REALTIME MEETING SRL

First Edition
Treatment targets in IBD (Inflammatory Bowel Disease): is it time for new strategies?

Firenze, 25th e 26th September 2026

Hotel NH Firenze

Program

Friday, September 25th 2026

13.30 Welcome Coffee and participant registration

14.00 **Opening session**
Siro Bagnoli, Gabriele Dragoni, Andrea Galli, Monica Milla

14.15 **LECTURE: The evolving landscape and treatment strategies of IBD (Inflammatory Bowel Disease) in the last 20 years**
Ambrogio Orlando
Introduce: Siro Bagnoli

Session CURRENT IBD (Inflammatory Bowel Disease) TREATMENT
Moderators: *Franco Scaldaferri, Flavio Caprioli*

14:45 **Repositioning Mesalazine in Modern Inflammatory Bowel Disease Management**
Francesco Costa

15:05 **Anti-TNFs (anti- Tumor necrosis factor inhibitors): still a valid first line outside cost reasons?**
Ferdinando D'Amico

15:25 **Leukocyte-trafficking modulators: pros and cons**
Giammarco Mocci

15:45 **Navigating the world of anti-IL23 (anti-Interlukin23)**
Sara Onali

16:05 **JAK (Janus Kinase) inhibitors: what to choose and why?**
Davide Giuseppe Ribaldone

16:20 ***Q&A (Question and Answer) discussion***
Mariangela Allocca, Alessandro Armuzzi, Siro Bagnoli, Emma Calabrese, Flavio Caprioli, Fabiana Castiglione, Francesco Costa, Gabriele Dragoni, Ferdinando D'Amico, Andrea Galli, Massimo Claudio Fantini, Gionata Fiorini, Camilla Fiorindi, Marietta Iacucci, Tommaso Innocenti, Loris Riccardo Lopetuso, Gianluca Matteoli, Monica Milla, Gianmarco Mocci,

Gloria Mumolo, Sara Onali, Ambrogio Orlando, Davide Giuseppe Ribaldone, Francesca Rogai, Franco Scaldaferri.

16:40 ***Coffee Break***

Session BEYOND STANDARD ASSESSMENT: novel diagnostic tools
Moderators: *Francesco Costa, Emma Calabrese*

17:00 **Biomarkers: how can the lab further help us?**
Tommaso Innocenti

17:20 **Intestinal ultrasound: what to expect in the near future**
Mariangela Allocca

17:40 **Endoscopy: real technological progress or too time consuming?**
Marietta Iacucci

18:00 **Q&A (Question and Answer) discussion**
Mariangela Allocca, Alessandro Armuzzi, Siro Bagnoli, Emma Calabrese, Flavio Caprioli, Fabiana Castiglione, Francesco Costa, Gabriele Dragoni, Ferdinando D'Amico, Andrea Galli, Massimo Claudio Fantini, Gionata Fiorini, Camilla Fiorindi, Marietta Iacucci, Tommaso Innocenti, Loris Riccardo Lopetuso, Gianluca Matteoli, Monica Milla, Gianmarco Mocci, Gloria Mumolo, Sara Onali, Ambrogio Orlando, Davide Giuseppe Ribaldone, Francesca Rogai, Franco Scaldaferri.

18.20 **End of the day**

Saturday, September 26th 2026

LECTURE
9:00 **Sequencing vs combining advanced treatments: is it possible to break the ceiling?**
Alessandro Armuzzi
Introduce: *Gabriele Dragoni*

Session BEYOND ADVANCED TREATMENTS: where are we?
Moderatori: *Massimo Claudio Fantini, Gabriele Dragoni*

9:30 **Antifibrotic strategies for Crohn's disease**
Gianluca Matteoli

9:50 **FMT (Fecal Microbiome Transplantation) and microbiota shaping**
Loris Riccardo Lopetuso

10:10 **Bone marrow transplantation and CAR-T cells (Chimeric Antigen Receptor T cells)**
Luca Antonioli

10:30 **Q&A (Question and Answer) discussion**
Mariangela Allocca, Alessandro Armuzzi, Siro Bagnoli, Emma Calabrese, Flavio Caprioli, Fabiana Castiglione, Francesco Costa, Gabriele Dragoni, Ferdinando D'Amico, Andrea Galli,

Massimo Claudio Fantini, Gionata Fiorini, Camilla Fiorindi, Marietta Iacucci, Tommaso Innocenti, Loris Riccardo Lopetuso, Gianluca Matteoli, Monica Milla, Gianmarco Mocci, Gloria Mumolo, Sara Onali, Ambrogio Orlando, Davide Giuseppe Ribaldone, Francesca Rogai, Franco Scaldaferri.

10:50 **Coffee Break**

Session BEYOND THE CLASSIC MDT (Multidisciplinary Team): new must-have professionals
Moderators: *Gionata Fiorino /Fabiana Castiglione*

11:10 **Dietary needs in IBD (Inflammatory Bowel Disease) patients**
Camilla Fiorindi

11:30 **Psychological support for holistic remission**
Francesca Rogai

11:50 **The pregnancy clinic**
Gloria Mumolo

12:10 **Q&A (Question and Answer) discussion**
Mariangela Allocca, Alessandro Armuzzi, Siro Bagnoli, Emma Calabrese, Flavio Caprioli, Fabiana Castiglione, Francesco Costa, Gabriele Dragoni, Ferdinando D'Amico, Andrea Galli, Massimo Claudio Fantini, Gionata Fiorini, Camilla Fiorindi, Marietta Iacucci, Tommaso Innocenti, Loris Riccardo Lopetuso, Gianluca Matteoli, Monica Milla, Gianmarco Mocci, Gloria Mumolo, Sara Onali, Ambrogio Orlando, Davide Giuseppe Ribaldone, Francesca Rogai, Franco Scaldaferri.

