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Translating Advances into Practice: Lessons from Today's IBD Landscape

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Dr. Iroku:
Hello, my name is Ugo Iroku. I'm the Clinical Assistant Professor at Mount Sinai School of Medicine, and my pleasure to introduce you today to Dr. Rubin.

Dr. Rubin:
Hi, Ugo. It's nice to be with you to talk about updates in IBD and to wrap up this exciting set of modules.

Dr. Iroku:
This has been an exciting set of modules. We've talked about a lot, and we're going to see if in the next 3 minutes we can do a quick summary to make sure our listeners get the key points that they need for each point of our conversation.

So let's start at the very beginning. I just got off with a patient, a virtual health visit with a patient who wanted to know why they couldn't just stay on steroids. They seemed to work quickly. They worked efficiently. Why is that not a long-term strategy for our patients with Crohn's or ulcerative colitis?

Dr. Rubin:
Well, one of the main themes of our discussions through these modules has been using our newer therapies, which, in addition to being effective at controlling symptoms and achieving more durable outcomes, they are all being shown to be steroid sparing, which is an important goal in management.

We know that long-term steroids are not just ineffective; they really don't allow for bowel healing and stability of control. The side effects are much worse than any of our other treatments, actually, and the outcomes are worse. And so, steroid sparing and steroid avoidance altogether. Some of our new treatments are so fast that you can skip the steroids if you know you're going to put a patient on one of these effective therapies.

So I think that's a major message, and one of the ways to do that, of course, is to treat early with effective therapy. If I had to say there was one golden rule in IBD in 2026, that's it: get people on the drugs they need based on their presentation and based on their prognosis.

Dr. Iroku:
So, on that note, let's talk about what those drugs are.

So, it turns out there's only so many classes of medications that we're dealing with, as many as there may seem, and so we can be

lumpers for a little bit in a world of splitters. Let's start by talking about our anti-TNFs. What's one takeaway, or a couple of takeaways, that you have for that class of patients?

Dr. Rubin:
Yeah, I love the term lumping and not splitting because that's really the message for our clinician colleagues.

Anti-TNF was the second revolution in IBD management, in my opinion, after steroids. And we still, 25, almost 30 years later, are using anti-TNF as one of our best options for people with moderate to severe Crohn's or colitis. We certainly have the most data for that class of therapy overall at this time. And the one takeaway now is that we have subcutaneous maintenance infliximab, a formulation that enables dosing every 2 weeks by self-injection. And we've learned that the pharmacokinetics of that are better than the infusions less frequently, where you get high peaks and troughs.

So our colleagues should know about this, and they should embrace it not just as a potentially more convenient option, but actually a more effective one. And we now have seen that you can avoid concomitant azathioprine or methotrexate based on how good the PK is with this dosing. So that's my takeaway there.

Dr. Iroku:
And just to push you one more point on these anti-TNFs. Do you use them? Do you not use them? Are they a medication of the past, or do they have a role in your current treatment in 2026?

Dr. Rubin:
Still have an important role. They're still excellent for patients with more systemic problems, including joint pain or skin inflammation, as well, but also the patient with perianal disease. And they're still an option—an important option—for the patient with severe colitis who's in the hospital. So, 100% still one of our mainstays of management.

Dr. Iroku:
All right, so let's move on to our anti-integrins. What's the take-home point that we can think about when we think of this class of medications?

Dr. Rubin:
Yeah, so the one most people are using still is vedolizumab in both Crohn's and ulcerative colitis. Extremely safe because it's a therapy that is gut selective, or the term they're using now is gut focused. And this also has a sub-Q maintenance formulation that finally got its FDA approval in the US. Same concept that it provides some convenience of dosing options for patients, but also perhaps some better PK and efficacy. Nonetheless, it's still one of our safest drugs.

Because it's so gut focused, not great for people who have extraintestinal problems, especially inflammatory extraintestinal problems. So, we like this for anybody, frankly, but also for the older patient or a patient who has some other concomitant problem that might make immune suppression a problem or challenge for them.

So, good option, definitely still available, and something we should think about as an early option. And we know from head-to-head trials against adalimumab that vedolizumab is superior in ulcerative colitis, so that's certainly reasonable there too.

Dr. Iroku:
All right, that brings us to our anti-interleukins. What are your thoughts on the class, and particularly the p19 inhibitors that exist?

