Efficacy and Safety of Guselkumab in Participants With Moderately to Severely Active Crohn's Disease Who Had Maintenance Dose Adjustment: Results From the Phase 3 GALAXI 2 & 3 Long-Term Extension

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Key Takeaways

- **Maintenance dose adjustment to guselkumab 200 mg q4w may benefit patients with Crohn's disease who experience inadequate response to guselkumab 100 mg q8w**
- **Nearly half of guselkumab 100 mg q8w participants receiving an adjustment to guselkumab 200 mg q4w achieved clinical remission or endoscopic response up to ~1 year after dose adjustment**
- **Efficacy outcomes in guselkumab 200 mg q4w participants who received a sham dose adjustment were generally similar to those who switched from guselkumab 100 mg q8w to 200 mg q4w**
- **Safety outcomes after dose adjustment were consistent with the established safety profile of guselkumab in approved indications**
- **Interpretation is affected by small sample sizes**

Background

- Guselkumab is a selective, dual-acting interleukin 23 (IL-23) p19 subunit inhibitor that potently neutralizes IL-23 and binds to CD64, a receptor on cells that produce IL-23
- Guselkumab demonstrated efficacy and safety through Week 48 in moderately to severely active Crohn's disease in the identically designed, randomised, double-blind GALAXI 2 & 3 phase 3 trials[1]
- Because of the remitting and relapsing nature of Crohn's disease, patients may experience flares after successful long-term maintenance therapy

Objective

- **To assess the efficacy and safety through Week 96 of guselkumab in participants who dose adjusted after an inadequate response to their randomised guselkumab maintenance regimen during Weeks 52–80 in the long-term extension (LTE) of the GALAXI 2 & 3 studies**

Methods

- Two randomised guselkumab maintenance regimens were evaluated in GALAXI 2 & 3: 100 mg SC q8w (100 q8w) and 200 mg SC q4w (200 q4w)
- Guselkumab participants who completed treatment through Week 48, and would benefit from continued study treatment as assessed by the investigator, were allowed to continue into the LTE on the same dose regimen they received during maintenance (100 q8w or 200 q4w)
- From Weeks 52–80 of the GALAXI 2 & 3 LTE, participants who met inadequate response criteria (not in clinical response AND CDAI ≥220) received a one-time dose adjustment or sham dose adjustment (if already receiving 200 q4w) to guselkumab 200 q4w
- Treatment allocation in the LTE remained blinded until all participants had completed treatment through Week 48, the Week 48 database was locked, and the Week 48 analysis was finalised
- Per the prespecified analysis plan, participants undergoing dose adjustment in the LTE were evaluated as follows:
  - Clinical response and clinical remission were assessed 16 weeks after dose adjustment and at Week 96
  - Endoscopic response and endoscopic remission were assessed at Weeks 48 and 96
  - Safety was assessed through Week 96
- Nonresponder imputation and handling of missing data: participants who experienced events indicative of lack of efficacy were considered nonresponders at all analysis timepoints after experiencing the event. Participants who discontinued study agent due to COVID-19 related reasons (excluding COVID-19 infection) or regional crisis had their observed data used, if available, to determine responder and nonresponder status at the analysis timepoint. Participants who were missing endpoint scoring data at the analysis timepoint were considered not having achieved the endpoint at the analysis timepoint.

Clinical response:	≥100-point reduction in CDAI score from the time of dose adjustment or CDAI score <150	**Endoscopic response:**	≥50% improvement from Week 0 in SES-CD or SES-CD ≤2
Clinical remission:	CDAI score <150	**Endoscopic remission:**	SES-CD ≤4 and at least a 2-point reduction from Week 0 and no subscore >1 in any individual component

