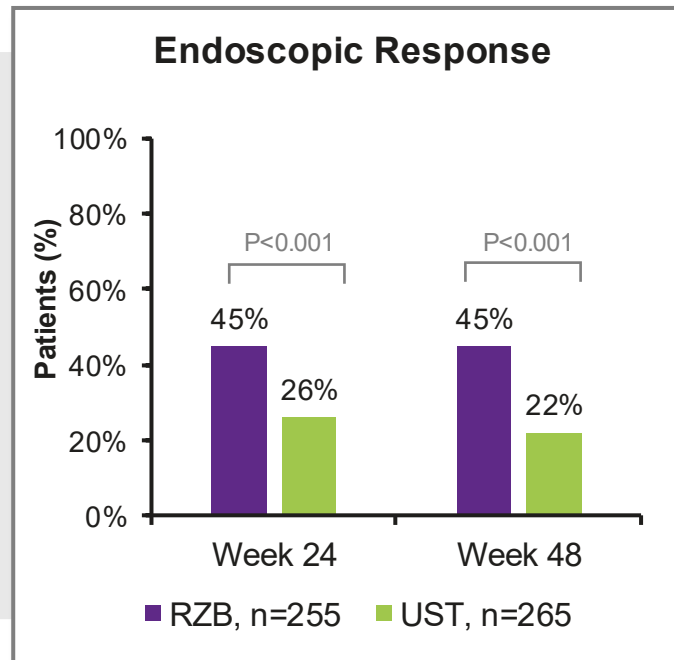
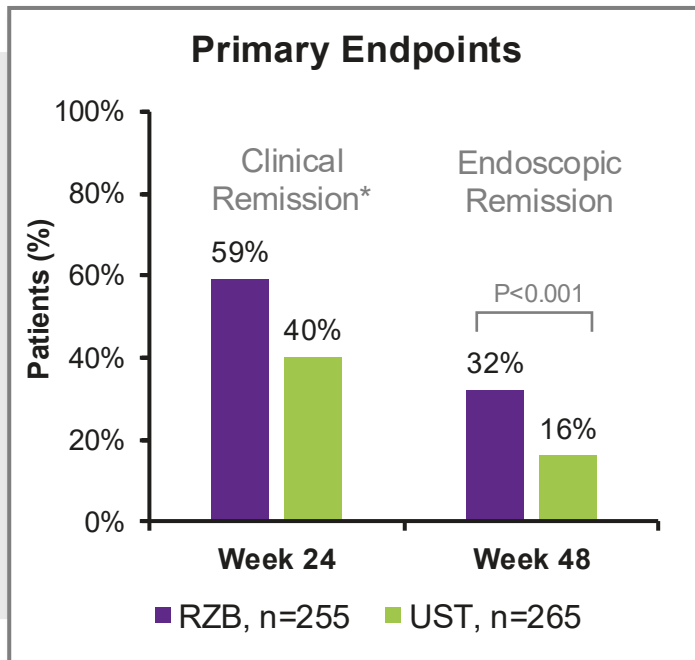


Endoscopic response defined as >50% decline in SES-CD vs baseline by central reviewer (or in patients with SES-CD of 4 at baseline, ≥ 2 -point decrease vs baseline); CDAI clinical remission, a CDAI of <150.

Ferrante M, et al. *Lancet*. 2022;399(10340):2031–2046.

SEQUENCE

Risankizumab vs Ustekinumab in CD



*Noninferiority met.

Peyrin-Biroulet L, et al. *N Engl J Med.* 2024;391:213–223.

Patient Cases: What Would You Do?

*Audience, Community/Rural Clinician, KOL, AI,
and Faculty Responses to Three Patients with IBD*



PATIENT VOICE

Natalie Hayden, Patient Advocate

- 42-year-old female with long-standing Crohn's ileitis, diagnosed at age 21
- Worsening symptoms over 6–8 weeks
 - Increased abdominal pain/cramping and bloating
 - Loose stools/diarrhea and fatigue
 - Decreased appetite; weight stable
- Previously in long-term remission on adalimumab
 - Payer-mandated non-medical switch to an adalimumab biosimilar 3 months ago (no dose/schedule change)
 - Expresses frustration with payer-driven switch but understands coverage constraints
- Required a recent short course of budesonide with partial symptom relief
- Denies fevers or vomiting
- Reports embarrassment discussing bowel symptoms and concern about losing disease control
- Prefers to avoid IV therapies
 - Cites work as a news reporter, concerns about time away from work, visibility, and stigma
 - Asks about options for durable control without long-term steroids or infusions
- Notes mild psoriasiform rash (umbilicus, ears, now scalp), increasingly bothersome



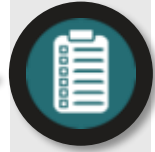


PATIENT VOICE

Natalie Hayden, Patient Advocate

Endoscopy: Colonoscopy with SES-CD score: 11 (moderate to marked disease activity within the ileum)

	Result	Reference Range
C-reactive protein (CRP)	9.8 mg/L	<10 mg/L: normal/low, common in healthy adults
Fecal calprotectin	620 µg/g	<50 µg/g: normal (low inflammation)
Adalimumab trough level	19 µg/mL	4.5 µg/mL to 12 µg/mL: optimal trough levels
Anti-adalimumab abs	None detected	—
Hemoglobin	11.2 g/dL	13.5 g/dL to 17.5 g/dL: normal range for women
Platelets	420,000/µL	150,000/µL to 450,000/µL: normal
Albumin	3.5 g/dL	3.5 g/dL to 5 g/dL: normal





AUDIENCE POLLING

What would you do next?

