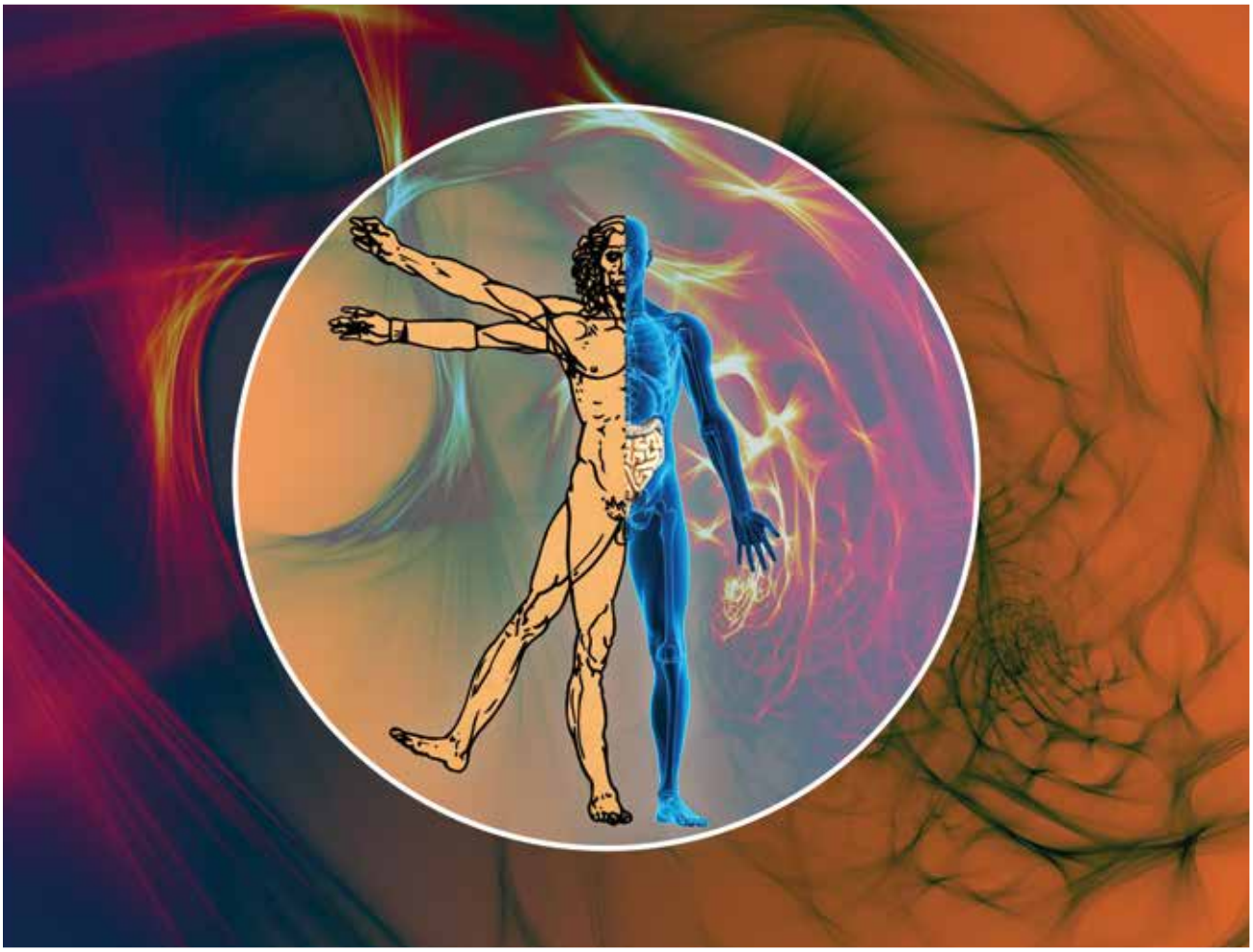
# MEETING OF THE MINDS

## WESTIN HARBOUR CASTLE, TORONTO

SATURDAY, November 15, 2025

# Canada Future Directions in IBD



#IBDMinds2025

Co-Chairs: **Remo Panaccione**, MD FRCPC and **A. Hillary Steinhart**, MD MSc FRCPC

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# MEETING OF THE MINDS

## WESTIN HARBOUR CASTLE, TORONTO

## MENTORING in IBD THE MASTER CLASS XXVI

## Canada Future Directions in IBD

**Mentoring in IBD XXVI Curriculum** and **Canada Future Directions in IBD** are funded by unrestricted educational grants from...

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# TABLE OF CONTENTS

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# ABOUT Canada Future Directions in IBD

*Canada Future Directions in IBD* is Crohn's and Colitis Canada's premier conference for healthcare professionals and researchers who care for patients with inflammatory bowel diseases (IBD) and carry out research into these disorders.

One of the goals of *Canada Future Directions in IBD* is to present the best new scientific research in IBD and advance knowledge on the state of the science. Crohn's and Colitis Canada's Promise Statement and Mission statements emphasize our long-term commitment to finding cures for Crohn's disease and ulcerative colitis as well as our commitment to undertakings that will have a more immediate impact on the lives of Canadian children and adults affected by these chronic diseases.

**Our Promise:** To cure Crohn's disease and ulcerative colitis and improve the lives of children and adults affected by these chronic diseases.

Knowledge translation is important to delivering on our Promise. Now in its 14th year, the *Canada Future Directions in IBD* national symposium remains one of our key programs to translate what is learned in research into the hands of the practitioners treating IBD patients and to highlight the significant progress being made by our funded researchers.

Again this year, *Canada Future Directions in IBD* hosts the Canadian IBD Nurses (CANIBD) Annual Conference. This educational initiative provides nurses with a tailored program to meet their evolving needs.

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# LEARNING OBJECTIVES

*Canada Future Directions in IBD* reaches forward to translate what is learned in research into the hands of practitioners treating patients living with inflammatory bowel diseases, to present the best new scientific research in IBD and to advance knowledge on the state of the science.