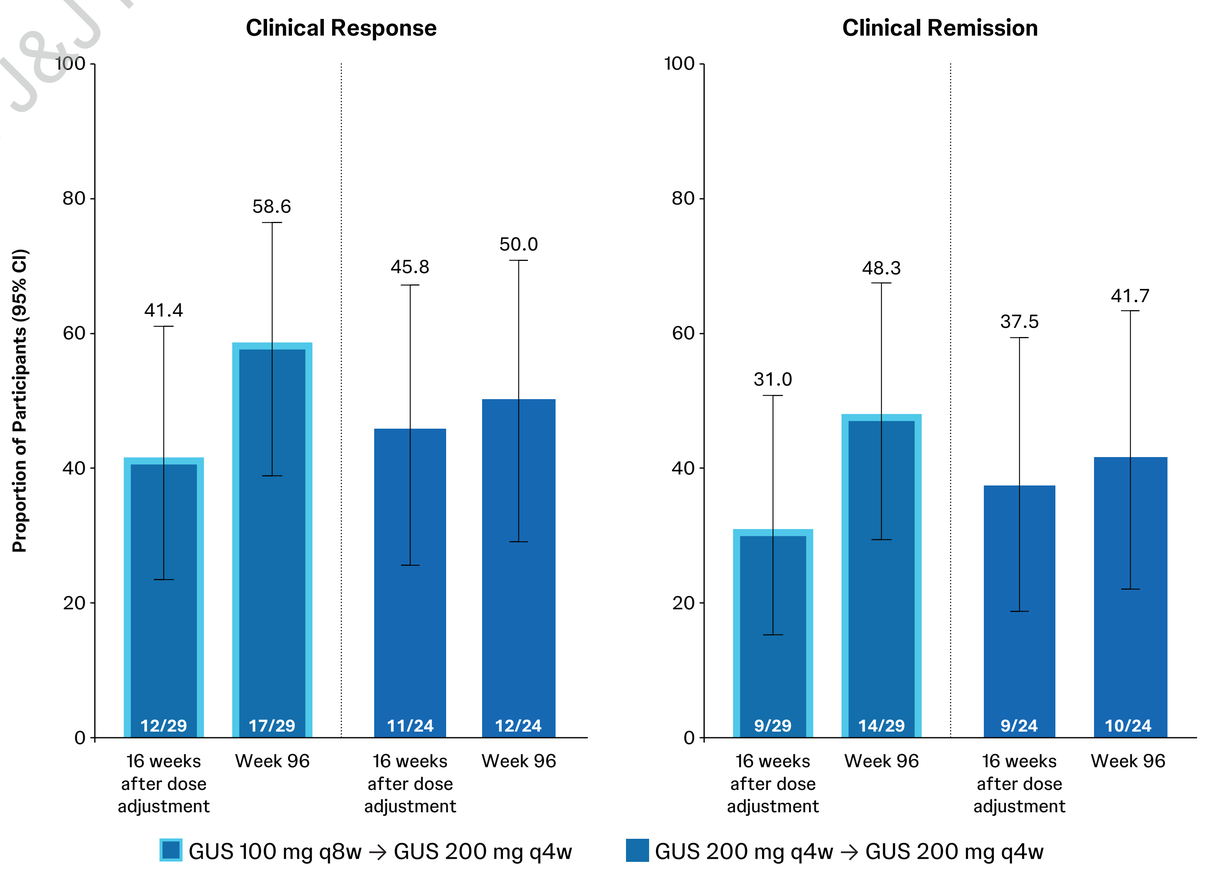
Results

Characteristics of GALAXI 2 & 3 participants who did and did not receive dose adjustment

