IBD-GAPS: Inflammatory Bowel Disease Guidelines Alignment in Clinical Practice Survey

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Key Takeaways

- **Clinicians' self-reported clinical practice in moderate-to-severe luminal Crohn's disease was more reflective of recently published evidence than the 2019 BSG guidelines.**
- **Leading IBD experts, primarily from English teaching hospitals, reported using advanced therapy often at diagnosis, with anti-TNF plus immunomodulator the most common first-line choice. Practices were reportedly reflective of their wider MDT.**
- **Barriers such as costs and local restrictions persist.**
- **Updated BSG guidelines were published in June 2025.[3] It will be important to understand the changes these will bring to clinical practice in the UK.**

Background

Inflammatory bowel disease (IBD) affects >500,000 people in the UK. In 2024, one in three patients rated their care as 'fair' or 'poor' in a UK-wide IBD Patient Survey conducted by IBD UK, a partnership of professional bodies, royal colleges and patient organisations.[1] These results indicated a stagnation in perceived care quality since 2019, highlighting a need for health leaders, policymakers, and commissioners to work with healthcare professionals (HCPs) and industry to improve IBD care.

With a rapidly evolving treatment landscape, it was unclear whether clinical practice in the UK aligned with the consensus guidelines on the management of IBD published by the British Society of Gastroenterology (BSG) in 2019.[2]

A survey was conducted to assess HCPs' self-reported practices in managing moderate-to-severe luminal Crohn's disease (CD).

Objectives

To evaluate self-reported perceptions of UK HCPs who treat patients with IBD on the alignment of their clinical practice with 2019 BSG IBD guidelines, specifically, regarding the management of moderate-to-severe luminal CD. The survey focused on the following aspects of clinical practice: 1) Induction and maintenance of disease remission; 2) Disease monitoring; 3) Awareness and general use of BSG IBD guidelines

Methods

- IBD-GAPS was a national cross-sectional survey that document self-reported clinical practice of UK HCPs treating adults with IBD. The survey was exploratory and not designed to ensure statistical representation of opinions from across specific populations.
- Participants were recruited by Johnson and Johnson (J&J) Medical Science Liaisons (MSLs) by convenience sampling, whereby a J&J database of HCPs was used to recruit physicians, nurse specialists and pharmacists from across the UK. Selection criteria for participants are included in Table 1.
- The structured interviews were performed by MSLs and guided by a questionnaire and interview script. A pre-interview introduction and checklist was conducted to ensure confidentiality and obtain written consent, in addition to collecting demographic data such as UK region and job role.
- Data collection was conducted from 20th February to 21st March 2025. The questionnaire employed a mixture of close-ended, multiple-choice and open-ended questions (total of 36 questions), delivered via Microsoft Teams or in person, individually or in a group setting, and were designed to last 45–60 minutes. MSLs completed the questionnaire on behalf of the participants using Microsoft Forms.
- Quantitative and qualitative data from the survey were analysed separately and synthesised and developed into summary tables. Demographic data and data from multiple-choice questions were summarised as descriptive statistics.
- Qualitative data were assessed using content analysis in Microsoft Word. Frequency of words, themes or concepts was summarised quantitatively for each question. Dual coding was used for 10% of the sample, results compared, and differences discussed and aligned upon. A single coder approach was used for the remaining responses. Quotes are not available as data collected did not include verbatim responses.

