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Summary

Current role for thiopurines in the management of IBD: Should I go?

Joana Torres

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The speaker argues that thiopurines should be discontinued in selected IBD patients, particularly those on anti-TNF combination therapy in sustained remission, older patients, and those with high cumulative exposure, based on limited disease-modifying efficacy and safety concerns.

KEY POINTS

- The speaker presented Profile study results showing that early combination therapy with infliximab plus immunomodulator in newly diagnosed Crohn's disease led to better long-term outcomes than a conventional step-up approach, with significantly lower rates of surgery, disease progression, and hospitalisation over five years in the top-down strategy.
- Post-hoc analysis from Liberty trials and the Minimised study showed no differences in efficacy, drug levels, or immunogenicity between subcutaneous infliximab with or without concomitant immunomodulator, suggesting thiopurines may not be necessary with subcutaneous infliximab formulations.
- Danish data presented by the speaker showed cancer risk associated with thiopurines increases with age and cumulative exposure beyond five years, with serious infection rates of 3% in patients over 65 versus 1% in younger patients on thiopurine monotherapy.
- The SPARE trial demonstrated that stopping thiopurines in patients on stable combination therapy with infliximab did not increase relapse rates compared to continuing combination therapy, while stopping infliximab led to higher relapse.
- The speaker recommends considering thiopurine discontinuation in patients on anti-TNF combination therapy with sustained clinical, biomarker, and endoscopic remission, patients over 60-65 years old, those with high cumulative thiopurine exposure, and those with additional malignancy risk factors, emphasizing individualized decision-making.

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