Ελληνική Γαστρεντερολογική Εταιρεία, Τμήμα Βορείου Ελλάδας
Επιστημονική Εκπαιδευτική Διημερίδα

Αποφασίζοντας την πρώτη επιλογή θεραπείας στα ΙΦΝΕ

Κωνσταντίνος Σουφλέρης

Γαστρεντερολόγος, Επιμελητής Α' Ε.Σ.Υ.

Γαστρεντερολογική Κλινική

«Θεαγένειο» Α.Ν.Θ.

Θεσσαλονίκη

6 Οκτωβρίου 2018, Ολυμπιακό Μουσείο Θεσσαλονίκης

ΔΗΛΩΣΗ ΣΥΓΚΡΟΥΣΗΣ ΣΥΜΦΕΡΟΝΤΩΝ (Disclosures)

Abbvie (Humira)	*Τιμητικές Αμοιβές, Ταξιδιωτικές Χορηγίες*
Aenorasis (Inflectra)	*Τιμητικές Αμοιβές, Ταξιδιωτικές Χορηγίες*
Janssen (Stelara)	*Τιμητικές Αμοιβές*
Merck (Remicade, Simponi)	*Τιμητικές Αμοιβές, Ταξιδιωτικές Χορηγίες*
Pfizer (Xeljanz)*	*Τιμητικές Αμοιβές*
Takeda (Entyvio)	*Τιμητικές Αμοιβές, Ταξιδιωτικές Χορηγίες*

Νόσος του Crohn-Βιολογικές Θεραπείες

- **Infliximab-1998**
- **Adalimumab-2007**
- **Vedolizumab-2014**
- **Ustekinumab-2016**

Ελκώδης Κολίτιδα-Βιολογικές Θεραπείες

- **Infliximab-2005**
- **Adalimumab-2012**
- **Golimumab-2013**
- **Vedolizumab-2014**
- **Tofacitinib-2019***

Νόσος του Crohn

American College of Gastroenterology
Digestive Disease Specialists Committed to Quality in Patient Care

24. Anti-TNF agents (infliximab, adalimumab) should be used to treat Crohn's disease that is resistant to treatment with corticosteroids *(strong recommendation, moderate level of evidence)…*

25. Anti-TNF agents should be given for Crohn's disease refractory to thiopurines or methotrexate *(strong recommendation, moderate level of evidence)…*

27. For patients with moderately to severely active Crohn's disease and objective evidence of active disease, anti-integrin therapy (with vedolizumab) with or without an immunomodulator is more effective than placebo and should be considered to be used for induction of symptomatic remission in patients with Crohn's disease *(strong recommendation, high level of evidence)…*

30. Ustekinumab should be given for moderate-to-severe Crohn's disease patients who failed previous treatment with corticosteroids, thiopurines, methotrexate, or anti-TNF inhibitors or who have had no prior exposure to anti-TNF inhibitors *(strong recommendation, high level of evidence)…*

Lichtenstein, Am J Gastroenterol 2018

Νόσος του Crohn

American College of Gastroenterology
Digestive Disease Specialists Committed to Quality in Patient Care

33. Anti-TNF agents (infliximab, adalimumab) can be considered to treat severely active Crohn's disease *(strong recommendation, moderate level of evidence)…*

34. Infliximab may be administered to treat fulminant Crohn's disease *(conditional recommendation, low level of evidence)…*

35. Infliximab is effective and should be considered in treating perianal fistulas in Crohn's disease *(strong recommendation, moderate level of evidence)…*

36. Infliximab may be effective and should be considered in treating enterocutaneous and rectovaginal fistulas *(strong recommendation, moderate level of evidence)…*

37. Adalimumab may be effective and should be considered in treating perianal fistulas *(strong recommendation, low level of evidence)…*

58. In high-risk patients, anti-TNF agents should be started within 4 weeks of surgery in order to prevent postoperative Crohn's disease recurrence *(conditional recommendation, low level of evidence)…*

Lichtenstein, Am J Gastroenterol 2018

Ελκώδης Κολίτιδα

EUROPEAN CROHN'S & COLITIS ORGANIZATION
ECCO

11I.Patients with steroid-dependent disease should be treated with a thiopurine [EL2], anti-TNF [EL1] [preferably combined with thiopurines, at least for infliximab [EL2]], vedolizumab [EL2], or methotrexate [EL2]…

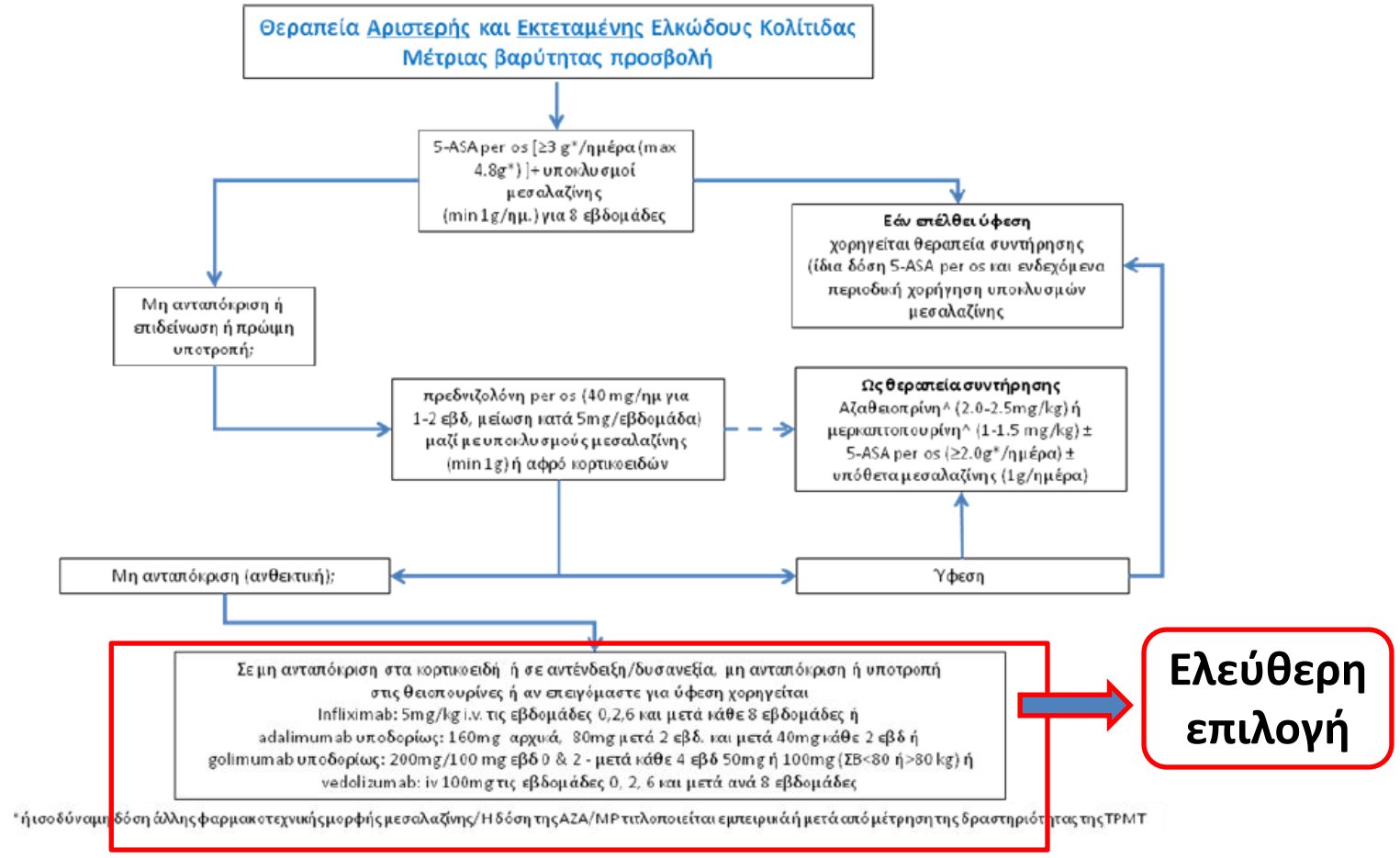
11J. Moderate disease refractory to oral steroids should be treated either with Intravenous steroids [EL4] or anti-TNF [EL1] preferably combined with thiopurines, at least for infliximab [EL2], vedolizumab [EL2], or tacrolimus [EL2]…

11K.Patients with moderate colitis refractory to thiopurines should be treatedwith anti TNF [EL1], preferably combined with thiopurines, at least for infliximab [EL2], or vedolizumab [EL2]…

11H.The response to intravenous steroids should be best assessed by the third day [EL3]; In non-responders, treatment options including ciclosporin [EL1], infliximab [EL1], tacrolimus [EL2], or surgery should be considered…

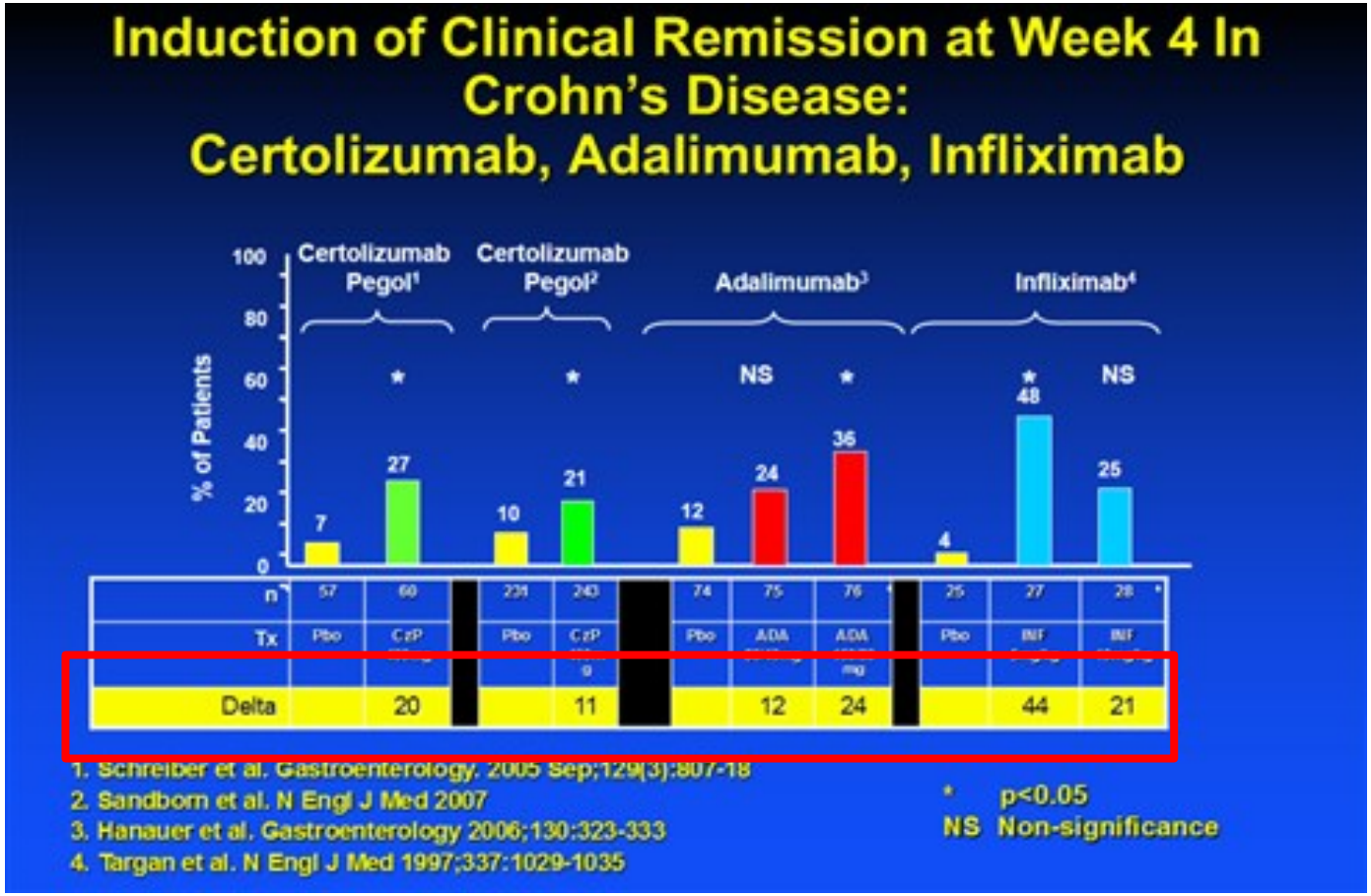
Harbord, Journal of Crohn's and Colitis 2017