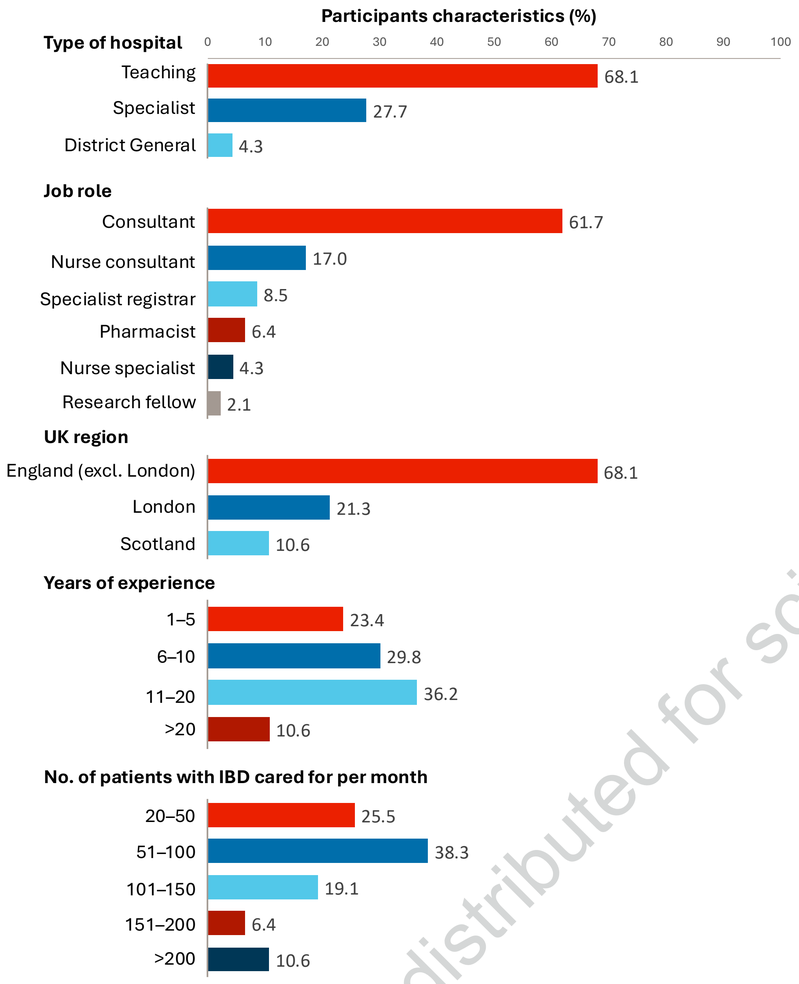
Table 1: Inclusion criteria

Participant Group	Inclusion Criteria
All	• Capacity to consent • Affiliation with an IBD MDT, which they attend on at least a monthly basis
Physicians	• ≥5 years' experience specialising in IBD • On average, manages ≥20 patients with IBD per month
Clinical nurse specialists	• Specialist interest and a competency in IBD • On average, provides care for ≥20 patients with IBD per month
Pharmacists	• On average, provides input on the care of ≥20 patients with IBD per month

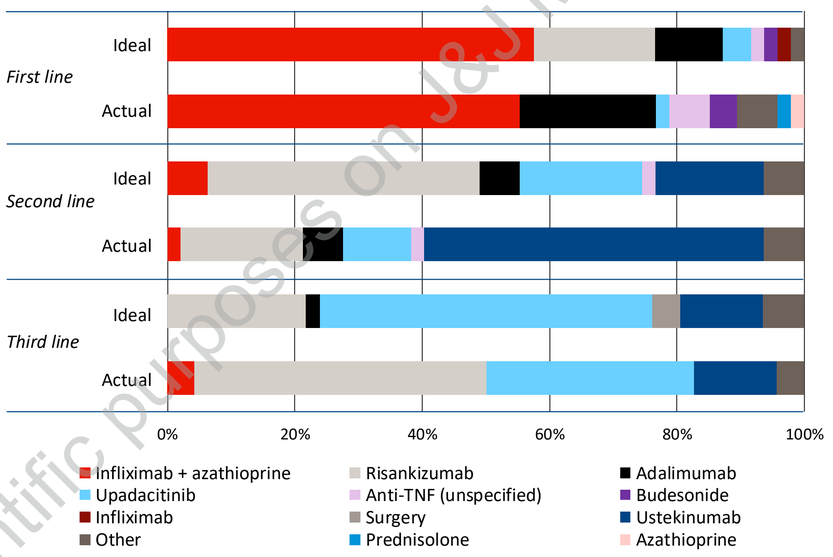
IBD: inflammatory bowel disease; MDT: multidisciplinary team.

