Efficacy and Safety of Subcutaneous Guselkumab Induction Therapy in Patients with Ulcerative Colitis: Results Through Week 12 from the Phase 3 ASTRO Study

Laurent Peyrin-Biroulet[1], Jessica R. Allegretti[2], Silvio Danese[3], Matthew Germinaro[4], Thomas Baker[4], Yelina Alvarez[4], Silke Jörgens[4], Lingjing Jiang[4], Hongyan Zhang[4], Alejandro Lizano Corzo[4], Tadakazu Hisamatsu[5], David T. Rubin[6], Millie Long[7] on behalf of the ASTRO Investigators

[1]University of Lorraine, Inserm, NGERE, F-54000 Nancy, France and Groupe Hospitalier privé Ambroise Paré-Hartmann, Paris IBD Centre, 92200 Neuilly sur Seine, France; [2]Division of Gastroenterology, Hepatology, and Endoscopy, Brigham and Women's Hospital, Harvard Medical School, Boston, MA, USA; [3]Gastroenterology and Endoscopy, IRCCS Ospedale San Raffaele and University Vita-Salute San Raffaele, Milan, Italy; [4]Johnson & Johnson, Spring House, PA, USA; [5]Kyorin University School of Medicine, Tokyo, Japan; [6]University of Chicago Medicine Inflammatory Bowel Disease Centre, Chicago, IL, USA; [7]Division of Gastroenterology and Hepatology, University of North Carolina at Chapel Hill, Chapel Hill, NC, USA

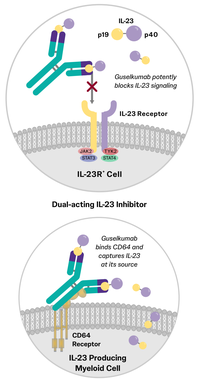
Scan the QR code for the full digital poster
The QR code is intended to provide scientific information for individual reference, and the information should not be altered or reproduced in any way.

Key Takeaways

- **Week 12 results from ASTRO establish the efficacy of SC induction therapy with GUS in UC**
- **Clinically meaningful benefit was also observed in patients naïve to BIO/JAKi/S1Pi and in those with BIO/JAKi/S1Pi-IR**
- **The safety of SC induction therapy was consistent with the well-characterized and favourable safety profile of GUS in approved indications**
- **These results complement the QUASAR[2] data, demonstrating that both IV and SC induction with GUS are efficacious therapeutic options, thus providing patients and healthcare providers the flexibility to choose the induction route of administration that aligns with their preferences**

Background

- Guselkumab (GUS) is a selective, dual-acting interleukin (IL)-23p19 subunit inhibitor that potently blocks IL-23 and binds to CD64, a receptor on immune cells that produce IL-23[1]
- Intravenous (IV) induction followed by subcutaneous (SC) maintenance was efficacious and safe in participants with moderately-to-severely active ulcerative colitis (UC) in the QUASAR Phase 3 studies[2]
  - GUS is approved in some countries for UC, including the United States
- SC induction provides patients and healthcare providers with greater flexibility and requires less time compared to IV



Objectives

The ASTRO study (NCT05528510) evaluated the efficacy and safety of GUS SC induction in participants with moderately-to-severely active UC

Methods

- ASTRO study: Phase 3, randomized, double-blind, placebo-controlled, treat-through design

