IBD Horizon

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Crohn's and colitis: the guide

Understanding your illness, getting treatment, living well and keeping hope: the essentials in 22 sheets.

For people with Crohn's disease or ulcerative colitis, and for those close to them.

Understand · Get treated · Live well · Hope

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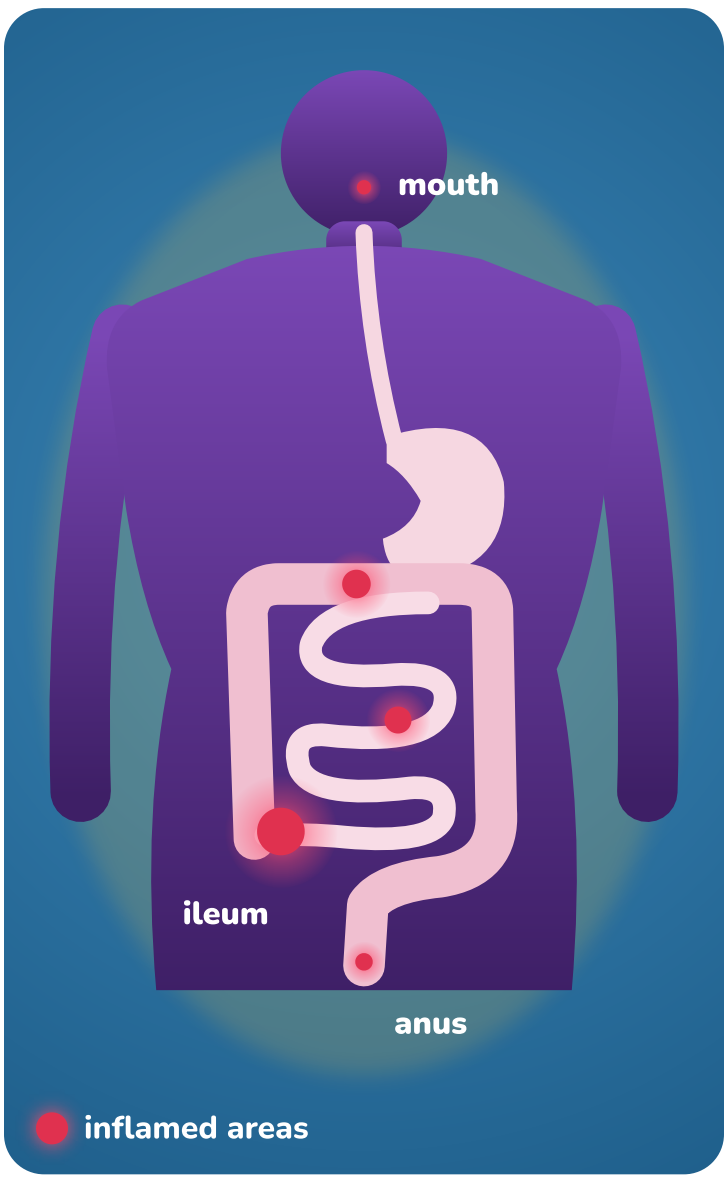
Read this first

This guide is based on current guidelines and recent studies. It helps you understand and ask the right questions, but it never replaces the advice of your gastroenterologist. Difficult words are explained in the short glossary at the end.

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Crohn's: what we know now

The discoveries of recent years that are changing the way we see and treat the disease.



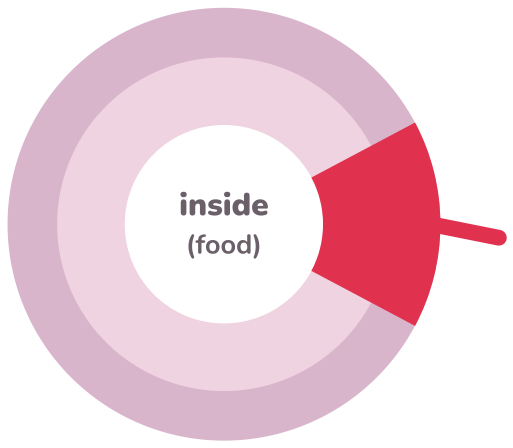
Identity card

Where?
Anywhere from the mouth to the anus. Most often at the end of the small intestine (ileum).

How?
In patches, with healthy areas in between.

How deep?
Through the whole thickness of the bowel wall. Hence strictures and fistulas.

The bowel cut in a slice, like a tube seen end-on



The inflammation goes through the whole thickness of the tube

It can break through outside: that is a fistula

As it heals, the tube narrows: that is a stricture

What has changed

1

BEFORE The disease starts with the first symptoms.

NOW It starts silently. In research, a blood test picks up signs up to 16 years before diagnosis (not yet a routine test).

Gastroenterology 2025; Nature Communications 2025

2

BEFORE You start gently and step up if it isn't enough.

NOW Treating early and hard changes the future: 79% lasting remission versus 15%, and far fewer emergency operations.

PROFILE trial, 2024

3

BEFORE If I have no more symptoms, I've won.

NOW The aim is a healed bowel wall. Calprotectin (stool test) and bowel ultrasound make it possible to check without a colonoscopy every time.

STRIDE international recommendations

4

BEFORE Having surgery means failure.

NOW When Crohn's affects only a short segment at the end of the ileum, early surgery is a real option, just as valid as medicines.

LIR!C trial and its long-term follow-up

5

BEFORE A stricture can only be treated with surgery or dilation.

NOW The first anti-scarring medicines are being tested in humans, including a large trial of 320 patients since October 2026.

Ontunisertib, NOV-ERA trial

6

BEFORE Crohn's is a single disease.

NOW More than 200 regions of the genome are involved, and Crohn's of the ileum differs from Crohn's of the colon. We are moving towards tailor-made treatments.

International genetic studies

7

BEFORE Diet doesn't really matter.

NOW In children, 100% liquid nutrition calms flares as well as cortisone does. Ultra-processed foods are linked to a higher risk.

ECCO/ESPGHAN recommendations; large cohorts

8

BEFORE One treatment at a time.

NOW Combinations of two biologics are being tested, with more healed lining than with just one.

ABBV-466, DUET programme

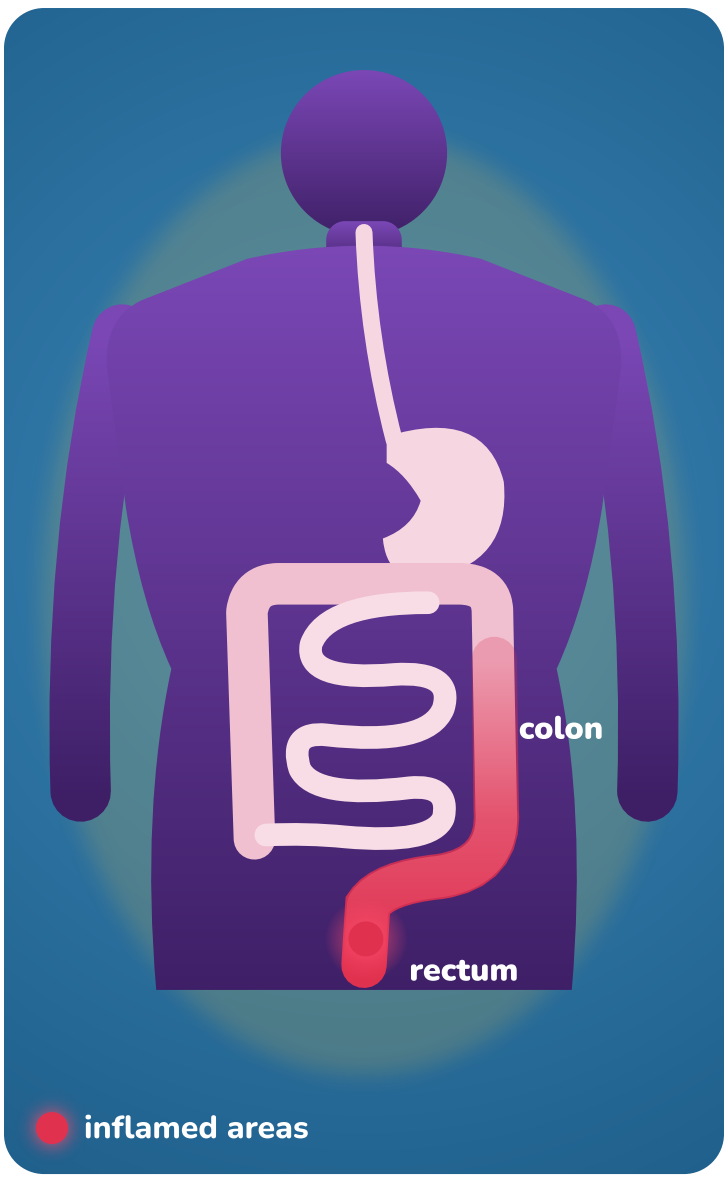
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Part 1 · Understanding your illness · 2/22

UC: what we know now

Ulcerative colitis: the discoveries of recent years that are changing the picture.



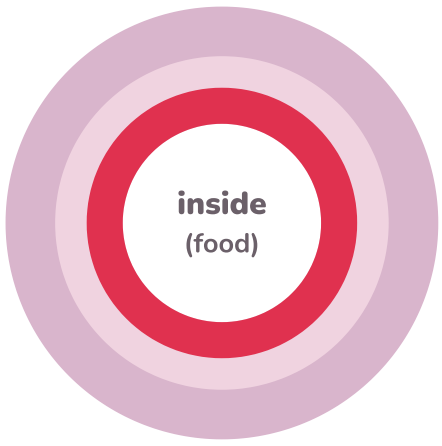
Identity card

Where?
Only the large intestine (colon). Almost always starts in the rectum.

How?
Continuously: it spreads upwards from the rectum, with no healthy area in between.

How deep?
Only the surface layer (the lining, or mucosa).

The bowel cut in a slice, like a tube seen end-on



Only the inner surface
is inflamed (in red)

The rest of the wall
stays healthy

Usually no fistula. A stricture
must always be investigated

What has changed

1

BEFORE The disease starts with the first bleeding.

NOW Signs can be picked up in the blood several years before diagnosis (blood tests taken a median of 7 years before), but less clearly than for Crohn's.

Gastroenterology 2025

2

BEFORE The appendix has nothing to do with UC.

NOW In patients in remission, removing the appendix on top of treatment reduced relapses at 1 year: 36% versus 56%. Not yet an official recommendation.

ACCURE trial, Lancet Gastroenterol Hepatol 2025

3

BEFORE If your stools are normal, all is well.

NOW The aim is a healed lining, even under the microscope: that is what best protects against relapses.

STRIDE international recommendations

4

BEFORE Long-term treatment means an injection or an infusion.

NOW Several families exist as tablets (Rinvoq, Velsipity, Zeposia…) and obefazimod could follow.

European authorisations 2021-2024

5

BEFORE UC often leads to colon cancer.

NOW The risk has fallen markedly thanks to surveillance colonoscopies and better treatments.

Large Scandinavian studies

6

BEFORE Gut microbes are best left alone.

NOW Faecal microbiota transplant helps some patients in trials. It is not yet a standard treatment.

Randomised trials

7

BEFORE You wait for the flare before acting.

NOW Calprotectin (stool test) often rises before a relapse: treatment can be adjusted earlier.

Calprotectin monitoring

8

BEFORE One treatment works for everyone.

NOW Each treatment puts only some patients into remission (often 30 to 50%). To go further, two biologics are combined: several trials are under way.

