Infliximab Safe in Crohn's With Strictures, Stenosis

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ORLANDO, FLA. — Results from two studies shed new light on the medical and surgical management of patients with Crohn's disease.

Infliximab and other treatments used for Crohn's disease do not cause or worsen intestinal strictures, stenosis, or obstructions, data from a large prospective observational study suggest.

A second study showed that overweight patients with Crohn's disease have a disease course that differs from that seen in their nonoverweight counterparts, and they require surgical intervention significantly sooner after diagnosis than do those who are underweight.

The data on infliximab came from the Therapy, Resource, Evaluation, and Assessment Tool (TREAT) registry of more than 6,300 patients. Patients treated with infliximab had complications—intestinal strictures, stenosis, or obstructions—more often than did those treated with other therapies (2.1 vs. 1.2 events per 100 patient-years). But a multivariate analysis suggests that the difference was due to greater disease severity in the infliximab patients, G.R. Lichtenstein, M.D., reported at the annual meeting of the American College of Gastroenterology.

About half of the patients in the registry were treated with infliximab, and compared with those on other therapies, significantly more had moderate to severe disease (34% vs. 11%) and severe to fulminant disease (3% vs. 0.6%) at enrollment. Also, in the prior year significantly more were hospitalized (29% vs. 20%) or had surgery (19% vs. 14%). Also, significantly more infliximab patients were taking corticosteroids (28% vs. 17%) or immunomodulators (50% vs. 33%), said Dr. Lichtenstein of the University of Pennsylvania, Philadelphia.

Significant predictors of strictures, stenosis, or obstructions were moderate, severe, or fulminant disease at baseline (relative risk 1.99), disease duration (relative risk 1.03), and ileal disease (relative risk 1.87), but not prior infliximab therapy (relative risk 1.06), immunomodulator use (relative risk 1.40), or corticosteroid use (relative risk 1.62), he said.

The findings, based on more than 4,200 patient-years of follow-up for infliximab patients and more than 3,500 patient-years of follow-up for patients on other treatments, appear to debunk concerns that rapid mucosal healing with infliximab promotes strictures, stenosis, or obstructions.

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The second, retrospective study included 148 Crohn's disease patients seen between 1997 and 2002, of whom 48 were overweight as defined by a body mass index of 25 kg/m² or greater. Overweight patients were significantly older at diagnosis than those with a body mass index under 25 kg/m² (35 years vs. 23 years). The median duration of disease at the time of the study was 213 months for the nonoverweight patients and 156 months for the overweight patients, reported David J. Hass, M.D., of the University of Pennsylvania, Philadelphia.

There were no significant differences between overweight and nonoverweight patients in time from symptom onset to disease diagnosis, number of surgeries, disease distribution, or escalation of medical therapy. But when overweight patients were compared with underweight patients (those with a body mass index less than 18.5 kg/m²), there was a significant difference in the median time to first surgery: 24 months among the overweight patients, compared with 252 months among the underweight patients.

The differences in disease course in overweight persons might be explained by the well-documented increase in TNF-α production in adipose tissue and the increased amount of adipose tissue in overweight patients. Inflammation plays a role in Crohn's disease; therefore patients who are overweight might have a more severe disease course, Dr. Haas said. The findings suggest that more aggressive therapy earlier in the disease course is indicated in those who are overweight, he added. ■

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