Despite some worrying reports on social unrest in Barcelona, more than 13,000 attendees from 122 countries had come to the city on the north-east coast of Spain. They were all welcomed at the Opening session by UEG President Paul Fockens, The Netherlands, and Prof Herbert Tilg, Austria, Chair of the UEG Scientific Committee.

**Time to change clinical practice**

Traditionally, at the Opening session awards are presented. The first award was the UEG Top abstract award of 10,000 Euro, which was presented to Dr Lissy de Ridder, a paediatric Gastroenterologist from The Netherlands. She presented her study, which was on top-down versus step-up treatment with infliximab in children with Crohn’s disease (CD).

- It is known that paediatric CD carries a high risk for complicated disease – chronic uncontrolled inflammation leads to accumulating tissue damage, Dr de Ridder explained.

The hypothesis for her study was that initiation of infliximab directly after diagnosis of moderate-to-severe CD patients prevents the inflammatory cascade. This was tested in a multicenter, open-label, randomised controlled trial. Children 3 - 17 years with untreated CD were included and randomised to either top-down (treatment start at the top of the therapeutic ladder, and tapered when patient responds) or step-up (treatment starts low on the therapeutic ladder with steroids, and escalated if the patient does not respond). Both groups received azathioprine 2 -3 mg/kg concomitantly.

- The primary endpoint was clinical remission at week 52, without need for additional CD-related therapy or surgery, Dr de Ridder continued.

At week 10, 61 % of patients in the top-down group had endoscopic remission, defined as a Simple Endoscopic Score for Crohn’s Disease (SES-CD) less than 3. In the step-up group only 14 % achieved this. The inflammatory markers were also higher in the step-up group.

- At week 52, primary endpoint was met by 49 % of those on top-down. This can be compared with 11 % for step-up. Also significantly more step-up patients received anti-TNF at week 52.

Her conclusion was that top-down infliximab is superior to step-up therapy in children with newly diagnosed moderate-to-severe CD.

- It’s time to change daily clinical practice – to start with anti-TNF in this patient group.

Dr de Ridder explained that they now are going to follow the long term results, with a clinical follow-up of 2 - 5 years.

- A challenge is the risk of overtreatment – since 11 % do well on exclusive
enteral nutrition, prednisolon and azathioprine, she pointed out at the end.

The virome hypothesis
The UEG Research Prize was also presented at the Opening session, to Prof Silvio Danese, Italy. This prize is on 100,000 Euro. He was awarded for his project “The gut virome as a trigger for IBD: from metagenomics to pathogenesis”. Prof Danese is a member of many organizations related to the IBD field, and he is the current President for ECCO.

He talked about next generation sequencing, and described it as a breakthrough for microbiota discovery.

– The intestinal microbiota in IBD is characterized by gut epithelial barrier disruption and microbe translocation from the lumen to the mucosal tissue. Also by aberrant mucosal immune response and chronic inflammation. Changes in microbiota composition – including the virome alterations – are associated with IBD pathogenesis, Prof Danese explained.

The virome hypothesis is that eukaryotic viruses impact on the transcriptional state of host’s cells, defining the “viotype” of healthy people. Virotypes may also predispose to disease.

Prof Danese presented studies that show that eukaryotic viruses colonize UC gut mucosa – and that eukaryotic virome may trigger intestinal inflammation.

– Norovirus infection accelerates colitis onset in mouse models, he pointed out.

His perspectives for further research is to integrate the eukaryotic virome in IBD pathogenesis.

– This could lead to a new therapeutic approach: Specific small integrating RNAs (siRNAs) or antiviral drugs. I hope to present our abstracts at future UEG Weeks, Prof Danese stated.

Higher incidence of IBD than previously reported
In another session, researchers from the UK presented a study that had examined IBD cases from the beginning of the century in order to attain accurate data on ulcerative colitis (UC) and CD prevalence in the UK. Previously only limited, or old, data existed but by utilising data from a nationally representative primary care database, the investigators could show that IBD prevalence is three times higher than previously reported.

UC and CD prevalence has increased by 55 % and 83 % respectively between year 2000 and 2017. The study also showed that IBD prevalence is predicted to rise by almost 25 % from 2017 to 2025.