DUET, Spyre, MORF-057 + Omvoh

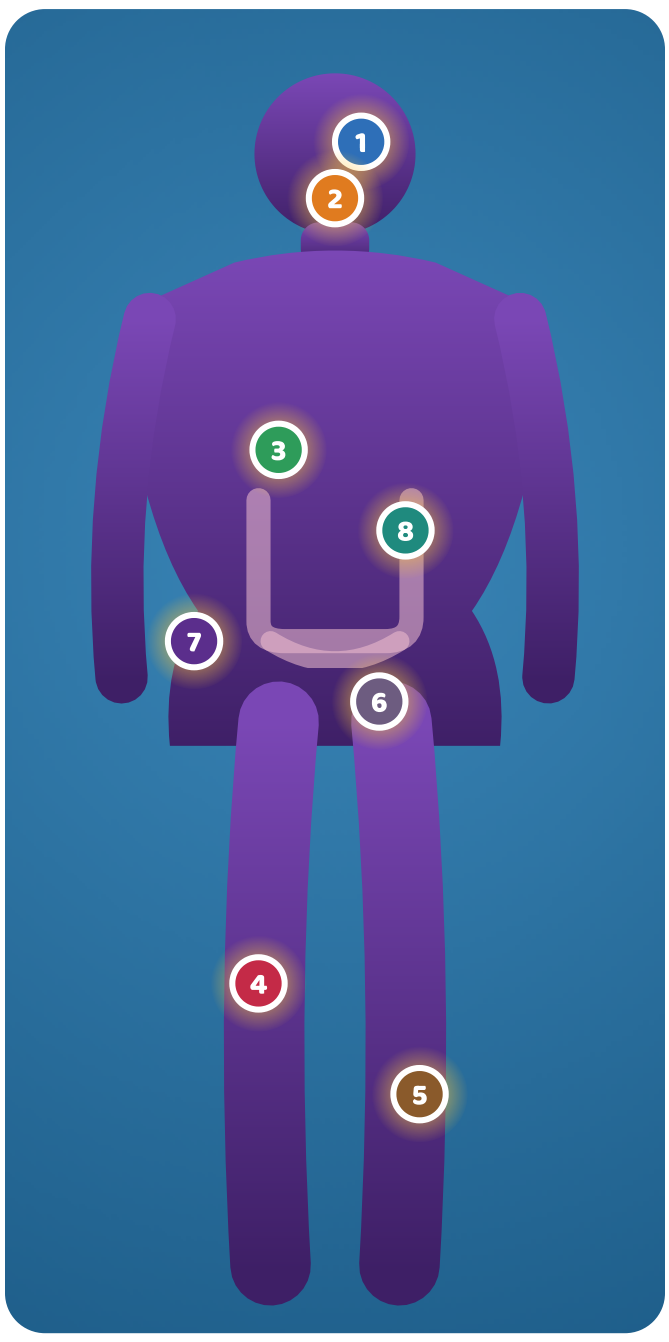
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Part 1 · Understanding your illness · 3/22

Beyond the gut

IBD can also affect the eyes, skin, joints, liver, bones... Recognising these signs means they can be treated better.



Up to 1 patient in 2
will one day have a sign outside the gut. It is not “something else”: it is often the same disease showing itself elsewhere.

1. Eyes
2. Mouth
3. Liver
4. Joints
5. Skin
6. Bones
7. Blood
8. Kidneys

Emergency, don't wait

- Painful red eye with blurred vision
- Swollen, painful calf
- Sudden breathlessness or chest pain

Some follow the flares: knees and ankles, lumps on the shins, a red eye that is not very painful. They settle down with the flare.

Others run their own course: back, uveitis, liver. They need separate follow-up.

1 The eyes

What it looks like : A red eye that is not very painful (episcleritis), often during a flare. Rarer: a painful red eye, blurred vision, sensitivity to light (uveitis).

What to do : Painful red eye or blurred vision: see an eye specialist urgently.

2 The mouth

What it looks like : Mouth ulcers that keep coming back, often with flares.

What to do : Mention them: they can also come from a deficiency (iron, B9, B12, zinc).

3 The liver and bile ducts

What it looks like : Most often nothing you can feel. Sclerosing cholangitis, especially with UC, shows up on a blood test (liver tests).

What to do : Regular liver tests. If it is present: a surveillance colonoscopy every year.

4 The joints

What it looks like : The most common. Swollen or painful knees, ankles, wrists. Or lower back pain, stiff in the morning.

What to do : Tell your gastro, and avoid ibuprofen: paracetamol, or even a rheumatologist.

5 The skin

What it looks like : Red, painful lumps on the shins (erythema nodosum), especially during a flare. Rarer: a wound that grows for no reason.

What to do : Show it to a doctor quickly, especially a wound that won't heal.

6 The bones

What it looks like : Silent osteoporosis: cortisone, lack of vitamin D, inflammation.

What to do : Bone density scan if you have repeated courses of cortisone. Vitamin D and calcium.

7 The blood

What it looks like : Anaemia (tiredness, breathlessness). And a higher risk of clots (deep vein thrombosis, embolism), especially during a flare or in hospital.

What to do : Swollen, painful calf, or sudden breathlessness: A&E.

8 The kidneys

What it looks like : Kidney stones are more common, especially if Crohn's affects the ileum or after an operation.

What to do : Drink plenty. Violent pain in the back or side: see a doctor.

The habit to get into

Tell your gastro about any new symptom, even if it seems unrelated to your gut. And tell your other doctors (eye specialist, rheumatologist, dermatologist) that you have IBD.

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Part 2 · Getting treatment today · 4/22

Good habits

What to do, what to avoid, and when to worry.

Do

Get your vaccinations before a biologic
Flu, pneumococcus, Covid, shingles, hepatitis B, HPV... Live vaccines (MMR, chickenpox, yellow fever) are given at least 4 weeks before treatment.

Keep track of your calprotectin
Always at the same lab, so the results can be compared with each other.

Have your stores measured every year
Iron, B12, B9, vitamin D, zinc. See the sheet “Tiredness”.

Protect your skin
Sunscreen and check-ups with a dermatologist while on an immunosuppressant.

Have your surveillance colonoscopies
They protect against colon cancer.

Claim your rights
In France: ALD (long-term condition status, with 100% cover) and the afa's “Urgent toilet” card.

Prepare your appointments
Write down your symptoms and questions before the appointment.

Don't

Take ibuprofen
Anti-inflammatories (NSAIDs) can trigger a flare. The habit: paracetamol.

Stop your treatment because you feel well
It is the treatment that keeps you in remission.

Stay on cortisone for months, or stop it suddenly
It helps out in a flare, nothing more (bones, weight, diabetes, eyes...). And it is always reduced gradually.

Take a medicine without mentioning it
Example: allopurinol (Zyloric) with azathioprine is dangerous unless the dose is adjusted. Always tell the doctor and the pharmacist what treatment you are on.

Smoke
With Crohn's, smoking makes the disease worse and increases the risk of an operation.

Have a live vaccine without advice
Yellow fever, MMR... should be avoided while on an immunosuppressant.

Block a severe flare with an anti-diarrhoeal
Especially in UC: risk of a serious complication of the colon.

Believe in miracle cures
No diet or supplement replaces long-term treatment.

Warning signs

I keep an eye on it

Usual mild discomfort, slight tiredness, one or two more stools than usual.

I call my gastro

A flare that has been building for a few days (blood, pain, more stools), pain or swelling near the anus. Fever above 38.5 °C or chills while on an immunosuppressant: advice the same day.

Emergency

High fever with severe pain. Swollen belly with vomiting, no more wind or stools. Heavy bleeding or feeling faint. 6 or more bloody stools a day, especially with fever or a racing heart. Painful red eye, swollen calf.

This is not medical advice: talk to your gastroenterologist or your GP.

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Part 2 · Getting treatment today · 5/22

The treatment staircase

The main families of treatment available today for Crohn's and UC, from the gentlest to the most targeted.

A change of strategy

BEFORE
~~Step by step~~
You started gently, and only stepped up if it wasn't enough.

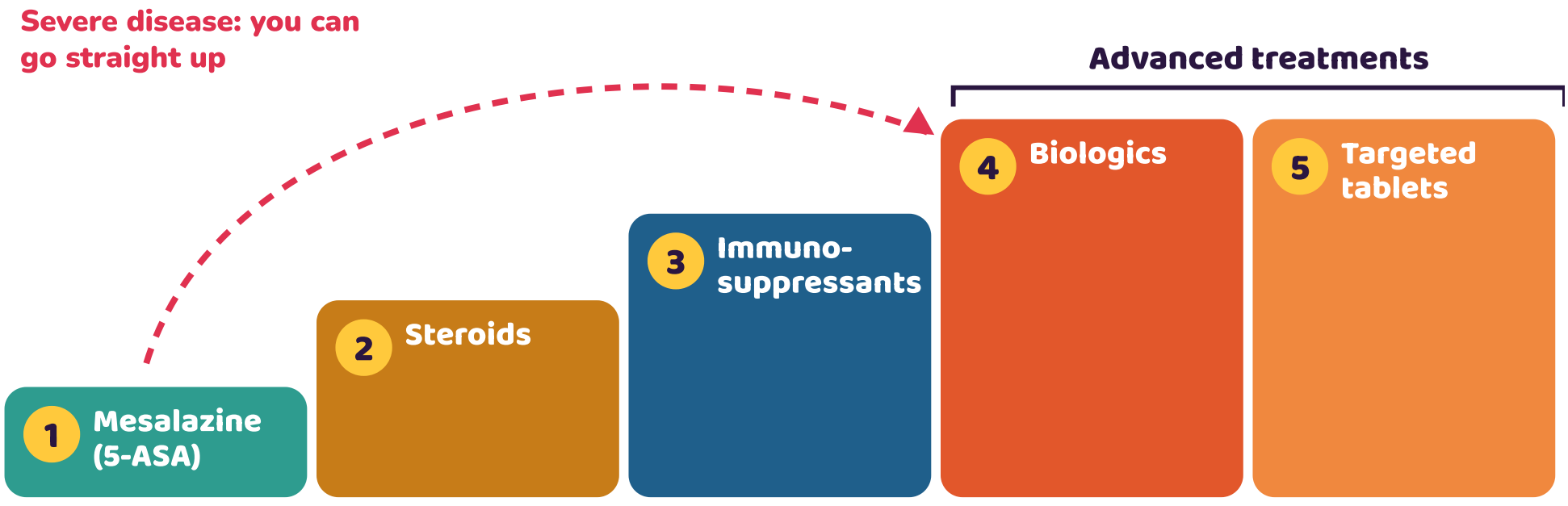
TODAY, IN CROHN'S
Hit hard from the start
In many patients, a biologic is started early, sometimes with an immunosuppressant.

AND IN UC?
It depends
Mild UC is often treated well with mesalazine. If it is moderate to severe, advanced treatments are brought in quickly.

Why?

- Crohn's can damage the bowel little by little, even when you feel well: strictures, fistulas, operations.
- Treatments work better early in the disease, before the damage sets in.
- The PROFILE trial (2024): 79% lasting remission when treating hard from the outset, versus 15% when stepping up gradually, and far fewer emergency operations.

Severe disease: you can go straight up



The goal
Remission without cortisone, with a healed bowel.

Nothing works?
You change route: there is often another option.

The right treatment
It is chosen with your gastro, according to your disease and your life.

1 Gut anti-inflammatories
5-ASA (mesalazine)

They act directly on the bowel wall. They are not NSAIDs like ibuprofen.

Pentasa, Fivasa, Rowasa · **Salazopyrine**

Who for : Mainly mild to moderate UC, as long-term treatment. Not very effective in Crohn's.

How : Tablets, granules, suppositories, enemas

2 Cortisone
steroids (corticosteroids)

It quickly puts out a flare, but does not stop it coming back.

Prednisone — Cortancyl
Prednisolone — Solupred
Budesonide — Entocort, Mikicort (Crohn's); Cortiment (UC)

Who for : Crohn's and UC, for a few weeks only. Never as long-term treatment: bones, weight, sugar, eyes, mood.

How : Tablets, sometimes a drip in hospital

3 Immunosuppressants
thiopurines, methotrexate

They calm the immune system. Often combined with a biologic to stop the body making antibodies against it.

Azathioprine — Imurel
6-mercaptopurine — Purinethol
Methotrexate — Metoject, Imeth: Crohn's
Ciclosporin — in hospital, severe UC

Who for : Crohn's and UC. They take 2 to 3 months to work. TPMT test before azathioprine, regular blood tests, sun protection. Methotrexate: just one dose a week.

