

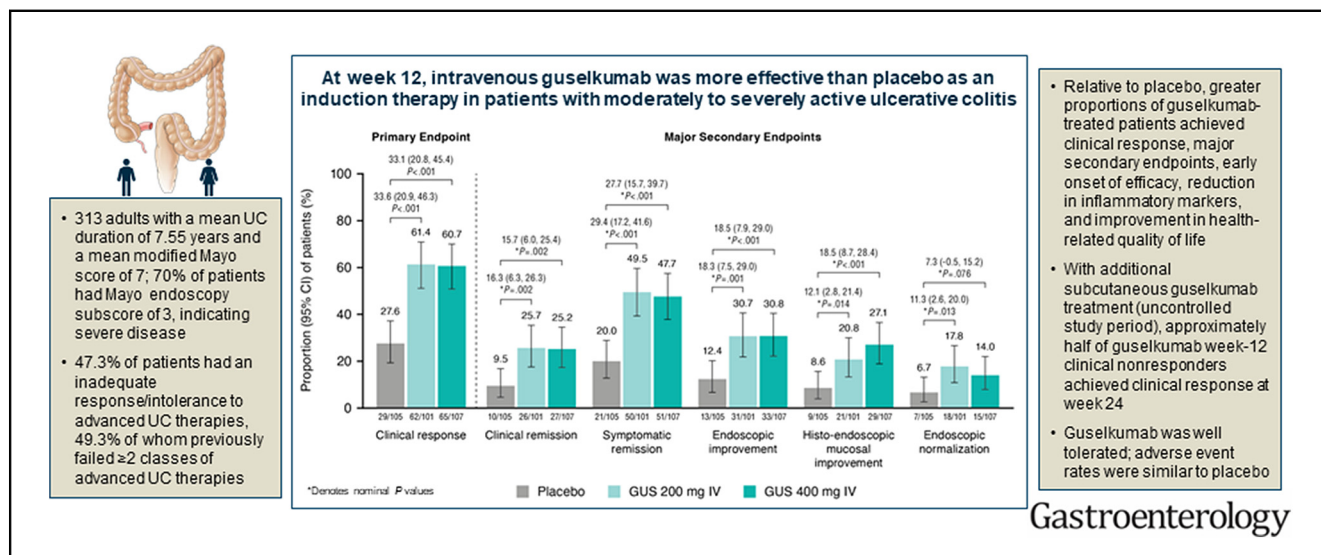
INFLAMMATORY BOWEL DISEASE

Guselkumab in Patients With Moderately to Severely Active Ulcerative Colitis: QUASAR Phase 2b Induction Study



Laurent Peyrin-Biroulet,^{1,2,3,4,5,6} Jessica R. Allegretti,⁷ David T. Rubin,⁸ Brian Bressler,⁹ Matthew Germinaro,¹⁰ Kuan-Hsiang (Gary) Huang,¹⁰ Nicole Shipitofsky,¹⁰ Hongyan Zhang,¹⁰ Rebecca Wilson,¹⁰ Chenglong Han,¹⁰ Brian G. Feagan,¹¹ William J. Sandborn,¹² Julian Panés,¹³ Tadakazu Hisamatsu,¹⁴ Gary R. Lichtenstein,¹⁵ Bruce E. Sands,¹⁶ and Axel Dignass,¹⁷ on behalf of the QUASAR Study Group