**Participants in this program will be able to:**

- Explore therapies on the horizon with a focus on TL1A inhibitors
- Explore the role obesity and altered metabolism play in IBD
- Integrate basic science and clinical practice by participating in a choice of workshops:
  - By the end of this workshop, participants will be able to describe the current status and therapeutic applications of cell-based therapy in IBD
  - By the end of this workshop, participants will be able to discuss the present and emerging roles of artificial intelligence in IBD management
  - By the end of this workshop, participants will be able to apply strategies for sequencing biologics and small molecules in pediatric IBD patients
  - By the end of this workshop, participants will be able to evaluate current evidence and best practices for managing IBD during pregnancy
- Explore future options in the prevention and prediction of IBD

# AGENDA

| Time | Topic | Speakers |
|---|---|---|
| 08:30 | **0.1 Welcome, Awards and Crohn's and Colitis Canada Overview**<br>Nurse and Physician Award of the Year, Women in IBD Research Award, DEI in IBD Award | Josh Berman, President & CEO, Crohn's and Colitis Canada |
| 09:00 | **0.2 Opening Remarks – Welcome, program objectives** | CO-CHAIRS: Remo Panaccione & Hillary Steinhart |
| **Session I: On the Horizon: New therapies in IBD** | | SESSION CHAIR: Jeffrey McCurdy |
| 09:15 | PLENARY PRESENTATION<br>**1.1 Molecular Target Discovery in IBD** | Dermot McGovern |
| 09:35 | PLENARY PRESENTATION<br>**1.2 New Therapies with a Focus on TL1As** | Vipul Jairath |
| 09:55 | **1.3 Ask-the Expert Panel Session** | MODERATOR: Jeffrey McCurdy<br>PANEL: Vipul Jairath, Dermot McGovern, Remo Panaccione |
| 10:15 | **1.4 Junior Investigator Award Presentation**<br>**Dietary Enhancement of Microbial Tryptophan Metabolism Restores AhR Signalling and Reduces Colitis** | MODERATOR: Hillary Steinhart<br>Liam Rondeau |
| | *Thank you Pfizer – Meeting of the Minds Benefactor Sponsor* | |
| 10:35 | Refreshment Break (15 minutes) | |
| **Session II: What does fat have to do with it?** | | SESSION CHAIR: Jean-Eric Ghia |
| 10:50 | PLENARY PRESENTATION<br>**2.1 Established and emerging indications for GLP-1 medicines** | Daniel Drucker |
| 11:10 | PLENARY PRESENTATION<br>**2.2 Obesity and Fat Metabolism in IBD: Clinical and Therapeutic Implications** | Joelle St. Pierre |
| 11:30 | **2.3 Ask-the Expert Panel Session** | MODERATOR: Jean-Eric Ghia<br>PANEL: Daniel Drucker, Maitreyi Raman, Joelle St. Pierre |
| 11:50 | **2.4 Rising Star Award & Presentation** | MODERATOR: Roshane Francis, Crohn's and Colitis Canada |
| | *Thank you Johnson & Johnson – Meeting of the Minds Benefactor Sponsor* | |
| 12:10 | Lunch (50 minutes) | |
| **Session III: Workshops – Hot Topics from Bench to Policy** | | |
| 13:00 | **3.1 Cell Based Therapies in IBD: Past, present and future** | Theodore Steiner & Ryan Ungaro |
| | **3.2 From Pixels to Patients: Optimizing AI in the Management of IBD** | Michael Byrne & Peter Rossos |
| | **3.3 Advanced Sequencing of Biologics and Small Molecules in Pediatrics** | Anne Griffiths & Sally Lawrence |
| | **3.4 Global View on Managing Pregnancy in IBD** | Vivian Huang & Cynthia Seow |
| 13:50 | Grab & Go Break (10 minutes) | |
| | *Thank you Celltrion – Meeting of the Minds Benefactor Sponsor* | |
| 14:00 | **4.0 Women in IBD Research Award and DEI in IBD Award Winners** | MODERATOR: Kate Lee, Crohn's and Colitis Canada |
| **Session IV: The Future of Monitoring in IBD** | | SESSION CHAIR: Eric Benchimol |
| 14:25 | PLENARY PRESENTATION<br>**4.1 Predicting who will develop IBD: State of the Art 2025** | Sun-Ho Lee |
| 14:45 | PLENARY PRESENTATION<br>**4.2 Prevention of IBD: Where we are and where we need to go** | Ryan Ungaro |
| 15:05 | **4.3 Ask-the Expert Panel Session** | MODERATOR: Eric Benchimol<br>PANEL: Sun-Ho Lee, Dermot McGovern, Ryan Ungaro |
| | *Thank you Abbvie – Meeting of the Minds Benefactor Sponsor* | |
| 15:25 | **Closing Remarks and Program Evaluation** | CO-CHAIRS: Remo Panaccione & Hillary Steinhart |