How : Tablets, or an injection for methotrexate

4 Biologics
antibodies

Each one blocks a specific inflammation signal. Biosimilars are as effective as the original.

Anti-TNF — Remicade, Humira, Simponi (UC) and biosimilars
Anti-integrin — Entyvio
Anti-IL-12/23 — Stelara and biosimilars
Anti-IL-23 — Skyrizi, Omvoh, Tremfya

Who for : Moderate to severe Crohn's and UC. Before starting: screening for infections (tuberculosis, hepatitis, HIV, chickenpox) and vaccinations up to date.

How : Injections at home or drips in hospital

5 Targeted tablets
small molecules

Tablets that cut a relay of inflammation inside the cells, or hold back white blood cells.

JAK — Rinvoq (Crohn's, UC), Xeljanz (UC), Jyseleca (UC)
S1P — Zeposia, Velsipity (UC)

Who for : Moderate to severe Crohn's and UC depending on the molecule. They work quickly. Monitoring with blood tests; caution for some (heart, clots, shingles).

How : Tablets, once or twice a day

Alongside the staircase

Surgery
A tool like any other, not a failure (see the dedicated sheet).

Antibiotics
For some fistulas or infections.

Nutrition
100% liquid nutrition treats Crohn's flares in children.

Deficiencies
Iron, vitamin D, B12... to be corrected (sheet “Tiredness”).

Good to know
In France, availability and reimbursement vary from one molecule to another: your gastro will tell you what is possible for you. Under each molecule: its brand name or a detail.

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Part 2 · Getting treatment today · 6/22

How your treatments work

Why there are several families of treatment, and why you can switch between them.

Each treatment has its step

Inflammation follows a chain, from the alarm to the damaged bowel wall. Some treatments cut the chain at one precise point, others calm the whole chain. Here are all the treatments available today.

1. The alarm

The gut's defences overreact, often to microbes.

BLOCKED BY

No treatment here yet: it is one of the leads for tomorrow.

2. The messengers

Signals (TNF, IL-12, IL-23) give the order to inflame the bowel.

BLOCKED BY

- **Anti-TNF** — Remicade, Humira, Simponi (UC) and biosimilars
- **Anti-IL-12/23** — Stelara and biosimilars
- **Anti-IL-23** — Skyrizi, Omvoh, Tremfya

3. The relay inside the cell

The message is passed on inside the white blood cells by the JAK family.

BLOCKED BY

- **Anti-JAK** — Rinvoq, Xeljanz, Jyseleca

4. Leaving the lymph nodes

Activated white blood cells leave the lymph nodes and head for the bowel.

BLOCKED BY

- **S1P modulators** — Zeposia, Velsipity

5. Getting into the bowel

They use a “key” (α4β7) to get into the bowel wall.

BLOCKED BY

- **Anti-integrin** — Entyvio

6. Inflammation of the bowel wall

The white blood cells damage the bowel wall: pain, diarrhoea, blood, ulcers.

BLOCKED BY

- **Mesalazine** — Pentasa, Fivasa, Rowasa
- **Sulfasalazine** — Salazopyrine

And those that act on the whole chain

Cortisone

It quickly puts out the whole chain, but only for the length of a flare. Budesonide acts mainly in the bowel, with fewer effects on the rest of the body.

- **Prednisone** — Cortancyl
- **Prednisolone** — Solupred
- **Budesonide** — Entocort, Mikicort (Crohn's); Cortiment (UC)

Immunosuppressants

They slow down the activation and multiplication of lymphocytes, broadly and slowly (2 to 3 months). They also help biologics stay effective.

- **Azathioprine** — Imurel
- **6-mercaptopurine** — Purinethol
- **Methotrexate** — Metoject, Imeth: Crohn's, 1 dose a week
- **Ciclosporin** — in hospital, severe UC

The key message

When a treatment stops working, the next one is often chosen to cut the chain at a different point. Example: after an anti-TNF, you can move to an anti-IL-23, to Entyvio or to a JAK tablet. There is almost always another option.

This is not medical advice: talk to your gastroenterologist or your GP.

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Part 2 · Getting treatment today · 7/22

Crohn's: which treatment for which situation?

How well treatments work depending on what is affected: the bowel, fistulas, after an operation, strictures.

Which treatment works best, and for what?

Each situation has its treatments of choice. The levels summarise the European guidelines (ECCO), the large comparisons of studies and the key trials, cited under each card.

Strongest evidence of efficacy · Effective, proven in trials · More limited evidence or supporting role

Mild flare of the ileum

limited, mildly active Crohn's

Strongest evidence of efficacy
- **Budesonide** — Entocort, Mikicort

More limited evidence or supporting role
- **Mesalazine** — not very effective in Crohn's

The figures from the trials

Budesonide: about 1 patient in 2 in remission after 8 weeks, versus 1 in 5 without active treatment (disease of the ileum and/or the right colon).

Useful for a flare, not for maintenance: if the flare comes back, you move on to a long-term treatment.

Sources : ECCO 2024; Greenberg, NEJM 1994; Cochrane review

Moderate to severe Crohn's

the most common situation with biologics

Strongest evidence of efficacy
- **Infliximab** — Remicade
- **Adalimumab** — Humira
- **Risankizumab** — Skyrizi
- **Guselkumab** — Tremfya
- **Upadacitinib** — Rinvoq

Effective, proven in trials
- **Ustekinumab** — Stelara
- **Mirikizumab** — Omvoh
- **Vedolizumab** — Entyvio

More limited evidence or supporting role
- **Azathioprine, methotrexate** — not for a flare; useful for maintenance or alongside a biologic

The figures from the trials

In patients never treated with these drugs: infliximab + azathioprine, 57% in steroid-free remission at 6 months, versus 44% with infliximab alone (SONIC).
After an anti-TNF has failed: at 48 weeks, lesions gone or almost gone on colonoscopy in 32% on Skyrizi versus 16% on Stelara (SEQUENCE, patients not blinded).

The large comparisons put anti-TNFs, anti-IL-23s and Rinvoq at the top, with modest differences. Rinvoq requires precautions after age 65, in smokers and in people with heart risk.

Sources : Meta-analyses: Barberio, Gut 2023 and AGA 2025; SONIC, NEJM 2010; SEQUENCE, NEJM 2024

Fistulas near the anus

with or without an abscess

Strongest evidence of efficacy
- **Anti-TNF** — especially Remicade
- **Surgeon** — drainage, seton

Effective, proven in trials
- **Ustekinumab** — Stelara
- **Guselkumab** — Tremfya

More limited evidence or supporting role
- **Upadacitinib** — Rinvoq, partial data
- **Vedolizumab** — Entyvio
- **Antibiotics** — as an add-on

The figures from the trials

Remicade, in those who had responded to the first 3 infusions: fistulas no longer draining at 1 year in 36% versus 19% on placebo (ACCENT II).
Fistula closed and confirmed on MRI: Tremfya 28% versus 10% at 24 weeks (FUZION, results announced by the manufacturer); Stelara 62% versus 25% at 3 months (USTAP, 32 patients).

Always a two-person job: the surgeon drains first, then the long-term treatment heals.

Sources : ECCO 2024; ACCENT II, NEJM 2004; FUZION, DDW congress 2026; USTAP (GETAID), Gut 2026

After an operation

to stop Crohn's coming back

Strongest evidence of efficacy
- **Anti-TNF** — Remicade, Humira

Effective, proven in trials
- **Vedolizumab** — Entyvio
- **Azathioprine** — Imurel, more modest effect

More limited evidence or supporting role
- **Metronidazole** — a few months
- **Stelara** — no comparative trial yet

The figures from the trials

Remicade: recurrence seen on colonoscopy at 76 weeks (about 18 months) in 31% versus 60% on placebo; relapses with symptoms were not clearly reduced over this period (PREVENT).
Entyvio, in patients at risk: severe recurrence at 6 months in 23% versus 62% on placebo (REPREVIO, 80 patients).

A colonoscopy 6 to 12 months after the operation to check. Stop smoking: tobacco doubles the risk of recurrence.

Sources : ECCO surgery 2024; PREVENT, Gastroenterology 2016; REPREVIO, Lancet Gastroenterol Hepatol 2025

Stricture (narrowing)

depending on whether it is inflammatory or scar tissue

Inflammatory
- **Biologic** — especially anti-TNF

Scar tissue
- **Dilation** — during an endoscopy
- **Surgery** — resection, strictureplasty

Tomorrow
- **Anti-Fibrosis** — in trials (sheet 18)

The figures from the trials

Humira in a stricture with symptoms: success at 6 months in 64% of patients, with no operation or dilation (CREOLE study, no comparison group).

MRI or ultrasound help to tell how much is inflammation and how much is scar tissue.

Sources : ECCO 2024; CREOLE (GETAID), Gut 2018

Read this before comparing

This is not a personal ranking. The percentages come from trials in selected patients, often compared with a placebo: in real life, and after several treatments, they are often lower. The differences between treatments are often small, and they were measured in different studies. The best treatment for you depends on where the disease is, your past treatments, your other health problems and your plans. A "lower-ranked" treatment may be the right one for you. Some figures come from small trials or recent congresses and may change.

This is not medical advice: the choice of treatment is always made with your gastroenterologist.

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Part 2 · Getting treatment today · 8/22

UC: which treatment for which situation?

How well treatments work depending on the extent and severity of the disease, and in special cases.

Which treatment works best, and for what?

Each situation has its treatments of choice. The levels summarise the European guidelines (ECCO), the large comparisons of studies and the key trials, cited under each card.

Strongest evidence of efficacy · Effective, proven in trials · More limited evidence or supporting role

Proctitis (rectum only)
the most limited form

Strongest evidence of efficacy
- **Mesalazine suppositories** — Pentasa, Fivasa, Rowasa, Osperzo

Effective, proven in trials
- **Mesalazine tablets** — in addition
- **Local steroids** — foams, enemas

For the rectum, local treatment works better than tablets alone, and the two can be combined if that is not enough.

Sources : ECCO UC 2022

Mild to moderate UC
left colon or extensive

Strongest evidence of efficacy
- **Mesalazine** — tablets + enemas

Effective, proven in trials
- **Budesonide** — Cortiment
- **Conventional steroids** — short course, if other treatment fails

A good dose of mesalazine, every day, is enough for many patients. Steroids put out the flare but are not a maintenance treatment.

Sources : ECCO UC 2022

Moderate to severe UC
when mesalazine is no longer enough

Strongest evidence of efficacy
- **Upadacitinib** — Rinvoq
- **Infliximab** — Remicade
- **Risankizumab** — Skyrizi
- **Guselkumab** — Tremfya

Effective, proven in trials
- **Mirikizumab** — Omvoh
- **Vedolizumab** — Entyvio
- **Ustekinumab** — Stelara
- **S1P** — Zeposia, Velsipity
- **Other JAKs** — Xeljanz, Jyseleca
- **Golimumab** — Simponi

A little less effective in the comparisons
- **Adalimumab** — Humira

The figures from the trials

Rinvoq: 26% in remission at 8 weeks versus 5% on placebo (U-ACHIEVE, about half of the patients had already failed a biologic).
Head to head: remission at 1 year in 31% on Entyvio versus 23% on Humira (VARSITY).

Rinvoq often comes out on top in the large comparisons, but the differences remain modest. JAK inhibitors (Rinvoq, Xeljanz, Jyseleca) require precautions after age 65, in smokers and in people with heart risk.

Sources : AGA 2024 summary; network meta-analyses 2022-2024; U-ACHIEVE, Lancet 2022; VARSITY, NEJM 2019

Very severe flare
in hospital, it is an emergency

First
- **Intravenous steroids** — for 3 to 5 days

If that fails
- **Infliximab** — Remicade
- **Ciclosporin** — just as effective

As a last resort
- **Surgery** — a real treatment, not a failure

The figures from the trials

Intravenous steroids: about 2 patients in 3 respond.
If they are not enough, infliximab and ciclosporin are on a par. On a very demanding endpoint (steroid-free remission at 3 months, with no relapse or operation), failure affected 54% versus 60%, a non-significant difference (CYSIF).