¹Department of Gastroenterology, Nancy University Hospital, F-54500 Vandœuvre-lès-Nancy, France; ²INSERM, NGERE, University of Lorraine, F-54000 Nancy, France; ³INFINY Institute, Nancy University Hospital, F-54500 Vandœuvre-lès-Nancy, France; ⁴FHU-CURE, Nancy University Hospital, F-54500 Vandœuvre-lès-Nancy, France; ⁵Groupe Hospitalier privé Ambroise Paré-Hartmann, Paris IBD Center, 92200 Neuilly sur Seine, France; ⁶Division of Gastroenterology and Hepatology, McGill University Health Centre, Montreal, Quebec, Canada; ⁷Division of Gastroenterology, Hepatology and Endoscopy, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts; ⁸University of Chicago Medicine Inflammatory Bowel Disease Center, Chicago, Illinois; ⁹University of British Columbia, Vancouver, British Columbia, Canada; ¹⁰Janssen Research & Development, LLC, Spring House, Pennsylvania; ¹¹Western University, London, Ontario, Canada; ¹²University of California San Diego, La Jolla, California; ¹³Hospital Clínic de Barcelona, IDIBAPS, CIBERehd, Barcelona, Spain; ¹⁴Kyorin University, Tokyo, Japan; ¹⁵University of Pennsylvania Health System, The Raymond and Ruth Perelman School of Medicine of the University of Pennsylvania, Gastroenterology Division, Philadelphia, Pennsylvania; ¹⁶Dr. Henry D. Janowitz Division of Gastroenterology, Icahn School of Medicine at Mount Sinai, New York, New York; and ¹⁷Department of Medicine I, Agaplesion Markus Hospital, Goethe University, Frankfurt, Germany



BACKGROUND & AIMS: The QUASAR Phase 2b Induction Study evaluated the efficacy and safety of guselkumab, an interleukin-23p19 subunit antagonist, in patients with moderately to severely active ulcerative colitis (UC) with prior inadequate response and/or intolerance to corticosteroids, immunosuppressants, and/or advanced therapy. **METHODS:** In this double-blind, placebo-controlled, dose-ranging, induction study, patients were randomized (1:1:1) to receive intravenous guselkumab 200 or 400 mg or placebo at weeks 0/4/8. The primary endpoint was clinical response (compared with baseline, modified Mayo score decrease $\geq 30\%$ and ≥ 2 points, rectal bleeding subscore ≥ 1 -point decrease or subscore of 0/1) at week 12. Guselkumab and placebo week-12 clinical nonresponders received subcutaneous or intravenous guselkumab

200 mg, respectively, at weeks 12/16/20 (uncontrolled study period). **RESULTS:** The primary analysis population included patients with baseline modified Mayo scores ≥ 5 and ≤ 9 (intravenous guselkumab 200 mg, $n = 101$; 400 mg, $n = 107$; placebo, $n = 105$). Week-12 clinical response percentage was greater with guselkumab 200 mg (61.4%) and 400 mg (60.7%) vs placebo (27.6%; both $P < .001$). Greater proportions of guselkumab-treated vs placebo-treated patients achieved all major secondary endpoints (clinical remission, symptomatic remission, endoscopic improvement, histo-endoscopic mucosal improvement, and endoscopic normalization) at week 12. Among guselkumab week-12 clinical nonresponders, 54.3% and 50.0% of patients in the 200- and 400-mg groups, respectively, achieved clinical response at week 24. Safety was similar among guselkumab and

placebo groups. **CONCLUSIONS:** Guselkumab intravenous induction was effective vs placebo in patients with moderately to severely active UC. Guselkumab was safe, and efficacy and safety were similar between guselkumab dose groups. [ClinicalTrials.gov](https://clinicaltrials.gov/ct2/show/study/NCT04033445) number: NCT04033445.

Keywords: Advanced Therapy; Interleukin-23p19 Subunit Antagonist; QUASAR; Ulcerative Colitis.

Ulcerative colitis (UC) is a chronic and disabling inflammatory bowel disease (IBD).¹⁻³ Advanced therapies approved for the treatment of UC include tumor necrosis factor (TNF)- α antagonists, the interleukin (IL)-12/23 antagonist ustekinumab, the $\alpha 4\beta 7$ integrin antagonist vedolizumab, Janus kinase (JAK) inhibitors, and the sphingosine 1-phosphate receptor modulator ozanimod.⁴⁻¹¹ Despite the availability of these therapies, many patients fail to respond to treatment or lose their initial response over time.¹²⁻¹⁵ Therefore, there is an important unmet need for more effective therapies for UC, especially over the long term.

