DDW GI Potpourri
Colitides beyond UC and Crohn

Deborah Flomenhoft, MD

Professor of Internal Medicine

DDW Review 8/22/2026

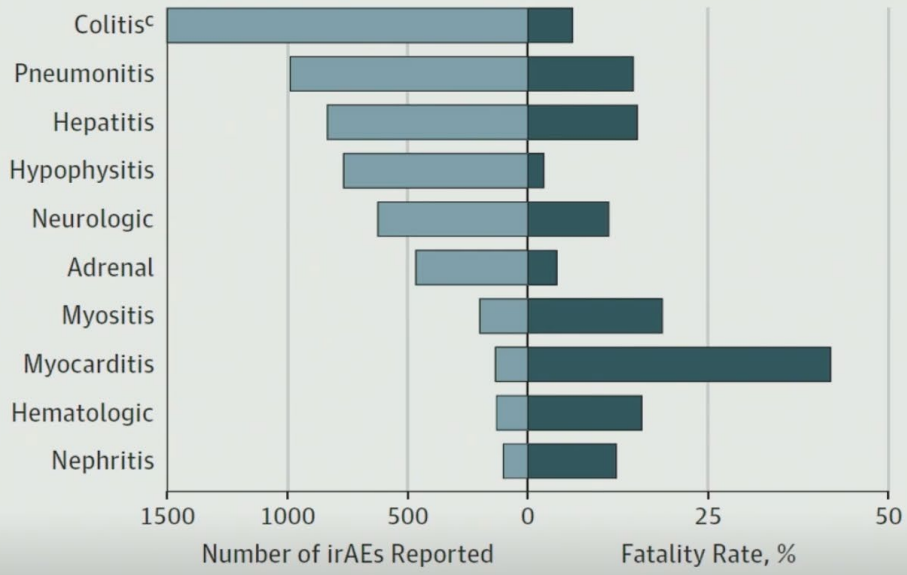
Disclosures

- I will be discussing off label usage of medications as presented in studies at DDW
- Janssen: consultant, speaker
- Abbvie: consultant

Objectives

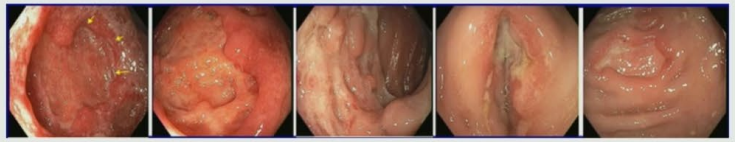
- Review risks of Check point inhibitors systemically
- Apply appropriate treatment modalities for ICI colitis
- Outline demographics and treatment patterns of microscopic colitis in the community.
- Review Rome V changes to DGBI and understand how changes may affect practice.

FATALITIES FROM IRAES BY ORGAN INVOLVED

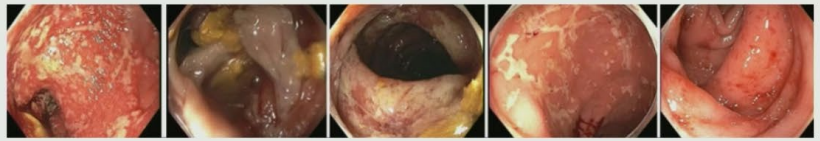


Wang et al. JAMA Oncol. 2018;4(12):1721-1728

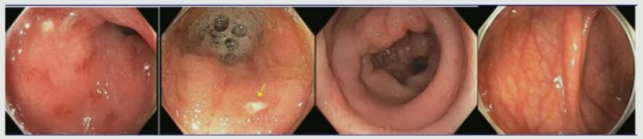
ENDOSCOPY FEATURES



Severe inflammation with large deep ulcers



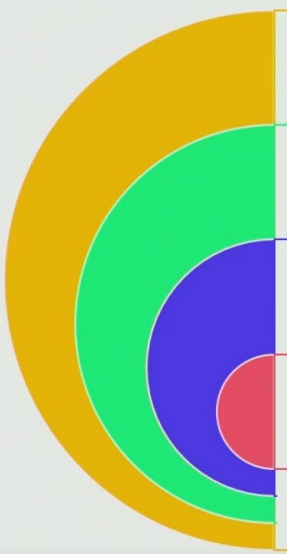
Moderate inflammation with erythema, exudate, superficial ulcers



Mild inflammation with patchy erythema, aphtha, edema, or normal mucosa

Wang et al Inflammatory Bowel Disease 2018;24(8):1695-1705.

TREATMENT OPTIONS



Supportive	• Loperamide • Fiber • Diphenoxylate/atropine
Non-immunosuppressant	• Mesalamine • Cholestyramine
Immunosuppressants	• Corticosteroid (Prednisone, Budesonide) • SITs (Infliximab, Vedolizumab, Ustekinumab, Tofacitinib)
Investigational	• Fecal transplantation • Tocilizumab

Treatment regimens are based on CTCAE grade, endoscopy finding and treating physician's expertise.