12:30 **Learning questionnaire and final conclusion**
Siro Bagnoli

First Edition
Treatment targets in IBD (Inflammatory Bowel Disease): is it time for new strategies?

Firenze, 25th e 26th September 2026
Hotel NH Firenze

RATIONAL

Current therapeutic strategies focus on goals like clinical remission and mucosal healing, as outlined in treat-to-target approaches. However, a growing body of evidence suggests that these endpoints might not fully capture the disease burden or predict long-term outcomes for all patients. Emerging data highlight the importance of deeper remission, including histologic healing, transmural healing, and biomarker normalization. Additionally, patient-reported outcomes and quality of life are gaining recognition as essential parts of therapeutic success. Despite these advances, there are still challenges in defining optimal goals, standardizing assessment tools, and balancing treatment intensity with safety and cost considerations.
This First Edition explores whether the current treatment goals in IBD are enough or if new strategies are needed. It looks at evolving therapeutic targets, new biomarkers, and personalized medicine approaches aimed at improving long-term disease control. The course also covers the potential role

of early intervention and close monitoring in changing disease progression. In conclusion, while treat-to-target strategies have improved patient outcomes, there's a growing push to rethink therapeutic goals in IBD. Future strategies may require a more comprehensive and personalized approach that combines clinical, biological, and patient-centered measures.

NOME E ID. DEL PROVIDER: Realtime Meeting Srl nr. Provider Standard 477

OBIETTIVO FORMATIVO: Documentazione clinica. Percorsi clinico – assistenziali diagnostici e riabilitativi, profili di assistenza – profili di cura
Tra gli obiettivi del corso residenziale avremo:

- La standardizzazione del processo di presa in carico e follow-up del paziente con MM
- La personalizzazione delle cure e miglioramento della qualità della vita del paziente con MM
- Valutazione rapporto costi/benefici nella cura del paziente con MM

SEDE DELL' EVENTO: Hotel NH Firenze – Cat **** - Piazza Vittorio Veneto, 4, 50123 Firenze

TIPOLOGIA DI FORMAZIONE: Formazione residenziale

TOTALE ORE FORMATIVE: 12

CREDITI FORMATIVI ECM: 12

DESTINATARI DELL'OFFERTA FORMATIVA:
Nr. 50 Medici Chirurghi, specializzati in Gastroenterologia, Medicina Interna, Chirurgia Generale

Responsabili Scientifici
Siro Bagnoli
SOD Gastroenterologia Clinica
Centro di Riferimento Regionale per le Malattie Infiammatorie Croniche Intestinali
AOU Careggi, Firenze

Gabriele Dragoni
SOD Gastroenterologia Clinica
Centro di Riferimento Regionale per le Malattie Infiammatorie Croniche Intestinali
AOU Careggi, Firenze

Presidente Onorario
Monica Milla
Responsabile del Centro di Riferimento Regionale Malattie Infiammatorie Croniche Intestinali
AOU Careggi, Firenze

FACULTY

1. Mariangela Allocca, Milano
2. Alessandro Armuzzi, Milano
3. Siro Bagnoli, Firenze
4. Emma Calabrese, Roma
5. Flavio Caprioli, Milano
6. Fabiana Castiglione, Napoli
7. Francesco Costa, Pisa
8. Gabriele Dragoni, Firenze

9. Ferdinando D'Amico, Pavia
10. Andrea Galli, Firenze
11. Massimo Claudio Fantini, Cagliari
12. Gionata Fiorini, Roma
13. Camilla Fiorindi, Firenze
14. Marietta Iacucci, Irlanda
15. Tommaso Innocenti, Firenze
16. Loris Riccardo Lopetuso, Roma
17. Gianluca Matteoli, KU Leuven
18. Monica Milla, Firenze
19. Gianmarco Mocci, Cagliari
20. Gloria Mumolo, Pisa
21. Sara Onali, Cagliari
22. Ambrogio Orlando,Palermo
23. Davide Giuseppe Ribaldone, Torino
24. Francesca Rogai, Firenze
25. Franco Scaldaferri, Roma

NOME COGNOME	PROFESSIONE	DISCIPLINA	ENTE DI APPARTENENZA/LIBERA PROFESSIONE	DESCRIZIONE ATTVITA'PROFESSIONALE/FORMATIVA
Mariangela Allocca	Medico chirurgo	Gastroenterologia	Ospedale San Raffaele Milano	Dirigente medico UOC Gastroenterologia Ospedale San Raffaele Milano
Alessandro Armuzzi	Medico chirurgo	Gastroenterologia	Humanitas Rozzano Milano	Professore Ordinario di Gastroenterologia Responsabile UO Malattie Infiammatorie Croniche Intestinali Humanitas Rozzano Milano
Siro Bagnoli	Medico Chirurgo	Gastroenterologia	AOU Careggi, Firenze	SOD Gastroenterologia Clinica Centro di Riferimento Regionale per le Malattie Infiammatorie Croniche Intestinali AOU Careggi, Firenze
Emma Calabrese	Medico Chirurgo	Gastroenterologia	Università degli Studi di Roma Tor Vergata Roma	Professore Associato di Gastroenterologia Dipartimento di Medicina dei Sistemi Università degli Studi di Roma Tor Vergata Roma
Flavio Caprioli	Medico Chirurgo	Gastroenterologia	Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico di Milano	Professor of Gastroenterology Department of Pathophysiology and Transplantation Università degli Studi di Milano Head, Unit of Gastroenterology and Endoscopy Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico di Milano
Fabiana Castiglione	Medico Chirurgo	Gastroenterologia	Università degli Studi di Napoli Federico II	Professore Associato di Gastroenterologia Universita degli Studi di Napoli Federico II
Francesco Costa	Medico Chirurgo	Gastroenterologia	Azienda Ospedaliera Universitaria Pisana PISA	Azienda Ospedaliera Universitaria Pisana Dipartimento di Chirurgia Dirigente medico Responsabile Sezione professionale dipartimentale PDTA MICI
Gabriele Dragoni	Medico Chirurgo	Gastroenterologia	AOU Careggi, Firenze	SOD Gastroenterologia Clinica Centro di Riferimento Regionale per le Malattie Infiammatorie Croniche Intestinali AOU Careggi, Firenze