IL-23 blockade has been shown to be effective in moderately to severely active UC¹⁶⁻¹⁸ and Crohn's disease.¹⁹⁻²¹ Guselkumab, a fully human immunoglobulin G1 lambda (IgG1 λ) monoclonal antibody, binds with high affinity and specificity to the p19 subunit of human IL-23, blocking the binding of extracellular IL-23 to the cell surface IL-23 receptor and inhibiting IL-23-specific intracellular signaling and subsequent activation of cytokine production.²² Guselkumab is approved in several countries for the treatment of other inflammatory diseases including moderate-to-severe plaque psoriasis and active psoriatic arthritis.^{22,23} In a recent Phase 2, double-blind, placebo-controlled study in patients with moderately to severely active Crohn's disease with prior inadequate response and/or intolerance to corticosteroids, immunosuppressants, or biologic therapy, guselkumab induced greater clinical and endoscopic improvements at week 12 compared with placebo and had a favorable safety profile.²¹

In a Phase 2b/3 clinical development program for guselkumab in UC (NCT04033445), the efficacy and safety of guselkumab compared with placebo is being evaluated in patients with moderately to severely active UC in 3 separate studies under a single protocol called QUASAR. Here, we report the efficacy and safety results of guselkumab as induction therapy in the QUASAR Phase 2b Induction Study.

Materials and Methods

The QUASAR protocol includes a Phase 2b dose-ranging induction study (QUASAR Phase 2b Induction Study), a Phase 3 induction study (QUASAR Phase 3 Induction Study), and a Phase 3 randomized withdrawal maintenance study (QUASAR Maintenance Study). The QUASAR Phase 2b Induction Study was a randomized, double-blind, placebo-controlled, dose-ranging clinical study conducted between September 2019 and February 2022, with participants randomized in 141 centers across 27 countries/territories. The primary objective of the study was to evaluate the efficacy and safety of guselkumab

WHAT YOU NEED TO KNOW

BACKGROUND AND CONTEXT

Interleukin-23 plays a crucial role in the pathogenesis of inflammatory bowel disease. Efficacy and safety of the interleukin-23p19 subunit inhibitor guselkumab were evaluated in patients with moderately to severely active ulcerative colitis.

NEW FINDINGS

At week 12, clinical response was significantly greater with intravenous guselkumab induction vs placebo. Efficacy and safety were similar between dose groups. Additional subcutaneous treatment in the uncontrolled study period provided benefit to clinical nonresponders.

LIMITATIONS

Not all major secondary endpoints were sufficiently powered to detect differences between guselkumab and placebo.

CLINICAL RESEARCH RELEVANCE

These results, in addition to the established efficacy and safety of guselkumab in approved indications and clinical proof-of-concept in Crohn's disease, suggest that guselkumab is a promising therapy for ulcerative colitis.

BASIC RESEARCH RELEVANCE

Guselkumab efficacy in patients with ulcerative colitis confirms that interleukin-23-specific intracellular signaling has an important role in the pathogenesis of inflammatory bowel disease.

in patients with moderately to severely active UC. Guselkumab dose response was also evaluated to inform induction dose selection for the QUASAR Phase 3 Induction Study.

Study Population

Eligible patients were aged ≥ 18 years and had confirmed diagnosis of moderately to severely active UC for ≥ 3 months before screening. The primary analysis population for this study consisted of randomized and treated patients with a modified Mayo score of ≥ 5 and ≤ 9 at induction baseline (week 0). Although the protocol allowed enrollment of patients who had a modified Mayo score of 4, which was limited to $\leq 5\%$ of the total enrolled population, patients with a modified Mayo score of 4 were excluded from the primary analysis population. The modified Mayo score (range 0-9) is calculated as the sum of stool frequency, rectal bleeding, and endoscopy subscores.²⁴

Abbreviations used in this paper: AE, adverse event; COVID-19, coronavirus disease 2019; CRP, C-reactive protein; HRQoL, health-related quality of life; IBD, inflammatory bowel disease; IBDQ, Inflammatory Bowel Disease Questionnaire; IL, interleukin; IV, intravenous; JAK, Janus kinase; PROMIS-Fatigue SF-7a, Patient-Reported Outcomes Measurement Information System-Fatigue Short Form 7a; SC, subcutaneous; TNF- α , tumor necrosis factor alpha; UC, ulcerative colitis.

