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Optimizing Outcomes in Crohn's Disease across the Care Continuum: Closing Care Gaps with Early Biologic Strategies, Monitoring, and Patient-Centered Decision-Making

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Supported by an independent educational grant from Takeda.

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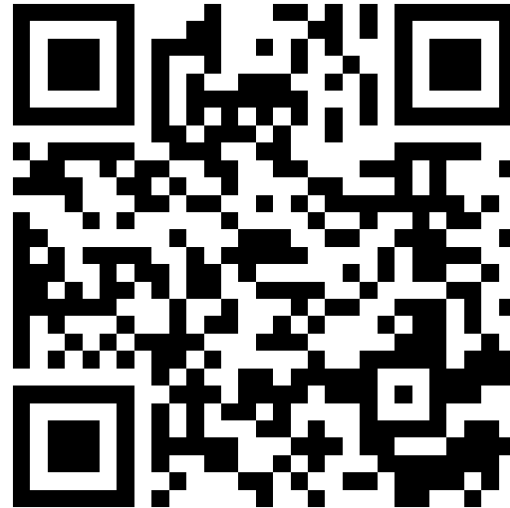
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Disclosures

- **Christina Ha, MD, FACG, AGAF:** Advisory Board—AbbVie, Johnson & Johnson (J&J), Lilly, Merck, Pfizer, Sanofi, Takeda; Educational Programming Support—AbbVie, Celltrion, Janssen, Lilly, Pfizer, Takeda; Steering Committee—IBD Education Group, MILESTONE IBD

Learning Objectives

- Identify major care gaps in CD that drive complications and postoperative recurrence, including diagnostic delay, therapeutic inertia, and steroid dependence
- Evaluate clinical evidence for advanced therapies across the full CD treatment landscape, including biologics and small molecules, to optimize treatment selection throughout the disease course
- Apply risk stratification at diagnosis and after surgery to guide early biologic selection and implement postoperative prophylaxis and monitoring in CD to prevent endoscopic recurrence
- Implement patient-centered IBD management strategies that integrate individualized care planning and culturally competent communication to optimize shared decision-making and clinical outcomes

Key Concepts for Understanding the Natural History of Crohn's Disease

- **Only 20-30% of CD patients will have a nonprogressive or indolent course**
- Corticosteroid dependency → 25% of patients will have prolonged exposure to steroids
 - Up to 50% CD patients → steroid dependent/resistant without advanced therapy
- Up to 80% require hospitalization during clinical course; risks of hospitalization greatest during the first year of diagnosis
- 10-year risk of major abdominal CD surgery → 30%
- Unplanned health care utilization contributes to high costs of IBD care
- Disease activity associated with higher rates of absenteeism, unemployment, caregiver costs



Most CD patients will require advanced therapy

Key Concepts for Disease Assessment of Crohn's Disease

Crohn's disease is **PROGRESSIVE** for most patients (70-80%), 50% risk of developing an intestinal complication by 20 years post-diagnosis

Symptoms do NOT correlate with inflammatory disease activity;
OBJECTIVE ASSESSMENTS
are needed to guide and assess response to treatment.

Key Concepts for Assessing Disease Activity in Crohn's Disease



Disease activity

Mild activity

- 2-4 bowel movements per day
- Mild abdominal pain
- Ambulatory
- Eating and drinking normally
- < 10% weight loss
- No signs or symptoms of dehydration

Moderate activity

- > 5 bowel movements per day
- > 10% weight loss
- Intermittent nausea and vomiting
- Moderate abdominal pain
- Significantly elevated biochemical markers (C-reactive protein or fecal calprotectin)
- Hypoalbuminemia
- Anemia

Severe activity

- > 5-7 bowel movements per day
- Cachexia
- Fevers
- Persistent nausea and vomiting
- Signs or symptoms concerning for obstruction
- Significantly elevated biochemical markers (C-reactive protein or fecal calprotectin)
- Hypoalbuminemia
- Anemia

“Patients should have confirmation of active inflammation based on CD-related symptoms, biomarkers, and/or endoscopic evaluation before starting advanced therapies.”

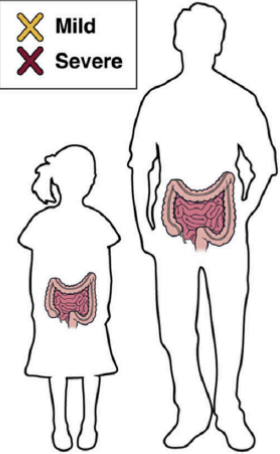
What Is MODERATE to SEVERE Crohn's Disease?

Predictors of worse outcomes

- **Large or deep ulcers**
- Fistulas or abscess
- Intestinal resection
- **Ileal** and upper GI **location**
- **Extensive disease**
- Cigarette smoking
- **Perianal disease**
- 2+ positive serologies
- NOD2 mutation

Disease severity variables	CD	UC	Disease activity variables*
Clinical			Clinical
Limited anatomic extent	X	X	Symptoms
Growth impairment (pediatric)	X		Biomarkers
Age at diagnosis <14 years	X	X	C-reactive protein
Age at diagnosis <40 years (adults)	X	X	Fecal calprotectin
Smoking history	X		Albumin
Perianal or severe rectal disease	X		Hemoglobin
Penetrating disease	X		Endoscopic
Stricturing disease	X		Disease activity scores
Multi- or long-segment ileal (>20 cm), disease proximal to TI	X		
Extensive bowel involvement	X	X	
Emergent diagnosis, hospitalization	X	X	
Delay in diagnosis	X	X	
Need for systemic steroids	X	X	
C difficile, cytomegalovirus infection	X	X	
Serologies			
ASCA (+)	X		
ANCA (+)	X	X	
Anti-Cbir (+) (UC: pediatric)	X	X	
Anti-GMCSF (+)	X		
Genetic			
NOD2 mutation	X		

X Mild
X Severe



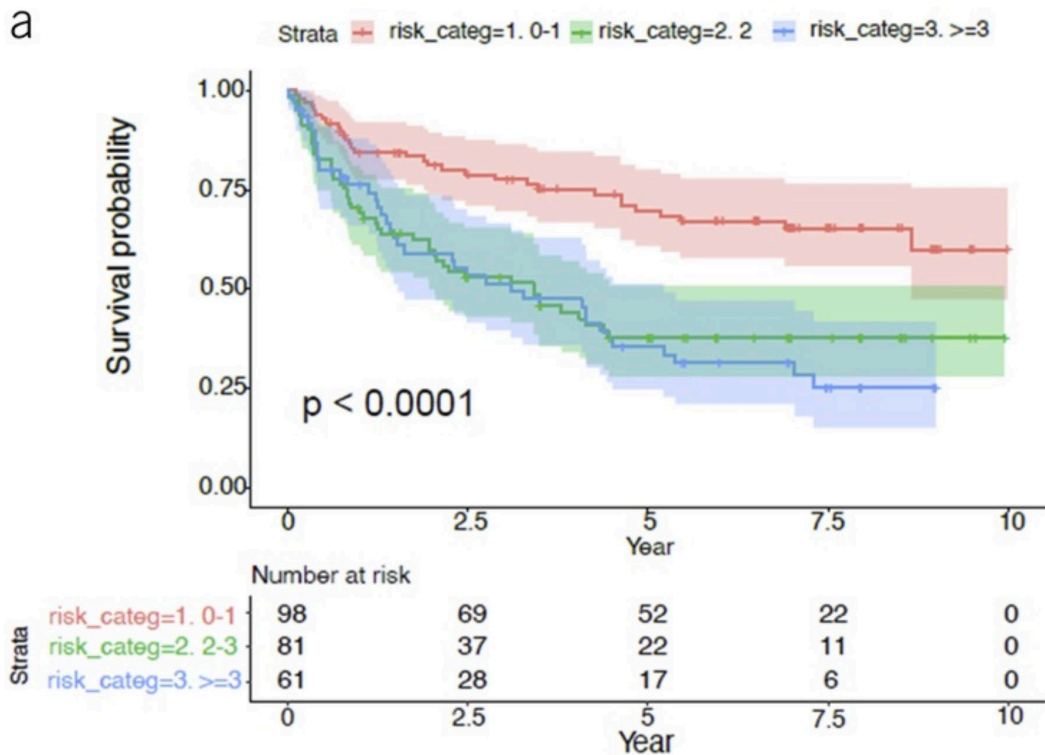
* Based on data from Torres et al, Lancet, 2017 (CD) and Rubin et al, AJG, 2019 (UC)

UC = ulcerative colitis; TI = terminal ileum; ASCA = anti-*Saccharomyces cerevisiae* antibody; ANCA = anti-neutrophil cytoplasmic antibodies; GMCSF = granulocyte-macrophage colony-stimulating factor.

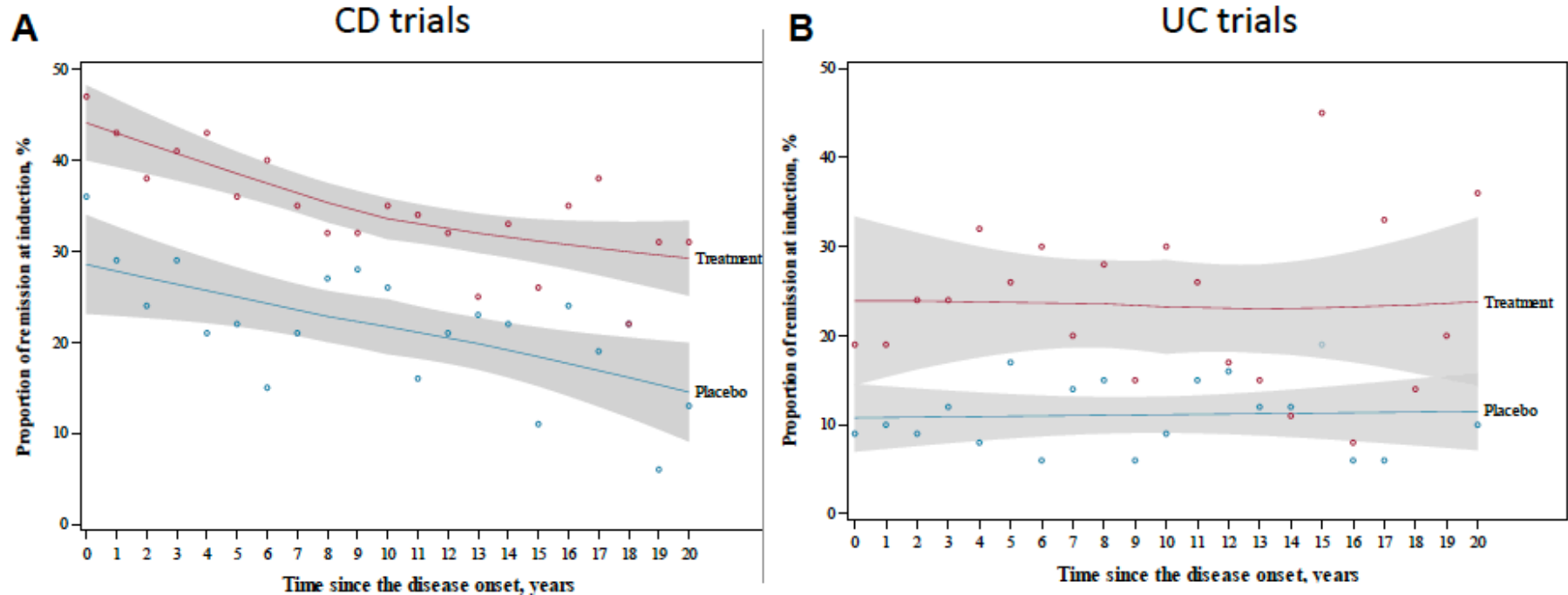
Agrawal M, et al. *Gastroenterology*. 2021;161(1):47-65.