– Our study suggests that IBD prevalence is going to rise substantially over the next decade, said Dr Dominic King, UK.

He added that as there is currently no known cure for IBD, patients will often need complex and costly treatments throughout their lives.

– This predicted rise in prevalence may place an even greater strain on already overburdened healthcare systems.

The burden of IBD is compounded further by an association with colorectal cancer, Dr King continued.

– Our study found that patients suffering from CD had a 23 % increased risk of developing colorectal cancer compared to matched controls, whilst UC patients had a significantly elevated risk of 43 %. The rise in prevalence of IBD could therefore lead to an associated rise in colorectal cancer cases, Dr King underlined.
IBD patients are less productive at work

At a press conference Dr Sara van Gennep, The Netherlands, talked about the WORK-IBD study.

– Disease and economic burden due to IBD is substantial. Healthcare costs result from direct and indirect costs. Work productivity loss can be measured in absenteeism, which means absence from work – or presenteeism, which means productivity loss for patients that do go to work but can not perform as they are supposed to, she explained.

Prior economic analyses have focused on absenteeism, while 30% of IBD patients experience presenteeism.

– Therefore we can say that little is known about indirect costs in the working IBD population, Dr van Gennep said.

The aims of the study were to describe the prevalence of work productivity loss, to assess predictors of severe work productivity loss and to estimate associated indirect costs per patient per year.

It is an ongoing web-based questionnaire study, with questionnaires every 6 months during a 2 year follow-up. Patients with UC or CD participating in paid labour were included. A total of 510 patients were included in the analysis she presented.

– We found that work productivity loss is substantial in the working IBD population. 19% reported severe work productivity loss. The largest proportion of patients reporting work productivity loss used ustekinumab as a second or third line biologic and 5-ASA monotherapy, respectively. We are not blaming the drug – this is reflecting disease severity, Dr van Gennep said.

Disease activity and perianal disease are predictors of work productivity loss, and result in a significant increase of indirect costs.

– Work productivity loss leads to a cost of approximately 6,600 Euro per year per person, and presenteeism is the major cost driver, was the last of her conclusions.

Safety for vedolizumab and anti-TNF compared

In one session on new drugs, Dr Andres Yarur, USA, presented the results from the EVOLVE study. It is a real-world retrospective medical chart review study to evaluate long-term outcomes (up to 24 months) in patients with UC and CD treated with vedolizumab. A total of 1,095 patients from 42 sites in Canada, Greece and the USA were included – 598 on vedolizumab and 497 on anti-TNFs. The study investigated the number of serious adverse events (SAEs) and serious infections (SIs).

– The objective was to compare the safety of first-line biologic vedolizumab and anti-TNF agents, Dr Yarur explained.

Data were collected between May 2014 and March 2018.

– This represents the first large-scale, long-term study to assess and compare safety outcomes in biologic naïve UC and CD populations. The retrospective design allowed capture of data as occurring in real-world practice. However, one must remember that this limits the collection of data to what is documented, and may impose bias when comparing groups, he underlined.
Tofacitinib and non-melanoma skin cancer
There is evidence that patients with IBD are at increased risk of developing non-melanoma skin cancer (NMSC). Some have attributed the immunosuppressive effects of thiopurine treatment to this increasing risk, with the incidence rate significantly increasing with subsequent years of cumulative exposure.

This was pointed out by Prof Bruce Sands, USA, who presented an update on the integrated analysis of NMSC events in the tofacitinib UC clinical programme, with up to 6.1 years of treatment.

- In the Phase III UC trial, patients who received either placebo, tofacitinib 5 mg BID or 10 mg BID were analysed as three cohorts, he reminded the audience. In all, 1,124 patients received 5 or 10 mg tofacitinib. 19 of those developed NMSC. 7 of those had prior NMSC history, 18 had prior immunosuppressant exposure, 15 prior anti-TNF exposure and 15 had history of prior steroid exposure.

Tofacitinib and serious infections
A similar analysis on tofacitinib, but on serious infections, was presented by Prof Daniel Baumgart, Canada.

- In the UC programme, in the induction cohort, serious infections were more frequent with tofacitinib versus placebo – whereas in the maintenance cohort infections rates were comparable clinical programme, with similar incidence rates for basal cell carcinoma and squamous cell carcinoma and numerically similar incidence rates in the tofacitinib 5 mg and 10 mg groups, Prof Sands reported.