Ελλάδα: Θεραπευτικά Πρωτόκολλα και ΙΦΝΕ
Ελκώδης Κολίτιδα



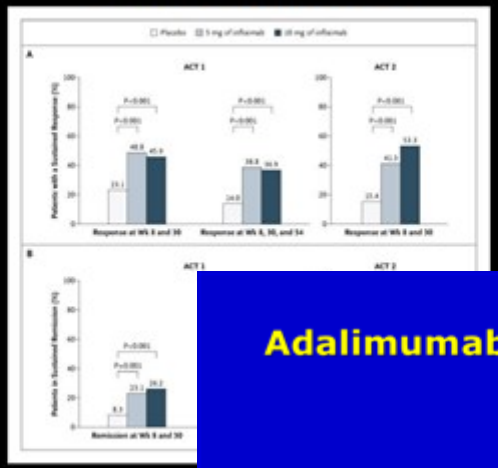
Επιστημονική Ομάδα Εργασίας Γαστρεντερολογικών Παθήσεων, Απρίλιος 2018

Σύγκριση μεταξύ των anti TNF σε νόσο του Crohn



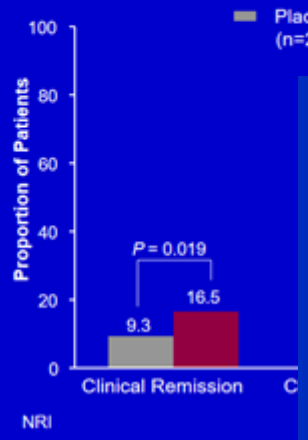
Anti TNF στην Ελκώδη Κολίτιδα

Proportion of Patients with a Sustained Clinical Response (Panel A) and in Sustained Clinical Remission (Panel B) in ACT 1 and ACT 2

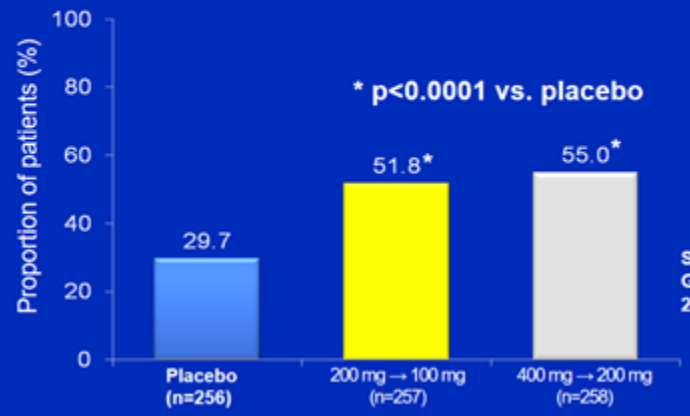


Rutgeerts P, Sandborn WJ, et al. N Engl J Med 2005;353:2462-2476

Adalimumab Induction for Ulcerative Colitis Results at Week 8



Golimumab Induction for Ulcerative Colitis Clinical Response† at Week 6

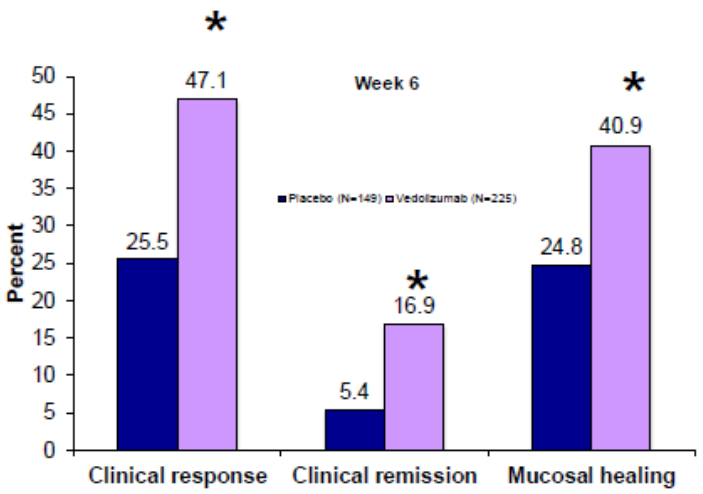


Sandborn W. Gastroenterology 2014

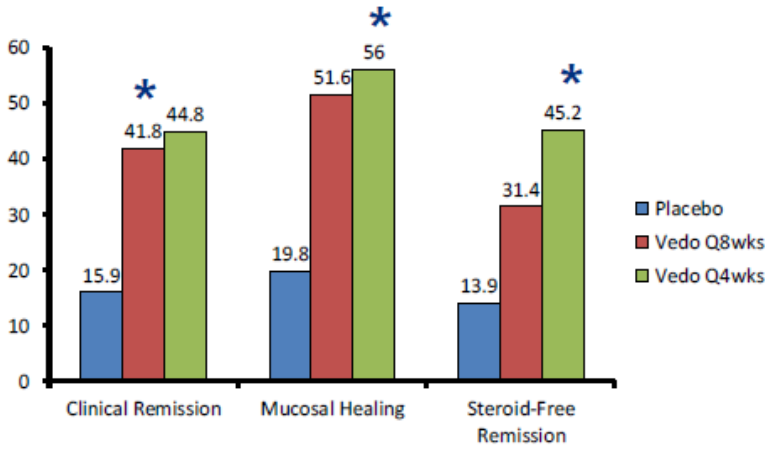
†Defined as a decrease from baseline in the Mayo score by ≥ 30% and ≥ 3 points, with either a decrease from baseline in the rectal bleeding subscore of ≥ 1 or a rectal bleeding subscore of 0 or 1