Presence of More CD Risk Factors Associated with Greater Risks of CD Complications (Hospitalizations, Surgery, Disease Progression)

- Diagnosis <30 years
- Large or deep ulcers
- Stricturing disease
- Fistulas or abscess
- Intestinal resection
- Severe rectal disease
- Extensive disease
- Perianal disease



Early Intervention Is More Effective Than Trying to Catch Up Later, Especially for Crohn's Disease



Don't Wait for Steroid-Refractory or Dependent Disease before Starting Advanced Therapy



Serious infection risk was 2- to 4-fold higher during periods with concomitant corticosteroids compared with periods without, with similar incremental risk increases across IBD therapies.

PS-matched comparison of patients with IBD							
Serious infections IR per 100 PY	IMM/AT Naive	IMM	TNFi	IMM+TNFi	Vedo	Uste	JAKi
+							
-							
HR	2.62	3.36	2.42	2.47	3.60	2.25	1.82

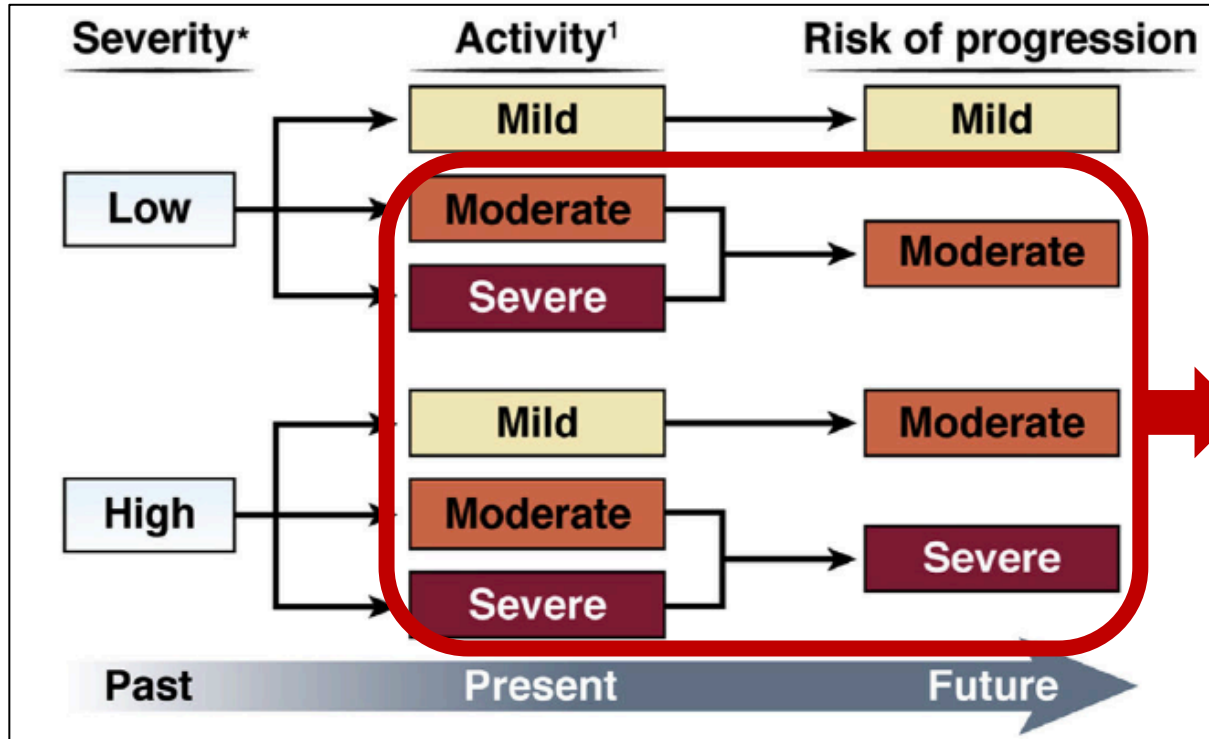
Steroids increased risks of infections 2- to 4-fold across all IBD treatment groups

Dual treatment with corticosteroids carried a 44-fold higher risk of opportunistic infections versus the general population, equating to one extra infection per 540 corticosteroid courses.

PS = propensity score; IR = incidence rate; PY = patient-year; IMM = immunomodulator; AT = advanced therapy; TNFi = TNF inhibitor; JAKi = JAK inhibitor.

Forss A, et al. *J Crohn's Colitis*. 2026;20(Suppl 1):i397(DOP123).

Risks of Disease Progression: Disease Severity + Activity

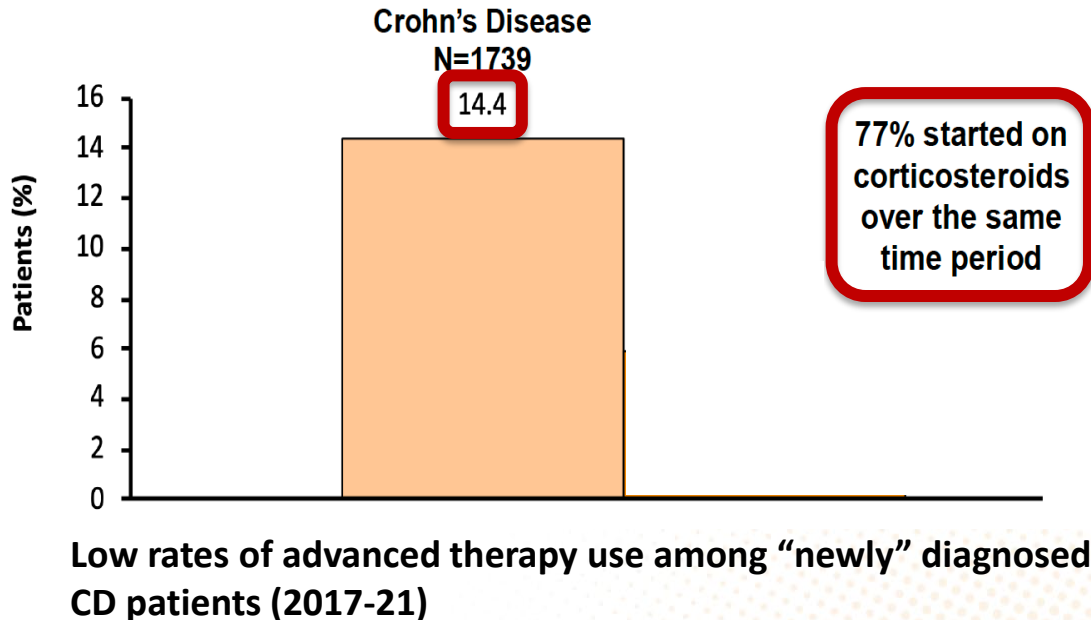


**Advanced
therapy**

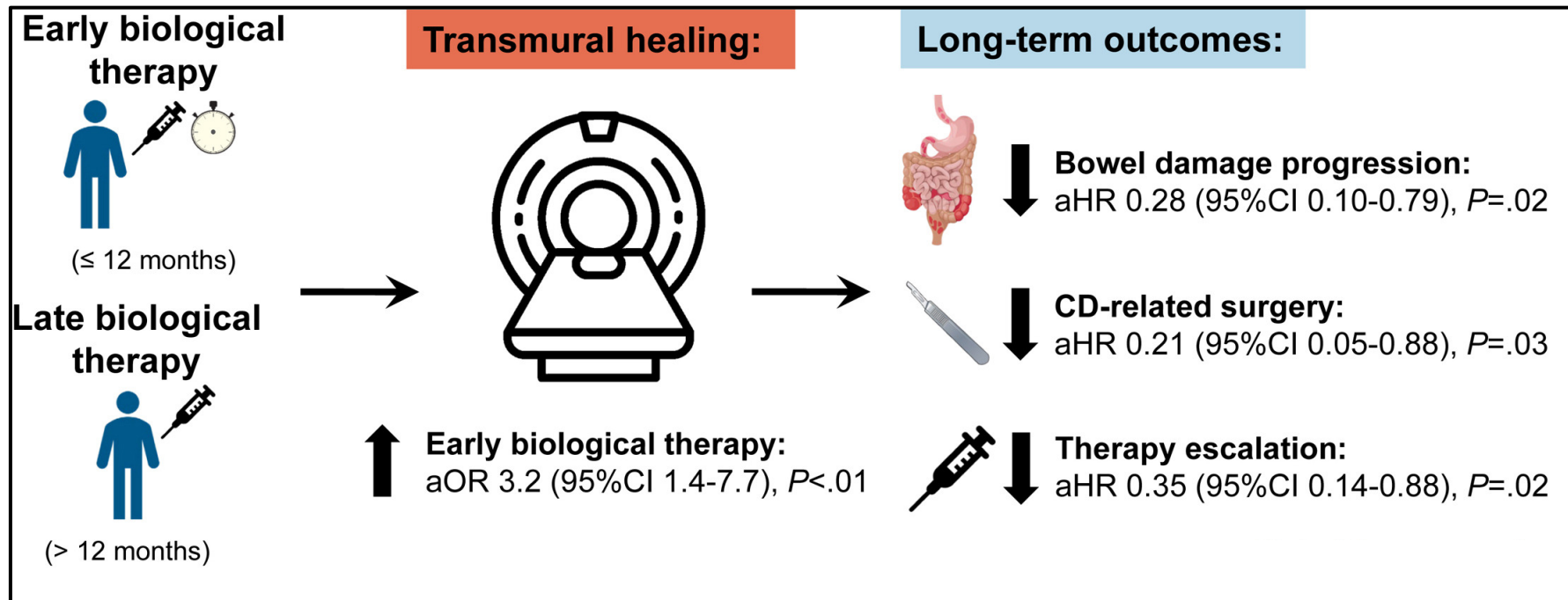
Key Concepts for Newly Diagnosed Moderate to Severe Crohn's Disease

ACG: We suggest **AGAINST requiring failure of conventional therapy** before initiation of advanced therapy for management of CD

AGA: In adult outpatients with moderate-to-severely active Crohn's disease the AGA suggests **upfront use of advanced therapy** compared with step-up therapy



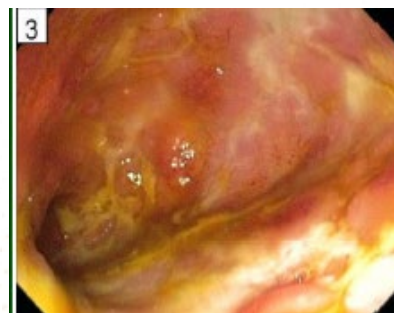
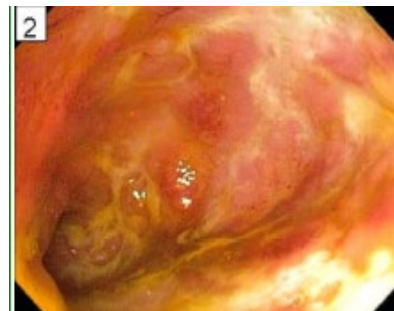
Early Biologics: More Transmural Healing, Better Longer-Term Outcomes in Crohn's Disease