The NMSC incidence rates were similar to those reported for tofacitinib in other indications – including rheumatoid arthritis and for biologic UC treatments.

- Step-wise Cox regression identified prior NMSC history and increasing age as significant risk factors for NMSC in these patients with UC receiving tofacitinib – which are all known risk factors for the development of NMSC in the background population, was Prof Sands conclusion.

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- In the UC programme, in the induction cohort, serious infections were more frequent with tofacitinib versus placebo – whereas in the maintenance cohort infections rates were comparable
between placebo and tofacitinib 5 and 10 mg groups. Overall cohort incidence rates were generally stable over time, he said.

Increased BMI and leucopenia were identified as risk factors for serious infections.

– In the general population, obesity has been associated with a higher risk of several types of infections. Leucopenia was also identified as a risk factor for serious infections in the tofacitinib rheumatoid arthritis programme.

In the maintenance cohort, the herpes zoster incidence rate was numerically higher in the tofacitinib 10 mg group versus the 5 mg group. However, the overall rate was stable over time. Non-herpes zoster opportunistic infections occurred rarely.

Prof Baumgart ended by saying that serious infection rates were similar to those reported in patients with rheumatoid arthritis treated with tofacitinib, and with other UC therapies.

**Similar risks with infliximab in the elderly as in young adults**

Elderly patients with IBD account for almost 20 % of all IBD patients (this figure includes both those with elderly onset, and those with long-lasting IBD).

– Elderly patients have different pharmacodynamic and pharmacokinetic characteristics and – in addition – they may have different immune response due to immunosenescence (= gradual deterioration of the immune system brought on by natural age advancement), said Dr Margalida Calafat, Spain.

She presented a study that aimed to compare the rate of infliximab-related immunomediated adverse events between elderly IBD patients and young adults with IBD. The secondary endpoint was to compare the rate of secondary loss of response between elderly and young adult patients with IBD.

It was a retrospective cohort study based on the ENEIDA registry by GETECCO (the Spanish working group in Crohn’s and colitis). All patients included in the registry who received a first course of biological treatment were identified, and only those who started infliximab were included. Patients were grouped as elderly – defined as starting infliximab over 60 years of age – and young adult group who started infliximab between 18 and 50 years of age. There were 939 patients in the elderly group and 6,844 patients in the young adult group.

– Our results shows that precisely 14,8 % of patients in both groups had immunorelated adverse events. Treatment withdrawal due to this was 12,1 % in the elderly and 11,4 % in the young adults. There was no difference!

Hence Dr Calafat’s conclusions were that elderly IBD patients who start treatment with infliximab have a similar risk of developing immunomediated adverse events and secondary loss of response as younger patients have.

– And elderly patients would benefit from combination therapy in the same way that younger patients do.
**Vedolizumab and ustekinumab in pregnancy**

Dr Pauline Wils, France, talked about a study on vedolizumab and ustekinumab in pregnancy.

- IBD has a high incidence in the female population of childbearing age. A proportion of female patients will be exposed to IBD medications during pregnancy in order to maintain remission. The American Gastroenterology Association recommends to stop vedolizumab or ustekinumab 6 - 10 weeks before estimated date of confinement, however data on the use and safety of these novel biologic agents in pregnancy is poor, Dr Wils explained.

In 19 French tertiary centres affiliated with the French IBD organization GETAID, female patients with a diagnosis of IBD were included. They had received at least one injection of ustekinumab or vedolizumab during pregnancy, or within 2 months before conception. In total, there were 39 patients under vedolizumab and 26 patients under ustekinumab.

- In total, there were 65 pregnancies. 2/3 of these patients maintained vedolizumab and 3/4 maintained ustekinumab during pregnancy. Except one congenital corpus callosum hypoplasia under vedolizumab, and one tetralogy of Fallot under ustekinumab, no severe neonatal complications were observed. No severe maternal complications were reported, Dr Wils told the audience.

Before using ustekinumab or vedolizumab in clinical practice during pregnancy in IBD patients, additional prospective evaluations regarding pregnancy outcomes are necessary, she finished by adding.

