**Transcript Details**
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A New Era in Primary Biliary Cholangitis Treatment

**Announcer:**
You're listening to *GI Insights* on ReachMD. Here's your host, Dr. Charles Turck.

**Dr. Turck:**
Welcome to ReachMD. I'm Dr. Charles Turck, and joining me to discuss recent advances in the management of primary biliary cholangitis is Dr. Alan Bonder. He's an Associate Professor of Medicine and the Medical Director of Liver Transplant at Beth Israel Deaconess Medical Center in Boston. Dr. Bonder, thanks for being here today.

**Dr. Bonder:**
Thank you, Dr. Turck, for having me. It's a pleasure to be with ReachMD again, and I hope this podcast is useful for everyone.

**Dr. Turck:**
Absolutely. Well, to set the stage for us, Dr. Bonder, how has the treatment landscape for primary biliary cholangitis changed over the past decade, and what's driving those changes?

**Dr. Bonder:**
So I think this is a really fun answer for most of our audience. I think for us who do research on this in the PBC world, we've seen a major shift over the last 20 years. We went from only having one approved therapy called ursodiol from 1993 to 2016, to right now, with two different receptors, PPARs and FXR agonists. And as we basically move along in 2026, I think we have, right now, two newly approved medications, plus the first-line therapy, and then another three to four new medications in the pipeline, getting really deep into phase 2 to phase 3 clinical trials. And hopefully, we will have them available soon.

**Dr. Turck:**
And would you walk us through what's changing in how we assess treatment response or success?

**Dr. Bonder:**
This is really one of the most important questions. So, what we do is, in patients who have PBC, we assess response based on three things. Number one is the alkaline phosphatase. We would like to lower the alkaline phosphatase to below the 1.67 upper limit of normal between six and 12 months. Also, we aim to get bilirubin less than 0.6 or between 0.6 or 1.0. And also, another thing that we use now as a marker for disease activity is elastography, or what's called in the offices FibroScans.

So, based on those three markers, we can basically risk stratify patients and tell them who is a responder—so those patients who get the alkaline phosphates below 1.67, a bilirubin around 0.6, and a FibroScan or an elastography that basically stabilizes and does not go above 10, which means advanced stage of fibrosis.

**Dr. Turck:**
Let's talk now about some of the emerging agents. How do drugs like obeticholic acid, seladelpar, and elafibranor differ in their respective mechanisms of action and roles in therapy?

**Dr. Bonder:**
That's an important question. So, as I mentioned, those medications come from two different types of receptors: the FXR agonists, like obeticholic acid, and the PPAR agonists, such as elafibrinor and seladelpar. It is very important to mention, Dr. Turck, that currently, the FDA has removed obeticholic acid from the market. So right now, we have only the potential use of PPAR agonists—seladelpar, which is a PPAR delta agonist, and elafibrinor, a PPAR alpha and delta agonist.


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**Dr. Turck:**
For those just tuning in, you're listening to ReachMD. I'm Dr. Charles Turck, and I'm speaking to Dr. Alan Bonder about evolving treatment options for patients with primary biliary cholangitis.

So, Dr. Bonder, beyond disease modification, symptom control is becoming a bigger part of the treatment conversation. Would you tell us about recent advances on that front?

**Dr. Bonder:**
Yes. We reviewed most of the data, so in the phase 3 clinical trials—in both the responses on the ELATIVE trial, which are basically the phase 3 to 4 elafibrinor/seladelpar—as secondary outcomes, symptoms were part of those. And we can see that patients who got treated with symptoms, specifically fatigue and itching, or pruritus—those patients who were treated with those two medications actually improved in their symptoms. So we are seeing now, for the first time published in our papers, not only just disease activity on heart markers like liver tests, we are now seeing symptom-based therapies improving quality of life. And we are really happy to see that because, I think, as people are aware, patients with PBC have really bad quality of life and really need these therapies to improve their quality of life, so they can not improve only in their disease activity, but also in their day-to-day and their life issues.

**Dr. Turck:**
And if we zero in on personalized care for a moment, what does that look like in practice for a patient who has primary biliary cholangitis today?

**Dr. Bonder:**
This is one of the key things that we focus on right now in our clinics. When a patient comes in, personalization of medicine is not only looking at a patient with a diagnosis of PBC, but now, based on their markers and their baseline characteristics—age, gender, and ethnicity, but also symptoms—we can basically personalize care. We can give that patient the best therapy of what we have available to improve both disease activity and symptom-based therapies, as well as, finally, the quality of life.

**Dr. Turck:**
Now, as we come to the end of our program, Dr. Bonder, what research directions or unanswered questions do you think are most critical to advancing the management of primary biliary cholangitis?

**Dr. Bonder:**
This is one of the key questions. So what we look forward to in the near future—I think number one is, can we take the personalization of medicine even a step ahead? For example, looking at major disparities as far as response. Can we look at, also, different symptoms or different bile acids based on symptoms to see if we can also treat down their different therapies? And, finally, right now, a response means an alkaline phosphatase less than 1.67, but we have seen in studies that normal should be completely normal. So should we really aim to normalize every single blood test that we have available to really improve outcomes? And again, those are key questions that we are really now addressing with the new design of clinical trials, and hopefully, in the next two to three years, we'll get better answers so we can really get better therapies, and, looking in the near future, almost completely control this disease.

**Dr. Turck:**
Well, with those insights in mind, I want to thank my guest, Dr. Alan Bonder, for joining me to discuss how primary biliary cholangitis care is advancing. Dr. Bonder, it was great having you on the program.

**Dr. Bonder**
Thank you, Dr. Turck. And again, it's a pleasure to be with you guys again.

**Announcer:**
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