Ferdinando D'Amico	Medico Chirurgo	Gastroenterologia	IRCCS Ospedale San Raffaele di Milano	Gastroenterologo dell'Unità di Gastroenterologia ed Endoscopia Digestiva IRCCS Ospedale San Raffaele di Milano
Andrea Galli	Medico Chirurgo	Gastroenterologia	Azienda Ospedaliero Universitaria Careggi Firenze	Professore Ordinario di Gastroenterologia Università di Firenze Università degli Studi di Firenze Dirigente Medico I Livello SOD Gastroenterologia presso Azienda Ospedaliero Universitaria Careggi Firenze
Massimo Claudio Fantini	Medico Chirurgo	Gastroenterologia	Cittadella Universitaria di Monserrato - Asse Didattico I	Professor of Gastroenterology University of Cagliari Dep. of Medical Science and Public Health Cittadella Universitaria di Monserrato - Asse Didattico I
Gionata Fiorini	Medico Chirurgo	Gastroenterologia	Ospedale San Camillo-Forlanini, Roma (Italia)	Responsabile della Ricerca Clinica in IBD UOS Malattie Infiammatorie Croniche Intestinali, Unità Operativa Complessa di Gastroenterologia ed Endoscopia Digestiva Diagnostica ed Operativa, Ospedale San Camillo-Forlanini, Roma (Italia)
Camilla Fiorindi	Dietista	Scienze dell'Alimentazione	AOU Careggi Firenze	Dietista Dipartimento delle Professioni Tecnico Sanitarie e Riabilitative AOU Careggi Firenze
Marietta Iacucci	Medico Chirurgo	Gastroenterologia	University College Cork	Prof Marietta Iacucci is a leading researcher in the field of AI and a pioneer in 'endo-omics' that fuses endoscopic and histologic information with 'multi-omics data. In addition to her role as PI at APC she is Professor of Gastroenterology at University College Cork and Consultant Gastroenterologist Mercy University Hospital and Cork University Hospital. Prof Iacucci qualified in Medicine from the University of Rome and obtained her PhD in 2009. She trained and did research in Germany, the United Kingdom, and Japan and previously held permanent faculty positions at the Universities of Calgary, Canada and Birmingham, UK. She was a key investigator at the National Institute of Health Research in Birmingham. She led transdisciplinary work that predicted disease courses and outcomes in colonic neoplasia and inflammatory bowel disease, bridging engineering, bioinformatics, and imaging/omics. She has delivered key plenary talks at prestigious international conferences such as the American Gastroenterology Association/ American Society of Gastrointestinal Endoscopy, International Organisation for Study of IBD, European Crohn's and Colitis Organization and European Society of Gastrointestinal Endoscopy. She has been nominated for leadership positions in multiple international organisations. Her goal is to drive transdisciplinary precision medicine research connecting APC, Tyndall, IPIC and Insight.