- A. Increase dosing frequency of her current adalimumab therapy
- B. Switch to another anti-TNF agent
- C. Switch to an IL-23 inhibitor
- D. Switch to vedolizumab
- E. Switch to upadacitinib
- F. Manage symptoms with budesonide and re-evaluate in 3 months





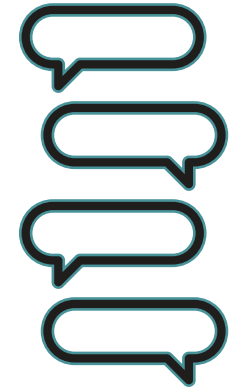
EXPERT FACULTY

Live Discussion



Decision Point

Patient Case: Natalie Hayden





COMMUNITY GASTROENTEROLOGIST

Audio Recording: Case 1



C Switch to an IL-23 inhibitor

- **Moderate disease activity** with flare requiring steroids, anemia symptoms, and elevated biomarkers
- **Escalation beyond anti-TNF warranted** → switch to a different advanced therapy class
- **IL-23 inhibitor favored:** strong efficacy, favorable safety vs JAK inhibitors, potential benefit for psoriasis
- **Vedolizumab:** acceptable alternative if gut-selective therapy preferred, but likely less efficacious
- **Subcutaneous administration preferred** to align with patient's social and work circumstances



RURAL GASTROENTEROLOGIST: 12 YEARS

Audio Recording: Case 1



A Increase dosing frequency of her current adalimumab therapy

- **Long-term remission on adalimumab** prior to recent biosimilar switch
- **Short symptom duration (6–8 weeks)** → may reflect pharmacokinetic loss of response
- **Dose escalation is practical and payer-friendly** before changing mechanism
- **Assess before switching:** check trough/antibodies; rule out *C. difficile*; recheck CRP and fecal calprotectin

Rule outs

- **Another anti-TNF:** reserve for antibodies or clear secondary loss
- **IL-23 inhibitor:** prefer more long-term real-world experience first
- **Vedolizumab:** IV only, slower onset
- **Upadacitinib:** higher monitoring and safety burden; not first move
- **Budesonide alone:** risks masking disease activity and promoting steroid dependence



COMMUNITY MD: 9 YEARS

Audio Recording: Case 1



C Switch to an IL-23 inhibitor

- **Loss of disease control** after anti-TNF biosimilar switch with steroid rescue
- **New psoriasiform rash** → consistent with paradoxical anti-TNF effect; favors mechanism change
- **Switch to IL-23 inhibitor** for durable, steroid-free control
- **Guselkumab preferred:** fully subcutaneous; avoids IVs/work disruption and aligns with patient priorities

Rule outs

- **Increase adalimumab dose:** possible if low exposure, but rash suggests class-related issue
- **Another anti-TNF:** paradoxical psoriasis often persists across class
- **Vedolizumab:** IV-based, slower onset, no skin benefit
- **Upadacitinib:** effective but reserved for later/need for speed due to safety monitoring
- **Budesonide alone:** risks masking disease and steroid dependence



Additional Community Gastroenterologist Responses for Case 1



RESPONDENT 1

C Switch to an IL-23 inhibitor

RESPONDENT 2

C Switch to an IL-23 inhibitor

RESPONDENT 3

C Switch to an IL-23 inhibitor

RESPONDENT 4

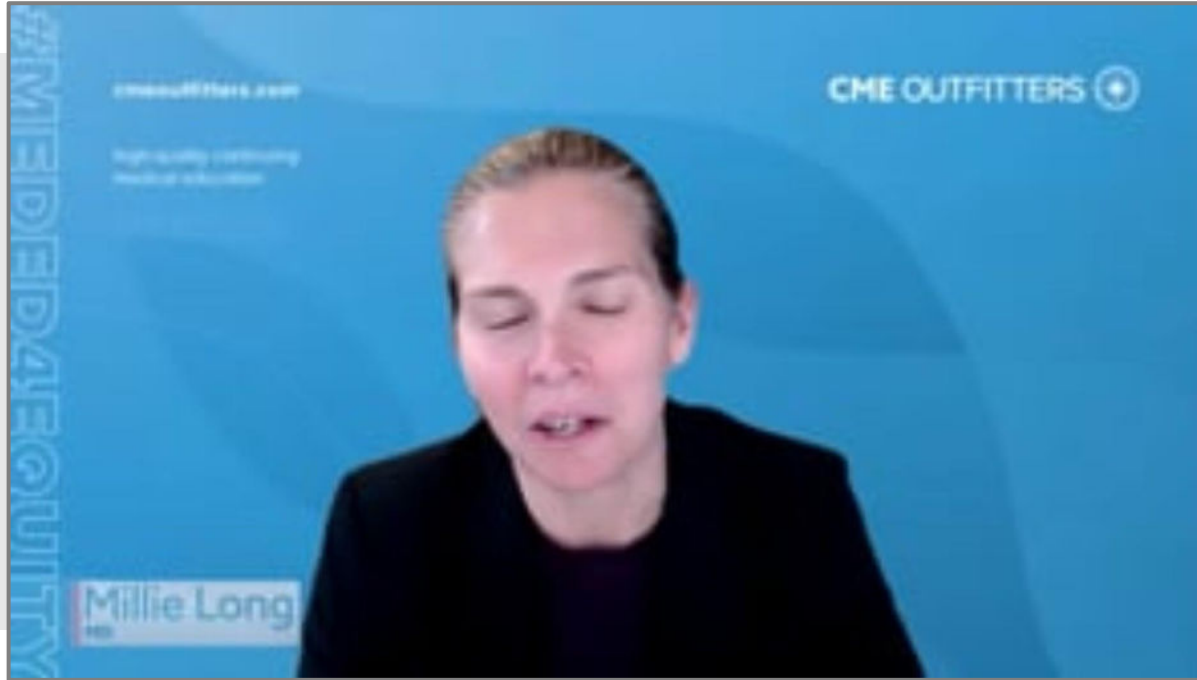
E Switch to upadacitinib



KOL: MILLIE D. LONG, MD, MPH

Video Recording: Case 1

C Switch to an IL-23 inhibitor



Paradoxical Psoriasiform Rash with Anti-TNF Therapy in IBD

- **What it is:** new-onset psoriasis/psoriasiform eruption (or flare/phenotypic shift of prior psoriasis) occurring during anti-TNF treatment, despite anti-TNFs being used to treat psoriasis
- **How often it happens in IBD:** systematic review/meta-analysis estimates an overall incidence of ~6% in anti-TNF-treated IBD
- **Common patterns:** frequently involves scalp, palms/soles (palmoplantar pustulosis), and plaque-type lesions; may be distressing and adherence-limiting
- **Who's at higher risk:** higher risk reported with smoking, female sex, younger age at anti-TNF start, and ileocolonic Crohn's; risk may vary by specific anti-TNF agent
- **Variation in the IL-23 receptor gene** may identify those at risk of anti-TNF α -induced paradoxical psoriasis (PP), beyond clinical variables



