## 2026年11月20日(金)

International Symposium | 全診療科

14:00 ~ 15:30 | 第5会場（1F 会議室102）

### 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-1] Evolution of Treatment Strategies in IBD: Past, Present, and Future

*Stefan Wolfgang Schreiber (1. Department Medicine I, University Hospital Schleswig-Holstein, Kiel University, Germany)

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

*Shu-Chen Wei (1. Department of Internal Medicine, National Taiwan University Hospital, Taiwan)

[IS-3] Management of Crohn's Perianal Fistula: Indications, Timing, and Outcomes

*Yong Sik Yun (1. University of Ulsan College of Medicine & Asan Medical Center, Korea)

[IS-4] Challenges and Future Perspectives of Surgery for Ulcerative Colitis

*Koji Okabayashi[1,2], Kohei Shigeta[2], Kenichi Okada[1], Kazuo Koyanagi[1], Seiichiro Yamamoto[1] (1. Department of Gastrointestinal Surgery, Tokai University School of Medicine, Japan, 2. Department of Surgery, Keio University School of Medicine, Japan)

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## [IS-1] Evolution of Treatment Strategies in IBD: Past, Present, and Future

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IBD therapy has evolved from broad immunosuppression to an expanding repertoire of targeted drug classes. Corticosteroids, azathioprine and anti-TNF antibodies established the first effective therapeutic era: steroids induced remission, thiopurines maintained disease control in selected patients, and anti-TNF therapy changed the natural history of Crohn’s disease and ulcerative colitis by reducing inflammation, complications and the need for surgery.
The current era is defined by pathway-selective intervention. α4β7-integrin blockade provides gut-selective anti-trafficking therapy. IL-12/23 and, more specifically, IL-23 p19 inhibition have become central cytokine-directed strategies, with ongoing refinement of anti-IL-23 positioning, sequencing and use in early disease. Oral targeted therapies have added speed and flexibility: JAK inhibitors act broadly and rapidly on cytokine signalling, whereas S1P receptor modulators reduce lymphocyte egress.
The next wave will add new mechanisms rather than only more agents within existing classes. TL1A blockade may target inflammation and fibrosis-relevant pathways. Obefazimod, an oral small-molecule upregulator of miR-124, introduces an RNA-modulating therapeutic principle. Further approaches include barrier-protective therapies, epithelial protective receptor pathways, immunometabolic interventions such as the tryptophan–NAD axis, cellular therapies, organoid-based repair and rational biologic combinations, including heterofunctional antibodies.
Precision medicine should guide these choices: who receives which therapy, who needs early switching, and who should receive combination therapy. The future strategy is mechanism-based selection, early reassessment and rational escalation before irreversible damage occurs.
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## [IS-2] Current Medical Management of IBD in the Era of Advanced Therapies

*Shu-Chen Wei (1. Department of Internal Medicine, National Taiwan University Hospital, Taiwan)

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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## [IS-3] Management of Crohn's Perianal Fistula: Indications, Timing, and Outcomes

*Yong Sik Yun (1. University of Ulsan College of Medicine & Asan Medical Center, Korea)

Crohn's perianal fistula (CPF) remains one of the most challenging manifestations of Crohn's disease, significantly impairing quality of life and frequently requiring multidisciplinary management. Despite substantial advances in biologic therapies, surgical intervention continues to play a pivotal role in achieving durable fistula healing and controlling sepsis.

The management of CPF should be individualized according to fistula anatomy, disease activity, and the presence of rectal inflammation. Initial treatment focuses on adequate drainage and sepsis control, most commonly through seton placement. While long-term fistula closure rates with seton drainage alone remain limited, it provides an essential bridge to subsequent definitive treatment and optimization of medical therapy.

Advances in biologic agents, particularly anti-TNF therapy, have improved outcomes when combined with appropriate surgical management. However, a considerable proportion of patients continue to experience persistent or recurrent disease. Therefore, sphincter-preserving strategies have gained increasing attention. In selected patients with simple fistulas and controlled luminal disease, fistulotomy may achieve excellent long-term healing rates. For complex fistulas, regenerative approaches such as mesenchymal stem cell therapy have demonstrated promising efficacy and safety. At our institution, long-term fistula closure rates following stem cell therapy exceeded 80% in carefully selected patients. More recently, polynucleotide (PDRN) injection therapy has been utilized as an adjunctive treatment, showing accelerated healing and improved closure rates compared with conventional management.

Based on contemporary evidence and our institutional experience, successful CPF management requires appropriate patient selection, optimal timing of surgical intervention, meticulous control of perianal sepsis, and close integration with medical therapy. Future treatment strategies are expected to incorporate regenerative medicine and personalized multidisciplinary approaches to further improve long-term outcomes and quality of life in patients with Crohn's disease.

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## [IS-4] Challenges and Future Perspectives of Surgery for Ulcerative Colitis

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Restorative proctocolectomy with ileal pouch-anal anastomosis (RPC-IPAA) is the standard surgical treatment for refractory ulcerative colitis (UC). While minimally invasive surgery (MIS) improved outcomes, challenges remain regarding abdominal wall trauma and stoma management. Previously, we evaluated various MIS approaches, including laparoscopy, hand-assisted laparoscopic surgery (HALS), and reduced port surgery with transanal total mesorectal excision (RPS+taTME), showing that tailored selection minimizes complications. Recently, we developed a unique technique: fully intracorporeal J-pouch construction with a "ghost ileostomy." The specimen is extracted transanally, and the pouch is formed completely intracorporeally to minimize additional incisions. To ensure length and perfusion, we utilize transanal transillumination of the mesentery and indocyanine green (ICG) fluorescence angiography for selective vascular division. The ghost ileostomy serves as an effective safety net, allowing us to safely omit a routine defunctioning stoma. However, achieving the standardization of this highly demanding intracorporeal approach remains the ultimate challenge, as its reproducibility currently depends on expert skills. As a future perspective, integrating robot-assisted surgery may overcome these ergonomic limitations, as its multi-joint articulation and stable instrumentation can facilitate deep pelvic dissection and intracorporeal suturing. Overcoming these technical barriers to standardize this sophisticated procedure is essential for its widespread adoption. In conclusion, this presentation discusses future perspectives in UC surgery, focusing on pathways toward standardizing next-generation intracorporeal innovations.

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