Tommaso Innocenti	Medico Chirurgo	Gastroenterologia	AOU Careggi Firenze	Professore Associato Gastroenterologist endoscopist IBD specialist AOU Careggi Gastroenterology Unit IBD Referral Centre Florence
Loris Riccardo Lopetuso	Medico Chirurgo	Gastroenterologia	Link University, Roma	Professore Associato di Gastroenterologia, Link University, Roma
Gianluca Matteoli	Medico Chirurgo	Gastroenterologia	KU Leuven One Health Institute	professor Faculty of Medicine member of Leuven One Health – KU Leuven One Health Institute member of LISCO - KU Leuven Institute for Single Cell Omics
Monica Milla	Medico Chirurgo	Gastroenterologia	AOU Careggi, Firenze	Responsabile del Centro di Riferimento Regionale Malattie Infiammatorie Croniche Intestinali AOU Careggi, Firenze
Gianmarco Mocci	Medico Chirurgo	Gastroenterologia	Azienda Ospedaliera G. Brotzu, Cagliari	U.O.C. Gastroenterologia, Azienda Ospedaliera G. Brotzu, Cagliari
Gloria Mumolo	Medico Chirurgo	Gastroenterologia	Azienda Ospedaliero Universitaria Pisana, Pisa	Dirigente Medico UO Gastroenterologia Universitaria Azienda Ospedaliero Universitaria Pisana, Pisa
Sara Onali	Medico Chirurgo	Gastroenterologia	Università degli studi di Cagliari	Professore associato Gastroenterologia Universita degli studi di Cagliari
Ambrogio Orlando	Medico Chirurgo	Gastroenterologia	Azienda Ospedaliero Palermo	Dal 1/11/2003 a 10.6.2004 Dirigente Medico di I livello di ruolo a tempo pieno di Gastroenterologia presso la divisione di Medicina generale (Az. Osp." V.Cervello" di Palermo Via Trabucco 180. Direttore: dr. Gennaro D'Amico). Dal 10.6.2004 al 27.10.2017 Dirigente Medico di I livello di ruolo a tempo pieno di Medicina Interna presso la divisione di Medicina Interna I dell'Az. Osp. "V.Cervello" prima e Az.Osp. Ospedali Riuniti "Villa Sofia-Cervello dopo di Palermo; Via Trabucco 180 (90146). Direttore. Prof. Mario Cottone. Dal 1/7/98 al 27/10/2017 incarico professionale (ex art.57 comma 3 let.a del CCNL pubblicato il 30/1/96) di " Attività per l'oncologia epatica". Dal 16/11/2017 a tutt'oggi Direttore U.O.S.D. M.I.C.I. Azienda Ospedaliera Ospedali Riuniti "Villa Sofia-Cervello" - Palermo
Davide Giuseppe Ribaldone	Medico Chirurgo	Gastroenterologia	Università degli Studi di Torino	Professore Associato di Gastroenterologia Università degli Studi di Torino – Department of Medical Sciences; A.O.U. "CITTÀ DELLA SALUTE E DELLA SCIENZA DI TORINO"
Francesca Rogai	Medico Chirurgo	Gastroenterologia	Azienda Ospedaliero-Universitaria Carreggi di Firenze	Dirigente Medico I Livello di Gastroenterologia presso l'Azienda Ospedaliero-Universitaria Carreggi di Firenze, fa anche la libera professione al Careggi
Franco Scaldaferri	Medico Chirurgo	Gastroenterologia	Fondazione Policlinico Universitario A. Gemelli IRCCS	Direttore di UOS Malattie infiammatorie croniche intestinali presso UOC CEMAD (Centro Malattie Apparato Digerente) e UOC di Medicina Interna e Gastroenterologia, Dipartimento di Scienze Mediche e Chirurgiche, Fondazione Policlinico Universitario A. Gemelli IRCCS

				Professore aggregato in Gastroenterologia (MED012 — ricercatore RTDA) presso Università Cattolica del Sacro Cuore, sede di Roma, Facoltà di Medicina e Chirurgia 01/07/2014-31/03/2015 assegnata di ricerca, vincitore di concorso disciplina MED12 25/03/2013 Dottore di Ricerca in "Fisiopatologia della Nutrizione e del Metabolismo", CICLO XXV Università Cattolica del Sacro Cuore, Facoltà di Medicina e Chirurgia Dal 2007 al 2009 – Post Doc Research Fellowship Lerner Research Institute – Pathobiology Department The Cleveland Clinic – Cleveland OHIO – USA- Supervisore Prof. Claudio Fiocchi 15/10/2009 Specialista in Gastroenterologia ed Endoscopia Digestiva, Università Cattolica del Sacro Cuore, Facoltà di Medicina e Chirurgia, con il massimo dei voti 25/7/2005 Laurea in Medicina e Chirurgia Università Cattolica del Sacro Cuore, Facoltà di Medicina e Chirurgia – magna cum laude

Il provider, ai sensi dall' art. 47 del DPR n.445/2000, consapevole delle conseguenze previste dall'art. 76, dichiara:
- di aver fornito all'interessato l'informativa sul trattamento dei dati personali (art. 13 del Regolamento europeo 2016/679; artt. 68, 70, 76, 96 Accordo Stato-Regioni 2017 "La formazione continua nel settore salute"- Rep. Atti 14/CSR del 2.2.2017 - Par. 4.6, lett. j) Manuale Nazionale di Accreditamento per l'Erogazione di Eventi ECM);
- di aver informato l'interessato che il programma dell'evento ECM, di cui le suddette informazioni contribuiscono a formarne il contenuto minimo, verrà inserito nel catalogo degli eventi E.C.M. tenuto dall'ente accreditante;

ABSTRACT

The evolving landscape and treatment strategies of IBD in the last 20 years

Over the past two decades, the management of inflammatory bowel disease (IBD), encompassing Crohn's disease (CD) and ulcerative colitis (UC), has undergone a profound transformation driven by advances in disease pathogenesis, diagnostic techniques, and therapeutic options. The incidence of IBD has continued to rise globally, particularly in newly industrialized countries, highlighting its growing public health burden. Improved understanding of the genetic, immunological, microbial, and environmental factors underlying IBD has shifted treatment paradigms from symptom control toward targeted modulation of disease mechanisms and long-term prevention of intestinal damage. Since the early 2000s, therapeutic strategies have evolved from conventional corticosteroids and immunomodulators to biologic therapies targeting tumor necrosis factor (TNF), integrins, interleukin (IL)-12/23, and IL-23, followed by the introduction of small-molecule agents such as Janus kinase (JAK) inhibitors and sphingosine-1-phosphate (S1P) receptor modulators. These innovations have expanded treatment options for patients with moderate-to-severe disease and enabled more personalized approaches based on disease phenotype, prognostic factors, and treatment response. Simultaneously, the adoption of treat-to-target principles, tight disease monitoring using biomarkers and endoscopy, and early intervention strategies has improved disease control and reduced rates of hospitalization and surgery. Despite these advances, significant challenges remain, including primary and secondary loss of response, treatment-related adverse events, high healthcare costs, and persistent unmet needs in achieving sustained remission and preventing disease progression. Emerging precision medicine approaches integrating molecular biomarkers, therapeutic drug

monitoring, multi-omics technologies, and artificial intelligence hold promise for optimizing individualized treatment selection and improving long-term outcomes. This review summarizes the major developments in the epidemiology, pathophysiological understanding, and therapeutic management of IBD over the last 20 years, highlighting the transition from empirical treatment to precision-targeted care and discussing future directions that may further reshape clinical practice.