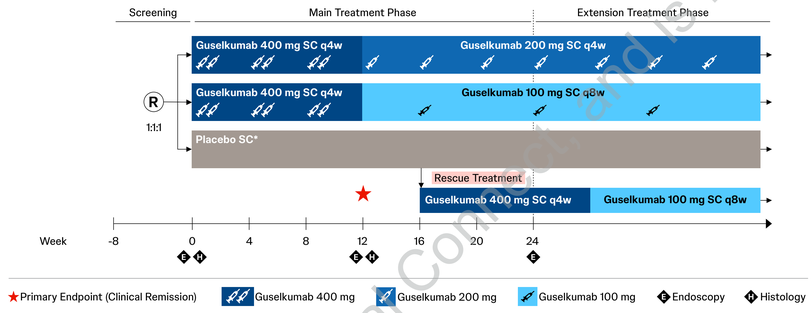
Key eligibility criteria

- Baseline (Week 0) modified Mayo score of 5 to 9, inclusive
- Baseline Mayo rectal bleeding subscore ≥1, Mayo endoscopic subscore ≥2 (centrally reviewed)
- Inadequate response/intolerance (IR) to tumor necrosis factor (TNF)α blockers, vedolizumab, Janus kinase (JAK) inhibitors, or sphingosine 1-phosphate inhibitors (S1Pi) (BIO/JAKi/S1Pi-IR) **OR** naïve to BIO/JAKi/S1Pi (or exposed to BIO/JAKi/S1Pi without IR) and IR to corticosteroids, 6-mercaptopurine (6-MP), or azathioprine (AZA)

Stratified randomization

- BIO/JAKi/S1Pi-IR status: Yes or No
- Mayo endoscopic subscore at baseline: Moderate (2) or Severe (3)

FIGURE 1: ASTRO study design



*All Week 12 endpoints compared GUS 400 mg SC to placebo; data from the two ramdomized GUS groups were combined as pts in both groups received the same GUS 400 mg SC induction regimen prior to Week 12.
GUS=Guselkumab, **q4w**=Every 4 weeks, **q8w**=Every 8 weeks, **R**=Randomization, **pts**=Patients, **SC**=Subcutaneous

Results

Demographics and baseline clinical characteristics

TABLE 1: Demographics and baseline disease characteristics

	Placebo SC	Combined GUS 400 mg SC q4w
Full analysis set, N	139	279
Age in years, mean (SD)	39.5 (13.58)	42.9 (14.43)
Male, n (%)	90 (64.7%)	166 (59.5%)
UC disease duration in years, mean (SD)	6.61 (6.228)	8.04 (6.847)
Modified Mayo score[a] (0-9), mean (SD)	6.8 (1.09)	6.7 (1.18)
Modified Mayo score of 7-9 (severe), n (%)	87 (63.0%)	172 (61.6%)
Mayo endoscopic subscore of 3 (severe), n (%)	78 (56.1%)	156 (55.9%)
Extensive UC, n (%)	73 (52.5%)	151 (54.1%)
C-reactive protein,[b] median in mg/L (IQR)	3.8 (1.2; 10.9)	4.1 (1.5; 8.2)
C-reactive protein[b] >3 mg/L, n (%)	77 (55.8%)	161 (58.3%)
Fecal calprotectin,[c] median in mg/kg (IQR)	1749.0 (617.0; 3202.0)	1494.5 (678.0; 2963.0)
Fecal calprotectin[c] >250 mg/kg, n (%)	119 (90.8%)	226 (89.0%)

[a]Modified Mayo score: 3-component (stool frequency, rectal bleeding, and endoscopy subscores) Mayo score without the physician's global assessment. [b]Based on N=138 for Placebo SC, N=276 for Combined GUS 400 mg SC q4w. [c]Based on N=131 for Placebo SC, N=254 for Combined GUS 400 mg SC q4w. **GUS**=Guselkumab, **IQR**=Interquartile range, **q4w**=Every 4 weeks, **SC**=Subcutaneous, **SD**=Standard deviation, **UC**=Ulcerative colitis

TABLE 2: UC-related medication history and baseline UC medications

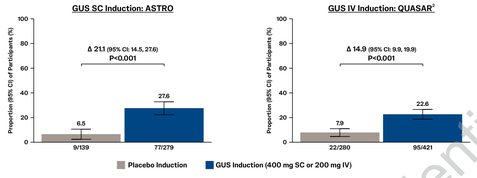
	Placebo SC	Combined GUS 400 mg SC q4w
Full analysis set, N	139	279
Naïve to BIO/JAKi/S1Pi, n (%)	79 (56.8%)	164 (58.8%)
BIO/JAKi/S1Pi-IR, n (%)	56 (40.3%)	112 (40.1%)
One class[a]	39 (69.6%)	78 (69.6%)
Two classes[a]	13 (23.2%)	21 (18.8%)
Three or more classes[a]	4 (7.1%)	13 (11.6%)
At least one anti-TNF[a] (regardless of other BIO/JAKi/S1Pi)	39 (69.6%)	88 (78.6%)
Vedolizumab[a] (regardless of other BIO/JAKi/S1Pi)	25 (44.6%)	49 (43.8%)
JAK inhibitors[a] (regardless of other BIO/S1Pi)	11 (19.6%)	19 (17.0%)
Ozanimod[a] (regardless of other BIO/JAKi)	2 (3.6%)	3 (2.7%)
History of IR or dependence to corticosteroids, n (%)	104 (74.8%)	208 (74.6%)
History of IR to 6-MP or AZA, n (%)	56 (40.3%)	108 (38.7%)
Baseline oral corticosteroid use, n (%)	46 (33.1%)	91 (32.6%)
Baseline use of 6-MP, AZA, or MTX, n (%)	28 (20.1%)	56 (20.1%)