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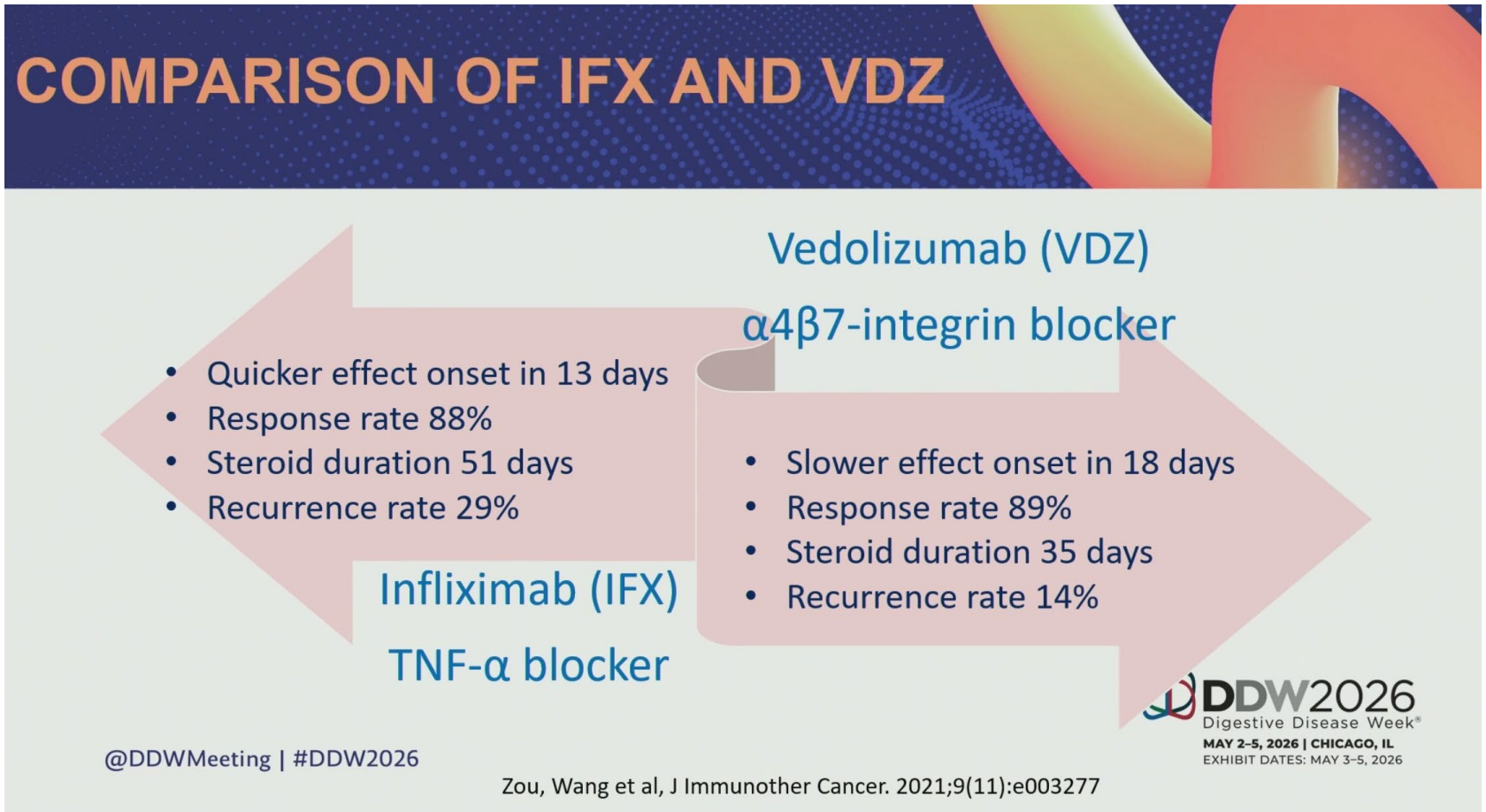
COMPARISON OF IFX AND VDZ



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Zou, Wang et al, J Immunother Cancer. 2021;9(11):e003277

AIM AND INCLUSION CRITERIA

Aim: to prove that vedolizumab is non-inferior to infliximab in achieving therapeutic efficacy for IMC

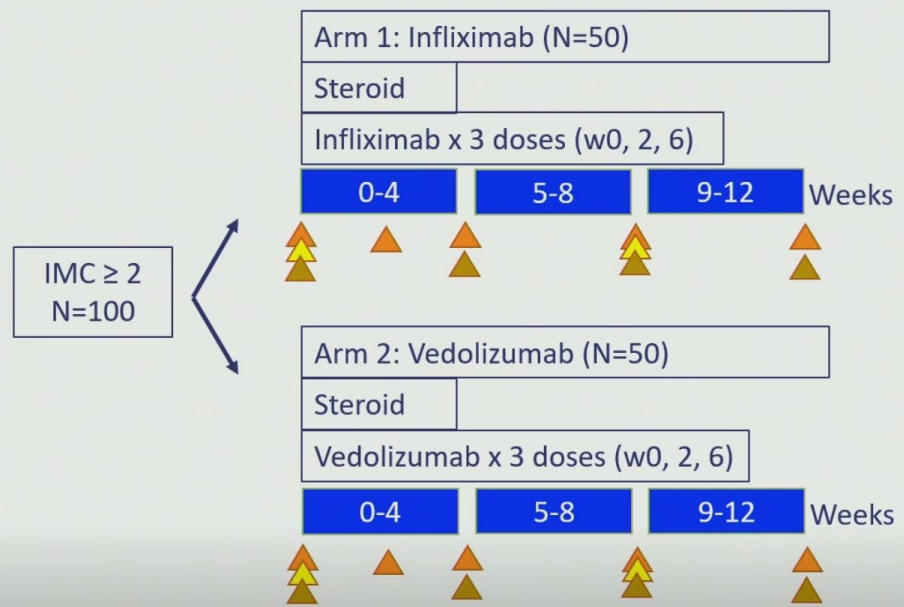
- Single center phase 2 study at UT MD Anderson Cancer Center
- 05/01/2021 – 12/01/2025

Inclusion criteria:

- Adults age ≥ 18
- ICI diarrhea/colitis (CTCAE 2+)
- All cancer types
- No pre-existing IBD, microscopic colitis, or active GI infection

NCT 04407247

STUDY DESIGN



Clinical and adverse event assessment

Endoscopy/histology assessment

Research stool and blood sample

ENDPOINTS

Primary endpoints:

