SESSION 2

ULCERATIVE COLITIS

Beyond 5-ASAs: Positioning advanced therapies for ulcerative colitis

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The advanced therapies for ulcerative colitis beyond 5-ASAs include the biologics, i.e., monoclonal antibodies, and the oral small molecules. The Tumor Necrosis Factor inhibitors (TNFi) include infliximab, adalimumab, and golimumab, and biosimilars. The anti-interleukin 12/23 inhibitors include ustekinumab, and the anti-integrin, vedolizumab. Recently, oral small molecules have been approved, including the sphingosine 1 phosphate (S1P) agonist modulator, ozanimod, and the janus kinase inhibitors (JAKi), tofacitinib and upadacitinib.

The choice of which advanced therapy to administer for IBD largely depends on the patient phenotype, disease severity, and safety considerations. Although head-to-head studies are emerging, there is a paucity of comparative effectiveness data, thus network meta-analyses and personal experience are required to make decisions on appropriate therapy.

My talk focuses on the positioning of therapy, and much of this discussion is my opinion and based on experience and data. For acute-severe ulcerative colitis, infliximab in combination with an immunomodulator, e.g., thiopurine or methotrexate, is often the first-line therapy. For those patients who have previously received a TNFi, a JAKi, e.g., tofacitinib or upadacitinib, is a good option. For outpatients with moderate-to-severe ulcerative colitis who are naïve to advanced therapies, and not facing impending hospitalization, there are several good choices in addition to the TNFi's: vedolizumab, ustekinumab, and ozanimod, that all work best when used as the first therapy.

Finally, there are specific circumstances that may guide therapy selection. Patients with aggressive extraintestinal manifestations that often do not parallel the course of IBD, e.g., pyoderma gangrenosum, central arthritis (ankylosing spondylitis), and uveitis, often benefit from a TNFi as the first treatment. For patients who are pregnant or considering conception in the near term, any of the monoclonal antibodies are safe and do not need to be stopped or held in pregnancy. At present, and until more data are available, the oral small molecules should not be administered in pregnancy and should be stopped 30 days in advance of conception.

References

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