crohn's colitis

Loss of Response OR Partial Response for Patients on Advanced Therapy

Objective

Achieve and maintain remission with Advanced Therapy.

Patient Population

Patients diagnosed with inflammatory bowel disease on Advanced Therapy.

Highlight Box

New IBD therapies are continuously becoming available, however the approach to loss of response or partial response for patients on Advanced Therapy remains inconsistent. The main objective is to achieve and maintain remission by dose optimization and reassessment of response to medications and switching therapies as required.

Introduction

This CCP recommends a common approach to any IBD patient who is on Advanced Therapy and who is exhibiting symptoms of loss of response or partial response. While initially developed for guidance regarding drug level monitoring and dose optimization for patients losing response to anti-TNF therapies, this CCP also provides suggestions for how to approach patients who are on newer biologics and small molecules. Where applicable, the guidance reflects published data and recommendations established by the global IBD community.

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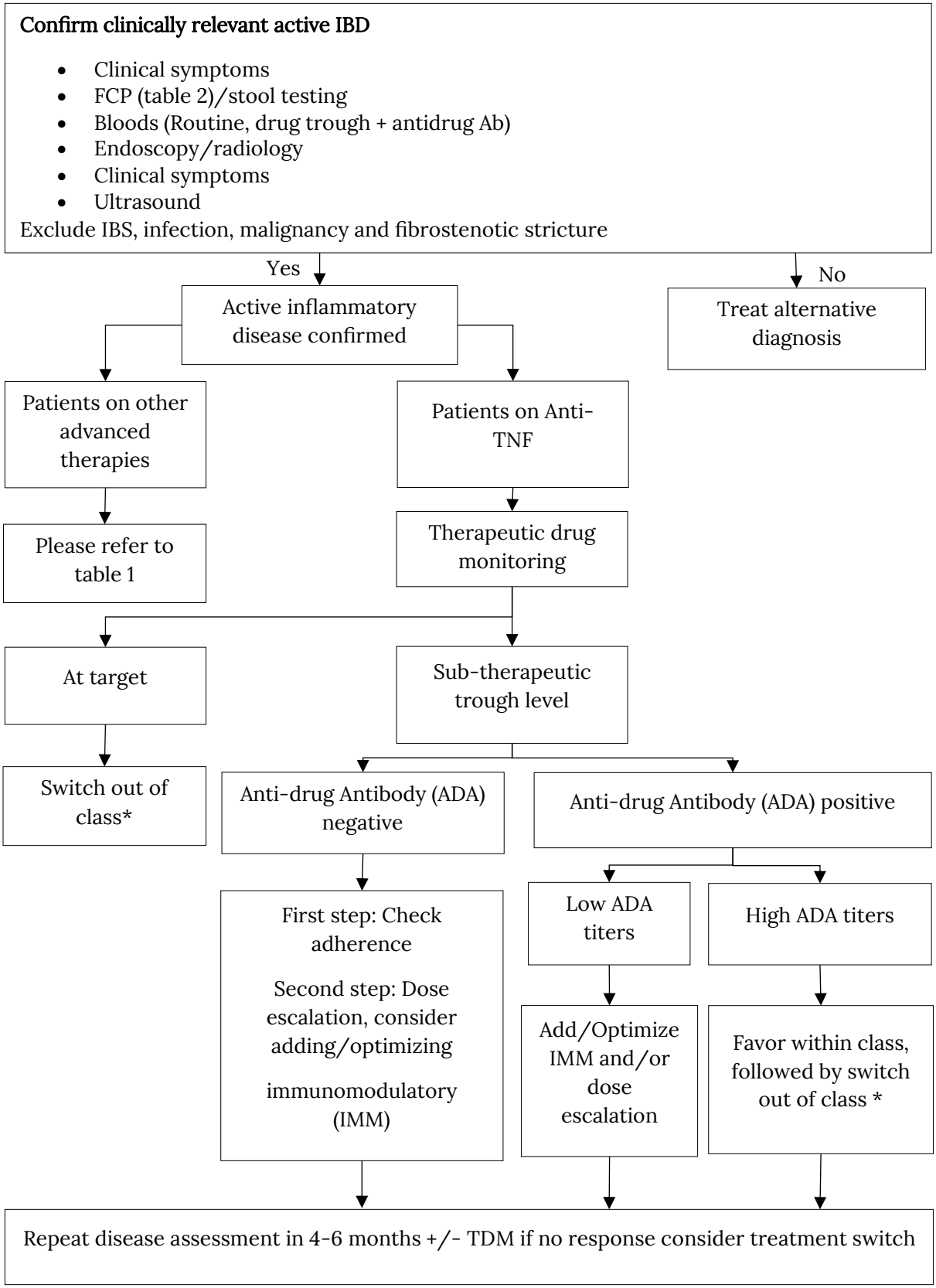

Table 1: Approach to managing other advanced therapies

Drug	Dose optimization	Time to reassess
Vedolizumab	Escalate to q4w dosing*	At the 3rd q4w dosing
Ustekinumab	Escalate to q4w dosing OR request IV reloading dose	At the 3rd q4w dosing OR 3 to 4 months after IV reloading dose
Tofacitinib	10mg po BID	After 8 weeks
Upadacitinib	30mg po bid (for those on 15mg qd)	After 8 weeks
Risankizumab	N/A	
Ozanimod	N/A	

*Optimization has limited benefit based on evidence.
Always discuss the potential risks associated with changing advanced therapies with the patient, including the risk of a lesser response and potential side effects.

Table 2: Fecal Calprotectin results and clinical approach

Fecal Calprotectin (µg/g)	Interpretation	Suggested Management
<50-100	Quiescent disease likely	Continue current therapy
>100-250	Inflammation possible	Investigate (e.g., colonoscopy) to confirm inflammation
>250	Inflammation likely	Optimize/switch therapy

Table 3: Approach to Managing Thiopurine Therapy

Etiology of Thiopurine Failure	6-TGN Level (pmol/10^8 erythrocytes)	6-MMP Level (pmol/10^8 erythrocytes)	6-MMP/6-TGN Ratio	Proposed Treatment Strategy
Inadequate dose	Low (<230)	Low (<5700)	Normal (4-24)	Increase dose
Excessive TPMT	Low (<230)	High (>5700)	High (>24)	TPMT modulation by the addition of allopurinol or 5-ASA, dose splitting, switch to alternative agent, such as MTX
Lack of adherence	Low (<230)	Low (<5700)	Normal (4-24)	Verify adherence
True drug ineffectiveness	Normal (230-400)	Normal (<5700)	Normal (4-24)	Alternative therapy

5-ASA: Mesalamine
6-MMP-methyl mercaptopurine
6-TGN: 6-thioguanine nucleotides
MTX: Methotrexate
TPMT: Thiopurine methyltransferase

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