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Building Bridges in IBD
Symposium 216
Brussels (Belgium), September 13–14, 2019

Symposium 216
Building Bridges in IBD

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“Building bridges in inflammatory bowel disease”

Great advances in our understanding of inflammatory bowel disease (IBD) have been made in recent years, including breakthroughs in diagnosis and treatment of the disease. However, this progress should not obscure the fact that many unmet needs still exist for both conditions. Experts now anticipate that future advances will be the result of better and more rapid translation of new research findings into clinical practice, as well as the result of closer collaboration between all specialty fields involved in the treatment of Crohn’s disease and ulcerative colitis. “We need to build bridges in inflammatory bowel disease“: this was the fitting conclusion drawn at Symposium 216 convened by the Falk Foundation e.V. in Brussels.

In spite of numerous advances, the management of ulcerative colitis and Crohn’s disease frequently remains challenging. The goal of Symposium 216 was therefore to identify the unmet needs in the areas described above and to discuss possible solutions. The importance of collaboration between different specialties with the goal of improving patient care was reflected in the program at the Brussels meeting, in which several “tandem lectures” were held by two speakers simultaneously: one gastroenterologist together with another expert from a different field, for example a surgeon, rheumatologist, dermatologist, or gynecologist.

Scientific organizers
Prof. S. Vermeire, Prof. I. Dotan, Prof. M. Ferrante, Prof. E. Louis, Prof. D. Rachmilewitz

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Inflammatory bowel disease: many advances, but unsolved questions remain

There is no one-size-fits-all treatment strategy for Crohn’s disease or ulcerative colitis. Instead, the highest priority is to select the best treatment option possible for each individual patient. Many questions remain fully or partly unanswered, including which medication is best for a specific patient at which time point, when and how medications should be combined, how long medications should be administered, and when treatment escalation or a step-down is justified. How to address these questions in clinical practice was the topic of many exciting discussions at Symposium 216 convened by the Falk Foundation e.V. in Brussels.

According to B. Siegmund, Berlin (Germany), many questions remain unsolved particularly on the topic of mild forms of inflammatory bowel disease (IBD). This is especially the case for mild to moderate Crohn’s disease. About two-thirds of Crohn’s patients have a mild or moderate form of the disease that can often be treated successfully with budesonide. Many of these patients never even need to be treated with steroids. “However,” as Siegmund explained in Brussels, “it can sometimes be difficult to identify such patients.”

Predicting the course of Crohn’s disease

Several predictive factors can be used to reach a rough prognosis of whether a patient’s disease will take a mild form or a more severe form with a high risk of complications. B. Siegmund listed several risk factors for complicated disease, including onset at a relatively young age, very high levels of C-reactive protein (CRP), and early development of complications such as fistulas. On the other hand, patients who are older when diagnosed with Crohn’s and who have no special risk factors have a greater probability of sustained mild disease.

There is currently no precise definition of mild to moderate disease or severe disease. Nonetheless, the diagnosis of “mild Crohn’s disease of the terminal ileum” clearly does not allow for the presence of stenoses, strictures, fistulas, or ulcers. In these patients, the condition is often diagnosed as an incidental finding, for example during a colonoscopy for the early detection of colorectal cancer.

Fig. 1: Approximately 50% of patients with mild Crohn’s disease achieve remission with budesonide at a dosage of 9 mg daily (source: Greenberg GR, et al. N Engl J Med. 1994;331:836–41).
Mild to moderate Crohn’s disease: use the right tool for the job

According to B. Siegmund, there is an unfortunate lack of meaningful studies on the best therapeutic approach to mild ileal Crohn’s disease. In particular, there is a need for evidence to aid in the decision of whether corticosteroid or even biological therapy should be prescribed. Despite this uncertainty, the ECCO guidelines may provide some guidance. These guidelines favor budesonide treatment for patients with mild Crohn’s disease that is restricted to the ileocecal region. According to several studies, approximately two-thirds of patients with mild Crohn’s who were treated with 9 mg budesonide per day achieved remission within 8 weeks (fig. 1). A clear improvement in patients’ quality of life was reported in addition to the other successful outcomes (fig. 2).