Don't wait: with 6 or more bloody stools a day plus fever, a racing heart, marked paleness or intense fatigue, seek urgent medical care.

Sources : ECCO UC 2022; Turner, Clin Gastroenterol Hepatol 2007; CYSIF, Lancet 2012

Pouchitis
inflammation after an ileoanal pouch

Strongest evidence of efficacy
- **Antibiotics** — ciprofloxacin, metronidazole

Effective, proven in trials
- **Vedolizumab** — Entyvio, if it resists antibiotics

More limited evidence or supporting role
- **Probiotics** — prevention, limited evidence

The figures from the trials

Entyvio in chronic pouchitis that resists antibiotics: 31% in remission at 14 weeks versus 10% on placebo (EARNEST).

Most cases of acute pouchitis heal with two weeks of antibiotics.

Sources : ECCO guidelines; EARNEST, NEJM 2023

Signs outside the bowel
Crohn's and UC: joints, skin, eyes

Strongest evidence of efficacy
- **Anti-TNF** — the most evidence

Effective, proven in trials
- **Other biologics and JAK inhibitors** — depending on the organ affected, with the specialist

Calming the bowel often calms pain in the large joints and skin nodules, but not always the spine, the eyes or the liver, which have their own follow-up. Entyvio acts mainly in the bowel.

Sources : ECCO 2024, extra-intestinal manifestations

Read this before comparing

This is not a personal ranking. The percentages come from trials in selected patients, often compared with a placebo: in real life, and after several treatments, they are often lower. The differences between treatments are often small, and they were measured in different studies. The best treatment for you depends on where the disease is, your past treatments, your other health problems and your plans. A "lower-ranked" treatment may be the right one for you. Some figures come from small trials or recent congresses and may change.

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This is not medical advice: the choice of treatment is always made with your gastroenterologist.

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IBD Horizon

Part 2 · Getting treatment today · 9/22

Tests, without the stress

What each test is for, and what really happens.

Why so many tests?
Because you can feel well and still have inflammation. Tests check that the bowel is really healing, and they are less and less unpleasant.

The blood test

No preparation* · 5 minutes

What it is for : Spotting inflammation (CRP), anaemia and deficiencies, and checking that the treatment is well tolerated (liver, kidneys, blood cells).

What happens : A simple blood test. *Sometimes after fasting. The level of the drug in the blood can also be measured to adjust the dose.

A normal result does not mean the bowel is calm: CRP sometimes stays normal even during a flare.

Calprotectin

Stool · Painless

What it is for : Measuring bowel inflammation in the stool. It is the simplest test to know whether the disease is active.

What happens : A small pot of stool taken back to the lab. Result in µg/g: under 50, reassuring; between 50 and 250, to be watched; over 250, inflammation likely.

First stool of the morning, same lab, no ibuprofen beforehand. In France, it is reimbursed 2 times a year when prescribed by the gastroenterologist or paediatrician, if there is no blood in the stool and no raised CRP; otherwise you pay for it yourself, often 40 to 50 €.

Bowel ultrasound

No radiation · No preparation · 15 to 30 min

What it is for : Seeing whether the bowel wall is thickened or inflamed, and following the effect of a treatment.

What happens : A probe with gel placed on the abdomen, like a pregnancy ultrasound. The result is given straight away.

Used more and more, but not yet available everywhere: ask your gastro.

Colonoscopy

Short anaesthetic · Preparation

What it is for : Looking directly inside the colon and the end of the ileum, taking small samples (biopsies), and monitoring the risk of cancer.

What happens : Under a short general anaesthetic (with an anaesthetic consultation beforehand): you feel nothing. The hardest part is the preparation: a liquid to drink, often in two goes (the evening before and the morning).

For the preparation: drink it chilled, and eat a low-fibre diet (no fruit or vegetables) in the days before.

MR enterography

No radiation · 30 to 45 min

What it is for : Seeing the whole small bowel, which colonoscopy cannot reach: strictures, fistulas, abscesses. A pelvic MRI is also used for fistulas near the anus.

What happens : You drink a large volume of liquid before the scan, then lie in a noisy tunnel, with an injection.

If you are afraid of enclosed spaces, say so beforehand: they can help you relax.

Capsule endoscopy

No anaesthetic · 8 to 12 h

What it is for : Filming the inside of the small bowel, where other tests see poorly.

What happens : You swallow a capsule containing a tiny camera. It films during the day, then passes out naturally in the stool.

Be careful if you have a stricture: the capsule can get stuck. A test capsule that dissolves is often used first.

CT scan

Quick · X-rays

What it is for : Mainly in A&E: quickly looking for an abscess, a blockage or a perforation.

What happens : A few minutes lying in a ring, often with an injected contrast agent.

It uses X-rays: for regular follow-up, MRI or ultrasound is preferred.

The usual follow-up schedule

Every 3 to 6 months
Blood test and calprotectin, often.

About once a year
Ultrasound or MRI depending on your disease.

As needed
Colonoscopy, including to monitor the risk of cancer when the disease has affected the colon for several years.

Good to know
The schedule depends on your disease and your treatment: your gastro adapts it. Don't hesitate to ask what each test is for and when you will get the result.

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Part 2 · Getting treatment today · 10/22

Surgery, no taboos

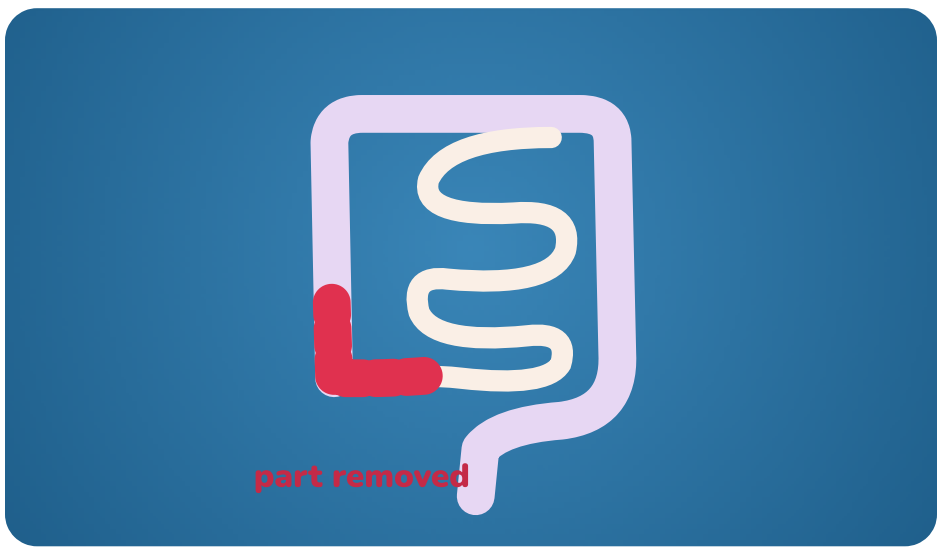
Which operations, why, and what happens in Crohn's and UC.

An operation is not a failure

It is a treatment like any other, sometimes the best one. Well prepared and done at the right time, it can give back years of quality of life.

In Crohn's

The damaged area is removed or repaired



Ileocaecal resection

The most common: the diseased end of the ileum is removed and the bowel is stitched back together. Often by keyhole surgery (laparoscopy, small scars).

Strictureplasty

A stricture is widened without removing any bowel, to keep its full length.

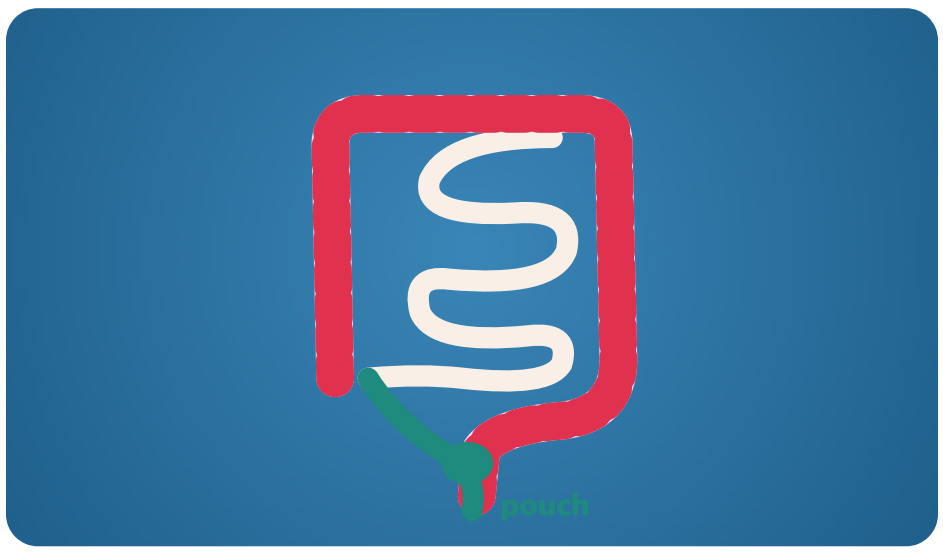
Anal fistulas and abscesses

Drainage, and placing a seton: a small soft thread that stops the abscess coming back while the treatment takes effect.

Crohn's can come back near the join: preventive treatment and a colonoscopy at around 6 months are often offered.

In UC

The colon and rectum are removed



Proctocolectomy

The colon and rectum are removed. UC can no longer affect the colon, but the pouch can become inflamed and some signs outside the gut may persist.

Ileoanal pouch

A reservoir made from the small intestine replaces the rectum: no bag on the belly. Often done in 2 or 3 stages, with a temporary stoma.

And afterwards?

About 4 to 7 stools a day, sometimes one at night. Inflammation of the pouch (pouchitis) is possible: it is treated well, often with antibiotics.

After an ileoanal pouch, female fertility may fall: discuss it beforehand if you plan to have children.

When is surgery done?

As an emergency

Perforation, an abscess that won't heal, bowel obstruction, a very severe flare of UC that does not respond to treatment.

Planned

A fibrous (scarred) stricture that causes problems, disease that resists treatment, or lesions at risk of cancer.

A stoma, for real

The bowel is attached to the skin of the belly and the stools go into a bag. It is often temporary. You can work, do sport, swim, travel and have an intimate life. The bag cannot be seen under clothes. In France, the afa has a peer-support network for people with a stoma.

Getting well prepared

- Stop smoking: one of the most effective ways, along with preventive treatment, to stop Crohn's coming back.
- Correct anaemia or malnutrition before the operation.
- Reduce cortisone if possible, with your doctor.
- Choose a centre that often operates on IBD (in France, a CHU, i.e. a university hospital).

Questions to ask the surgeon

- Which operation, and by keyhole surgery?
- Will there be a stoma? Temporary or permanent?
- How many days in hospital, and how long before going back to work?
- What treatment afterwards, to prevent it coming back?

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This is not medical advice: every operation is discussed with your gastro and your surgeon.

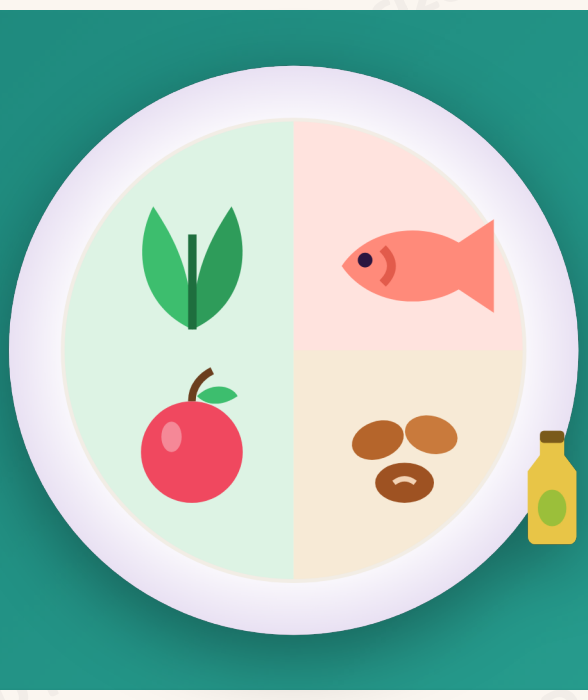
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Part 3 · Living well with IBD · 11/22

Eating well with IBD

What the guidelines say, what experience teaches, and how to find what works for you.