Session CURRENT IBD TREATMENT

Repositioning Mesalazine in Modern Inflammatory Bowel Disease Management

Recent advances in drug formulations have improved targeted delivery throughout the gastrointestinal tract, enhancing therapeutic efficacy while minimizing systemic exposure. In parallel, increasing emphasis on personalized medicine has reinforced the importance of selecting mesalazine according to disease extent, activity, patient characteristics, and treatment goals. Although advanced therapies have transformed the management of moderate-to-severe IBD, mesalazine retains an essential role in patients with mild disease, as adjunctive therapy in selected clinical scenarios, and in long-term maintenance strategies where safety and adherence are paramount.

Anti-TNFs: still a valid first line outside cost reasons?

The therapeutic landscape of inflammatory bowel disease (IBD) has expanded dramatically over the past two decades, with the introduction of multiple biologic classes and small-molecule agents offering new opportunities for individualized treatment. Despite this growing therapeutic armamentarium, anti-tumor necrosis factor (anti-TNF) agents continue to occupy a central role in the management of moderate-to-severe Crohn's disease and ulcerative colitis. Although the increasing availability of biosimilars has reinforced their cost-effectiveness, an important question remains: do anti-TNFs still deserve consideration as first-line advanced therapy based on clinical merit alone?

Anti-TNFs have the longest and most robust body of evidence among advanced therapies, demonstrating sustained efficacy in inducing and maintaining remission, promoting mucosal healing, reducing corticosteroid dependence, and preventing hospitalization and surgery. Their effectiveness is supported by extensive randomized clinical trials, long-term extension studies, and real-world registries across diverse patient populations. Moreover, anti-TNFs remain the preferred first-line biologic in several clinical scenarios, including penetrating and fistulizing Crohn's disease, severe extraintestinal manifestations, and pregnancy, where their efficacy and safety profiles are particularly well established.

Leukocyte-trafficking modulators: pros and cons

The principal advantages of leukocyte-trafficking modulators include their gut-selective mechanism of action, favorable long-term safety profile, low rates of serious and opportunistic infections, and minimal risk of malignancy compared with broader immunosuppressive therapies. Agents such as anti-integrin therapies have demonstrated durable efficacy for induction and maintenance of remission, while sphingosine-1-phosphate (S1P) receptor modulators provide the convenience of oral administration and rapid reversibility of immune effects. These characteristics make trafficking modulators particularly attractive for elderly patients, individuals with significant comorbidities, or those at increased risk of infectious complications.

Despite these benefits, important limitations remain. Gut-selective biologics may exhibit a slower onset of action than anti-TNF agents or Janus kinase (JAK) inhibitors, potentially limiting their use in acute severe disease. Their efficacy may also vary according to disease phenotype, prior biologic exposure, and treatment history. In addition, S1P receptor modulators require careful patient selection because of potential cardiovascular, hepatic, ophthalmologic, and hematologic adverse effects, necessitating baseline screening and ongoing monitoring. The absence of validated predictive biomarkers further complicates optimal treatment selection within this therapeutic class.

Navigating the world of anti-IL23 (S

Clinical trials and real-world evidence have consistently shown that anti-IL-23 therapies achieve high rates of clinical remission, endoscopic healing, and sustained disease control, with a favorable safety profile and low immunogenicity. Their efficacy appears to be maintained across a broad spectrum of patient populations, including individuals previously exposed to anti-tumor necrosis factor (anti-TNF) agents and other advanced therapies. Furthermore, selective IL-23 inhibition is associated with low rates of serious infections and malignancy, making these agents attractive options for long-term disease management and for patients in whom safety is a major therapeutic consideration.

Despite these advantages, several challenges remain. Direct head-to-head comparisons with other advanced therapies are limited, the optimal positioning of anti-IL-23 agents within treatment algorithms continues to evolve, and predictive biomarkers capable of identifying the patients most likely to benefit are still lacking. Questions also persist regarding sequencing strategies, combination therapy, long-term durability, and cost-effectiveness in an increasingly complex therapeutic landscape.

JAK inhibitors: what to choose and why?

Current JAK inhibitors differ in their relative selectivity for JAK isoforms, pharmacokinetic profiles, and clinical indications, resulting in meaningful differences in therapeutic positioning. Their principal advantages include rapid onset of action, oral administration, absence of immunogenicity, and effectiveness in both biologic-naïve and biologic-experienced patients, including those with previous anti-tumor necrosis factor (anti-TNF) or other advanced therapy failure. These features make JAK inhibitors particularly valuable for patients requiring prompt disease control or seeking an alternative to parenteral biologic therapy. Safety considerations remain central to treatment selection. Concerns regarding herpes zoster infection, venous thromboembolism, major adverse cardiovascular events, malignancy, and laboratory abnormalities have led to recommendations for individualized risk assessment before treatment initiation. The degree of JAK selectivity may influence both efficacy and adverse event profiles, although long-term comparative data remain limited. Consequently, patient age, cardiovascular risk, history of thrombosis, comorbidities, concomitant medications, and therapeutic goals all contribute to optimal drug selection. This review examines the evolving role of JAK inhibitors in contemporary IBD management, focusing on the practical question of what to choose and why. By integrating evidence from randomized clinical trials, head-to-head comparisons where available, real-world studies, and current international guidelines, it compares efficacy, safety, speed of response, durability, and positioning within treatment algorithms.

