



LIVESTREAM

A CaseWise™ Initiative

Mission Possible: Matching Treatment Goals of Patients and Providers in IBD in Clinical Practice

SYLLABUS AND COURSE GUIDE

A free, 120-minute live activity

Premiere date: Friday, January 23, 2026

3:00 PM–5:00 PM ET



LOGIN

<http://www.cmeoutfitters.com/possiblestream>



PRESENTING FACULTY

Miguel Regueiro, MD (moderator)
Anita Afzali, MD, MPH, MHCM, FACG, AGAF
Edward L. Barnes, MD, MPH
Angelina Collins, MSN, ANP-BC

CONTRIBUTING KEY OPINION LEADERS

Jessica R. Allegretti, MD, MPH, FACG, AGAF
Edward V. Loftus, Jr., MD
Millie D. Long, MD, MPH

PATIENT ADVOCATES

Natalie Hayden
Kaylaa' White

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Information for Participants

STATEMENT OF NEED

Despite major advances in inflammatory bowel disease (IBD) management, real-world data show that many patients continue to experience suboptimal outcomes due to misaligned treatment goals, therapeutic inertia, and limited integration of novel therapies, particularly IL-23 inhibitors—into individualized care plans. While gastroenterologists and other members of the care team are increasingly aware of new efficacy and safety data, many report uncertainty in selecting, sequencing, and communicating these treatment choices in ways that align with patient preferences, quality-of-life priorities, and long-term disease control.

This fast-paced and highly interactive livestream CaseWise™ symposium from CME Outfitters will bring real-world clinical decision-making to life. Through dynamic patient cases, learners will compare their treatment choices to those of leading experts, peers in the room, providers in the community, patients themselves, and even AI-based insights. Learners will see how evidence translates into practice, what doesn't, and why. Designed to challenge assumptions and sharpen strategy, this immersive format empowers clinicians to immediately apply the latest IL-23 inhibitor data, enhance communication and shared decision-making, and deliver truly patient-centered IBD care.

LEARNING OBJECTIVES

At the conclusion of this activity, learners will be able to better:

- Integrate the latest data and guideline recommendations for IL-23 inhibitors into clinical practice as part of treatment selection for patients with IBD
- 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
- Evaluate the latest clinical trial efficacy and safety data for recently approved IL-23 therapies in IBD
- Utilize the latest clinical evidence in real-world patient scenarios

FINANCIAL SUPPORT

Supported by an educational grant from Johnson & Johnson.

TARGET AUDIENCE

Gastroenterologists, gastroenterology fellows, nurse practitioners (NPs), and physician associates (PAs)

Presenting Faculty

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

Miguel Regueiro, MD, is the chief of the Digestive Disease Institute at Cleveland Clinic, and a professor in the Department of Medicine, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University. He is responsible for the clinical operations and academic mission of the Institute, which includes the departments of general surgery, colorectal surgery, gastroenterology, hepatology, and nutrition with sites in Ohio, Florida, London, and Abu Dhabi.

Dr. Regueiro's main clinical and research interest is inflammatory bowel diseases (IBD) with a focus on the natural course and medical-surgical management of Crohn's disease and ulcerative colitis. He leads research on postoperative prevention of Crohn's disease, as well as developing new models of healthcare, including the first-of-its-kind specialty medical home for IBD.

ANITA AFZALI, MD, MPH, MHCM, FACG, AGAF

Professor of Medicine

Interim Chair, Department of Internal Medicine

University of Cincinnati College of Medicine

Cincinnati, Ohio

Anita Afzali, MD, is a professor of medicine and the James F. Heady Endowed Chair in Medicine. She serves as executive vice chair of the Department of Internal Medicine at the University of Cincinnati (UC), associate chief medical officer of UC Health Systems, and was recently appointed the inaugural Physician Operations Executive for UC Health, leading system-wide service optimization. In November 2025, she assumed the role of interim chair of the Department of Internal Medicine.

An internationally renowned, board-certified gastroenterologist, public health professional, and health-systems redesign leader, Dr. Afzali is an accomplished physician executive with extensive experience in academic medicine, advanced clinical care in inflammatory bowel disease, and global clinical research as a principal investigator for novel therapies and diagnostic trials. She is widely recognized as an innovator and expert in program development and healthcare operations, known for creating national programs, forging multidisciplinary and strategic partnerships, fostering community engagement, and advancing entrepreneurial initiatives.

EDWARD L. BARNES, MD, MPH

Associate Professor of Medicine

University of North Carolina at Chapel Hill

Chapel Hill, North Carolina

Edward L. Barnes, MD, MPH, is an associate professor of medicine in the Division of Gastroenterology and Hepatology and co-director of the Multidisciplinary Inflammatory Bowel Diseases Center at the University of North Carolina–Chapel Hill. Dr. Barnes has a research interest in the epidemiology and clinical outcomes of patients with inflammatory bowel disease, with a particular interest in improving our understanding of inflammatory conditions of the pouch after restorative proctocolectomy with ileal pouch anal anastomosis (IPAA).

ANGELINA COLLINS, MSN, ANP-BC

Nurse Practitioner

Inflammatory Bowel Disease Center

UC San Diego Health

La Jolla, California

Angelina Collins, MSN, ANP-BC, is a board-certified adult nurse practitioner at the Inflammatory Bowel Disease Center at the University of California–San Diego. She received her nursing and master in nursing degrees from the University of San Diego.