The experts' message

There is no single diet for IBD. The recommended basis for almost everyone: a Mediterranean-style diet, home-cooked, with little salt, sugar and ultra-processed food.

AGA 2024 and IOIBD guidelines

Eat more of

Vegetables
cooked, puréed or raw, depending on how you tolerate them

Fruit
peeled or cooked if needed

Oily fish
sardines, mackerel, salmon: omega-3

Olive oil
your everyday fat

Eggs
protein, B12, vitamin D

Meat and poultry
unprocessed: iron, zinc, B12

Pulses
lentils, chickpeas, puréed at first

Grains
bread, rice, pasta, semolina

Yoghurts
often well tolerated

Nuts
walnuts, almonds, ground if needed

In moderation

Large amounts of red meat
especially with UC: weak signal, depending on your tolerance

Sugar and pastries

Fizzy drinks and sweeteners

Too much saturated fat
fried food, palm oil

Avoid

Cured and processed meats
nitrites and additives

Ultra-processed food
biscuits, ready meals

Emulsifier additives
E466, E433, E407: read the labels

Trans fats
“partially hydrogenated” oils

What about milk?

Many patients tolerate milk and cheese well: **it really depends on the person**.

Lactose intolerance does exist, a little more often when Crohn's affects the small intestine. Aged cheeses and yoghurts contain very little lactose.

If you are on an immunosuppressant or a biologic, avoid raw milk and raw-milk cheeses (especially soft cheeses), because of listeria.

During a flare

Keep things simple while the flare lasts: cooked food, less tough fibre, small meals, and plenty to drink. Then bring foods back in.

If you have a stricture

Fibre is no longer off-limits: vegetables and fruit cooked, peeled, blended and well chewed. Avoid skins, seeds and tough fibre.

Pain without inflammation

A low-FODMAP diet may bring relief, for a short time and with a dietitian.

The food diary

At first, write down what you eat and how you feel. You will spot **your** problem foods, because everyone reacts differently.

Day	I ate	How I felt	Verdict
Monday	Lentils	Bloating	Try again
Tuesday	Fish, rice	Nothing	OK
Thursday	Raw salad	Pain	Later, cooked
Saturday	Yoghurt	Nothing	OK

It's not forever

A food you tolerate badly today, during a flare or just after, may suit you very well in 6 months. Try it again in a small amount, later on.

Avoid cutting out too many foods: that opens the door to deficiencies and malnutrition.

When food becomes a treatment

100% liquid nutrition

Nutritional drinks for 6 to 8 weeks can put Crohn's into remission, especially in children. Also useful before surgery.

Crohn's Disease Exclusion Diet

A specific diet combined with a nutritional drink, suggested by the European guidelines for mild to moderate Crohn's flares, including in adults.

Always with your gastro and a dietitian. The “miracle” diets found on the internet have not been proven.

Experiment, observe, adjust

Food remains a very complex subject: everyone has their own genetics (the lactase gene, metabolism genes such as APOE…), their own microbiota, their own digestive enzymes, and a very personal relationship with food. So there is no rule that works for everyone. The pointers on this sheet are a starting point, not a list of forbidden foods. Listen to your body, keep enjoying your food, and let your diary guide you.

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This is not medical advice: for a specific diet, get support from a dietitian and your gastro.

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Part 3 · Living well with IBD · 12/22

Fatigue is not inevitable

With IBD, you are often short of vitamins and minerals. The good news: they can be measured, and corrected.

Have you been told "it's normal to be tired with IBD"?

Not necessarily. Part of the fatigue comes from deficiencies that can be corrected. And "within the normal range" does not mean "at its best": a result at the bottom of the range can be enough to wear you out. Ask for the blood test, and aim high.

Ferritin

units: µg/L (= ng/mL)

Your iron stores. Too low: fatigue, breathlessness, hair loss.

DEFICIENT	LOW	TARGET
< 30 µg/L	30 to 70 µg/L	70 to 150 µg/L

At risk : Bleeding, flares, heavy periods.

Supplement tip
Iron bisglycinate + vitamin C, every other day, away from tea, coffee and dairy (black stools: that's normal). Recheck at 3 months. During a flare, with marked anaemia or if you tolerate it badly: iron by infusion is often better.

During a flare, inflammation pushes ferritin up: it can look fine even though you are short of iron. During a flare, a ferritin below 100 µg/L can already hide a deficiency: transferrin saturation is checked too (above 20%).

Vitamin D

units: ng/mL or nmol/L

Bones, muscles, immune defences. Very often low with IBD.

DEFICIENT	LOW	TARGET	TOO HIGH
< 20 ng/mL < 50 nmol/L	20 to 50 ng/mL 50 to 125 nmol/L	50 to 80 ng/mL 125 to 200 nmol/L	> 100 ng/mL > 250 nmol/L

At risk : Everyone in winter, steroids, Crohn's of the ileum.

Supplement tip
D3 + K2 (MK-7) drops: 2,000 IU a day (or 50,000 IU a month), with a meal containing some fat. A higher dose only on medical advice, with a follow-up blood test.

A high target suited to autoimmune diseases, with a blood test every 3 to 6 months. Kidney stones: also have your urine calcium measured. 1 ng/mL = 2.5 nmol/L.

Vitamin B12

units: pg/mL or pmol/L

Energy, nerves, memory, mood.

DEFICIENT	LOW	TARGET
< 200 pg/mL < 150 pmol/L	200 to 450 pg/mL 150 to 330 pmol/L	> 450 pg/mL > 330 pmol/L

At risk : Crohn's of the ileum, ileum operated on.

Supplement tip
Methylcobalamin (under the tongue or swallowed): 1,000 µg a day is often absorbed even with a diseased ileum. After major surgery on the ileum or if you have pins and needles: injections, with your doctor.

Many practitioners aim for 600 to 1,000 pg/mL. A deficiency is not trivial: anaemia, pins and needles, memory problems, and nerve damage that can become permanent. Tired with an "acceptable" B12? Ask for homocysteine and MMA.

Vitamin B9

units: ng/mL or nmol/L

Folates: they make red blood cells and help the gut lining repair itself.

DEFICIENT	LOW	TARGET
< 4 ng/mL < 9 nmol/L	4 to 8 ng/mL 9 to 18 nmol/L	> 8 ng/mL > 18 nmol/L

At risk : Methotrexate, Salazopyrin, few green vegetables.

Supplement tip
Active folates (5-MTHF, such as Quatrefolic) rather than folic acid, always together with B12.

On methotrexate, folic acid is prescribed at a set dose on a set day: do not replace it without medical advice. For a pregnancy, follow your folic acid prescription.

Zinc

units: µg/dL or µmol/L

Healing, taste, skin, immune defences.

DEFICIENT	LOW	TARGET	TOO HIGH
< 70 µg/dL < 10.7 µmol/L	70 to 90 µg/dL 10.7 to 13.8 µmol/L	90 to 120 µg/dL 13.8 to 18.4 µmol/L	too many supplements

At risk : Long-lasting diarrhoea, fistulas, Crohn's of the small intestine.

Supplement tip
Zinc bisglycinate or picolinate, 15 to 25 mg a day with a meal, for 2 to 3 months, then a recheck. On the days without iron: they get in each other's way.

Blood test in the morning on an empty stomach (during a flare, zinc drops without a true deficiency). Long term, no more than 25 mg a day in total (European limit): too much zinc makes copper drop.

On your plate: the most nutritious foods

- **Liver and offal** — B12, B9, iron, zinc
- **Oysters, mussels** — zinc, B12, iron
- **Red meat** — well-absorbed iron, zinc, B12
- **Sardines, mackerel, salmon** — vitamin D, omega-3
- **Eggs** — B12, vitamin D
- **Cooked green vegetables** — B9
- **Puréed lentils, chickpeas** — B9, iron, zinc
- **Yoghurt, cheese** — calcium, B12

Iron from plants is absorbed better with vitamin C (kiwi, citrus fruit). If you have a stricture: vegetables well cooked or blended, without skins or seeds.

Supplements don't replace your plate

They correct a shortfall, but nothing beats a rich and varied diet. The trap is "empty" foods: lots of calories, almost no vitamins or minerals.

- Fizzy drinks and shop-bought juices
- Shop-bought biscuits and cakes
- Crisps and party snacks
- Sugary breakfast cereals
- White bread and pastries
- Ultra-processed ready meals
- Sweets and chocolate bars
- Alcohol

Going further and optimising

Magnesium

Often low with IBD (diarrhoea, small intestine affected or operated on). It affects energy, muscles, sleep and stress.

How : once a day, as bisglycinate or glycerophosphate (better tolerated). Avoid oxide and citrate if you have diarrhoea: they can make it worse.

Coenzyme Q10

The cells' "fuel". With IBD, the gut's antioxidant defences are often lowered. The UC trial that reported an effect (200 mg a day for 8 weeks) was retracted by the journal in 2022: there is no reliable evidence to date.

How : No dose to recommend: no reliable evidence in IBD.

How often

Once a year
at the very least, a full set of blood tests.

3 months
after starting any supplement, a recheck.

All year round
vitamin D: in France, from late October to March, the skin makes almost none. Without a supplement, your level is bound to fall. Take it continuously, adjusting according to your blood tests.

Caution

These targets come from functional medicine (practitioners' benchmarks), not from official reference ranges. Talk to your doctor or pharmacist before taking any supplement. No vitamin K2 or coenzyme Q10 if you are on a vitamin K antagonist anticoagulant (Previscan, Coumadine). Magnesium: be careful if you have kidney failure. On methotrexate, do not change the folic acid you have been prescribed. Too much vitamin D or zinc is dangerous.

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This is not medical advice: talk to your gastroenterologist or your GP.

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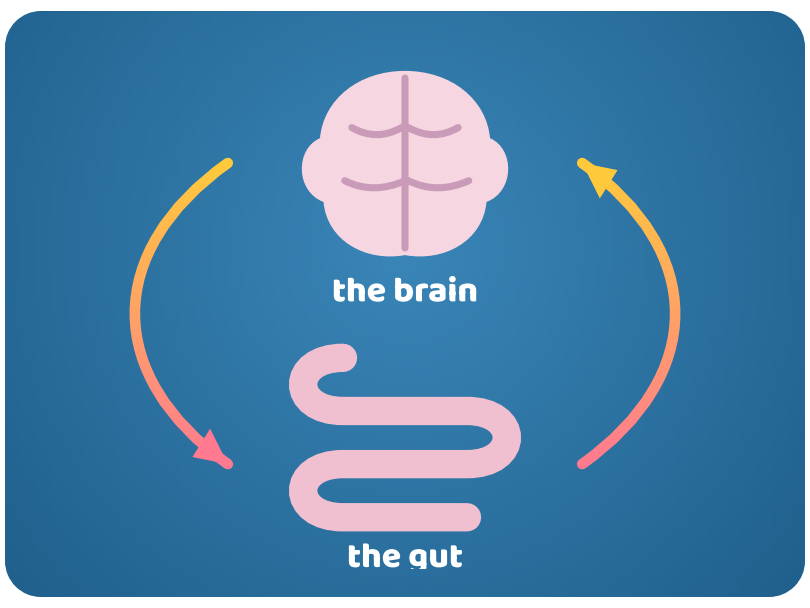
Part 3 · Living well with IBD · 13/22

Let's talk about mood

Anxiety, stress, feeling low: frequent companions of IBD. People rarely talk about them, yet they can be treated.

Your mood matters too

Feeling low with IBD is common, it is not a weakness, and it can be treated. Looking after your mind is also looking after your gut.



The gut-brain axis

↓ **From brain to gut:** stress and anxiety increase pain, bloating and the urgent need to go to the toilet.

↑ **From gut to brain:** inflammation is tiring and can bring your mood down.

There is no proof that stress causes IBD. But it can make symptoms worse, and untreated depression is linked to more flares.