[a]Denominator is patients who were BIO/JAKi/S1Pi-IR. **6-MP**=6-mercaptopurine, **AZA**=Azathioprine, **BIO**=Biologic, **GUS**=Guselkumab, **IR**=Inadequate response, **JAKi**=Janus kinase inhibitor, **MTX**=Methotrexate, **q4w**=Every 4 weeks, **S1Pi**=Sphingosine 1-phosphate inhibitor, **SC**=Subcutaneous, **TNF**=Tumor necrosis factor, **UC**=Ulcerative colitis

Primary endpoint: clinical remission at Week 12

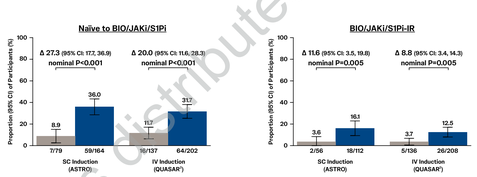
- **Clinical remission:** A Mayo stool frequency subscore of 0 or 1 and not increased from baseline, a Mayo rectal bleeding subscore of 0, and a Mayo endoscopic subscore of 0, or 1 with no friability

FIGURE 2: Primary endpoint (ASTRO and QUASAR)



CI=Confidence interval, **GUS**=Guselkumab, **IV**=Intravenous, **SC**=Subcutaneous

FIGURE 3: Clinical remission at Week 12: SC or IV GUS induction in naïve to BIO/JAKi/S1Pi vs BIO/JAKi/S1Pi-IR

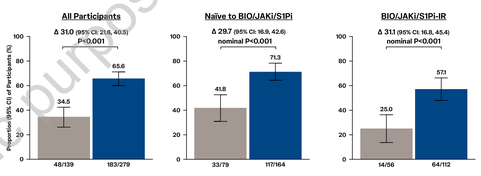


BIO=Biologic, **CI**=Confidence interval, **GUS**=Guselkumab, **IR**=Inadequate response, **IV**=Intravenous, **JAKi**=Janus kinase inhibitor, **S1Pi**=Sphingosine 1-phosphate inhibitor, **SC**=Subcutaneous

Clinical response at Week 12

- **Clinical response:** A decrease from baseline in the modified Mayo score by ≥30% and ≥2 points, with either a ≥1-point decrease from baseline in the rectal bleeding subscore or a rectal bleeding subscore of 0 or 1

FIGURE 4: Clinical response at Week 12

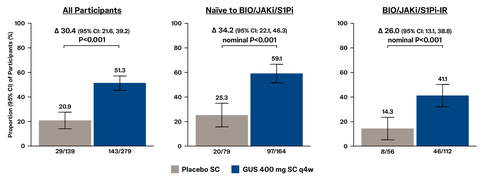


Data presented as n (%); Δ (adjusted treatment difference) vs placebo. Subpopulation analyses were not multiplicity controlled. Patients who, prior to Week 12, had an ostomy or colectomy, a prohibited change in concomitant UC medications, discontinued study agent due to lack of efficacy or an AE of worsening UC were considered not to meet the endpoint criteria at Week 12. Patients who discontinued study agent due to COVID-19 related reasons (excluding COVID-19 infection) or regional crisis had their observed data used, if available. Patients who discontinued study agent for other reasons prior to Week 12 were considered not to meet the endpoint criteria at Week 12. After accounting for these scenarios, patients who were missing data necessary for calculation of the outcome measure at Week 12 were considered not to have achieved that endpoint at Week 12. **AE**=Adverse event, **BIO**=Biologic, **CI**=Confidence interval, **GUS**=Guselkumab, **IR**=Inadequate response, **JAKi**=Janus kinase inhibitor, **q4w**=Every 4 weeks, **S1Pi**=Sphingosine 1-phosphate inhibitor, **SC**=Subcutaneous, **UC**=Ulcerative colitis