As B. Siegmund explained, this combination of robust effectiveness and favorable tolerability of budesonide observed in patients with mild Crohn’s disease has been confirmed by the results of a Cochrane analysis.

Nevertheless, in her opinion this positive data on budesonide should not overshadow the therapeutic importance of mesalazine, which can also induce remission in patients with mild disease. Unfortunately, there is currently a lack of studies that might help physicians better assess the role of mesalazine for inducing and maintaining remission in Crohn’s disease.

Furthermore, it remains unclear whether mild ileal Crohn’s disease represents a unique phenotype of Crohn’s disease with its own immunological characteristics. “In any case,” explained B. Siegmund “the high rates of clinical remission with budesonide and mesalazine argue against the use of biologics for this disease phenotype.” In her view, biologics are inappropriately potent for mild ileal Crohn’s disease, and she advised using the right tool for the job.

Exhaust all conventional treatment options first

In light of the large number of biologic agents that have been approved in recent years for the treatment of IBD, P.L. Lakatos, Montreal (Canada), warned against losing sight of the importance of conventional drugs. For example, mild to moderate ulcerative colitis should initially be treated with mesalazine, while moderate to severe ulcerative colitis is primarily treated with steroids.

If treatment fails, confirm patient adherence first

Should these strategies not yield the desired outcome, patient adherence should be probed in detail before escalating treatment. As P.L. Lakatos explained, insufficient compliance with treatment can pave the way to recurrence (fig. 3).
Furthermore, he explained, it may be advisable to switch to an alternative steroid with colon-specific delivery before prescribing a biologic agent, as this method of delivery has been shown to induce remission when used as second-line treatment. According to P.L. Lakatos, immunosuppressants such as azathioprine may also be used for maintenance therapy.

In his opinion, biologics are only indicated once the conventional treatment options have failed to deliver the desired treatment outcome. “However,” he emphasized, “the landscape of the available biologics is highly complex.” Multiple drugs are available for treatment escalation, from anti-TNF regimens to vedolizumab to tofacitinib. As P.L. Lakatos explained, both the biologics and tofacitinib are highly-effective drugs that have proven to be effective at both inducing and maintaining remission.

Choosing the proper agent and the proper time point must take the therapeutic spectrum and the potential adverse effects of each agent into account on a patient-by-patient basis. P.L. Lakatos also stressed that patient preferences must always be considered in addition to the benefit-risk profile of each strategy, and that treatment decisions must always be discussed with the patient.

Modify treatment accordingly as the disease develops

As K. Gecse, Amsterdam (Netherlands), explained, such treatment decisions should not be permanently set in stone, since these disorders can take quite variable courses that require modification of the treatment strategy (fig. 4).

Treatment modification can take two forms: treatment should be escalated for patients with progressive disease, whereas de-escalation should also be considered for patients who experience deep, long-term remission. In the latter scenario, patients must be closely monitored in order to detect any potential recurrence and re-commence treatment in a timely manner. Resuming the prior treatment strategy is successful in about 70% of such cases.

![Curves showing the natural clinical course of ulcerative colitis (UC) and Crohn’s disease (CD)](source: Solberg JC, et al. Clin Gastroenterol Hepatol. 2007;5:1430–8.)

<table>
<thead>
<tr>
<th>Curve 1</th>
<th>Curve 2</th>
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<tr>
<td>CD: 43%</td>
<td>CD: 3%</td>
<td>CD: 19%</td>
<td>CD: 32%</td>
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<td>UC: 59%</td>
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**Curve 1:** Decrease in the severity of symptoms over follow-up

**Curve 2:** Increase in the severity of symptoms over follow-up

**Curve 3:** Chronic, continuous symptoms over follow-up

**Curve 4:** Chronic, relapsing symptoms over follow-up

Fig. 4: Ulcerative colitis (UC) and Crohn’s disease (CD) both can have variable courses (source: Solberg JC, et al. Clin Gastroenterol Hepatol. 2007;5:1430–8.).
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IBD Patients - In the Center of Care
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B. Siegmund, Berlin (Germany)
Scientific Co-Organization
J. Burisch, Frederikssund (Denmark)
J. Halfvarson, Örebro (Sweden)
“Interdisciplinary cooperation is crucial at all levels”