Most current article

© 2023 The Author(s). Published by Elsevier Inc. on behalf of the AGA Institute. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

0016-5085

<https://doi.org/10.1053/j.gastro.2023.08.038>

At baseline, patients were also required to have a Mayo rectal bleeding subscore ≥ 1 and a Mayo endoscopy subscore ≥ 2 obtained during central review of the screening endoscopy video.

Patients were also required to have had an inadequate response and/or intolerance to corticosteroids, immunosuppressants, and/or advanced therapy. This could include a history of inadequate response, loss of response, or intolerance to oral corticosteroids (including budesonide and beclomethasone dipropionate) or immunosuppressants (6-mercaptopurine or azathioprine), and a history of corticosteroid dependence (ie, an inability to successfully taper corticosteroids without a return of UC symptoms). Inadequate response and/or intolerance to advanced therapy could include a primary nonresponse (ie, no initial response), secondary nonresponse (ie, responded initially with subsequent loss of response), or intolerance to ≥ 1 TNF- α antagonist, integrin-receptor antagonist (vedolizumab), and/or JAK inhibitor (tofacitinib) at a dosage approved for the treatment of UC.

Previous use of IL-12 and/or IL-23 inhibitors was prohibited. Patients were also required to discontinue the following medications before receiving the first dose of study treatment: TNF- α antagonists for ≥ 8 weeks; integrin-receptor antagonist vedolizumab for ≥ 12 weeks; and JAK inhibitors for ≥ 2 weeks or 5 half-lives, whichever was longer. The use of immunosuppressants (except 6-mercaptopurine, azathioprine, or methotrexate), biologics, investigational IBD medications, and thalidomide or related agents was prohibited. Patients could receive concomitant immunosuppressants (6-mercaptopurine, azathioprine, or methotrexate if taking for ≥ 12 weeks) but must have been at a stable dose for ≥ 4 weeks before screening and had to maintain a stable dose through the end of induction. Patients could receive oral 5-aminosalicylic acid but must have been at a stable dose for ≥ 2 weeks before screening and had to maintain a stable dose through the end of induction. Patients could receive oral corticosteroids (≤ 20 mg/d prednisone or equivalent) but must have been at a stable dose for ≥ 2 weeks before screening and had to maintain a stable dose through the end of induction. These concomitant medications could only be reduced in dose or discontinued if required because of toxicity or medical necessity per investigator judgment.

Other key exclusion criteria were a diagnosis of Crohn's disease, UC limited to the rectum only or to < 20 cm of the colon, imminent colectomy, gastrointestinal surgical interventions within 2 months before screening, history of extensive colonic resection, presence of stoma, and presence or history of fistula.

Study Design

Patients were randomly assigned (1:1:1) to receive intravenous (IV) guselkumab 200 mg or 400 mg or placebo IV at weeks 0, 4, and 8 as induction therapy (Supplementary Figure 1). An Interactive Web Response System was used for permuted block randomization stratified by advanced therapy failure status (ie, inadequate response/intolerance to advanced therapy [Yes/No]), region (Eastern Europe, Asia, or rest of the world), and concomitant use of corticosteroids at baseline (Yes/No). The study investigators, site personnel, central laboratory, central readers, and patients were blinded to patient treatment assignment throughout the study.

At week 12, patients were evaluated for clinical response, defined as a decrease in the modified Mayo score from baseline of $\geq 30\%$ 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 (see Supplement). Clinical response status (using Interactive Web Response System data) determined subsequent study intervention (Supplementary Figure 1). Patients who achieved clinical response to IV guselkumab or placebo at week 12 entered the QUASAR Maintenance Study and were not included in evaluations beyond week 12 for this induction study.