Symptomatic remission at Week 12

- **Symptomatic remission:** A stool frequency subscore of 0 or 1 and not increased from baseline, and a rectal bleeding subscore of 0

FIGURE 5: Symptomatic remission at Week 12

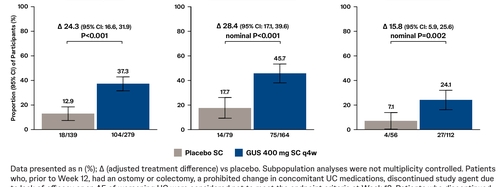


Data presented as n (%); Δ (adjusted treatment difference) vs placebo. Subpopulation analyses were not multiplicity controlled. Patients who, prior to Week 12, had an ostomy or colectomy, a prohibited change in concomitant UC medications, discontinued study agent due to lack of efficacy or an AE of worsening UC were considered not to meet the endpoint criteria at Week 12. Patients who discontinued study agent due to COVID-19 related reasons (excluding COVID-19 infection) or regional crisis had their observed data used, if available. Patients who discontinued study agent for other reasons prior to Week 12 were considered not to meet the endpoint criteria at Week 12. After accounting for these scenarios, patients who were missing data necessary for calculation of the outcome measure at Week 12 were considered not to have achieved that endpoint at Week 12. **AE**=Adverse event, **BIO**=Biologic, **CI**=Confidence interval, **GUS**=Guselkumab, **IR**=Inadequate response, **JAKi**=Janus kinase inhibitor, **q4w**=Every 4 weeks, **S1Pi**=Sphingosine 1-phosphate inhibitor, **SC**=Subcutaneous, **UC**=Ulcerative colitis

Endoscopic improvement at Week 12

- **Endoscopic improvement:** An endoscopic subscore of 0, or 1 with no friability

FIGURE 6: Endoscopic improvement at Week 12

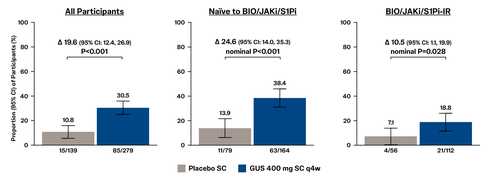


Data presented as n (%); Δ (adjusted treatment difference) vs placebo. Subpopulation analyses were not multiplicity controlled. Patients who, prior to Week 12, had an ostomy or colectomy, a prohibited change in concomitant UC medications, discontinued study agent due to lack of efficacy or an AE of worsening UC were considered not to meet the endpoint criteria at Week 12. Patients who discontinued study agent due to COVID-19 related reasons (excluding COVID-19 infection) or regional crisis had their observed data used, if available. Patients who discontinued study agent for other reasons prior to Week 12 were considered not to meet the endpoint criteria at Week 12. After accounting for these scenarios, patients who were missing data necessary for calculation of the outcome measure at Week 12 were considered not to have achieved that endpoint at Week 12. **AE**=Adverse event, **BIO**=Biologic, **CI**=Confidence interval, **GUS**=Guselkumab, **IR**=Inadequate response, **JAKi**=Janus kinase inhibitor, **q4w**=Every 4 weeks, **S1Pi**=Sphingosine 1-phosphate inhibitor, **SC**=Subcutaneous, **UC**=Ulcerative colitis

Histo-endoscopic mucosal Improvement at Week 12

- **Histo-endoscopic mucosal improvement:** Achieving a combination of histologic improvement (neutrophil infiltration in <5% of crypts, no crypt destruction, and no erosions, ulcerations or granulation tissue per Geboes grading system) and endoscopic improvement