Case

- A 28-year-old man presents with 6 months of worsening diarrhea (6-8/day), crampy abdominal pain, 10-lb unintentional weight loss, and fatigue
- (+) intermittent low-grade fevers, (+) nocturnal stools
- Treated twice with short courses of prednisone from urgent care with partial, temporary improvement
- CRP and fecal calprotectin are elevated
- MR enterography: 20 cm of terminal ileal inflammation with early stricturing features but no abscess
- Advanced therapy-naïve and is anxious to “avoid surgery”

Colonoscopy: Terminal ileum



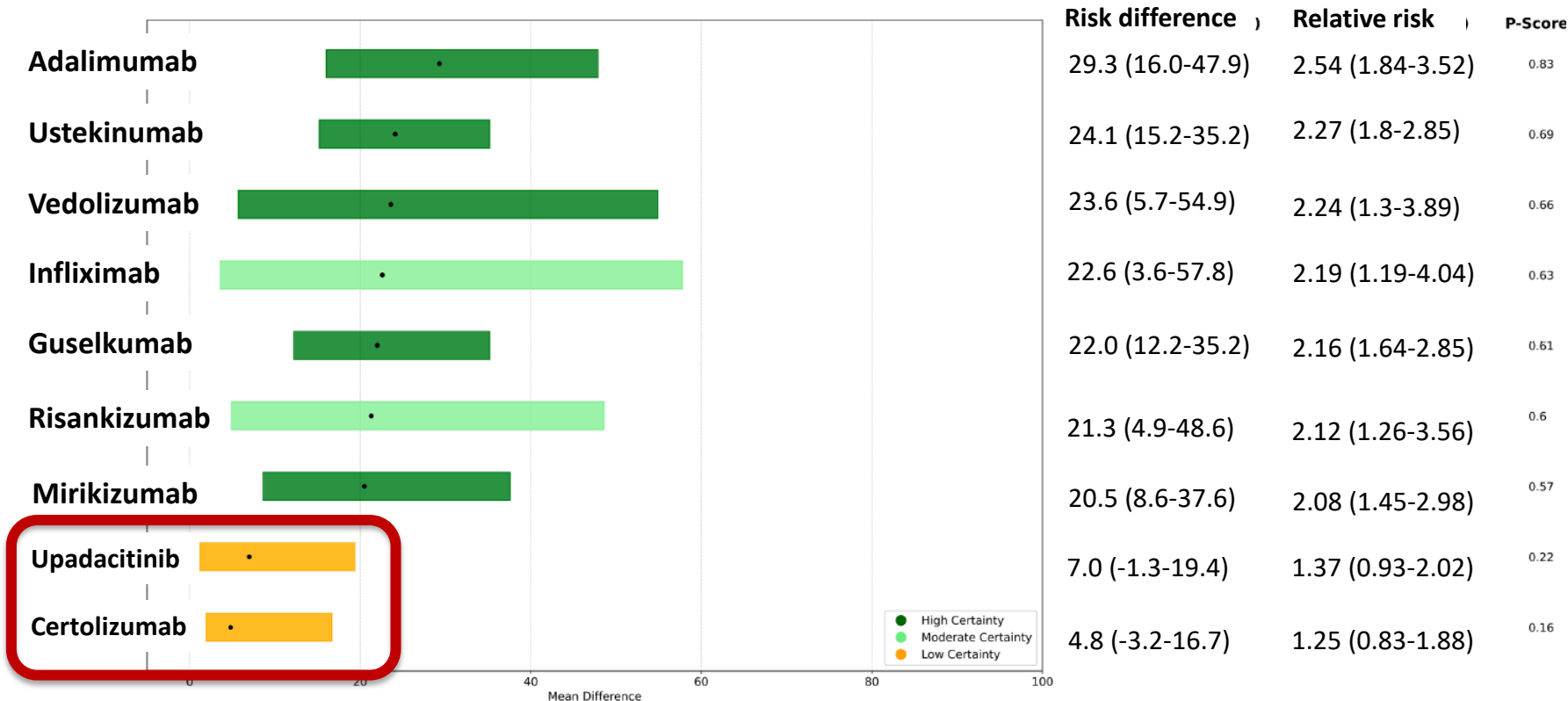
Which of the Following Would You Recommend Next?

- A. Infliximab + azathioprine
- B. Vedolizumab
- C. Mirikizumab
- D. Upadacitinib
- E. Surgical resection

Treatment Options for Mod-Severe Crohn's Disease

IL = interleukin; MACE = major adverse cardiovascular event; VTE = venous thromboembolism;
EIM = extra-intestinal manifestation.

Network Meta-Analysis Advanced Therapies for Bio-Naïve Crohn's Disease



Treatment Options for Mod-Severe Crohn's Disease

ADVANCED THERAPY-NAÏVE PATIENTS (FIRST-LINE THERAPY)

SUGGEST using a HIGHER efficacy rather than a lower efficacy medication
(Conditional recommendation, low to high certainty of evidence)

HIGHER EFFICACY MEDICATIONS:

Infliximab, adalimumab, vedolizumab, ustekinumab, risankizumab, mirikizumab, guselkumab

LOWER EFFICACY MEDICATIONS:

Certolizumab pegol, upadacitinib*

PRIOR EXPOSURE TO ONE OR MORE ADVANCED THERAPIES, PARTICULARLY TNF ANTAGONISTS

SUGGEST using a HIGHER efficacy, or INTERMEDIATE efficacy medication, rather than a lower efficacy medication
(Conditional recommendation, low to moderate certainty of evidence)

HIGHER EFFICACY MEDICATIONS:

Adalimumab, risankizumab, guselkumab, upadacitinib

INTERMEDIATE EFFICACY MEDICATIONS:

Ustekinumab, mirikizumab

LOWER EFFICACY MEDICATIONS:

Certolizumab pegol, vedolizumab

Treatment Options for Mod-Severe Crohn's Disease

- **Dose optimization** (anti-TNF, anti-IL12/23, anti-integrin therapy) may be considered for patients with inadequate/partial/loss of response to therapy
- **Extended induction** (select IL23 antagonists) *may* be beneficial for patients with more severe disease or suboptimal response to standard induction therapy
 - Risankizumab—extended IV induction for Crohn's disease
- **Higher maintenance doses** (upadacitinib, guselkumab, risankizumab)
 - aTNF experienced, higher inflammatory burden, disease complications, severe disease

aTNF = anti-TNF.

Lichtenstein GR, et al. *Am J Gastroenterol*. 2025;120(6):1225-1264. Scott FI, et al. *Gastroenterology*. 2025;169(7):1397-1448.

Safety of First-Line Advanced Therapies

Anti-TNF: IFX or ADA	Anti-integrin (vedolizumab)	Anti-IL23 (ustekinumab)	Anti-IL23 (risankizumab; mirikizumab; guselkumab)
• Combo tx w/IMM (increased infectious, lymphoma risk esp in older adults) • Immunogenicity (may be less important in IFX SQ) • Infection risk • Reactivation of hep B/TB • Contraindications: MS, CHF	• Minimal risk of increased infection unless disease not controlled	• Minimal risk of increased infection unless disease not controlled	• Minimal risk of increased infection unless disease not controlled • Liver test monitoring

Older population and safety of advanced therapy

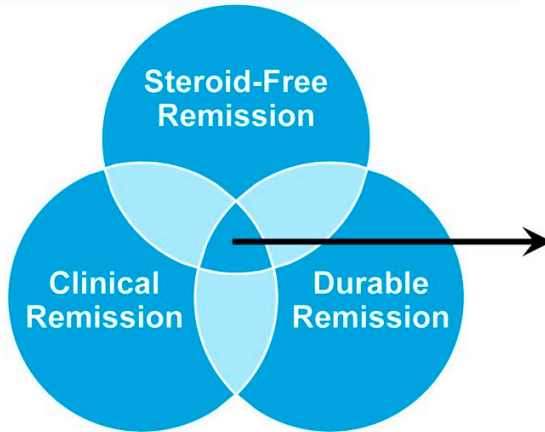
- Thiopurines: significantly higher risk of lymphoma, skin cancer in pts >60
- Biologics: Safety data is conflicted, mostly showing low rates of adverse events overall but may have slightly higher increased risk of infection in older adults

IFX = infliximab; ADA = adalimumab; tx = treatment; TB = tuberculosis; MS = multiple sclerosis; CHF = chronic heart failure. Solitano V, et al. *Clin Gastroenterol Hepatol*. 2023;21(4):907-921.e2. Ananthakrishnan AN, et al. *Gastroenterology*. 2021;160(1):445-451.

Clinical Prediction Tools: Vedolizumab for Crohn's Disease

MODEL DEVELOPMENT

Individual Participant Data
GEMINI 2 RCT



Common Predictors

- No prior bowel surgery (+ 2 points)
- No prior anti-TNF exposure (+ 3 points)
- No prior fistulizing disease (+ 2 points)
- Baseline albumin g/L (+ 0.4 points per g/L)
- Baseline CRP mg/L
 - (- 0.5 points if 3.0-10.0 mg/L)
 - (- 3.0 points if > 10 mg/L)