	GUS 100 mg q8w[a]		GUS 200 mg q4w[a]	
	Did NOT receive dose adjustment	Received dose adjustment	Did NOT receive dose adjustment	Received sham dose adjustment
N[b]	208	29	218	24
CHARACTERISTICS AT BASELINE (WEEK 0)				
Crohn's disease duration (y), median (IQR)	4.9 (1.8; 10.2)	8.2 (5.3; 14.5)	4.1 (1.6; 9.0)	6.3 (3.0; 14.3)
History of BIO-IR, n (%)	102 (49.0%)	17 (58.6%)	98 (45.0%)	14 (58.3%)
CDAI score, median (IQR)	280.0 (248.0; 329.0)	294.0 (263.0; 319.0)	283.5 (252.0; 334.0)	289.0 (264.0; 328.5)
SES-CD, median (IQR)	11.0 (7.0; 17.0)	13.0 (7.0; 19.0)	11.0 (7.0; 17.0)	13.0 (9.5; 18.0)
Endoscopic disease severity (per SES-CD)				
Moderate (7–16), n (%)	116 (55.8%)	14 (48.3%)	106 (48.6%)	11 (45.8%)
Severe (>16), n (%)	55 (26.4%)	12 (41.4%)	61 (28.0%)	9 (37.5%)
Involved GI areas by central reader				
Ileum only, n (%)	41 (19.7%)	6 (20.7%)	56 (25.7%)	6 (25.0%)
Colon only, n (%)	80 (38.5%)	13 (44.8%)	87 (39.9%)	6 (25.0%)
Ileum and colon, n (%)	87 (41.8%)	10 (34.5%)	75 (34.4%)	12 (50.0%)
C-reactive protein (mg/L), median (IQR)	7.2 (2.1; 19.4)	8.5 (2.9; 36.2)	6.5 (2.8; 19.8)	6.1 (2.1; 31.1)
Fecal calprotectin (µg/g), median (IQR)[c]	903.0 (390.0; 1892.0)	848.5 (403.5; 2116.5)	982.0 (319.0; 1936.5)	1354.5 (658.5; 1747.5)
CHARACTERISTICS AT WEEK 48				
CDAI score, median (IQR)	69.5 (30.0; 128.5)	155.0 (81.0; 232.0)	68.5 (32.0; 112.0)	138.5 (72.0; 206.5)
SES-CD, median (IQR)[d]	4.0 (0.0; 7.0)	7.0 (4.0; 15.0)	3.0 (1.0; 6.0)	6.0 (3.5; 10.5)
In endoscopic response, n (%)	128 (61.5%)	9 (31.0%)	149 (68.3%)	8 (33.3%)
In endoscopic remission, n (%)	91 (43.8%)	4 (13.8%)	106 (48.6%)	5 (20.8%)
Endoscopic disease severity (per SES-CD)[d]				
Moderate (7–16), n (%)	49 (24.0%)	10 (34.5%)	36 (16.7%)	8 (33.3%)
Severe (>16), n (%)	5 (2.5%)	7 (24.1%)	6 (2.8%)	2 (8.3%)
C-reactive protein (mg/L), median (IQR)[e]	1.8 (0.8; 5.8)	5.9 (0.8; 12.7)	2.2 (0.9; 4.6)	4.0 (0.6; 8.3)
Fecal calprotectin (µg/g), median (IQR)[f]	173.5 (65.0; 555.0)	591.0 (115.0; 1739.0)	121.0 (47.0; 408.0)	160.0 (49.0; 336.0)