KOL: JESSICA R. ALLEGRETTI, MD, MPH, FACG, AGAF

Video Recording: Case 1

C Switch to an IL-23 inhibitor





KOL: EDWARD V. LOFTUS, JR., MD

Video Recording: Case 1

C Switch to an IL-23 inhibitor





AI: ChatGPT 5.2

User-Fed Response: Case 1



New chat → Here's the case subjective, objective, and plan/multiple choice question. Based on the information provided, which answer choice would you choose and what is your brief rationale for your chosen answer and unchosen options?



C Switch to an IL-23 inhibitor



Rationale: active Crohn's despite therapeutic adalimumab levels and no antibodies → mechanistic failure, not underdosing. An IL-23 offers durable efficacy, subcutaneous dosing, and potential improvement in psoriasiform rash



Rule outs

- Another anti-TNF:** dose escalation or class cycling unlikely to help
- Budesonide:** delays disease-modifying therapy
- Vedolizumab:** IV induction and slower onset conflict with patient preferences
- Upadacitinib:** broader systemic safety considerations; no skin benefit



NATALIE HAYDEN

Video Clip: Introduction





NATALIE HAYDEN

Video Clip: Quality of Life





Case Perspective Summary

Case 1



	Community/Rural	KOLs	AI
Increase dosing frequency of her current adalimumab therapy	1	—	—
Switch to another anti-TNF agent	—	—	—
Switch to an IL-23 inhibitor	5	3	1
Switch to vedolizumab	—	—	—
Switch to upadacitinib	1	—	—
Manage symptoms with budesonide and re-evaluate in 3 months	—	—	—

Pearls Learned from Natalie's Case

➡➡ CD, anti-TNF experience, payer switch, EIMs, patient preferences



EIMs can guide mechanism selection

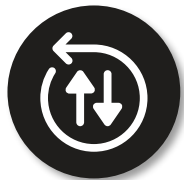
New or worsening psoriasiform rash during anti-TNF therapy supports moving away from the class and considering IL-23–targeted therapy



Durable control requires aligning efficacy with patient priorities

High-efficacy therapies with subcutaneous dosing can improve adherence and long-term success when treatment choice reflects work, stigma, and lifestyle concerns

ACG explicitly highlights patient-specific factors: prior intolerance, safety profile, RoA, and life stage considerations



Loss of control after a non-medical switch warrants reassessment—not reassurance

Symptom relapse and steroid rescue following a biosimilar switch should prompt evaluation for mechanistic failure and appropriate therapy escalation



AUDIENCE POLLING REVISITED

NOW, what would you do next?

- A. Increase dosing frequency of her current adalimumab therapy
- B. Switch to another anti-TNF agent
- C. Switch to an IL-23 inhibitor
- D. Switch to vedolizumab
- E. Switch to upadacitinib
- F. Manage symptoms with budesonide and re-evaluate in 3 months





PATIENT VOICE

Kaylaa' White, Patient Advocate

- 34-year-old female with ulcerative colitis
- Ongoing symptoms for 3–4 months
 - 5–6 loose stools per day with intermittent blood
 - Urgency and occasional incontinence
 - Lower abdominal cramping and fatigue
 - Symptoms significantly limit ability to work full time
- Steroid-dependent disease
 - ≥3 prednisone tapers in the past year
 - Concerned about long-term effects of repeated steroid use
- Inadequate response to optimized oral and rectal 5-aminosalicylic acid (ASA) therapy
- Prior infliximab intolerance
 - Severe fatigue, headaches, and infusion reactions
- Feels discouraged by prior treatment failures
 - Seeks a treatment plan she can maintain long term
- Family planning considerations
 - Considering pregnancy within the next year





PATIENT VOICE

Kaylaa' White, Patient Advocate

Endoscopy

- Flexible sigmoidoscopy shows continuous moderate inflammation involving the rectum and sigmoid colon, with no deep ulcerations

Disease Activity

- Partial Mayo Score = 3 (moderate disease activity)
- Mayo endoscopy subscore = 2 (moderate disease activity)

	Result	Reference Range
CRP	12 mg/L	<10 mg/L: normal/low, common in healthy adults
Fecal calprotectin	850 µg/g	<50 µg/g: normal (low inflammation)
Hemoglobin	11.2 g/dL	13.5 g/dL to 17.5 g/dL: normal range for women
Albumin	3.5 g/dL	3.5 g/dL to 5 g/dL normal





AUDIENCE POLLING

What would you do next?

