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csgna
Canadian Society of Gastroenterology Nurses & Associates
Société canadienne des infirmières et infirmiers en gastroentérologie et travailleurs associés

Crohn's and Colitis Canada
Crohn et Colite Canada

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GOLD — abbvie

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De-escalation of Therapy In IBD

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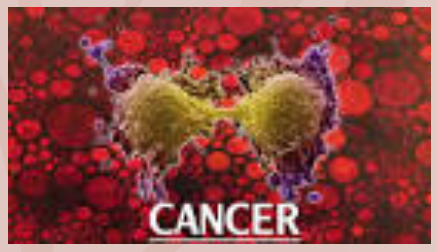
Objectives

- Understand the reasons why clinicians would/should consider a de-escalation in IBD therapies
- Recognize which patients might be suitable for de-escalation in treatment
- Review the current evidence on de-escalation of treatments for IBD

Why de-escalate?

- Risk of infections
- Risk of neoplasm
- Pregnancy
- Social Economic/ Patient preference



Concerns regarding combination therapy

Infection

TREAT REGISTRY

- 6273 CD on IFX
- Long term safety of IFX in large cohort
  - Moderate to severe disease activity
  - Narcotic
  - Prednisone
  - IFX

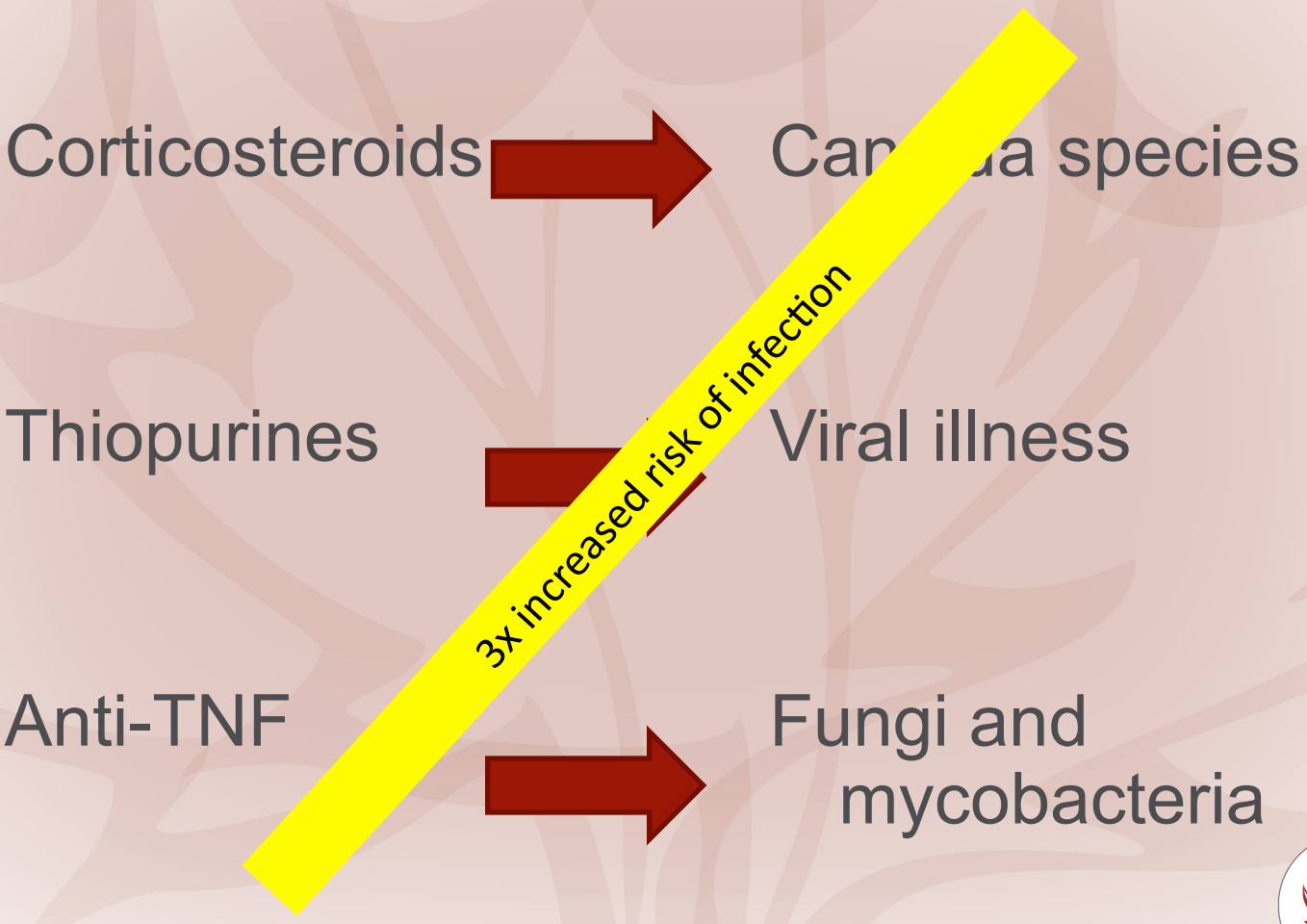
Infections

Corticosteroids → Candida species

Thiopurines → Viral illness

anti/-TNF → Fungi and mycobacteria

Infections


Corticosteroids
Thiopurines
Anti-TNF
Viral illness
Fungi and mycobacteria
3x increased risk of infection

Cancer

TREAT Registry

Independent association with malignancy

- Baseline age
- Disease duration
- Smoking

No increased risk with mono or combo therapy

Economic Issues

In some countries, economic issues are limited patients access to anti-TNF where clinicians are encouraged to de-escalate does and/or to withdraw anti-TNF when

What's the target?

- Mucosal healing
- Clinical symptoms
- Biomarkers

What's the target?

Mucosal healing

Deep Remission

Clinical symptoms

Sustained >1 year

Biomarkers

FCal, CRP, Hgb, WBC

Show me the…

IS + anti-TNF vs. anti-TNF monotherapy

SONIC

What did Sonic tell us?

Patients receiving IFX + AZA had significantly higher rates of CS-free clinical remission and mucosal healing as compared to those receiving either treatment alone

What about those patient who are refractory to conventional IS?

Should we continue both?