Why does inflammation affect mood? Neuroinflammation

1. The messengers of inflammation (TNF, IL-6, IL-1) don't stay in the gut: they enter the bloodstream and alert the brain, in particular through the vagus nerve.
2. The brain in turn switches on its own defence cells. The result: fatigue, anxiety, wanting to stay in bed, low mood, just like when you have flu.
3. Inflammation also diverts tryptophan, the raw material for serotonin, one of the messengers of good mood.

It's biological, not a lack of willpower. And the good news: when the inflammation settles, mood often follows.

1 in 3
have symptoms of anxiety, and 1 in 2 during a flare

1 in 4
have symptoms of depression

1 in 3
in remission still have pain without inflammation, of the “irritable bowel” type

Anxiety, the most common

It often takes these forms:

- fear of not finding a toilet or of having an accident;
- dread before going out, a journey, a meeting;
- fear of the next flare or the next test;
- constantly watching for the slightest signal from your gut;
- sometimes panic attacks (racing heart, shortness of breath).

It is not trivial: it is linked to more hospital stays and more changes of treatment. It deserves to be treated.

Simple tools:

- **Breathe slowly**: 5 seconds in, 5 out, for 5 minutes.
- **Plan your outings**: find out where the toilets are, carry a toilet access card (in France, the afa “Urgence toilettes” card), a small change-of-clothes kit.
- **Don't avoid everything**: giving up on going out brings relief in the moment but keeps the fear going. A psychologist can help you get back on your feet step by step.

What really helps

Talking to a psychologist
Cognitive behavioural therapy (CBT) has been proven for anxiety and depression.

Moving
Walking, cycling, swimming... Physical activity suited to you improves mood and fatigue.

Not staying alone
Talking with other patients often does a lot of good: groups run by afa (the French patient association), patient groups.

Gut-directed hypnotherapy
It helps ease pain and urgency when there is no inflammation.

Sleeping
Lack of sleep increases pain and anxiety. Talk about it if your nights are bad.

Antidepressants, a possible ally

Some are compatible with IBD treatments, and many also treat anxiety. In a large Danish study of nearly 43,000 patients, those who took them had fewer relapses and needed steroids or anti-TNF drugs less often. They may have a small anti-inflammatory effect, and at low doses some also ease pain. These results still need to be confirmed by trials, and antidepressants never replace your maintenance treatment: something to discuss with your doctor, without shame.

Mon soutien psy
In France: up to 12 sessions a year with a psychologist registered with the scheme, covered by the Assurance maladie (French national health insurance) and your mutuelle (top-up health insurance), without a prescription, for mild to moderate distress. Directory on ameli.fr.

afa
The French patient association: guidance towards psychological support and self-help groups for patients and their loved ones. afa.asso.fr

Loved ones
They live with the disease too. Explaining it to them helps, and they also have the right to ask for support.

3114
free
24 hours a day, 7 days a week

Dark thoughts: you need to talk about them

They are more common with IBD: about 1 patient in 6 has had them, and the risk of acting on them is a little higher, especially in the first year after diagnosis. It is neither shameful nor a weakness. If you have dark thoughts or want to end your life, call 3114 (the national suicide prevention line in France) or talk to someone close to you or your doctor straight away. You are not alone.

This is not medical advice: talk to your GP, your gastro or a psychologist.

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Part 3 · Living well with IBD · 14/22

Pregnancy and fertility

There are many misconceptions. Here is what recent international recommendations say.

Yes, you can have children with IBD

The secret: a planned pregnancy, while the disease is calm. The experts' principle: a healthy mum is what best protects the baby.

Before

- Aim to have been in remission for at least 3 to 6 months before conceiving.
- Talk to your gastro so the treatment can be adjusted if needed.
- Start the prescribed folic acid (vitamin B9).

During

- Keep taking your long-term treatment: a flare is riskier for the baby than most treatments.
- Close follow-up shared between your gastro and your obstetrician.
- Cortisone or a test is still possible if needed.

After

- Most treatments allow breastfeeding.
- Vaginal delivery most of the time; a caesarean is sometimes offered (active disease around the anus, ileoanal pouch).
- Stay alert: a flare can occur after the birth.

Treatments during pregnancy

Continued during pregnancy

Mesalazine, azathioprine, anti-TNF (Remicade, Humira...), Entyvio, Stelara, anti-IL-23 (Skyrizi, Omvoh, Tremfya). Breastfeeding possible.

With caution

Salazopyrine: with a folate supplement. Cortisone: possible for the length of a flare.

Stop before conceiving

Methotrexate: at least 3 months before. JAK tablets (Rinvoq, Xeljanz, Jyseleca): at least 4 weeks before. S1P tablets: Zeposia 3 months before, Velsipity 1 to 2 weeks before. No breastfeeding with JAK and S1P tablets.

Never stop a treatment on your own when you find out you are pregnant: call your gastro.

And dads?

Most treatments do not stop you having a child. Salazopyrine can lower sperm count, reversibly. For methotrexate, talk about it beforehand.

Baby's vaccinations

If the mum received a biologic during pregnancy, tell the paediatrician: no BCG for at least 6 months (some experts say 12). The rotavirus vaccine (live) should be discussed with them. The other vaccines follow the normal schedule.

Fertility

It is normal when the disease is calm. Pelvic surgery can reduce it, but IVF works as well as it does for anyone else.

Will my child have IBD?

The risk is a little higher than average, but the vast majority of children of affected parents will not have it.

This is not medical advice: any plan for a pregnancy should be prepared with your gastroenterologist.

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Part 3 · Living well with IBD · 15/22

Your rights and everyday life

What exists in France to make life with IBD easier, and who to turn to.

Your rights (in France)

ALD: care covered at 100%

In France, Crohn's disease and ulcerative colitis are on the list of ALD (affections de longue durée, long-term conditions). Your GP makes the application: care related to your IBD is then covered at 100% of the Sécurité sociale (French national health insurance) rate (excluding extra fees charged above that rate and the fixed patient deductibles known as franchises).

RQTH: protecting your job

The RQTH (recognition as a disabled worker), applied for through the MDPH (the local disability office), gives you the right to adjustments: working hours, working from home, a desk near the toilets. Nobody is obliged to show it to their employer.

Borrowing to buy a home

Since 2022, there is no health questionnaire for a home loan of less than €200,000 per person, repaid before age 60. Above that, the AERAS agreement helps you get insurance.

Children and teenagers: the PAI

The PAI (projet d'accueil individualisé, an individual care plan), signed with the school, allows a child, for example, to go to the toilet without asking or to take a treatment.

The social worker

At the hospital or the town hall: they help with sick leave, therapeutic part-time work, an invalidity pension or the AAH (allowance for disabled adults), depending on your situation.

Everyday life

Travelling

- Medicines in your cabin bag, with the prescription (names of the active substances) and a certificate for the pens.
- Cool bag for biologics that must be kept cold.
- European Health Insurance Card or travel insurance.
- On an immunosuppressant, no live vaccines (yellow fever): see your doctor 2 to 3 months before a long trip.

At work

- The occupational health doctor is bound by confidentiality: they can suggest adjustments without telling your employer everything.
- Therapeutic part-time work lets you return gently after a flare.

Toilets

- The afa “Urgence toilettes” (toilet emergency) card helps you get access to toilets in shops and public places. It is not yet legally binding: afa is campaigning for an official card.
- The “Où sont les toilettes ?” (Where are the toilets?) app to find them near you.

You are not alone

afa Crohn RCH France

The French national association for people with IBD, officially recognised as being of public benefit. It supports patients and their loved ones:

- MICI Infos helpline
- Social, legal and dietary advice sessions
- Guidance on psychological support and working life
- Self-help groups: young people, parents, people with a stoma
- MICI Connect platform and health diary

afa.asso.fr

Expert centres at university hospitals (CHU)

Don't hesitate to ask for an opinion at an IBD expert centre in a CHU (French university hospital), especially if:

- one treatment after another fails;
- surgery is being considered;
- you are planning a pregnancy;
- you want to take part in a clinical trial.

Your gastro or your GP can refer you. Asking for a second opinion is your right.

General information, to be checked against your own situation. This is not medical or legal advice.

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Part 4 · The future · 16/22

Research at full speed

Scientists have never worked so hard on Crohn's disease and ulcerative colitis. Here is where they are aiming, and what AI is changing.

~60
research projects in Phase 2 worldwide

20
new molecules in Phase 2 or beyond

16
large Phase 3 trials under way, most of them expected in 2028

Research has never been so active

Researchers are attacking the chain of inflammation at points never targeted before, and adding two new steps: repairing the gut wall and tackling scarring. Here is everything currently in trials.

Ph. 3 soon: see “The treatments on the way” Ph. 2 Ph. 1-2 later: see “Future leads”

Upstream: a possible cause

A bacterium (MAP) is suspected in some people with Crohn's. Not proven yet.

IN TRIALS

- **Anti-MAP vaccine** Ph. 2 — Oxford, not yet open to recruitment
- **RHB-204** Ph. 2 planned — antibiotics

1. The alarm

New: targeting the microbe detector (NOD2, RIPK) and the basic alarms.

IN TRIALS

- **OD-001** Ph. 2 — RIPK2
- **ABBV-668** Ph. 2 — RIPK1
- **BI 3032950** Ph. 2 — TREM-1
- **Lutikizumab** Ph. 2 — IL-1

2. The messengers

A new messenger targeted: TL1A. And the IL-23 receptor blocked by a tablet, or with an injection every 3 to 6 months.

IN TRIALS

- **Tulisokibart** Ph. 3 — TL1A
- **Duvakitug** Ph. 3 — TL1A
- **Afimkibart** Ph. 3 — TL1A
- **Icotrokinra** Ph. 3 — IL-23 receptor, tablet
- **SPY002, SPY003** Ph. 2 — TL1A, IL-23

3. The relay inside the cell

A more targeted relay than today’s JAK drugs.

IN TRIALS

- **Zasocitinib** Ph. 2 — TYK2

4. Leaving the lymph nodes

A new molecule from the same family as Zeposia and Velsipity.

IN TRIALS

- **Tamuzimod** Ph. 2 — S1P, future uncertain

5. Getting into the gut

The equivalent of Entyvio in a tablet, and a new “key” being targeted (CCR9).

IN TRIALS

- **Emvistegrast** Ph. 2 — α4β7 tablet
- **MORF-057** Ph. 2 — α4β7 tablet
- **SPY001** Ph. 2 — α4β7
- **AZD7798** Ph. 2 — CCR9

6. Inflammation of the gut wall

New: strengthening the body’s natural brakes on inflammation instead of blocking.

IN TRIALS

- **Obefazimod** Ph. 3 — miR-124
- **Omilancor** Ph. 3 — LANCL2
- **ALTB-268** Ph. 2 — PSGL-1
- **Eltrekibart** Ph. 2 — neutrophils

7. Repair

Helping the gut wall rebuild itself.

IN TRIALS

- **Garutadustat** Ph. 2 — HIF, designed by AI

8. Scarring (strictures)

For the first time, treatments against fibrosis.

IN TRIALS

- **Ontunisertib** Ph. 2 — ALK5
- **PALI-2108** Ph. 1-2 — PDE4
- **MBF-118** Ph. 2 — PPARγ
- **Duvakitug** Ph. 2 planned — TL1A

Metabolism

Tirzepatide + Omvoh (Ph. 3), for people who are overweight.

Two targets in one

JNJ-4804: IL-23 + TNF (Ph. 2b met its goals, Ph. 3 announced). ABBV-466: IL-23 + α4β7 (Ph. 2).

Artificial intelligence is speeding everything up

200 million
protein shapes predicted by **AlphaFold**, almost all of those known. Knowing the shape of a target means knowing where a drug can latch on. Nobel Prize in Chemistry 2024.

12 months
to find garutadustat, a drug candidate for ulcerative colitis designed by AI, with about 115 molecules tested (according to the company Insilico). Traditional methods take 4 to 5 years on average.

4 years
before diagnosis: in research, a blood test can already pick up signs of Crohn's. One day, we might be able to stop the disease from starting.

What is the point of all this?