- A. Continue current therapy and attempt another prednisone taper
- B. Switch to another anti-TNF agent
- C. Switch to an IL-23 inhibitor
- D. Switch to upadacitinib
- E. Switch to vedolizumab
- F. Begin thiopurine monotherapy and reassess in 3–6 months





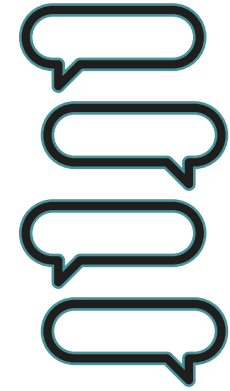
EXPERT FACULTY

Live Discussion



Decision Point

Patient Case: Kaylaa' White





COMMUNITY GASTROENTEROLOGIST

Audio Recording: Case 2



E Switch to vedolizumab

- **Moderate UC** with recurrent flares requiring repeated steroid rescue
- **TNF intolerance** → avoid further anti-TNF therapy
- **Continued steroids:** ineffective and unsafe long term
- **Advance therapy warranted:** IL-23 and upadacitinib are options
- **Vedolizumab preferred** given pregnancy planning and gut-selective profile





COMMUNITY MD: 9 YEARS

Audio Recording: Case 2



E Switch to vedolizumab

- **Escalation needed:** failure of optimized oral and rectal 5-ASA
- **Prior infliximab intolerance** → avoid anti-TNF agents
- **Pregnancy planning** within the next year influences therapy choice
- **Vedolizumab selected** for gut-selective mechanism and pregnancy comfort
- Clinician has **limited familiarity with IL-23 data in pregnancy**

Rule outs

- **Do not continue 5-ASA alone:** inadequate response; delays control and increases steroid risk
- **Do not restart infliximab:** prior infusion reactions and systemic intolerance
- **Another anti-TNF:** considered given pregnancy data, but prior intolerance raises adherence concerns
- **IL-23 inhibitor:** appealing efficacy, but limited pregnancy data influence caution
- **Avoid upadacitinib:** pregnancy planning makes risk profile unfavorable





RURAL GASTROENTEROLOGIST: 18 YEARS

Audio Recording: Case 2



E Switch to vedolizumab

- **Moderate–severe UC** with persistent symptoms impacting work and quality of life
- **Steroid dependence** (≥ 3 prednisone tapers in past year) → urgent need to stop steroid cycle
- **Goal:** durable, safe maintenance therapy with rapid steroid withdrawal
- **Vedolizumab selected:** effective in UC with strong long-term safety profile
- **Practical choice:** manageable monitoring and feasible in a rural practice

Rule outs

- **Do not continue prednisone tapers:** confirms steroid dependence and increases long-term toxicity
- **Another anti-TNF:** possible, but favors mechanism change given ongoing steroid reliance
- **IL-23 inhibitor:** effective option, but preference for more real-world durability and payer predictability before first-line use
- **Upadacitinib:** rapid efficacy but greater systemic safety and monitoring burden; reserved for later lines
- **Thiopurine monotherapy:** too slow and insufficient for current disease severity



