

Best of 2025/2026
IBD articles

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Disclosures

- Research support (subinvestigator on protocols)
 - CorEvitas
 - Vedanta Biosciences
 - Roche/Genentech
 - Abivax

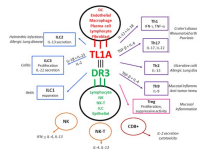
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Three molecules, one
target

Anti-TL1A
comes of age

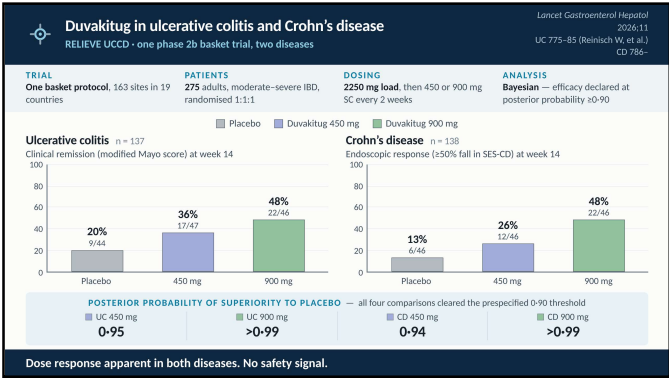
TL1A drives both intestinal inflammation and
fibrosis

Between late 2025 and 2026, three structurally
distinct anti-TL1As reported controlled data in IBD.



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Three anti-TL1A molecules, three independent signals

What matters more than a single trial:
Three structurally distinct antibodies, three independent development programmes, and a consistent direction of effect. That is much harder to explain as chance than one positive phase 2 result — TL1A is behaving like a validated therapeutic class, not a single promising drug.

Molecule	Trial and publication	Population	Key result
Tulisokibart (MK-7240)	ARTEMIS-UC, phase 2 N Engl J Med 2024;391:1119-1129	Moderate-to-severe UC	Clinical remission at week 12: 26% vs 1% placebo (cohort 1); 32% vs 11% in the biomarker-positive cohort 2.
Afinikibart (RVF-3101)	TUSCANY-2, phase 2b Lancet Gastroenterol Hepatol 2025;10:882-895	Moderate-to-severe UC	Clinical remission at week 14: 26% / 23% / 24% (50, 150, 450 mg) vs 12% placebo. Primary endpoint was NOT statistically significant — but the direction was consistent across all three doses and secondary endpoints.
Duvakitug	RELIEVE UC, phase 2b Lancet Gastroenterol Hepatol 2026;11:775-796	Moderate-to-severe UC and CD	UC clinical remission at week 14: 48% vs 20% placebo. CD endoscopic response at week 14: 48% vs 13% placebo.

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What this means for Monday morning

Start the conversation now with your most refractory patients — clinical trial participation is currently the only route of access to anti-TL1A therapy

Consider TL1A-directed trials particularly for fibrostenotic Crohn's disease

TL1A drives fibrosis as well as inflammation, which no currently approved mechanism targets directly

Consider for patients who have failed multiple mechanistic classes, where the next approved option offers diminishing returns

Three independent programmes pointing the same direction means this class is very likely to reach the clinic

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Interventions that aren't drugs



Disease modification does not only come only from immunosuppression.

An operation, an earlier operation, and a diet — each tested against a real comparator, each with a result worth changing a conversation over.

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ACCURE Appendectomy for maintenance of remission in ulcerative colitis

Lancet Gastroenterol Hepatol 2025; 10:550-561

PATIENTS
197 adults with UC in remission after a relapse in the past year

DESIGN
Pragmatic **open-label RCT**, 1:1
· 22 centres, NL / Ireland / UK

COMPARISON
Laparoscopic appendectomy + usual therapy vs usual therapy alone

WHY THE APPENDIX
A reservoir of immune activity, long linked to lower UC risk

Relapse within 1 year masked adjudication · each circle = 1 patient in 100

Medical therapy alone

56%

55 of 98 patients



Plus appendectomy

36%

36 of 99 patients



READ WITH CARE

- Open-label, with no sham-surgery arm — a placebo effect cannot be excluded
- Enrolled over 10 years; likely participation bias
- Not every relapse was confirmed endoscopically

Relative risk 0.65 95% CI 0.47-0.89 · p = 0.005

No colectomies in either arm · 2% serious surgical complications

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LIRIC What the trial has shown, and what is new at 10 years

Lancet Gastroenterol Hepatol 2026; 11:314-322

ONE RANDOMISED COHORT, FOLLOWED FOR A DECADE

2017
The original trial
143 adults with limited (≤40 cm) non-stricturing ileocaecal Crohn's. Resection gave **similar quality of life** to infliximab at 1 year.