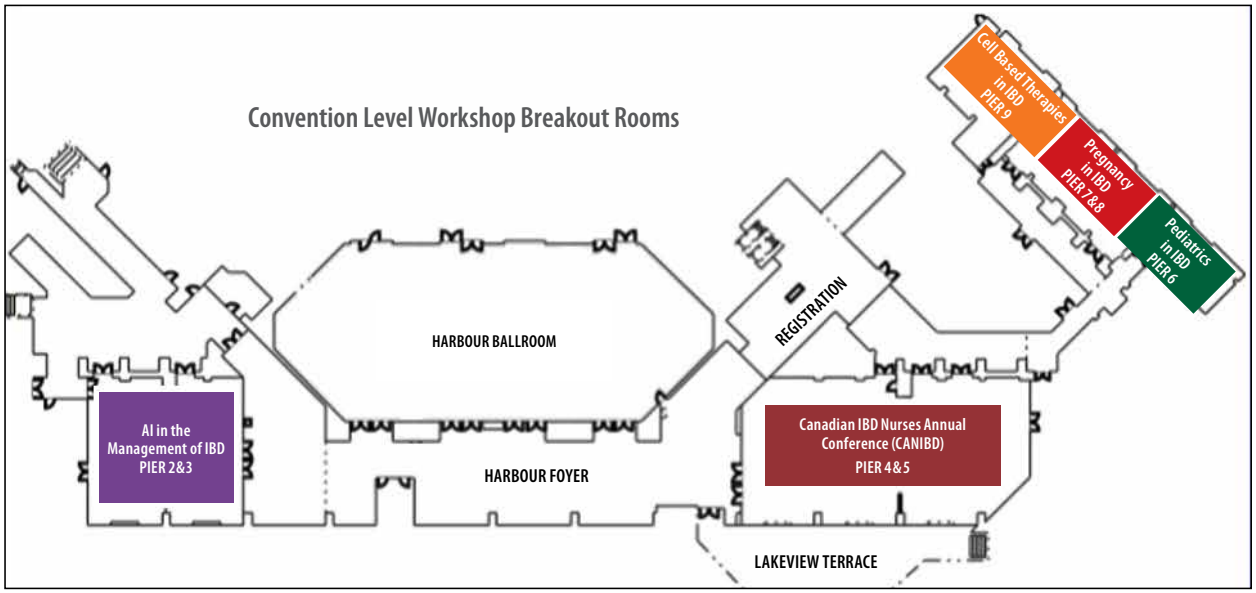
# SCHEDULE OF EVENTS

| Time | Events | | Location |
|---|---|---|---|
| 06:30 | Sponsor Exhibit Set-up | | Harbour Ballroom Foyer, Convention Level |
| 07:30 | Registration, Breakfast & Sponsor Exhibits | | Harbour Ballroom and Foyer |
| 08:30 | Canada Future Directions in IBD Convenes | | Harbour Ballroom |
| 10:35 | Refreshment Break | | Harbour Ballroom and Foyer |
| 10:50 | Canada Future Directions in IBD Reconvenes | | Harbour Ballroom |
| 12:10 | Lunch Buffet & Sponsor Exhibits | | Harbour Ballroom and Foyer |
| 13:00 | Workshop Breakouts | **3.1** Cell Based Therapies in IBD: Past, present and future | Pier 9 |
| | | **3.2** From Pixels to Patients: Optimizing AI in the Management of IBD | Pier 2&3 |
| | | **3.3** Advanced Sequencing of Biologics and Small Molecules in Pediatrics | Pier 6 |
| | | **3.4** Global View on Managing Pregnancy in IBD | Pier 7&8 |
| 13:50 | Grab & Go Break | | Harbour Ballroom and Foyer |
| 14:00 | Canada Future Directions in IBD Reconvenes | | Harbour Ballroom |
| 15:35 | Canada Future Directions Meeting Adjourns | | |

# WORKSHOP BREAKOUT GROUPS, LOCATIONS AND FACILITATORS

| | Convention Level | | | |
|---|---|---|---|---|
| **Workshop Groups** 13:00 – 13:50 | Global View on Managing Pregnancy in IBD | From Pixels to Patients: Optimizing AI in the Management of IBD | Cell Based Therapies in IBD: Past, present and future | Advanced Sequencing of Biologics and Small Molecules in Pediatrics |
| **Location** | Pier 7&8 | Pier 2&3 | Pier 9 | Pier 6 |
| **Facilitators** | Vivian Huang<br>Cynthia Seow | Michael Byrne<br>Peter Rossos | Theodore Steiner<br>Ryan Ungaro | Anne Griffiths<br>Sally Lawrence |

Delegates attend one pre-selected 45-minute workshop – Time includes 5 minutes for rotation.



SESSION I

# ON THE HORIZON: NEW THERAPIES IN IBD

## 1.1 Molecular Target Discovery in IBD

*Dermot P.B. McGovern*

### Objectives

- Review molecular target discovery
- Discuss new therapies in inflammatory bowel disease (IBD) with a focus on TL1A inhibitors
- Bench to bedside discussion

### Abstract

Molecular advances provide opportunities for better outcomes in inflammatory bowel disease (IBD) through 1) novel target identification, 2) opportunity for pharmacogenomics and companion diagnostic development, and 3) discovery of optimal target synergy for combination therapeutics. Genetic susceptibilities to IBD are linked with established therapies including anti-integrins, anti-IL12, and notably the coding loss of function variant in *IL23R*. Many 'IBD genes' have pleiotropic effects across immune-mediated inflammatory diseases (IMIDs) in part, explaining the effectiveness of these drugs across IMIDs. Phenome-wide approaches (Phewas) may also inform developers about potential adverse events to expect with any given intervention. A recent example of the 'gene to drug' process are the emerging drugs targeting TL1A (lead programs currently in phase 3), a transcription factor with pleiotropic effects across immune and fibrotic 'pathways'. *TNFSF15* is the gene encoding for TL1A and non-coding variants at this locus have been associated with IBD (with the largest effect seen in East Asian ancestry populations) and sub-phenotypes such as stricturing Crohn's disease. Starting with a molecular signature in drug development such as *TNFSF15* creates opportunities for development of companion/complementary diagnostics to identify people more likely to respond. This would represent an important step towards a more precision medicine approach in IBD. Early findings with diagnostics from TL1A trials are promising but require replication. There is considerable interest in combination therapies in IBD and access to molecular signatures may help identify drugs that are truly synergistic rather than just additive or even antagonistic,replacing the current 'random' approach for drug combination.

### References

Feagan BG, Sands BE, Siegel CA, et al. Phase 2 induction trial of anti-tl1a monoclonal antibody tulisokibart for Crohn's disease. *Lancet Gastroenterol Hepatol*. 2025;10(8):715–25.

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Yamazaki K, McGovern D, Ragoussis J, et al. Single nucleotide polymorphisms in TNFSF15 confer susceptibility to Crohn's disease. *Hum Mol Genet*. 2005;14(22):3499–506.

SESSION I

# ON THE HORIZON: NEW THERAPIES IN IBD

## 1.2 New Therapies with a Focus on TL1As

*Vipul Jairath*


### Abstract

The pivotal role of TL1A in modulating immune pathways critical for inflammatory bowel disease (IBD) and intestinal fibrosis has presented a promising new therapeutic target. In 2019, a phase 1a trial confirmed the safety and tolerability PF-06480605 of single and multiple ascending doses in healthy subjects. The phase 2a TUSCANY trial was an open-label, single-arm study in 50 subjects with moderate-to-severe ulcerative colitis (UC), employing a Simon's two stage design, demonstrating a statistically significant proportion of participants (38.2%) achieved endoscopic improvement at week 14, leading to further development of PF-06480605. The phase 2 ARTEMIS-UC study evaluated the efficacy and safety of tulisokibart (MK-7240, previously PRA023), an anti-TL1A monoclonal antibody as induction therapy for adults with moderate-to-severe UC, with a companion diagnostic (CDx) to potentially identify patients who would benefit the most. A significantly higher proportion of tulisokibart-treated patients achieved the primary endpoint of clinical remission at week 12 (26.0% versus 1.5% for placebo; delta of 25.0%, $p < 0.001$). The APOLLO-CD trial investigated the efficacy and safety of tulisokibart as induction therapy for adults with moderate-to-severe CD utilizingan open-label design with a primary outcome of endoscopic response at week 12, using historical placebo rates for benchmark comparison. RELIEVE UCCD was a 14-week phase 2b, randomized, double-blind, dose-ranging, basket trial, using Bayesian methodology, which also demonstrated consistent and positive results for duvakitug over placebo across a range of endpoints. All three compounds are now in phase 3 trials..


### References


Danese S, Klopocka M, Scherl EJ, et al. Anti-TL1A antibody PF-06480605 safety and efficacy for ulcerative colitis: a phase 2a single-arm study. *Clin Gastroenterol Hepatol*. 2021;19(11):2324–32.e6.

Feagan BG, Sands B, Siegel CA, et al. DOP87 the anti-TL1A antibody PRA023 demonstrated proof-of-concept in Crohn's disease: phase 2a APOLLOCD study results. *J Crohn's Colitis*. 2023;17:i162–4.

Sands B, Feagan B, Peyrin-Biroulet L, et al. Phase 2 of anti-TL1A monoclonal antibody tulisokibart for ulcerative colitis. *N Engl J Med*. 2024;391(12):1119–29.