Ms. Collins is passionate about educating nurse practitioners and physician assistants in the comprehensive management of inflammatory bowel disease and has served as faculty for Advances in Inflammatory Bowel Diseases (AIBD) Advanced Practice Providers (APP) Institute, Crohn's and Colitis Congress, Gastroenterology and Hepatology Advanced Practice Providers (GHAPP), IBDHorizons APP, IBD Cutting Edge; is a steering committee member of Milestone APP; and is co-director of ChatAPP, a monthly IBD case series for APPs.

Contributing Key Opinion Leaders

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

Cambridge, Massachusetts

Jessica R. Allegretti, MD, MPH, FACG, AGAF, is an associate professor of medicine at Harvard Medical School and serves as the medical director of the Crohn's and Colitis Center at Brigham and Women's Hospital, where she built and leads the Clinical Trials and the Fecal Microbiota Transplant programs. She graduated from The Miller School of Medicine at the University of Miami in Miami, Florida; trained in internal medicine at Massachusetts's General Hospital; and completed her gastroenterology fellowship training at Brigham and Women's Hospital before joining faculty there. She later earned a master of public health degree from the Harvard School of Public Health.

Dr. Allegretti is a physician-scientist dedicated to discovering and developing innovative microbiome therapeutics and novel treatments for inflammatory bowel disease (IBD). Her research focuses on the mechanism of recurrent *C. difficile* infection (CDI) and the intersection of CDI and IBD. She has received funding from the National Institutes of Health (NIH), the American College of Gastroenterology, and the Crohn's and Colitis Foundation. She has authored more than 100 peer-reviewed publications and has been featured on HBO, BBC, and Netflix, in the *New York Times*, and in numerous other media outlets. Dr. Allegretti has also received the Sherman Emerging Leader Prize for Excellence in Crohn's and Colitis.

EDWARD V. LOFTUS, JR., MD

Maxine and Jack Zarrow Family Professor of Gastroenterology

Mayo Clinic College of Medicine and Science

Rochester, Minnesota

Edward V. Loftus, Jr., MD, is a gastroenterologist with extensive experience as a lecturer and clinician researcher in the field of inflammatory bowel diseases (IBD). He is the Maxine and Jack Zarrow Family Professor of Gastroenterology Specifically for IBD at Mayo Clinic College of Medicine and Science in Rochester, Minnesota. Professor Loftus has published more than 600 original articles, book chapters, or editorials, and over 800 abstracts. He was awarded American Gastroenterological Association's Distinguished Clinician Award and the Immunology, Microbiology & Inflammatory Bowel Diseases (IMIBD) section's Research Mentor Award in 2019. Dr. Loftus has been the principal investigator on several funded studies focusing on the epidemiology and natural history of IBD and has served as the local PI on multiple clinical trials of investigational agents for IBD. He serves on the steering committees and data safety monitoring boards of several clinical development programs in IBD.

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*

Millie D. Long MD, MPH, is board certified in internal medicine, preventive medicine, and gastroenterology. She received her medical degree from the University of Virginia in 2002. She then completed residency in internal medicine and a chief residency at the University of Alabama–Birmingham. Dr. Long completed fellowships in gastroenterology and hepatology, preventive medicine, and inflammatory bowel disease, all at the University of North Carolina (UNC). She is currently a professor of medicine in the Department of Medicine and chief of the Division of Gastroenterology and Hepatology at UNC–Chapel Hill.

Dr. Long's clinical practice is at the UNC Multidisciplinary Inflammatory Bowel Diseases Center. Her research interests include prevention of complications of inflammatory bowel disease (IBD), women's health, and clinical epidemiology. She is currently a co-principal investigator for the Pregnancy in IBD and Neonatal Outcomes (PIANO) study. Dr. Long has contributed more than 200 peer-reviewed publications, book chapters, and review articles to the medical literature. She is the current co-editor in chief of the *American Journal of Gastroenterology*. She also serves as an invited reviewer for journals such as *New England Journal of Medicine*, *Inflammatory Bowel Diseases*, and *Gastroenterology*.

Dr. Long is a fellow of the American College of Gastroenterology, where she serves on the Board of Trustees. She also is a fellow of the American Gastroenterological Association and the Crohn's and Colitis Foundation. She is the 2024 Sherman Prize recipient in IBD clinical research.

Patient Advocates

NATALIE HAYDEN

*Patient Advocate
Founder, Lights, Camera, Crohn's*

Natalie Hayden, 42, is a former TV news anchor and reporter living in the Midwest who was diagnosed with Crohn's disease in 2005. Her award-winning blog, *Lights, Camera, Crohn's*, covers everything from overcoming struggles to celebrating small victories throughout all aspects of the patient journey—from diagnosis and beyond.