Additional Community Gastroenterologist Responses for Case 2



RESPONDENT 1

C

Switch to an IL-23 inhibitor

RESPONDENT 2

E

Switch to vedolizumab

RESPONDENT 3

E

Switch to vedolizumab

RESPONDENT 4

C

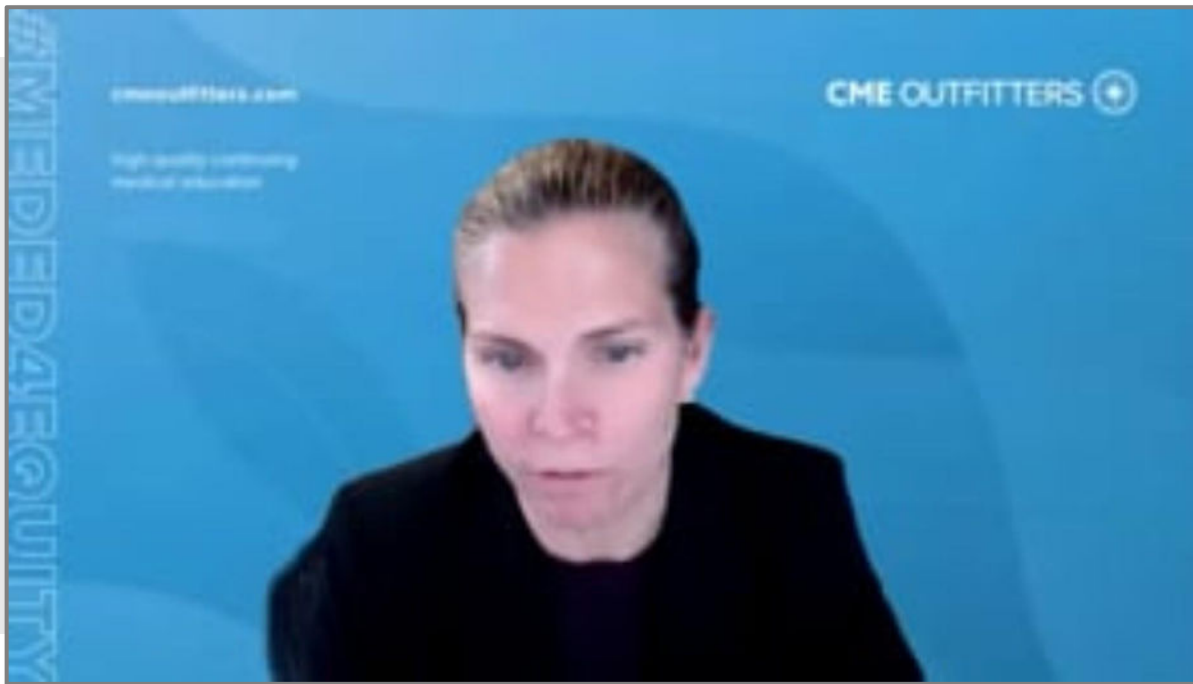
Switch to an IL-23 inhibitor



KOL: MILLIE D. LONG, MD, MPH

Video Recording: Case 2

C Switch to an IL-23 inhibitor





KOL: JESSICA R. ALLEGRETTI, MD, MPH, FACG, AGAF

Video Recording: Case 2

C Switch to an IL-23 inhibitor



Pearls from the PIANO Study



Active disease poses greater pregnancy risk

Poor control—not biologic therapy—drives adverse maternal and neonatal outcomes



Biologics did not increase adverse outcomes

No higher risk of congenital anomalies, infections, or developmental harm



Steroid exposure carries measurable risk

Associated with preterm birth, low birth weight, and NICU admission



Continuation of effective therapy is recommended

Maintaining remission through pregnancy improves outcomes



Pregnancy should guide proactive treatment planning

Pregnancy should guide therapy choice—not delay escalation

IBD Medications from Preconception through Pregnancy and Lactation

Medication	Preconception	First Trimester	Second Trimester	Third Trimester	Lactation
Aminosalicylates • Folic acid supplementation with sulfasalazine	☑	☑	☑	☑	☑
Thiopurine • Monitor metabolites, liver enzymes	☑	☑	☑	☑	☑
Methotrexate • Teratogen • Cessation 1–3 months prior to conception	☒	☒	☒	☒	☒
Corticosteroids • Minimize use • Employ steroid-sparing therapy	☑	☑	☑	☑	☑
Anti-TNF	☑	☑	☑	☑	☑
Anti-integrin	☑	☑	☑	☑	☑
Anti-IL-12/23 or anti-IL-23	☑	☑	☑	☑	☑
JAKi • Avoid • Use only if no other viable option for maternal health	!	!	!	!	!
S1P receptor modulator • Avoid • Use only if no other viable option for maternal health	!	!	!	!	!

☑, appropriate to use during pregnancy; ☒, avoid during pregnancy; !, avoid unless no viable option for maternal health.



KOL: EDWARD V. LOFTUS, JR., MD

Video Recording: Case 2

C Switch to an IL-23 inhibitor





AI: CHATGPT 5.2

User-Fed Response: Case 2



New chat → Here's the case subjective, objective, and plan/multiple choice question. Based on the information provided, which answer choice would you choose and what is your brief rationale for your chosen answer and unchosen options?

E Switch to vedolizumab

Rationale: This patient has moderate, steroid-dependent ulcerative colitis with objective inflammation, despite optimized 5-ASA therapy. Continued steroid tapers are no longer appropriate. **Vedolizumab** offers effective disease control with a favorable long-term safety profile and is well suited for a patient planning pregnancy, making it the best overall choice.

Rule outs

- Another prednisone taper:** perpetuates steroid dependence
- Another anti-TNF:** less favorable due to prior infliximab intolerance
- Thiopurine monotherapy:** slow onset and limited efficacy
- Upadacitinib:** effective but contraindicated with pregnancy planning
- IL-23 inhibitor:** reasonable option, but less pregnancy safety data than vedolizumab



KAYLAA' WHITE

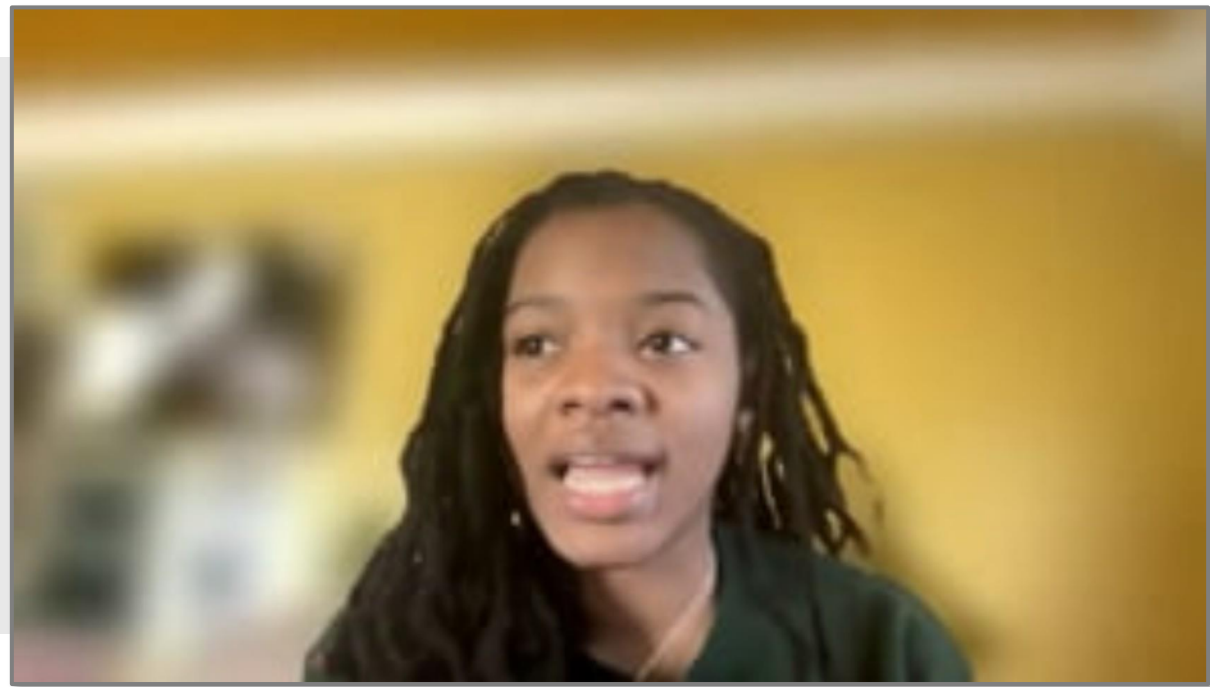
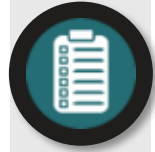
Video Clip: Introduction and Symptom Onset





KAYLAA' WHITE

Video Clip: Acute Symptom Flare





Case Perspective Summary

Case 2



	Community/Rural	KOLs	AI
Continue current therapy and attempt another prednisone taper	—	—	—
Switch to another anti-TNF agent	—	—	—
Switch to an IL-23 inhibitor	2	3	—
Switch to upadacitinib	—	—	—
Switch to vedolizumab	5	—	1
Begin thiopurine monotherapy and reassess in 3–6 months	—	—	—

Pearls Learned from Kaylaa's Case

➤ UC, steroid dependence, TNF intolerance, pregnancy planning, safety-first strategy



Steroid dependence defines disease severity and mandates durable maintenance therapy

Repeated prednisone tapers indicate uncontrolled UC and should trigger transition to effective, steroid-sparing advanced therapy

ACG reinforces that **recurrent or steroid-dependent UC should not be managed with repeated tapers**



Treatment intolerance is as meaningful as treatment failure

Prior infusion reactions and systemic intolerance appropriately steer clinicians away from class cycling—even when efficacy data exist



Therapy selection must balance efficacy with long-term safety confidence

In patients planning pregnancy, choosing a therapy with established safety and real-world familiarity supports timely disease control and sustained adherence



AUDIENCE POLLING REVISITED

NOW what would you do next?