- REDUCED DISEASE ACTIVITY
- LESS RISK OF NEEDING TO SWITCH TO ANTOHER ANIT-TNF
- GREATER ANO-FISTULA CLOSURE

De-escalation strategies

Corticosteroids

Ineffective as maintenance/minimize expose

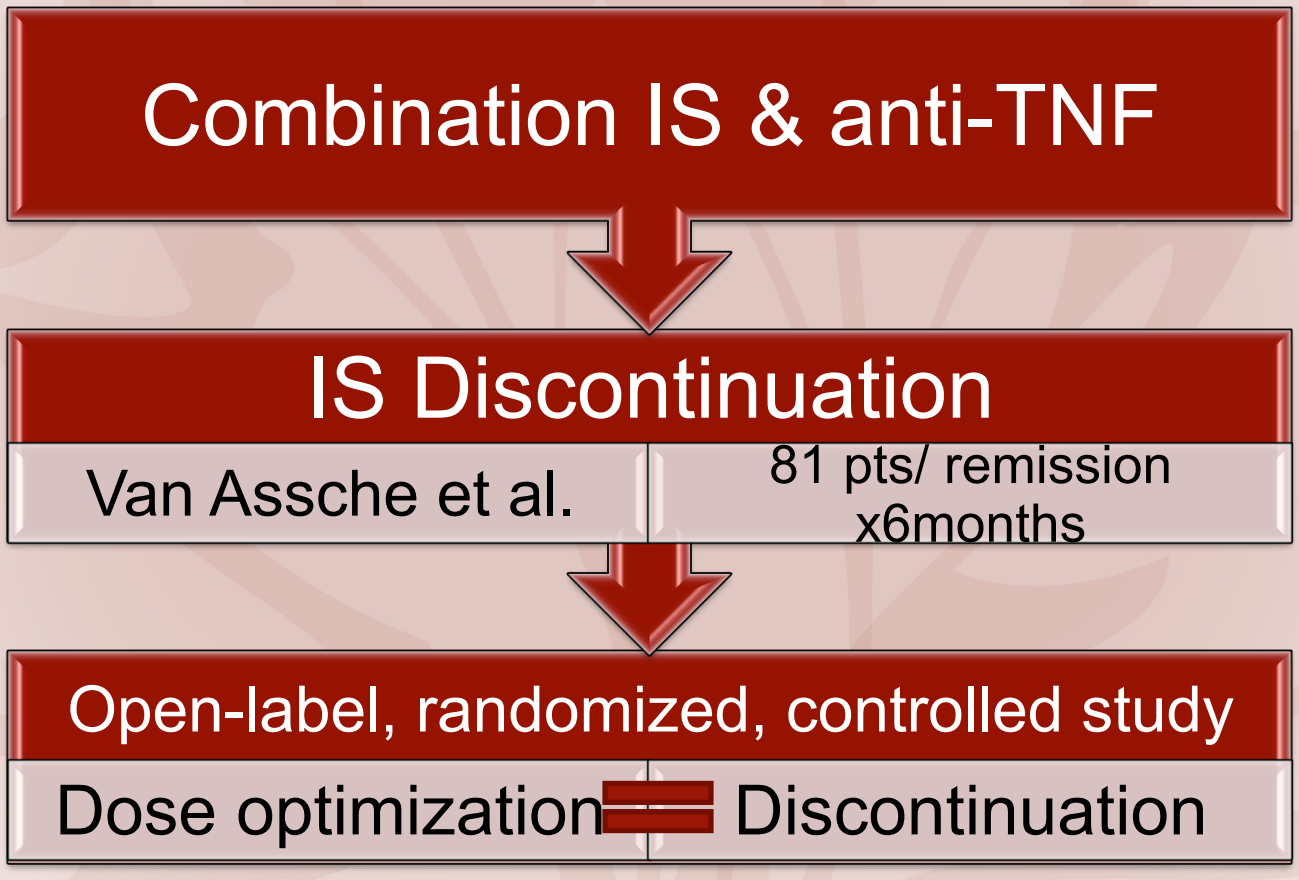
Immunosuppressives

Immunogenicity	MTX/Thiopurines

Anti-TNF

Dose optimization	Increase/decrease interval

De-escalation strategies from two to one drug…



De-escalation strategies from two to one drug…

Combination IS & anti-TNF

↓

Anti-TNF Discontinuation

Rheumatology	Saleem et al. 2010

↓

47 patients in clinical remission on MTX/IFX

Main predictor of successful withdrawal was time to treatment from diagnosis

So what about IBD?
2 Prospective Trials

GETAID 2008	STORI 2012
115 CS dependent CD patients	115 CD/CS remission x6m IFX/AZA x1y
IFX 0,2,6 vs placebo then AZA	44 relapses at 12m 7 more at 24m
At week 12, 75% IFX pts in remission off CS	15% relapse within 1year with 2 or<

Risk for relapse

- Male
- No prior surgery
- WBC
- CRP
- FeCal
- Hgb

Summary

- Patients exposed to a combination of IS and anti-TNF have an increased risk of infection
- No clear signal for associated cancers compared to single therapy
- IS alone relapse rates at 12 months following IS cessation is close to 20% CD & 30% UC
- No IBD studies examined anti-TNF withdrawal in scheduled monotherapy

Summary

- In patients receiving IS & IFX for at least 6 months, relapse rate of IFX failure following IS cessation is near 20% at 24 months and seems to be similar to those who continued combo therapy
- Anti-TNF cessation in CD on combo-therapy shows a relapse rate close to 40% and 50% over 1 and 2years respectively.
- Special populations: young male, pregnancy and the elderly require special consideration

De-escalation treatment strategy should be mainly considered in patients with high risk of severe adverse events and low relapse risk (patients in deep remission) after drug withdrawal.

Thank-you