**Head-to-head trial on oral versus intravenous iron supplement**

Iron deficiency anaemia (IDA) is a serious complication of IBD – resulting from inflammation, chronic mucosal blood loss and iron malabsorption. Treatment of IDA involves iron-replacement therapy, often with oral ferrous iron medication in the first instance.

- However, use of oral ferrous iron medications may be limited by poor absorption and adverse events which can lead to many unwell patients having to receive intravenous iron in hospital, said Dr Stefanie Howaldt, Germany.

Dr Howaldt was one of the investigators of a study on a new oral iron supplementation – ferric maltol. It had been compared to intravenous ferric carboxymaltose in a head-to-head trial in IBD patients.

- We know that ferric maltol is effective with an established tolerability profile in patients with IBD, based on earlier research. But no head-to-head studies between ferric maltol and intravenous iron have been conducted so far, she continued.

It was a prospective, multicentre, Phase IIb, open-label randomised controlled study. IBD patients were randomised to 12 weeks of oral ferric maltol 30 mg twice daily or to intravenous ferric carboxymaltose administered according to standard prescribing information. Treatment could continue – if the patient wanted to – for up to 52 weeks.
Patient stratification to prevent overtreatment essential

Dr Johan Burisch, Denmark presented a study that aimed to assess the use of 5-ASA in CD, and to investigate the disease course of a subgroup of patients with mild CD defined by needing 5-ASA as monotherapy first year of the disease.

– The primary endpoint was Hb responder rate. The primary efficacy analysis was performed for the per protocol population using observed cases approach, and supportive analysis was performed for intention-to-treat population with missing values imputed using multiple imputation, Dr Howaldt explained.

Will change treatment regimens

It was a non-inferiority trial – and at 12 weeks the responder rate of oral ferric maltol was found to be non-inferior to the intravenous alternative, well within the 20 % non-inferiority limit.

This was a quite surprising find, as oral iron normally has much lower efficacy compared to intravenous iron, and therefore is not generally recommended for IBD patients. So in what way does ferric maltol differ from other oral therapies?

– There is a sugar coating that enables iron to reach the blood vessel, was Dr Howaldt’s answer.

She pointed out that the results of this head-to-head study may facilitate physicians treatment decisions – enabling them to improve clinical practice and help more patients with IDA and IBD.

– Fatigue is a big problem in IBD, also in young patients. IDA is one of the main drivers for fatigue.

The difference for the patient is that he or she does not have to come to the centre, which could be 100 km away. Instead they can take it at home. The difference for health care is that if the patient has a defined need for iron, it is less costly to administrate.

The study’s conclusion was that oral ferric maltol may offer an alternative treatment option to intravenous iron even in patients who have failed, or not tolerated, current oral treatment.

– The message is that we now have a new oral product – comparable to intravenous iron – and with very little side effects (5 - 9 %). It will change treatment regimens. The really severe IDA patients will be treated with this and intravenous iron in the future, Dr Howaldt stated.

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Patient stratification to prevent overtreatment essential

Dr Johan Burisch, Denmark presented a study that aimed to assess the use of 5-ASA in CD, and to investigate the disease course of a subgroup of patients with mild CD defined by only needing 5-ASA as monotherapy first year of the disease.

– The scientific evidence regarding the efficacy of 5-ASA in CD patients is in sharp contrast to clinical practice. We have shown in the Epi-IBD group that in our cohorts the use of 5-ASA in CD is still high, he explained.

Data for the study he presented came from a population-based inception Epi-IBD cohort with 488 CD patients and 5 years of follow-up.

– 78 (16 %) received 5-ASA monotherapy during the first year of disease. The median duration of treatment was 34 months, and these patients were older at diagnosis – median 37 versus 32 years. They also more often came from Eastern Europe, Dr Burisch said.
212 (43%) of patients received 5-ASA during follow-up, and 68% started the drug right after diagnosis. Most patients eventually needed to step up therapy – 35% with immunomodulators, 23% with biological therapy, 18% with surgery and 24% with prednisolone/budesonide.

So a large number of CD patients were started on 5-ASA, but subsequently stepped up treatment during follow-up. A substantial proportion of CD patients needed only mild treatment during follow-up, and this subgroup experienced a quiescent disease course with low progression and surgery, Dr Burisch summarised.