- A. Continue current therapy and attempt another prednisone taper
- B. Switch to another anti-TNF agent
- C. Switch to an IL-23 inhibitor
- D. Switch to upadacitinib
- E. Switch to vedolizumab
- F. Begin thiopurine monotherapy and reassess in 3–6 months





PATIENT VOICE

Brandon

- 28-year-old male with recently diagnosed ileocecal Crohn's disease
- Persistent symptoms x 3 months
 - 4–5 loose stools per day with urgency
 - Lower abdominal discomfort and fatigue
 - Symptoms interfere with gym routine and social activities
- Unintentional 7-lb weight loss over several weeks
- Completed a 2-month course of budesonide with ongoing active symptoms
- Concerned about prolonged steroid exposure
 - Seeking durable disease control rather than repeated steroid courses
- Biologic- and small molecule-naïve





PATIENT VOICE

Brandon

Endoscopy

- Ileocolonoscopy shows inflammation involving the distal 15 cm of the ileum and the cecum
- SES-CD score: 12
- No strictures, stenosis, or perianal involvement

	Result	Reference Range
CRP	14 mg/L	<10 mg/L: normal/low, common in healthy adults
Fecal calprotectin	<ul style="list-style-type: none">• 1,050 µg/g prior to budesonide• 1,100 µg/g after 2 months of budesonide	<50 µg/g: normal (low inflammation)
Hemoglobin	11.2 g/dL	13.5 g/dL to 17.5 g/dL: normal range for women
Albumin	3.5 g/dL	3.5 g/dL to 5 g/dL: normal





AUDIENCE POLLING

What would you do next?

- A. Initiate vedolizumab
- B. Initiate an IL-23 inhibitor
- C. Initiate upadacitinib
- D. Initiate an anti-TNF agent
- E. Initiate 5-ASA therapy
- F. Initiate thiopurine monotherapy and reassess in 3–6 months





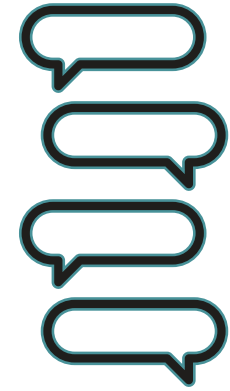
EXPERT FACULTY

Live Discussion



Decision Point

Patient Case: Brandon





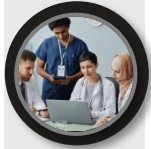
COMMUNITY GASTROENTEROLOGIST

Audio Recording: Case 3



B Initiate an IL-23 inhibitor

- **Advanced therapy warranted:** failure of conventional therapy with at least moderately severe Crohn's disease
- **IL-23 inhibitor preferred:** high likelihood of clinical and deep remission; avoids further steroid use
- **Vedolizumab or mesalamine:** less effective for this disease severity
- **Upadacitinib:** reasonable option, but **reserved for second line** per guideline positioning





COMMUNITY GASTROENTEROLOGIST, 9 YEARS

Audio Recording: Case 3



D Initiate an anti-TNF agent

- **Moderate Crohn's disease** (SES-CD 12) with ileocecal involvement, weight loss, and budesonide failure
- **Biologic-naïve patient** → start with therapy with longest track record
- **Anti-TNF selected:** proven efficacy in moderate–severe and ileal Crohn's; rapid symptom control
- **Practical first biologic:** predictable insurance access, extensive real-world data, clear optimization pathways
- **Strategy:** start strong, avoid repeated steroid rescue and early cycling; pivot mechanisms if needed later

Rule outs

- **Vedolizumab:** favorable safety, but slower and less reliable in ileal Crohn's with weight loss
- **IL-23 inhibitors:** strong data, but limited personal real-world experience; prefer to reserve early
- **Upadacitinib:** effective, but not first-line in biologic-naïve Crohn's due to safety and monitoring burden
- **5-ASA:** ineffective for moderate ileocecal Crohn's
- **Thiopurine monotherapy:** too slow and unreliable for active disease severity





COMMUNITY GASTROENTEROLOGIST, 9 YEARS

Audio Recording: Case 3



B Initiate an IL-23 inhibitor

- **Moderate CD** with ileocecal involvement, weight loss, and budesonide failure → escalation required
- **Biologic- and small molecule-naïve patient** → opportunity for early, effective disease control
- **IL-23 inhibitor selected:** high efficacy with strong mucosal healing potential
- **Durable, treat-to-target strategy:** early control to prevent progression
- **Subcutaneous maintenance dosing** supports adherence and active lifestyle
- **Avoids anti-TNF limitations** (immunogenicity, secondary loss of response)

Rule outs

- **Anti-TNF:** reasonable option, but IL-23 favored for long-term durability and convenience
- **Vedolizumab:** strong safety, but less predictable efficacy in ileal Crohn's with weight loss
- **Upadacitinib:** effective, but typically reserved for later lines due to safety/monitoring considerations
- **5-ASA:** not appropriate for moderate ileocecal Crohn's
- **Thiopurine monotherapy:** too slow and unreliable; risks delaying disease control