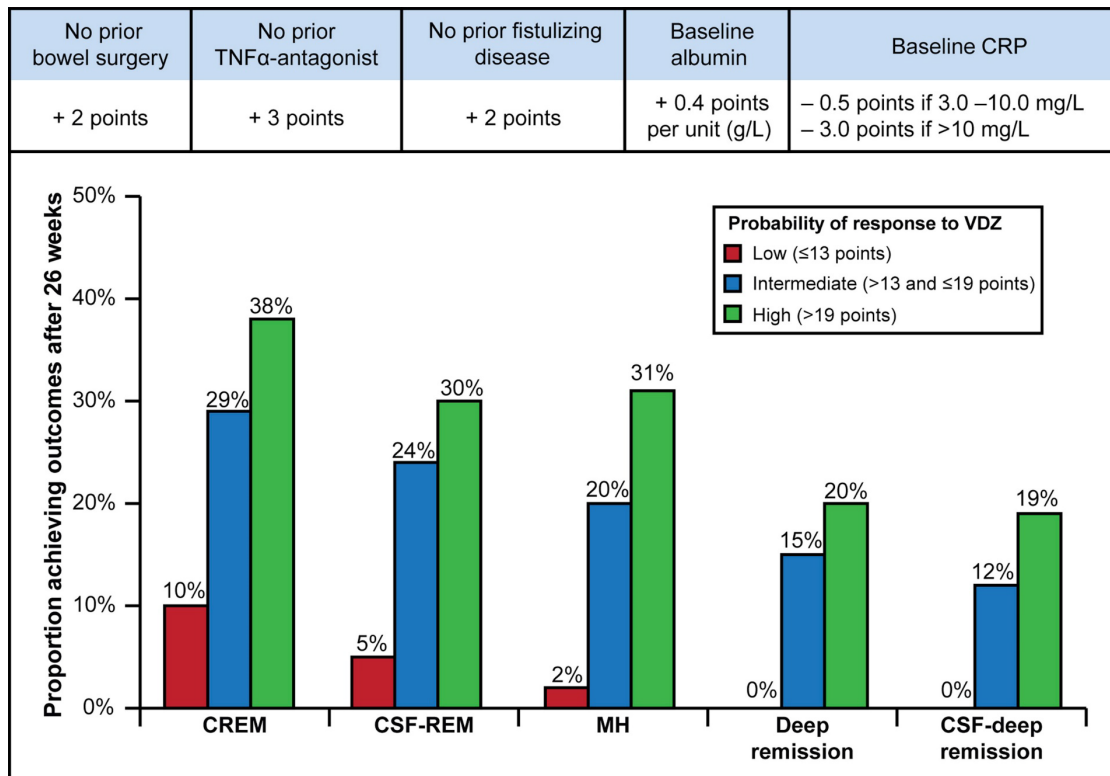
MODEL VALIDATION

VICTORY Consortium
Clinical Practice Cohort

**Low Probability
of Response**
(≤ 13 points)

**High Probability
of Response**
(> 19 points)

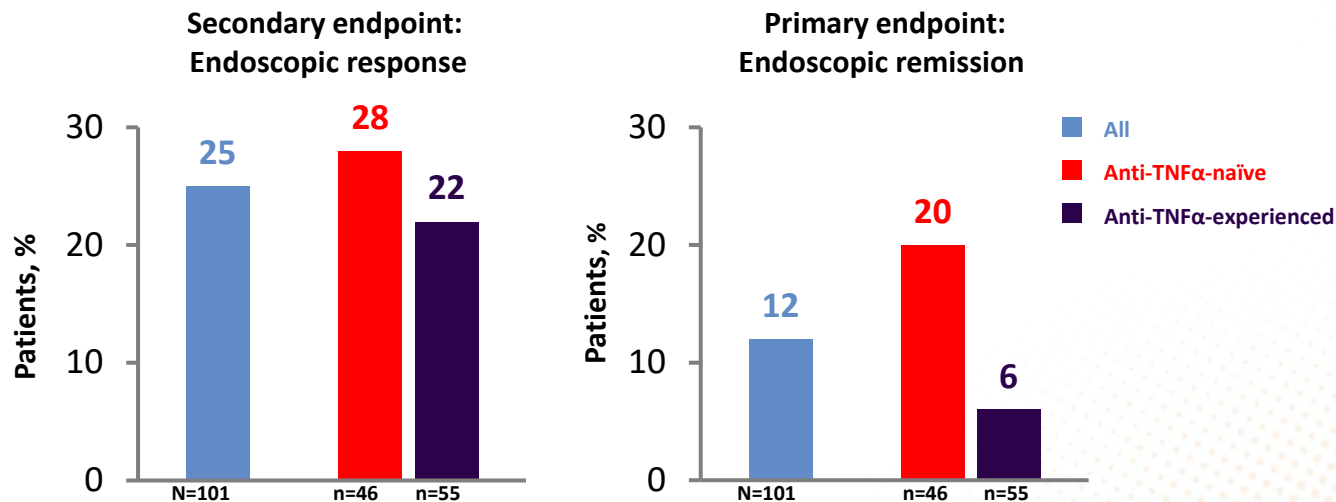
Crohn's Disease Probability of Response to Vedolizumab



CREM = clinical remission; CSF-REM = corticosteroid-free remission; MH = mucosal healing; VDZ = vedolizumab.
 Dulai PS, et al. *Gastroenterology*. 2018;155(3):687-695.

VERSIFY: Endoscopic Response and Remission with VDZ Were Greater in Anti-TNF-Naïve Patients with CD

- Endoscopic response rates were greater than endoscopic remission rates
- Both followed a similar pattern, but **HIGHER RATES IN ANTI-TNF-NAÏVE PATIENTS**

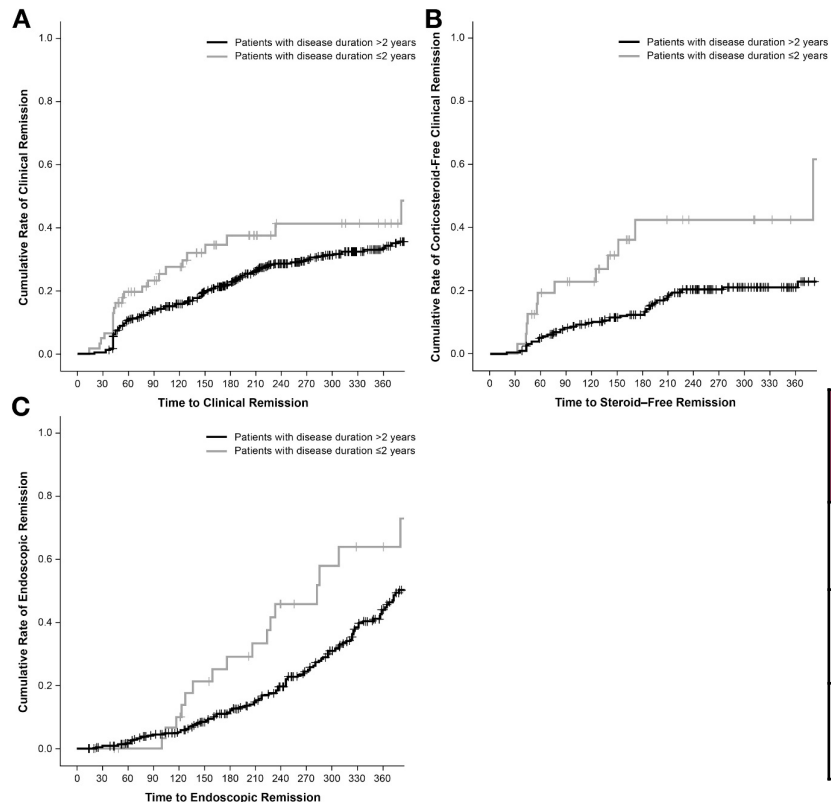


Endoscopic response: SES-CD $\geq 50\%$ reduction from baseline; endoscopic remission: SES-CD ≤ 4 .

SES-CD = Simple Endoscopic Score for CD.

Danese S, et al. *J Crohn's Colitis*. 2018;12(Suppl 1):S016-S017.

Earlier Use of Vedolizumab Associated with Better Clinical Outcomes



- Multi-center retrospective cohort study
 - 650 CD patients, 437 UC patients
- **SHORTER DISEASE DURATION (<2 YEARS) ASSOCIATED WITH BETTER OUTCOMES IN CD**
- No association with UC

CD Outcome	Adjusted HR (95% CI) for Disease Duration <2 Years
Clinical remission*	1.59 (1.02-2.49)
Steroid-free remission**	3.39 (1.66-6.92)
Endoscopic remission***	1.90 (1.06-3.39)

*Adjusted for stricturing disease, disease severity, hospitalizations, prior TNF exposure. **Adjusted for albumin, prior TNF exposure. ***Adjusted for CRP, albumin, disease severity, prior TNF exposure.

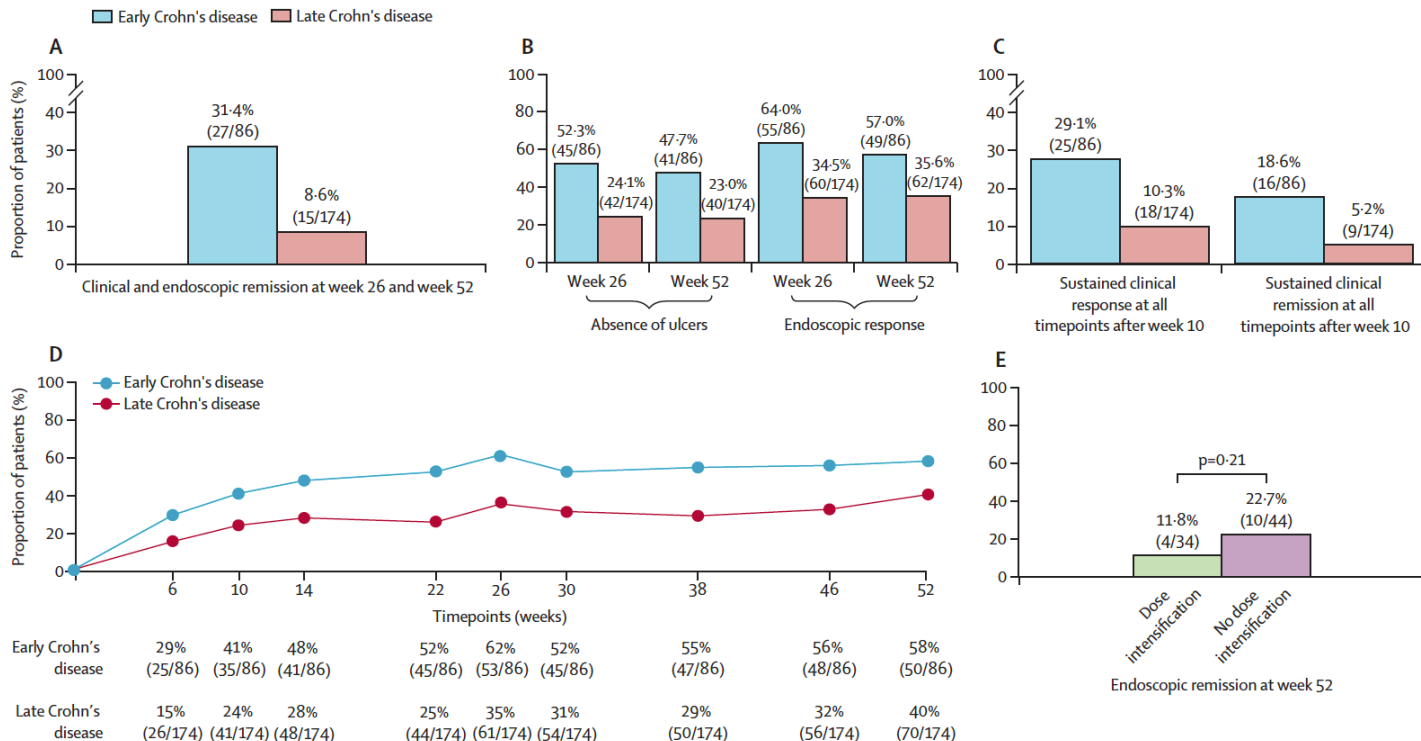
Faleck DM, et al. *Clin Gastroenterol Hepatol*. 2019;17(12):2497-2505.e1.