Results

A total of 47 participants completed the survey, most were consultants, mostly from teaching hospitals, and from England



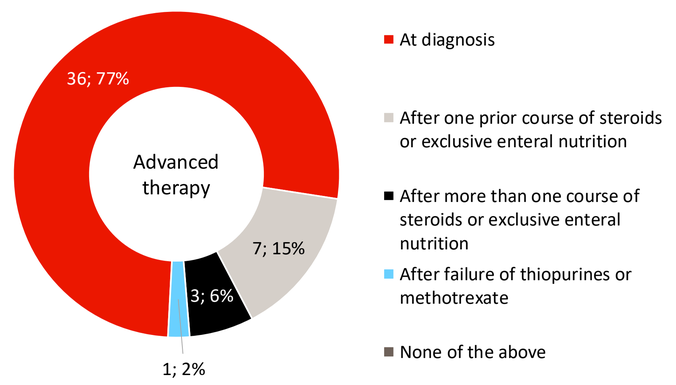
Treatment choice in the first, second, and third-line: there were differences between the ideal and actual treatments used in patients with active luminal moderate-to-severe Crohn's disease



TNF, tumour necrosis factor.
Question regarding ideal treatment: If all treatments cost the same, and there were no practical restrictions, what treatment would you choose for induction and maintenance of remission in patients with active luminal moderate-to-severe Crohn's disease in: A) The first line; B) The second line, following your first-line choice; C) The third line, following your first- and second-line choice.
Question regarding actual treatments used: What treatment do you use in practice for induction of remission in patients with active luminal moderate-to-severe Crohn's disease in: A) The first line; B) The second line, following your first-line choice; C) The third line, following your first- and second-line choices.
Some participants provided separate answers for patients with moderate and severe disease, in which case the preferred/actual treatment for luminal moderate Crohn's disease was recorded.
When participants reported using infliximab alone or infliximab + immunomodulator, these responses were coded as infliximab + azathioprine.

- Provided reasons for not using the preferred treatment options included:
  - Cost (n=25)
  - Integrated Care Board or local policy/pathway (n=10)
  - Resource constraints (n=4)
  - Additional factors influencing treatment choice (n=6)
- Most participants (n=37) indicated that their preferred treatment options reflected the preferences of their wider multidisciplinary team (MDT).

Most participants reported prescribing advanced therapy at diagnosis in patients with active luminal moderate-to-severe Crohn's disease



- Participants approach to advanced therapy was based on research (n=19) and on optimisation of patient outcomes (n=7)
- A total of 12 participants emphasised that the decision on when to prescribe advanced therapy was made on a case-by-case basis, considering factors such as:
  - Disease severity (n=5)
  - Disease activity (n=2)
  - Previous treatment failure (n=2)
  - Confidence in diagnosis (n=3)
  - Individual risk factors (n=2)
- Barriers to prescribing advanced therapy at diagnosis were reported by 8 participants, including diagnostic or treatment delays (n=5) and guidelines (n=2)

Corticosteroids and 5-ASA are infrequently, but still used as maintenance treatments in patients with moderate-to-severe Crohn's disease

	Corticosteroids used as maintenance, n (%)	5-ASA used as maintenance, n (%)
Always	0 (0)	0 (0)
Often	0 (0)	0 (0)
Sometimes	1 (2.1)	1 (2.1)
Rarely	18 (38.3)	8 (17.0)
Never	28 (59.6)	38 (80.9)
Total	**47**	**47**

5-ASA: 5-aminosalicylic acid.