Treatments that work better, are simpler to take, and are tailored to each person. If a treatment is not working for you today, others are coming: you have not run out of options.

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Part 4 · The future · 17/22

The treatments on the way

Crohn's disease and ulcerative colitis: every molecule in Phase 3 or under review for authorisation.

How a medicine reaches us

Phase 1
Is it safe? A few dozen people.

Phase 2
Does it work? A few hundred.

Phase 3
Confirming it on a large scale. Hundreds to thousands.

Authorised
Your doctor can prescribe it.

Reading the bar: blue = stage passed, yellow = stage under way.

Already arrived in Europe in recent years

Velsipity (UC, 2024), Skyrizi (UC, 2024), Omvoh (UC 2023, Crohn's 2025), Tremfya (Crohn's and UC, 2025). Stelara biosimilars are bringing prices down, and a first Entyvio biosimilar is under review in Europe. Ask your gastro which of these may concern you.

Anti-TL1A drugs: a brand-new family

They block TL1A, a signal that keeps inflammation going and encourages scarring in the gut.

Tulisokibart

MSD · Infusion then injection

Pathway: TL1A

- UC: Phase 3: goal met (June 2026), figures not yet released
- Crohn's: Phase 3 under way

Possible arrival: **around 2028**

Duvakitug

Sanofi and Teva · Infusion then injection

Pathway: TL1A

Phase 2b: 58% remission in UC at 44 weeks, among the 130 patients who had responded at the start of treatment (no placebo).

- UC: Phase 3 under way
- Crohn's: Phase 3 under way

Possible arrival: **2028-2029**

Afimkibart

Roche · Infusion then injection

Pathway: TL1A

Also being tested in children.

- UC: Phase 3, results expected in 2027
- Crohn's: Phase 3 under way

Possible arrival: **2028-2029**

The anti-IL-23 family (Skyrizi, Omvoh, Tremfya)

They cut off IL-23, a messenger that gives the order to inflame the gut.

Icotrokinra

Johnson & Johnson · Tablet

Pathway: IL-23 receptor

The first tablet that blocks the IL-23 receptor. Already approved in the US for psoriasis (March 2026).

- UC: Phase 3 under way
- Crohn's: Phase 2b/3 under way

Possible arrival: **after 2028**

Skyrizi: subcutaneous induction

risankizumab, AbbVie · Injection

Pathway: IL-23

Maintenance is already given as an injection at home. New: the start of treatment too, with 4 injections at home (an injector stuck on the skin) instead of 3 infusions in hospital.

- Crohn's: Approved in the US on 23 October 2026, Europe still to come

Possible arrival: **soon in Europe**

Two drugs in one

Two known brakes on inflammation are combined to go further than one alone.

JNJ-4804

Tremfya + Simponi, Johnson & Johnson · Injection

Pathway: IL-23 + TNF

DUET programme: Phase 2b met its goals in more than 1,000 patients (May 2026).

- UC: Phase 2b met its goals, Phase 3 announced
- Crohn's: Phase 2b met its goals, Phase 3 announced

Possible arrival: **2029 or later**

New tablets

Two new ways to calm the gut, with no injection.

Obefazimod

Abivax, a French company · Tablet

Pathway: miR-124

Boosts a natural brake on inflammation. Among those who had responded in the first 8 weeks: 51% remission at 44 weeks versus 10% on placebo.

- UC: Phase 3 met its endpoints, US filing planned for late 2026
- Crohn's: Phase 2b, results mid-2027

Possible arrival: **UC 2027-2028**

Omilancor

NImmune · Tablet

Pathway: LANCL2

Rebalances the defences in the gut wall.

- UC: Phase 3 announced by the company, results not yet published
- Crohn's: Phase 2

Possible arrival: **uncertain**

Dates are estimates and may change; in Europe, new treatments often arrive later than in the United States. This is not medical advice: talk to your gastroenterologist.

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Part 4 · The future · 18/22

Future leads

The main molecules in Phase 1 and 2: further off in time, but full of hope.

How a medicine reaches us

Phase 1 — Is it safe? A few dozen people.

Phase 2 — Does it work? A few hundred.

Phase 3 — Confirming it on a large scale. Hundreds to thousands.

Authorised — Your doctor can prescribe it.

Reading the bar: blue = stage passed, yellow = stage under way.

Against strictures (narrowings)

The first treatments that target scarring in the gut, not just inflammation.

Ontunisertib

Agomab · Tablet

Pathway: TGF-β / ALK5

Acts only in the gut. Strictures stable for up to 60 weeks in the 1st trial.

Crohn's — Phase 2b started in October 2026 (320 patients)

Possible arrival: **after 2030**

PALI-2108

Palisade Bio · Tablet

Pathway: PDE4

Switched on only in the gut.

Crohn's — Phase 1b in 6 patients: encouraging signals

UC — Phase 2b under way

Possible arrival: **after 2030**

MBF-118

Medibiofarma (Spain) · Tablet

Pathway: PPARγ

Anti-scarring and anti-inflammatory.

Crohn's — Phase 2a completed, large Phase 2 in preparation

Possible arrival: **after 2030**

Duvakitug

Sanofi and Teva · Infusion then injection

Pathway: TL1A

The anti-TL1A drug will soon be tested on strictures too.

Crohn's — Phase 2 planned

Possible arrival: **after 2030**

Two treatments in one

Two different brakes on inflammation are combined to go further than one alone.

ABBV-466

AbbVie · Injection

Pathway: IL-23 + α4β7

Skyrizi + an anti-α4β7 (Entyvio's family), given together. Gut lining healed at 6 months: 40% versus 22% with Skyrizi alone (trial with no placebo).

Crohn's — Phase 2; other AbbVie combinations being tested

Possible arrival: **after 2030**

SPY001, SPY002, SPY003

Spyre · Injection

Pathway: α4β7, TL1A, IL-23

Tested alone then together; the aim is one injection every 3 to 6 months.

UC — Phase 2, combination results in 2027

Possible arrival: **after 2030**

MORF-057 + Omvoh

Lilly · Tablet + injection

Pathway: α4β7 + IL-23

UC — Phase 2, results in 2027

Possible arrival: **after 2030**

More new tablets

New targets, still with no injection.

Emvistegrast

Gilead · Tablet

Pathway: α4β7

Like Entyvio, but as a tablet. At 12 weeks, 31% remission on the highest dose (59 patients) versus 8% on placebo (60 patients).

UC — Phase 2 positive, Phase 3 planned for 2027

Possible arrival: **around 2030**

MORF-057

Lilly · Tablet

Pathway: α4β7

Another "Entyvio in a tablet".

UC — Phase 2b completed, results awaited

Crohn's — Phase 2

Possible arrival: **after 2030**

OD-001

Odyssey · Tablet

Pathway: RIPK2 (NOD2)

Blocks RIPK2, the relay just after NOD2, the best-known Crohn's gene.

UC — Phase 2a with no placebo: 27% remission at 12 weeks, in 41 patients

Possible arrival: **after 2030**

ABBV-668

AbbVie · Tablet

Pathway: RIPK1

Blocks RIPK1, a switch for inflammation.

UC — Phase 2

Crohn's — Phase 2

Possible arrival: **after 2030**

Zasocitinib

Takeda · Tablet

Pathway: TYK2

Blocks TYK2, a relay for inflammation.

UC — Phase 2 completed, results by March 2027

Crohn's — Phase 2

Possible arrival: **after 2030**

Garutadustat

Insilico · Tablet

Pathway: HIF

Designed with the help of artificial intelligence. Helps the gut wall repair itself.

UC — Phase 2a, results in 2027

Possible arrival: **after 2030**

Tamuzimod

Lilly (formerly Ventyx) · Tablet

Pathway: S1P

Same family as Velsipity.

UC — Phase 2 met its endpoints, future uncertain

Possible arrival: **uncertain**

More new antibodies

Injections aimed at targets never used before in IBD.

ALTB-268

AltruBio · Injection

Pathway: PSGL-1

Calms overactive white blood cells.

UC — Phase 2a with no placebo, Phase 2b in preparation

Possible arrival: **after 2030**

AZD7798

AstraZeneca · Injection

Pathway: CCR9

Removes the white blood cells "programmed" to go to the gut.

Crohn's — Phase 2a completed, results awaited

Possible arrival: **after 2030**

Lutikizumab

AbbVie · Injection

Pathway: IL-1

On its own, not effective enough in UC; now being tested with Skyrizi.

Crohn's — Phase 2 in combination

Possible arrival: **after 2030**

Eltrekibart

Lilly · Injection

Pathway: neutrophils (CXC)

Slows the arrival of the "firefighter" white blood cells.

UC — Phase 2 completed, results awaited

Possible arrival: **after 2030**

BI 3032950

Boehringer Ingelheim

Pathway: TREM-1

Blocks an amplifier of inflammation.

UC — Phase 2

Possible arrival: **after 2030**

Drugs from other diseases

Treatments already known in other conditions, such as diabetes and excess weight, are being tested in IBD.

Tirzepatide + Omvoh

Lilly · Injection

Pathway: GLP-1 / GIP + IL-23

For people who are overweight: aiming for remission and weight loss at the same time.

Crohn's — Phase 3b under way, including in France

UC — Phase 3b under way

Possible arrival: **results in 2028**

GLP-1 drugs on their own

Ozempic, Mounjaro and others · Injection

Pathway: GLP-1

Large 2026 study: no fewer relapses, but no danger either. Not a treatment for IBD to date.

Crohn's — Observational studies

UC — Observational studies

Possible arrival: **not planned**

Tackling a possible cause

MAP is a bacterium suspected of playing a role in some people with Crohn's. This is not proven yet.

Anti-MAP vaccine

University of Oxford and King's College · Injection

Pathway: MAP bacterium

Crohn's — Phase 2 against placebo, not yet open to recruitment (United Kingdom)

Possible arrival: **after 2030**

RHB-204

RedHill · Tablet

Pathway: MAP bacterium

3 antibiotics. Trial restricted to patients who carry MAP.

Crohn's — Phase 2 planned (funding being sought)

Possible arrival: **after 2030**

Recently stopped (so as not to raise false hopes)

Etrasimod and ozanimod in Crohn's (not effective enough), rosnilimab in UC (failed in 2025), the anti-TNF tablet balinatunfib (stopped in 2026). Alofisel for fistulas (withdrawn in Europe at the end of 2024).

And further still

In research, a blood test picks up signs of Crohn's several years before diagnosis (about 4 years in a 2026 study). Trials are now trying to stop the disease from starting.

Antibodies that block IL-23 and TL1A at the same time are starting their first trials. And reprogramming the body's defence cells (CAR-T), spectacular in lupus, could one day follow.

IBD guide · v1.2 · updated 1 November 2026

Dates are estimates and may change; in Europe, new treatments often arrive later than in the United States. This is not medical advice: talk to your gastroenterologist.

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Off the beaten track

Vagus nerve, hyperbaric chamber, faecal microbiota transplant… What exists, what the studies say, and what is available in France.

First of all

These approaches never replace your long-term treatment. Stopping your treatment for a “natural” method exposes you to severe flares. Beware of promises of a cure, high prices and miracle testimonials. Always talk to your gastro about them: some are done within trials, and your gastro can refer you to them.

Promising positive trials, but still limited · **Being studied** no solid evidence yet · **Signal to be confirmed** small studies only · **No evidence** or abandoned · **Avoid** real risks

Vagus nerve stimulation

Being studied

A small stimulator, placed on the vagus nerve in the neck, might calm inflammation. A team in Grenoble was a pioneer.

What the studies say : A European trial treated 16 people with Crohn's that did not respond to biologics: improvement in some of them, but with no placebo. The same device has been approved in the United States since 2025 for rheumatoid arthritis, not for IBD.

En France : Only in trials

Sources : Bonaz, Neurogastroenterol Motil 2016; D'Haens, J Crohns Colitis 2023; FDA 2025

Hyperbaric chamber (oxygen under pressure)

Signal to be confirmed

You breathe pure oxygen in a pressurised chamber, to get more oxygen to the gut wall.