Patients initially randomized to IV guselkumab who did not achieve clinical response at week 12 received guselkumab 200 mg subcutaneously (SC) at weeks 12, 16, and 20. Patients initially randomized to placebo who did not achieve clinical response at week 12 crossed over to receive guselkumab induction (200 mg IV) at weeks 12, 16, and 20. This part of the study was uncontrolled. Matching IV or SC placebo was administered to all week-12 nonresponders to maintain blinding. Patients who achieved clinical response at week 24 entered the QUASAR Maintenance Study. Patients who were not in clinical response at week 24 did not receive further study treatment and had a safety follow-up visit approximately 12 weeks after receiving their last dose of guselkumab.

The protocol was approved by the Sterling institutional review board for US sites (approval number: 7439) and local ethics committees at each participating center for all other sites. All participants provided written informed consent. The study was conducted in compliance with the Declaration of Helsinki and International Council for Harmonisation Good Clinical Practice guidelines. All authors had access to data summaries and reviewed and approved the final manuscript.

Assessments

The primary efficacy endpoint was clinical response at week 12. The major secondary endpoints were clinical remission (a Mayo stool frequency subscore of 0 or 1 and not increased from induction baseline, a Mayo rectal bleeding subscore of 0, and a Mayo endoscopy subscore of 0 or 1 with no friability present on the endoscopy); symptomatic remission (a Mayo stool frequency subscore of 0 or 1 and not increased from induction baseline and a Mayo rectal bleeding subscore of 0); endoscopic improvement (a Mayo endoscopy subscore of 0 or 1 with no friability present on the endoscopy); histo-endoscopic mucosal improvement, a combined endpoint of endoscopic improvement and histologic improvement (neutrophil infiltration in $< 5\%$ of crypts, no crypt destruction, and no erosions, ulcerations, or granulation tissue according to the Geboes grading system, ie, Geboes score ≤ 3.1);²⁵ and endoscopic normalization (a Mayo endoscopy subscore of 0) at week 12. Clinical response at week 12 was selected as the primary endpoint because it provides more statistical power to detect a treatment difference at the planned sample size for interim analysis (ie, first 150 randomized patients) than the primary endpoint for the QUASAR Phase 3 Induction Study (clinical remission at week 12).

Additional prespecified endpoints included change from baseline in partial Mayo score (range 0–9; calculated as the sum of stool frequency, rectal bleeding, and physician's global assessment subscores) through week 12; achievement of a

stool frequency subscore of 0 or 1 or a rectal bleeding subscore of 0 through week 12; median serum concentrations of C-reactive protein (CRP) and fecal calprotectin through week 12; change from baseline in Inflammatory Bowel Disease Questionnaire (IBDQ) total score and Patient-Reported Outcomes Measurement Information System-Fatigue Short Form 7a (PROMIS-Fatigue SF-7a) score at week 12; and achievement of IBDQ remission (total IBDQ score ≥ 170), clinically meaningful improvement in total IBDQ score (≥ 16 -point improvement from baseline),²⁶ >20 -point improvement in total IBDQ score,²⁷ or fatigue response (≥ 7 -point reduction from baseline in PROMIS-Fatigue SF-7a score) at week 12. Symptomatic response (decrease from induction baseline in Mayo symptomatic score [sum of the stool frequency and the rectal bleeding subscores] by $\geq 30\%$ and ≥ 1 point, with either a ≥ 1 -point decrease from baseline in the rectal bleeding subscore or a subscore of 0/1) through week 12 was evaluated post hoc.

Adverse events (AEs), serious AEs, and signs or symptoms of infections were assessed throughout the study. Safety was also evaluated based on clinical laboratory tests, including hematology, blood chemistry, and serology. In addition, the presence of antibodies to guselkumab in serum was determined using a validated, sensitive, and drug-tolerant electrochemiluminescence method using the Meso Scale Discovery platform (Rockville, MD).²²

Statistical Analysis

The primary efficacy population was based on a modified intention-to-treat principle and included all randomized and treated patients with a baseline modified Mayo score of ≥ 5 and ≤ 9 who received ≥ 1 dose of study treatment analyzed according to the assigned treatment.