FIGURE 7: Histo-endoscopic mucosal improvement at Week 12



Data presented as n (%); Δ (adjusted treatment difference) vs placebo. Subpopulation analyses were not multiplicity controlled. Patients who, prior to Week 12, had an ostomy or colectomy, a prohibited change in concomitant UC medications, discontinued study agent due to lack of efficacy or an AE of worsening UC were considered not to meet the endpoint criteria at Week 12. Patients who discontinued study agent due to COVID-19 related reasons (excluding COVID-19 infection) or regional crisis had their observed data used, if available. Patients who discontinued study agent for other reasons prior to Week 12 were considered not to meet the endpoint criteria at Week 12. After accounting for these scenarios, patients who were missing data necessary for calculation of the outcome measure at Week 12 were considered not to have achieved that endpoint at Week 12. **AE**=Adverse event, **BIO**=Biologic, **CI**=Confidence interval, **GUS**=Guselkumab, **IR**=Inadequate response, **JAKi**=Janus kinase inhibitor, **q4w**=Every 4 weeks, **S1Pi**=Sphingosine 1-phosphate inhibitor, **SC**=Subcutaneous, **UC**=Ulcerative colitis

TABLE 3: Summary of adverse events through Week 12

	Placebo SC	Combined GUS 400 mg SC q4w
Safety analysis set, N	139	279
Average duration of follow-up, weeks	12.2	12.3
Average exposure, number of administrations	3.0	3.0
Deaths, n (%)	1 (0.7%)	0
Patients with 1 or more:		
AEs, n (%)	73 (52.5%)	110 (39.4%)
AEs by severity, n (%)		
Mild	42 (30.2%)	62 (22.2%)
Moderate	24 (17.3%)	43 (15.4%)
Severe	7 (5.0%)	5 (1.8%)
Serious AEs, n (%)	11 (7.9%)	7 (2.5%)
AEs leading to discontinuation of study agent, n (%)	8 (5.8%)	3 (1.1%)
Infections,[a] n (%)	28 (20.1%)	42 (15.1%)
Serious infections[a]	0	2 (0.7%)

- These 2 serious infections were **pilonidal disease** and **gastroenteritis**
  - Both were moderate in intensity, did not interrupt study drug administration, and resolved

Most common AEs among combined GUS 400 mg SC group:	Worsening of UC	Arthralgia	Headache
	4.7% Combined GUS	3.9% Combined GUS	3.6% Combined GUS
	12.2% Placebo	0.7% Placebo	1.4% Placebo

[a]Infections were defined as any adverse event coded to the MedDRA system organ class 'Infections and infestations'. **AE**=Adverse event, **GUS**=Guselkumab, **MedDRA**=Medical Dictionary for Regulatory Activities, **q4w**=Every 4 weeks, **SC**=Subcutaneous, **UC**=Ulcerative colitis