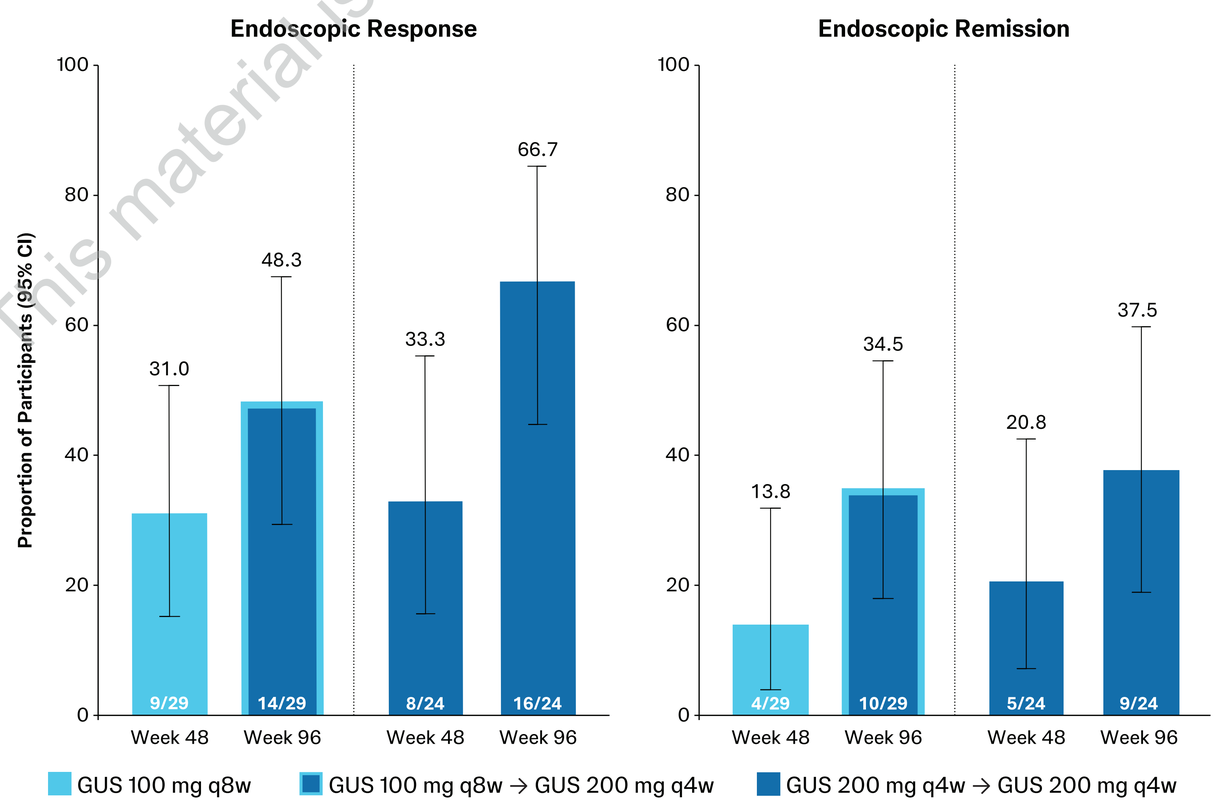
a. Treatment group at the start of the long-term extension period. Participants who had a dose adjustment between Week 52 and Week 80 received guselkumab 200 mg SC q4w. Participants who were already receiving the guselkumab 200 mg SC q4w maintenance dose and met the inadequate response criteria received a "sham" dose adjustment.
b. Participants with a Crohn's disease-related surgery (with the exception of minor procedures) prior to Week 48 or a prohibited change in Crohn's disease medications prior to Week 48 who remained on treatment and subsequently entered the LTE are excluded.
c. N=206 (GUS 100 non adjusters), 28 (GUS 100→200), 216 (GUS 200 non adjusters), and 24 (GUS 200→200) participants with evaluable samples at baseline.
d. N=204 (GUS 100 non adjusters), 29 (GUS 100→200), 216 (GUS 200 non adjusters), and 24 (GUS 200→200) participants with SES-CD data at Week 48.
e. N=205 (GUS 100 non adjusters), 27 (GUS 100→200), 213 (GUS 200 non adjusters), and 24 (GUS 200→200) participants with evaluable samples at Week 48.
f. N=198 (GUS 100 non adjusters), 27 (GUS 100→200), 206 (GUS 200 non adjusters), and 23 (GUS 200→200) participants with evaluable samples at Week 48.

Nearly half of participants achieved clinical response 16 weeks after dose adjustment and the percentage increased further by Week 96



Note: No participant was in clinical response or clinical remission at the time of dose adjustment per criteria for dose adjustment (not in clinical response AND CDAI ≥220).

Participants showed improvement in endoscopic outcomes after receiving dose adjustment