Vedolizumab for Early Crohn's Disease (LOVE-CD)



“Early” Crohn’s disease = diagnosis <2 years, advanced treatment-naïve

“Late” Crohn’s disease = diagnosis >2 years, prior treatment with steroids, IMM, and aTNFi (45% w/rsxn)



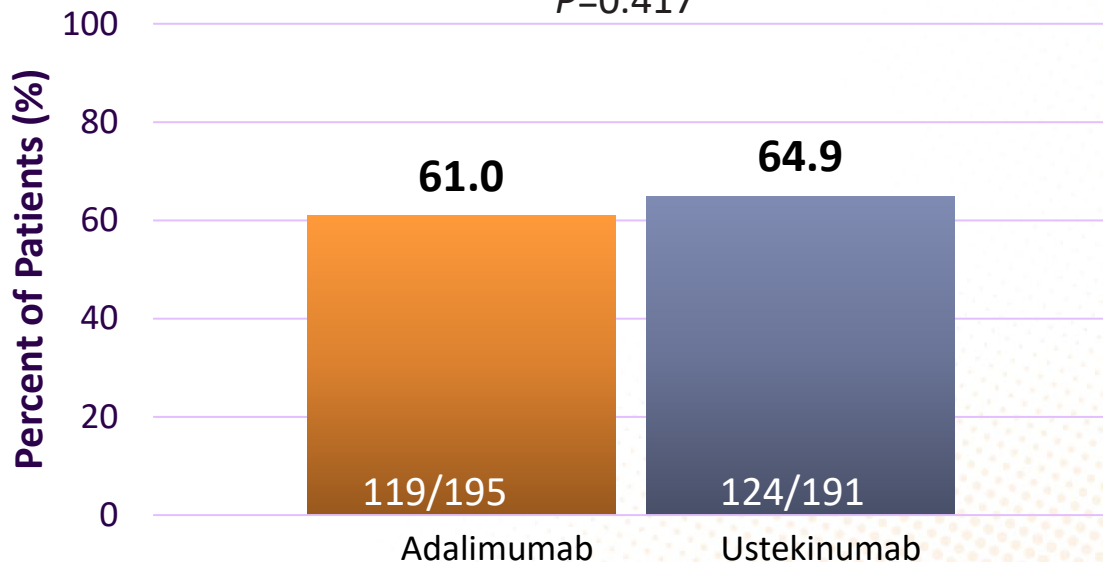
Ustekinumab vs Adalimumab as First-Line Advanced Therapy

- Head-to-head clinical trial
- Randomized monotherapy for bio-naïve pts
- 386 pts: Active disease with at least one ulcer on endoscopy
- Safety metrics similar
- Higher adalimumab cessation (11% vs 6%, $P=NS$)
- Endoscopic response rates: ADA 36.9% and UST 41.9%

Primary Endpoint: CDAI <150 wk 52

$\Delta = 4.0\%$ (95% CI: -5.5%, 13.5%)^c

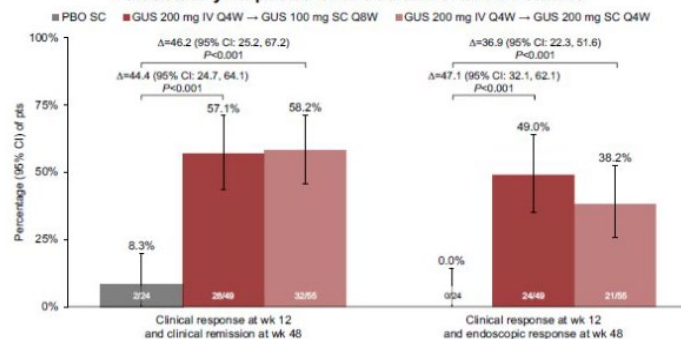
$P=0.417$



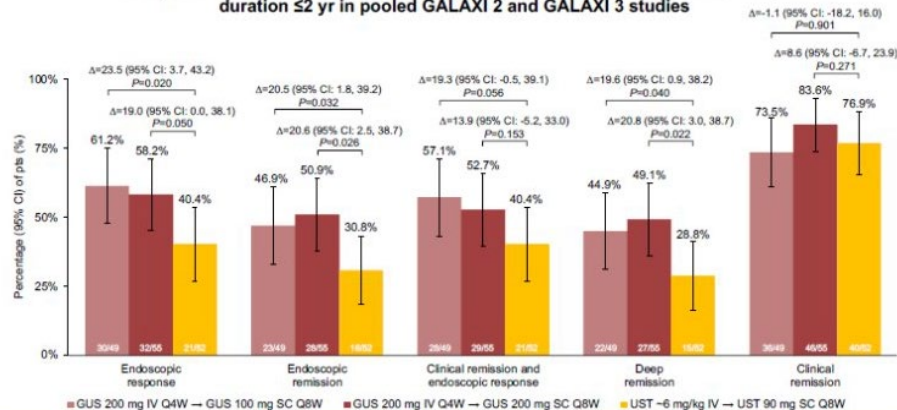
Guselkumab in Bio-Naïve Pts with CD <2 Yrs

- GALAXI 2 and 3: Pooled analysis of bio-naïve pts with CD <2 yrs (n=180)
 - Higher rates of clinical remission and endoscopic response at week 12 over PBO
 - Higher rates of endoscopic response, remission, clinical response + endoscopic response **over PBO and ustekinumab**

Composite endpoints for GUS vs PBO at wk 48 in biologic-naïve pts with disease duration ≤2 yr in pooled GALAXI 2 and GALAXI 3 studies



Composite endpoints for GUS vs UST at wk 48 in biologic-naïve pts with disease duration ≤2 yr in pooled GALAXI 2 and GALAXI 3 studies



Anti-IL 23 (Risankizumab) as First-Line Therapy

FORTIFY maintenance: n=462 (26% bio-naïve)

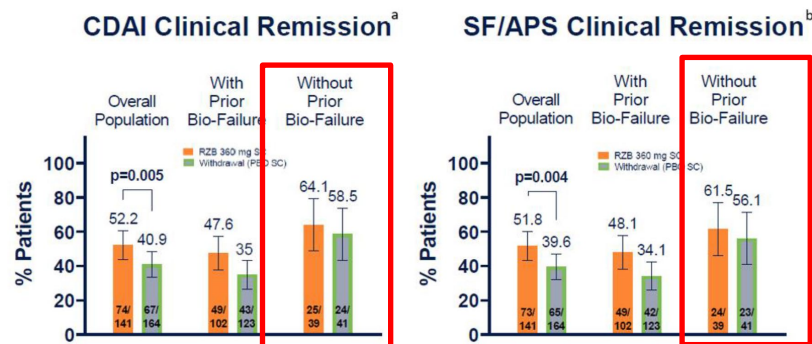


Figure 9. CDAI and SF/APS Clinical Remission at Week 52 of Maintenance (FORTIFY)

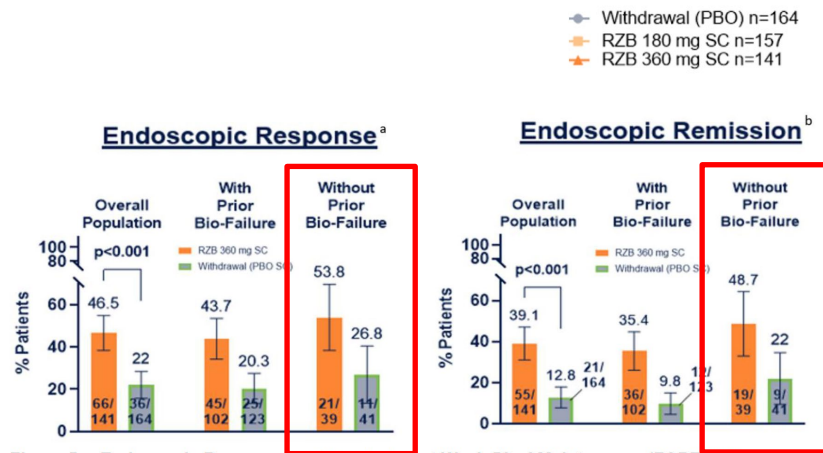
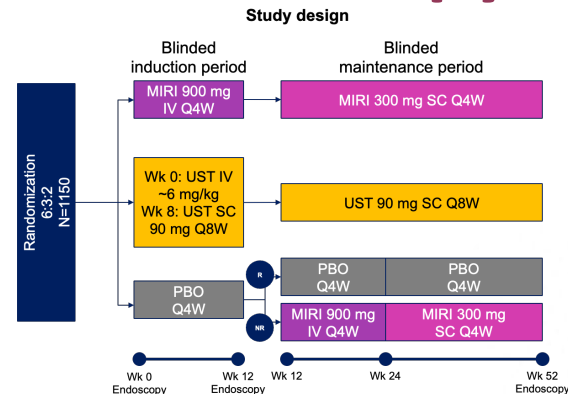


Figure 5. Endoscopic Response and Remission at Week 52 of Maintenance (FORTIFY)

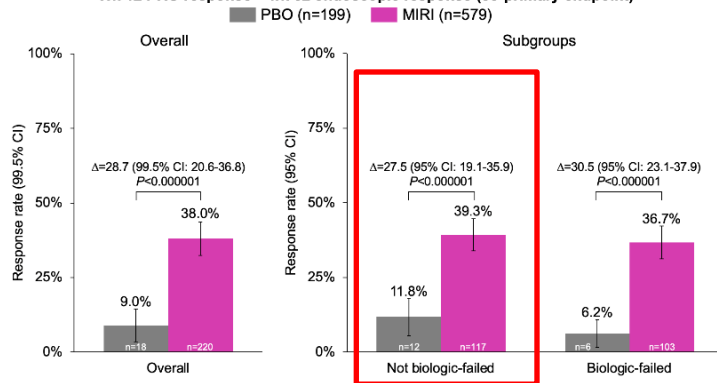
CDAI = Crohn's Disease Activity Index; SF/APS = stool frequency/abdominal pain score.
 Ferrante M, et al. *Lancet*. 2022;399(10340):2031-2046.

Anti-IL 23 (Mirikizumab) as First-Line Therapy

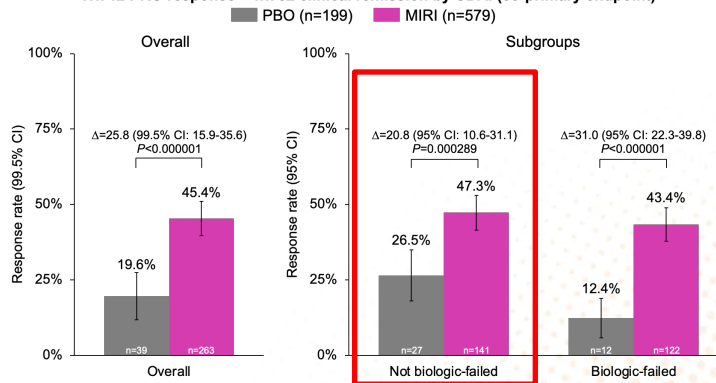
- VIVID-1 treat through randomized design: (n=1065) PBO (n=199); MIRI (n=579); UST (n=287)
 - 52% MIRI and 52% PBO: biologic-naïve
 - Only 10% ileal only disease in all groups
- Co-primary endpoint: wk 12 PRO response plus wk 52 endoscopic response and wk 12 PRO response plus wk 52 clinical remission



Wk 12 PRO response + wk 52 endoscopic response (co-primary endpoint)



Wk 12 PRO response + wk 52 clinical remission by CDAI (co-primary endpoint)



PROFILE: TOP-DOWN Achieved Substantially Better Outcomes at 1 Year than an Accelerated Step-Up Approach