Q&A discussion

This interactive Q&A discussion aims to address the most relevant and frequently debated issues in contemporary IBD care, drawing on current evidence, international guidelines, and expert clinical experience. Topics will include the positioning of biologics and small molecules, selection of first-line advanced therapies, optimization and switching strategies, therapeutic drug monitoring, management of extraintestinal manifestations, safety considerations, and future directions in precision medicine. Special attention will be given to challenging clinical cases where multiple therapeutic options exist and treatment decisions must balance efficacy, safety, patient preferences, comorbidities, and long-term disease outcomes.

Sessione BEYOND STANDARD ASSESSMENT: novel diagnostic tools

Biomarkers: how can the lab further help us?

Conventional biomarkers such as C-reactive protein (CRP) and fecal calprotectin remain the cornerstone of disease monitoring, offering accessible and validated measures of systemic and intestinal inflammation. However, their limitations in sensitivity, specificity, and predictive accuracy

have driven the search for more informative biomarkers. Advances in genomics, transcriptomics, proteomics, metabolomics, microbiome profiling, and serological testing are generating novel candidate biomarkers capable of identifying disease phenotype, forecasting disease progression, predicting response to specific therapies, and detecting subclinical inflammation. In parallel, therapeutic drug monitoring (TDM) has become an important component of biologic optimization, helping clinicians individualize dosing, distinguish pharmacokinetic from pharmacodynamic treatment failure, and improve long-term treatment durability.

Intestinal ultrasound: what to expect in the near future

Intestinal ultrasound (IUS) has rapidly evolved from a complementary imaging modality to an increasingly indispensable tool in the management of inflammatory bowel disease (IBD). Owing to its non-invasive nature, absence of ionizing radiation, point-of-care availability, and ability to provide real-time assessment of bowel inflammation, IUS is reshaping diagnostic pathways and disease monitoring in both Crohn's disease (CD) and ulcerative colitis (UC). Growing evidence supports its use for evaluating disease activity, treatment response, complications, and transmural healing, making it an attractive alternative or adjunct to endoscopy and cross-sectional imaging in routine clinical practice.

Recent technological advances, including high-resolution ultrasound, contrast-enhanced ultrasound (CEUS), elastography, and standardized scoring systems, have substantially improved the diagnostic performance and reproducibility of IUS. Integration into treat-to-target strategies enables frequent, patient-friendly monitoring, facilitating earlier therapeutic adjustments and potentially improving long-term outcomes. Furthermore, the increasing availability of structured training programs and international consensus recommendations is promoting wider implementation and greater consistency across centers.

Despite these advances, several challenges remain before IUS can achieve universal adoption. Operator dependency, variability in training and expertise, limited visualization of deep pelvic or proximal small bowel segments, and the need for standardized reporting continue to represent important barriers. In addition, further studies are needed to define its role in treatment algorithms, establish validated response criteria, and integrate IUS findings with biomarkers, endoscopy, and emerging digital health technologies.

Endoscopy: real technological progress or too time consuming?

High-definition endoscopy, virtual chromoendoscopy, dye-based chromoendoscopy, magnification techniques, and computer-assisted image analysis have improved the detection of subtle inflammatory changes, dysplasia, and colorectal neoplasia in patients with long-standing IBD. More recently, AI-based systems have shown promise in reducing interobserver variability, automating disease activity scoring, and supporting real-time clinical decision-making. At the same time, advances in endoscopic resection techniques and surveillance protocols have enhanced the management of IBD-associated neoplasia while reducing the need for surgery.

Despite these technological achievements, important questions remain regarding their implementation in routine practice. Many advanced techniques require additional expertise, increase procedure duration, or demand specialized equipment that may not be universally available. Cost, training requirements, variability in adoption, and uncertain incremental benefit in some clinical scenarios continue to limit widespread integration. Moreover, as non-invasive monitoring tools such as fecal biomarkers and intestinal ultrasound become increasingly accurate and accessible, the frequency and timing of endoscopic assessment are being reconsidered within modern monitoring algorithms.

Q&A discussion

This interactive Q&A discussion is designed to address key real-world challenges in IBD care, translating current evidence into practical clinical decision-making. Topics will span the positioning of advanced therapies, strategies for switching and combination approaches, optimization using therapeutic drug monitoring, interpretation of endoscopic and non-invasive disease markers, and the integration of emerging technologies such as intestinal ultrasound and artificial intelligence. Emphasis will be placed on controversial and unresolved issues where clinical judgment and individualized assessment remain essential.

End First Day

26th September 2026

Sequencing vs combining advanced treatments: is it possible to break the ceiling?
Traditionally, treatment has relied on sequential monotherapy, switching agents after primary non-response or loss of efficacy. However, emerging evidence and mechanistic rationale suggest that combination strategies targeting complementary inflammatory pathways may offer additive or synergistic benefits. Early experiences with dual biologic therapy or biologic–small molecule combinations have shown promising signals in highly refractory disease, including improved clinical response and mucosal healing in selected patients. Nevertheless, these approaches remain limited by concerns regarding safety, infection risk, immunosuppression burden, and the absence of robust randomized controlled trial data.
Sequencing strategies remain the cornerstone of current practice, guided by efficacy, safety, comorbidities, disease phenotype, and prior treatment exposure. Yet, optimal sequencing remains uncertain, particularly in the absence of validated biomarkers to guide mechanism-based selection. The concept of early, aggressive intervention with highly effective therapies has further challenged traditional step-up paradigms, raising the question of whether earlier or combined use of advanced therapies could improve long-term outcomes and modify disease course more effectively.