Vedolizumab-Ελκώδης Κολίτιδα

GEMINI 1



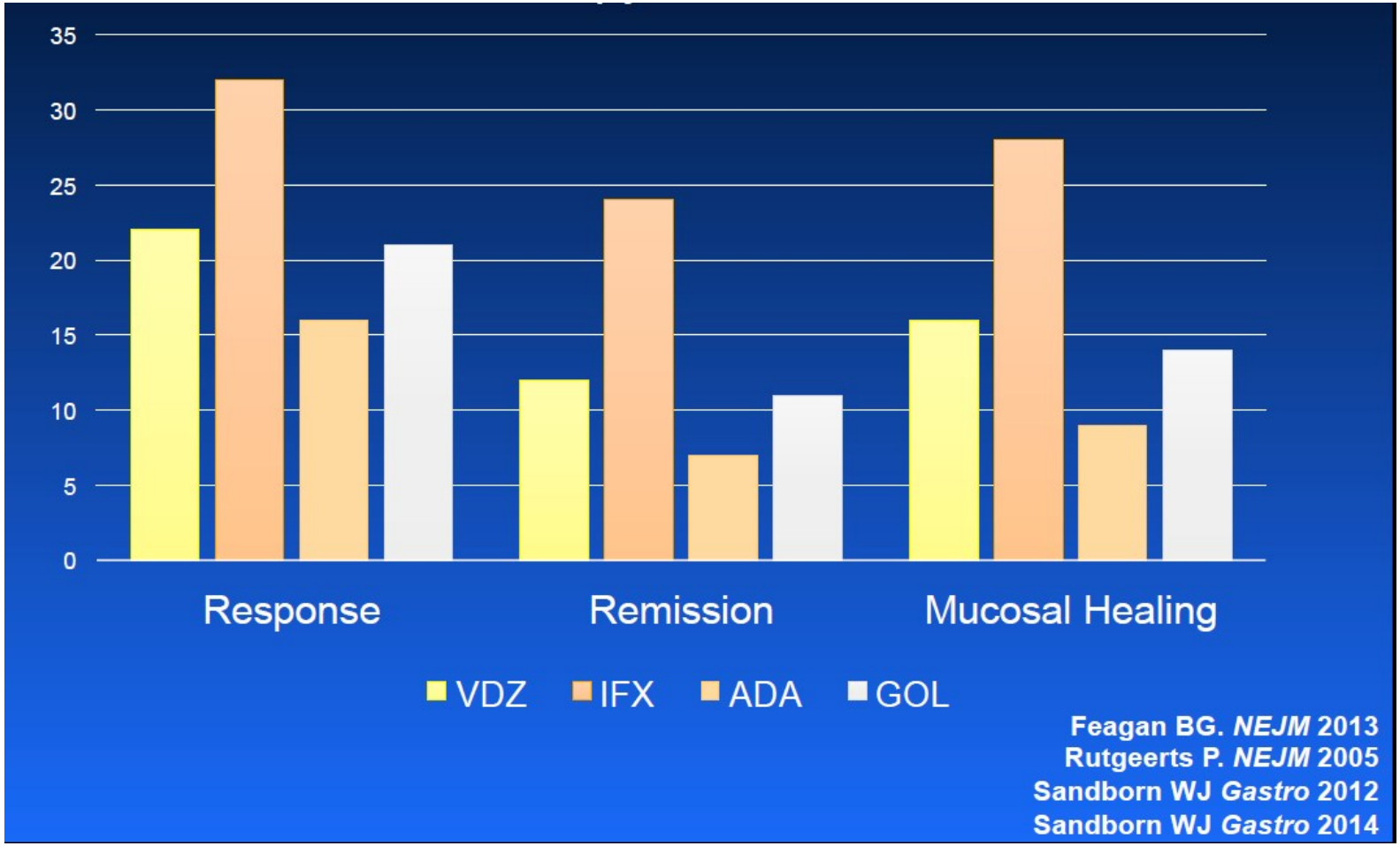
* p<0.001



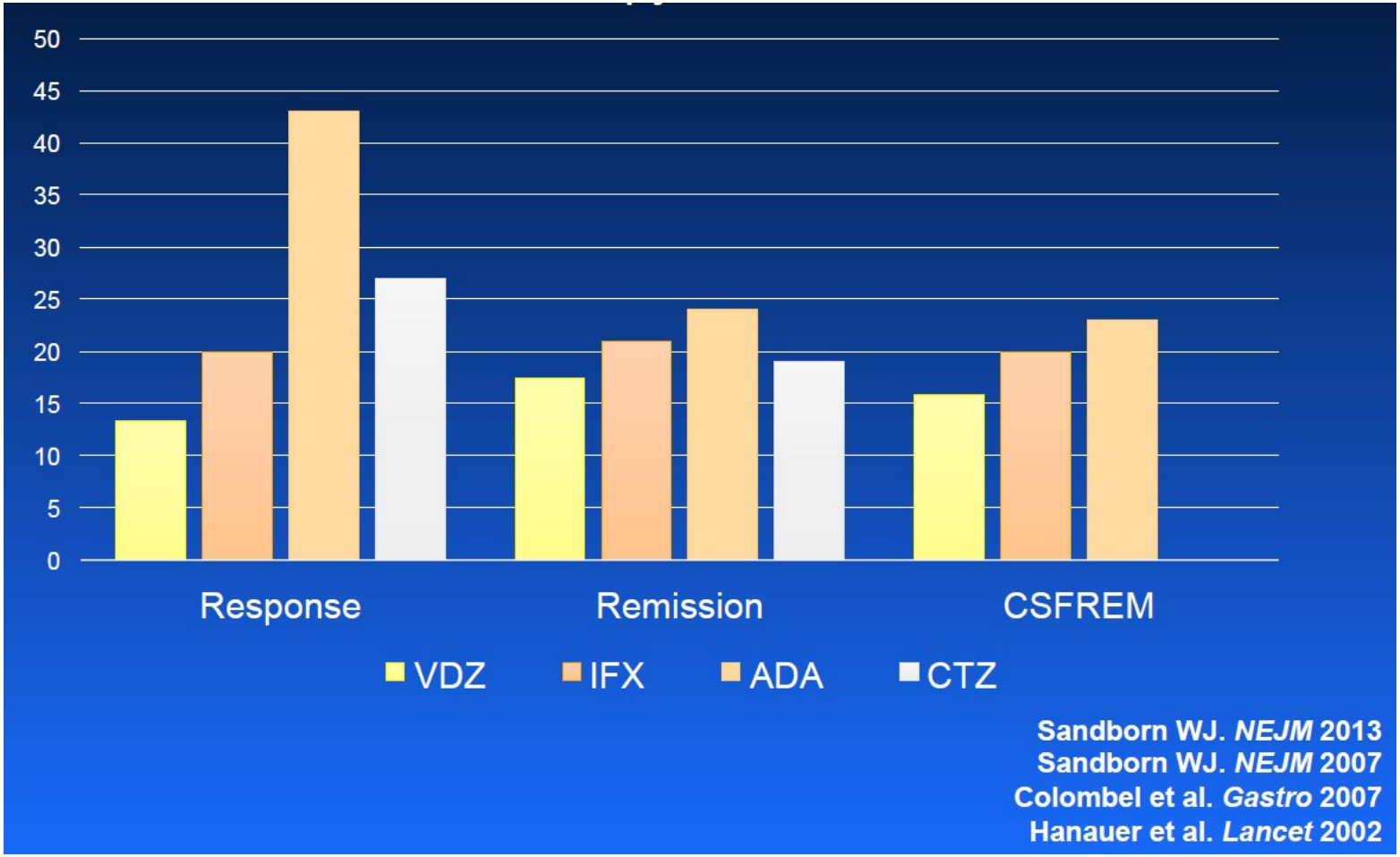
Randomized responders
Week 52

Feagan, NEJM 2013

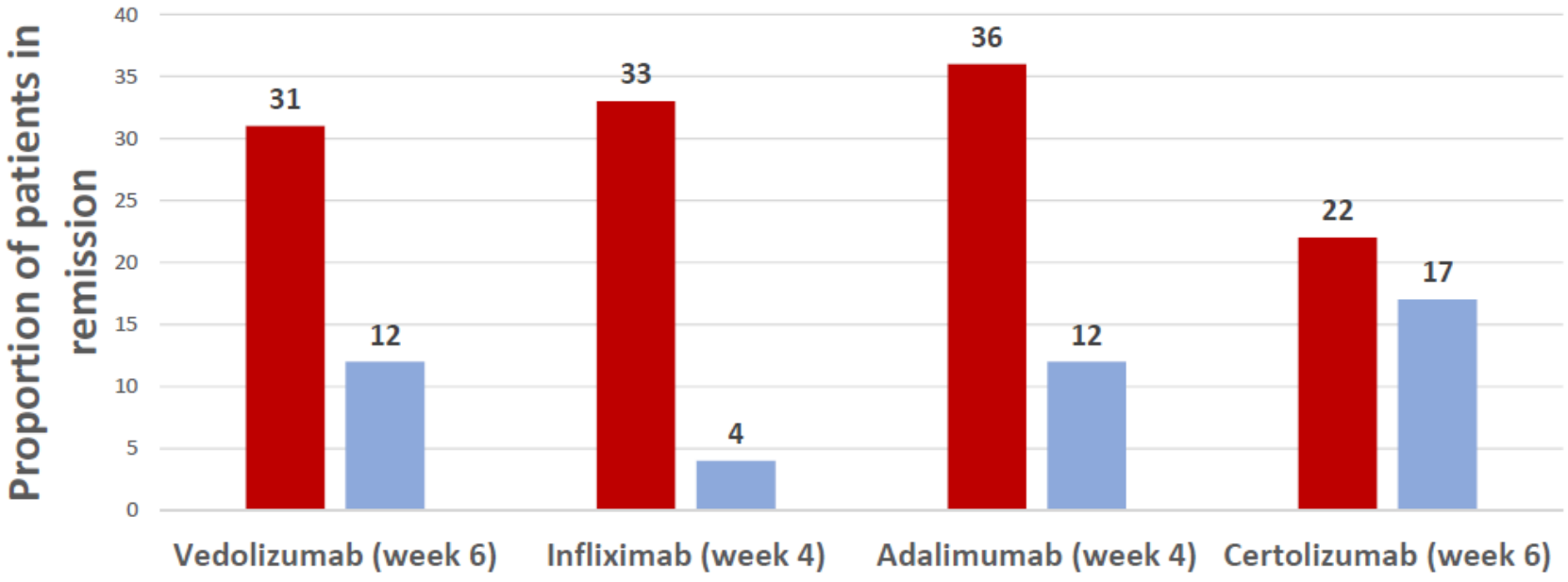
Ελκώδης Κολίτιδα και Βιολογικές Θεραπείες
Induction incremental benefits (Deltas)



Νόσος του Crohn και Βιολογικές Θεραπείες
Induction incremental benefits (Deltas)

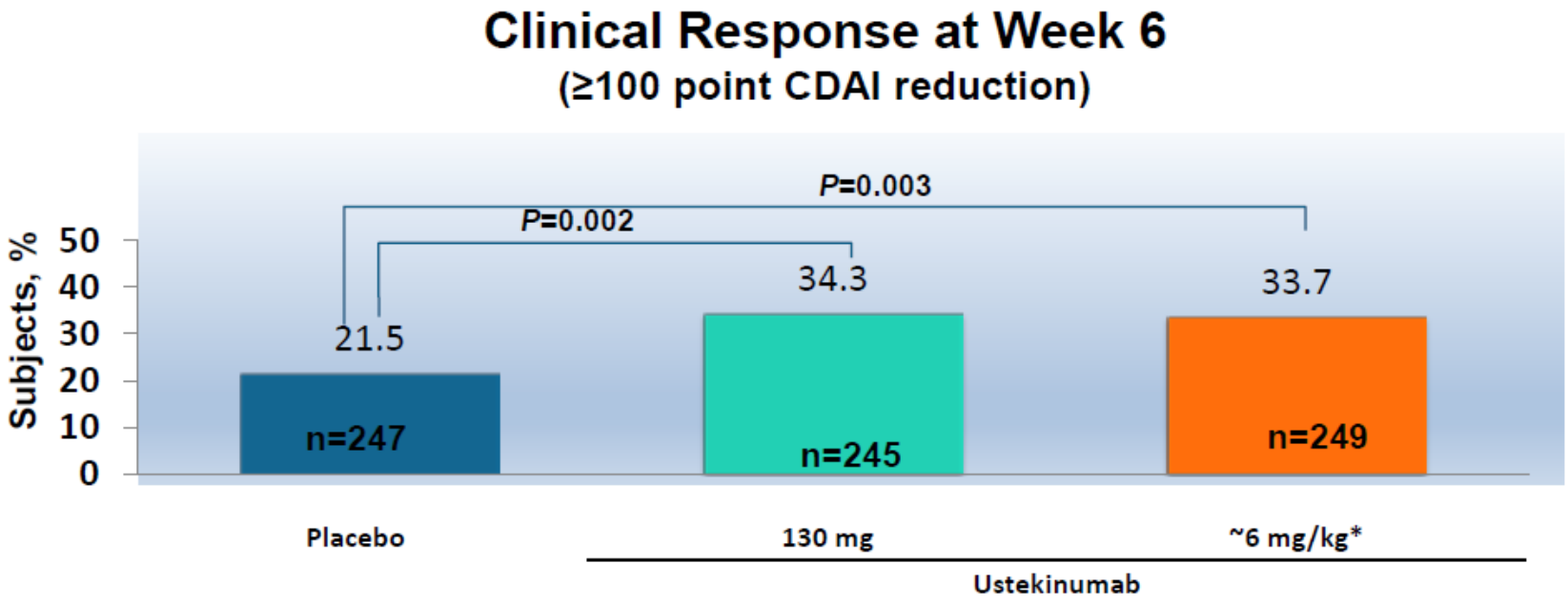


Induction σε naïve ασθενείς με νόσο του Crohn διαφορές βιολογικών θεραπειών;



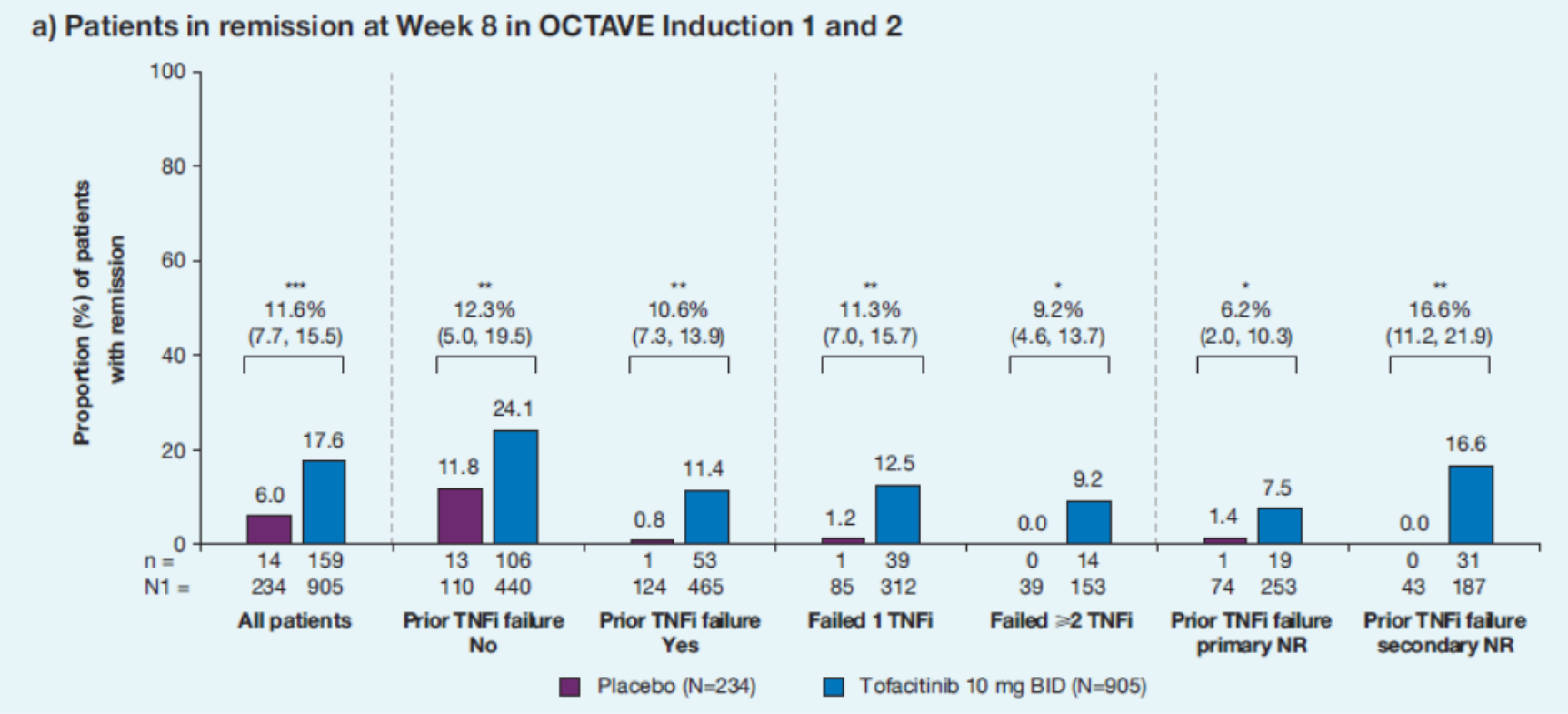
Sands BE, Gastro 2014
Targan SR, NEJM 1997
Hanauer SB, Gastro 2006
Sandborn WJ, NEJM 2007

Ustekinumab σε νόσο του Crohn



Feagan, NEJM 2016

Tofacitinib



Sandborn, NEJM 2017

Σύγκριση Βιολογικών θεραπειών και Κλινικές Μελέτες

- **Δεν υπάρχουν Head to Head μελέτε**ς
- **Comparative Effectiveness Research (CER)**-Ετερογένεια

-study time-points

-prior anti-TNF exposure

-study populations

-study endpoints

-large placebo effect

-dosing

- Νέες μελέτες

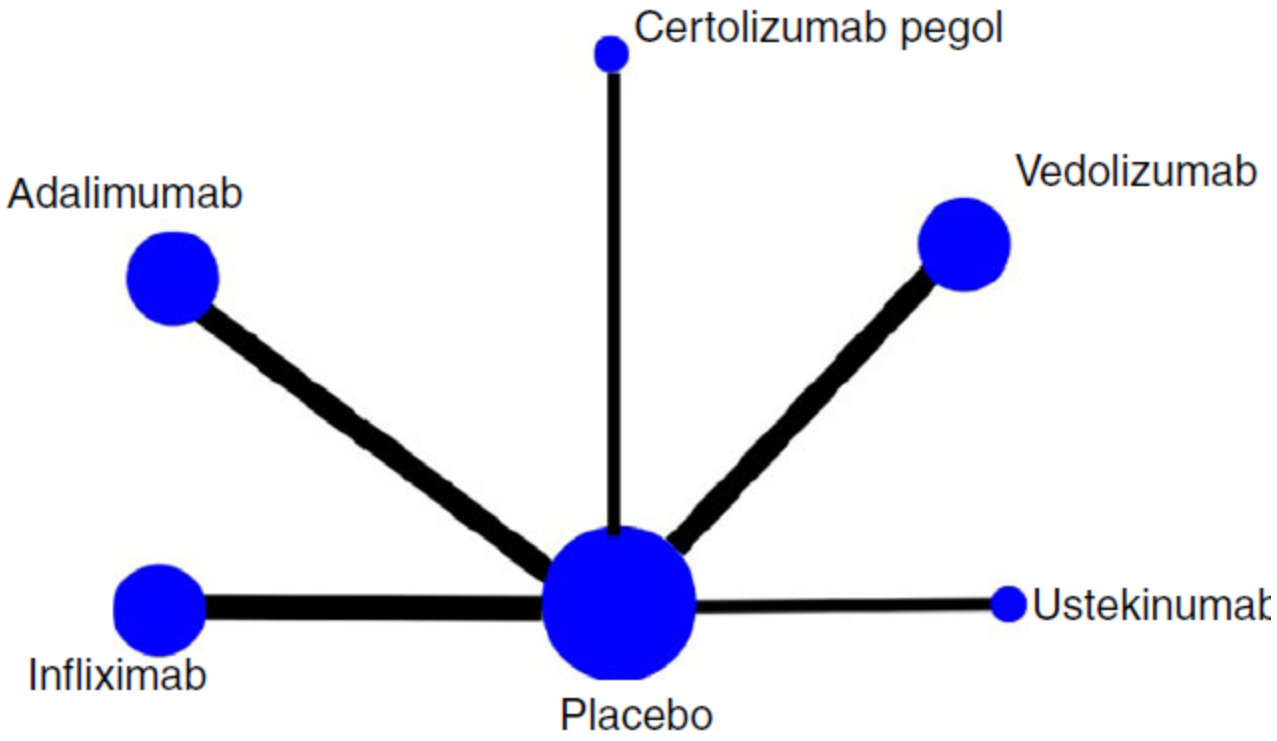
-placebo;

-superiority; (σύγκριση με πολύ αποτελεσματική θεραπεία-anti TNF)

-non inferiority (inferiority margin)

better/? Safer? Easier? Cheaper?