Ms. Hayden was the United States Patient Ambassador and global patient lead for the first-ever Global Consensus Conference on Pregnancy and IBD. She won a Lifetime Achievement Award from the Social Health Network in September 2025 for her inflammatory bowel disease (IBD) advocacy efforts and was selected to serve as a social media ambassador in September 2024 for the Crohn's and Colitis Foundation on a national level. She also is on advisory boards for IBD Moms and IBD Social Circle; is on the Patient Leadership Council for the Social Health Network; and is a contributor to Everyday Health, Healthy Women, The Insighters, Mamas Facing Forward, and IBD Moms. She is also a part of the Patient Partner Advisory Committee for the BIONIC study, which aims to explore the use of biological medications during pregnancy in patients with autoimmune disorders or asthma, and their potential impact on both maternal and infant health outcomes.

KAYLAA' WHITE

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

Kaylaa' White is a Crohn's disease warrior, ostomate, listener poet, creative, and advocate who is passionate about storytelling as a tool for healing and representation. She is pursuing a bachelor of fine arts degree in dramatic writing at New York University's Tisch School of the Arts, where her work explores chronic illness, identity, and resilience. Ms. White is dedicated to creating spaces that amplify underrepresented voices and build community through art.

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

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

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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

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

Speakers Bureau—Exact Sciences Corporation and Moderna Inc.

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

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

PATIENT ADVOCATES FACULTY

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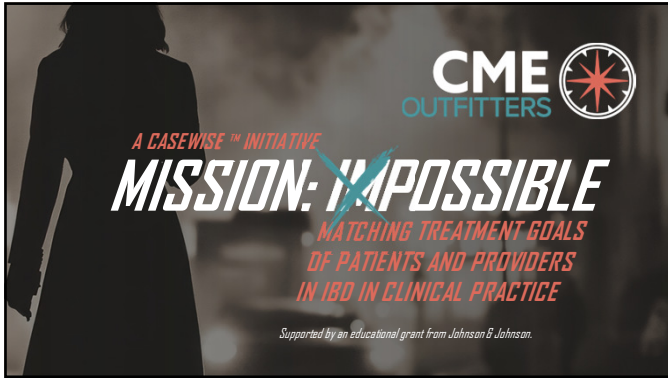
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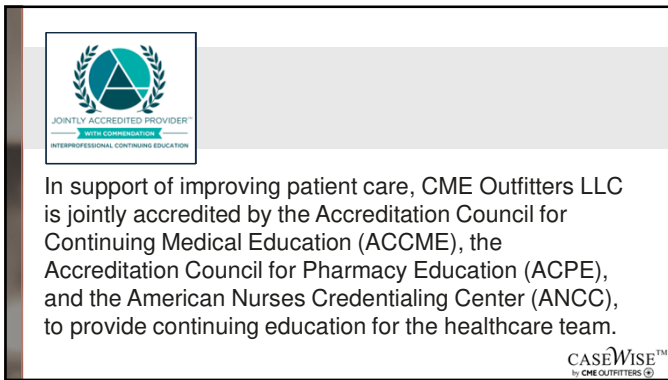
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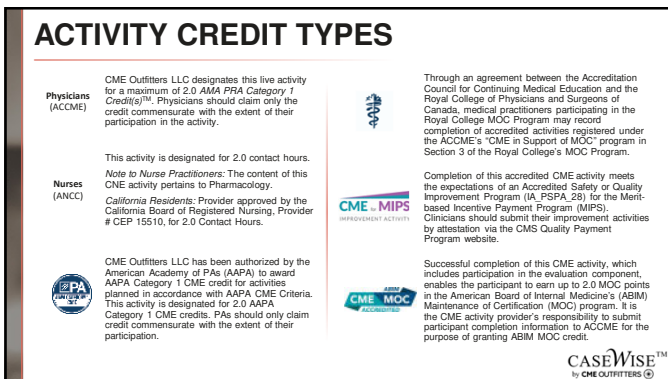




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4

To Ask a Question

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

5


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FACULTY



6



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7



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8



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Founder, Lights, Camera, Crohn's



Kaylaa' White
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COGI Ambassador




PATIENT ADVOCATES

9

Disclosures

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Advisory board—AbbVie Inc., Amgen Inc., Boehringer Ingelheim Pharmaceuticals Inc., (BIP), 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 UCSF Inc.
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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

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Consultant—Boomerang Medical, Takeda Pharmaceutical Company Limited, and Target RWE
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Speakers bureau—AbbVie Inc., Cristocot, Johnson & Johnson, Lilly, and Takeda Pharmaceutical Company Limited

All identified conflicts of interest have been mitigated.



10

Disclosures

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Jessica R. Allegretti, MD, MPH, FAGG, AGAF—reports the following financial relationships:

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Research support—AbbVie Inc., Gilead Sciences Inc., Janssen Pharmaceuticals Inc., and TRIX Bio
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Millie D. Long, MD, MPH—reports the following financial relationships:

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

PATIENT ADVOCATES

Natalie Hayden—reports no financial relationships to disclose

Kaylas' White—reports the following financial relationships:

Social media ambassador—Cologist

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Thai Nguyen, MD, MHA—no disclosures to report

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

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- 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.



11

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

12

LEARNING OBJECTIVES

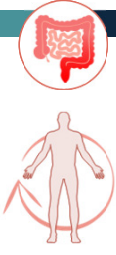
3 Evaluate the latest clinical trial efficacy and safety data for recently approved IL-23 therapies in IBD

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

13

From Treat-to-Target to Precision Care

What Guides IBD Decisions Today?

