Takeda SSG Lunch Symposium

A decade of Vedolizumab: From proven efficacy to personalised IBD care

The Takeda medical lunch symposium «A decade of Vedolizumab: Learning from the past, treating the present, personalising the future» took place during the 2025 annual meeting of the SGG in Interlaken.

The speakers, Prof. Dr. med. Luc Biedermann (Head of Inflammatory Bowel Diseases at the University Hospital Zurich) and Prof. Dr. med. Sebastian Zeissig (Clinic Director of Gastroenterology at Inselspital, Bern), guided the audience through a decade of clinical experience with Vedolizumab, from pivotal trial data to current practice and future directions. Their joint presentation underscored the shift from anti-TNF predominance towards a broader first-line role for Vedolizumab, while highlighting the importance of early therapeutic intervention, real-world data, and illustrative patient cases in optimising long-term outcomes.

Keywords: Inflammatory bowel disease (IBD), Ulcerative colitis (UC), Crohn's disease (CD), Vedolizumab (VDZ), biologic therapy, mucosal healing, VARSITY, LOVE-CD, EVOLVE, REPREVIO, personalised medicine

TAKE HOME MESSAGES

- **Vedolizumab has proven long-term efficacy and safety:** Evidence from a decade of clinical use, corroborated by randomised controlled trials (RCTs) including GEMINI, VARSITY, and VERSIFY, demonstrates favourable outcomes compared to TNFα antagonists, particularly in inducing clinical remission and achieving mucosal healing.
- **Early initiation of therapy improves outcomes:** LOVE-CD and $VEDO_{IBD}$ demonstrated that early initiation of Vedolizumab in Crohn's disease patients was associated with significantly higher remission and endoscopic healing rates.
- **The future of IBD care lies in personalisation:** Predictive tools (e.g. VDZ-CDST) and evolving treatment goals toward disease clearance and modification pave the way for individualised and more effective long-term management strategies.

It has now been ten years since the approval of Vedolizumab (VDZ) in Switzerland, when it was authorized as induction and maintenance therapy for Ulcerative colitis (UC) and Crohn's disease (CD).[1] In his presentation Prof. Biedermann acknowledged the pivotal role the GEMINI-1 and GEMINI-2 trials played, and noted that data from GEMINI-3 demonstrated efficacy in CD patients previously treated with advanced therapy (at that time mainly Tumour Necrosis Factor Alpha [TNFα] inhibitors).[2,3,4]
In this context Prof. Biedermann presented a case of a 32-year-old patient with ulcerative proctitis and a positive family history of UC. The patient initially achieved remission under conventional therapy but, over the subsequent years, developed recurrent flares and progression to left-sided colitis, illustrating the limitations of long-term disease control with standard treatment. Intestinal ultrasound during relapse revealed bowel wall thickening in the left hemi-abdomen and the clear need for an alternative treatment. This patient would have benefited from an advanced drug therapy early on and while the choice of the right drug can often be challenging, in this case, as Prof. Zeissig stated, the evidence from RCT and real-world data clearly favours VDZ over anti-TNFα therapy:

- **VARSITY:** Prospective, randomised head-to-head study, demonstrated superior efficacy of VDZ compared to adalimumab in achieving clinical remission, endoscopic improvement, and mucosal healing, while also confirming its favourable safety profile **(figure 1).**[5]
- **$VEDO_{IBD}$:** Prospective, observational real-world study in biologic-naïve UC patients. VDZ resulted in higher rates of steroid-free remission compared to anti-TNFα therapy over a two-year period.[6]
- **UK IBD BioResource:** Real-world data, confirmed significantly greater treatment persistence with VDZ compared with anti-TNFα agents over a five-year period.[7]

Starting early in CD: an important factor for long-term treatment success

Prof. Zeissig presented the case of a patient with ileocolonic CD, initially managed with corticosteroids. The disease soon became steroid-dependent, and subsequent treatment with an immunomodulator had to be discontinued due to pancreatitis. This case exemplified the risks of delayed escalation and highlighted the need for timely initiation of advanced therapy.
Early initiation of therapy in patients with CD is associated with improved outcomes. This was demonstrated in the post-hoc, prospective LOVE-CD study (n = 260), where patients with early disease (≤ 2 years from diagnosis) achieved significantly higher rates of combined steroid-free clinical and endoscopic remission compared with those with late disease.[8] Prof. Zeissig emphasised that disease progression is more pronounced in CD than in UC, and early use of effective biologics is critical to prevent complications such as strictures and fistulae. Furthermore, patients who initiated VDZ earlier in their disease course achieved the primary endpoint of endoscopic healing more frequently.[8]
This is confirmed in multiple studies, where biologic-naïve patients with CD achieved significantly higher rates of long-term steroid-free remission with VDZ compared with anti-TNFα therapy.[7,9] **«So, we have very clear arguments from real-world data for Vedolizumab in this situation,»** Prof. Zeissig concluded.
According to ECCO guidelines, VDZ is recommended as a first-line biologic therapy in both UC and CD.[10,11]

What role does disease location play?