Session BEYOND ADVANCED TREATMENTS: where are we?
Antifibrotic strategies for Crohn's disease
Fibrosis represents one of the most challenging long-term complications of Crohn's disease (CD), contributing to stricturing disease, bowel obstruction, and the need for surgical intervention. Despite major advances in anti-inflammatory therapies, currently available treatments have limited ability to reverse established fibrosis or reliably prevent its progression, highlighting an unmet need for effective antifibrotic strategies. As a result, intestinal fibrosis has emerged as a distinct therapeutic target within the broader goal of disease modification in CD.
The pathogenesis of Crohn's-related fibrosis is complex and multifactorial, involving persistent transmural inflammation, fibroblast activation, extracellular matrix deposition, epithelial-to-mesenchymal transition, and dysregulated tissue repair mechanisms. Key molecular pathways implicated include transforming growth factor-beta (TGF-β), platelet-derived growth factor (PDGF), Wnt/β-catenin signaling, and various cytokine-driven networks that link chronic inflammation to progressive tissue remodeling. Despite improved control of inflammatory activity through biologics and small molecules, fibrotic progression may continue independently, underscoring the need for therapies that directly target fibrogenesis. At present, no approved antifibrotic therapy exists for Crohn's disease, and management of stricturing complications remains largely endoscopic or surgical. However, several promising therapeutic approaches are under investigation, including agents targeting pro-fibrotic cytokines, inhibitors of fibroblast activation, modulators of tissue remodeling pathways, and strategies aimed at restoring epithelial barrier integrity. Advances in imaging, biomarkers, and intestinal ultrasound also offer improved tools for early detection and

monitoring of fibrostenotic disease, potentially enabling earlier intervention before irreversible structural damage occurs.

FMT and microbiota shaping

The intestinal microbiota has emerged as a central component in the pathogenesis and modulation of inflammatory bowel disease (IBD), with dysbiosis consistently observed in both Crohn's disease (CD) and ulcerative colitis (UC). This has led to growing interest in microbiota-targeted therapies, including fecal microbiota transplantation (FMT) and other strategies aimed at restoring microbial diversity and function. By transferring a complex microbial ecosystem from healthy donors, FMT seeks to re-establish a balanced intestinal environment and modulate host immune responses.

Clinical trials of FMT in IBD have shown variable efficacy, with the most consistent benefit observed in mild-to-moderate UC, while results in CD remain less robust and heterogeneous. Factors influencing outcomes include donor selection, route and frequency of administration, disease phenotype, baseline microbiota composition, and concomitant medications. Although FMT is generally well tolerated, safety considerations such as infectious risk, standardized donor screening, and long-term effects on immune homeostasis remain important challenges.

Beyond conventional FMT, the field is rapidly evolving toward more refined approaches to microbiota modulation. These include defined microbial consortia, next-generation probiotics, postbiotics, bacteriophage therapy, dietary interventions, and precision microbiome editing. Such strategies aim to overcome the variability and unpredictability of donor-derived FMT while enabling more targeted manipulation of microbial function. Advances in multi-omics technologies are further enhancing the understanding of host–microbiome interactions and enabling the identification of microbial signatures associated with treatment response.

Bone marrow transplantation and CAR-T cells

Inflammatory bowel disease (IBD) is a chronic immune-mediated disorder characterized by dysregulated mucosal immunity, genetic susceptibility, and environmental interactions. Despite major advances in biologic and small-molecule therapies, a subset of patients with refractory disease continues to experience persistent inflammation and progressive complications, highlighting the need for novel immune-resetting and disease-modifying strategies. Among emerging approaches, hematopoietic stem cell transplantation (HSCT), commonly referred to as bone marrow transplantation, and chimeric antigen receptor T-cell (CAR-T) therapies represent highly innovative but still experimental interventions in the field of IBD. Autologous HSCT aims to "reset" the immune system by eradicating autoreactive immune cells through conditioning regimens followed by immune reconstitution from hematopoietic stem cells. Early studies have demonstrated potential for inducing sustained remission in highly selected patients with severe, treatment-refractory Crohn's disease; however, relapse rates, treatment-related toxicity, and procedure-associated morbidity remain significant limitations. Consequently, HSCT is currently restricted to specialized centers and highly selected clinical scenarios. CAR-T cell therapy, which has revolutionized the treatment of hematologic malignancies, is now being explored as a potential future strategy for immune modulation in autoimmune diseases. In IBD, its application remains largely theoretical and preclinical, with ongoing research focused on identifying appropriate targets, ensuring safety, and minimizing off-target immune effects. The complexity of intestinal immune networks and the risk of excessive immunosuppression or immune dysregulation present substantial challenges to its clinical translation.

