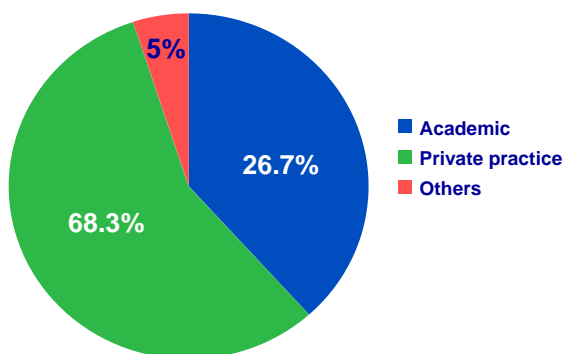


Use of biologic therapies and immunomodulators in patients with Crohn's disease

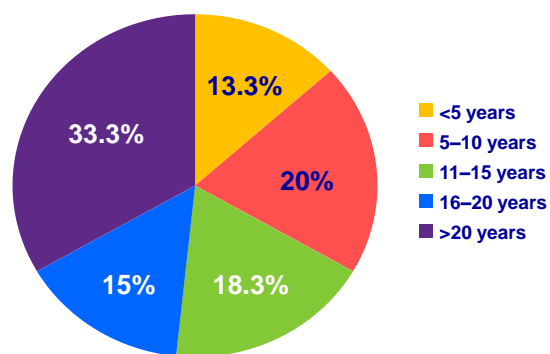
Participants and patient demographics

Survey participants included academic MDs (26.7%), private practice (68.3%), and others (5%). Most of the MDs had practiced as a Gastroenterologist for more than 20 years (33.3%). 13.3%, 20%, 18.3% and 15% practiced for less than 5 years, 5–10 years, 11–15 years, and 16–20 years, respectively. Most of the participants came from North American with a small number of responses from Europe, South America, Asia, Africa and Australia.

What type of practice are you in?



**How long have you practiced
as a Gastroenterologist?**

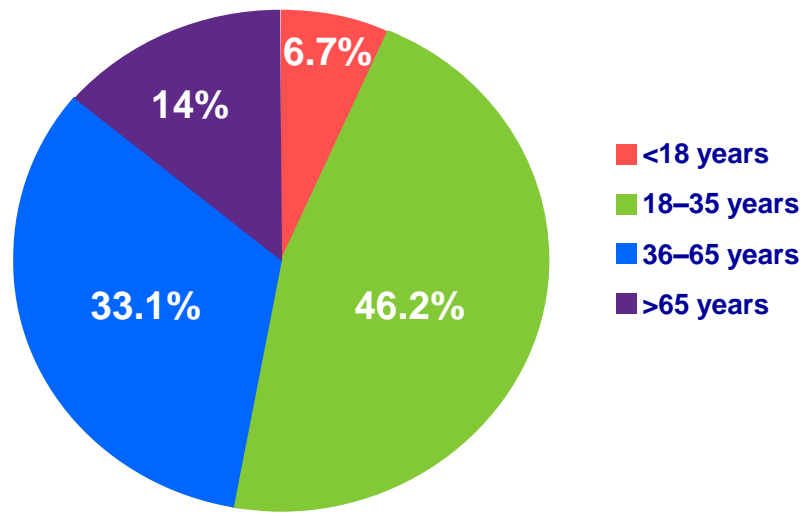


Participants typically see an average of 9 (SD 8) CD patients each week.

CD patients seen each week	Frequency	Percent (%)
<1	1	1.7
1–5	24	40.0
6–10	17	28.3
11–15	6	10.0
16–20	8	13.3
21–25	3	5.0
>25	1	1.7