ULCERATIVE COLITIS (UC)	CROHN'S DISEASE (CD)
DISEASE CHARACTERISTICS <ul style="list-style-type: none"> IBD severity Disease behavior/complications Early vs late disease Extraintestinal manifestations Associated IMID 	
PATIENT CHARACTERISTICS <ul style="list-style-type: none"> Age Comorbidities Pregnancy/fertility Prior malignancy Infection risk Biologic naïve vs biologic exposure Treatment preferences Administrative route 	
	ACCESS <ul style="list-style-type: none"> Insurance coverage Cost
	EFFICACY <ul style="list-style-type: none"> Available evidence Onset of action Durability of response PK/therapeutic drug monitoring Combination vs monotherapy Positioning and sequencing
	SAFETY <ul style="list-style-type: none"> Disease severity Drug-specific concerns

IBD, inflammatory bowel disease; IMID, immune-mediated inflammatory disease; PK, pharmacokinetics. Adapted from Imbrizi M, et al. World J Gastroenterol. 2025;31(29):107745.

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14

Why Target the IL-23/Th17 Axis in IBD

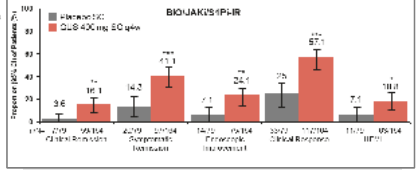
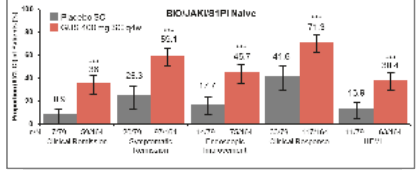
- IL-23 is a key driver of pathogenic Th17 responses in both UC and CD
- IL-23 promotes
 - Chronic intestinal inflammation
 - Resistance to anti-TNF therapy
 - Persistence to pathogenic immune memory
- Selective IL-23p19 inhibition
 - Suppresses pathogenic inflammation
 - Preserves protective IL-17 gut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

IL, interleukin; Th, T helper; TNF, tumor necrosis factor. Pugliano CL, et al. J Crohns Colitis. 2025;19(8):i144. Ananthakrishnan AN, et al. Gastroenterology. 2024;167(7):1460–1482.

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by CME OUTFITTERS

15

SC Guselkumab Induction in UC
ASTRO Phase 3
at Week 12

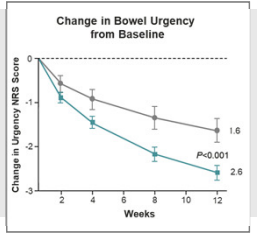
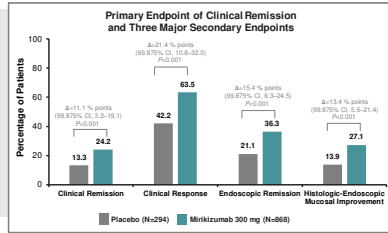


*Nominal P<0.05; **Nominal P<0.01; ***Nominal P<0.001.
 Clinical remission: Mayo SFS 0/1 and not increased from BL, a Mayo RBS=0, and MES 0/1 with no flailability.
 Symptomatic remission: SFS 0/1 and not increased from BL and RBS=0.
 Endoscopic improvement: MES 0/1 with no flailability.
 Clinical response: ≥30% and ≥2-point decrease from BL in Modified Mayo Score with ≥1-point decrease from BL in RBS or RFS 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; S1P1, sphingosine 1-phosphate inhibitor; S1P1-R, sphingosine 1-phosphate inhibitor–inadequate response.

Payin-Broulet L, et al. J Crohns Colitis. 2023;19(suppl 1):119–20.

25

Mirikizumab Induction in UC
LUCENT-1

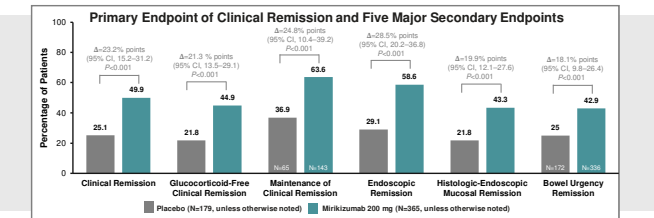


NRS, numeric rating scale.
 D'Haens G, et al. N Engl J Med. 2023;388(25):2444–2455.



26

Mirikizumab Maintenance in UC
LUCENT-2 Week 40 Endpoints after Induction

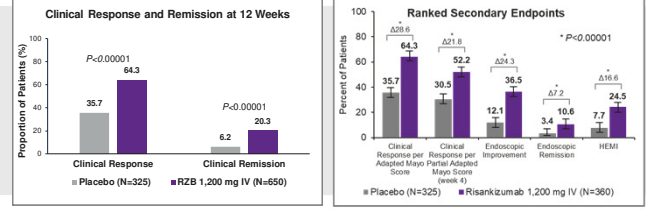


D'Haens G, et al. N Engl J Med. 2023;388(26):2444–2455.