SESSION I

## JUNIOR INVESTIGATOR AWARD

# 1.3 Dietary Enhancement of Microbial Tryptophan Metabolism Restores AhR Signalling and Reduces Colitis

*Liam Rondeau*

**Background:** Intestinal microbiota, diet, and the immune system contribute to the development of inflammatory bowel diseases (IBD). The aryl hydrocarbon receptor (AhR) is a critical regulator of intestinal immunity and barrier function, activated by microbial and host tryptophan (Trp) metabolites. IBD patients in large cohorts and in our own studies show reduced bacterial Trp metabolism genes and metabolites, which is associated with downregulation of colonic AhR activation, but the contribution of microbiota to this phenotype is unclear. Enhancing Trp metabolism through diet/probiotics may offer a therapeutic strategy to reduce inflammation in IBD.

**Aim:** To investigate how diet-microbe interventions modulate AhR activation and colitis in mice colonized with IBD and mouse microbiota with impaired Trp metabolism.

**Methods:** Germ-free C57BL/6 mice were colonized with microbiota from human healthy controls (HC) or IBD patients, and specific pathogen free (SPF) or a minimal microbiota composed of 8 species (MM). Mice were provided a high Trp (HT; 1% Trp) or control diet (0.14% Trp). Subsets of mice received probiotic Clostridium sporogenes with Trp metabolism genes. Colitis was induced in mice using dextran sulfate sodium (DSS; 2.5% w/v), 2,4,6-trinitrobenzenesulfonic acid (TNBS; 2% w/v), and IL-10-/- models. AhR antagonist (CH223191) or vehicle were provided daily during colitis. Trp metabolites were quantified by liquid chromatography-mass spectrometry (LC-MS). AhR activation was quantified by AhR reporter and reverse transcription quantitative polymerase chain reaction (RT-qPCR). Histologic analysis of distal colon, clinical scores, intestinal permeability (Ussing chambers), and inflammatory genes (Nanostring), were assessed.

**Results:** Humanized mice colonized with IBD microbiota had reduced Trp metabolism vs HC. MM microbiota mice had reduced Trp metabolism vs SPF. Reduced Trp metabolism was associated with exacerbated colitis severity. HT diet supplementation in IBD humanized mice increased Trp metabolism, activated AhR, and reduced DSS, TNBS, and IL-10-/- colitis. Probiotic supplementation was required with HT diet to achieve clinical colitis alleviation in mice with severe impairment of AhR signalling.

**Conclusions:** Transfer of AhR activation from humans to mice by microbiota transplant indicates that AhR activation is microbiota dependent. Impaired host/microbial Trp metabolism increases susceptibility to colitis. Trp supplementation and microbial interventions offer an approach to restore AhR signalling and reduce intestinal inflammation.

**Authors:** Rondeau L, Barbosa da Luz B, Muppidi P, et al.

SESSION II

# WHAT DOES FAT HAVE TO DO WITH IT?

## 2.1 Established and emerging indications for GLP-1 medicines

*Daniel J. Drucker*

### Objectives

- Overview
- Consider the use of glucagon-like peptide-1 (GLP-1s) and the future
- Discuss combination trials using GLP-1s

### Abstract

The pleiotropic actions of endogenous GLP-1 biology and striking metabolic efficacy of the GLP-1 receptor agonists, have elevated the enteroendocrine system and peptide hormone-based therapies as viable targets and platforms for development of improved next generation therapies for treatment of metabolic disorders. Here we review evidence and mechanisms linking the use of GLP-1-based medicines to improved cardiometabolic outcomes in people with type 2 diabetes and obesity. The evidence linking GLP-1 to reduced inflammation, often independent of weight loss, will be discussed. The future of GLP-1-based medicines, spanning new molecules and indications, will be highlighted, presaging the opportunity to extend GLP-1 therapeutics to a range of new disease indications. Next generation GLP-1-based medicines promise to deliver substantial improvements in glucose control, greater weight loss, reduction of inflammation, and decreased mortality, delivering major health benefits relevant to people living with type 2 diabetes, obesity, cardiorenal disorders and inflammatory disorders.

### References

Gonzalez-Rellan MJ, Drucker DJ. New molecules and indications for GLP-1 medicines. *JAMA*. 2025 Sep 15. doi: 10.1001/jama.2025.14392.

Drucker DJ. GLP-1-based therapies for diabetes, obesity and beyond. *Nat Rev Drug Discov*. 2025;24(8):631–50.

SESSION II

# WHAT DOES FAT HAVE TO DO WITH IT?

## 2.2 Obesity and Fat Metabolism in IBD: Clinical and Therapeutic Implications

*Joëlle St-Pierre*

### Objectives

- Review key considerations in the design of inflammatory bowel disease (IBD) prevention trials
- Provide an overview of potential prevention trial therapy targets and interventions
- Discuss ongoing and planned IBD prevention trials

### Abstract

The intersection of obesity and inflammatory bowel disease (IBD) presents new challenges for patient care. Beyond serving as an energy reservoir, visceral adipose tissue (VAT) is an immunometabolic organ that produces cytokines, adipokines, and microbial metabolites capable of amplifying gut and systemic inflammation. Experimental work has shown that microbial translocation into mesenteric fat can activate local immune responses and perpetuate chronic disease, highlighting VAT as a key pathophysiological driver.

Clinical evidence supports these mechanistic insights: higher VAT burden is associated with worse IBD outcomes, including reduced rates of remission following advanced therapy, independent of body mass index. This relationship is linked to distinct systemic inflammatory signatures, suggesting that VAT is both a mediator of inflammation and a potential biomarker of treatment response.

Therapeutic strategies aimed at reducing adiposity and modifying VAT biology are now emerging. A stepwise framework includes dietary modification, physical activity, behavioral support, and pharmacologic options such as glucagon-like peptide-1 (GLP-1) receptor agonists, with endobariatric and bariatric procedures considered in select patients. Importantly, these interventions may improve not only weight but also metabolic health, inflammatory pathways, and long-term outcomes in people living with IBD.

This presentation will review the role of VAT in IBD pathophysiology, evaluate interventions that target adiposity and metabolic health, and explore VAT as a biomarker, highlighting current and emerging methods of measurement, including imaging, body composition tools, and metabolomic profiling. Integrating these perspectives underscores the need to move beyond body mass index toward precision approaches to obesity management in IBD.

### References

Ha CWY, Martin A, Sepich-Poore GD, et al. Translocation of viable gut microbiota to mesenteric adipose drives formation of creeping fat in humans. *Cell*. 2020;183(3):666–83.e17.