- Clinical response/remission at 2 weeks timepoint
- Adverse events related to SIT within study window

Secondary endpoints:

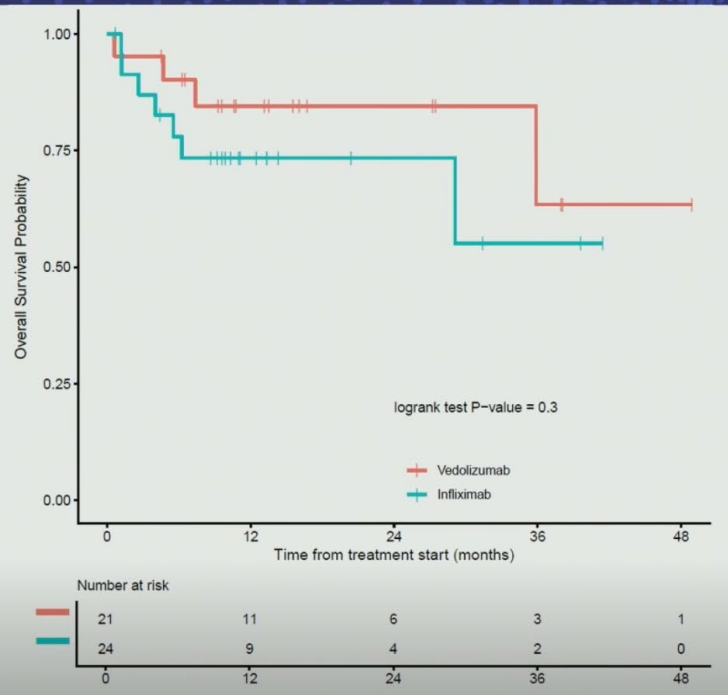
- Clinical response/remission at 12 weeks timepoint
- Steroid free remission at 30 days
- IMC recurrence in the study window of 3 months

STUDY OUTCOME (MODIFIED ITT)

Characteristics	No. (%)		
Outcome	Infliximab arm, n=23	Vedolizumab arm, n=21	P value
Remission achieved on SIT at 2 weeks	19 (83)	19 (90)	0.666
Median days of symptoms improvement after SIT, (IQR)	5 (1-14)	4 (2-8)	0.464
30 days steroid free remission	17 (77)	15 (71)	0.736
Remission achieved on SIT at 12 weeks, n=35	16 (80)	19 (100)*	0.106
Resumed ICI after colitis event, n=39	2 (9)	6 (29)	0.132
IMC recurrence in study window	7 (33)	4 (19)	0.484
Adverse events by 2 weeks	5 (24)	6 (29)	1.000

Only evaluable patients (Ferrington-Manning Method)

OVERALL SURVIVAL



Discovery at Every Turn

REAL-WORLD TREATMENT PATTERNS IN MICROSCOPIC COLITIS

A Nationwide Study from Sweden

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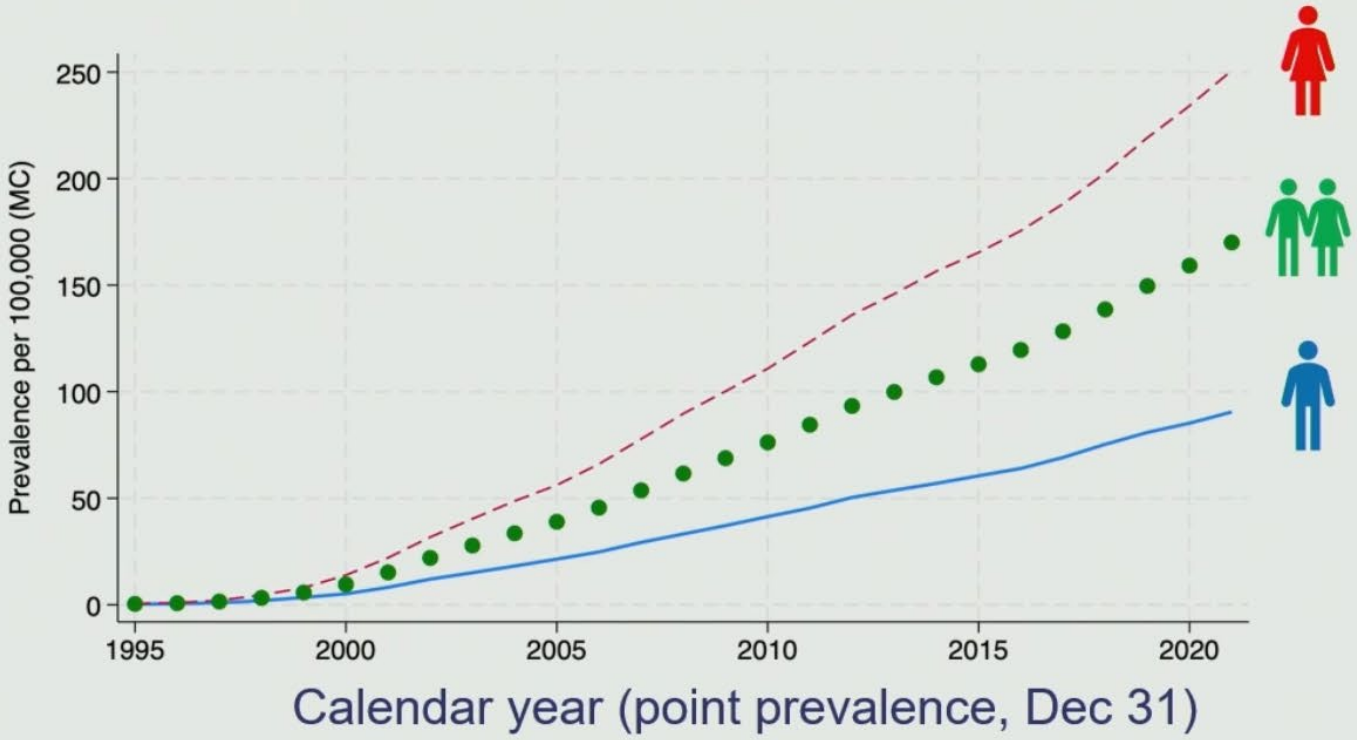
PREVALENCE



- Prevalence of MC 2021: 170 per 100,000 individuals
- Lifetime risk: 1 in 54 for women
- Lifetime risk: 1 in 133 for men.

