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Summary

Panel discussion: Cancer and IBD - Mitigating risk among uncertainty

UEG Postgraduate Teaching Programme Berlin 2025 | Presentation

Digestive Oncology | IBD

October 4, 2025

Panel discussion addressed personalized management of cancer in IBD patients, covering surgical approaches to immune checkpoint inhibitor colitis, criteria for segmental versus total colectomy in IBD-associated colorectal cancer, and surveillance strategies in non-standard risk scenarios.

KEY POINTS

- The speaker stated that current standard teaching favors total proctocolectomy for IBD-associated colorectal cancer due to field effect concerns, though segmental colectomy may be considered in select cases such as Crohn's disease patients in remission on biologics with multiple comorbidities, with pathologist input to distinguish sporadic from colitis-associated cancer.
- For immune checkpoint inhibitor colitis in IBD patients, the speaker noted that defunctioning ileostomy may not address the underlying T-cell dysregulation mechanism and that prophylactic switching to gut-selective agents like vedolizumab before starting checkpoint inhibitors is not yet routine but may be advised in the future.
- The speaker reported a decrease in IBD-associated cancer epidemiology, possibly a one-third reduction in prevalence in some studies, attributed to better inflammation control, earlier treatment, or improved detection.
- The speaker recommended targeted biopsies over random biopsies for dysplasia surveillance, stating there is no evidence that random biopsies increase yield, though random biopsies are still suggested for high-risk patients such as those with PSC or prior dysplasia.
- The speaker identified high-risk criteria for earlier surveillance in patients not meeting the eight-year disease duration threshold as severe inflammation, family history of colon cancer, young age, stricturing disease, and noncompliant behavior, recommending case-by-case discussion in a surveillance MDT.

– The speaker emphasized that surveillance timing should be calculated from symptom onset rather than formal diagnosis date, particularly in patients diagnosed at older ages who may have had unrecognized disease for longer.

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