Shneyderman M, Freid H, Kohler D, et al. Management of overweight and obesity in patients with inflammatory bowel disease. *Gastroenterol Hepatol (NY)*. 2024;20(12):712–22.

Yarur AJ, Bruss A, Moosreiner A, et al. Higher intra-abdominal visceral adipose tissue mass is associated with lower rates of clinical and endoscopic remission in patients with inflammatory bowel diseases initiating biologic therapy: Results of the Constellation Study. *Gastroenterology*. 2023;165(4):963–75.e5.

SESSION III

# WORKSHOPS – HOT TOPICS FROM BENCH TO POLICY

## 3.1 Cell Based Therapies in IBD: Past, present and future

*Theodore Steiner* and *Ryan Ungaro*

### Objectives

- Summarize the current evidence supporting the use of cell based therapies in inflammatory bowel disease (IBD)
- Evaluate the potential risks, benefits, and clinical scenarios where cell-based therapies may be considered

### Abstract

Monoclonal antibodies and small molecule biologics have greatly expanded therapeutic options for inflammatory bowel disease (IBD). However, many patients fail to achieve or maintain remission on these agents or develop adverse effects, rendering them ineffective. Patients refractory to multiple advanced therapies present a challenging clinical dilemma. Cellular therapies, including hematopoietic stem cell transplantation (HSCT), mesenchymal stem/stromal cells (MSCs), immune cell–based approaches, and organoid-derived epithelial patches are being actively investigated as ways to treat multi-refractory IBD. HSCT has demonstrated efficacy in highly refractory IBD through immune "resetting," though its use remains limited by treatment-related morbidity/mortality and is restricted to few expert centers worldwide. MSCs exert immunomodulatory and tissue-regenerative effects, with randomized trials confirming their benefit in perianal Crohn's disease fistulas and ongoing investigations assessing broader luminal disease. Additional strategies, such as regulatory T-cell therapy and engineered cellular platforms, are in early development, with some promising results shown in early trials. There are many challenges remaining before cellular therapy is ready for clinical use. These include ways to optimize cell isolation and manufacturing under Good Manufacturing Practice (GMP) conditions; effective delivery; durability of response; and safety, particularly with regard to infection and long-term risks such as malignancy. This session will attempt to synthesize current evidence for cellular therapies in IBD, discuss potential risks and benefits of cell-based therapies, and highlight clinical scenarios where cell-based therapies may be considered.

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Desreumaux P, Foussat A, Allez M, et al. Safety and efficacy of antigen-specific regulatory T-cell therapy for patients with refractory Crohn's disease. *Gastroenterology*. 2012;143(5):1207–17.

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SESSION III

# WORKSHOPS – HOT TOPICS FROM BENCH TO POLICY

## 3.2 From Pixels to Patients: Optimizing AI in the Management of IBD

*Michael Byrne* and *Peter Rossos*

### Objectives

- Describe current applications of artificial intelligence (AI) in inflammatory bowel disease (IBD), focusing on diagnostic imaging (endoscopy, intestinal ultrasound) and disease monitoring
- Analyze how AI can optimize treatment decisions and clinical trial efficiency in IBD
- Critically discuss limitations, ethical considerations, and strategies for integrating AI into routine clinical practice

### Abstract

Artificial intelligence (AI) is rapidly transforming how inflammatory bowel disease (IBD) is diagnosed, monitored, and managed. Advances in computer vision and machine learning are enabling more consistent, reproducible assessments of disease activity across multiple modalities. For example, AI-enhanced colonoscopy analysis can provide objective scoring of ulcerative colitis severity at the frame level, while AI-assisted intestinal ultrasound offers a non-invasive approach for real-time disease monitoring. Together, these innovations help clinicians "see" and "hear" inflammation more clearly, reducing variability and supporting timely, personalized treatment decisions.

In addition to improving routine patient care, AI has the potential to accelerate and strengthen clinical research. Automated endoscopic and ultrasound scoring can streamline clinical trials by reducing reliance on central readers, increasing efficiency, and generating novel digital biomarkers. Looking ahead, predictive models may support flare forecasting, treatment response stratification, and integration of multimodal data for personalized care pathways.

However, barriers remain. AI systems must be validated across diverse populations and practice settings, and challenges around workflow integration, clinician acceptance, data governance, and regulation need to be addressed. This workshop will review the current state of AI in IBD imaging, present illustrative case studies from endoscopy and ultrasound, and engage participants in a discussion of opportunities, limitations, and the roadmap toward clinical adoption.

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SESSION III

# WORKSHOPS – HOT TOPICS FROM BENCH TO POLICY

## 3.3 Advanced Sequencing of Biologics and Small Molecules in Paediatrics

*Anne Griffiths* and *Sally Lawrence*

### Objectives

- Compare available biologics and small molecules for paediatric inflammatory bowel disease (IBD) and their positioning within treatment algorithms
- Apply principles of therapeutic sequencing to optimize outcomes in paediatric patients with complex or refractory IBD

### Case-based discussion: Chronic ulcerative colitis in a paediatric patient

Our patient, now 17 years old, has had chronic ulcerative colitis (UC; pancolitis) for 9 years with normal growth and pubertal development but difficulty achieving sustained steroid-free remission, resulting in a significant impact on quality of life. She had presented at age 8 years with bloody diarrhea escalating over a 3-month period (initial Pediatric Ulcerative Colitis Activity Index [PUCAI] score of 60). She responded promptly to steroids (initially given intravenously), initiated oral 5-aminosalicylic acid (5-ASA) as first maintenance therapy, but quickly proved steroid-dependent despite optimized 5-ASA. Infliximab was introduced with guidance from proactive therapeutic drug monitoring but failed to alleviate steroid dependency (i.e., primary pharmacodynamic failure). Intravenous (IV) vedolizumab was also ineffective. However, IV ustekinumab induction and subcutaneous maintenance therapy (q8 weekly) proved successful in achieving more than 2 years of continuous steroid-free clinical remission with normalization of fecal calprotectin. Two-and-a-half years following commencement of ustekinumab (and not alleviated by intensification of ustekinumab regimen or trials of adjunctive oral 5-ASA or per rectal therapies), there was a return to previous pattern: recurring bloody diarrhea easily settling with oral steroids but dependent on low dose prednisone. She failed screening for the paediatric tofacitinib study, while receiving 10 mg prednisone daily. Recently, due to continued steroid-dependency, colonoscopy is repeated with specific instructions to reduce prednisone below her threshold for control. What would you recommend as the next step in management?

