

Physician Opinions on Treatment Preferences and Long-term Treatment Goals for Moderate-to-Severe Inflammatory Bowel Disease in China, Japan, and Germany

Irina Blumenstein,¹ Hong Yang,² Xiaoxiao Alice Lu,³ Bo Chen,⁴ Ayako Sasaki,⁵ Ursula Kleine-Vossbeck,⁶ Shashi Adsul,⁷ Tiange Liu,³ Meshal Imran,³ Jia Zhong,⁸ Aolin Wang,⁹ Han Gao,⁴ Rouven Hecht,⁶ Lukas Scharfenberger,⁶ Keira Herr,¹⁰ Ivana Bravata,⁶ Darren Piscitelli,⁷ Claudia Ott,¹¹ Katsuyoshi Matsuoka¹²

¹ Fachärztin für Innere Medizin, Gastroenterologie, Universitätsmedizin Frankfurt, Medizinische Klinik 1, Leiterin der CED Hochschulambulanz und der CED Studienambulanz, Germany; ² Department of Gastroenterology, Peking Union Medical College Hospital, Chinese Academy of Medical Sciences, Beijing, China; ³ Johnson & Johnson, Raritan, USA; ⁴ Johnson & Johnson, Beijing, China; ⁵ Johnson & Johnson, Tokyo, Japan; ⁶ Johnson & Johnson, Neuss, Germany; ⁷ Johnson & Johnson, Horsham, USA; ⁸ Analysis Group, Inc., Beijing, China; ⁹ Analysis Group, Inc., New York, NY, USA; ¹⁰ Johnson & Johnson, Singapore; ¹¹ Fachärztin für Innere Medizin, Schwerpunkt CED, Gastroenterologie, Facharztzentrum Regensburg, Germany; ¹² Toho University Sakura Medical Center, Chiba, Japan

Background

The burden of IBD, including ulcerative colitis (UC) and Crohn’s disease (CD), has increased substantially in recent decades in countries such as China, Japan, and Germany,^{1,2,3} alongside an evolving but still limited treatment landscape with the introduction of new advanced therapies.

Guselkumab, a selective dual-acting IL-23p19 subunit inhibitor, was approved in China, Japan, and Germany for moderate-to-severe UC and CD by mid-2025 and is the first IL-23 inhibitor to offer both intravenous (IV) and subcutaneous (SC) induction options.

Given the rapidly evolving treatment landscape, understanding physician perspectives on treatment preferences and long-term treatment goals may provide important insights into contemporary treatment decision-making for patients with moderate-to-severe UC and CD.

Objectives

This study aimed to understand physicians’ preferences on route of administration, long-term treatment goals, and early perceptions on guselkumab use for moderate-to-severe UC and CD in China, Japan, and Germany.

Methods

Study Design

- Gastroenterologists in China, Japan, and Germany were recruited for a cross-sectional, online survey (China: May 2025 – Feb 2026; Japan: Oct – Nov 2025; Germany: Sept – Oct 2025).
- The questionnaire was evaluated by experts with relevant expertise and configured to mandate answers for all relevant questions, ensuring there was no missing data at the item level.

Study Measures

- Data on physician demographics were collected.
- Physicians reported preferences for routes of administration between SC and IV.
- Physicians ranked long-term treatment goals and factors influencing the first-line use and dosing of guselkumab on a 5-point Likert-type scale.

Eligibility Criteria

- Certified physician with Gastroenterology as the primary specialty
- Practice located in China, Japan, or Germany
- Have prescribed any advanced therapy to ≥1 patient with moderate-to-severe active UC or CD in the past 12 months

Statistical analysis:

- Continuous measures were summarized as means and standard deviations (SDs), and categorical measures as counts and proportions.

Results

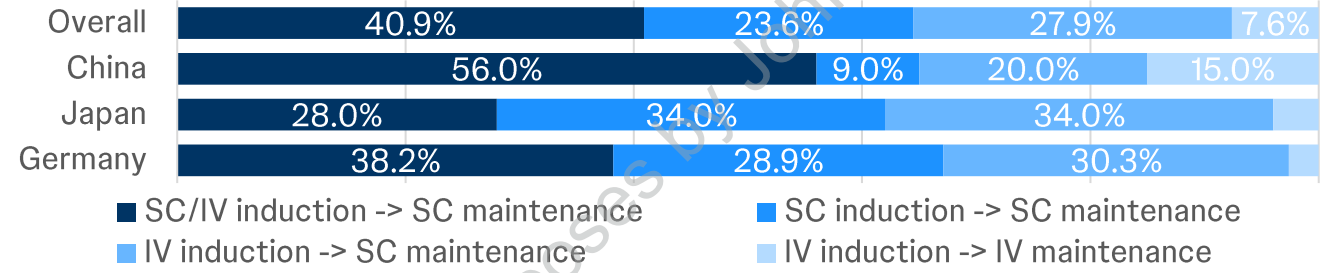
The survey included 276 physicians (overall mean age 46.7 years; 69.2% male; >80% with ≥10 years of practice; Table 1).