Patient stratification at baseline to prevent overtreatment is important. Further studies are needed to identify clinical, serological or genetic markers to identify this group of patients, were Dr Burisch last conclusions.

**Post-hoc analysis on risankizumab in CD**
The IL-23 pathway is implicated in the pathogenesis of immune-mediated inflammatory diseases including CD. Risankizumab is a selective IL-23 inhibitor targeting the p19 subunit. It has shown efficacy and safety in inducing clinical remission in patients with CD, said Prof Brian Feagan, Canada.

He presented a study with the aim to report the assessment of early symptom improvement with risankizumab during the first period of a Phase II study on risankizumab in CD.

– Clinical remission at week 12 based on symptom improvement was 6.1% for placebo, 13.9% for risankizumab 200 mg, and 23.9% for 600 mg. It was a significant difference to placebo, Prof Feagan underlined.

The data from the Phase II study do not show any increased safety signals, when compared to placebo. No dose-related increases for any adverse events were associated with risankizumab treatment.

– My first conclusion is that in post-hoc analysis, risankizumab induction treatment led to significant improvements in clinical symptoms and disease activity as early as week 2, which continued through 12 weeks of treatment – in a highly refractory patient population with moderately to severely active CD.

Prof Feagan’s second conclusion was that rates of clinical remission based on symptom improvement supported the previously reported superiority of risankizumab versus placebo for inducing CDAI remission at week 12.

**Multidisciplinary treatment of perianal fistulae**
Gastroenterologist Krisztina Gecse, The Netherlands, and Surgeon Janindra Warusavitame, UK, had a tandem talk about the benefits of an interdisciplinary approach to peri-anal fistula in CD.

Dr Gecse pointed out that perianal
They ended by presenting a treatment algorithm for interdisciplinary approach:

- If abscess is present, the first thing to do is to ensure drainage. Then perform an examination under anaesthesia (EUA). After that a seton placement and/or induction with combined medical treatment. Next step is seton removal. If then active disease in the rectum or anal stricture is found, optimise medical treatment and dilate. If active disease remains, try new biological agents (anti-IL12/23) or deviation as a last resort. If mucosal healing is found after removing seton, but fistulae is active – advance -

The disease affects 25% of all CD patients, and the cumulative probability increases with disease duration.

- One third of fistulizing patients will have recurrent episodes, and 70 - 80% of perianal fistulas are complex, she continued.

Mr Warusavitame stressed that one of the most important things for the surgeon is to avoid delay – because that means a delay in treatment.

- When we multidisciplinary treat perianal CD, we have to consider several factors: The epithelialisation of the fistula – is it continuous or in islands? Also microbiological factors, dysregulated inflammation, presence of physical connection in the “high pressure zone” and failure of wound repair, he said.

Dr Gecse talked about the medical approach with antibiotics and immunosuppressives. They all have their pros and cons, which also goes for biologicals.

- There are increasing evidence for an adequate drug exposure, she continued and presented data on infliximab that illustrated this.

- But remember that initial control of associated sepsis is required before treatment!

**Treatment algorithm**

Combined medical-surgical treatment is associated with increased healing – 52 % versus 43 % for biologics only, Mr Warusavitame pointed out.

- A 3D reconstruction for the surgeon is very good – it enables us to visualize the fistula tract.

He said that for patients refractory to medical therapy, defunctioning or proctectomy are the options.

- Defunctioning gives temporary relief, but the disease is left behind and only 10 % of stomas are reversed. Proctectomy improves quality of life, despite 20 % risk of recurrence and reoperation.

- It is all about the right patient, the right procedure at the right time, Dr Gecse underlined.

Mr Warusavitame ended the talk by presenting the State of the Art treatment concepts in the 21st century. They are as follows:

- Multidisciplinary working, patient-centred – to improve quality of life, no breaks in medication, optimized medical treatment, understanding the fistula anatomy and anatomical treatment of fistulae tracts, he stated.