Additional Community Gastroenterologist Responses for Case 3



RESPONDENT 1

B

Initiate an IL-23 inhibitor

RESPONDENT 2

D

Initiate an anti-TNF agent

RESPONDENT 3

D

Initiate an anti-TNF agent

RESPONDENT 4

B

Initiate an IL-23 inhibitor



KOL: MILLIE D. LONG, MD, MPH

Video Recording: Case 3

D Initiate an anti-TNF agent

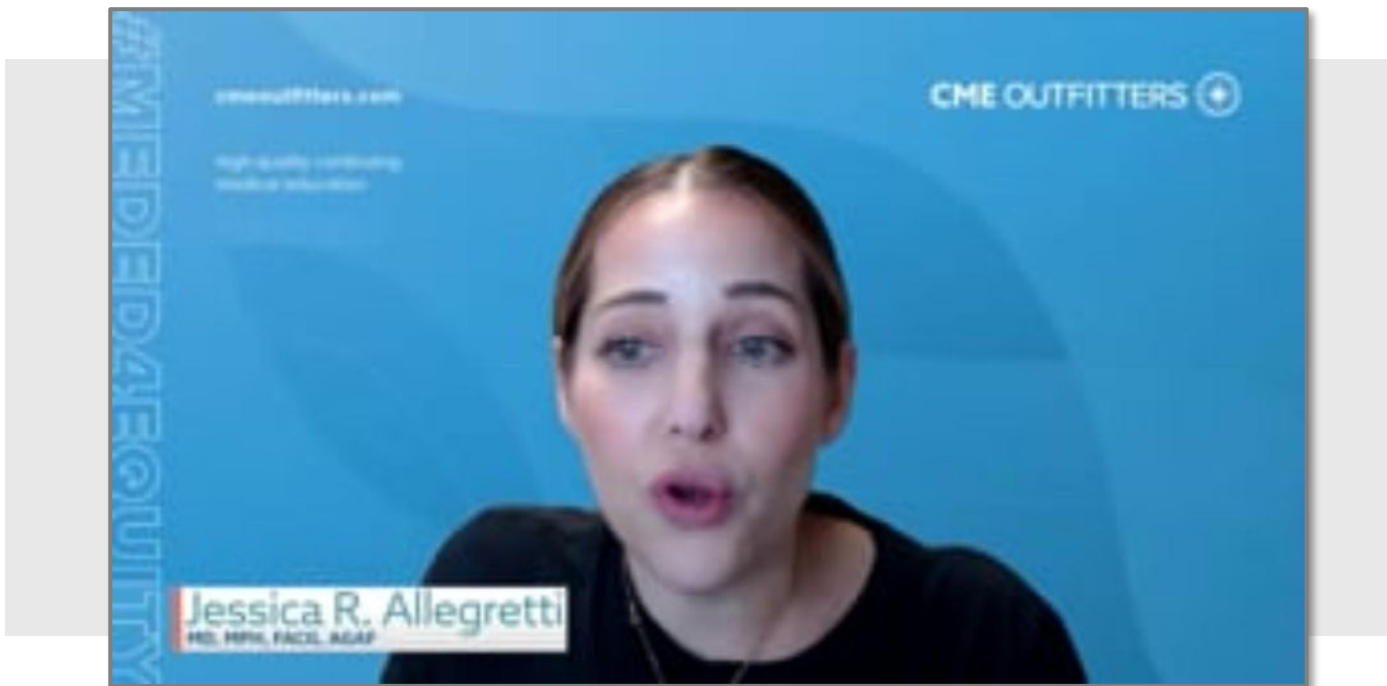




KOL: JESSICA R. ALLEGRETTI, MD, MPH, FACG, AGAF

Video Recording: Case 3

B Initiate an IL-23 inhibitor





KOL: EDWARD V. LOFTUS, JR., MD

Video Recording: Case 3

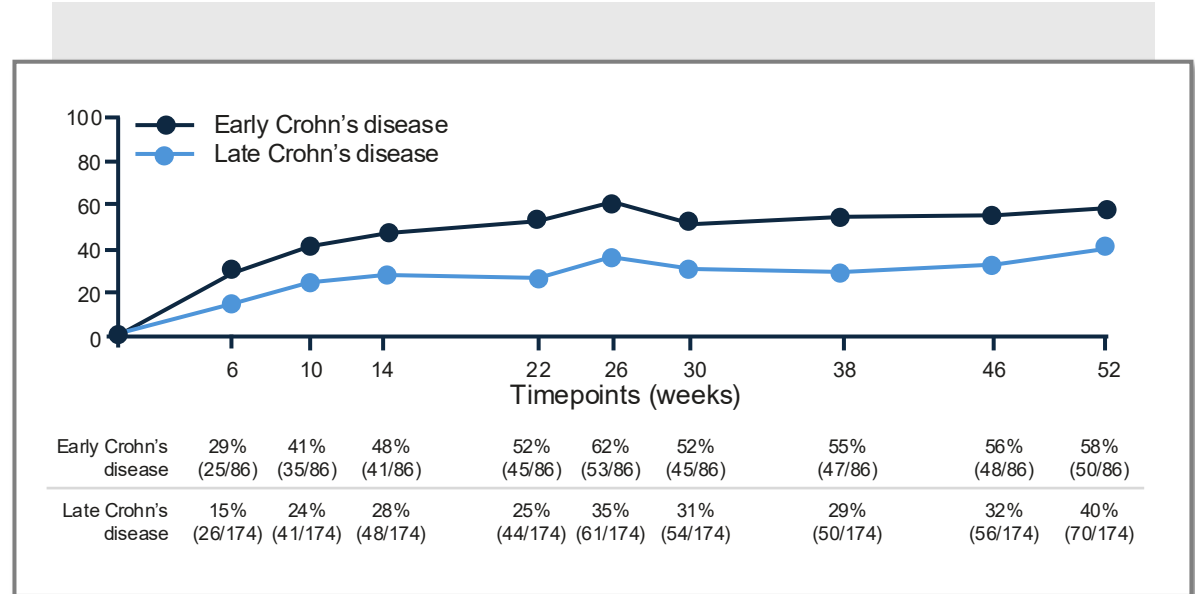
B Initiate an IL-23 inhibitor



Vedolizumab in Early and Late CD

LOVE-CD

- Vedolizumab shows greater safety and effectiveness in early-stage CD compared to late-stage disease
- It may be a favorable treatment option for patients who are biologic-naïve
- The benefits are most pronounced in individuals with a short disease duration





AI: CHATGPT 5.2

User-Fed Responses: Case 3



New chat → Here's the case subjective, objective, and plan/multiple choice question. Based on the information provided, which answer choice would you choose and what is your brief rationale for your chosen answer and unchosen options?