Table 1. Characteristics of participating physicians

	Overall N = 276	China N = 100	Japan N = 100	Germany N = 76
Age (years)	46.7 (9.7)	40.5 (6.8)	48.2 (9.8)	52.9 (8.1)
Male	191 (69.2%)	33 (33.0%)	93 (93.0%)	65 (85.5%)
Years practicing medicine				
5-9 years	34 (12.3%)	24 (24.0%)	8 (8.0%)	2 (2.6%)
10-19 years	112 (40.6%)	52 (52.0%)	33 (33.0%)	27 (35.5%)
≥ 20 years	130 (47.1%)	24 (24.0%)	59 (59.0%)	47 (61.8%)
Number of moderate-to-severe UC patients				
Treated in the past 12 mons	45.7 (67.8)	35.5 (66.8)	19.9 (33.4)	92.3 (78.9)
Prescribed ≥1 ADT in the past 12 mons	29.9 (50.4)	26.4 (53.8)	12.4 (17.9)	58.1 (61.7)
Number of moderate-to-severe CD patients				
Treated in the past 12 mons	41.7 (85.2)	39.4 (115.1)	9.8 (16.2)	87.4 (72.9)
Prescribed ≥1 ADT in the past 12 mons	29.8 (73.9)	34.5 (111.1)	8.3 (12.8)	52.5 (48.9)

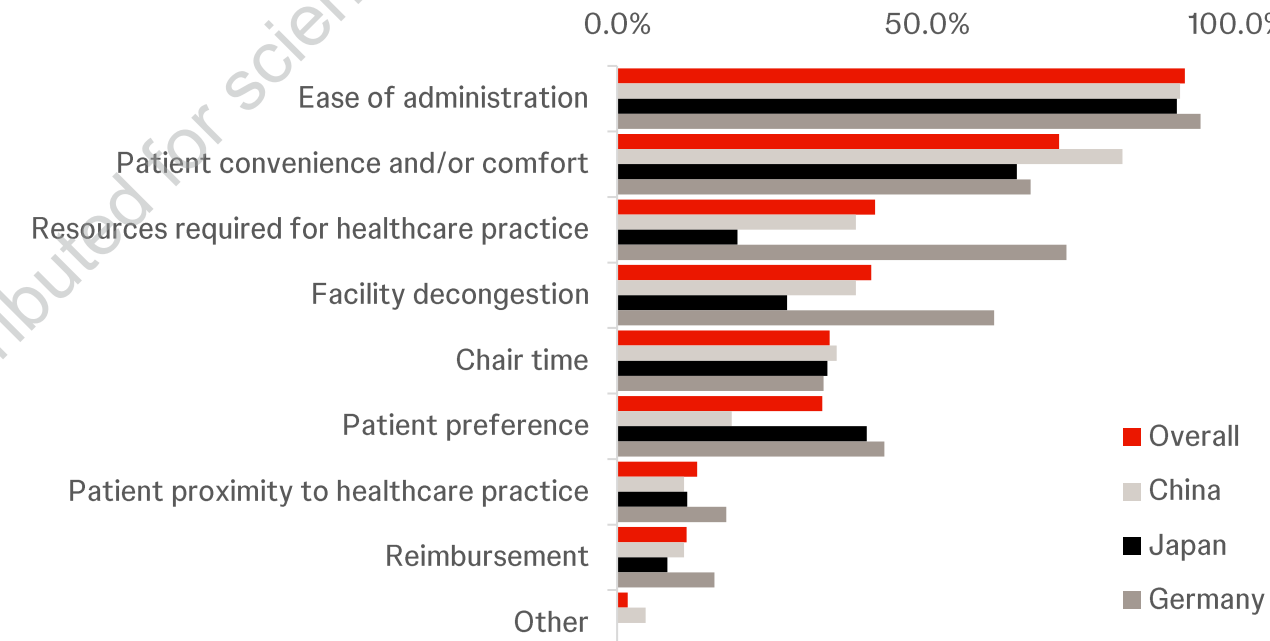
Across countries, 64.5% of physicians preferred biologics incorporating SC induction (Figure 1).

Figure 1. Physician preferences on route of administration for biologic therapy



Physicians cited ease of administration, patient convenience and/or comfort, and resources required for healthcare practice as the top reasons for preferring SC or flexible SC over IV induction (Figure 2).

Figure 2. Physician-reported reasons for preference of SC induction



Key Takeaways

Physicians in China, Japan, and Germany shared common treatment priorities for moderate-to-severe IBD, including preference for SC administration, focus on clinical and endoscopic improvements, and targeted use of guselkumab in patients with high inflammatory burden or severe disease activity.

These descriptive, perception-based findings highlight the clinical value of flexible routes of administration and provide real-world context on physician priorities during early adoption of advanced therapies.

Clinical remission, clinical response, and PRO remission were consistently ranked as the most important long-term treatment goals, with endoscopic response and remission also highly prioritized (Figure 3).