**Histologic changes with ozanimod**

STEPSTONE is an ongoing Phase II open label multicenter trial of ozanimod 1 mg once daily for 12 weeks in patients with CD. Eligible patients had active CD, and inadequate or loss of response to at least one treatment used in CD.
First histologic data on mirikizumab in UC
Mirikizumab is a p19-directed IL-23 antibody that demonstrated efficacy and was well tolerated during 12 weeks of induction followed by an additional 40 weeks of maintenance treatment in a Phase II, randomised clinical trial in patients with active to moderate UC.
Prof William Sandborn, USA, presented a study with the objective to evaluate the effect of mirikizumab on histologic outcomes at week 12 and week 52.
- Endoscopy was performed at weeks 0, 12 and 52, with biopsy of the colon obtained at the most affected area lying at least 30 cm from the anal verge, Prof Sandborn said.
Pathologists were blinded to clinical details, treatment assignment and time in study.
Patients in the study were randomised to either placebo (63), mirikizumab 50 mg (63), 200 mg (62) or 600 mg (61) every 4th week.
- The majority of patients in the mirikizumab 200 mg arm achieved histological remission at week 52. Among patients with histological remission at week 12, 81 % in the 200 mg group remained...
in remission at week 52. A stringent definition of histologic remission that included the absence of neutrophils in the crypt an lamina propria was utilized, Prof Sandborn underlined.

He pointed out that these are the first histologic data with an IL-23p19-targeted antibody in patients with UC.

– Mirikizumab is currently being evaluated in Phase III clinical trials in patients with moderately to active UC and CD.

Non-colonic surveillance

In a symposium on surveillance in IBD, Dr Johan Burisch, Denmark, asked the audience a question.

– Do IBD patients have a higher risk for extra-intestinal cancer?

92 % of them answered yes to this, and he commented that they were right in doing so.

Exposure to thiopurines increases the risk of lymphoma in IBD, and this risk increases with the age of the patient, according to data Dr Burisch presented.

– The influence of anti-TNF on the risk of cancer is unclear. We have two studies with conflicting results. One Danish nationwide study on 56,146 IBD patients found no increased risk, but a French nationwide study on 189,289 patients did find an increased risk for lymphoma. Both studies are very good, but have opposite results – so the situation is that we do not know.

A meta-analysis on the risk for melanoma in IBD published in 2014 showed an increased risk. It included 172,837 patients, and 179 cases of melanoma. A Danish study confirmed this finding.

– ECCO recommendations are as soon as IBD is diagnosed, patients should be instructed on the life-long use of sun protection measures, and regular full-body skin examinations should also be considered, Dr Burisch continued.

On the risk of cervical cancer/dysplasia, studies investigating this in IBD have also reported conflicting data. However, a meta-analysis of 8 studies on 77,116 patients found that the risk of cervical neoplasia in IBD overall is increased.

Dr Burisch summarised it all in his conclusions:

– For lymphoproliferative disorders there are no screening recommendations. Communicate risks associated with therapy prior to initiation. Consider avoiding prolonged combination therapy with thiopurines and anti-TNF beyond two years in young men, and consider alternatives to thiopurines in young men seronegative for EBV.

For skin cancer consider regular skin exams by dermatologist if on thiopurine or anti-TNF therapy in high risk patients. Recommend avoidance of excessive sun exposure and use of sunscreen.

– For cervical cancer ensure regular gynaecologic screening, and vaccinate against HPV – in both men and women!

Mesalazine the initial treatment for proctitis

Proctitis is defined as inflammation of the lower 15 cm of the rectum. The symptoms can vary greatly, but include painful defecation, tenesmus, bleeding and proximal constipation, among others, Prof Janneke van der Woude said in her talk on the subject.

– In our IBD cohort in Rotterdam, 30 % of newly diagnosed patients have proctitis, she said.

Induction therapy with topical mesalazine do get a lot of patients in remission. It is also effective for maintenance.

Prof van der Woude presented some studies on topical corticosteroids in proctitis. 200 mg hydrocortisone showed a clinical remission rate of 42,1 %, 5 mg betamethasone enema versus 20 mg prednisolone enema had clinical remission rates of 55 % versus 44 %.

– If that fails, there are immunomodulators and biologics. However, there are not a large number of patients in those studies on outcome in proctitis. One with 13 patients on infliximab showed a clinical response of 69 %. A larger multicenter retrospective trial on infliximab, adalimumab and golimumab on 106 patients showed a clinical response of 77 %, and clinical remission for 55 %.

