Panel discussion: Precision in practice: The future of drug optimisation in IBD

Postgraduate Teaching Programme Barcelona 2026 | Presentation

IBD

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This panel discussion addressed optimization strategies for IBD treatment including therapeutic drug monitoring, treatment goals, combination therapy, and management in special populations including pregnancy and perianal disease.

KEY POINTS

- The speaker distinguished between optimizing a partially effective therapy by adding treatment versus completely switching, with the decision based on how far the patient has progressed and likelihood of achieving the target outcome.
- The speakers stated that trough levels from subcutaneous infliximab must be interpreted differently than IV infliximab with different targets, and that IV dosing offers more flexibility for dose intensification.
- For perianal disease, the speaker recommended starting at 10 milligram per kilogram IV with combination treatment, continuing until surgical fistula closure plus 3 to 6 months, then potentially switching to subcutaneous formulation once in complete remission.
- The speakers stated that combination therapy with thiopurines should continue at least six months, with proactive de-escalation at 6 to 12 months guided by therapeutic drug monitoring, and that this approach applies to both Crohn's disease and ulcerative colitis.
- Therapeutic drug monitoring in pregnancy should follow the same approach as non-pregnant patients, maintaining remission throughout pregnancy without dose reduction based on small studies showing level increases.
- The speakers stated that point of care testing with half-hour turnaround time may be useful in active disease such as acute severe colitis or severe perianal disease during induction, but not clearly indicated during maintenance treatment.

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