Figure 3. Physicians’ ranking of long-term treatment goals for moderate-to-severe UC and CD

A. UC	Overall	China	Japan	Germany	B. CD	Overall	China	Japan	Germany
Clinical remission	4.5	4.6	4.6	4.4	Clinical remission	4.5	4.6	4.5	4.4
Remission in PROs	4.4	4.4	4.4	4.2	Remission in PROs	4.4	4.3	4.4	4.4
Clinical response	4.4	4.6	4.5	4.1	Clinical response	4.4	4.5	4.4	4.2
Endoscopic response	4.3	4.6	4.3	3.8	Prevention of complications	4.3	4.4	4.4	4.1
Endoscopic remission	4.3	4.6	4.3	3.9	Endoscopic response	4.3	4.6	4.3	3.9
Transmural healing	4.2	4.4	3.8	3.6	Endoscopic remission	4.3	4.5	4.2	4.1
Corticosteroid-free remission	4.2	4.3	4.1	4.2	Corticosteroid-free remission	4.2	4.3	4.0	4.4
Histological healing	4.2	4.5	4.0	4.0	Histological healing	4.1	4.4	3.9	4.0
Mucosal healing	4.2	n/a	4.3	4.1	Transmural healing	4.0	4.4	3.8	3.9
Normalization of fecal calprotectin	3.8	4.0	3.6	3.7	Normalization of CRP	3.8	3.9	3.8	3.5
Normalization of CRP	3.8	4.0	3.8	3.4	Normalization of fecal calprotectin	3.7	3.9	3.5	3.6
Normalization of LRG	3.5	n/a	3.5	n/a	Normalization of LRG	3.5	n/a	3.5	n/a

Participants were asked to rank the long-term treatment goals they would like to achieve from 1 (least important) to 5 (most important). The mean importance scores were displayed in the figure.

For both UC and CD, guselkumab was more likely to be considered by physicians as a first-line advanced therapy in patients with high inflammatory burden or severe disease activity (Figure 4), with higher maintenance dosing considered for severe disease or inadequate post-induction response (Figure 5).

Figure 4. Physicians’ ranking of patient profiles preferred for guselkumab as a first-line therapy

A. UC	Overall	China	Japan	Germany	B. CD	Overall	China	Japan	Germany
High inflammatory burden	1.0	1.4	0.6	1.1	High inflammatory burden	1.1	1.2	0.9	1.2
Pancolitis	1.0	1.3	0.6	1.1	Presence of severe symptoms	1.0	1.2	0.6	1.2
Presence of severe symptoms	0.9	1.3	0.2	1.2	Patients <40 years	0.8	0.9	0.7	0.9
Patients with comorbidities	0.7	1.4	0.2	0.3	Presence of small bowel lesions	0.7	1.0	0.5	0.6
Patients <40 years	0.7	0.9	0.6	0.7	Patients with comorbidities	0.6	1.1	0.2	0.3
Presence of extraintestinal manifestations	0.6	1.3	0.2	0.4	Presence of extraintestinal manifestations	0.6	1.1	0.3	0.4
Patients ≥65 years	0.2	0.5	0.2	0.1	Presence of stenosis	0.6	0.9	0.5	0.4
					Presence of perianal fistula	0.5	0.9	0.4	0.0
					Patients ≥65 years	0.2	0.2	0.2	0.0
					Active smoker	-0.1	0.2	-0.4	-0.1

Figure 5. Physicians’ ranking of factors preferring 200mg every 4 weeks over 100mg every 8 weeks as maintenance

A. UC	Overall	China	Japan	Germany	B. CD	Overall	China	Japan	Germany
Severe disease activity	1.2	1.4	0.8	1.3	Inflammatory burden	1.2	1.3	0.9	1.4
No sufficient improvements 8 wks post-induction	1.2	1.3	1.1	1.0	Severe disease activity	1.1	1.4	0.9	1.2
Inflammatory burden	1.1	1.4	0.6	1.3	No sufficient improvements 8 wks post-induction	1.1	1.2	1.1	1.1
High-risk factors	1.1	1.4	0.7	1.4	History of advanced treatment	0.9	1.3	0.6	0.8
History of advanced treatment	0.9	1.3	0.8	0.5	Presence of stenosis	0.7	1.1	0.6	0.3
Steroid dependency	0.7	1.0	0.6	0.6	Presence of small bowel lesions	0.7	1.1	0.5	0.6
Presence of extraintestinal manifestations	0.6	1.1	0.3	0.3	Steroid dependency	0.7	0.9	0.6	0.8
Duration of disease ≥2 years	0.5	1.1	0.2	0.1	Presence of extraintestinal manifestations	0.6	1.1	0.4	0.2
Immuno-suppressant use	0.5	0.9	0.2	0.4	Presence of perianal fistula	0.6	1.0	0.4	0.1
At risk of opportunistic infections	0.0	0.7	-0.3	-0.4	Duration of disease ≥2 years	0.6	1.1	0.2	0.4
					Immuno-suppressant use	0.5	0.9	0.1	0.5
					Active smoker	-0.1	0.4	-0.4	-0.4

In Figures 4 and 5, scores reflect the degree of influence each factor has on physicians’ decisions, using a scale from +2 (most likely) to -2 (least likely). Higher scores indicate a greater likelihood of the factor positively impacting treatment choice. Figure showed the mean scores.