SESSION 2
OPTIMIZING MANAGEMENT IN IBD: BEYOND ANTI-TNFs
Case-based Workshop

Objectives

- Examine how to fully optimize existing therapy before switching to another

CASE

Your 34-year-old male patient with colonic and perianal Crohn's disease has been on TNF-α inhibitor monotherapy for the last 6 years and has been in excellent clinical remission with confirmed endoscopic mucosal healing. Over the past year he has experienced some occasional diarrhea and some seepage from an old perianal fistula. These symptoms are more pronounced shortly before his next TNF-α inhibitor treatment.

Decision Node 1

Discuss at least 3 things you need to do before considering this to be loss of response to the biologic.

His stool cultures are negative. He has delayed a few doses of his TNF-α inhibitor by no more than a week, but otherwise adheres to his therapy. The company's support service is able to confirm this. Laboratory investigation reveals fecal calprotectin (FCP) of 874 µg/g and a subtherapeutic trough level with no antidrug antibodies (ADAs). MRI of the pelvis shows a left-sided trans-sphincteric fistula tract but no abscess. He does not want to change his biologic.

Decision Node 2

Discuss what can be done to optimize his current therapy.

You add methotrexate 15 mg PO weekly, prescribe a 2-week course of ciprofloxacin plus metronidazole, and increase his TNF-α inhibitor dose. He returns in 16 weeks to report no improvement.

Decision Node 3

What needs to be done now to allow further optimization?

Before calling this loss of response, you again arrange objective monitoring with therapeutic drug monitoring (TDM) and FCP (based on the elevated baseline level). His TNF-α inhibitor trough level is now 17 µg/mL (you recognize the individuality in drug levels required for remission) and his FCP remains elevated at 980 µg/g.

Decision Node 4

Has he lost response to the biologic agent?

Decision Node 5

What else can you do to optimize therapy before calling this loss of response and advancing to another therapy?