Bergman et al. Increasing incidence and prevalence of Microscopic Colitis in Sweden: A nationwide population-based cohort study, *Clinical Gastroenterology and Hepatology*

TREATMENT

Risk factors

Comorbidities

Medical Treatment

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DISEASE ACTIVITY

Hjortswang criteria[1]

- **Clinical remission**
- Mean of <3 stools per day
- and <1 watery stool per day over a given week

MCDAI[2]

- **Disease activity**
- Average number of unformed stools per day
- Presence of nocturnal stools
- Abdominal pain
- Weight loss
- Fecal urgency
- Fecal incontinence

MCS[3]

- **Disease activity**
- Nocturnal stools disrupting
- Loose stools
- Urgency
- Fecal leakage
- Abdominal pain.

MCDAI, Microscopic Colitis Disease Activity Index; MCS, Microscopic Colitis Score

1. Hjortswang H, et al. Defining clinical criteria for clinical remission and disease activity in collagenous colitis. *Inflamm Bowel Dis* 2009; 15: 1875–1881. 20090605. DOI: 10.1002/ibd.20977.
2. Cotter TG, et al. Development of a Microscopic Colitis Disease Activity Index: a prospective cohort study. *Gut* 2018; 67: 441–446. 20161213. DOI: 10.1136/gutjnl-2016-313051.
3. Pihl Lesnovska K, et al. Development and validation of a novel patient-reported outcome for microscopic colitis-Microscopic Colitis Score (MCS). *J Crohns Colitis* 2025; 19. DOI: 10.1093/ecco-jcc/jjaf153.

AIMS

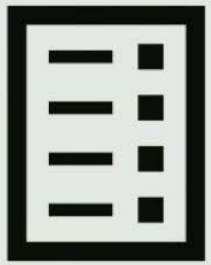
- **Aim 1**: To suggest a register-based definition for MC disease activity based on prescription records

- **Aim 2**: To describe and quantify treatments of MC in Sweden

ESPRESSO
Epidemiology Strengthened by Histooathology Reports in Sweden

DATA SOURCES

Patients with GI-biopsy



National Patient Register

Cause of Death Register

Total Population Register

Prescribed Drug Register

Medical Birth Register

Cancer Register

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AIM 1: BUDESONIDE PROXY

Treatment classes based on the first year post diagnosis[4]

- **Class 1:** No budesonide use
- **Class 2:** Single treatment episode
- **Class 3:** Repeated treatment episodes

AIM 2: TREATMENT HIERARCHY

*Infliximab, Adalimumab, Ustekinumab, Rituximab, Vedolizumab, Tofacitinib

Symptomatic or no treatment

Budesonide

Cholestyramine

5-ASA

Required absence of

IBD

Azathioprine

Required absence of

Rheumatoid arthritis

SLE

Autoimmune hepatitis

Myositis

Polyarteritis nodosa

Autoimmune hemolytic anemia

ITP

Biologics*

Required absence of

MS

RA

JRA

Behcet´s disease

Spondyloarthritis

Polyarthritis

Psoriasis

Psoriatic arthritis

Ankylosing spondylitis

IBD

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BASELINE CHARACTERISTICS

	Study population
Number of patients with MC (%)	19,942 (100)
- Collagenous colitis (%)	6,686 (33.5)
- Lymphocytic colitis (%)	13,256 (66.5)
Women (%)	14,276 (71.5)
Median age (IQR)	64 (51-74)

RESULTS: BUDESONIDE USE

- **Class 1:** No budesonide use
- **Class 2:** Single treatment episode
- **Class 3:** Repeated treatment episodes