Successful management of inflammatory bowel disease often requires addressing issues outside of the field of gastroenterology. Patients frequently develop extraintestinal manifestations that require the expertise of a rheumatologist or even a dermatologist. Moreover, gastroenterologists themselves need to work closely with surgeons when it comes to managing complications. Many IBD patients also have medical concerns above and beyond the disease itself that require the expertise of yet other specialties such as gynecology. This call for wide-ranging interdisciplinary cooperation was put into direct practice at the symposium in Brussels in the form of several tandem lectures.

The gastro-surgical tandem

It is not unusual for IBD patients to find themselves in a situation at some point in their disease where physicians must decide whether conventional treatment is sufficient, or whether a surgical approach is indicated. In these situations, the gastroenterologist M. Ferrante, Leuven (Belgium), and the surgeon A. D’Hoore, Leuven (Belgium), consider close collaboration between their two fields to be indispensable for proper patient care. As M. Ferrante pointed out, the ECCO guidelines also recommend multidisciplinary case conferences. These recommendations reflect the fact that many patients will develop progressive disease with an increasing risk of complications. Case conferences should include a discussion of each patient’s individual situation, and should work out an optimal treatment strategy. This approach is particularly important for patients with complicated forms of Crohn’s disease. It is often difficult to determine whether a surgical intervention is necessary and if so, what the optimal time point is. As M. Ferrante explained, “we are lacking better predictors of long-term prognosis.” Even after a medical approach using an anti-TNF strategy, 37% of patients still require surgery within only four years. Conversely, 26% of patients undergoing upfront surgery require anti-TNF therapy within four years.

The question of whether to conduct surgery in patients with stricturing disease is of particular relevance. Patients with a low risk of progression can continue their medical and endoscopic treatment. For patients with a moderate risk of extensive stricturing, conventional therapy should be optimized and patients should be re-evaluated every 6 to 12 months. Surgery should always be an option for patients at high risk, and physicians must determine whether surgery is indicated and whether the risks of surgery are acceptable.

The gastro-rheumatology tandem

According to the lecture by the gastroenterologist G.J. Mantzaris, Athens (Greece), half of all IBD patients develop extraintestinal manifestations, with the primary manifestation being musculoskeletal involvement in 15-39% of IBD patients. Other common manifestations include peripheral or axial spondyloarthritis, arthralgias, enthesitis, and/or dactylitis, as the rheumatologist D. Vassilopoulos,
In brief

Rheumatologic manifestations typically represent an additional major impact on patients’ quality of life, and can also lead to disabilities and restricted mobility. Hence, early diagnosis and treatment are of critical importance, especially since most biologics alleviate both gastroenterological symptoms as well as rheumatologic issues.

It is important to note in this context that arthralgia can also be induced by anti-TNF therapy, as well as by the drugs vedolizumab and ustekinumab. The symptoms of arthralgia usually subside when the medication is discontinued or when patients are switched to another biologic, although steroid therapy may help bridge this period.

The gastro-gynecology tandem

IBD typically has an onset relatively early in life, which often has gynecological implications. As the gastroenterologist A. Shitrit, Jerusalem (Israel) and the gynecologist S. Grisaru-Granovsky, Jerusalem (Israel), reported, women with IBD are typically still in their reproductive years and often desire (more) children. A. Shitrit pointed out that “close cooperation between a patient’s gastroenterologist and gynecologist is needed before, during, and after pregnancy.”

In her opinion, most women with IBD can carry out a pregnancy with no issues; however, an increased incidence of premature deliveries and even miscarriages must be taken into account. “Nonetheless, most women will experience a completely normal pregnancy and delivery” explained S. Grisaru-Granovsky. It is important that the time point of pregnancy be planned well in advance, and conception should preferably occur during a period of complete IBD remission. When these criteria are met, the relapse rate of pregnant women is the same as that of non-pregnant women. In contrast, when conception occurs during a phase of disease activity, it must be assumed that this high level of disease activity will continue or even increase during pregnancy.