### Discussion points

1. Choosing and sequencing:
   - a. First maintenance therapy following steroid response in a paediatric patient with newly recognized moderately severe or acute severe UC?
   - b. First advanced therapy (biologic or oral small molecule) in a paediatric patient whose symptoms respond well to steroids?
   - c. Advanced therapy following failure of infliximab: Pharmacodynamic failure or secondary loss of response related to anti-drug antibody development?
2. Optimization and monitoring of response to advanced therapies in children with UC
3. Second- and third-line advanced therapy strategies in paediatric UC practice

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SESSION III

# WORKSHOPS – HOT TOPICS FROM BENCH TO POLICY

## 3.4 A Global View on Managing Pregnancy in IBD

*Vivian Huang* and *Cynthia Seow*

### Objective

- Assess the safety profiles of inflammatory bowel disease (IBD) therapies during conception, pregnancy and lactation
- Integrate current evidence-based strategies into personalized management plans for pregnant individuals with IBD

### Abstract

Limited knowledge by individuals and providers on the interplay of IBD on pregnancy, and vice versa, can affect pregnancy rates, medication adherence, disease control and ultimately impact both maternal and infant health. A pervasive fear of harming the fetus is reflected in inconsistent use of medications during pregnancy. Societal beliefs, available resources, and individual interpretation of the literature result in variation in care. With this in mind, the first Global Consensus on the Management of Pregnancy in Inflammatory Bowel Disease was published August 2025 with the goal to provide data-driven and practical guidance to improve the care of women based on the best available research. The group consisted of 39 IBD and content experts and 7 patient advocates from 6 continents, covering 10 categories. These included maternal factors impacting pregnancy; fertility; pre-conception counselling and optimization; management of disease activity during pregnancy; management of pregnancy; IBD medications during pregnancy; IBD medications during lactation; pregnancy adverse events; fetal and neonatal adverse events; and vaccines. This resulted in 34 Grading of Recommendations Assessment, Development and Evaluation (GRADE) recommendations and 35 consensus statements. Key recommendations include the continuation of all biologics and thiopurines throughout pregnancy and lactation, and provision of preconception counselling to improve outcomes. Suggestions include avoidance of small molecules during pregnancy and lactation unless there is no effective alternative therapy to maintain maternal health, to provide low dose aspirin to reduce pre-term preeclampsia in those deemed at higher risk, and cesarean delivery in the setting of active perianal fistula, rectovaginal fistula, or the presence of an ileo-anal pouch anastomosis. Infant recommendations include the provision of inactive and live vaccines on schedule regardless of medication exposure, with the exception of the Bacille Calmette-Guérin (BCG) vaccine, which may be provided after six months of age in infants exposed to biologics in utero.

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SESSION IV

# THE FUTURE OF MONITORING IN IBD

## 4.1 Predicting who will develop IBD: State of the Art 2025

*Sun-Ho Lee*

### Objectives

- Consider biomarkers to predict inflammatory bowel disease (IBD) - potential targets
- Discuss risk stratification of high-risk individuals
- Examine study design to better understand the pre-disease phase

### Abstract

**Background:** The prediction of inflammatory bowel disease (IBD) is advancing, supported by prospective first-degree relative cohorts (e.g., GEM Project cohort) and pre-diagnostic biobanks. Multiple biomarkers—including genetic, microbial, proteomic, glycomic, and antibody signatures—precede Crohn's disease (CD) diagnosis, supporting the existence of a prolonged pre-disease phase.

**Current Challenges:** Despite these discoveries, significant gaps remain. Predictive value is modest given the low prevalence of IBD in the general population, and unlike type 1 diabetes, IBD lacks a consensus staging framework for the pre-disease phase. Rigorous validation of candidate biomarkers across independent cohorts and populations is urgently needed to confirm reproducibility and generalizability.

**Emerging Directions:** Integrative models that combine complementary biomarkers are showing promise for stratifying high-risk individuals. Beyond validation, innovative methods such as time-trajectory analyses may enable mapping of dynamic biomarker shifts and the delineation of molecular "stages" within the pre-disease phase. These approaches, while still exploratory, could help define optimal thresholds and intervention windows for preventive strategies.

**Conclusion:** Advances in biomarker discovery are laying the foundation for risk-based surveillance and disease interception in IBD. Establishing a consensus framework for the pre-disease phase, through multi-cohort validation, longitudinal sampling, and global collaboration, will be essential. Ongoing efforts led by the GEM Project and international initiatives such as the PROMISE Consortium exemplify the collaborative infrastructure required to validate biomarkers, define pre-disease stages, and ultimately translate prediction into prevention.

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SESSION IV

# THE FUTURE OF MONITORING IN IBD

## 4.2 Prevention of IBD: Where We Are and Where We Need to Go

*Ryan C. Ungaro, MD MS*

### Objectives

- Review key considerations in the design of inflammatory bowel disease (IBD) prevention trials
- Overview of potential prevention trial therapy targets and interventions
- Discuss ongoing and planned IBD prevention trials

### Abstract

There is growing recognition that IBD, including Crohn's disease (CD) and ulcerative colitis (UC), is preceded by a prolonged preclinical phase, presenting the opportunity for prevention trials to ultimately usher in an era of disease prevention and early interception. Other immune mediated diseases, including type 1 diabetes and rheumatoid arthritis, have already successfully completed disease prevention trials. IBD prevention trials will present a number of key challenges and considerations including identification and longitudinal monitoring of at-risk individuals based on biomarkers, clear definitions of inclusion and exclusion criteria distinguishing a primary prevention trial to prevent disease in at-risk individuals from a secondary prevention trial in individuals with signs of subclinical disease, accurate risk stratification of participants, use of time-to-event endpoints, risk-benefit balancing in intervention choice, appropriate criteria to trigger a full work-up for IBD, and engagement of at-risk individuals. Early alterations associated with development of IBD, often detectable years before diagnosis, offer a window of opportunity for disease interception and may point to potential modifiable prevention trial targets. Potential interventions include diet and lifestyle but also therapies that may target pathways associated with development of disease. For example, anti-flagellin antibodies, anti-granulocyte-macrophage colony-stimulating factor (GM-CSF) autoantibodies, glycome alterations, and integrin-targeted immune responses have all been linked to development of IBD and are potentially targetable for prevention therapies. Efforts to prevent IBD are in its early days, but a number of ongoing and planned trials and initiatives are rapidly pushing this field forward.