Βιολογικές θεραπείες και Νόσος του Crohn
Network Meta-analysis
8 RTCs, 1458 pts



Singh, APT 2018

Βιολογικές Θεραπείες σε bio-naive ασθενείς με νόσο του Crohn

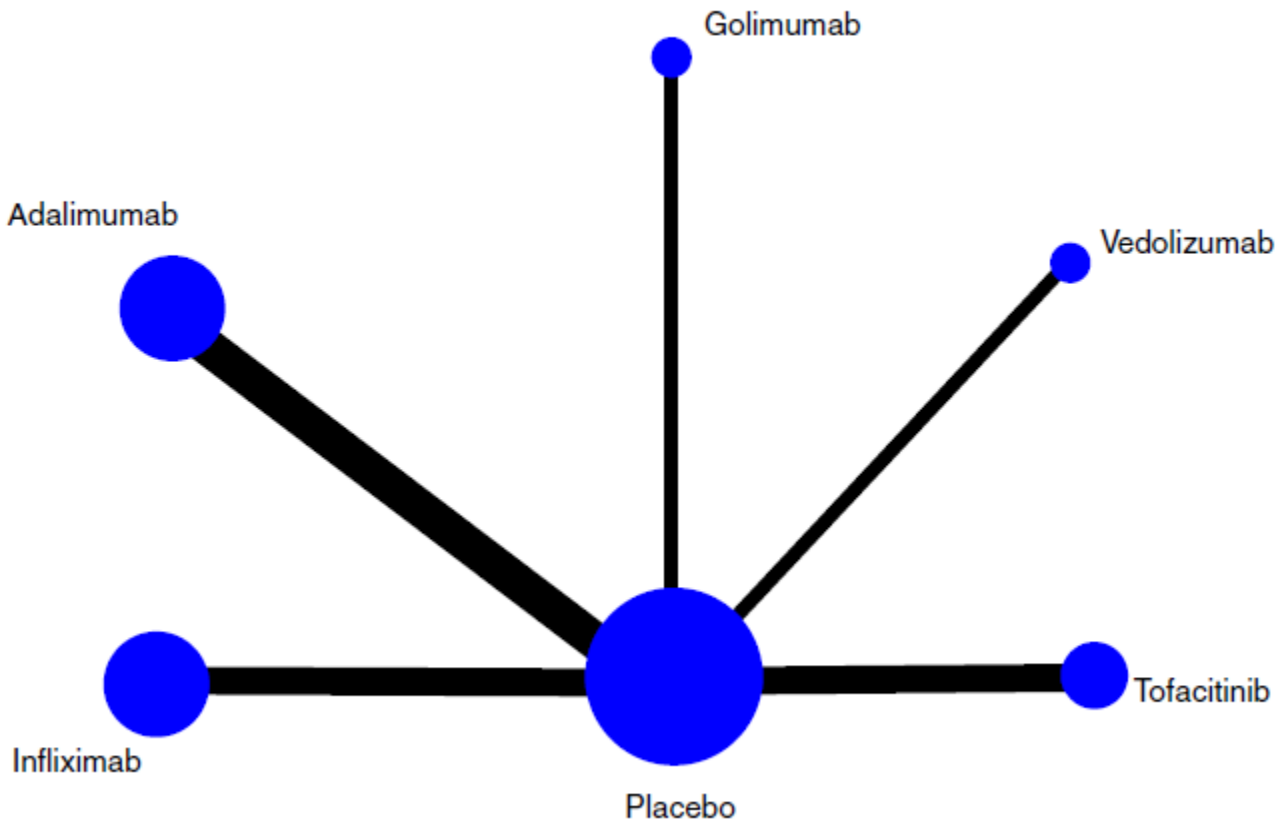
Επαγωγή Ύφεσης	
• Placebo	20,0%
• Infliximab	59,6%
• Adalimumab	48,7%
• Ustekinumab	40,7%
• Vedolizumab	40,2%

SUCRA Surface Under the Cumulative Ranking	
• Infliximab	0,90
• Adalimumab	0,75
• Ustekunumab	0,56
• Vedolizumab	0,55

Maintenance: Adalimumab, Infliximab,2nd line: Ustekinumab (adalimumab if LOR)

Singh, Aliment Pharmacol Therap 2018

Βιολογικές θεραπείες και Ελκώδης Κολίτιδα
Network Meta-analysis
12 RCTs, 2720 patients



Singh, APT 2018

Βιολογικές Θεραπείες σε bio-naive ασθενείς με Ελκώδη Κολίτιδα

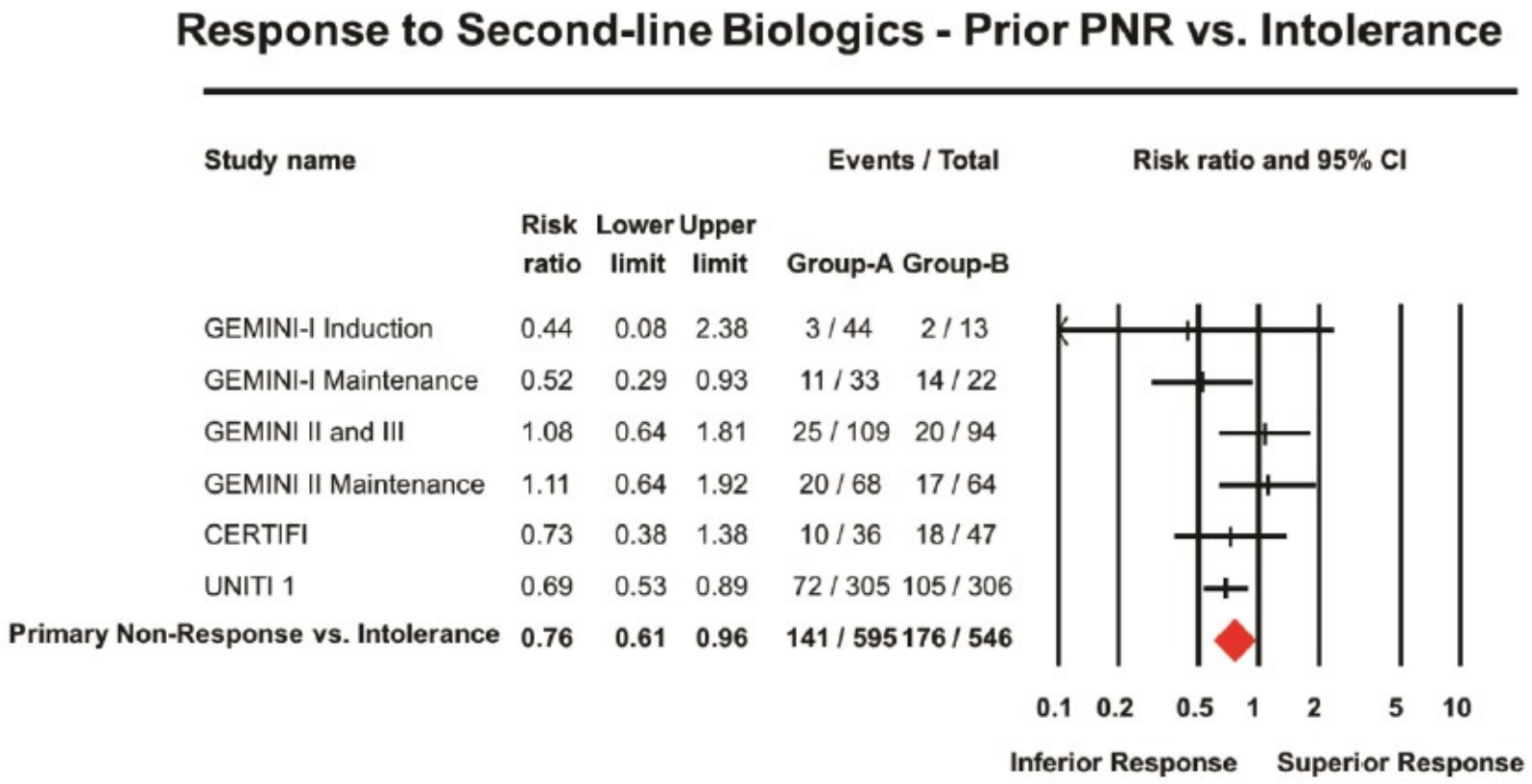
Επαγωγή Ύφεσης Remission %	
• Placebo	9,81%
• Infliximab	30,9%
• Vedolizumab	31,6%
• Golimumab	23,0%
• Tofacitinib	18,9%
• Adalimumab	16,1%

SUCRA Surface Under the Cumulative Ranking	
• Infliximab	0,85
• Vedolizumab	0,82
• Golimumab	0,58
• Tofacitinib	0,43
• Adalimumab	0,31

2nd Line SUCRAs: tofacitinib 0.96, vedolizumab 0.62, adalimumab 0.31

Singh, Aliment Pharmacol Therap 2018

PNR versus LOR/Intolerance to anti-TNF:
27% μικρότερη ανταπόκριση σε 2ης γραμμής βιολογική θεραπεία



Singh, JCC 2018

Anti-TNFs-Τοξικότητα

- **Ανοσογονικότητα**
- **Αντιδράσεις στην έγχυση (infliximab)**
- **Αντιδράσεις καθυστερημένης υπερευασθησίας (infliximab)**
- **Τοπικές αντιδράσεις στο σημείο της έγχυσης (adalimumab, golimumab)**
- **Αυτο-αντισώματα (κυρίως infliximab, λιγότερο adalimumab)**
- **Φαρμακευτικός Λύκος**
- **Non Hodgin Λέμφωμα (και το ηπατοσπληνικό λέμφωμα σε νεαρή ηλικία με infliximab ή adalimumab και αζαθιοπρίνη)**
- **Σοβαρές Λοιμώξεις**
- **Ευκαιριακές Λοιμώξεις (φυματίωση, ιστοπλάσμωση)**
- **Απομυελινωτική Νόσος**

Anti-TNF και Κίνδυνος για Σοβαρές Λοιμώξεις

Anti-TNF Monotherapy, Combination Therapy, Thiopurines

Table 3. Multivariable Adjusted HRs (95% CIs)[a] of Serious Infections According to Medication Exposure, Overall and by Infection Site

Type of Infection	Exposed to Combination Therapy vs Anti-TNF Monotherapy	Exposed to Combination Therapy vs Thiopurine Monotherapy	Exposed to Anti-TNF Monotherapy vs Thiopurine Monotherapy
Serious infections, overall	1.23 (1.05–1.45)	2.11 (1.80–2.48)	1.71 (1.56–1.88)
Pulmonary infections	1.40 (0.99–1.98)	3.14 (2.24–4.40)	2.24 (1.83–2.75)
GI infections	1.34 (0.93–1.93)	1.84 (1.30–2.60)	1.37 (1.12–1.68)
Skin infections	1.08 (0.76–1.54)	1.86 (1.30–2.68)	1.72 (1.38–2.15)
Urinary tract infections	0.89 (0.56–1.41)	1.69 (1.07–2.67)	1.90 (1.47–2.45)
ENT infections	1.47 (0.60–3.59)	1.95 (0.80–4.73)	1.32 (0.83–2.12)
Musculoskeletal infections	1.89 (0.78–4.55)	2.58 (1.07–6.23)	1.36 (0.68–2.73)
Other infections	1.26 (0.89–1.79)	2.03 (1.44–2.87)	1.61 (1.29–2.01)