A step-up Hochberg multiple testing procedure was used to control the type-I error at a 2-sided .05 significance level over the 2 comparisons of guselkumab to placebo for the primary endpoint. The major secondary endpoints were tested at the 2-sided .05 significance level regardless of the significance of the primary endpoint and were not adjusted for multiplicity; thus, all *P* values except those for the primary endpoint are nominal.

Dichotomous endpoints were compared between each guselkumab group and placebo with the use of Cochran-Mantel-Haenszel chi-square test (2-sided) stratified by advanced therapy failure status (Yes/No) and concomitant use of corticosteroids at baseline (Yes/No). The adjusted treatment difference and confidence intervals were based on the Wald statistic with Cochran-Mantel-Haenszel weight. Continuous endpoints were analyzed using a mixed-effect model for repeated measures or analysis of covariance with adjustment for baseline value, treatment group, advanced therapy failure status, and concomitant use of corticosteroids at baseline.

To evaluate the consistency of the treatment effect for the primary endpoint, clinical response was analyzed in prespecified subgroups. Clinical response, clinical remission, symptomatic remission, endoscopic improvement, histo-endoscopic mucosal improvement, and endoscopic normalization at week 12 were prespecified to be analyzed based on history of inadequate response/intolerance to advanced therapy status subgroups.

Patients who had a prohibited change in UC medication, had an ostomy or colectomy, or discontinued study treatment because of lack of efficacy or an AE of worsening of UC before an analysis time point were considered not to have achieved

the dichotomous endpoints and had their baseline value carried forward from the time of the event onward for the continuous endpoints (ie, consistent with nonresponder imputation for dichotomous endpoints). Data after discontinuation of study treatment due to coronavirus disease 2019 (COVID)-19-related reasons (excluding COVID-19 infection) were considered to be missing. Patients missing 1 or more modified Mayo subscore (stool frequency, rectal bleeding, or endoscopy) or other component pertaining to an endpoint at week 12 were considered not to have achieved the endpoint.

The minimum sample size for this study was 150 patients required for an interim analysis based on statistical power considerations. The assumptions for sample size were based on data from a Phase 3 ustekinumab induction study²⁸ and a Phase 2 mirikizumab study²⁹ in patients with moderately to severely active UC. Based on these studies, the clinical response rates in this study were assumed to be 30% for placebo and 60% for each guselkumab dose. With these assumed rates, 150 patients for the interim analysis would be sufficient to provide $\geq 80\%$ statistical power to detect a treatment difference in the primary endpoint of clinical response at week 12 between guselkumab and placebo at a .05 significance level. The study was not powered to detect treatment differences between guselkumab and placebo for the major secondary endpoints. While interim data were being analyzed, enrollment into this study was allowed to continue.

The primary safety population included all randomized and treated patients with a baseline modified Mayo score of ≥ 5 and ≤ 9 (excluding patients with a modified Mayo score of 4) who received ≥ 1 dose of study treatment, analyzed according to the treatment they actually received. The frequency and types of AEs were summarized. Selected safety analyses were also provided for all treated patients, regardless of baseline modified Mayo score.

Immunogenicity analyses included all guselkumab-treated patients with a modified Mayo score of ≥ 5 and ≤ 9 at baseline who had ≥ 1 blood sample obtained after their first guselkumab dose.

Results

Patient Disposition and Baseline Demographics

A total of 313 patients were included in the primary analysis (placebo, *N* = 105; guselkumab 200 mg IV, *N* = 101; guselkumab 400 mg IV, *N* = 107) (Figure 1). Only 1 patient withdrew from the study for COVID-19-related reasons.

Baseline demographic and disease characteristics were similar among treatment groups and indicative of patients with moderately to severely active UC (Table 1). Overall, 40.9% of patients were female and had a mean age of 41.6 years, mean UC duration of 7.6 years, a mean Mayo score of 9.2, and a mean modified Mayo score of 7.0. Seventy percent of patients had a Mayo endoscopy subscore of 3, indicating severe disease. Of the 313 patients assessed, 125 (39.9%) were using oral corticosteroids at baseline and 148 (47.3%) had prior inadequate response/intolerance to advanced therapy for UC.