The topic of IBD medications during pregnancy remains thorny. According to both speakers, the aminosalicylates appear to be safe and are not associated with greater risks for the mother or the child. Metronidazole may also potentially be a safe option, yet should not be prescribed during the first trimester. This advice also applies to corticosteroids and thiopurines, both of which may continue to be administered during pregnancy in order to induce or maintain remission. Due to the limited data, it is not yet possible to draw any conclusions on most biologics.

The gastro-dermatology tandem

The gastroenterologist H. Yanai, Petah Tikva (Israel) and the dermatologist A. van Laethem, Leuven (Belgium), explained how dermatological disorders are often associated with IBD. Such disorders may be triggered by malabsorption secondary to restricted nutrition, but they may also represent a drug reaction or an extraintestinal manifestation.

H. Yanai listed the following conditions as examples of cutaneous disorders that may occur in patients with IBD:

- aphthous stomatitis,
- periodontitis,
- pyoderma gangrenosum,
- erythema nodosum,
- vasculitis,
- hidradenitis suppurativa, and
- psoriasis.

A potential link to drug therapy should especially be taken into consideration for patients with alopecia.
Close collaboration is also needed with nutritionists

Since the pathogenesis of IBD clearly involves not only genetic predisposition but also environmental factors – with diet playing a central role – J.D. Lewis, Philadelphia (USA), and T. Pfeffer Gik, Petah Tikva (Israel), reminded the audience of the obvious need for close collaboration between gastroenterologists and nutritionists. As the two speakers pointed out, the importance of nutrition is underscored by the fact that many patients still do not respond well to conventional medications. As T. Pfeffer Gik explained, “there are clearly factors present in patients’ guts that are triggering inflammation.” According to J.D. Lewis, cooperation between gastroenterologists and nutritionists is also necessary to help answer patients’ questions about what foods they should be eating, especially when specific diets such as elimination diets are planned. The appropriate experts should also be consulted when patients with a stoma develop issues, according to S. Gabe, London (Great Britain).

A high level of adherence is critical for all nutrition-related issues, as it is for IBD therapy in general, explained P. Munkholm, Copenhagen (Denmark). Based on preliminary data, treatment compliance can be improved using e-health technologies, especially home monitoring apps. M.J. Pierik, Maastricht (Netherlands), believes that telemedicine may also represent an important tool for building bridges between patients and their health care providers. This technology can additionally be used to build regional patient-support networks, and it also plays an important role in health research.

Do not underestimate psychosocial aspects

In addition to medical treatment, patients with Crohn’s disease or ulcerative colitis also frequently require psychosocial support – an aspect that must always be kept in mind. “Depression and anxiety disorders are widespread comorbidities of IBD” explained D. Schwartz, Beer Sheva (Israel). Many patients also develop fatigue, and this debilitating exhaustion represents an additional burden for these patients. As D. Schwartz said, “these symptoms are frequently an enormous hurdle to patients trying to manage their disease.”

A holistic treatment approach is important in cases such as these, and a psychotherapist or a psychiatrist should always be included in the patient’s treatment strategy.

Y. Inspector, London (Great Britain), also called for routine biopsychosocial support for IBD patients, since it is not just the symptoms of IBD that can impact patients. Other factors may include:

- secondary effects of the disease, such as fatigue,
- side effects of the drugs prescribed,
- fear of surgery, especially stoma surgery,
- emotions such as guilt and shame associated with the disease, and
- social stigma, which often leads to social withdrawal.
As Y. Inspector, himself a psychotherapist, explained, “the disease can impact all areas of a patient’s life.” However, under no circumstances should patients be branded as simply “mentally ill”.

On the role of pathogens

As J.-F. Colombel, New York (USA) explained, the causes of IBD have still not been completely elucidated. Patients’ genetic background plays an important role, and there is also no doubt about the etiological importance of environmental factors and the involvement of both the immune system and the microbiome. However, the consequences of each of these individual factors or how they interact with each other remain unclear.