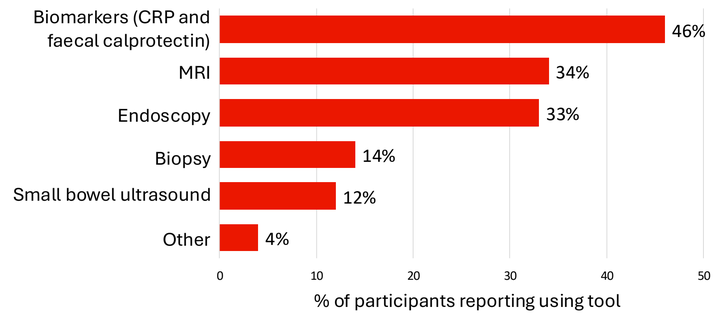
- When asked whether they would withdraw therapy for patients receiving a biologic or small molecule oral medication in stable remission for one year, most participants (40/47; 85.1%) reported that they would not, four (8.5%) responded yes, and three (6.4%) responded not sure
  - For those responding yes, the reasons given for this approach were patient choice and patient history

Frequency of monitoring of patients with moderate-to-severe Crohn's disease in remission every 2-3 months is more common with JAKi and immunomodulators than with other treatments

	Once per month n (%)	Every 2–3 months n (%)	Every 4–6 months n (%)	Annually, or less frequently n (%)	Patient-initiated n (%)	Never n (%)	N/A
JAKi	0 (0)	26 (55.3)	20 (42.6)	1 (2.1)	0 (0)	0 (0)	0 (0)
Anti-IL-12/23	0 (0)	15 (31.9)	28 (59.6)	4 (8.5)	0 (0)	0 (0)	0 (0)
Anti-IL-23	0 (0)	15 (31.9)	29 (61.7)	3 (6.4)	0 (0)	0 (0)	0 (0)
Anti-TNF	0 (0)	16 (34.0)	28 (59.6)	3 (6.4)	0 (0)	0 (0)	0 (0)
Anti-integrin	0 (0)	15 (31.9)	26 (55.3)	5 (10.6)	0 (0)	1 (2.1)	0 (0)
Immunomodulator	0 (0)	33 (70.2)	8 (17)	4 (8.5)	1 (2.1)	0 (0)	1 (2.1)

IL: interleukin; JAKi: Janus kinase inhibitor; NA: not applicable; TNF: tumour necrosis factor. Question asked to participants: How often do you monitor patients with moderate-to-severe Crohn's disease who are in remission on a stable maintenance regimen receiving the following: JAKi; anti-IL-12/23; anti-IL-23; anti-TNF; anti-integrin; immunomodulators.

Biomarkers are the tools more frequently used to monitor patients with Crohn's disease during established maintenance medical therapy



CRP, C-reactive protein; MRI, magnetic resonance imaging.

- Of the 35 participants who did not report using small bowel ultrasound for routine monitoring, 26 (74.3%) indicated they anticipate using it within the next 5 years

2019 BSG guidelines were in place at the time of the survey, and several treatment options had become available in the UK afterwards, limiting the usefulness of those guidelines at the beginning of 2025

- Participants indicated consulting the BSG guidelines quarterly (36%), annually or less often (32%), monthly (15%), never (11%), or weekly (6%)
- A total of 17 participants reported having no challenges implementing the BSG guidelines. Of those that did report challenges, resource constraints (n=11) including understaffing (n=3), clinic capacity (n=2) and tight budgets (n=3) were mentioned. Competing guidelines, such as those imposed by NICE and integrated care boards, were reported as a barrier by 9 participants

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ABBREVIATIONS: CD, Crohn's disease; DGH, district general hospital; IBD, inflammatory bowel disease; IL, interleukin; HCP, healthcare professional; JAKi, Janus kinase inhibitor; J&J, Johnson and Johnson; MDT, multidisciplinary team; MSL, medical science liaison; TNF, tumour necrosis factor; UK, United Kingdom