Press Release

Challenges in chronic inflammatory bowel disease
How best to use the therapy options

Prague. The first intensive scientific exchange on chronic inflammatory bowel disease (IBD) took place in 2003 at an international symposium of the Falk Foundation in Prague. Now, 13 years later, a Falk Foundation symposium on Crohn's disease and ulcerative colitis took place there again. It was very clear that in the meantime, there have been significant advances extending from improved pathophysiological understanding and deeper knowledge of the available therapy concepts to the development of biologics and their increasing availability as biosimilars. How the best therapy can be selected from the increasingly complex choice of therapy options was discussed in a practical context by internationally renowned experts. A glimpse into the future was also provided. Here, there is the prospect of new, interesting options with autologous stem cell transplants or mesenchymal stromal cell therapy.

“An operation does not cure the disease”

Around 80% of patients with Crohn's disease need to undergo an operation during the course of their disease; 70% of these experience a recurrence and require another, two, three or even four operations. “An operation does not cure the disease,” stresses Prof. Axel Dignaß, Frankfurt. Therefore, prevention of postoperative recurrence is essential to keep the disease under control. The risk is particularly high:

- when there is increased preoperative disease activity,
- for smokers,
- when there is penetrating disease,
- when there is endoscopic inflammation in the region of the anastomosis and
- when there is extensive disease.

The younger the patient at the time of the operation, the greater the likelihood of them needing another surgical procedure. A look at the one-year recurrence rates shows the greatest advantage in terms of prevention for anti-TNF therapy, with a clinical recurrence of 0% and a postoperative endoscopic recurrence of 0 to 21%.

Immunosuppression and perioperative risks

The data on the connection between immunosuppression and perioperative complications are contradictory. In this case, Dignaß recommended looking at the current ECCO guidelines. According to these, 20 mg/day prednisolone for more than six weeks is considered to be a risk factor. Therefore, respective doses of steroids should be discontinued. The picture is different for azathioprine, which can be administered safely in the perioperative period and beyond. It remains unclear whether the rate of postoperative complications during or following anti-TNF therapy increases.
How does combination therapy help?

Combination therapy promises improved therapy effects – possibly also in patients who do not respond to monotherapy – faster relief of symptoms and fewer side effects if the dose of the individual active substances can be reduced. In contrast, there is a fear of interactions, increased morbidity and also increased costs. In IBD therapy, the existing data for combinations are rather poor, criticised Prof. Wolfgang Kruis, Cologne. It is an interesting option to improve currently available therapies with single substances, but it requires “a practised hand”. For ulcerative colitis, it is worthwhile to combine oral and rectal administration of a 5-aminosalicylate agent such as mesalazine. This is demonstrated by data from patients with recurring ulcerative colitis who are taking the combination and who remain in remission for significantly longer time. In induction therapy, combining oral application is also worthy of consideration in highly active ulcerative colitis. It may be beneficial to combine azathioprine with allopurinol. The efficacy of the immunosuppressant is improved as 6-TGN (thioguanine nucleotide) levels increase. In a study of 110 patients with IBD, the combination of azathioprine 1.9 mg/kg body weight plus allopurinol 100 mg/d achieved clinical remission as first-line therapy in 76% of patients, and also in 60% of the primary non-responders.

Non-response or undertherapy?

How important is monitoring of the active substance levels and antibodies during biologic therapy? According to Prof. Ann Gils, Leuven, therapeutic drug monitoring is suitable for distinguishing non-responders from patients with insufficient exposure to active substance and is also suitable for patients with secondary loss of response and for patients in clinical remission.

Biosimilars: are they interchangeable?

The comparability of biosimilars to the original preparation is a topic that has currently been widely discussed. To date, there is a focus on infliximab as a biosimilar in IBD therapy. It was first awarded marketing authorisation in Norway. According to the three-year experience of Prof. Björn Moum, Oslo, comparably good responder and remission rates can be achieved. Experiences in the Czech Republic and Hungary are just as positive – also with regard to tolerability and immunogenicity. In general, switching treatment was discussed in more detail than initiating treatment. The effect of switching from Remicade to Remsima is currently being investigated in the Nor-Switch study, which is the only blinded study so far to address this issue. The availability of cheaper biosimilars has already led to tangible clinical consequences, according to Moum in Norway. More patients are being placed on TNF-α inhibitors, even when there is moderate disease. These are being prescribed earlier and treatment will not be stopped for economic reasons.

Source
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