PRESENTED AT: Florida Society of Rheumatology (FSR) Annual Meeting; Lake Buena Vista, FL, USA; June 19-22, 2025. **REFERENCES: 1.** Atreya R. *J Crohns Colitis.* 2024;18(suppl):S470. **2.** Rubin DT. *Lancet.* 2025;405(10472):33-49. **ACKNOWLEDGEMENTS:** The authors thank the patients, investigators, and study personnel who made the ASTRO study possible. This work was supported by Johnson & Johnson. Under the direction of the authors and in accordance with Good Publication Practices, Charles Miller of Johnson & Johnson provided writing and editorial assistance. Layout design and reformatting for this encore presentation was provided by Sandeep Chavan of SIRO Medical Writing Pvt Ltd, Thane, India (funded by Johnson & Johnson). **DISCLOSURES: LPB** reports grants or contracts from Celltrion, Fresenius Kabi, Medac, MSD, and Takeda; consulting and/or payment or honoraria and/or data safety monitoring board or advisory board participation for AbbVie, Abivax, Adacyte, Alfasigma, Alimentiv, Amgen, Applied Molecular Transport, Arena, Banook, Biogen, Bristol Myers Squibb, Celltrion, Connect Biopharm, Cytoki Pharma, Enthera, Ferring, Fresenius Kabi, Galapagos, Genentech, Gilead, Gossamer Bio, GlaxoSmithKline, IAG Image Analysis, Index Pharmaceuticals, Inotrem, Johnson & Johnson, Kern Pharma, Eli Lilly, Medac, Morphic, MSD, Nordic Pharma, Novartis, Oncodesign Precision Medicine, ONO Pharma, OSE Immunotherapeutics, Pandion Therapeutics, Par' Immune, Pfizer, Prometheus, Protagonist, Roche, Samsung, Sandoz, Sanofi, Satisfay, Takeda, Telavant, Theravance, Thermo Fischer, Tigenix, Tillots, Viatris, Vectivbio, Ventyx, and Yospin; and meeting attendance/travel support from Abbvie, Alfasigma, Amgen, Celltrion, Connect Biopharm, Ferring, Galapagos, Genentech, Gilead, Gossamer Bio, Johnson & Johnson, Eli Lilly, Medac, Morphic, MSD, Pfizer, Sandoz, Takeda, Thermo Fischer, and Tillotts. **JRA** reports grant support from Johnson & Johnson, Merck, and Pfizer; consultancy fees from AbbVie, Adiso, Bristol Myers Squibb, Ferring, Genentech, GlaxoSmithKline, Johnson & Johnson, Merck, Pfizer, Roivant, and Seres Therapeutics; payments for speaking from AbbVie, Bristol Myers Squibb, and Johnson & Johnson; and is a steering committee member and investigator for Johnson & Johnson. **SD** reports consultancy fees from AbbVie, Alimentiv, Allergan, Amgen, AstraZeneca, Athos, Biogen, Boehringer Ingelheim, Celgene, Celltrion, Eli Lilly, Enthera, Ferring, Gilead, Hospira, Inotrem, Johnson & Johnson, MSD, Mundipharma, Mylan, Pfizer, Roche, Sandoz, Sublimity, Takeda, TiGenix, UCB, and Vifor; and reports lecture fees from AbbVie, Amgen, Ferring, Gilead, Johnson & Johnson, Mylan, Pfizer, and Takeda. **MG, TB, YA, SJ, LJ, HZ,** and **ALC** are employees of Johnson & Johnson, and may own stock in Johnson & Johnson. **TH** reports research grants from AbbVie GK, Boston Scientific Corporation, EA Pharma Co. Ltd., JIMRO Co. Ltd., Kissei Pharmaceutical Co. Ltd., Kyorin Pharmaceutical Co. Ltd., Mitsubishi Tanabe Pharma Corporation, Mochida Pharmaceutical Co. Ltd., Nippon Kayaku Co. Ltd., Pfizer Inc., Takeda Pharmaceutical Co. Ltd., and Zeria Pharmaceutical Co. Ltd.; consulting fees from AbbVie GK, Abivax, Bristol Myers Squibb, EA Pharma Co. Ltd., Gilead Sciences, Johnson & Johnson Pharmaceutical K.K., Eli Lilly, Mitsubishi Tanabe Pharma Corporation, and Pfizer Inc.; and lecture fees from AbbVie GK, EA Pharma Co. Ltd., Johnson & Johnson, K.K., JIMRO Co., Kissei Pharmaceutical Co. Ltd., Kyorin Pharmaceutical Co. Ltd., Mitsubishi Tanabe Pharma Corporation, Mochida Pharmaceutical Co., Ltd., Pfizer Inc., and Takeda Pharmaceutical Co. Ltd. **DTR** reports consulting and/or speaker fees and/or advisory board participation for AbbVie, Altrubio, Apex, Avalo, Bristol Myers Squibb, Buhlmann Diagnostics, Celgene, Connect BioPharma, Intouch Group, Iterative Health, Johnson & Johnson, Eli Lilly, Pfizer, Samsung Neurologica, and Takeda; Altrubio, Datos Health, and Iterative Health stock options; grants from Takeda; and membership on the Board of Directors of Cornerstones Health, Inc and on the Crohn's & Colitis Foundation's Board of Trustees. **ML** reports research support from Lilly, Pfizer, and Takeda; consulting for AbbVie, Bristol Myers Squibb, Intercept, Johnson & Johnson, Eli Lilly, Pfizer, Prometheus, Roivant, Takeda, and Target RWE. Previously presented at ECCO 25 Congress; Berlin, Germany; February 19–22, 2025; Congress of Clinical Rheumatology - East (CCR-East); Destin, FL, USA; May 1–4, 2025.