International Symposium | All

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International Symposium State-of-the-Art Management of IBD: Integrating Medical and Surgical Strategies in Clinical Practice

Moderator: Katsuyoshi Matsuoka (Division of Gastroenterology and Hepatology, Department of Inernal Medicine, Toho University Sakura Medical Center, Japan), Keisuke Hata (Toyoshima Endoscopy Clinic, Japan. Faculty of Medicine, The University of Tokyo, Japan)

[IS-2] Current Medical Management of IBD in the Era of Advanced Therapies

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The therapeutic landscape for inflammatory bowel disease (IBD) has transformed dramatically, expanding from three conventional drug classes to over 15 targeted pathways within a single generation. Network meta-analyses and head-to-head trials now guide agent selection with greater precision: upadacitinib and IL-23p19 inhibitors lead for endoscopic remission in UC, while risankizumab anchors maintenance therapy in CD. Current AGA/ACG guidelines consistently prioritize early advanced therapy over step-up approaches, with treatment decisions further refined by the IOIBD disease velocity framework — distinguishing rapid progressors who require immediate top-down biologics from indolent cases suitable for conservative management. Monitoring follows the STRIDE-II treat-to-target ladder, progressing from early clinical and biomarker response toward histologic and transmural healing as the ultimate goal.

The impact of advanced therapies on surgical outcomes has been substantial. UC colectomy rates have fallen approximately 55% in the biologic era (from 35–45% to 15–20% at 10 years), and CD resection rates have declined roughly 35% (from 70–80% to 40–50%). Yet surgery has not been eliminated — its indications have shifted. Multi-biologic failure now accounts for ~60% of UC colectomies, while fibrostenotic strictures and penetrating sepsis increasingly drive CD resections.

Three high-stakes clinical scenarios demand particular attention. Acute severe UC (ASUC) requires structured inpatient protocols: IV corticosteroids, Day 3 failure prediction, and timely rescue with infliximab or tofacitinib — with colectomy decision not delayed beyond 7 days. Perianal CD management relies on a combined medical-surgical strategy: abscess drainage and seton placement before advanced immunosuppression, infliximab-based induction with therapeutic drug monitoring, and emerging regenerative options such as darvadstrocel for refractory fistulas. For dysplasia and colorectal cancer surveillance, high-definition chromoendoscopy with risk-stratified colonoscopy intervals beginning 8 years after disease onset remains mandatory; tight mucosal inflammation control is the most effective cancer risk modifier.

Across all these domains, multidisciplinary team (MDT) co-management — integrating gastroenterology, colorectal surgery, and allied specialists — remains indispensable. Even in the era of advanced biologics, optimal IBD care demands coordinated decision-making that no single specialty can deliver alone.

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