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Summary

Reducing immunosuppression: When and how to de-escalate therapy

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IBD | Immunology | Surgery

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De-escalation of biologic therapy in IBD may be considered in selected patients to avoid overtreatment and reduce costs, but requires careful individual risk assessment as relapse rates remain substantial even in patients with deep remission.

KEY POINTS

- The speaker stated that population-based studies show over 50% of IBD patients have a favourable disease course, suggesting potential for overtreatment with long-term biologics.
- According to an individual participant data meta-analysis presented, the risk of relapse after anti-TNF cessation is approximately 38%, with risk factors including younger age, smoking, proximal Crohn's location, and elevated inflammatory markers.
- The SPARE trial showed that after two years of combination therapy in remission, continuing the immunomodulator provided no additional clinical benefit, with similar relapse-free survival whether the immunomodulator was withdrawn or discontinued entirely.
- The LADY trial confirmed non-inferiority of lengthening adalimumab intervals, with over 80% of patients maintained on the extended interval at one year, though fewer were in remission and more required rescue medication.
- The Scandinavian stoppage trial demonstrated a high 50% clinical relapse rate despite selecting patients in deep remission with no endoscopic or radiological activity, highlighting difficulty in identifying low-risk patients.
- The speaker recommended against de-escalation in patients with perianal fistula disease, citing a 42% relapse risk within two years, and emphasized the need for better molecular markers to identify patients at low risk of relapse.

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