Disease registries and population-based cohorts have provided and continue to provide great promise in this regard. According to J.F. Colombel, these resources may indeed help answer some unanswered questions, as they have already demonstrated clear regional differences in the incidence and prevalence of IBD, for example. However, these studies have also raised several new questions: for example, there is still no hypothesis as to why the highest incidence of IBD in the world is found on the Faroe Islands. As the US-based physician pointed out, “this phenomenon cannot be fully explained by dietary habits or other environmental factors.”

State-of-the-art lecture

Strengthening the microbiome

As J. Braun, Los Angeles (USA), explained, the role of the microbiome in the pathogenesis of IBD has long been a topic of much discussion. Valid findings have been published which suggest that the gut microbiota is involved in the development of IBD and can also promote disease activity. The composition of the microbiome appears to play a key role in these processes and is closely correlated with individual dietary habits, which may promote the presence of certain enterotypes.

The specific composition of the microbiome may also potentially be of prognostic importance. For example, according to J. Braun there are indications that bacterial dysbiosis in patients with remission may be a predictive factor for disease progression within the subsequent two years. Hence, reconstitution of patients’ normal gut microbiota should be a therapeutic goal.

However, it must be remembered that gut bacterial flora is not the only etiological factor. It is also quite conceivable that the fungi located in the gut may additionally be involved in disease pathogenesis as a form of fungal microbiome. This aspect has likely been overly neglected in the past.
Biomarkers: still much room for improvement

S. Vermeire, Leuven (Belgium), sees much room for improvement both in terms of our understanding of IBD but also in the development of biomarkers. In her opinion, new biomarkers could help physicians diagnose IBD at earlier time points and improve the classification of different potential forms of the disease. It may even be possible one day to identify at-risk patients earlier through the use of special predictive biomarkers and/or to use biomarkers to more reliably predict patients’ prognosis (see fig. 5).

S. Vermeire cited fecal calprotectin and specific type IgA anti-Saccharomyces cerevisiae antibodies (ASCA) as potentially relevant biomarkers. Interestingly, biomarkers such as fecal calprotectin and C-reactive protein (CRP) are already in use in IBD. According to M. Allez, Paris (France), these biomarkers may help measure disease activity and monitor treatment outcomes on an individual basis.

Can we predict the outcomes and potential side effects of drug treatment?

As Y. Chowers, Haifa (Israel), described, the ability to predict treatment outcomes and the potential side effects of drug treatment would be highly desirable in light of the large number of new drugs available to treat IBD, many of which use vastly different mechanisms of action. Individual drugs are also frequently combined, and new treatment options are continuously under development. Such insights are required given that only about one-third of patients currently respond to any given medication – and it is not possible to predict in advance which patient will respond to which drug.

Physicians must also be aware of the differing risks of side effects associated with each drug, despite the fact that it is currently very difficult to predict which side effects any given patient may have to a specific therapy. There is also major room for improvement in this aspect of IBD treatment.

Combining different drugs is an especially problematic issue, as E. Louis, Liège (Belgium), explained. While the concept of increasing response rates by combining multiple biologics may appear tempting at first, this strategy is plagued by numerous problems: not only is it more expensive, but there is also a risk of potentiation of the risk of side effects.
As I. Dotan, Petah Tikva (Israel), explained, these challenges will likely be overcome in the future by in-depth patient stratification. Such a stratification strategy might utilize several different attributes, for example differentiating patients by age of disease onset, by disease phenotype, and/or by their reaction to treatment. I. Dotan also encouraged a multidisciplinary approach to treatment and biomarker-based treatment strategies.

**Visualizing the disease**

In addition to biomarker development, K. Novak, Calgary (Canada), described the intensive efforts being made toward advancing the imaging options for IBD. Major progress has been achieved in particular with intestinal ultrasound, which is enjoying increasing importance in the diagnosis and monitoring of IBD. Ultrasound can also be used to gauge disease activity and the extent of inflammation, as well as to determine whether complications such as strictures have already developed. The advantages of intestinal ultrasound include its relatively low cost as well as the fact that it is a non-invasive modality that accordingly enjoys widespread acceptance among patients.