D Initiate an anti-TNF agent

Rationale: This patient has newly diagnosed, moderate-to-severe ileocecal CD with persistent symptoms, weight loss, and a high inflammatory burden despite budesonide, indicating the need for advanced therapy. **Early initiation of an anti-TNF agent** offers the best chance for rapid symptom control, mucosal healing, and durable remission.

Rule outs

- 5-ASA:** ineffective for Crohn's disease
- Thiopurine monotherapy:** slow onset; delays adequate control
- Vedolizumab:** effective but slower onset; less ideal with significant inflammation and weight loss
- IL-23 inhibitor:** reasonable option, but anti-TNF has strongest first-line evidence in biologic-naïve Crohn's
- Upadacitinib:** typically reserved for patients with prior biologic exposure



Case Perspective Summary

Case 3



	Community/Rural	KOLs	AI
Initiate vedolizumab	—	—	—
Initiate an IL-23 inhibitor	4	2	—
Initiate upadacitinib	—	—	—
Initiate an anti-TNF agent	3	1	1
Initiate 5-ASA therapy	—	—	—
Initiate thiopurine monotherapy and reassess in 3–6 months	—	—	—

Pearls Learned from Brandon's Case

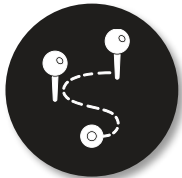
➤ Biologic-naïve CD, ileocecal involvement, early weight loss, treatment sequencing



Early objective disease activity warrants early advanced therapy

Persistent symptoms, weight loss, and endoscopic inflammation in newly diagnosed Crohn's disease argue against "step-up" delay and favor timely initiation of an effective biologic

ACG emphasizes moving beyond step-up inertia, particularly in patients with moderate disease, QoL impairment, and objective inflammation



First-line biologic choice shapes long-term disease trajectory

Selecting a therapy with strong efficacy and mucosal healing potential early may reduce future flares, steroid exposure, and treatment cycling



Durability and feasibility matter in young, active patients

Therapies that offer subcutaneous dosing and low treatment friction can support adherence and sustained disease control in patients balancing work, fitness, and social life



AUDIENCE POLLING Revisited NOW what would you do next?

- A. Initiate vedolizumab
- B. Initiate an IL-23 inhibitor
- C. Initiate upadacitinib
- D. Initiate an anti-TNF agent
- E. Initiate 5-ASA therapy
- F. Initiate thiopurine monotherapy and reassess in 3–6 months



Mission Possible

Turning Complexity Into Clarity in IBD Care

IBD care is about choosing the *right therapy for the right patient at the right time.*



Uncontrolled disease demands action, not delay

Steroid dependence, weight loss, and objective inflammation require timely escalation to effective maintenance therapy



Mechanism matters—and so does context

Loss of response, intolerance, extraintestinal manifestations, and life stage (e.g., pregnancy) should guide mechanism selection, not habit



Efficacy alone is not enough

Durability, safety confidence, route of administration, and real-world feasibility determine long-term success



The “right” therapy is patient-specific

Optimal outcomes come from aligning evidence, guidelines, and what matters most to the patient



Put information into action!

Takeaways from this program can be implemented into your practice to improve patient care.

- **Improve clinician confidence by $\geq 20\%$** in applying clinical trial evidence, FDA labeling, and guideline recommendations to individualized IBD treatment decisions
- **Increase documented shared decision-making by $\geq 25\%$** among patients with IBD, incorporating treatment goals, route of administration, quality-of-life considerations, and patient preferences at the time of therapy selection
- **Increase appropriate consideration of IL-23 inhibitor therapy by $\geq 20\%$** for patients with moderate-to-severe IBD who require escalation beyond corticosteroids or anti-TNF therapy
- **Increase steroid-free clinical remission by $\geq 15\%$ – 20%** by reducing reliance on repeated corticosteroid courses and transitioning eligible patients to evidence-based advanced therapies

QUESTIONS & ANSWERS

Thank you for joining us.
Don't forget to collect your credit.

Additional Resources

Visit www.cmeoutfitters.com
for clinical information and
certified educational activities



Visit the Gastroenterology Hub

Free resources and education to educate
health care professionals and patients

<https://www.cmeoutfitters.com/gastrohub/>

Claim Credit

Scan the appropriate QR code for your mode of participation in this activity and create or log in to a CME Outfitters learner account. Complete the necessary requirements (e.g., pre-test, post-test, evaluation) and then claim your credit.*

Thank you for your participation!



*To receive credit, participants must register an account and apply for credit within 10 days of the live activity. For questions or technical difficulties, please contact info@cmeoutfitters.com.

In-Person



Livestream



Claim ABIM MOC Credit

3 Steps to Complete

1. Actively participate in the discussion today by **responding to questions** and/or **asking the faculty questions** (*MOC credit can be claimed even if a question goes unanswered or an incorrect response is entered*)
2. Complete the post-test and evaluation at the conclusion of the webcast
3. Enter your **ABIM ID number** and **DOB** (MM/DD) on the evaluation, so credit can be submitted to ABIM



CME for MIPS Improvement Activity

How to Claim This Activity as a CME for MIPS Improvement Activity

- Actively participate today by responding to ARS questions and/or asking the faculty questions
- Complete the post-test and activity evaluation at the link provided
- Over the next 3 months, actively work to incorporate improvements from this presentation into your clinical practice
- In approximately 3 months, complete the follow-up survey from CME Outfitters



CMEO will send you confirmation of your participation to submit to CMS attesting to your completion of a CME for MIPS Improvement Activity.



A CASEWISE™ INITIATIVE

MISSION: ~~IMPOSSIBLE~~

*MATCHING TREATMENT GOALS
OF PATIENTS AND PROVIDERS
IN IBD IN CLINICAL PRACTICE*

Supported by an educational grant from Johnson & Johnson.