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Navigating IBD Guidelines: What Clinicians Need to Know Now

Announcer:

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Dr. Rubin:

Hi, I'm Dr. David Rubin from the University of Chicago, and joining me is my good friend, Dr. Michael Dolinger, who's at the NYU Grossman School of Medicine. Hi, Mike.

Dr. Dolinger:

How you doing?

Dr. Rubin:

I'm good.

There have been some new guidelines published in ulcerative colitis and Crohn's disease in the United States, and certainly many new therapies and many new concepts. What are your major takeaways from these guidelines to help our colleagues take care of these patients in 2026?

Dr. Dolinger:

That you can dissect them in a variety of ways. When I think about common themes between the guidelines and how we want to manage IBD in 2026, and hopefully beyond that we get it right in these guidelines now, is that we start with taking our patients. We want to make them feel better, but we want to go beyond that. We want to go beyond treating to symptoms, and we want to go and treat to objective markers of inflammation. And ultimately, we do want to heal that inflammation.

We have new ways in both guidelines of monitoring that objective inflammation, and now we can directly look with intestinal ultrasound, a transabdominal ultrasound, where we can take a probe during a clinic visit and precisely see a patient's inflammation and follow that to healing. So we have biomarkers, and these are going to continue to improve, where we can treat beyond symptoms to objective markers of inflammation and heal the bowel.

Then I think when we think about how are we going to do that within the guidelines, we now have effective therapies that are new. They're targeted, and they're very safe. There are a variety of options, and they can be confusing to people and overwhelming.

The most important theme, I think when you have at least someone with moderate to severe disease in both Crohn's disease and ulcerative colitis, is taking an effective therapy, going beyond conventional therapies, maybe mesalamine in ulcerative colitis and immunomodulators in Crohn's disease, and using it early. It doesn't necessarily matter which one. There may be limitations from insurances and prescriber patterns across the country. I think using an effective therapy as early as possible is key to treating

inflammation, healing, and really altering the natural history, and that's evident in both guidelines.

Dr. Rubin:

Yeah, that's a really good point, and these are great pearls for our colleagues. It can be overwhelming seeing these new guidelines come out, and they're often 20-30 pages in length, and both the AGA and the ACG have come out with new guidelines in the last year or 2.

So the major takeaway messages that you highlighted, I agree with completely. We want patients to feel better right away, and fortunately, most of our new therapies do that quickly. But also we want to objectively confirm control the disease process, which means using benchmark biomarkers to know that we're actually getting there. And not leaving people on therapies that aren't working, undertreating, waiting for consequences and complications, we don't want that any longer.

I think it's really interesting in ECCO, the European Crohn's and Colitis Organization, their guidelines, and now in the US, the ACG guidelines and the AGA guidelines, they've all also made the point that we no longer require patients to go through conventional therapies before getting to advanced drugs. And I want to emphasize this because too often we have patients who are being undermanaged, undertreated, living with active disease when, in fact, we have more effective strategies that might do a better job. That means using 5-ASA in Crohn's, which is recommended against. It means too often using steroids repeatedly, which is actually a form of overtreatment, actually, or using thiopurines when they're not accomplishing their goals. And as most of our colleagues in the US certainly appreciate, we don't use them very often as much anymore. They still are used in other parts of the world, though. But I agree with everything you said.

The one other point that's a passion of mine is to recognize all the extraintestinal manifestations, not just because they coexist and affect quality of life, but they're a way to choose therapies to understand that if a patient has an inflammatory arthropathy or just joint pain or a skin problem, it might give you a clue that you'll use a therapy that might treat that in addition to the bowel.

So I think that that summarizes these guidelines. I haven't personally been a big fan of ranking our therapies. I think we need to think carefully about which drug to use in an individual patient. And for the community gastroenterology colleague who's not sure what to do, I suggest you use what you know. Just make sure you're getting where you need to go, and if it doesn't work, after the first few doses, you are ready to move on.

Dr. Dolinger:

That's a perfect summary, right there.

Dr. Rubin:

Well, you set me up really well for that. That's great. Any major takeaways for our colleagues as we conclude our final bite-sized discussion?

Dr. Dolinger:

I love the point about extraintestinal manifestations, and I think about that in ulcerative colitis as well. I think a lot of people think that maybe that only pertains to Crohn's disease patients, but you really have to think about that in all inflammatory bowel diseases, and we see that in UC as well.

Dr. Rubin:

That's a very nice point. I think people should just remember, we take it one step at a time with our patients, so we make sure they're getting into remission and that we're going to keep them there and avoid long-term steroid exposures, the things that they've been hearing for years. But now we have many good options that are available and safe and increasingly convenient, so we don't have any good excuses to be avoiding these treatments at this point.

Of course, the other barrier that continues to exist, and we specifically addressed it in the ulcerative colitis guidelines, is insurance barriers. And we recognize that therapies are too expensive, and frankly, living with active disease is also too expensive. And so this is an ongoing challenge for all of us that we acknowledge, but we do need to work one patient at a time to get them where they need to go.

So with that, I'm going to conclude this final bite-sized conversation. I want to thank Mike Dolinger for being with me for this one. And thank you all for participating in this important conversation.

Dr. Dolinger:

Thanks everyone.

Announcer:

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