A. Bourreile, Nantes (France), described another imaging technique that has gained importance in the diagnosis and monitoring of IBD: capsule endoscopy. This method is particularly useful in Crohn’s disease, since it allows the examination and assessment of disease lesions and even mucosal healing in the small intestine and the colon.

However, not only do these advances in imaging modalities improve our ability to diagnose and monitor Crohn’s disease and ulcerative colitis, but they can also help detect colorectal cancer at early stages, as H. Neumann, Mainz (Germany), explained. These methods can increase neoplasm detection rates, improve the differentiation of lesions, and thereby help minimize the rate of unnecessary biopsies.

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**State-of-the-art lecture**

**Fibrosis in IBD: still an unsolved problem**

According to F. Rieder, Cleveland (USA), fibrosis represents a very common complication of IBD that affects both ulcerative colitis and Crohn’s disease patients. In both conditions, fibrosis leads to the formation of strictures and may even cause intestinal obstruction and a need for surgery. Accordingly, intensive efforts are underway to develop new anti-fibrotic drugs. Although several different immunosuppressants and disease-modulating drugs are presently available, none of the existing agents is effective against fibrosis. “The treatment options are thus limited” noted F. Rieder. The triggers of fibrosis processes in IBD patients also remain unclear. A putative role of the microbiome has been postulated, as well as hyper-trophy of mesenteric adipose tissue in Crohn’s disease, a phenomenon known as “creeping fat.”
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V. Keitel, Düsseldorf (Germany)
M. Trauner, Vienna (Austria)
Poster prizes: awards for young scientists

At its symposia, the Falk Foundation e.V. regularly awards poster prizes to young scientists who present innovative and relevant new research in a poster. The recipients of the poster prizes at Symposium 216 were:

1st prize: Dr. Saleh Daher, Jerusalem (Israel), for the poster “Inflammatory bowel diseases patient profiles are related to specific information needs – a nationwide survey.”

2nd prize: Prof. Norsaf Bibani, Tunis (Tunisia), for the poster “Inflammatory stricturing Crohn’s diseases: Results of medical treatment.”

3rd prize: Dr. Annick Moens, Leuven (Belgium), for the poster “Pregnancy outcomes in inflammatory bowel disease patients treated with Vedolizumab, anti-TNF or conventional therapy: Result of the European CONCEIVE study.”
"We need a workable network with participants from all fields"

"Building bridges in inflammatory bowel disease": Symposium 216 was convened in Brussels under this motto. We talked with Prof. Dr. Severine Vermeire, University Hospital Leuven, one of the scientific organizers of this symposium. She explained what this motto means in practice and why it was picked for this meeting.

Eds.: Professor Vermeire, why was the metaphor of building bridges in inflammatory bowel disease (IBD) chosen as the motto of this meeting?

Prof. Vermeire: We need many different bridges in IBD: some need to be strengthened, and some still need to be built. One important topic is the bridge between those physicians involved in diagnosing the disease and those involved in treating it. Collaboration between basic research and clinical practice is another very important topic, and is of critical importance if we want patients to benefit from recent research findings. Furthermore, we need a strong bridge between patients and the physicians who treat them, in order to build a foundation for adherence and success of treatment. The bridges I have mentioned are a key component of patient care in general and of IBD care in particular. As physicians, we shouldn’t feel like we are stranded on an island, and we shouldn’t act that way, either. Patients also shouldn’t feel like they’re stranded on an island. Instead, they need to recognize that they are being treated by a team that is made up of doctors from many different fields. They should also know that they have an even larger team of health care providers surrounding them, including special IBD nurses, general nursing staff, and other professionals such as physical therapists and social workers. Everybody involved in this collaboration must understand that teamwork is priority number one when caring for people with IBD. Against this backdrop, we have tried to address all of the relevant fields in this symposium and to emphasize the crucial role of interdisciplinary collaboration between different fields.

What fields play an important role in the diagnosis and treatment of IBD?