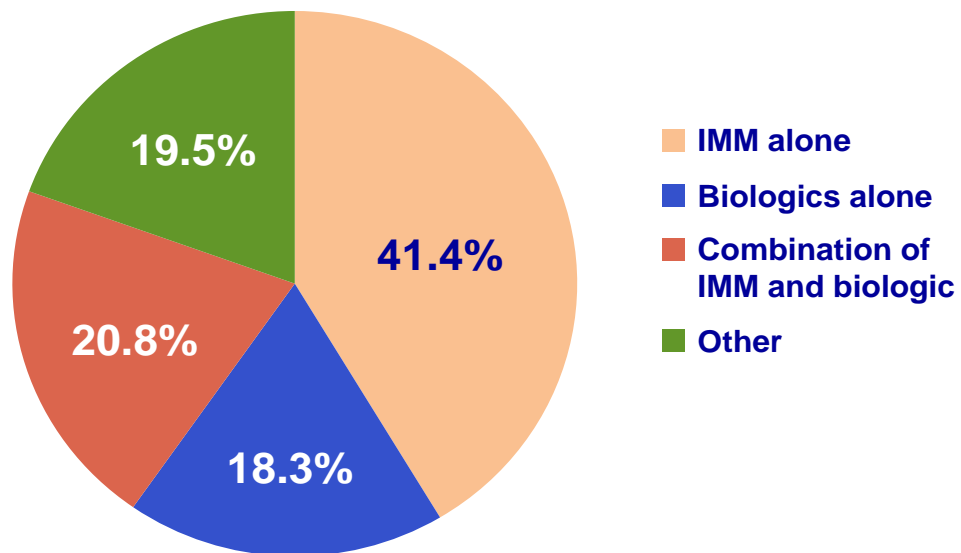
61% of these patients had mild-to-moderate disease, and 39% of these patients had moderate-to-severe disease.

Patient age groups



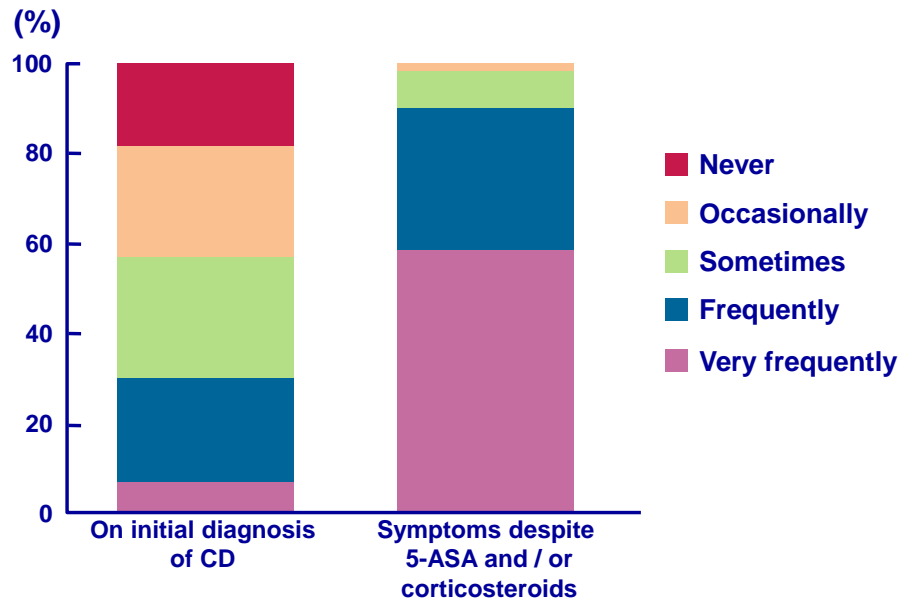
41.4%, 18.3%, 20.8% and 19.5% of patients are currently being treated with immunomodulators (IMM) alone, biologics alone, combination of biologics and immunomodulators, and others, respectively.

Treatment choices



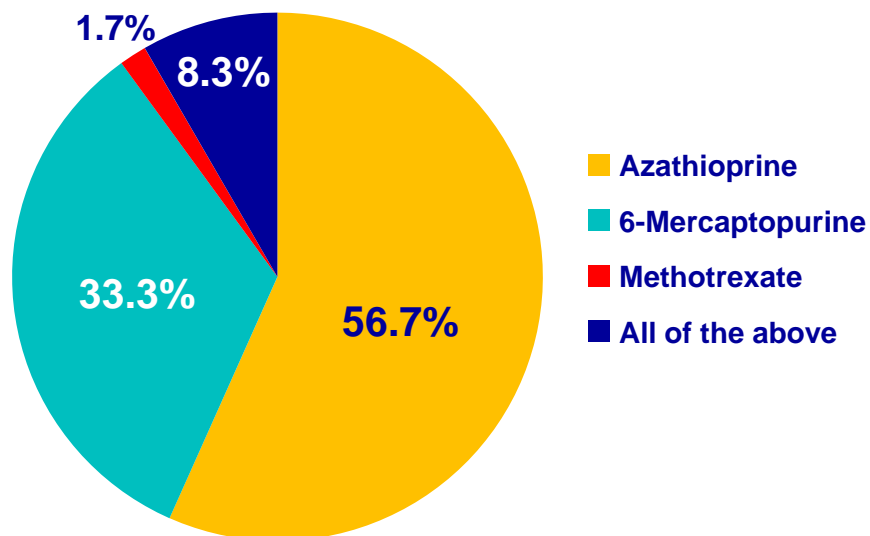
Participants typically initiate treatment with an immunomodulator when patients experience symptoms despite treatment with 5-ASA and/or corticosteroids, rather than on initial diagnosis of CD.

