

## Dr. Russell Cohen explains how physicians choose the best biologic for each patient

### Video Transcript

Hi. I'm Dr. Russell Cohen, professor of medicine and director of the Inflammatory Bowel Disease Center here at the University of Chicago. Today we're going to discuss how do we choose which biologic therapy to start our patients on with inflammatory bowel disease. Currently, there are two main classes of biological therapy. The anti-tumor necrosis factor, or anti-TNF agents, and then the anti-adhesion molecule agents. These are very different approaches to treating patients with inflammatory bowel disease. The anti-TNF agents, which you might know as infliximab, or adalimumab, or certolizumab, or golimumab, generally work rather rapidly in patients with inflammatory bowel disease. And since they do affect the rest of the body too, are very helpful if patients also have joint pain, maybe skin problems, or other related problems to their bowels.

The second group, the anti-adhesion molecule antibodies, which are natalizumab and vedolizumab, are gut-specific only. So if the only problem is in the gut, that might be an option we choose. However, their onset of action is often slower than the first agents that I discussed. If a patient is sick, unless we can get them better initially with another therapy, it might be a better option for us to choose the first set of therapies I mentioned, the anti-TNFs, since they do work faster in many patients. Sometimes the decision is based upon whether a patient has had a previous therapy, perhaps a biologic therapy, whether they've had an allergic reaction to it, or whether they have, or have recently had, an infection, or even a cancer.

Patients who have active infections are encouraged first to have the infection treated before starting a biological therapy. This is especially true with the first group, the anti-TNF therapies, since they do affect the rest of the body and can impact that body's ability to fight off another infection. There are rare instances where we may have a patient, for example, who has a high risk for a certain infection such as tuberculosis, perhaps because of their background, or perhaps because of travel plans. In those patients, we might choose to use an agent such as the second group, the anti-integrin antibodies, because they don't seem to need for us to require first clearing of tuberculosis or testing for tuberculosis prior to starting therapy. Although in reality, if there's ever any suspicion of an infection, be it tuberculosis or other, we would diagnose that and treat that before starting therapy.

The final reason to choose a biologic therapy might be dictated by your insurance company. Often they will have a preferred therapy that, if it is medically reasonable, it's much easier and faster for us to go with that one. However, I do want to make it clear that if it's not medically reasonable, then we would insist on you getting the therapy that we discuss with you and agree to. This is Dr. Russell Cohen. Thank you for joining me again today.