Anti-TNF vs Thiopurines: X 1.7

Unexposed:	**8,4/1,000 patient/years**	
Thiopurines Monotherapy:	**10,5/1,000 patient/years**	**RR:1,3**
Anti-TNF Monotherapy:	**18,9/1,000 patient/years**	**RR:2,3**
Combination Therapy:	**22,4/1,000 patient/years**	**RR:2,8**

Kirchgesner, Gastro 2018

Anti-TNF και Κίνδυνος για Ευκαιριακές Λοιμώξεις
Anti-TNF Monotherapy, Combination Therapy, Thiopurines

Table 4. Multivariable Adjusted HRs (95% CIs)[a] of Opportunistic Infections According to Medication Exposure, Overall and by Pathogen

Type of Infection	Exposed to Combination Therapy vs Anti-TNF Monotherapy	Exposed to Combination Therapy vs Thiopurine Monotherapy	Exposed to Anti-TNF Monotherapy vs Thiopurine Monotherapy
Opportunistic infections, overall	1.96 (1.32–2.91)	2.11 (1.45–3.08)	1.08 (0.83–1.40)
Viral infections	1.98 (1.00–3.94)	1.13 (0.62–2.08)	0.57 (0.38–0.87)
Mycobacterial infections	2.17 (1.08–4.36)	4.30 (2.10–8.80)	1.98 (1.15–3.40)
Bacterial infections	1.99 (0.99–4.01)	4.73 (2.10–10.7)	2.38 (1.23–4.58)
Fungal infections	0.78 (0.21–2.88)	0.96 (0.26–3.61)	1.24 (0.49–3.16)

-Anti TNF αυξάνουν τον κίνδυνο για ευκαιριακές λοιμώξεις (Tbc, Bacteria)
-Θιοπουρίνες αυξάνουν τον κίνδυνο για ιογενείς ευκαιριακές λοιμώξεις

Kirchgesner, Gastro 2018

Anti-TNF και Κίνδυνος για Λέμφωμα

Anti-TNF Monotherapy, Combination Therapy, Thiopurines

Table 2. Incidence of Lymphoma According to Exposure Group

Lymphoma Type	Overall (1 060 336 PY)		Unexposed to Thiopurines or Anti-TNF Agents (838 611 PY)		Exposed to Thiopurine Monotherapy (129 743 PY)		Exposed to Anti-TNF Monotherapy (77 229 PY)		Exposed to Combination Therapy (14 753 PY)	
	No. of Events	IR per 1000 PY (95% CI)	No. of Events	IR per 1000 PY (95% CI)	No. of Events	IR per 1000 PY (95% CI)	No. of Events	IR per 1000 PY (95% CI)	No. of Events	IR per 1000 PY (95% CI)
All Patients										
All lymphoma	336	0.32 (0.28-0.35)	220	0.26 (0.23-0.29)	70	0.54 (0.41-0.67)	32	0.41 (0.27-0.55)	14	0.95 (0.45-1.45)
Hodgkin lymphoma	55	0.05 (0.04-0.07)	30	0.03 (0.02-0.04)	13	0.10 (0.05-0.15)	6	0.08 (0.02-0.14)	6	0.41 (0.08-0.74)
Non-Hodgkin lymphoma	281	0.27 (0.21 -0.33)	190	0.23 (0.20-0.26)	57	0.44 (0.33-0.55)	26	0.34 (0.21-0.47)	8	0.54 (0.16-0.92)
Patients With Incident IBD[a]										
All lymphoma	69	0.27 (0.21-0.33)	48	0.24 (0.17-0.31)	12	0.39 (0.17-0.61)	5	0.24 (0.03-0.45)	4	0.79 (0.01-1.57)
Hodgkin lymphoma	13	0.05 (0.02-0.08)	10	0.06 (0.03-0.09)	1	0.04 (0.0-0.10)	0	0	2	0.40 (0.0-0.95)
Non-Hodgkin lymphoma	56	0.22 (0.16-0.28)	38	0.19 (0.13-0.25)	11	0.36 (0.15-0.57)	5	0.24 (0.03-0.45)	2	0.40 (0.0-0.95)

Abbreviations: IBD, inflammatory bowel disease; IR, incidence rate; PY, person-years; TNF, tumor necrosis factor.

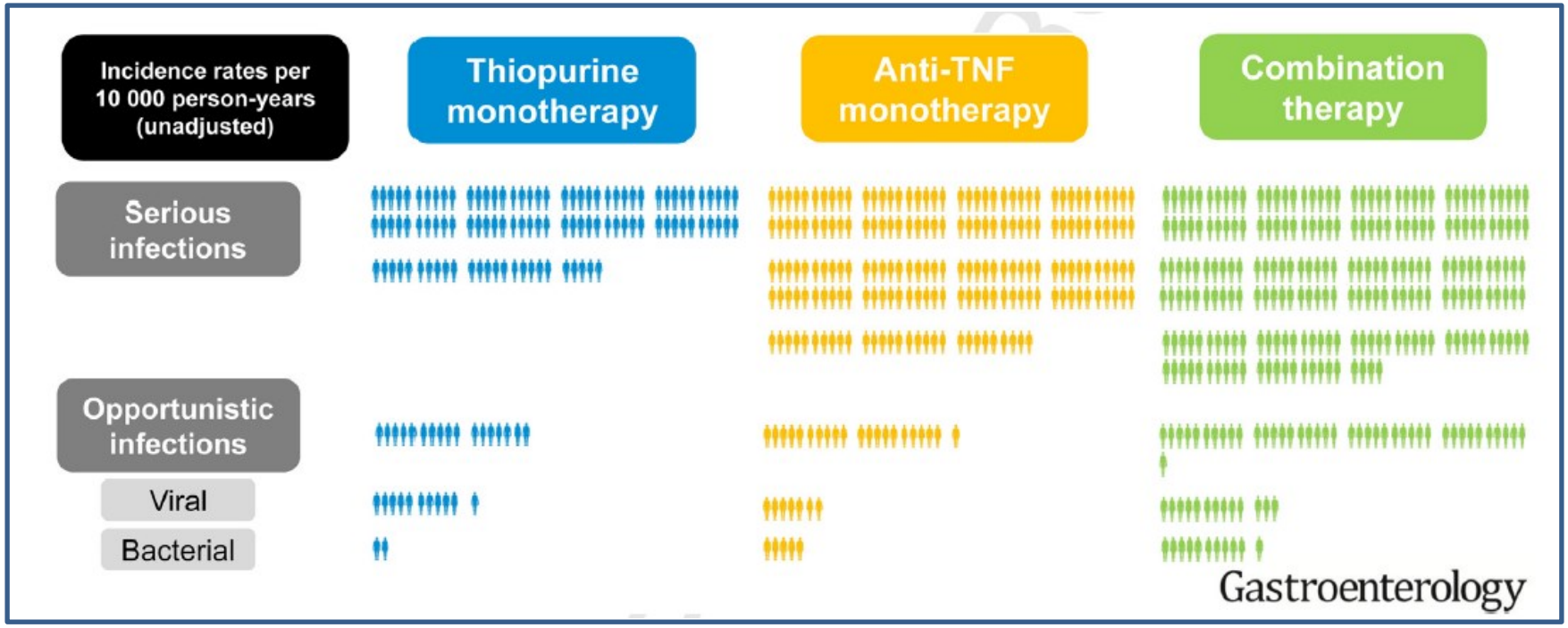
[a] Patients with incident IBD account for 254 927 PY of follow-up overall: 198 555 as unexposed, 30 698 as exposed to thiopurine monotherapy, 20 637 as exposed to anti-TNF monotherapy, and 5037 as exposed to combination therapy.

Treatment	No thiopurine no IFX	Thiopurine mono	IFX mono	Combotherapy
Pts.yrs	522 487	111 113	60 736	11 514
Lymphoma n HR (IC_{95})	166	56 **2.02** (1.08-2.26)	31 **1.75** (1.15-3.03)	13 **4.83** (2.51-9.16)

Lemaitre, JAMA 2017

Anti-TNF και Κίνδυνος για Λοιμώξεις

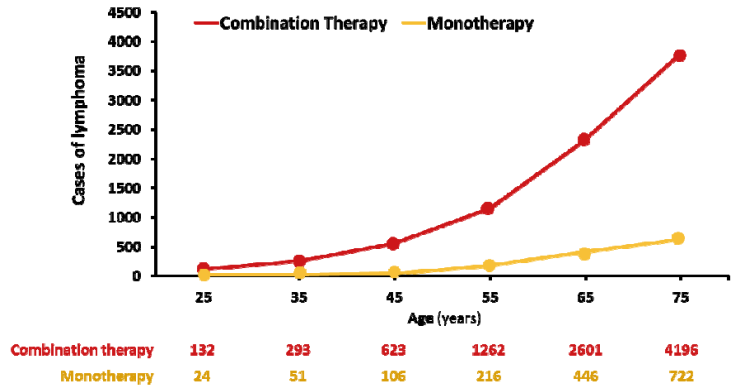
Anti-TNF Monotherapy, Combination Therapy, Thiopurines

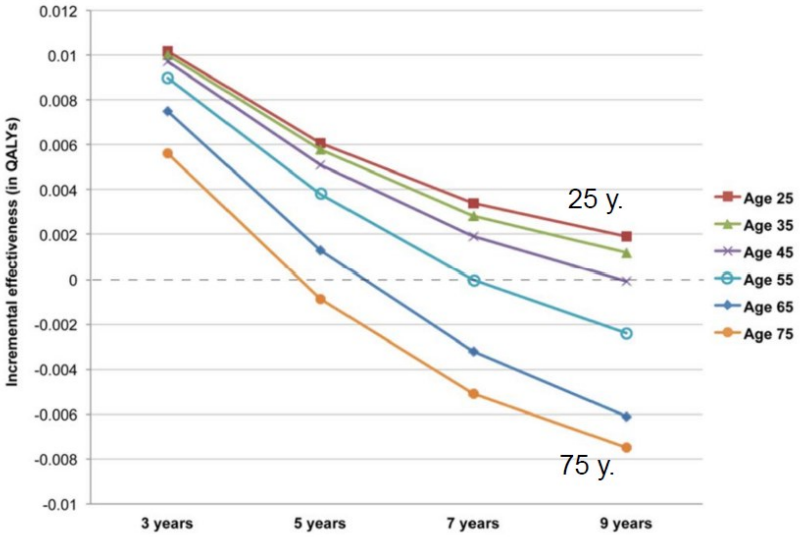


Ο κίνδυνος οφείλεται κυρίως στους anti-TNF

Kirchgesner, Gastro 2018

Anti-TNF (combo) και μεγάλη ηλικία: λιγότερη ασφάλεια αλλά και αποτελεσματικότητα





Scott, Clin Gastroenterol Hepatol 2016

Vedolixumab και Ασφάλεια

- Πρόγραμμα Κλινικών Μελετών GEMINI

-χωρίς σημαντικά αυξημένο κίνδυνο σοβαρών λοιμώξεων

-κανένα περιστατικό PML

-παράγοντες κινδύνου για λοιμώξεις: στεροειδή, anti TNF αποτυχία

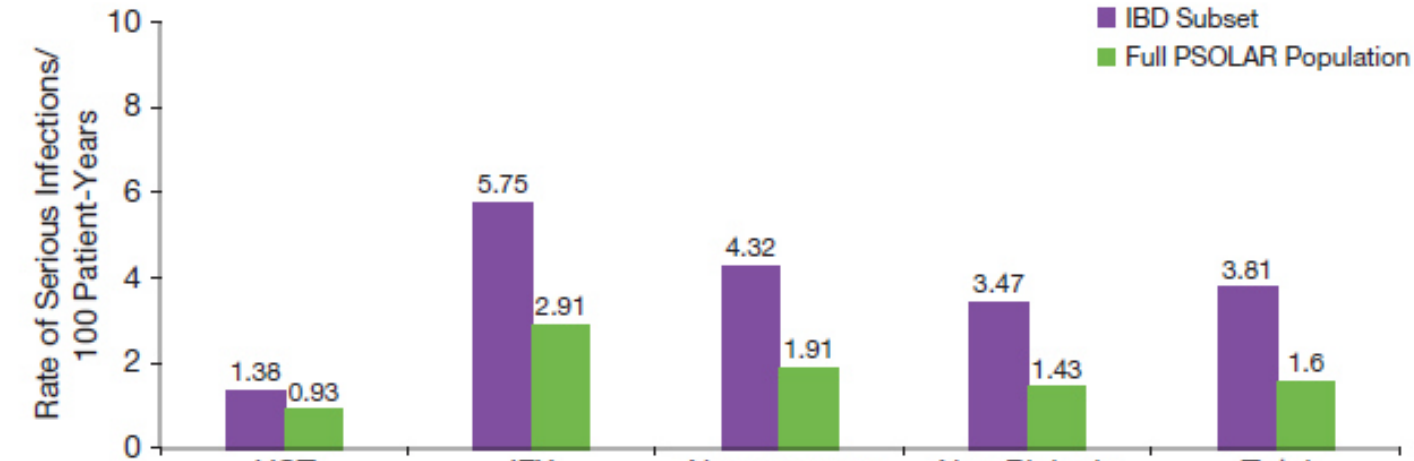
Colombel, Gut 2017

- **No black box warning**
- Περιεγχειρητική χρήση μάλλον ασφαλής

Lightner, JCC 2017

Ustekinumab και ασφάλεια

Figure 3. Rates of Serious Infections per 100 Patient-Years Within 91 Days of Biologic Administration