27

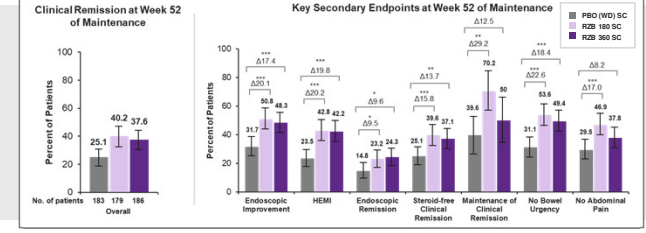
Risankizumab Induction in UC
INSPIRE



*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(105):S624-S625.

28

Risankizumab Maintenance in UC
COMMAND Week 52 Endpoints



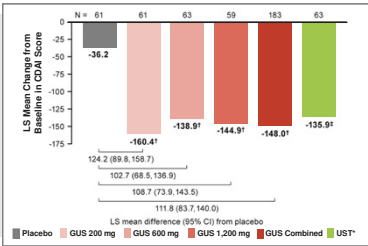
*P ≤0.05; **P ≤0.01; ***P ≤0.001 vs PBO (WD) SC.
HEMI, hiato-endoscopic mucosal improvement; IR, inadequate response; PBO, placebo; WD, withdrawal.
Louis E, et al. J Crohns Colitis. 2024;18(Suppl 1):110-112.

29



30

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

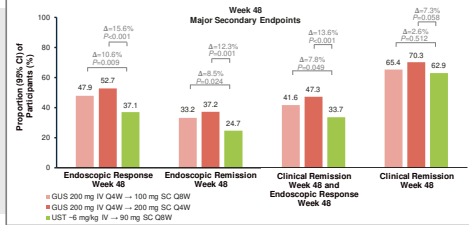
*UST 6 mg/kg IV → 90 mg SC; * <0.05 for GUS vs placebo; *Nominal <0.05 from post hoc analysis of UST vs placebo. CDAI, Crohn's disease activity index; DBPC, double-blind placebo controlled; LS, least squares; UST, ustekinumab. Sandborn W, et al. *Gastroenterology*. 2022;162(6):1650-1664.



31

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



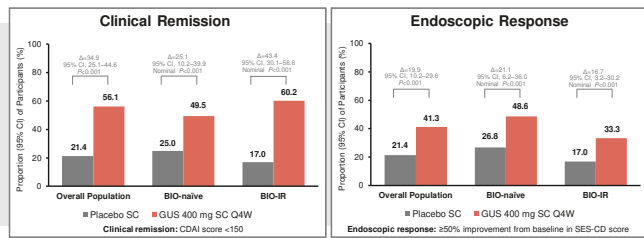
Clinical response: ≥100-point reduction from baseline in CDAI or CDAI <150
Endoscopic response: ≥50% improvement from baseline in SES-CD or SES-CD ≤2
Clinical remission: CDAI <150
Endoscopic remission: SES-CD ≤4 and a ≥2-point reduction from baseline and no subscore greater than 1 in any individual component

Fanaccione R, et al. *American College of Rheumatology (ACR) Convergence 2024*, Abstract 1135. <https://abstracts.ocr.org/abstract/efficacy-and-safety-of-guselkumab-therapy-in-patients-with-moderately-to-severely-active-crohn>. Abstract results of the galaxi 2-3 phase 3 studies.



32

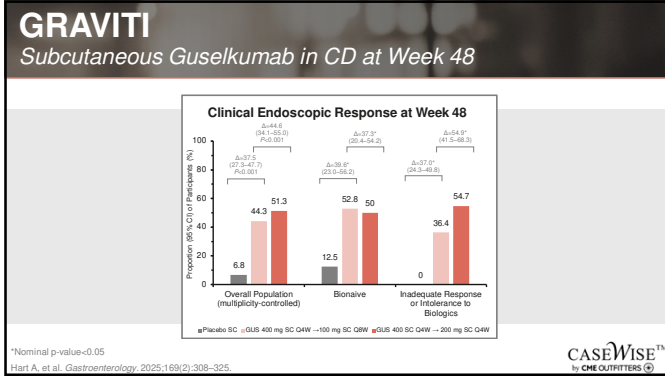
GRAVITI
Subcutaneous Guselkumab in CD at Week 12



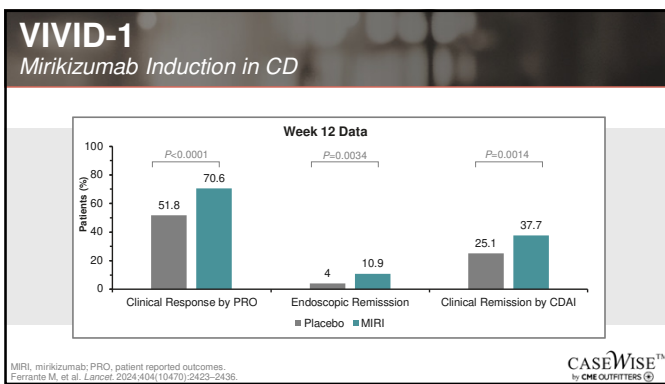
Hart A, et al. *Gastroenterology*. 2025;169(2):308-326.