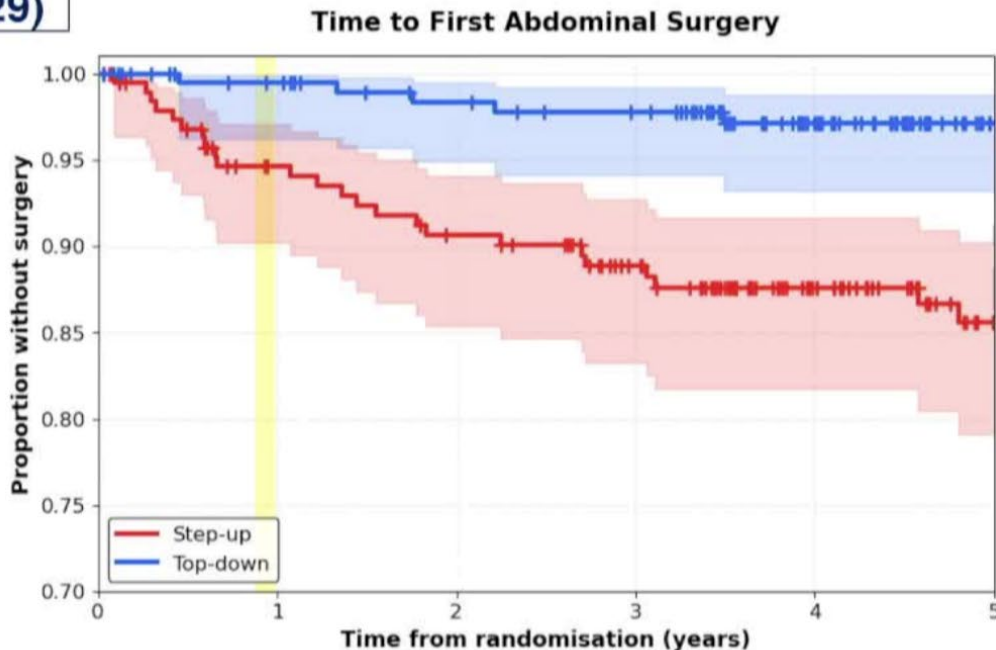
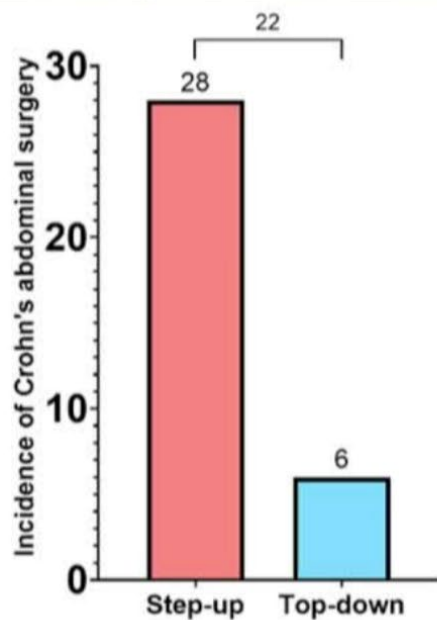
QoL = quality of life; AE = adverse event.

Noor NM, et al. *Lancet Gastroenterol Hepatol*. 2024;9(5):415-427.



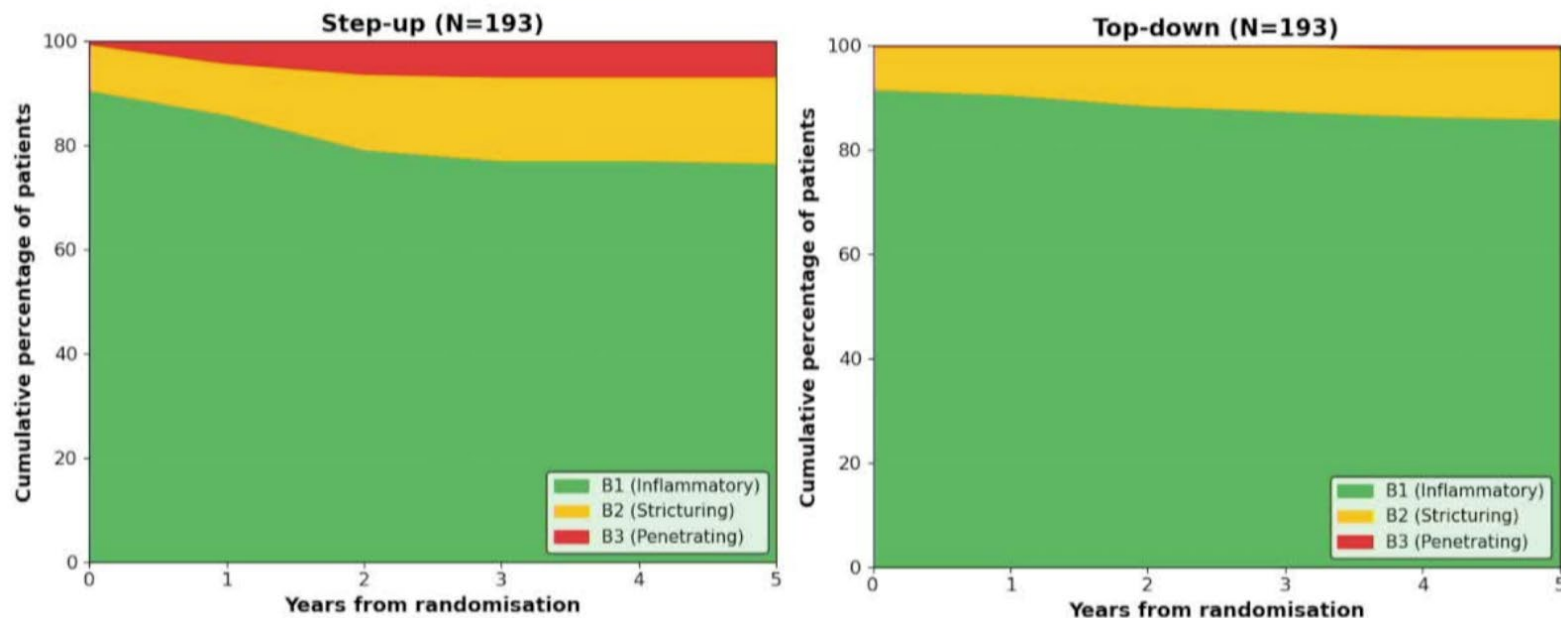
PROFILE: TOP-DOWN Achieved Substantially Better Outcomes at 5 Years than an Accelerated Step-Up Approach

RR = 4.33 (95% CI=1.82 – 10.29)



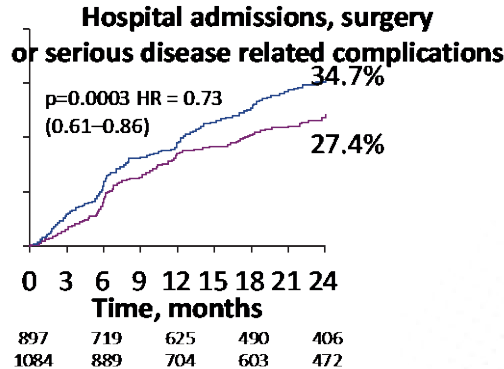
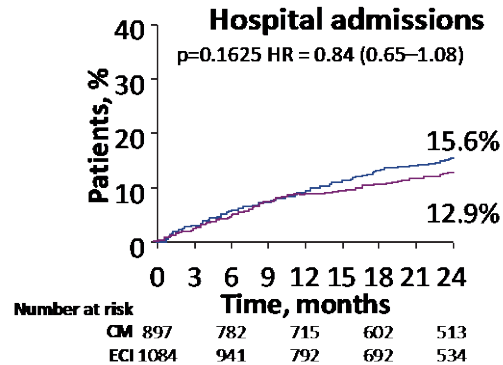
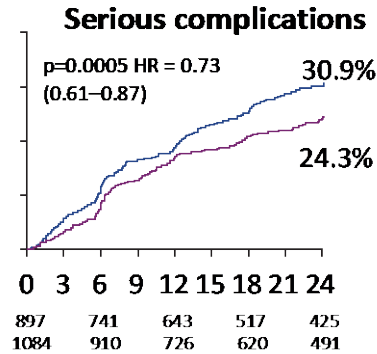
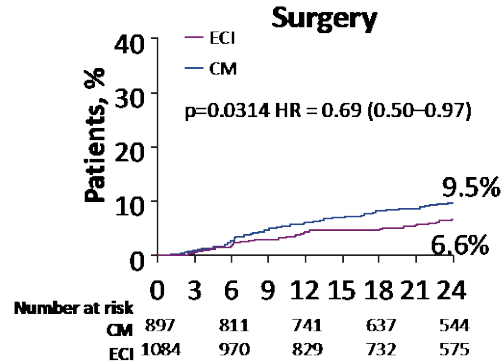
PROFILE: TOP-DOWN Achieved Substantially Better Outcomes at 5 Years than an Accelerated Step-Up Approach

RR = 2.50 (95% CI=1.33 – 4.54)



The Risk of Major Adverse Outcomes Is LOWER with Early Combined Immunosuppression vs Conventional Management

REACT

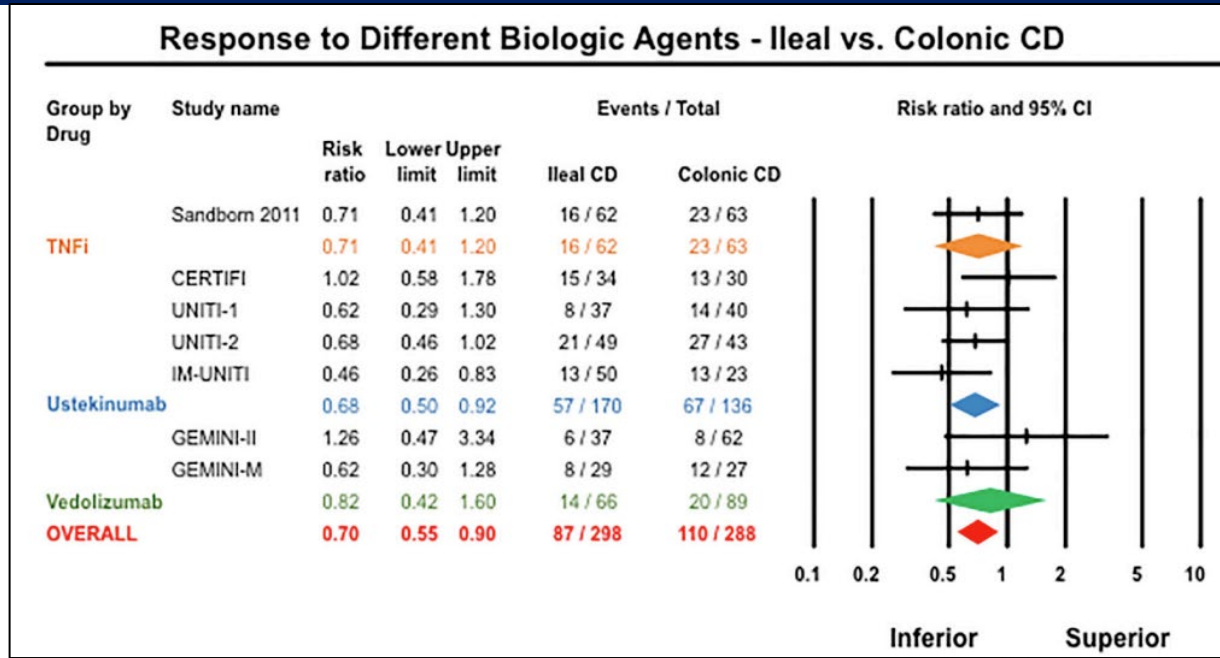


While clinical remission rates with ECI were not significantly different to CM, **ECI-treated patients experienced a reduction in major adverse outcomes including surgery, hospitalization, serious disease-related complications**

ECI = early combined immunosuppression; CM = conventional management.
Khanna R, et al. *Lancet*. 2015;386(10006):1825-1834.

Should Disease Location Impact Decision-Making?

