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Summary

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

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Immunology | Mechanisms & Personalised Medicine | IBD

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The speaker presented evidence supporting the continued role of thiopurines in IBD treatment in 2026, focusing on their pharmacology, clinical scenarios for use, and practical monitoring strategies.

KEY POINTS

- The speaker stated thiopurines importantly reduce immunogenicity in patients starting infliximab, supported by the SONIC trial showing combination therapy superior to monotherapy for steroid-free remission in Crohn's disease and the UC SUCCESS study showing benefit for mucosal healing in ulcerative colitis.
- The speaker reported that adding thiopurines when switching to second-line anti-TNF therapy after first-line immunogenicity reduces the risk of developing antibodies to the second agent.
- The speaker stated that roughly one in ten Europeans are TPMT heterozygotes requiring 50% dose reduction, and one in 300 are homozygous for low activity and should avoid thiopurines, though TPMT testing identifies only about 25% of patients who develop myelosuppression.
- The speaker reported that roughly 50% of European patients are hypermethylators with high 6-MMP and low TGN levels, requiring dose reduction to 30-50% and addition of allopurinol after two weeks to reverse the skewed metabolism.
- The speaker stated that thiopurines are slow-acting with no role in induction therapy, but may be considered for maintenance monotherapy in patients under 65 years with steroid-dependent ulcerative colitis, depending on the healthcare system.
- The speaker recommended pre-treatment testing including viral status, TPMT genotyping if available, and vaccination status, with monitoring of blood counts and liver function at weeks 2, 4, 8, and 12, then every three months during the first year.

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