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Released: 12/31/2025
Valid until: 12/31/2026
Time needed to complete: 1h 00m

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Switching Strategies: Switch or Stay—What's Your Call?

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Ms. Hodnick:
Hello. I'm Brooke Hodnick, and you're listening to CE on ReachMD. Dr. David Rubin is here with me today.

We've all seen patients who just don't hit remission on their first biologic. The big question is, do you switch, stay, or stack? Let's unpack what guidelines say about the next steps when treatment response falls short.

Dr. Rubin:
Hi, Brooke. That's a really important point. So it's unfortunately true that many patients don't respond to their first therapy. And figuring out whether this is truly a primary nonresponse or whether it's a delayed response, where continuing that treatment a bit longer will get us where we need to go, or whether there was some response but now they've just lost response, is a clinical challenge.

You want to make sure, though, that you're assessing the patient both symptomatically and more objectively so that you can understand. Sometimes people have improvement in their inflammatory markers, but they're not quite feeling better yet. And other times, people will say, "I'm feeling so much better," but the inflammatory marker doesn't show it yet. In those situations, I keep going—both of those scenarios. But when someone says, "I'm not feeling any better," and you finish the whole loading phase of whatever drug you chose, it's really time to consider, is there an infection? Is this actually getting into their body the way we hoped it would? And should we move on? And in general, it's more efficient to change class of therapy and just move to something completely different.

And I think we have enough treatments now in the IBD space to do that. And I think that this is something people should become comfortable with, as long as you know you're not overtreating when, in fact, it's just scar tissue or an irritable bowel. And that would be the case if the patient feels no better and you don't have reliable inflammatory markers to know what's going on. And for example, they have fibrostenotic small bowel Crohn's disease, where you're trying to treat a stricture, and that's when someone should probably go to a surgical consultation.

Ms. Hodnick:
Thank you, Dr. Rubin. So when a patient isn't responding to their first advanced therapy, how do you decide if it's truly a treatment failure versus an underdosing or a delayed responder?

Dr. Rubin:

It's a very important question, and I think that you have to be very methodical about this. When I start someone on therapy, I schedule them in advance for a 6-week follow-up. Now, that might be a clinic visit, it might be a phone call, it might be an intestinal ultrasound, but it also is accompanied by some labs. If they make CRP—and remember, some people don't—if they have an elevated CRP at baseline, it's an easy thing to do is to repeat that at 6 weeks and make sure it's trending in the right direction. If you have an elevated calprotectin at baseline, that's also a reasonable thing to repeat, although patients don't love handling their stool, of course. But you want something objective. And then you decide, do I keep going or should I be moving along?

Most drugs, though, are going to achieve their goals within the time period of induction. That means 6 to 12 weeks, and you're going to expect that people should be feeling well. One of our mistakes is we go too long with treatments that are not accomplishing our goals, in part because it takes so much energy to get them on therapy in the first place. But you really should be thinking carefully and move along when someone is not improved by the end of that induction period.

Ms. Hodnick:
Great. Thank you. I love the tip about being methodical in our approach and follow-up.

Once you've ruled out other factors, when do you decide it's time to switch rather than push the dose?

Dr. Rubin:
Well, pushing the dose is a very reasonable thing to do if you can do it. The challenge is that insurance companies are making that a bit difficult for us now. So for example, our anti-TNF drugs, the ones we've known the most about for the longest, about 50% of people will need dose adjustment. So it's completely reasonable to expect that might be the case. And it's only the anti-TNFs where checking a drug level is available and the data would support doing so.

In the other drugs that we have, drug levels, even if they're asked for by an insurance company, are not supported by the data or our guidelines. So you have to think, is this person responding but not quite there where I want push more of this drug and get more into them? Can I reduce the frequency? Can I increase the dose? We have the option of doing that with a couple of our IL-23 inhibitors and with our JAK inhibitors, where they actually have 2 doses approved by the FDA. So you have the option of increasing the dose in some people.

When you can't do it, then it's time to do something else or add a second drug. Adding a second drug can be complicated, because, again, who's going to pay for it? How do you get it? And how do you know that you shouldn't just switch? In general, the simple answer is, switching class of therapy is the right thing to do, and that may include sending them for a surgical consultation.

Ms. Hodnick:
Great information. Thank you.

Well, that's our time. I hope you found this information useful, and thank you for tuning in.

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