What the studies say : Severe UC flare in hospital: a small trial of 18 patients showed more remissions than with a sham chamber; a Swedish trial found no difference. A large placebo-controlled trial (126 patients) is under way in the United States. Crohn's fistulas: studies with no comparison group.

En France : Only in trials

Sources : Dulai, Am J Gastroenterol 2018; Pagoldh, Scand J Gastroenterol 2013; NCT05987852

Faecal microbiota transplant

Promising

Gut bacteria from a healthy donor are transferred, by colonoscopy, enema or capsules.

What the studies say : UC: the transplant makes remission about 1.8 times more frequent than placebo, according to a review of 10 trials and 468 patients (low certainty according to Cochrane). Crohn's: weak evidence; a French trial (MIRACLE, AP-HP, Paris) is under way. It is a medicine: never do it yourself.

En France : Only in trials

Sources : Sci Rep 2023; Cochrane 2023; ANSM (French medicines agency); MIRACLE trial

The patient’s own fat in fistulas

Being studied

The patient’s own fat, and cells extracted from it, are injected around an anal fistula that will not heal.

What the studies say : A first study in 10 patients was encouraging. The ADICROHN II trial (Marseille) is comparing it with a placebo. The earlier stem-cell product (Alofisel) was withdrawn in Europe in December 2024, because its efficacy was not confirmed.

En France : Only in trials

Sources : ADICROHN II trial, NCT04010526; EMA 2024

Probiotics

Signal to be confirmed

“Friendly” bacteria in capsules or sachets.

What the studies say : Useful mainly to prevent pouchitis after an ileo-anal pouch, and one strain (E. coli Nissle) for maintenance in UC. No proven effect in Crohn's.

En France : Sold over the counter (supplement)

Sources : ECCO guidelines

Phages and targeted bacteria

Being studied

Viruses that attack only certain bacteria suspected in Crohn's (“sticky” E. coli).

What the studies say : A first trial in humans has been completed in the United States, with no published results; another molecule of this type has been abandoned.

En France : Not available in France

Sources : NCT03808103; NCT03943446

Low-dose naltrexone (LDN)

No evidence

An old medicine, used at a very low dose (about 4.5 mg).

What the studies say : Two small, older trials were encouraging, but the most recent Dutch trial (41 patients, against placebo) was stopped because it had no effect on inflammation; only fatigue seemed to decrease.

En France : Off-label, on prescription, not reimbursed

Sources : Cochrane 2018; LDN Crohn, Dig Dis Sci 2026

Intestinal worms (helminths)

No evidence

Worm eggs swallowed to “retrain” the immune system.

What the studies say : The large trials showed no benefit in Crohn's: this approach has been abandoned. Do not buy worms on the internet.

En France : Not available in France

Sources : TRUST-I 2013; TRUST-II, J Crohns Colitis 2017

Autologous bone marrow transplant

Avoid

The immune system is “reset” with chemotherapy, followed by the patient’s own stem cells.

What the studies say : Two British trials: improvement in some patients, but serious complications, including deaths; the second was stopped for this reason. Reserved for exceptional cases, in a specialist centre.

En France : Exceptional, specialist centre

Sources : ASTIC, JAMA 2015; ASTIClite, Lancet Gastroenterol Hepatol 2024

Indigo naturalis

Avoid

A Chinese medicine plant sold online.

What the studies say : Effective in a Japanese trial in UC, but it can cause serious pulmonary hypertension and complications in the gut. Not authorised in France.

En France : Not available in France

Sources : Japanese trial (UC); safety alerts

Ozone, colon cleansing, “detox”, homeopathy

Avoid

Methods offered outside medicine, often expensive.

What the studies say : No evidence in IBD. Colon cleansing and rectal ozone can cause infections or perforations in an inflamed gut. In France, homeopathy has not been reimbursed since 2021.

En France : Private circuits, steer clear

Sources : No serious studies; Assurance Maladie (French national health insurance) 2021

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To finish · 20/22

Mistakes to avoid

Lessons learned from more than 20 years of Crohn's.

Here I share lessons drawn from experience: more than 20 years of living with Crohn's, watching, searching and learning, sometimes the hard way. These are the mistakes I have made or seen around me, so that you can avoid them.

Personal account, not medical advice

MISTAKE NO. 1

Staying alone with the really tough times

Your usual gastro remains your first point of contact. But when things get really tough (one treatment after another without success, complications, an operation being considered), it is a good idea to get in touch with a university hospital team (a CHU, in France): these teams see a lot of IBD patients, work with surgeons, radiologists and dietitians, and have access to trial protocols and the newest treatments. This opinion comes on top of your gastro's, in liaison with them.

MISTAKE NO. 2

Putting up with your disease

Take an “active” stance towards your disease: understand how your body reacts, how your treatment works, and listen to yourself.

MISTAKE NO. 3

Turning up to a consultation without preparing anything

Be at ease with your gastroenterologist: prepare all your questions before an appointment, and don't hesitate to discuss with them a possible change or adjustment of treatment if it becomes necessary (feeling unwell, pain getting worse, side effects). It is important to have a good relationship with your gastroenterologist.

MISTAKE NO. 4

Wanting to stop everything

Quite often, over a lifetime with the disease, you will want to “stop everything”. This feeling is understandable, but the consequences are real: about 1 patient in 2 relapses in the year or two after stopping a biologic, even in remission, and stopping then restarting can make the drug less effective. Hence the importance of psychological support if needed, and of a really close relationship with your gastro to discuss adjusting your treatment.

MISTAKE NO. 5

Letting time slip by

Time is our number one enemy (not the weather, time as in the clock!). If pain or signs of the disease appear, pay attention and react quickly: don't wait 3 weeks before contacting your gastro. The faster you react, the better your chances of “cutting off” the inflammation quickly before it takes hold again.

MISTAKE NO. 6

Masking the pain

Be careful with painkillers (paracetamol, tramadol...). They are useful to ease pain, but pain is a signal, and the painkiller masks that signal. Taking them occasionally and for a short time, or while the long-term treatment takes effect, yes. But if your treatment was started a long time ago, it is not normal to take them often: don't ignore this signal and contact your gastro if it goes on. Tramadol also carries a risk of dependence, and ibuprofen is best avoided.

MISTAKE NO. 7

Sending your gastro a vague message

When you contact your gastro (by email, for example), get all the details ready. The more clues your doctor has, the better they can help you:

- ☐ Where it hurts
- ☐ Since when
- ☐ Number of stools per day
- ☐ Blood in the stool
- ☐ Fever
- ☐ Weight loss
- ☐ Vomiting
- ☐ Treatment taken

MISTAKE NO. 8

Ignoring a fever

If you have unusual pain or a strange feeling, remember to check whether you have a fever. Crohn's-related pain with a fever is an important warning sign. If there is also vomiting (or a swollen belly, no more wind), call 15 (the emergency medical number in France) or go to A&E. On an immunosuppressant, any fever deserves a call the same day.

MISTAKE NO. 9

Carrying on smoking

Tobacco is a real enemy of Crohn's, and this is genuinely proven: it makes the disease worse, increases flares and operations, and doubles the risk of the disease coming back after an operation. Stopping is one of the best “treatments”, and you can get help: in France, Tabac Info Service, 39 89.

And also...

- **Keep a copy of all your reports** : colonoscopies, MRIs, blood tests: invaluable for a second opinion.
- **Don't compare yourself with other patients** : every Crohn's and every UC is different.
- **Keep an eye on your fatigue and deficiencies** : see the sheet “Fatigue is not inevitable”.

In short

You are not a spectator of your disease. Well supported, well informed and quick to react, you can live a full life with IBD. And research has never been so active: keep hoping.

The author, living with Crohn's for more than 20 years

Figures: stopping infliximab, STORI trial (GETAID), Gastroenterology 2012 and Gisbert meta-analysis; smoking and recurrence after an operation, Reese meta-analysis, Int J Colorectal Dis 2008.

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To finish · 21/22

The little glossary

The words you hear in consultations, explained simply.

The disease

IBD
Inflammatory bowel disease. Mainly Crohn's disease and ulcerative colitis.

UC
Ulcerative colitis. Affects the rectum and the colon, continuously, only on the surface.

Remission
A calm period. Clinical: no more symptoms. Deep: the bowel is also healed when examined.

Colon
The large bowel. It ends with the rectum.

Fistula
A small abnormal tunnel between the bowel and another organ or the skin, often near the anus.

Mucosa
The inner layer of the bowel, the one we are trying to heal.

Crohn's disease
A type of IBD that can affect the whole digestive tract, in patches, through the full thickness of the wall.

Flare
A period when the disease wakes up: pain, diarrhoea, blood, fatigue.

Ileum
The last part of the small bowel. The area most often affected in Crohn's disease.

Stricture
Narrowing of the bowel, due to inflammation or to scar tissue (fibrosis).

Abscess
A pocket of pus. Fever and severe pain: needs treating quickly.

Extra-intestinal manifestations
Signs of IBD outside the bowel: joints, skin, eyes, liver.

Tests

Calprotectin
A protein measured in the stool. It reflects inflammation of the bowel.

Endoscopy
A test using a camera: colonoscopy, gastroscopy.

Trough level
The level of the drug in the blood just before the next dose, used to adjust the treatment.

CRP
A marker of inflammation measured in the blood.

Biopsy
A tiny sample of the wall, examined under a microscope. It doesn't hurt.

MR enterography
A specialised MRI to look at the small bowel, without radiation.

Treatments

Long-term treatment
Taken continuously to maintain remission, even when everything is going well.

Steroid dependence
When you cannot stop steroids without relapsing. A sign that the treatment needs to change.

Biologic
A drug made by living cells (an antibody) that blocks a precise target.

Small molecule
A drug in tablet form: it cuts a relay inside the cells (JAK) or keeps white blood cells in the lymph nodes (S1P).

Immunogenicity
The body makes antibodies against the drug, which then works less well.

Induction / maintenance
Induction: the start, often at a high dose. Maintenance: what follows, to keep it working over time.

Immunosuppressant
A drug that calms the immune system: azathioprine, methotrexate.

Biosimilar
A copy of a biologic, just as effective and safe, and cheaper.

Combination therapy
A biologic and an immunosuppressant taken together.

Loss of response
A treatment that used to work becomes less effective over time. It can be adjusted or changed.

Surgery and daily life

Resection
An operation that removes the diseased part of the bowel.

Postoperative recurrence
In Crohn's disease, the disease often comes back near the join: it is prevented with treatment.

Stoma
The bowel is connected to the skin of the abdomen, with a bag. Sometimes only temporary.

ALD
In France, affection de longue durée (long-term condition status): care related to IBD is covered at 100% of the Social Security rate.

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This is not medical advice: talk to your gastroenterologist or your GP (family doctor).

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To finish · 22/22

The final word

Where we come from, where we are now, and why I have so much hope.



13
molecules authorised in Europe since 1999

6
different families of treatment

15 months
on average between two new treatments since 2014

When I was diagnosed, Crohn's was frightening. And 30 years ago, there was good reason: in 1996, there were no biologics. Patients only had steroids, mesalazine, azathioprine... and surgery when nothing else worked.

Then everything changed with infliximab, the first biologic: authorised in Europe in 1999, at first reserved for the most severe forms, it really came into widespread use in France in the mid-2000s. For the first time, we could aim for real remission, and even heal the bowel wall.

Since then, everything has been speeding up: 13 molecules authorised in Europe, from 6 different families, 10 of them since 2014. That's a new treatment every 15 months on average! And dozens more are in trials all over the world. If one treatment doesn't work for you, there is almost always another option.

And I sincerely believe the best is yet to come. Artificial intelligence is starting to transform research: it helps us understand diseases faster, design drugs in a few months instead of several years, and perhaps one day spot the disease before it even starts.

So yes, Crohn's and UC are still difficult diseases. But I have never had as much hope as I do today. Take care of yourselves, stay in charge of your disease, and never give up: the best is ahead of us.

The author, living with Crohn's for more than 20 years

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Figures: European Commission authorisations 1999-2026 (13 molecules, 10 of them since 2014). This is not medical advice.

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