When do you typically initiate treatment with an IMM?



When commencing an IMM, 56.7%, 33.3%, 1.7% and 8.3% of the participants usually choose AZA, 6-MP, methotrexate, and all of the above, respectively.

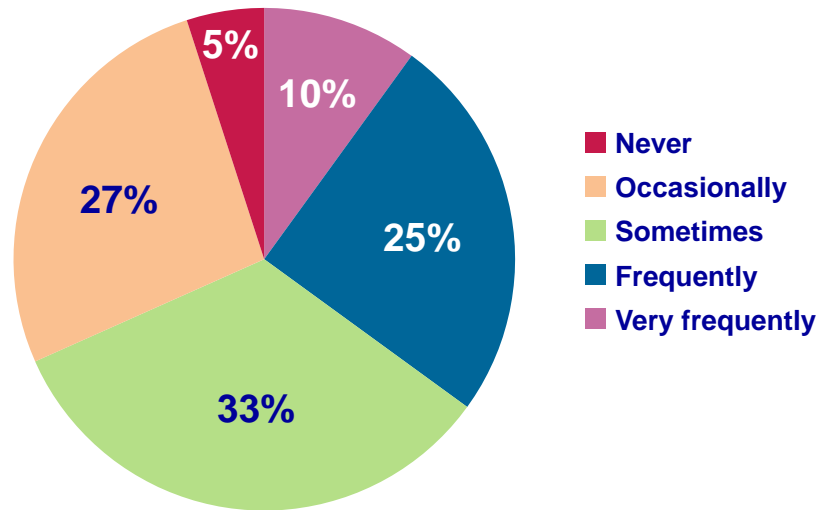
When you commence an IMM, which agent do you usually choose?



Approximately 40% of participants use IMM in combination with biologic therapies very frequently or frequently. 35% use the combination sometimes, and 20% and 3.3% of participants use IMM in combination with biologic therapies occasionally and never, respectively.

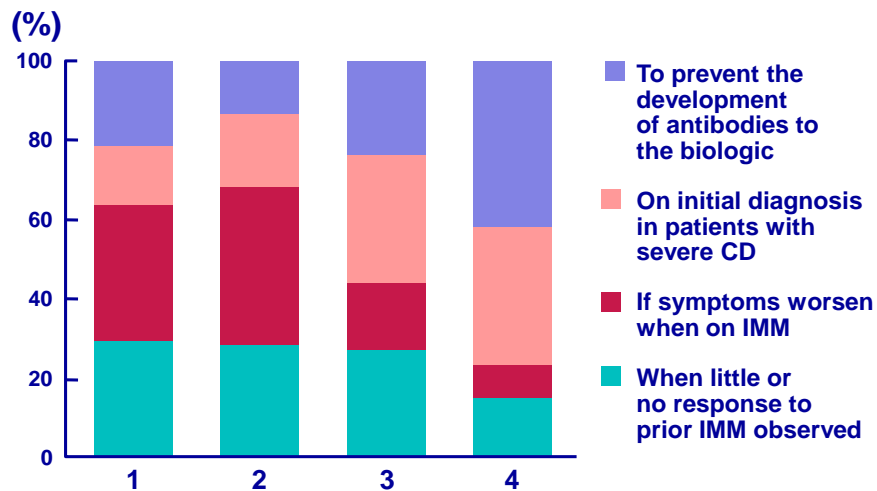
For many participants the age of the patient affects the decision to use the combination of IMM and biologics.

Does the age of the patient you are treating affect your decision to use the combination of IMM and biologics?



Participants were more likely to use a biologic-IMM combination if symptoms worsen when on IMM or when little or no response to prior IMM observed, rather than on initial diagnosis with severe CD or to prevent the development of antibodies to the biologic.