Q&A discussion

The treatment landscape of inflammatory bowel disease (IBD) is rapidly evolving, driven by continuous advances in immunology, therapeutics, diagnostics, and microbiome science. As clinicians are confronted with an expanding range of therapeutic options—including biologics, small

molecules, microbiota-based interventions, advanced endoscopic techniques, and emerging cellular therapies—numerous practical questions arise that extend beyond the scope of existing clinical guidelines and trial data. These uncertainties relate to optimal treatment selection, sequencing versus combination strategies, safety management, monitoring approaches, and the integration of novel and experimental therapies into clinical practice. This interactive Q&A discussion aims to address key real-world challenges in contemporary IBD management, translating rapidly evolving evidence into practical, clinically relevant decision-making. Topics will include positioning of advanced therapies, management of refractory disease, role of microbiome modulation, interpretation of biomarkers and imaging modalities, and future perspectives on immune-resetting strategies such as stem cell transplantation and CAR-T cell therapy. Particular emphasis will be placed on complex clinical scenarios where individualized judgment is required and where evidence remains limited or evolving.

Session BEYOND THE CLASSIC MDT: new must-have professionals

Dietary needs in IBD patients

Diet plays a fundamental role in the management of inflammatory bowel disease (IBD), influencing disease onset, activity, symptom burden, and long-term outcomes. Although nutrition is not considered a primary etiological factor, growing evidence supports a significant interaction between dietary patterns, the gut microbiome, mucosal immunity, and intestinal barrier function. As a result, dietary strategies have become an important adjunct to pharmacological therapy, particularly in Crohn's disease (CD), where exclusive enteral nutrition (EEN) remains an established induction therapy in selected populations. Patients with IBD frequently experience nutritional deficiencies, including iron, vitamin D, vitamin B12, folate, and zinc, due to chronic inflammation, malabsorption, dietary restriction, and increased metabolic demands. Malnutrition and sarcopenia are common, especially in active disease, and are associated with poorer clinical outcomes, increased complication rates, and reduced quality of life. Therefore, systematic nutritional assessment and individualized dietary counseling are essential components of comprehensive IBD care. Beyond deficiency management, interest has expanded toward dietary modulation of inflammation. Diets such as the Mediterranean diet, specific carbohydrate diet, Crohn's disease exclusion diet, and low FODMAP approaches have shown varying degrees of benefit in symptom control, microbiome modulation, and possibly inflammatory activity, although high-quality comparative data remain limited. Importantly, excessive dietary restriction without professional guidance may lead to further nutritional compromise and reduced adherence.

Psychological support for holistic remission

Inflammatory bowel disease (IBD) is a chronic, relapsing condition with significant physical, psychological, and social burden. Beyond achieving clinical and endoscopic remission, there is increasing recognition that optimal disease control must also address mental health, quality of life, and functional well-being. Anxiety, depression, stress, and fatigue are highly prevalent in patients with IBD and are closely associated with increased disease activity, reduced treatment adherence, impaired quality of life, and higher healthcare utilization. This has led to the emerging concept of "holistic remission," which integrates psychological well-being into traditional therapeutic targets.

The bidirectional interaction between the gut and the brain, mediated through neuroendocrine, immune, and microbiome-related pathways, provides a biological basis for the influence of psychological factors on IBD activity. Psychological stress can exacerbate intestinal inflammation, while active disease can in turn worsen psychological distress, creating a self-perpetuating cycle. Consequently, addressing mental health is not merely supportive but may have direct implications for disease outcomes.Psychological interventions, including cognitive behavioral therapy (CBT), mindfulness-based therapies, stress management programs, and gut-directed hypnotherapy, have shown benefits in symptom perception, quality of life, and coping strategies, although their effects

on objective inflammatory markers are variable. Integrated care models involving gastroenterologists, psychologists, dietitians, and specialized IBD nurses have demonstrated improved patient-reported outcomes and may enhance long-term disease management.

The pregnancy clinic

Pregnancy in women with inflammatory bowel disease (IBD) requires specialized, multidisciplinary management to optimize maternal health, fetal outcomes, and long-term disease control. The establishment of dedicated pregnancy clinics represents an important evolution in IBD care, integrating gastroenterology, obstetrics, nutrition, and nursing expertise to provide coordinated, evidence-based management before conception, during pregnancy, and in the postpartum period. Such structured care models aim to reduce disease-related complications and improve pregnancy outcomes through preconception counseling, optimized disease control, and individualized therapeutic planning. Active IBD at conception or during pregnancy is associated with increased risks of adverse outcomes, including preterm birth, low birth weight, miscarriage, and cesarean delivery. Conversely, well-controlled disease at conception is strongly predictive of favorable maternal and neonatal outcomes. Consequently, the primary goal of pregnancy clinics is to maintain sustained remission throughout pregnancy and lactation, emphasizing the importance of preconception planning and continuity of effective therapy. Most conventional IBD therapies, including aminosalicylates, corticosteroids, thiopurines, and several biologics, are considered safe during pregnancy and breastfeeding, whereas treatment discontinuation is associated with a higher risk of disease relapse and pregnancy complications. However, therapeutic decision-making must be individualized, balancing disease severity, medication safety profiles, and patient preferences. Close monitoring using clinical assessment, biomarkers, and non-invasive imaging is essential to guide treatment adjustments while minimizing fetal risk.

Q&A discussion

This interactive Q&A discussion aims to address practical and frequently encountered clinical questions in the management of pregnant patients with IBD. Key topics will include optimization of disease control prior to conception, safety profiles of conventional and advanced therapies during pregnancy and lactation, management of flares in pregnancy, use of biomarkers and imaging for monitoring, and coordination of care within multidisciplinary pregnancy clinics. Special attention will be given to real-world decision-making scenarios where guideline recommendations must be adapted to individual patient circumstances.

Genova, 26/06/2026

Michele Savarino
Rappresentante Legale
Realtime Meeting Srl