Adverse event rates during the LTE were similar before and after dose adjustment

	Randomised treatment and up to dose adjustment[a]	After dose adjustment[b]	Randomised treatment and up to dose adjustment[a]	After sham dose adjustment[b]
	GUS 100 mg q8w	GUS 100 mg q8w →200 mg q4w	GUS 200 mg q4w	GUS 200 mg q4w →200 mg q4w
N[c]	36	36	28	28
Average duration of follow-up, weeks	12.1	33.6	12.9	33.1
Participant–years (P–Y) of follow-up	8.3	23.2	6.9	17.7
Participants with ≥1 AE, n (%)	19 (52.8%)	24 (66.7%)	14 (50.0%)	15 (53.6%)
Events/100 P–Y (95% CI)*	360.7 (243.4, 514.9)	341.1 (270.0, 425.1)	519.1 (363.6, 718.7)	484.6 (387.6, 598.5)
Participants with ≥1 SAE, n (%)	0	3 (8.3%)	1 (3.6%)	1 (3.6%)
Events/100 P–Y (95% CI)*	0.0 (0.0, 36.0)	13.0 (2.7, 37.9)	14.4 (0.4, 80.3)	5.6 (0.1, 31.4)
Participants with ≥1 AE leading to discontinuation, n (%)	0	2 (5.6%)	1 (3.6%)	0
Events/100 P–Y (95% CI)*	0.0 (0.0, 36.0)	17.3 (4.7, 44.2)	14.4 (0.4, 80.3)	0.0 (0.0, 16.9)
Participants with ≥1 infection, n (%)	7 (19.4%)	12 (33.3%)	4 (14.3%)	9 (32.1%)
Events/100 P–Y (95% CI)*	120.2 (57.7, 221.1)	77.7 (46.1, 122.8)	72.1 (23.4, 168.3)	84.5 (47.3, 139.4)
Participants with ≥1 serious infection, n (%)	0	1 (2.8%)	0	0
Events/100 P–Y (95% CI)*	0.0 (0.0, 36.0)	4.3 (0.1, 24.1)	0.0 (0.0, 43.2)	0.0 (0.0, 16.9)
Participants who died, n (%)	0	0	0	0

**CI based on an exact method assuming that the observed number of events follows a Poisson distribution.*
a. Treatment group at the start of the long-term extension. Includes events for participants who received a dose adjustment from Week 48 up to the time point of dose adjustment.
b. Only events after dose adjustment (including "sham") are included in this column. Participants receiving GUS 100 mg SC q8w who met inadequate response criteria between Week 52 and Week 80 had a dose adjustment to GUS 200 mg SC q4w. Participants receiving GUS 200 mg SC q4w who met the inadequate response criteria between Week 52 and Week 80 received "sham" dose adjustment.
c. All participants who met criteria for dose adjustment are included.
Note: Participants are counted only once for any given events, regardless of the number of times they actually experienced the event. Adverse events are coded using MeDRA version 27.0.

