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STRIDE II Guidelines & Updates

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Lewis:
Hello, everyone. I'm Dr. Ayanna Lewis. I am an Assistant Professor of Medicine at the Icahn School of Medicine at Mount Sinai. I work at Mount Sinai West and Morningside Hospitals where I'm Director of the Inflammatory Bowel Disease Program. And today I'll be talking to you about the STRIDE II guidelines.

One of the key things that the STRIDE II guidelines wanted to emphasize in their update on the 2015 guidelines was that it's important to hit short-term, intermediate, and long-term targets for the treatment of inflammatory bowel disease. In the short term, these targets look like a symptomatic response, where patients are feeling better. And the intermediate term, we're talking about symptomatic remission and normalization of biomarkers. And in the long term, we look at endoscopic healing, normalization of quality of life, and the absence of disability.

In order to assess patients clinically, there are various scoring tools that are available. Two of these are the CDAI or Crohn's Activity Index, or the PRO2, a two-item patient-reported outcomes index for ulcerative colitis, which are pictured here.

In terms of clinical assessment, there's some definitions that need to be met. Clinical response needs to be defined in Crohn's patients as at least a decrease of 50% in that PRO2 in the factors of abdominal pain and stool frequency; and children; it's a decrease in the Pediatric Crohn's Disease Activity Index of at least 12.5 points; and in the weighted Pediatric Crohn's Disease Activity index, a decrease of at least 17.5 points. In ulcerative colitis, adults, a decrease of 50% in PRO2 of rectal bleeding and stool frequency is looked at; and in children, a decrease of the Pediatric Ulcerative Colitis Activity Index of at least 20 points is considered response.

When we talk about remission, which is that harder endpoint, we want almost no findings in the PRO2s, the PCDAI in Crohn's patients, and also in the UC patients, little to no rectal bleeding, normal stool frequency, or using the partial Mayo score of less than 3. In children, the Pediatric Ulcerative Colitis Activity Index should be less than 10 points.

In the domain of clinical assessment, clinical response is an important immediate treatment target, whereas clinical remission is an intermediate treatment target. In children the restoration of normal growth is a long-term treatment target. And neither clinical response or remission are considered to be sufficient in the long term. So, if patients are having response or remission, but not meeting long-term goals, changes in therapy need to be considered.

In the domains of endoscopic and transmural assessment, endoscopic healing should be measured by the SES-CD score on endoscopy, which measures the amount of ulceration, inflammation, etc., that is seen on an endoscopy for a Crohn's patient. Healing is defined as that being less than 3 points. In ulcerative colitis, a Mayo endoscopic subscore of 0 points, or a UCEIS of less than 1 point, is considered healing. And this is a long-term treatment target. Assessment of endoscopic healing can be achieved by either

sigmoidoscopy or colonoscopy. However, when it's not feasible, alternatives can be considered in Crohn's disease patients of capsule endoscopy or balloon enteroscopy.

Histologic remission is not a treatment target, but it can be used as an adjunct to endoscopic remission to represent deeper healing. And transmural healing as assessed by either CT enterography, MR enterography, or bowel ultrasound is not a treatment target, but again can be used as an adjunct.

In terms of biomarkers, normalization of biomarkers is an intermediate target for both ulcerative colitis and Crohn's disease. And these include C-reactive protein values to under the upper limit of normal, as well as a fecal calprotectin between 100 and 250.

And then finally, in terms of quality of life and disability, an absence of disability is a long-term treatment target and normalized health-related quality of life is considered a long-term treatment target as well.

So, in summary, a treat to target approach should be employed across the domains of clinical assessment, endoscopic and transmural assessment, biomarkers, quality of life, and disability. Consideration should be given for changes in therapy if these targets are not met in the short-term, intermediate-term, or long-term assessments of inflammatory bowel disease response.

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