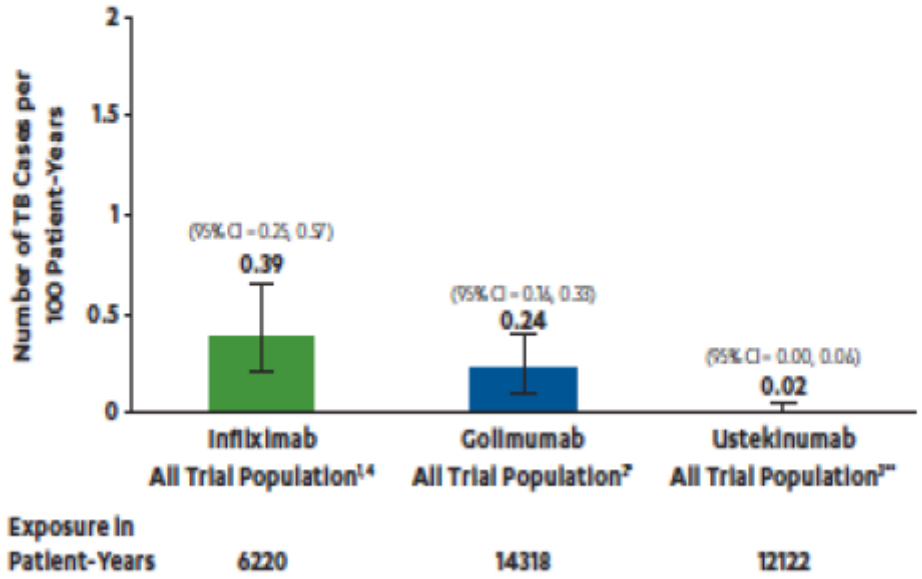


Patient-Years (N)	UST	IFX	Non-sponsor Biologic	Non Biologic	Total
IBD Subset	218	226	301	173	918
Full PSOLAR	7944	3301	12823	16322	40389

Loftus, ECCO 2016

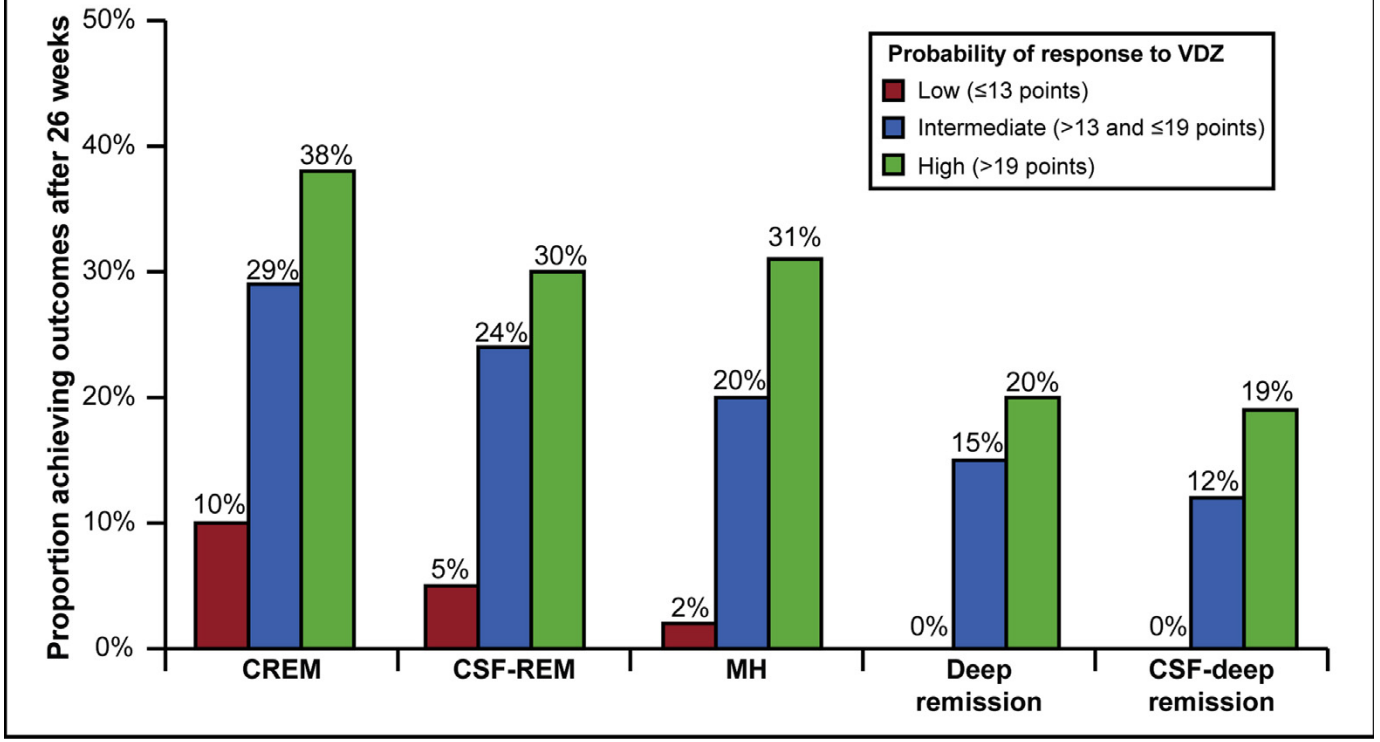
Βιολογικές θεραπείες και Φυματίωση

- Comparison of active TB cases across infliximab, golimumab and ustekinumab development programs



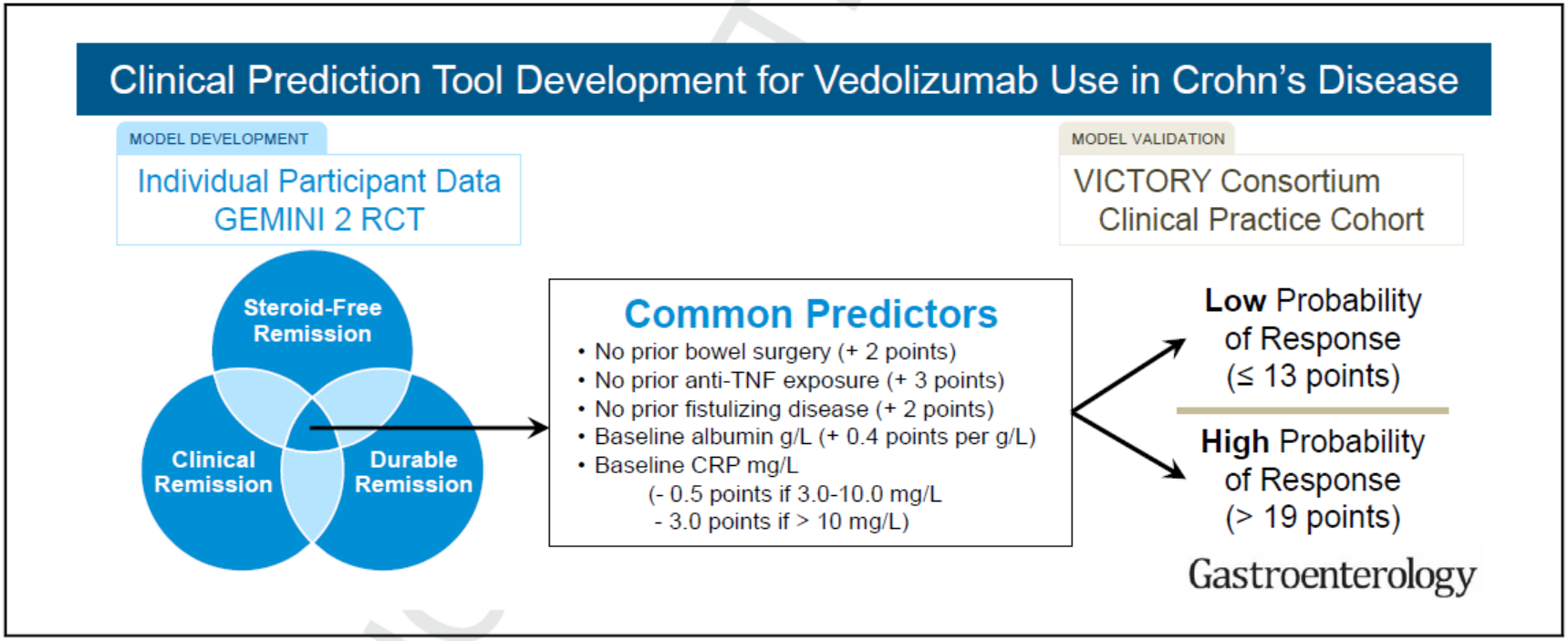
Έξυπνη Χρήση Vedolizumab σε Νόσο του Crohn

No prior bowel surgery	No prior TNFα-antagonist	No prior fistulizing disease	Baseline albumin	Baseline CRP
+ 2 points	+ 3 points	+ 2 points	+ 0.4 points per unit (g/L)	– 0.5 points if 3.0 –10.0 mg/L – 3.0 points if >10 mg/L



Dulai, Gastro 2018

CD: Vedolizumab Precision Tool



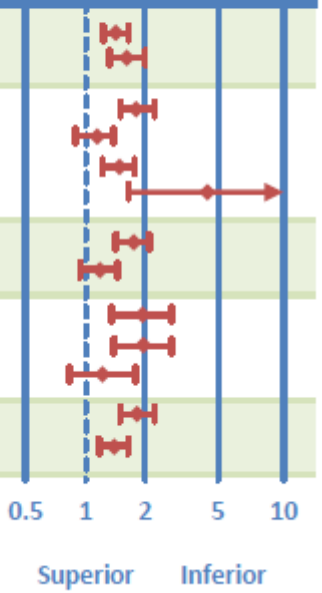
Dulai, Gastro 2018

BMI Και Ανταπόκριση σε Βιολογική θεραπεία
54 cohorts, 19,372 patients

Subgroup Analyses

Obesity and Failure to Achieve Remission/Response

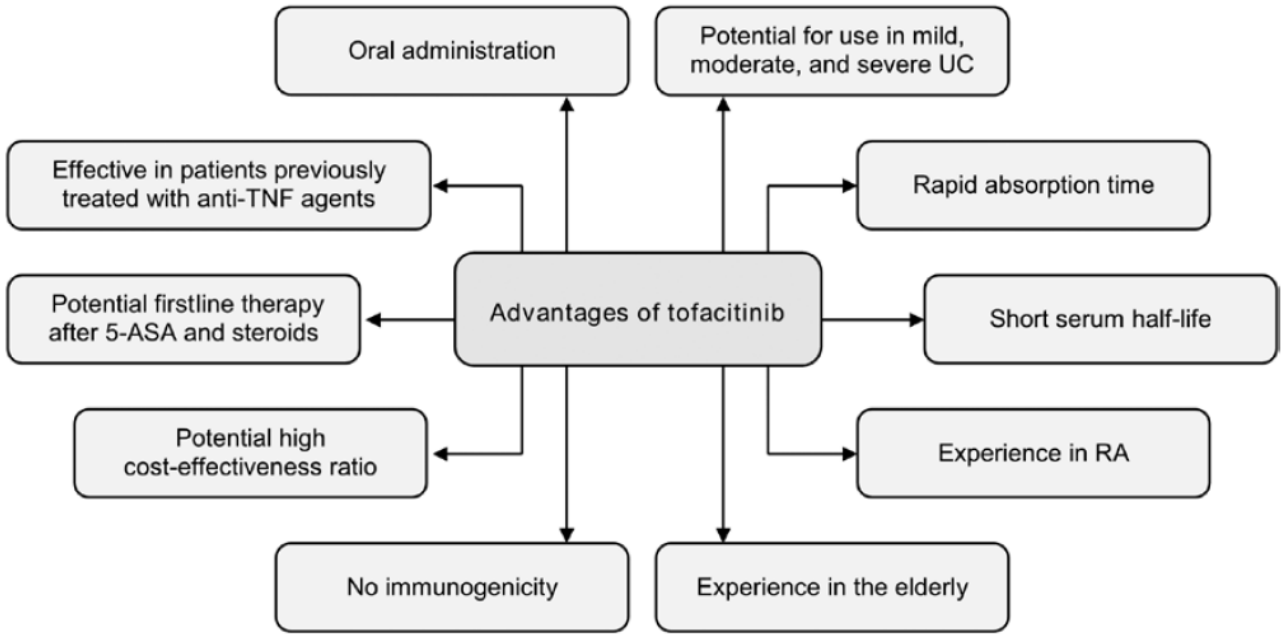
Subgroups	Categories (No. of Studies)	Odds Ratio	Lower Limit	Upper Limit
Study Design	RCTs (23)	1.46	1.26	1.70
	Observational (32)	1.65	1.38	1.98
Diseases	Rheumatoid Arthritis (11)	1.83	1.54	2.17
	IBD (19)	1.13	0.92	1.39
	Psoriasis/Psoriatic Arthritis (19)	1.50	1.24	1.82
	Spondyloarthopathies (6)	4.19	1.73	10.15
Outcome Definition	Disease Activity Indices (41)	1.77	1.46	2.14
	Failure of Therapy (14)	1.19	1.00	1.41
Exposure Comp-arators	Obese vs. Non-Obese (12)	1.92	1.36	2.71
	Obese vs. Normal BMI (15)	1.99	1.48	2.68
	Overweight vs. Normal BMI (9)	1.24	0.83	1.86
Dosing Type	Weight-based Dosing (15)	1.72	1.25	2.36
	Fixed Dose (28)	1.38	1.22	1.56