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# ACADEMIC ACTIVITIES ADDRESSING CANMEDS ROLES

| Activity | Roles | | | | | | |
|---|---|---|---|---|---|---|---|
| | Medical Expert | Communicator | Collaborator | Leader | Health Advocate | Scholar | Professional |
| **Workshops**<br>**3.1** 1 Cell Based Therapies in IBD: Past, present and future<br>**3.2** From Pixels to Patients: Optimizing AI in the Management of IBD<br>**3.3** Advanced Sequencing of Biologics and Small Molecules in Pediatrics<br>**3.4** Global View on Managing Pregnancy in IBD | X | X | X | X | X | X | X |
| **Plenary Presentations**<br>**1.1** Molecular Target Discovery in IBD<br>**1.2** New Therapies with a Focus on TL1As<br>**1.3** Dietary Enhancement of Microbial Tryptophan Metabolism Restores AhR Signalling and Reduces Colitis<br>**2.1** Established and emerging indications for GLP-1 medicines<br>**2.2** Obesity and Fat Metabolism in IBD: Clinical and Therapeutic Implications<br>**2.3** Rising Star Award Presentation<br>**4.0** Women in IBD Research and DEI in IBD Award Presentations<br>**4.1** Predicting who will develop IBD: State of the Art 2025<br>**4.2** Prevention of IBD: Where we are and where we need to go | X | | X | X | X | X | X |
| **Ask-the-Expert Panel Q&A Sessions**<br>**Session I:** On the Horizon: New therapies in IBD – Plenary 1.1, 1.2 and 1.3<br>**Session II:** What does fat have to do with it? – Plenary 2.1 and 2.2<br>**Session IV:** The Future of Monitoring in IBD – Plenary 4.1 and 4.2 | X | X | X | X | X | X | X |
| **Program Evaluation** | X | X | X | | X | X | X |

**Medical Expert:** As Medical Experts, physicians integrate all of the CanMEDS Roles, applying medical knowledge, clinical skills, and professional values in their provision of high-quality and safe patient-centred care. Medical Expert is the central physician Role in the CanMEDS Framework and defines the physician's clinical scope of practice.

**Communicator:** As Communicators, physicians form relationships with patients and their families that facilitate the gathering and sharing of essential information for effective health care.

**Collaborator:** As Collaborators, physicians work effectively with other health care professionals to provide safe, high-quality, patient-centred care.

**Leader:** As Leaders, physicians engage with others to contribute to a vision of a high-quality health care system and take responsibility for the delivery of excellent patient care through their activities as clinicians, administrators, scholars, or teachers.

**Health Advocate:** As Health Advocates, physicians contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change.

**Scholar:** As Scholars, physicians demonstrate a lifelong commitment to excellence in practice through continuous learning and by teaching others, evaluating evidence, and contributing to scholarship.

**Professional:** As Professionals, physicians are committed to the health and well-being of individual patients and society through ethical practice, high personal standards of behaviour, accountability to the profession and society, physician-led regulation, and maintenance of personal health.

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To ensure balance, independence, objectivity, and scientific rigour in all educational and scientific activities, the faculty participating in this educational event are expected to disclose to the audience any significant financial interest or other relationships. The intent of this initiative is to provide members of the audience with information on the speaker's and moderator's interests or relationships that could influence the presentation with respect to interpretations, recommendations, and conclusions.

Please note: Unless listed below, faculty disclosure information was not provided.

The following faculty have indicated that they **do not** have a significant financial interest:

| Faculty | Applicable Date |
|---|---|
| Eric Benchimol | 15 Nov 25 |
| Jean-Eric Ghia | 15 Nov 25 |

| Faculty | Applicable Date |
|---|---|
| Maitreyi Raman | 15 Nov 25 |
| Theodore Steiner | 15 Nov 25 |

The following faculty have indicated that they **do** have a significant financial interest:

| Faculty | Applicable Date | Commercial Interest | Nature and resolution of relevant financial relationship | | |
|---|---|---|---|---|---|
| | | | What was received? | For what role? | Planned resolution |
| Michael Byrne | 15 Nov 25 | Dova Health Intelligence | Shareholder | Founder | Program vetted by Co-Chairs, Steering Committee |
| Daniel Drucker | 15 Nov 25 | Amgen, AstraZeneca Inc, Alnylam, Eli Lilly Inc, Insulet, Kallyope, Pfizer Inc. | Honorarium | Consultant | Program vetted by Co-Chairs, Steering Committee |
| | | Amgen, Lilly, Pfizer, Zealand | Grant Support | Investigator | |
| | | Novo Nordisk | Honorarium | Speaker | |
| Anne Griffiths | 15 Nov 25 | AbbVie, Alfasigma, Johnson & Johnson, Lilly | Honorarium | Advisory Board | Program vetted by Co-Chairs, Steering Committee |
| | | AbbVie, Alfasigma, Johnson & Johnson, Pfizer, Takeda | Honorarium | Consultant | |
| | | AbbVie, Johnson & Johnson, Takeda, Pfizer | Honorarium | Speaker | |
| | | AbbVie | Research support | Investigator-initiated Research | |
| Vivian Huang | 15 Nov 25 | Johnson & Johnson, Lilly, Merck, Pfizer, Takeda | Honorarium | Advisory Board Member | Program vetted by Co-Chairs, Steering Committee |
| | | Johnson & Johnson, Lilly | Honorarium | Consultant | |
| | | Abbvie, Amgen, Celltrion, Ferring, Johnson & Johnson, Organon, Pfizer, Takeda | Honorarium | Speaker | |

| Faculty | Applicable Date | Commercial Interest | Nature and resolution of relevant financial relationship | | |
|---|---|---|---|---|---|
| | | | What was received? | For what role? | Planned resolution |
| Vipul Jairath | 15 Nov 25 | AbbVie, Alimentiv, Amgen, Anaptyis Bio, Arena pharmaceuticals, Asahi Kasei Pharma, Asieris, Astra Zeneca, Biomebank, Blackbird Laboratories, Boehringer Ingelheim, Bristol Myers Squibb, Caldera Therapeutics, Calluna, Celltrion, CX4 Discovery, Domain Therapeutics, Eli Lilly, Endpoint Health, Enthera, Ensho, Exeliom Biosciences, Ferring Ventures, Flagship Pioneering, Fresenius Kabi, Galapagos, GlaxoSmithKline, Genentech, Gilead, Granite Bio, Innomar Strategies, JAMP, Janssen, Merck, Metacrine, Mylan, MRM Health, Novartis, Nxera, Organon, OSE Immunotherapeutics, Pandion, Pendopharm, Pfizer, Protagonist, Prometheus Biosciences, Reistone Biopharma, Roche, Roivant, Salvina, Sandoz, Sanofi, Second Genome, Shattuck Labs, Sorriso, Spyre, Synedgen, Takeda, Teva, Thabor Therapeutics, Union Therapeutics, Ventus, Ventyx, Vividion, Xencor, Zealand Pharma | Honorarium | Advisory Board Member, Consultant and/or Speaker | Program vetted by Co-Chairs, Steering Committee |
| | | Boston Scientific, Bristol Myers Squibb, Celltrion, Eli Lilly, Ferring, Fresenius-Kabi, Merck, Organon, Pendopharm | Grant | Education | |
| Sally Lawrence | 15 Nov 25 | Abbvie, Celltrion | Honorarium | Speaker | Program vetted by Co-Chairs, Steering Committee |
| Sun-Ho Lee | 15 Nov 25 | AbbVie, Bristol Myers Squibb, Celltrion | Honorarium | Consultant | Program vetted by Co-Chairs, Steering Committee |
| | | Abbvie, Johnson & Johnson, Takeda | Honorarium | Research Meeting | |
| | | Johnson & Johnson | Honorarium | Speaker | |
| Jeffrey McCurdy | 15 Nov 25 | Abbvie, Celltrion, Ferring, Fresenius Kabi, Johnson & Johnson, Merck, Pfizer, Takeda | Honorarium | Consultant | Program vetted by Co-Chairs, Steering Committee |
| | | Abbvie, Ferring, Johnson & Johnson, Pfizer | Honorarium | Speaker | |