2020
Five-year follow-up
42% needed no additional Crohn's medical therapy; **74%** stayed free of biologics.

2026
Ten-year follow-up
129 of 143 (**90%**) traced, median follow-up **11 years**. Retrospective review of the randomised cohort.

THE REST OF THE EVIDENCE

- Only one other RCT exists — a Swedish trial stopped early, with no clinically significant difference.
- Observational cohort of **1279 patients**: resection linked to a **33% lower risk** of hospitalisation, steroids, surgery and perianal disease.

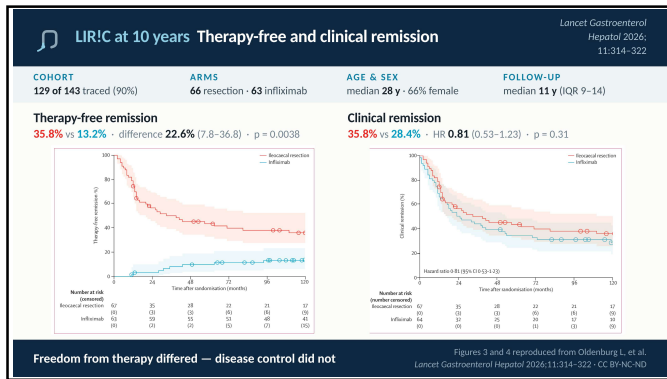
WHAT THIS STUDY ADDS

- **First long-term evidence** that many stay free of Crohn's medical therapy a decade after surgery.
- Exploratory signal that **younger patients gain most**.

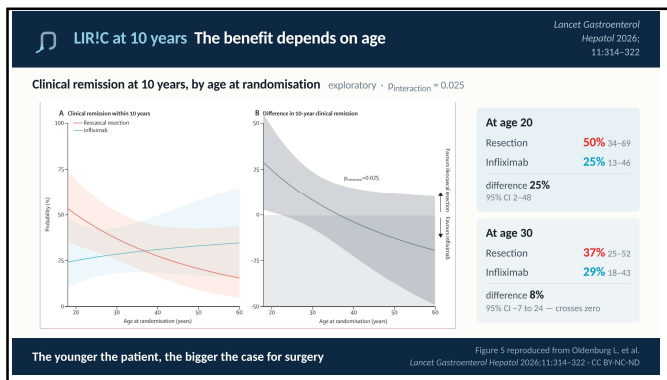
The randomisation is 2008-2015; the follow-up is retrospective

Care after year 1 was not protocolised

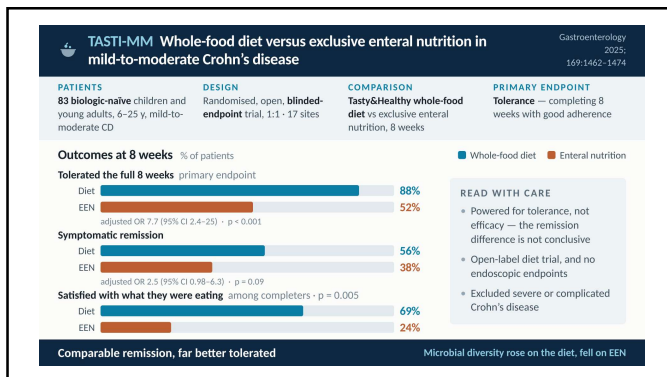
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What this means for Monday morning

Appendectomy - a legitimate option to raise with the UC patient who keeps relapsing despite adequate therapy

Buy time off drugs - bring surgery into the conversation early for limited, uncomplicated ileal CD, particularly in younger patients

Involve surgical colleagues as co-decision-makers early, not as the endpoint of failed medicine

Offer a specific, evidence-based diet in mild-to-moderate Crohn's disease rather than deflecting the question

All three interventions work alongside appropriate medical therapy, not instead of it

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The question every clinic now gets weekly

GLP-1 receptor agonists in IBD

Two datasets from 2025 and 2026 answer different halves of the question:

1. Is it safe in IBD?

2. Does it do anything for the IBD?



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Glucagon-like peptide 1 receptor agonists and the clinical outcomes of inflammatory bowel disease

Bayourmy AB, et al. J Crohns Colitis 2025;19(10):jaf1581

A systematic review and meta-analysis

STUDIES 11 observational studies, search to March 2025

PATIENTS 16,242 with IBD on GLP1s, with obesity and/or T2DM

DESIGN Systematic review and random-effects meta-analysis

EVIDENCE LEVEL No randomised trials – every study observational

IBD-related surgery pooled hazard ratio, random effects

THE ONE OUTCOME THAT CHANGED HR 0.61

Patients on GLP1s came to surgery at 0.61 times the rate of those not on GLP1s 95% CI 0.44-0.84 - p = 0.003 - I² = 0%

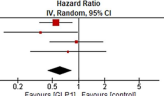
THE OTHER THREE OUTCOMES No difference

Hospitalization 0.91 - Steroids 1.02 - Advanced therapy 0.96 every CI crosses 1

Surgery - IBD

Study or Subgroup	log(Hazard Ratio)	SE	Weight	Hazard Ratio IV, Random, 95% CI
Desai (CD), 2024	-0.598	0.2162	57.6%	0.55 [0.38, 0.84]
Desai (UC), 2024	-0.5982	0.4939	11.0%	0.57 [0.14, 0.97]
Gorelik (CD), 2024	-0.054	0.3577	21.0%	0.95 [0.47, 1.91]
Gorelik (UC), 2024	-0.2727	0.5103	10.3%	0.76 [0.28, 2.07]
Total (95% CI)			100.0%	0.61 [0.44, 0.84]

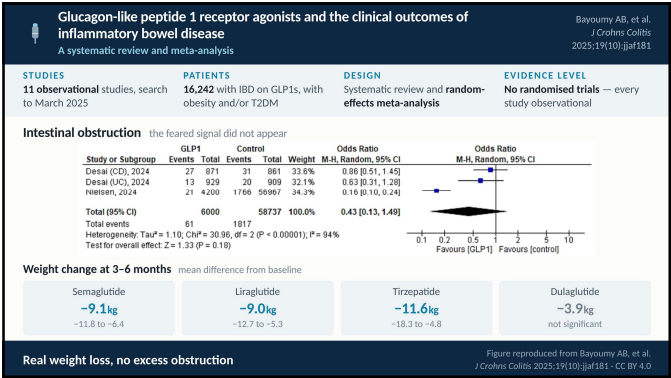
Heterogeneity: Tau² = 0.00; Chi² = 2.99, df = 3 (P = 0.40); I² = 0%
Test for overall effect: Z = 3.01 (P = 0.003)



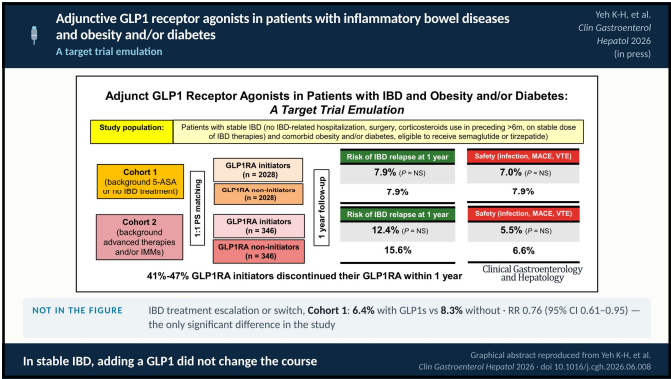
Fewer operations – and nothing else changed

Figure reproduced from Bayourmy AB, et al. J Crohns Colitis 2025;19(10):jaf1581 - CC BY 4.0

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What this means for Monday morning

It's Safe! GLP-1s do not increase IBD flares, and do not increase bowel obstruction

Continue prescribing GLP1s, or supporting their prescription, when obesity is present

Treat the obesity as the indication — obesity itself predicts worse IBD outcomes, more hospitalisation and more surgery

Do not use a GLP-1 receptor agonist as primary or adjunctive therapy for the IBD itself

Avoid overselling the anti-inflammatory story: it is safe, but not yet proven to be disease-modifying

Watch for the randomised mirikizumab plus tirzepatide trials, which will actually answer this question

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Questions?