Crohn’s disease and ulcerative colitis are highly complex conditions in which patients frequently develop complications and extraintestinal manifestations. As a result, physicians from many different fields outside of gastroenterology may be involved in patient care. In patients with complications, this often means surgeons, although it might also require the involvement of a rheumatologist and/or a dermatologist due to extraintestinal manifestations. However, we also can’t forget several other important fields. For example, IBD patients are often relatively young and are still planning to have children. Hence, questions on the topics of fertility, pregnancy, and childbirth are unavoidable. This is why we as gastroenterologists often need to work hand-in-hand with our patients’ gynecologists. The specific composition of an IBD treatment team is thus highly dependent on each patient’s particular situation. For example, a sizeable number of patients develop psychological issues pertaining to their disease. In these cases, a psychotherapist or psychiatrist must also be a member of the team. Naturally, the patient’s IBD nurses and any nutritionists or dietary assistants should also be members of the team.

Are there currently any gaps or areas where the team model needs improvement?

I’m sure that there is plenty of room for improvement on this subject. What currently works well in my experience is the cooperation between gastroenterologists and surgeons. However, there is still room for optimization in all other fields, perhaps because psychological or nutritional support is not yet optimal, or perhaps due to the hurdles in incorporating the remaining specialties. There is no single answer to this issue, and the problems likely differ from one center to the next. The appropriate structures do not exist at many facilities, with one particular problem being...
the difficulty of rapidly incorporating a physician from another field who is familiar with IBD into the team for a specific case. Patients often need to wait eight weeks or more before they can get an appointment with the right specialist. That’s just too long.

**How can we change that?**

We need to build networks that integrate all of the professions and fields required for the care of IBD patients. When that goal can’t be reached in-house at a center, those physicians will need to include colleagues from outside of their facility into the network. This type of interdisciplinary collaboration – with bridges between all participants – is of enormous importance for providing optimal care and treatment to patients with IBD.

**Why is interdisciplinary cooperation so important?**

We have made many advances in the management of Crohn’s disease and ulcerative colitis in recent years, and we continue to improve our understanding of the fundamentals of these conditions. However, these advances sadly don’t always get translated into sustained improvement in the care of all patients. Due to the complexity of the disease, patients often have highly divergent needs. Therefore, it is crucial that advances gained in different areas are actually made available to the patients who might benefit from any given insight. But we can only achieve this goal if the specialists in each field are tightly networked and work together in an interdisciplinary manner.

**Where do you see unmet needs in the areas of diagnosis and treatment of IBD?**

We now have a large number of varied treatment options, but we still need better biomarkers that allow us to provide patients with a more accurate prognosis. We also need biomarkers that allow us to predict which treatment strategy a patient will respond well to with a high degree of confidence. Of course, we would always like to have even more new drugs that are even more effective and better tolerated than the present options so that we can provide our patients optimal care. Therefore, interdisciplinary cooperation across all disciplines is also important for translating basic research into clinical interventions, allowing new advances to reach the right patients in each field even more quickly. Continuous exchange between colleagues, as we have practiced at this symposium, can be a major contribution toward reaching these goals. I am certain that many of my colleagues will leave this meeting with new insights and ideas for their research topics, and especially for optimizing the treatment of IBD patients.

**Professor Vermeire, thank you very much for the interview!**
IBD Management in the New Decade: Old Myths and New Realities

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International Symposia and Workshops

Scientific Dialogue in the Interest of Therapeutic Progress

Workshop
Primary Liver Cancer – Emerging Concepts and Novel Treatments
Mainz, Germany
February 13–14, 2020

Symposium 218
Current Challenges of Inflammatory Bowel Disease
Mexico City, Mexico
March 6–7, 2020

Workshop
Microscopic Colitis – New Insights and Recommendations
Copenhagen, Denmark
May 21, 2020

Symposium 219
IBD-Patients – In the Center of Care
Copenhagen, Denmark
May 22–23, 2020

Symposium 220
XXVI International Bile Acid Meeting: Bile Acids in Health and Disease 2020
Amsterdam, The Netherlands
July 10–11, 2020

Symposium 221
IBD Management in the New Decade: Old Myths and New Realities
Athens, Greece
October 2–3, 2020

Symposium 222
Eosinophilic Esophagitis – Advanced Science for Everyday Challenges in Clinical Practice
Zurich, Switzerland
November 20–21, 2020

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