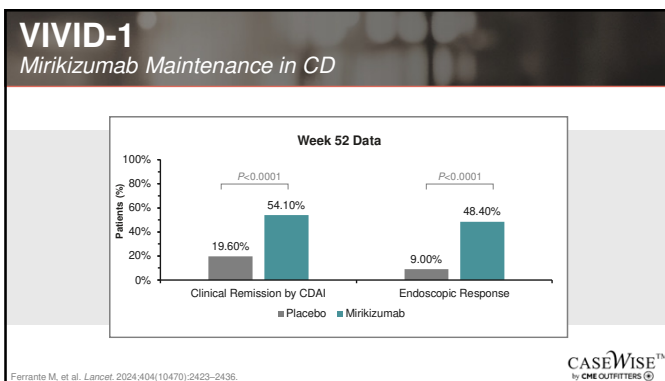
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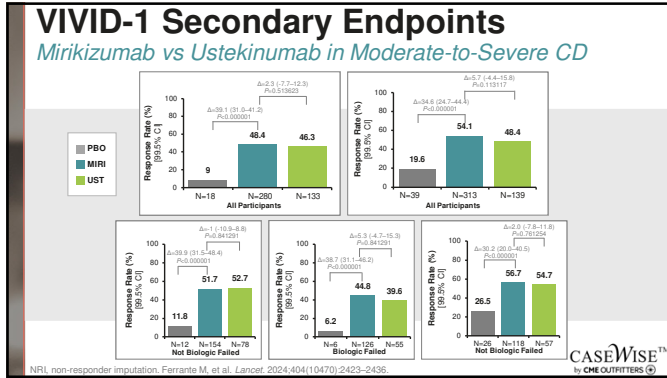
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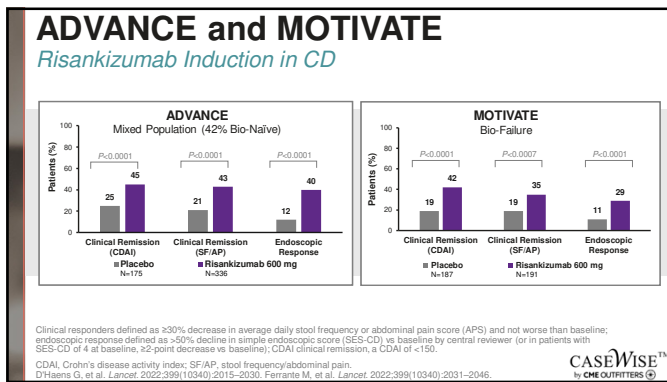
35



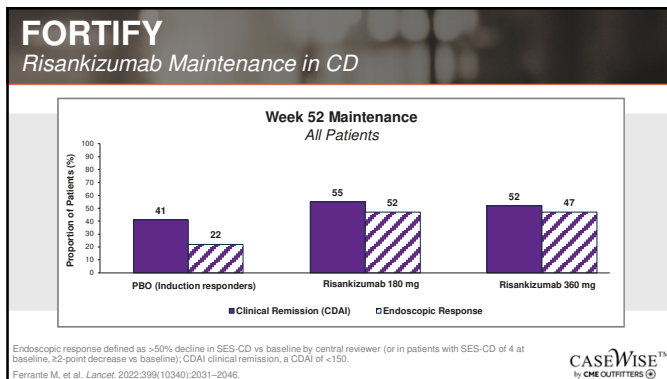
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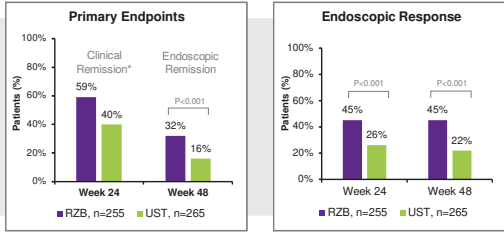
38



39

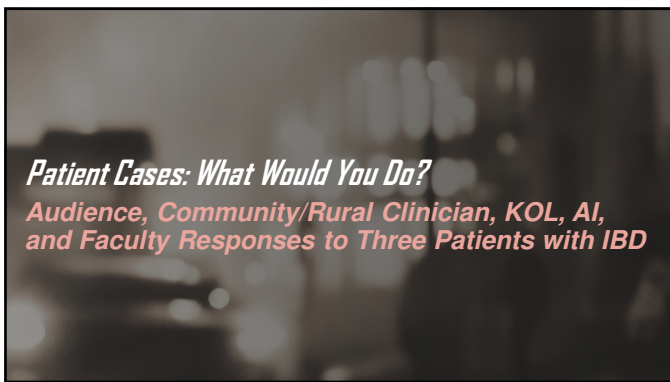
SEQUENCE

Risankizumab vs Ustekinumab in CD




*Noninferiority met.
Rayin-Broulet L, et al. N Engl J Med. 2024;391:219-223.

40



41



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

42

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

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43

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

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44


EXPERT FACULTY
Live Discussion

Decision Point
Patient Case: Natalie Hayden



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45



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

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46



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

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47



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

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48

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

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49

KOL: MILLIE D. LONG, MD, MPH
Video Recording: Case 1

C Switch to an IL-23 inhibitor



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Dr. Millie D. Long, Interview with CME Outfitters, January 2026.

50

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

Natt N, et al. *Aliment Pharmacol Ther.* 2026;63(3):405-413.
Xie W, et al. *Front Immunol.* 2022;13:847160. Atzall A, et al. *J Crohns Colitis.* 2014;8(6):480-488.