Proportion of budesonide treatment classes by year of diagnosis and overall

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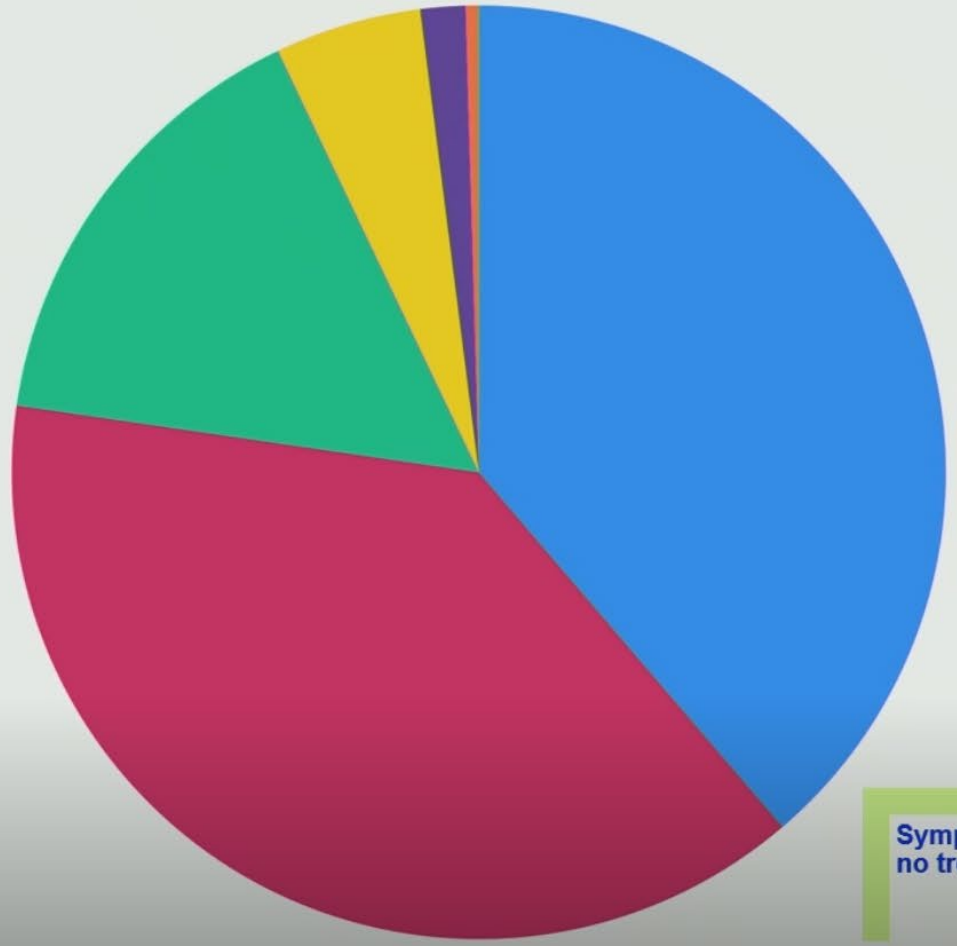
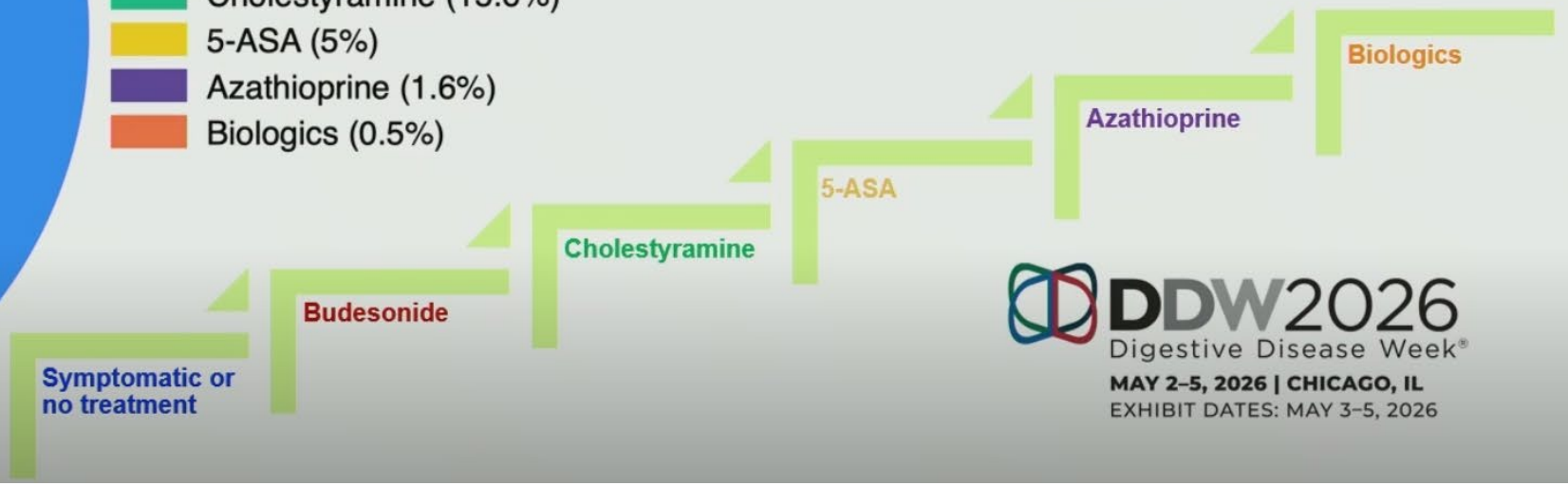
RESULTS: TREATMENT HIERARCHY

Highest achieved treatment among patients with MC in Sweden from 2006 to 2023



- None/symptomatic (38.7%)
- Budesonide (38.6%)
- Cholestyramine (15.6%)
- 5-ASA (5%)
- Azathioprine (1.6%)
- Biologics (0.5%)



