Identifying and treating patients at risk of disease progression was the focus for a satellite symposium at the ECCO Congress, sponsored by Takeda. Prof Remo Panaccione was the Chair.

This symposium will focus on two main questions: How can we identify those patients with Crohn’s disease (CD) who may benefit from early intervention and – once these patients are identified – how can we optimise therapeutic approaches within the available window of opportunity, Prof Panaccione said when he greeted everyone welcome.

Some patients will have an indolent disease course
Prof Edouard Louis was the first speaker, and he talked about the long term evolution of CD.

– The Swiss IBD cohort study compared data from an early treatment cohort with 292 CD patients with a late treatment cohort of 248 patients. The conclusion was that early use of anti-TNF therapy or immunomodulators is associated with reduced risk of bowel strictures in CD, Prof Louis said.

He also presented another study from the US that found earlier introduction to biologics tends to correlate with slower progression of bowel damage in CD. A study from 2019 showed that patients with shorter disease duration had higher clinical remission and mucosal healing rates with vedolizumab.

However, data from the Norwegian IBSEN study on 237 patients with CD, diagnosed 1990 - 1994, showed that CD is highly variable, and it is challenging to predict who will benefit from early treatment, he continued.

– In IBSEN, after 10 years, 3 % had an increase in symptom severity. 19 % had chronic continuous symptoms, 32 % chronic relapsing symptoms and 43 % a decrease in symptom severity, Prof Louis pointed out.

So early, intensive intervention may not benefit every patient.

– 20 - 30 % of patients will have an indolent disease course, and may not require early intervention – because this
may represent over-treatment and an unnecessary expense, he explained.

In other words, there is a need for patient stratification.

**Patient stratification is an important task**

In the blurry world of prediction, predictive models are problematic because they are strikingly influenced by the population initially studied, which variable was tested in the model and what outcome was looked at. Extrapolation and clinical applicability may therefore be limited.

– Identifying an at-risk population does not mean it represents the best candidates for early intensive drug intervention (versus surgery for limited ileal complicated disease), Prof Louis underlined.

But there are things to look for. Prof Louis presented an expert consensus on how to identify patients at high risk for complications.

– Younger age and/or perianal disease at diagnosis have a prognosis of disabling disease course. Smoking is associated with therapy escalation, complicated disease, need for surgery and postoperative recurrence.

Also ileal disease location, upper GI involvement and extraintestinal manifestations are associated with complicated behaviour.

Practical tips for assessing risk in clinical practice include not to just rely on symptoms – also identify location, extent and severity of lesions. Assess disease biology such as genetics. Mutations in NOD2 are a sign for complicated behaviour. Serologic reactivity to microbial antigens is also associated with complicated behaviour. Consider the whole patient – including environmental factors such as smoking, food etc.

In his conclusions Prof Louis established that CD is a progressive disease, and intensive therapy works better earlier than late.

– Due to disease heterogeneity, patient stratification is an important task. Stratification should rely on appropriate assessment of existing lesions, including projection of risk and potential consequences of lesion progression. And I like to stress the fact that the predictive value of any tool is limited – and prediction is just a starting point. Monitoring and re-assessment are mandatory complements, Prof Louis ended his lecture.

“Optimise key elements in your care”

Prof Panaccione then talked about the challenge in CD management: How can we identify the right strategy for the right patient at the right time?

– It is not as easy as it suggests, he said. Treating patients with biologics in CD requires a holistic approach.

Prof Panaccione stated that one should tailor a treat-to-target approach to one’s setting. Some settings may need to network with other hospitals to share expertise. Develop a tailored treat-to-target protocol approach to guide staff – and use faecal calprotectin, CRP or transabdominal ultrasound to monitor disease, he advised the audience.

– Optimise key elements available in your care setting may increase your chances of improving your quality of care!

All biologics show efficacy in achieving clinical remission in CD.

– But we have not seen a therapy that is 30 % more efficient than any else. This is a problem, Prof Panaccione underlined.

**Consider patient’s unique journey**

He presented data from the VERSIFY study, that showed vedolizumab demonstrated mucosal healing benefits in a refractory CD population.

– An interim analysis from the ongoing LOVE-CD prospective phase IV study show mucosal healing achieved in patients with refractory CD treated with vedolizumab. 110 patients were included in the analysis.

Prof Panaccione also talked about transmural healing – i.e. complete healing of all bowel layers.

– There is more and more talk of this, and it may be a potential future treating target.

Anti-TNF therapy has been associated with increasing infection risk in IBD studies (data from population studies). US VICTORY consortium has found lower rates of serious infections and serious adverse events with vedolizumab versus anti-TNF monotherapy in IBD patients.

– Consider each patient’s unique journey when monitoring. Patient’s monitoring preferences may be influenced by experiencing symptoms, convenience attributes, psychosocial factors and their information needs, Prof Panaccione continued.

When choosing therapy, consider the benefit ratio of risk and cost. Also consider predictive factors of response to therapy and patient preference, he said in his conclusions.

– Intervene at the right time – before it is too late. Monitoring is essential, and so is pre-emptive optimisation of the dose and the therapy!

**Patient’s choice should be taken into account**

Prof Subrata Ghosh presented some challenging cases. It was an interactive session, during which he made pauses in order for the audience to vote on how they thought one should continue. This was also commented by the panel.

– Early introduction of effective therapy is key to managing CD with the best results, Prof Ghosh then summarised.

Risk-factor profiling and full disease assessment is important, he continued.

– Treating-to-target should involve noninvasive markers such as faecal calprotectin and CRP. Vedolizumab is an effective, generally well tolerated biologic therapy with a favourable safety profile in CD. The choice of therapy should take into account patient preference and concerns, were Prof Ghosh conclusions from the cases.

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