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Summary

IBD treatment beyond anti-TNF (Part 2: Personalized medicine)

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Podcast Episode

IBD

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This discussion explores the positioning of IBD therapies beyond anti-TNF agents, emphasizing the challenges of precision medicine, the importance of optimizing conventional treatments, and the need for individualized decision-making in the absence of head-to-head trial data.

KEY POINTS

- Precision medicine in IBD has underdelivered despite a decade of research; molecular profiling and AI-assisted treatment selection remain expensive, unvalidated, and not yet practical for routine clinical use
- When patients lose response to anti-TNF therapy, clinicians must first rule out infections, C. difficile, CMV, strictures, and other complications before switching drug class; drug level and antibody testing guides whether to switch within or out of class
- Treatment decisions after anti-TNF failure require individualized assessment of disease phenotype, extraintestinal manifestations, patient preferences, and drug characteristics, as guidelines cannot rank therapies due to lack of head-to-head trials; network meta-analyses suggest JAK inhibitors perform well in this setting
- Conventional therapies remain underutilized: topical mesalamine should accompany every ulcerative colitis flare, high-dose mesalamine (over four grams) is preferred for induction, and azathioprine intolerance can often be managed by dose titration, switching to mercaptopurine, or adding allopurinol for hepatotoxicity
- Combination infliximab and azathioprine is the preferred first-line regimen for high-risk patients (young age, perianal or extensive Crohn's, deep colonic ulceration), while approximately one-third of Crohn's patients have mild disease that may be overtreated with advanced biologics

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