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51

KOL: JESSICA R. ALLEGRETTI, MD, MPH, FACG, AGAF
Video Recording: Case 1

C Switch to an IL-23 inhibitor



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by CME OUTFITTERS

Dr. Jessica R. Allegretti. Interview with CME Outfitters. January 2026.

52

KOL: EDWARD V. LOFTUS, JR., MD
Video Recording: Case 1

C Switch to an IL-23 inhibitor



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Dr. Edward V. Loftus, Jr. Interview with CME Outfitters. January 2026.

53

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

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by CME OUTFITTERS

OpenAI. Generated by ChatGPT, model 5.2. Used January 2026.

54

NATALIE HAYDEN
Video Clip: Introduction

CASEWISE™
by CME OUTFITTERS

Natalie Hayden. Interview with CME Outfitters, December 2025.

55

NATALIE HAYDEN
Video Clip: Quality of Life

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by CME OUTFITTERS

Natalie Hayden. Interview with CME Outfitters, December 2025.

56

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	—	—	—

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57

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

ACG, American College of Gastroenterology; EIMs, extraintestinal manifestations; RoA, route of administration; Maronese CA, et al. *J Invest Dermatol*. 2024;144(11):2364–2376.
Scott ST, et al. *Gastroenterology*. 2020;149(7):1307–1448; 948n; 949n; 950n; 951n; 952n; 953n; 954n; 955n; 956n; 957n; 958n; 959n; 960n; 961n; 962n; 963n; 964n; 965n; 966n; 967n; 968n; 969n; 970n; 971n; 972n; 973n; 974n; 975n; 976n; 977n; 978n; 979n; 980n; 981n; 982n; 983n; 984n; 985n; 986n; 987n; 988n; 989n; 990n; 991n; 992n; 993n; 994n; 995n; 996n; 997n; 998n; 999n; 1000n.



58



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



59



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



60



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

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61




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

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62




EXPERT FACULTY

Live Discussion


Decision Point

Patient Case: Kaylaa' White



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63




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



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64




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



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65




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



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66

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

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67

KOL: MILLIE D. LONG, MD, MPH
Video Recording: Case 2

C Switch to an IL-23 inhibitor

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Dr. Millie D. Long, Interview with CME Outfitters, January 2026.

68






KOL: JESSICA R. ALLEGRETTI, MD, MPH, FACG, AGAF
Video Recording: Case 2

C Switch to an IL-23 inhibitor

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Dr. Jessica R. Allegretti, Interview with CME Outfitters, January 2026.

69

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

PIANO. Pregnancy in inflammatory bowel disease and neonatal outcomes; NICU, neonatal intensive care unit. Mahadevan U, et al. *Clin Gastroenterol Hepatol*. 2025;23(11S):S1–S60. Mahadevan U, et al. *Gastroenterology*. 2021;160(4):1131–1139. © CASEWISE™ by CME OUTFITTERS

70

IBD Medications from Preconception through Pregnancy and Lactation

Medication	Preconception	First Trimester	Second Trimester	Third Trimester	Lactation
Aminosalicylates • Folic acid supplementation with sulfasalazine • Monitor metabolites, liver enzymes	☑	☑	☑	☑	☑
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. Mahadevan U, et al. *Clin Gastroenterol Hepatol*. 2025;23(11S):S1–S60. © CASEWISE™ by CME OUTFITTERS

71




KOL: EDWARD V. LOFTUS, JR., MD
Video Recording: Case 2


C Switch to an IL-23 inhibitor

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Dr. Edward V. Loftus, Jr. Interview with CME Outfitters, January 2026.

72



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







OpenAI. Generated by ChatGPT, model 5.2. Used January 2026.


73



KAYLAA' WHITE
Video Clip: Introduction and Symptom Onset















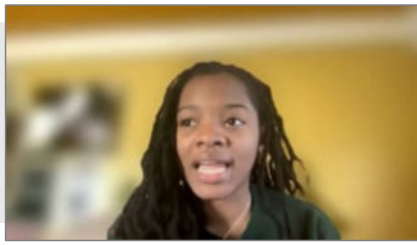
Kaylaa' White. Interview with CME Outfitters. December 2025.


74



KAYLAA' WHITE
Video Clip: Acute Symptom Flare





Kaylaa' White. Interview with CME Outfitters. December 2025.

75

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	—	—	—

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MM-162 Healthcare Provider Survey, CME Outfitters, January 2026.

76

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

Singh S, et al. *Gastroenterology*. 2024;167(7):1307–1343. Maronessa CA, et al. *J Invest Dermatol*. 2024;144(11):2364–2376. Scott FL, et al. *Gastroenterology*. 2025;169(7):1397–1448. Rubin DT, et al. *Am J Gastroenterol*. 2025;120(6):1187–1224.

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77

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

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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

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79



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

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80




AUDIENCE POLLING

What would you do next?

- Initiate vedolizumab
- Initiate an IL-23 inhibitor
- Initiate upadacitinib
- Initiate an anti-TNF agent
- Initiate 5-ASA therapy
- Initiate thiopurine monotherapy and reassess in 3–6 months

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81



EXPERT FACULTY
Live Discussion

Decision Point
Patient Case: Brandon

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82



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

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83



COMMUNITY GASTROENTEROLOGIST, 9 YEARS
Audio Recording: Case 3

D Initiate an anti-TNF agent

Rule outs

- **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
- **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

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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

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MM-162 Healthcare Provider Survey, CME Outfitters, January 2026.