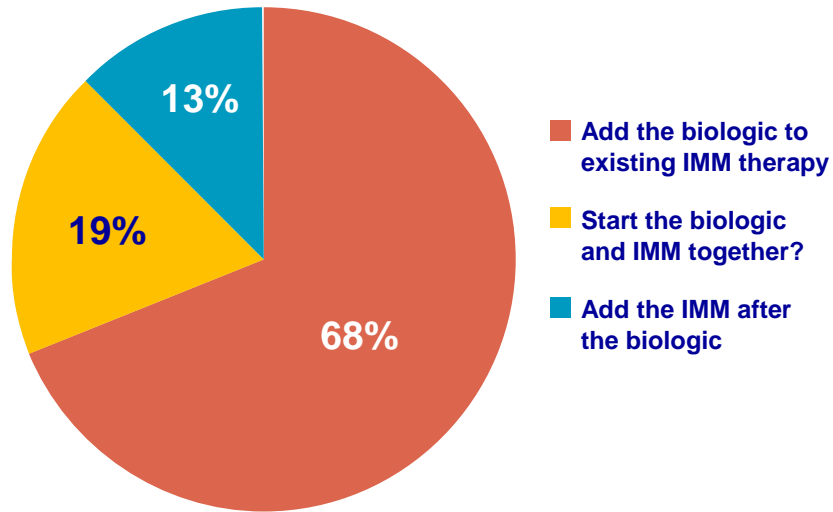
Rank the four rationales for using a biologic + IMM combination



1 = Most frequent
4 = Least frequent

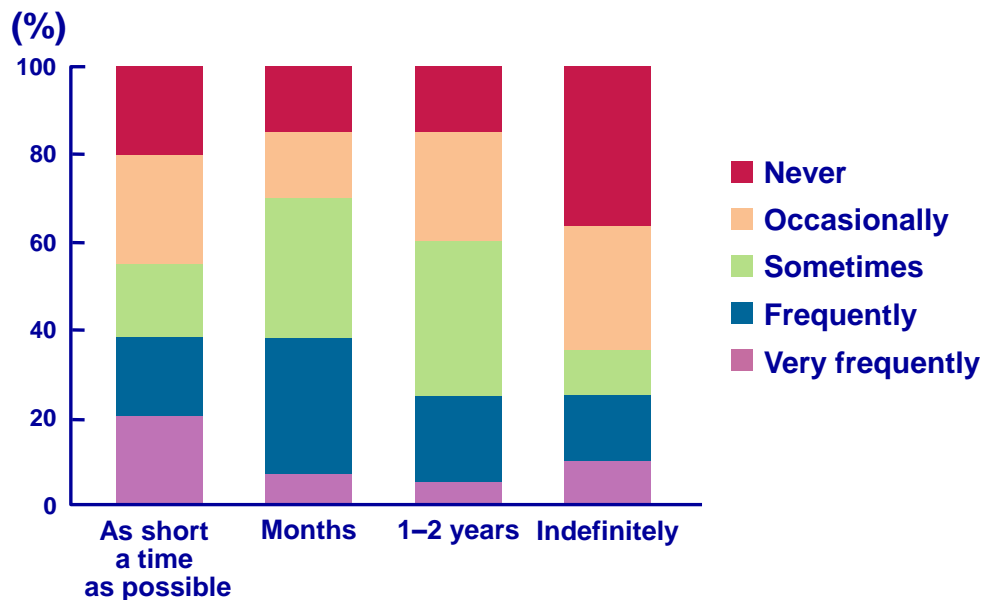
The majority of participants add the biologic to existing IMM therapy, followed by starting the biologic and IMM together and adding the IMM after the biologic. When using a combination of IMM and biologic therapies most participants used the same dose as for monotherapy, rather than increasing or decreasing the dose.

When using a combination of IMM and biologic therapies, do you typically...



In regards to maintaining patients on a combination of biologic and IMM therapies, participants use for as short a time as possible or months more frequently than 1–2 years or indefinitely.

How long do you maintain patients on a combination of biologic and IMM therapies?



91.7% of the survey takers have concerns with use of the combination of IMM and biologic therapies.

The majority of participants had concerns with use of the combination of IMM and biologic therapies on increased risk of infection and lymphomas. Safety in pediatric patients was also a concern for most participants.

Concerns with use of the combination of IMM and biologic therapies