Dr. Rubin:
Well, probably the most activity in that space, we now have 3 IL-23 p19 inhibitors. I call them the second-generation ustekinumab drugs, and that's how I explain it to my patients as well.

So, what we've learned about these is, of course, they're effective in Crohn's and colitis. They work well in patients who are advanced therapy naïve as their first advanced treatment, but they also work as a therapy after advanced therapies have not worked. So, after anti-TNF or anti-integrin, these are still very good options.

IL-23 is a spectacular drug for psoriasis, so patients with IBD and plaque psoriasis, or even TNF-induced psoriasis, great option there. We have head-to-head data showing that risankizumab is superior to ustekinumab, especially in the patients who are after anti-TNF, and guselkumab is superior to ustekinumab in Crohn's in any setting, bio-naïve or advanced therapy exposed. Mirikizumab works as well as ustekinumab but wasn't superior in the Crohn's evaluation.

Lots of commercials on TV, lots of interest. IL-23 is a safe strategy, and these are an incremental improvement over ustekinumab, which is a drug we've been using for years.

Dr. Iroku:
Great. And then we have some of our oral options. What are your takeaways on JAK-STAT inhibitors?

Dr. Rubin:
Yeah, so in my book, the oral synthetic targeted therapies are the third revolution in IBD because they help us avoid some of the challenges we've had with monoclonal antibodies and protein loss from inflamed bowels. So the nice thing about oral means that they're absorbed in the small bowel, and you have a predictable PK.

JAK-STAT, the JAK inhibitors are extremely fast acting. Some patients feel better within a day or 2, certainly by 1 week, and they're also potent. I say to patients, don't confuse convenience of delivery with safety because these are very powerful therapies. Having said that, they have been a game changer in many ways.

So, we have upadacitinib for both Crohn's and UC, and we have tofacitinib for UC only. And we know now that we can use these in patients who have low serum albumin, but we can also use them in any of our patients, especially if they have joint problems, concomitant spondyloarthropathy. Great option to consider there.

And they work so fast that I don't use steroids when I know I'm going to prescribe one of these agents.

They do have a risk of shingles. It is very important to vaccinate against shingles. You don't have to do it before you start the therapy. The attenuated vaccine actually works very well later when someone's already on treatment, but don't let your patient forget about that, and you shouldn't forget to make that recommendation because shingles is not something you want anyone to have.

Good drug. The label was updated in October of last year for upadacitinib. It doesn't have to be after anti-TNF anymore. If you have a patient in whom a TNF inhibitor might not be the best option and they have more severe disease, or they've been on another systemic therapy, this is a drug you can use.

So, I think we've made some progress there, and there's more to learn, but very good option.

Dr. Iroku:
And to wrap up the conversation, let's talk about the forgotten oral medication, the S1P modulators. When can we use those, and what's your take-home on that?

Dr. Rubin:
Well, the first takeaway is what you said. I haven't heard the term forgotten, but that's probably right. It's underutilized.

The second I want to say is don't confuse the S1P receptor modulators, ozanimod and etrasimod, with the other oral therapies, the JAK inhibitors that I just spoke about, because the S1P receptor modulators, which work by preventing activated lymphocytes from leaving lymph nodes, so they're essentially cellular trafficking inhibitors in the lymphatic system—don't confuse this with the JAK inhibitors because the S1P receptor modulators are very safe. They are only approved for ulcerative colitis, and they work better in moderate UC than in severe UC or in the salvage case of patients who've been on multiple other therapies.

Good drugs, work pretty quickly, within a couple weeks, oral once a day, very nice. But there are a couple things to keep in mind. They may have an off-target effect of asymptomatic bradycardia in the first couple days, really only the first couple days. So we do want to know that patient has sinus rhythm before you start the therapy. They do not cause cardiac problems otherwise. If you had a patient who, to your surprise, has second-degree heart block, in addition to sending them to a cardiologist or to an emergency department, you shouldn't prescribe this.

Otherwise, well tolerated, very safe, and the same class is used in multiple sclerosis, and our neurology colleagues really find it to be a preferable therapy.

I think we've been underutilizing them, to your point. I think they should be coming after 5-ASA, maybe after one course of steroids, but don't save these until much later. That's not the right positioning.

So, again, our modules get into a lot more details, but those are the high-level mentions.

Dr. Iroku:
That was a fantastic summary, and we'll have to leave it at that. Thank you for joining us today, and we look forward to seeing you on the next modules.

Dr. Rubin:
Yeah, this was great. Thank you so much.
Announcer:

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