**Note: Majority (70%) of Crohn's disease patients have ileal involvement—
isolated ileal disease (30%), ileocolonic disease (40%)**

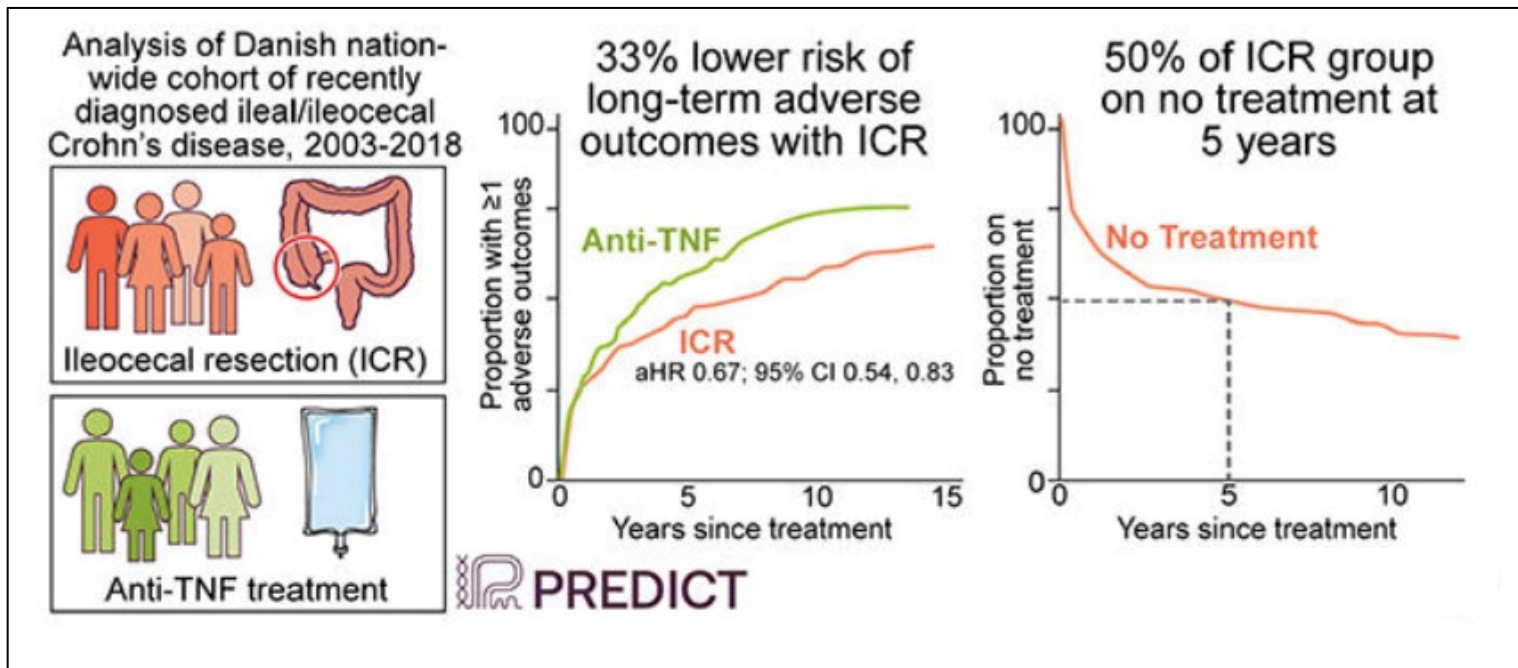


Should Disease Location Impact Decision-Making?

**Note: Majority (70%) of Crohn's disease patients have ileal involvement—
isolated ileal disease (30%), ileocolonic disease (40%)**

Efficacy of advanced therapies by DISEASE LOCATION in Crohn's disease			
Greater benefit with all advanced therapies in patients with colonic disease vs. ileal disease			
Anti-interleukins (9 RCTs)		JAK inhibitors (3 RCTs)	
Drug vs. Placebo: OR (95% CI)		Drug vs. Placebo: OR (95% CI)	
COLONIC disease	4.29 (2.77-6.44)	COLONIC disease	4.37 (2.67-7.15)
ILEAL disease	2.31 (1.44-3.70)	ILEAL disease	1.01 (0.54-1.89)
Anti-integrins (2 RCTs)		Anti-integrins (2 RCTs)	
Drug vs. Placebo: OR (95% CI)		Drug vs. Placebo: OR (95% CI)	
COLONIC disease	1.79 (0.55-5.87)	COLONIC disease	1.79 (0.55-5.87)
ILEAL disease	2.10 (0.80-5.53)	ILEAL disease	2.10 (0.80-5.53)

Surgery as First-Line Therapy in Ileal CD?



ICR = ileocolic resection.

Agrawal M, et al. *Gastroenterology*. 2023;165(4):976-985.e3.

Surgery as First-Line Therapy in Ileal CD?

L!RIC: Surgery vs Infliximab

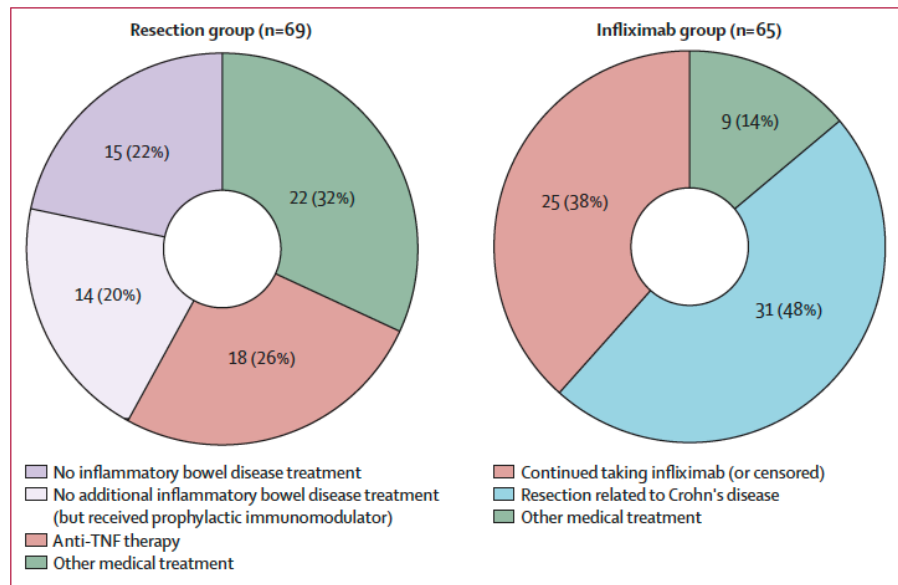


Figure 1: Need for anti-TNF therapy and surgery in each treatment group
 TNF=tumour necrosis factor.

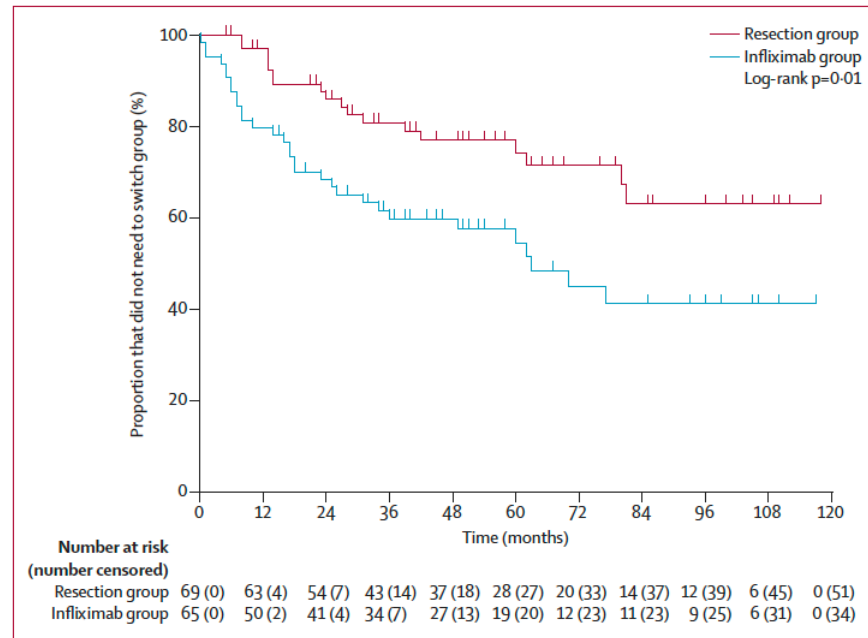
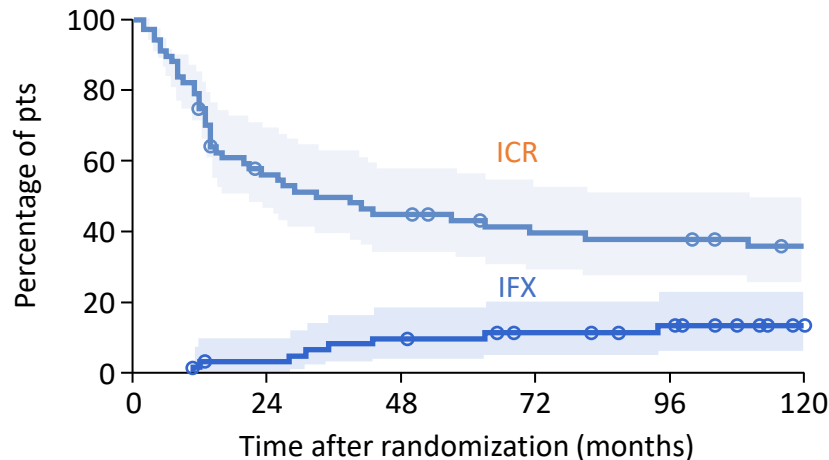


Figure 2: Time to switching of treatment
 Kaplan-Meier survival curve of the probability of surviving without switching to the treatment of the other group. The log-rank test was used to evaluate differences between the groups.

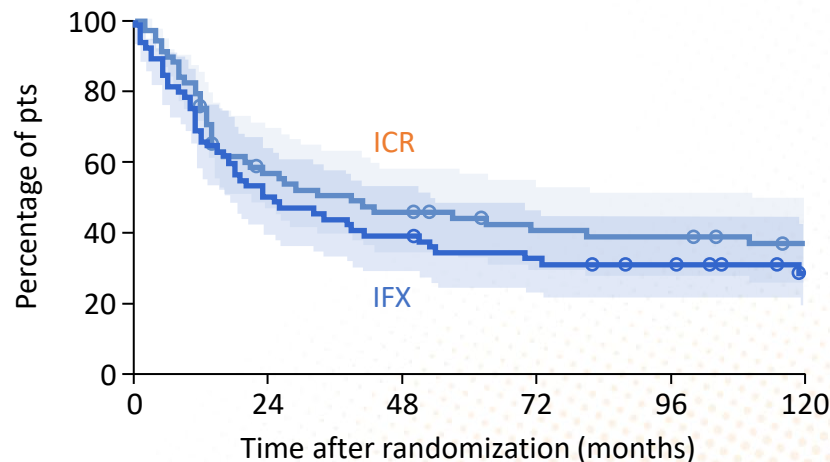
Surgery as First-Line Therapy in Ileal CD?