- **Σε όλες τις ρευματοπάθειες κακός προβλεπτικός δείκτης απάντησης σε anti-TNF**
- **1 Kg/m2 αύξηση του BMI, 6,5% υψηλότερη πιθανότητα αποτυχίας anti-TNF**
- **IBD;**

Singh, PLoS one 2018

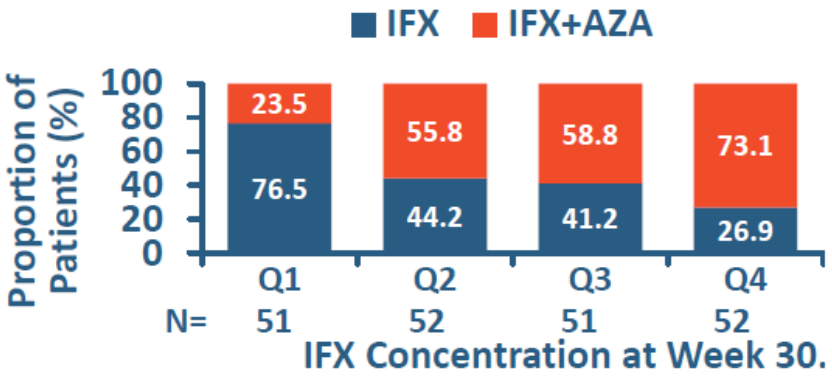
Tofacitinib και Ελκώδης Κολίτιδα

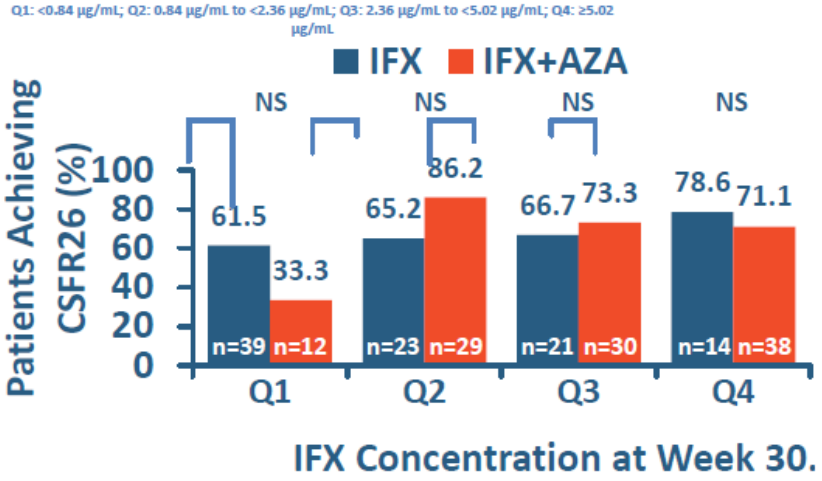


Ανοσοκαταστολή, Έρπητας Ζωστήρας;
Υπερλιπιδαιμία;
Κύηση;

Danese, Inflamm Bowel Dis 2018

SONIC: Infliximab combo vs mono: τα επίπεδα φαρμάκου κάνουν τη διαφορά -TDM





Colombel, Clin Gastroenterol Hepatol 2018

Βιοομοειδή-Biosimilars

…***Biosimilar infliximab and biosimilar adalimumab are effective treatments for patients with moderate-to-severe Crohn's disease and can be used for de novo induction and maintenance therapy.***

ACG Guidelines 2018

Εξατομικευμένη Θεραπευτική Προσέγγιση

- ✓ **Personalized Medicine**

  …is a medical procedure that separates patients into different groups with medical decisions, practices, interventions and /or products being tailored to the individual patient based on their predicted response or risk of disease

  Academy of Medical Science

- ✓ **Precision Medicine**

  …a form of medicine that uses information about the patients genes, proteins and environment to prevent, diagnose and treat disease

  National Cancer Institute

  National research Council

IBD: Personalized Medicine

Personalized medicine: Dream or reality?

Clinical | Serologic | Pharmacogenetics TDM Pharmacokinetics | Algorithms, Web-based Monitoring devices | Prediction of response | Microbiome Metabolome Diet Functional studies

Από Dotan, ECCO 2017

Προγνωστικοί δείκτες ανταπόκρισης σε biologics

-όχι vedolizumab: σε σοβαρή νόσο (κλινικά, ↑δείκτες φλεγμονής)
-ναι ustekinumab: L3 εντόπιση, χωρίς χειρουργείο, χωρίς επιπλοκή

(A)

Predictors of response in Crohn's disease	Anti-TNF alpha	Vedolizumab	Ustekinumab
Patient-related factors			
Young age at initiation			
Smoking			
High BMI			
Disease-related factors			
Shorter duration of disease			
Severe disease activity at induction			
Complicated phenotype (stricturing, penetrating)			
History of intestinal resection			
Ileocolonic disease			
Elevated inflammatory biomarkers			
No recent hospitalisation (12 months)			
Treatment-related factors			
Early response			
Mucosal healing			
Low trough level of biologic			
Anti-drug antibodies			
No prior anti-TNF exposure			
Concomitant steroid use			
Concomitant immunomodulator use			
Others			
Genetic: Fas-ligand-843 TT, caspase-9 93 CC/CT			
Microbiome: higher alpha diversity			

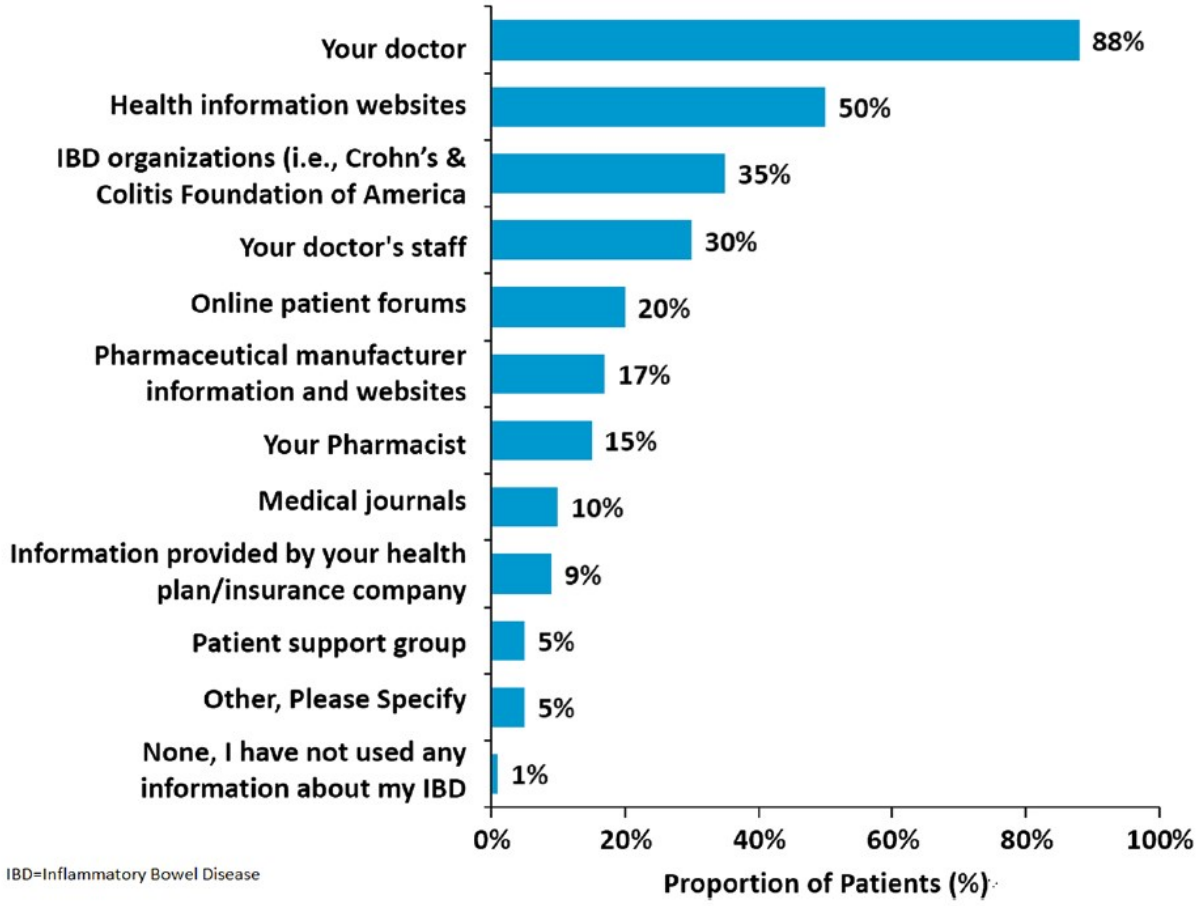
(B)

Predictors of response in ulcerative colitis	Anti-TNF alpha	Vedolizumab
Patient-related factors		
Young age		
High BMI		
Disease-related factors		
Severe disease activity at induction		
Disease extent		
Elevated inflammatory biomarkers		
High hemoglobin at baseline		
Low serum albumin		
pANCA +		
Treatment-related factors		
Early response		
Mucosal healing		
Low trough level of biologic		
Anti-drug antibodies		
No prior anti-TNF exposure		
Concomitant steroid use		
Concomitant immunomodulator use		
Others		
Genetic: high expression oncostatin M, TNF receptor 1 36G		

Positive predictor
Negative predictor
Insufficient data or controversy
Not examined

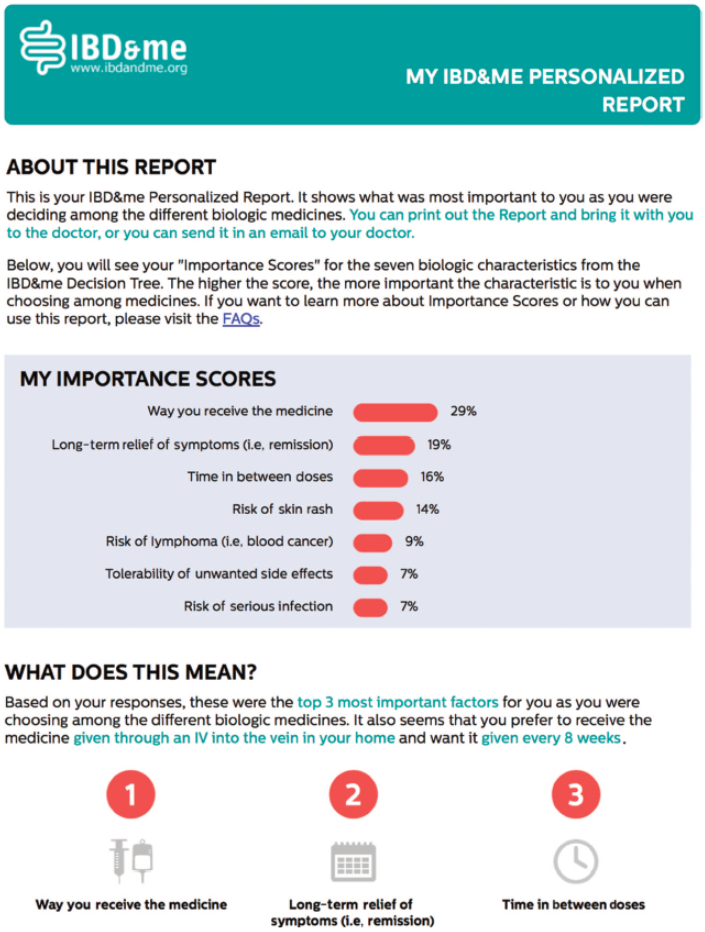
Barre, APT 2018

Shared decision Making: εφικτό;



Siegel, Patient 2015

Προτίμηση Ασθενή;
Μη προβλέψιμη! (δημογραφικά, χαρακτηριστικά της πάθησης)



IBD&me
www.ibdandme.org

MY IBD&ME PERSONALIZED REPORT

ABOUT THIS REPORT

This is your IBD&me Personalized Report. It shows what was most important to you as you were deciding among the different biologic medicines. You can print out the Report and bring it with you to the doctor, or you can send it in an email to your doctor.