| Faculty | Applicable Date | Commercial Interest | Nature and resolution of relevant financial relationship | | |
|---|---|---|---|---|---|
| | | | What was received? | For what role? | Planned resolution |
| Remo Panaccione | 15 Nov 25 | AbbVie, Alimentiv (formerly Robarts), Amgen, Arena Pharmaceuticals, AstraZeneca, Biogen, Boehringer Ingelheim, Bristol-Myers Squibb, Celgene, Eli Lilly, Ferring, Fresenius Kabi, Genentech, Gilead Sciences, Glaxo-Smith Kline, JAMP Bio, Janssen, Merck, Mylan, Novartis, Oppilan Pharma, Organon, Pandion Pharma, Pfizer, Progenity, Protagonist Therapeutics, Roche, Sandoz, Sanofi, Sublimity Therapeutics, Takeda Pharmaceuticals, Ventyx | Honorarium | Advisory Board Member | Program vetted by Co-Chairs, Steering Committee |
| | | Abbott, AbbVie, Abbivax, Alimentiv,Amgen, AnaptysBio, AstraZeneca, Biogen, Boehringer Ingelheim, Bristol-Myers Squibb, Celgene, Celltrion, Cosmos Pharmaceuticals, Eisai, Elan, Eli Lilly, Ferring, Galapagos, Inviva,Fresenius Kabi, Genentech, Gilead Sciences, Glaxo-Smith Kline, JAMP Bio, Janssen, Merck, Mirador, Novartis, Oppilan Pharma, Odyssey, Organon, Pandion Pharma, Pendopharm, Pfizer, Progenity, Prometheus Biosciences, Protagonist Therapeutics, Roche, Sandoz, Sanofi, Satisfai Health, Shire, Sublimity Therapeutics, Spyre Therapeutics, Takeda Pharmaceuticals, Teva,, Tillots, Trellus, Union Biopharma, Viatris, Ventyx, UCB | Consulting Fees | Consultant | |
| | | AbbVie, Amgen, Arena Pharmaceuticals, Bristol-Myers Squibb, Celgene, Eli Lilly, Ferring, Fresenius Kabi, Gilead Sciences, Janssen, Merck, Organon, Pfizer, Roche, Sandoz, Shire, Takeda Pharmaceuticals | Speaker Fees | Speaker | |

| Faculty | Applicable Date | Commercial Interest | Nature and resolution of relevant financial relationship | | |
|---|---|---|---|---|---|
| | | | What was received? | For what role? | Planned resolution |
| Peter Rossos | 15 Nov 25 | A.I. VALI Inc. | | Clinical Advisory Board Member/ Consultant | Program vetted by Co-Chairs, Steering Committee |
| | | Epic Healthcare | | Client CMIO | |
| | | Microsoft Healthcare | | Client CMIO, shareholder | |
| Cynthia Seow | 15 Nov 25 | Ferring | Honorarium | Advisory Board Member | Program vetted by Co-Chairs, Steering Committee |
| | | Abbvie, Celltrion, Eli Lilly, Johnson & Johnson, GSK, Organon, Pharmascience, Pfizer, Takeda | Honorarium | Advisory Board Member/Speaker | |
| Joelle St. Pierre | 15 Nov 25 | Abbvie, Lilly, Pfizer | Honorarium | Advisory Board Member/Speakers Bureau | Program vetted by Co-Chairs, Steering Committee |
| | | Takeda | Honorarium | Speaker | |
| Hillary Steinhart | 15 Nov 25 | Abbvie, Amgen, Celltrion, Lilly, Merck, Johnson & Johnson, Pfizer, Sandoz, Sanofi, Takeda | Honorarium | Advisory Board Member | Program vetted by Co-Chairs, Steering Committee |
| | | NKS Health (Greenshield Pharmacy) | Consultant fee | Consultant | |
| | | Abbvie, Celgene (BMS), Genentech/Roche, Gilead, Johnson & Johnson, Morphic Therapeutics, Takeda | Grant | Investigator | |
| | | Abbvie, Pfizer, Takeda | Honorarium | Speaker | |
| Ryan Ungaro | 15 Nov 25 | Abbvie, Celltrion, Genentech, Johnson & Johnson, Lilly, Pfizer, Takeda | Consultant Fee | Consultant | Program vetted by Co-Chairs, Steering Committee |
| | | Bristol Myers Squibb | Consultant Fee/ Research Grant | Consultant | |
| | | Abbvie, Takeda | Consultant Fee | Speaker | |

The following faculty have indicated that the content of their presentation **will** include discussion of investigative use or off-label application of medicines, medical devices, or procedures:

| Faculty | Applicable Date |
|---|---|
| Daniel Drucker | 15 Nov 25 |
| Anne Griffiths | 15 Nov 25 |
| Vivian Huang | 15 Nov 25 |
| Jeffrey McCurdy | 15 Nov 25 |
| Remo Panaccione | 15 Nov 25 |

| Faculty | Applicable Date |
|---|---|
| Cynthia Seow | 15 Nov 25 |
| Joelle St. Pierre | 15 Nov 25 |
| Theodore Steiner | 15 Nov 25 |
| Ryan Ungaro | 15 Nov 25 |

The following faculty have indicated that the content of their presentation **will not** include discussion of investigative use or off-label application of medicines, medical devices, or procedures:

| Faculty | Applicable Date |
|---|---|
| Eric Benchimol | 15 Nov 25 |
| Michael Byrne | 15 Nov 25 |
| Jean-Eric Ghia | 15 Nov 25 |
| Vipul Jairath | 15 Nov 25 |
| Sally Lawrence | 15 Nov 25 |

| Faculty | Applicable Date |
|---|---|
| Sun-Ho Lee | 15 Nov 25 |
| Peter Rossos | 15 Nov 25 |
| Maitreyi Raman | 15 Nov 25 |
| Hillary Steinhart | 15 Nov 25 |
| Eytan Wine | 15 Nov 25 |

# NOTES

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