PRESENTED AT: 21st Congress of the European Crohn's and Colitis Organisation (ECCO); February 18–21, 2026; Stockholm, Sweden. **REFERENCES: 1.** Panaccione R, Feagan BG, Afzali A, et al. Efficacy and safety of intravenous induction and subcutaneous maintenance therapy with guselkumab for patients with Crohn's disease (GALAXI-2 and GALAXI-3): 48-week results from two phase 3, randomised, placebo and active comparator-controlled, double-blind, triple-dummy trials. Lancet 2025; 406(10501): 358–375. **ACKNOWLEDGMENTS:** The authors thank the participants, investigators, and study personnel who made GALAXI 2 & 3 possible. Under the direction of the authors and in accordance with Good Publication Practices, Charles Miller of Johnson & Johnson provided writing and editorial assistance. This work was supported by Johnson & Johnson. **DISCLOSURES: Remo Panaccione** reports consulting fees from Abbivax, Abbott, AbbVie, Alimentiv (formerly Robarts), Amgen, AnaptysBio, Arena Pharmaceuticals, AstraZeneca, Biogen, Boehringer Ingelheim, Bristol Myers Squibb, Celgene, Celltrion, Cosmos Pharmaceuticals, Eisai, Elan, Eli Lilly, Ferring, Fresenius Kabi, Galapagos, Genentech, Gilead Sciences, GlaxoSmithKline, BioJAMP, Johnson & Johnson, Merck, Mylan, Novartis, Oppilan Pharma, Organon, Pandion Pharma, Pendopharm, Pfizer, Progenity, Prometheus Biosciences, Protagonist Therapeutics, Roche, Sandoz, Satisfai Health, Shire, Spyre Therapeutics, Sublimity Therapeutics, Takeda Pharmaceuticals, Theravance Biopharma, Trellus, Union Biopharma, Viatris, Ventyx Biosciences, and UCB; speaker's fees from AbbVie, Amgen, Arena Pharmaceuticals, Bristol Myers Squibb, Celgene, Eli Lilly, Ferring, Fresenius Kabi, Gilead Sciences, Johnson & Johnson, Merck, Organon, Pfizer, Roche, Sandoz, Shire, and Takeda Pharmaceuticals; and participation in advisory boards for AbbVie, Alimentiv (formerly Robarts), Amgen, Arena Pharmaceuticals, AstraZeneca, Biogen, Boehringer Ingelheim, Bristol Myers Squibb, Celgene, Eli Lilly, Ferring, Fresenius Kabi, Genentech, Gilead Sciences, GlaxoSmithKline, BioJAMP, Johnson & Johnson, Merck, Mylan, Novartis, Oppilan Pharma, Organon, Pandion Pharma, Pfizer, Progenity, Protagonist Therapeutics, Roche, Sandoz, Shire, Sublimity Therapeutics, Takeda Pharmaceuticals, and Ventyx Biosciences. **Tadakazu Hisamatsu** reports grant support from AbbVie, Daiichi-Sankyo, EA Pharma Co, Ltd. JIMRO, Mitsubishi Tanabe Pharma Corporation, Mochida Pharmaceutical Co., Ltd., Nippon Kayaku Co., Ltd., Pfizer Inc and Takeda Pharmaceutical Co., Ltd. Consulting fees from Bristol Myers Squibb, EA Pharma Co, Ltd., Eli Lilly, Gilead Sciences andJohnson & Johnson, Lecture fees from AbbVie, EA Pharma Co, Ltd., Kissei Pharmaceutical Co, Ltd., Mitsubishi Tanabe Pharma Corporation, Mochida Pharmaceutical Co., Ltd and Takeda Pharmaceutical Co., Ltd. **Anita Afzali** reports serving as a speaker for AbbVie, Bristol Myers Squibb, Johnson & Johnson, Pfizer, and Takeda; a consultant for AbbVie, Bristol Myers Squibb, Eli Lilly, Johnson & Johnson, Pfizer, and Takeda; an advisory board member for AbbVie, Bristol Myers Squibb, Eli Lilly, Gilead, Johnson & Johnson, Pfizer, and Takeda; received educational/research grants from AbbVie, Bristol Myers Squibb, Eli Lilly, Johnson & Johnson, Pfizer, and Takeda; and Co-Founder and Board Member of Scrubs & Heels Foundation. **Bruce E. Sands** reports reports grants from Johnson & Johnson; personal fees from Abivax SA, AbbVie, Adiso Therapeutics, Agomab Therapeutics, Alimentiv, Amgen, AnaptysBio, AstraZeneca, Biora Therapeutics, Boehringer-Ingelheim, Bristol Myers Squibb, Celltrion, ClostraBio, Cytoki Pharma, EcoR1 Capital, Eli Lilly, Enthera, Equilium, Ensho Therapeutics, Evommune, Ferring, Galapagos, Genentech, Gilead Sciences, GSK, Gossamer Bio, Imhotex, Immunyx Pharma Ltd., Index Pharmaceuticals, Innovation Pharmaceuticals, Johnson & Johnson, Kaleido, Kallyope, Kyowa Kirin, Merck & Co., Microba, Microbiotica Limited, Mirador Therapeutics, Morphic Therapeutic, MRM Health NV, Palisade Therapeutics, Pfizer, Prometheus Biosciences, Prometheus Laboratories, Protagonist Therapeutics, Q32 Bio, Sanofi, Sorriso Therapeutics, Surrozen, Takeda, Target RWE, Teva, TLL Pharmaceutical, TrIX Bio, Union Therapeutics, Ventyx Biosciences; non-financial support from Bristol Myers Squibb, Johnson & Johnson, Lilly, Pfizer, Takeda; stock/stock options from Ventyx Biosciences. **Silvio Danese** 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 lecture fees from AbbVie, Amgen, Ferring, Gilead, Johnson & Johnson, Mylan, Pfizer and Takeda. **Rian Van Rampelbergh, Jacqueline Yee, Wilbert van Duijnhoven,** and **Christopher Corbett** are employees of Johnson & Johnson and may hold shares in the company.