85

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**

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MM-162 Healthcare Provider Survey, CME Outfitters, January 2026.

86

KOL: MILLIE D. LONG, MD, MPH
Video Recording: Case 3

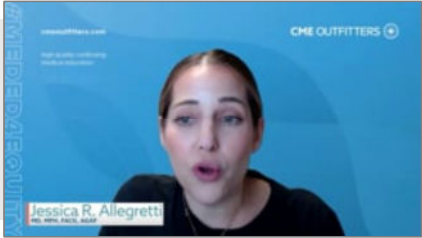
D Initiate an anti-TNF agent

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Dr. Millie D. Long, Interview with CME Outfitters, January 2026.

87

KOL: JESSICA R. ALLEGRETTI, MD, MPH, FACG, AGAF
Video Recording: Case 3

B Initiate an IL-23 inhibitor



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Dr. Jessica R. Allegretti, Interview with CME Outfitters, January 2026.

88

KOL: EDWARD V. LOFTUS, JR., MD
Video Recording: Case 3

B Initiate an IL-23 inhibitor



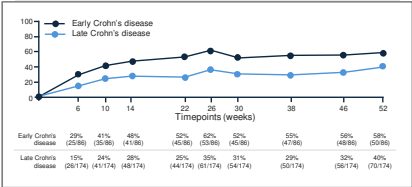
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Dr. Edward V. Loftus, Jr. Interview with CME Outfitters, January 2026.

89

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



Timepoints (weeks)	6	10	14	22	26	30	38	46	52
Early Crohn's disease	29% (25/86)	41% (35/86)	48% (41/86)	52% (45/86)	52% (45/86)	52% (45/86)	55% (47/86)	58% (49/86)	59% (50/86)
Late Crohn's disease	12% (2/17)	24% (4/17)	28% (4/14)	25% (4/17)	35% (5/17)	31% (4/17)	29% (5/17)	32% (5/17)	40% (7/17)

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©Haens GR, et al. Lancet Gastroenterol Hepatol. 2026;11(1):12-21.

90

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

OpenAI. Generated by ChatGPT, model 5.2. Used January 2026.

91

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	—	—	—

MM-162 Healthcare Provider Survey. CME Outfitters. January 2026.

92

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, CoL 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

Scott FL, et al. Gastroenterology. 2025;169(7):1397–1448. Rubin DT, et al. Am J Gastroenterol. 2025;120(6):1187–1234.

93

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

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94

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

Rubin DT, et al. *Am J Gastroenterol*. 2025;120(6):1187–1224.
Turner D, et al. *Gastroenterology*. 2021;150(5):1570–1583.

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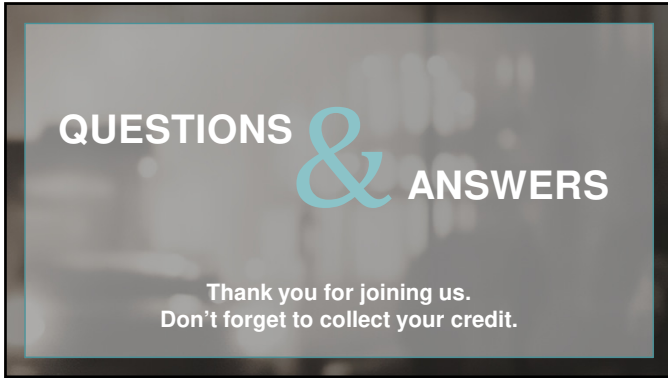
95

Put information into action!
Takeaways from this program can be implemented into your practice to improve patient care.

- **Improve clinician confidence by ≥20%** in applying clinical trial evidence, FDA labeling, and guideline recommendations to individualized IBD treatment decisions
- **Increase documented shared decision-making by ≥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 ≥20%** for patients with moderate-to-severe IBD who require escalation beyond corticosteroids or anti-TNF therapy
- **Increase steroid-free clinical remission by ≥15%–20%** by reducing reliance on repeated corticosteroid courses and transitioning eligible patients to evidence-based advanced therapies

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96



97



98



99


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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

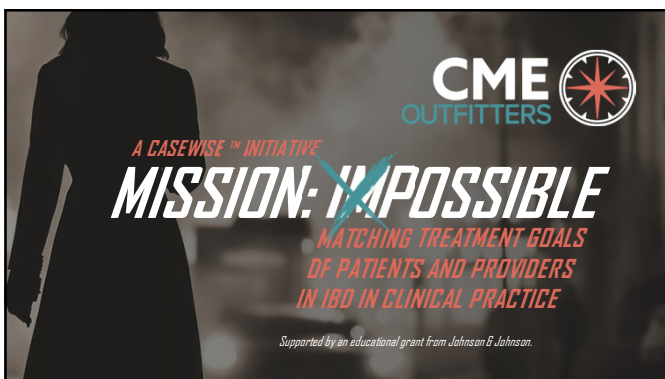
How to Claim This Activity as a CME for MIPS Improvement Activity

- 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.



101



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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.

102