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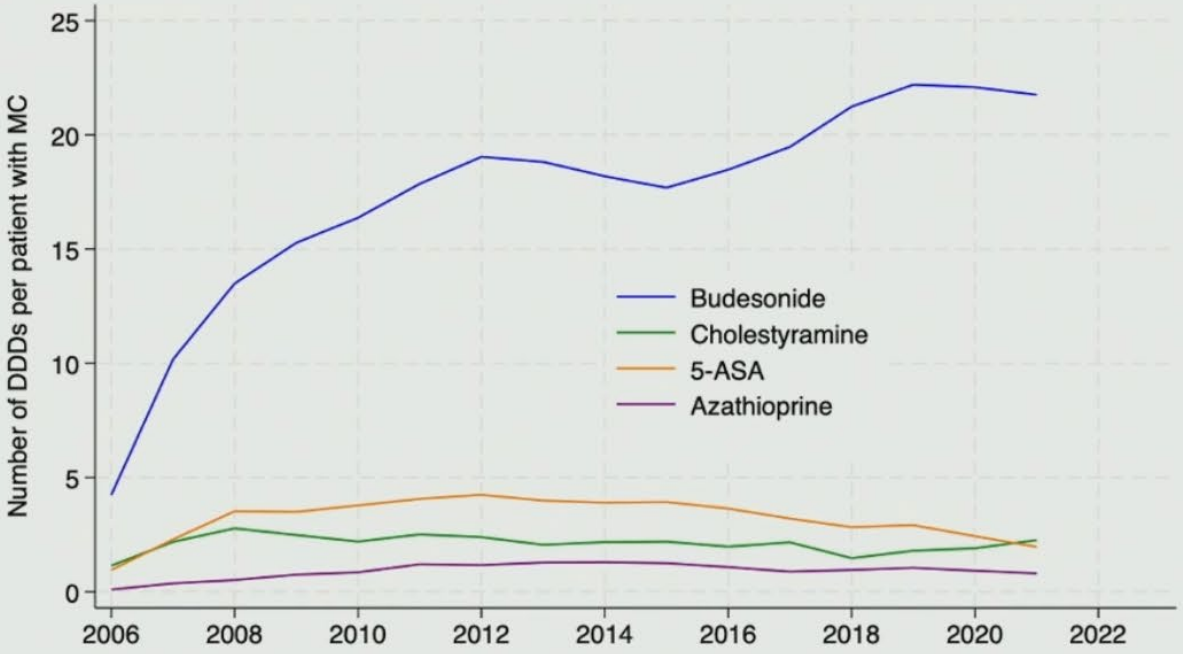
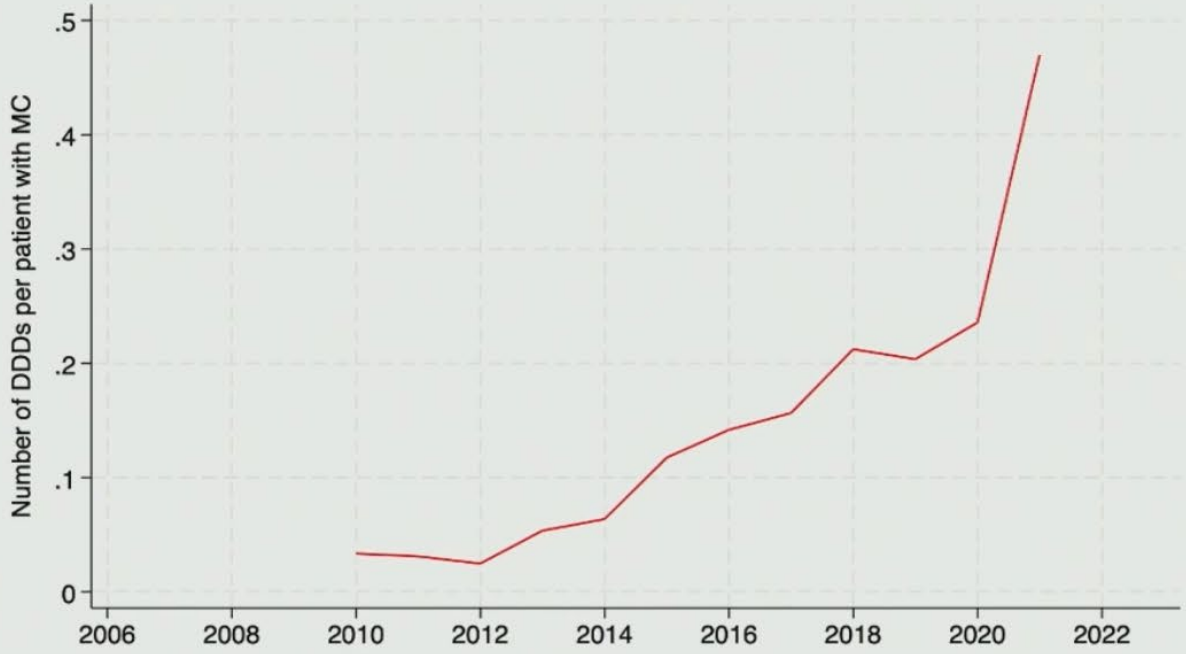
RESULTS – TEMPORAL TRENDS