Below, you will see your "Importance Scores" for the seven biologic characteristics from the IBD&me Decision Tree. The higher the score, the more important the characteristic is to you when choosing among medicines. If you want to learn more about Importance Scores or how you can use this report, please visit the FAQs.

MY IMPORTANCE SCORES

WHAT DOES THIS MEAN?

Based on your responses, these were the top 3 most important factors for you as you were choosing among the different biologic medicines. It also seems that you prefer to receive the medicine given through an IV into the vein in your home and want it given every 8 weeks.

- **Μηχανισμός δράσης;**
- **Τρόπος χορήγησης;**
- **Αποτελεσματικότητα;**

-ταχύτητα δράσης

-διάρκεια καλού αποτελέσματος

- **Ασφάλεια;**

-λοιμώξεις

-λέμφωμα

-εξάνθημα

Almario, Am J Gastroenterolo 2017

Επιλογή Βιολογικών στην Δερματολογία
Ψωρίαση

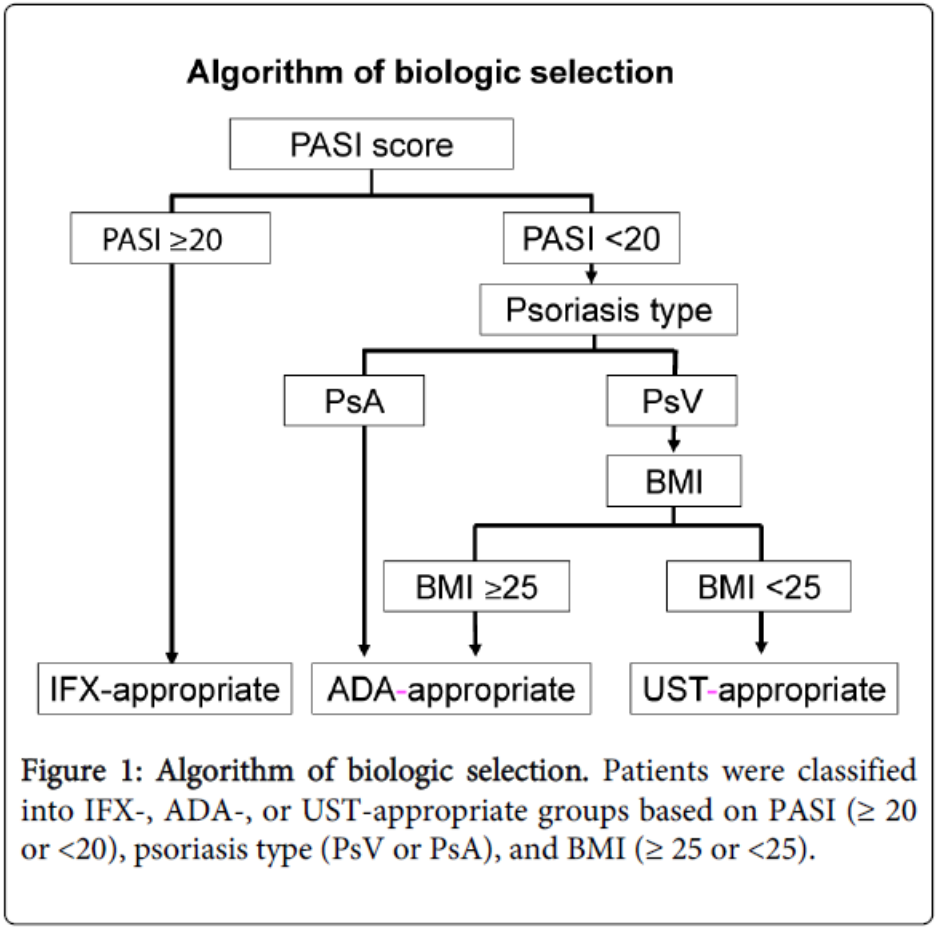
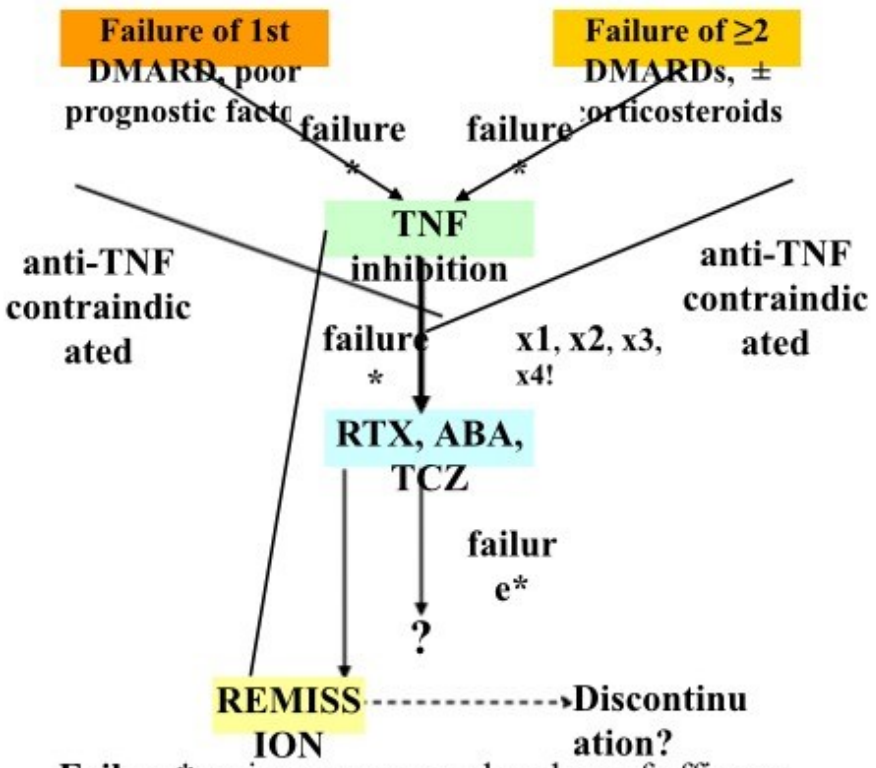


Figure 1: Algorithm of biologic selection. Patients were classified into IFX-, ADA-, or UST-appropriate groups based on PASI (≥ 20 or <20), psoriasis type (PsV or PsA), and BMI (≥ 25 or <25).

Umezawa J Clin Exp Dermatol Res 2015

Επιλογή Βιολογικών στην Ρευματολογία
Ρευματοειδής Αρθρίτιδα



Failure*: primary or secondary loss of efficacy, intolerance. Even moderate response! (After optimizing DMARD dose and/or trying combination of DMARDs).

Van Hollenhofe, 2015

Επιλογή Βιολογικού Παράγοντα 2018

Αποτελεσματικότητα

Δραστηριότητα Νόσου

Έκταση και Εντόπιση

Εξωεντερικές Εκδηλώσεις

Συρίγγια

Οξεία Βαριά Κολίτιδα

Σωματικό βάρος

Ασφάλεια

Ηλικία (<18, 18-65, >65)

Λοιμώξεις

Λέμφωμα (καρκίνος;)

Απομυελινωτική Νόσος

Καρδιακή Ανεπάρκεια

Κύηση

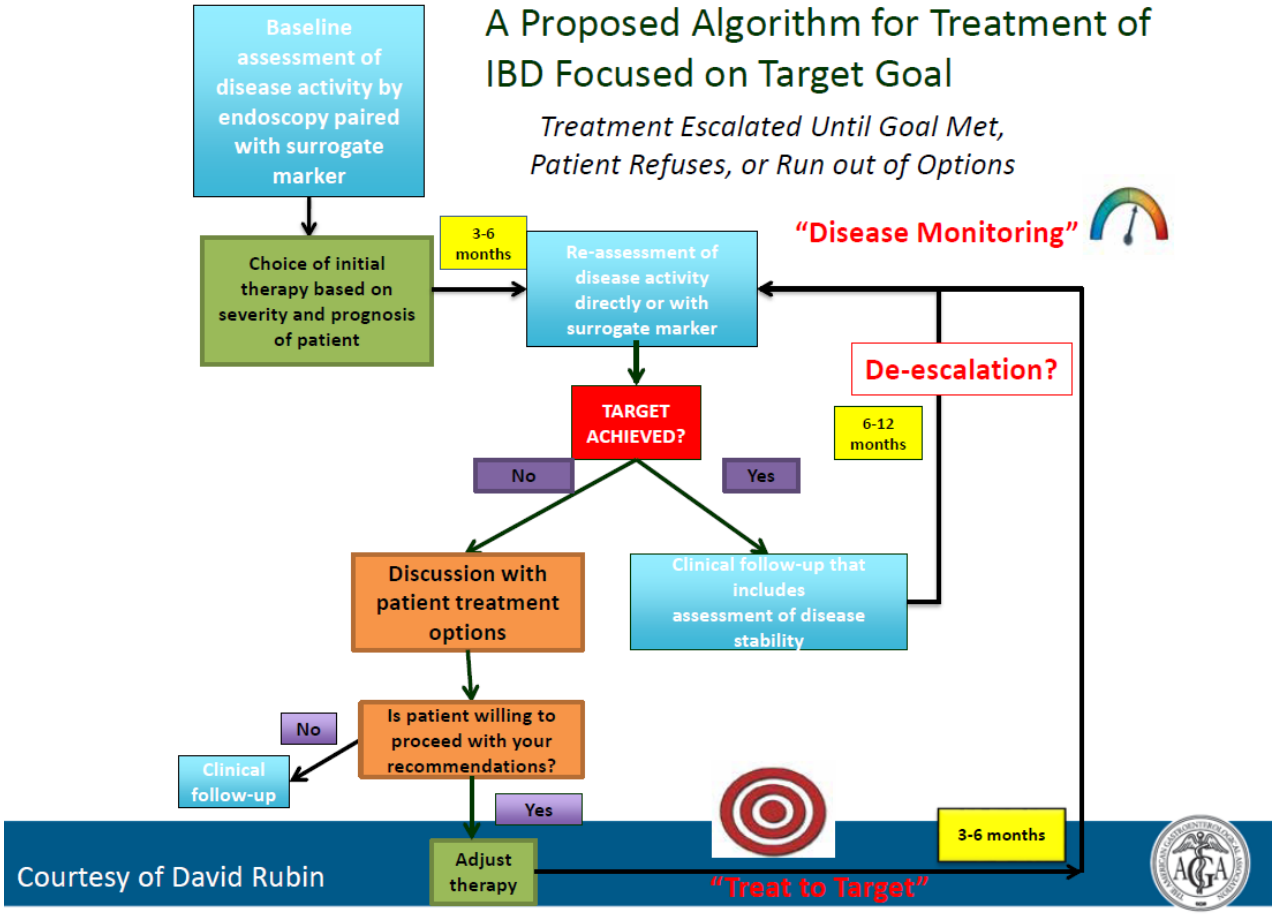
Προτίμηση ασθενή

Οδός Χορήγησης

Διαθεσιμότητα

Κόστος

Ανεξάρτητα από επιλογή, T2T



Ευχαριστώ Πολύ

ΕΛΛΗΝΙΚΗ ΓΑΣΤΡΕΝΤΕΡΟΛΟΓΙΚΗ ΕΤΑΙΡΕΙΑ
ΤΜΗΜΑ ΒΟΡΕΙΟΥ ΕΛΛΑΔΟΣ "ΜΑΚΕΔΟΝΙΑ"

Επιστημονική Εκπαιδευτική Διημερίδα

5-6 ΟΚΤΩΒΡΙΟΥ 2018

Ολυμπιακό Μουσείο Θεσσαλονίκης