The Swiss EVOLVE study demonstrated that VDZ is effective in both small- and large-intestinal CD, with comparable outcomes across ileal, colonic, and ileocolonic disease.[12] The REPREVIO trial confirmed a protective effect of VDZ in small intestinal disease, showing prevention of postoperative recurrence following ileocecal resection.[13]

> ***«Still occasionally it is thought that for patients with small intestinal Crohn's disease, Vedolizumab does not work in the small intestine. And honestly, it has been very clearly proven that it does.» – Prof. Zeissig***

The future of IBD treatment: Personalised care and disease modification

Personalised care seeks to match the right treatment to the right patient at the right time, making patient selection a key determinant of outcome. Predictive algorithms such as the Vedolizumab Clinical Decision Support Tool (VDZ-CDST) incorporate five predictors associated with higher response rates to VDZ: no prior bowel surgery, no prior anti-TNFα exposure, no prior fistulising disease, serum albumin, and C-reactive protein (CRP) levels.[14] **«The one thing that I think is really important are the clinical parameters. These have at least been shown to be predictive of response, much more than any potential biomarker that we would love to have but which unfortunately has not yet shown success,»** Prof. Biedermann noted. Tools such as the VDZ-CDST therefore represent a first step towards personalised treatment.

Another emerging trend is a shift in treatment goals from symptom relief towards disease modification.[15,16] In this context, interim data from the VERDICT trial has shown high success rates after 48 weeks of VDZ treatment in patients with moderate to severely active UC.[17]

- **90,3%** achieved symptom relief.
- **77,3%** achieved combined symptomatic and endoscopic remission.
- **67,2%** achieved the most ambitious goal of disease clearance.

«This success rate is exceedingly high. These targets are ambitious and may be too ambitious for some patients, but nevertheless they are worthwhile to discuss,» Prof. Biedermann commented. Disease clearance was achieved in a higher proportion of biologic-naïve patients compared with biologic-exposed patients (70% vs. 50%).[17]

> ***«Again, if you think about using Vedolizumab, consider doing so before the use of anti-TNFα therapy, this is where you see higher success rates.» – Prof. Biedermann***

In response to Prof. Biedermann's closing question on how to break the current therapeutic ceiling, Prof. Zeissig noted that there are several strategies to achieve clinical remission rates above 40–50%. One is to initiate advanced therapy early in patients who require it. Another is to aim for ambitious treatment targets such as combined symptomatic, endoscopic, and histological remission. Moreover, dual-targeted therapy is also being explored, for example combining the JAK inhibitor Upadacitinib with VDZ.[18]

As Vedolizumab enters its second decade, it has consolidated its role as a first-line biologic and a cornerstone of personalised IBD therapy.

Source

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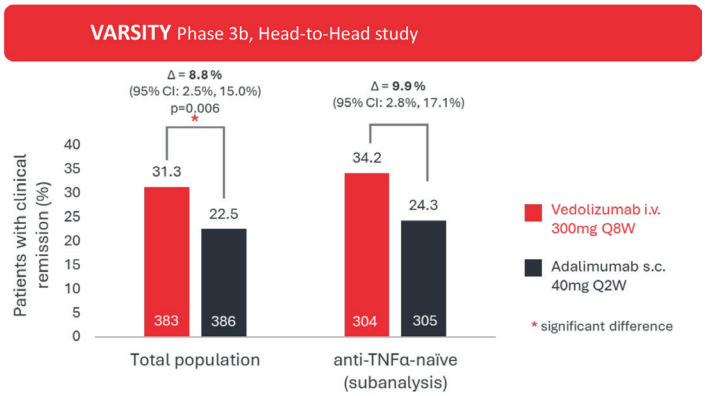

Figure 1: Primary endpoint of the VARSITY trial in patients with UC: Significantly more patients treated with Vedolizumab achieved clinical remission (tot. Mayo score of ⩽ 2 points and no individual subscore > 1 point) at week 52 compared with adalimumab.[5]

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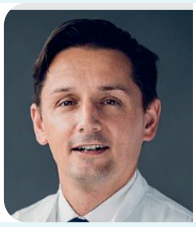

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