Number of defined daily doses per patient with MC in Sweden 2006-2021

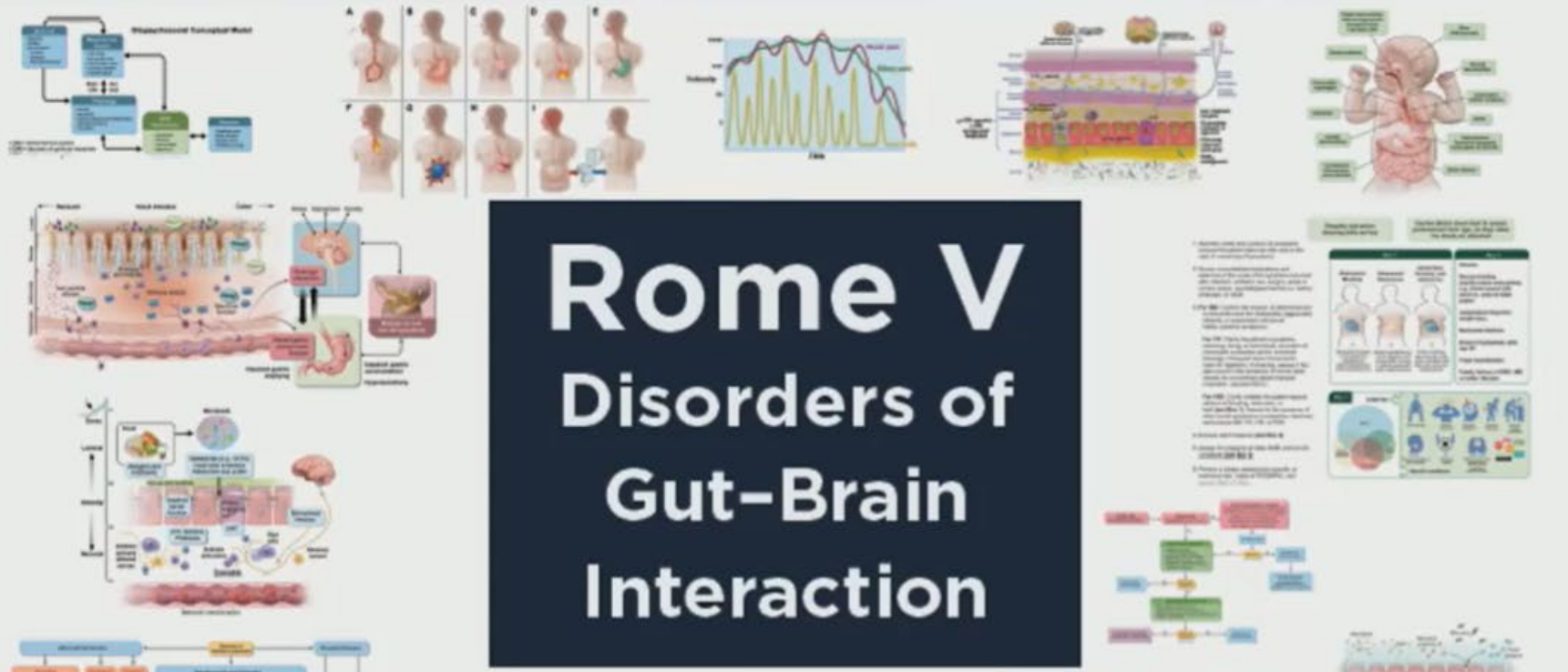


Number of defined daily doses (biologics*) per patient with MC in Sweden 2006-2021

*hospital administered infliximab not included

Gastroenterology

Volume 170 / Issue 6 May 2026 www.gastrojournal.org



Rome V
Disorders of Gut–Brain Interaction

Free access of Rome V Manuscripts in *Gastroenterology*

SCAN ME

B1: Functional Dyspepsia

B1a. PDS

In the presence of 1a and/or 1b, other bothersome symptoms (i.e., postprandial epigastric pain or burning, postprandial nausea, postprandial upper abdominal bloating, or postprandial excessive belching) that are elicited or worsened by food ingestion are part of PDS

B1b. EPS

Nausea and vomiting can coexist; however, in the presence of predominant nausea or recurrent vomiting the diagnosis of CNVS or gastroparesis should be considered.

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Diagnostic approach

Upper GI endoscopy not mandatory

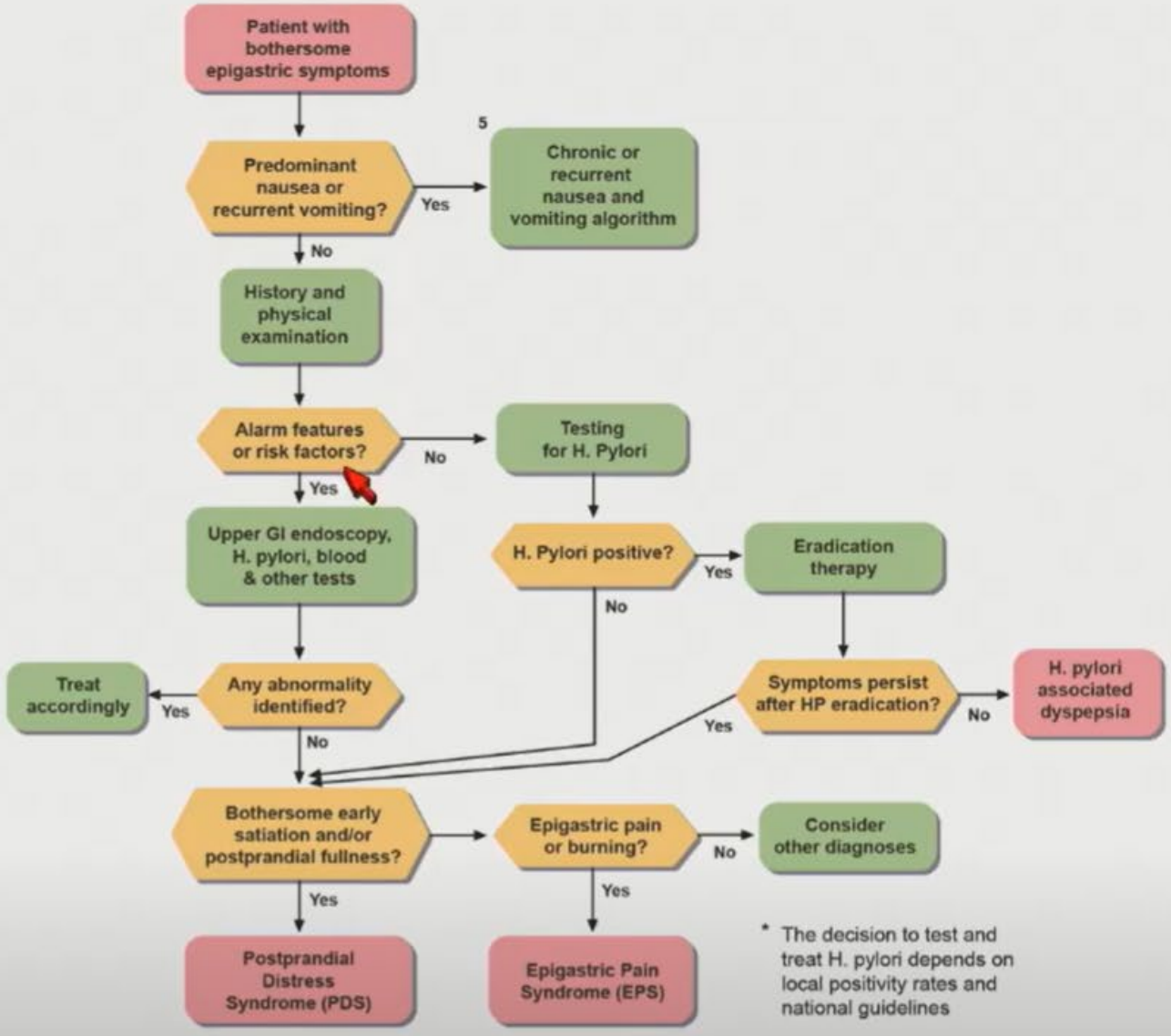
Diagnostic Criteria* for Functional Dyspepsia**

