crohn's colitis

Name of Clinical Care Pathway

Loss of Response or Partial Response for Patients on Advanced Therapy

Objective

Achieve and maintain remission with advanced therapy

Patient Population

Patients diagnosed with inflammatory bowel disease (IBD) on advanced therapy

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PACE Inflammatory Bowel Disease Clinical Care Pathways

Highlight Box

New IBD therapies are continuously becoming available. However, the approach to the loss of response or partial response for patients on advanced therapy remains inconsistent. The main objective is to achieve and maintain remission by dose optimization, reassessment of response to medications, and switching therapies as required.

These clinical decision support tools were developed by Canadian experts in IBD, based on their interpretation of current evidence and considerations specific to Canadian healthcare. International guidelines from Europe and the United States are available. However, these may reflect regional factors not directly applicable in Canada.

Introduction

This CCP recommends a common approach to any IBD patient who is on advanced therapy and who is exhibiting symptoms of loss of response or partial response. While initially developed for guidance regarding drug level monitoring and dose optimization for patients losing response to anti-TNF therapies, this CCP also provides suggestions for how to approach patients who are on newer biologics and small molecules. Where applicable, the guidance reflects published data and recommendations established by the global IBD community.

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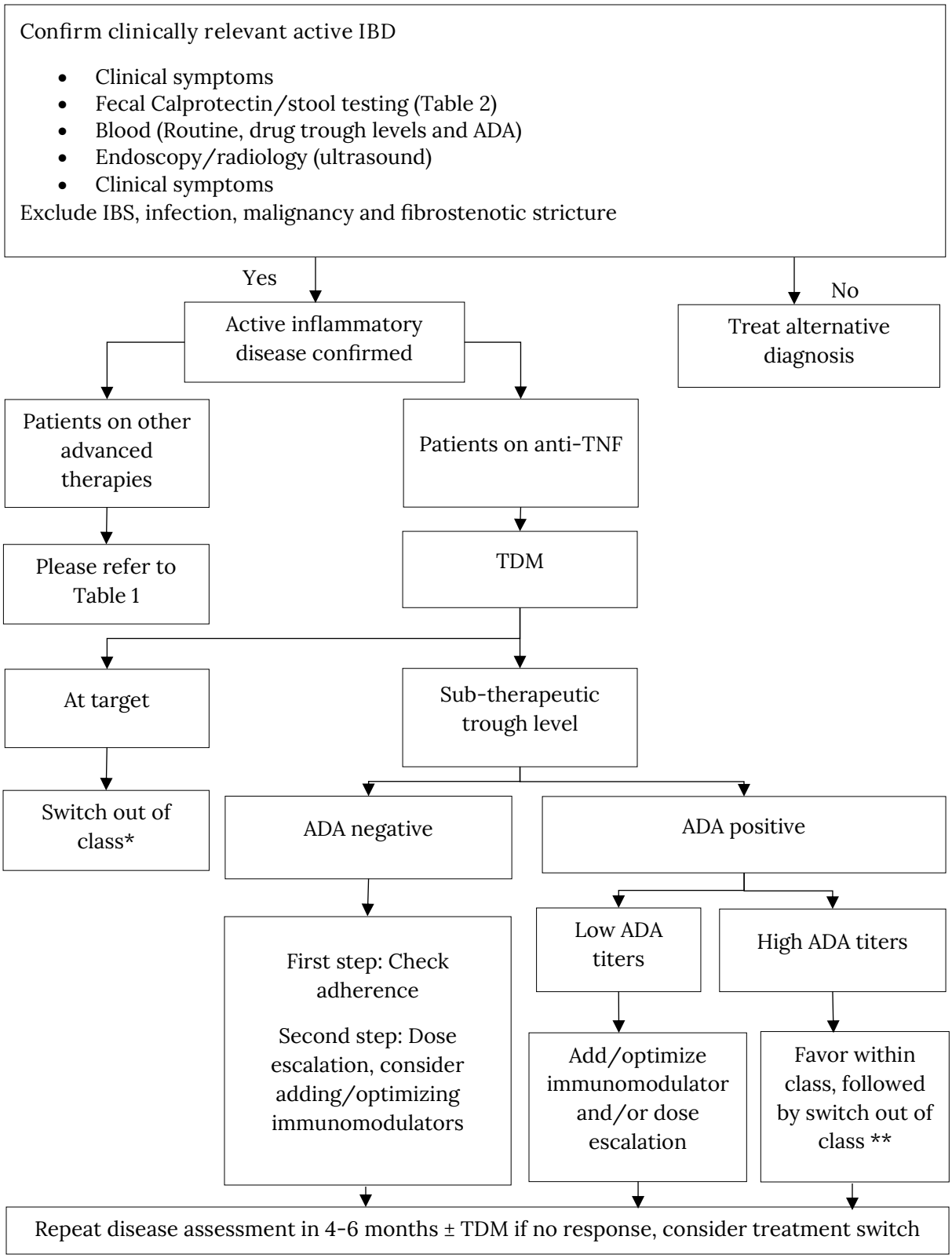

*Consider adding an immunomodulator if switching to another advanced therapy agent to prevent ADA formation.
**Add an immunomodulator if switching to another advanced therapy agent to prevent ADA formation.
Abbreviations: ADA: Anti-drug antibody TDM: Therapeutic drug monitoring

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Table 1: Approach to managing other advanced therapies

Drug	Dose optimization	Time to reassess
Vedolizumab	Escalate to q4w dosing*	At the 3rd q4w dosing
Ustekinumab	Escalate to q4w dosing OR request IV reloading dose	At the 3rd q4w dosing OR 3 to 4 months after IV reloading dose
Tofacitinib	10mg po BID	After 8 weeks
Upadacitinib	30 mg/daily	After 8-12 weeks
Risankizumab	N/A***	12-24 weeks
Ozanimod**	N/A***	
Etrasimod	N/A***	

*Optimization has limited benefits based on evidence.
**If there is no response or loss of response after 10 weeks, switch out of the class. Note that its availability may be limited, which could impact access for patients.
***There is insufficient observational data to make a recommendation
Always discuss the potential risks associated with changing advanced therapies with the patient, including the risk of a lesser response and potential side effects.
Abbreviations: q4w – every 4 weeks N/A – not applicable IV – intravenous PO – by mouth BID – twice daily

Table 2: Fecal Calprotectin results and clinical approach

Fecal Calprotectin (µg/g)	Interpretation	Suggested management
<50-100	Quiescent disease likely	Continue current therapy
>100-250	Inflammation possible	Investigate (e.g., colonoscopy) to confirm inflammation
>250	Inflammation likely	Optimize/switch therapy

Table 3: Approach to managing thiopurine therapy

Etiology of thiopurine Failure	6-TGN level (pmol/10^8 erythrocytes)	6-MMP level (pmol/10^8 erythrocytes)	6-MMP/6-TGN ratio	Proposed treatment strategy
Inadequate dose	Low (<230)	Low (<5700)	Normal (4-24)	Increase dose
Excessive TPMT	Low (<230)	High (>5700)	High (>24)	TPMT modulation by the addition of allopurinol or 5-ASA, dose splitting, switch to an alternative agent, such as MTX
Lack of adherence	Low (<230)	Low (<5700)	Normal (4-24)	Verify adherence
True drug ineffectiveness	Normal (230-400)	Normal (<5700)	Normal (4-24)	Alternative therapy

5-ASA: Mesalamine 6-MMP-Methyl mercaptopurine 6-TGN: 6-Thioguanine nucleotides
MTX: Methotrexate TPMT: Thiopurine methyltransferase

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