10-year outcomes from LIR!C trial

10-year therapy-free remission: 36% ICR vs 13% IFX, $p=0.002$



10-year clinical remission without therapy failure:
36% ICR vs 28% IFX, $p=0.27$



Key Concepts for Postoperative Crohn's Disease

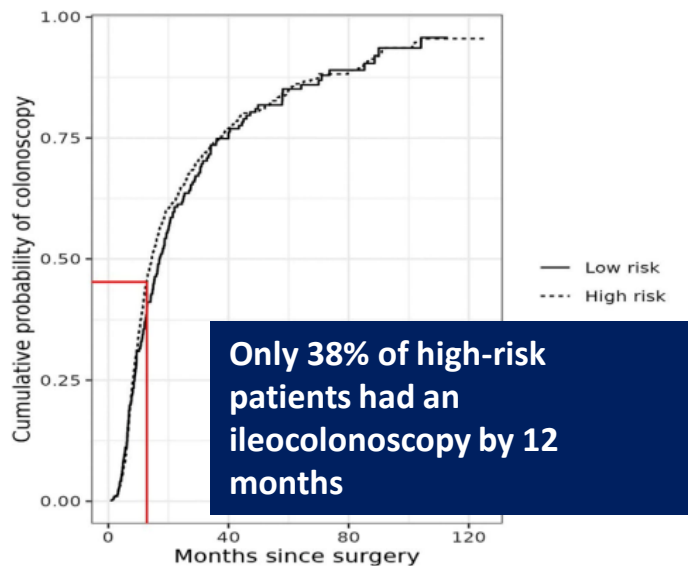


Fig. 1 Cumulative probability of colonoscopy by time in months, high-risk cohort only. Kaplan-Meier curve of the cumulative probability of completing a colonoscopy in patients considered high risk for recurrence over time measured in months since surgery. By 12 months, cumulative probability of such an event is 0.43, denoted by the red line

ACG: “In patients with surgically induced remission of CD, we suggest endoscopic assessment at 6-12 months over no monitoring.”

AGA

High pretest probability of developing post-operative recurrence

(Typically patients with one or more risk factors for post-operative recurrence and not on post-operative prophylaxis)



Perform endoscopic assessment of post-operative recurrence, rather than relying on biomarkers

(conditional recommendation, low to moderate certainty in evidence)

Post-Operative Crohn's Disease Recommendations

- In CD patients with low risk of post-operative disease, we suggest continued observation as compared with immediate initiation of medical therapy
- In patients with high-risk CD, we recommend anti-TNF (or vedolizumab) therapy to prevent post-operative endoscopic recurrence*

Higher risk	Lower Risk
Current cigarette smoker	Non-smoker
Prior IBD resections	1 st surgery for short segment fibrostenotic disease
Penetrating/fistulizing disease	Disease duration >10 years

* Limited post-operative data for other mechanisms of action.
Lichtenstein GR, et al. *Am J Gastroenterol*. 2025;120(6):1225-1264.

Post-Operative Crohn's Disease Recommendations

In patients with high-risk CD, we recommend anti-TNF (or vedolizumab) therapy to prevent post-operative endoscopic recurrence.*

**Earlier treatment initiation
yields better outcomes.**

	Any POR aHR (95% CI)	Endoscopic POR aHR (95% CI)
Starting within 4 weeks		
Anti-TNF	0.61 (0.40, 0.93)	0.49 (0.28, 0.84)
Vedolizumab	1.44 (0.59, 3.56)	0.40 (0.05, 2.86)
Ustekinumab	2.06 (0.84, 5.06)	1.77 (0.56, 5.62)
Starting within 4-12 weeks		
Anti-TNF	0.85 (0.67, 1.09)	0.71 (0.53, 0.96)
Vedolizumab	1.14 (0.64, 2.03)	0.44 (0.16, 1.20)
Ustekinumab	1.25 (0.60, 2.60)	1.26 (0.54, 2.93)
Starting within 12-24 weeks		
Anti-TNF	0.88 (0.69, 1.11)	0.78 (0.59, 1.03)
Vedolizumab	0.87 (0.45, 1.68)	0.45 (0.16, 1.22)
Ustekinumab	1.10 (0.57, 2.11)	1.12 (0.54, 2.34)

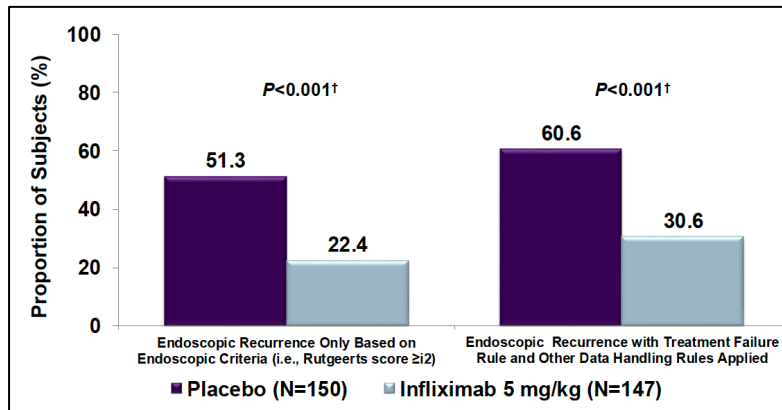
* Limited post-operative data for other mechanisms of action.

POR = post-operative recurrence.

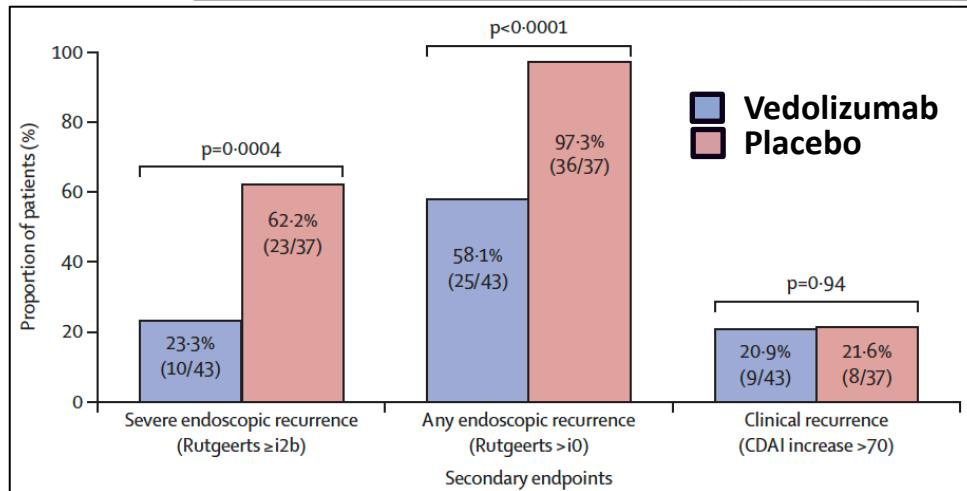
Lichtenstein GR, et al. *Am J Gastroenterol.* 2025;120(6):1225-1264. Axelrad JE, et al. *Inflamm Bowel Dis.* 2023;29(6):888-897.

RCT Data for Advanced Therapy to Prevent Post-Op CD Recurrence

PREVENT: endoscopic recurrence prior to week 76 infliximab versus placebo



REPREVIO: vedolizumab post-op recurrence @ 6 mo post-ICR



Treatment Options for Mod-Severe Crohn's Disease

ADVANCED THERAPY-NAÏVE PATIENTS (FIRST-LINE THERAPY)

SUGGEST using a HIGHER efficacy rather than a lower efficacy medication
(Conditional recommendation, low to high certainty of evidence)

SURGERY (w/post-op monitoring vs tx)

HIGHER EFFICACY MEDICATIONS:

Infliximab, adalimumab, vedolizumab, ustekinumab, risankizumab, mirikizumab, guselkumab

LOWER EFFICACY MEDICATIONS:

Certolizumab pegol, upadacitinib*

PRIOR EXPOSURE TO ONE OR MORE ADVANCED THERAPIES, PARTICULARLY TNF ANTAGONISTS

SUGGEST using a HIGHER efficacy, or INTERMEDIATE efficacy medication, rather than a lower efficacy medication
(Conditional recommendation, low to moderate certainty of evidence)

SURGERY (w/post-op monitoring vs tx)

HIGHER EFFICACY MEDICATIONS:

Adalimumab, risankizumab, guselkumab, upadacitinib

INTERMEDIATE EFFICACY MEDICATIONS:

Ustekinumab, mirikizumab

LOWER EFFICACY MEDICATIONS:

Certolizumab pegol, vedolizumab

Key Learning Points



The first-line standard for moderate to severe Crohn's disease is **early, evidence-guided advanced therapy**, with the specific agent chosen by **balancing efficacy, safety, disease phenotype, and patient priorities.**

1. Move beyond steroid-centered delay

Avoid letting temporary corticosteroid response substitute for a durable remission strategy in active moderate to severe disease.

3. Individualize without undertreating

Patient preference, safety, and route matter, but personalization should not be a reason to defer effective therapy in a clearly high-burden patient.

2. Start with a high-confidence mechanism

Advanced therapy and surgery should be considered legitimate starting points when matched to the clinical context.

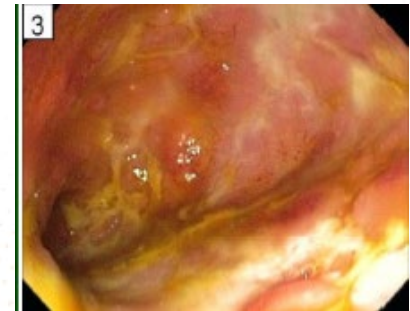
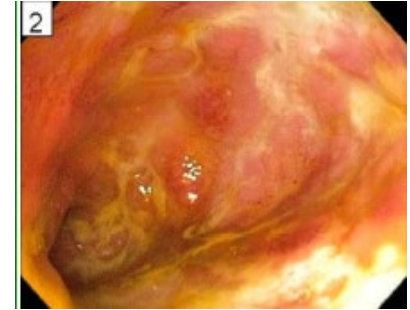
4. Think in terms of trajectory, not symptoms

First-line choices should support steroid sparing, deeper inflammatory control, and improved long-term disease course.

Case: Key Points for Consideration

Colonoscopy:
Terminal ileum

- A **28-year-old man** presents with 6 months of worsening diarrhea (6-8/day), crampy abdominal pain, **10-lb unintentional weight loss**, and fatigue
- (+) intermittent low-grade **fevers**, (+) nocturnal stools
- Treated **twice with short courses of prednisone** from urgent care with partial, temporary improvement
- **CRP and fecal calprotectin are elevated**
- MR enterography: 20 cm of terminal ileal inflammation with **early stricturing features but no abscess**
- Advanced therapy-naïve and is **anxious to “avoid surgery”**

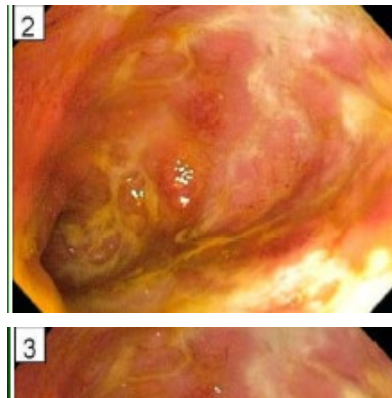


Case: Key Points for Consideration

Colonoscopy:
Terminal ileum

- Patient is HIGH-risk for disease progression
- Disease duration is “shorter”—approx. 6 months
- Ileal disease location is more difficult to treat
- No strictures/fistulizing disease, no rectal or perianal disease

Needs early advanced therapy:



ADVANCED THERAPY-NAÏVE PATIENTS (FIRST-LINE THERAPY)

SUGGEST using a HIGHER efficacy rather than a lower efficacy medication

SURGERY w/post-op tx + monitoring

HIGHER EFFICACY MEDICATIONS:

Infliximab, adalimumab, vedolizumab, ustekinumab, risankizumab, mirikizumab, guselkumab

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