1. *One or more* of the following:
   - a. Bothersome postprandial fullness
   - b. Bothersome early satiation
   - c. Bothersome epigastric pain
   - d. Bothersome epigastric burning

2. No evidence of structural, systemic, or metabolic disease that is likely to explain the symptoms

* Criteria fulfilled for the last 3 months with symptom onset at least 6 months before diagnosis

** Must fulfill criteria for B1a (postprandial distress syndrome) and/or B1b (epigastric pain syndrome)



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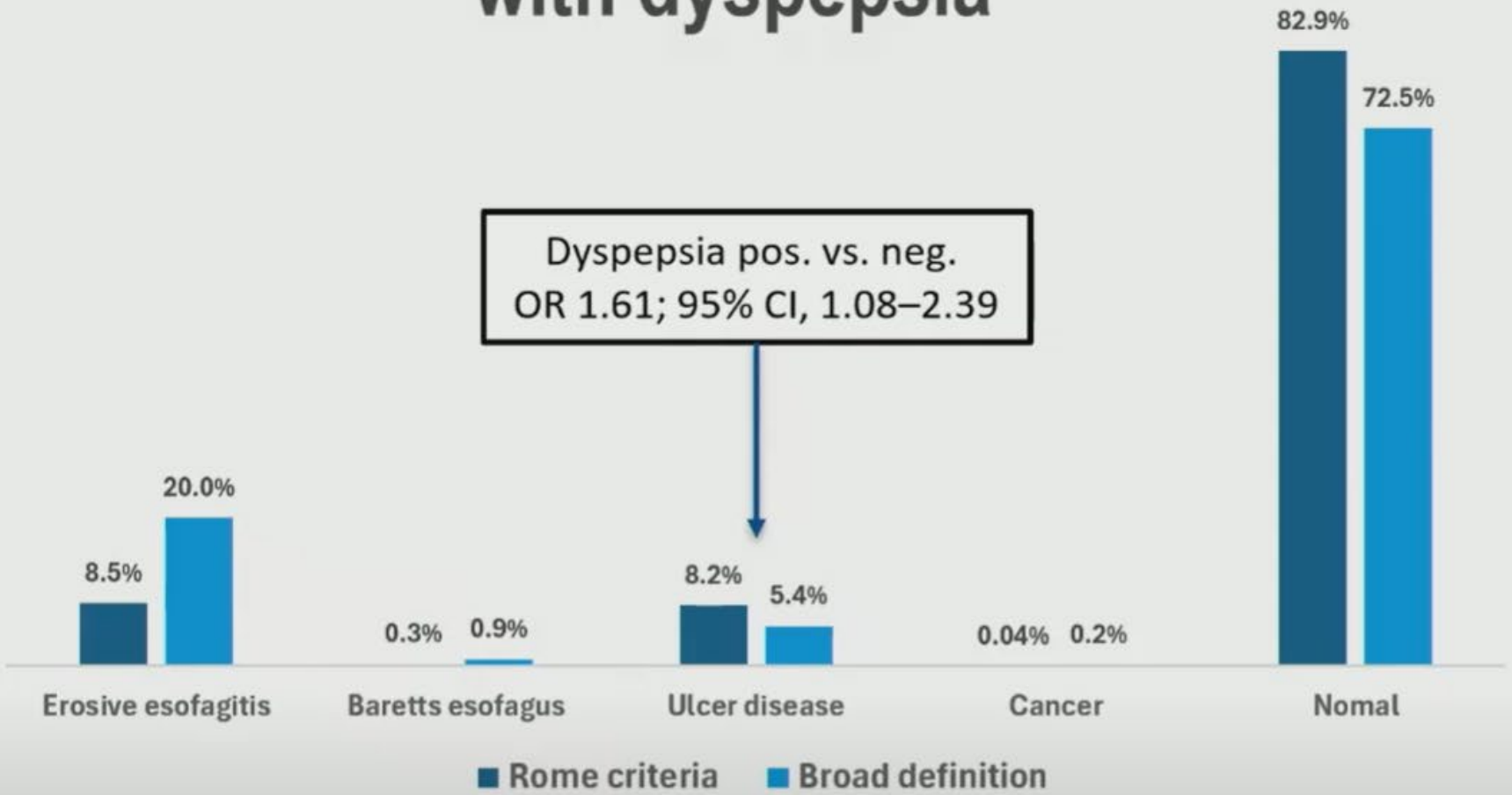
Clinically significant endoscopic findings in subjects with dyspepsia



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Nasseri-Maghaddam et al. Clin Gastroenterol Hepatol 2023

Rome V IBS: Diagnostic Recommendations

- More explicit – but still limited – testing
- Targeted testing
  - All: CBC, CRP, celiac testing
  - Selective: TSH, CMP, stook giardia antigen, enteric pathogen, calprotectin; celiac serology, selective stool testing
  - Selective: BAM, anorectal testing,
  - Do not routinely perform: SIBO, O&P, ESR, CT scan, colonoscopy, anti-vinculin antibody
- Recommendations included a global perspective
  - Informed by international guideline comparisons (including in supplemental material) to reduce over testing and improve efficiency