Prof van der Woude continued with rectal tacrolimus, which according to her is a rather good option.

– We just published a randomised, controlled trial on tacrolimus versus beclomethasone suppositories, in which tacrolimus showed superiority.

In her conclusions Prof van der Woude established that there is a high prevalence for proctitis and also a risk for proximal extension.
Sweden shows that after surgery, the loss – Luckily, pouch failure is very low – and stable over time. The outcomes were good, predictable, 409 patients after 15 years of follow-up. He also presented a study he himself that 1,83 % developed pouch neoplasia. A long time follow-up (25 years) showed that IRA has transanal defection, and no remaining disease (apart from rectal cuff in stapled anastomoses). IRA is said to be a less complicated procedure, has transanal defection, less frequent bowel movements and good continence. Disadvantages for IRA include proctitis, a need for anti-inflammatory medication urgencies, and need of surveillance due to cancer risk. IPAA is a more complicated procedure, have more frequent bowel movements, impaired continence (especially during the night) urgency and carries a risk for pouchitis, Prof Hahnloser explained.

According to him, some patients are suitable for an IRA, and some are not.
– Factors like disease activity in rectum, fertility, function, quality of life and risk for cancer have to be considered.

Since IRA does carry a higher risk of cancer, for a patient that already has rectal dysplasia IRA is not a good choice.
– But also pouches can develop cancer, Prof Hahnloser pointed out.

A long time follow-up (25 years) showed that 1,83 % developed pouch neoplasia.

He also presented a study he himself had published on Quality of Life from 409 patients after 15 years of follow-up. The outcomes were good, predictable, and stable over time.
– Luckily, pouch failure is very low – after both IPAA and IRA. Data from Sweden shows that after surgery, the loss of anal function is 4,1 % after one year. That is 96 % success! These data also shows that the risk is higher with IRA to lose function over time.

If an IPAA fails, one option is to re-do IPAA. Another is a Kock-pouch and the third alternative is a stoma. Prof Hahnloser underlined the importance to inform patients that around 10 % of them will need a stoma over time.
– My last message is that IPAA or IRA should be performed at a referral specialist high volume centre, he stated.

5 year data from the LIRIC trial
In a symposium on CD, Prof Christianne Buskens, The Netherlands, talked about surgical treatment.
– If the patient has penetrating disease with obstructive symptoms, abscess under anti-TNF, if percutaneous drainage is not feasible, in medical refractory disease or no resolution of the abscess fistulae after medical treatment and/or percutaneous drainage – then early surgery should be considered.

Prof Buskens continued by pointing out that surgery should be considered in any disease.
– Long-term data from the LIRIC trial – not published yet – show that nearly half of the patients that were on anti-TNF had to go through a resection after 5 years.

In her conclusion she said that surgery is a part of multimodal treatment.
– Avoiding or postponing surgery should not longer be the aim in CD!

“AVOIDING OR POSTPONING SURGERY SHOULD NOT LONGER BE THE AIM IN CD!”

Risk for complications increase with obesity
In the same symposium Prof Matthieu Alléz, France, talked about stratifying patients with CD.
– While the location of the disease is stable over time, the phenotype – i.e. inflammatory, stricturing and penetrating – is not, he said.

Prof Alléz presented the Lemann index – a scoring system that assess structural bowel damage, including strictureing lesions, penetrating lesions and surgical resection.
– Extensive small bowel disease (more than 100 cm or jejunal involvement) is associated with a poor outcome, and in a population-based study with a 3 to 7-fold increase in mortality.

The course of CD may be predicted by clinical factors, imaging and endoscopic findings. Disease location and extent must be precisely determined. Tissue damage must be evaluated – MRI, CT and ultrasound have a high accuracy for the diagnosis of small bowel stenosis and penetrating complications.
– Smoking is a strong predictor of poor outcome, therefore we need to do more to help our patients to stop, he continued.

In Europe, the incidence of obesity is rising.
– The risk of complications such as, hospitalisation and infection might be increased in patients with IBD, who are obese. Maybe we should take this into account when we decide on therapy, Prof Alléz ended his lecture.

And with this, IBD Congress News also ends its report from UEG Week 2019. Next year the Congress will be held in Amsterdam, 10 – 14th of October.

Per Lundblad