Efficacy

Primary and major secondary efficacy endpoints at week 12. At week 12, significantly greater proportions

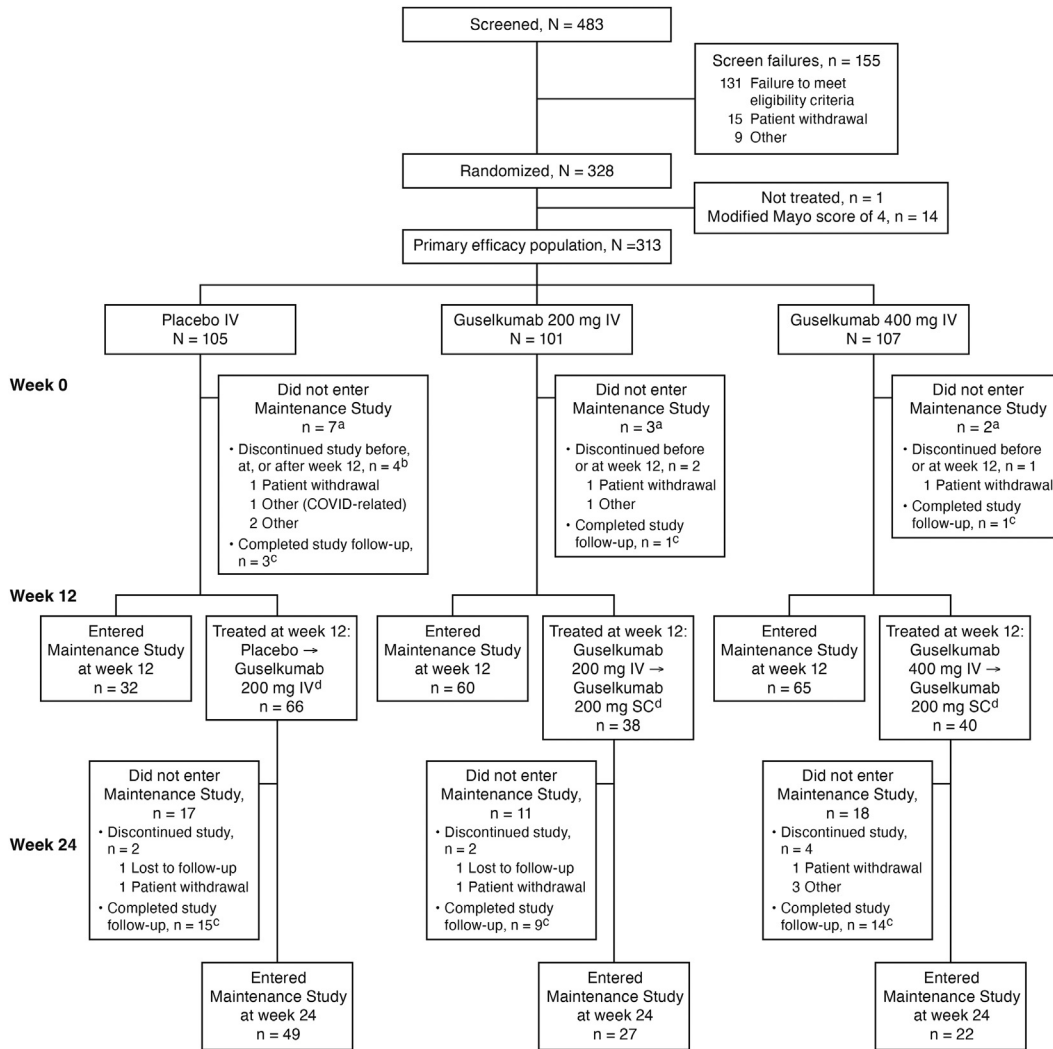


Figure 1. Patient disposition. ^aAmong patients treated at week 0 who did not receive additional treatment at week 12. ^bTwo patients discontinued after week 12. ^cPatients who discontinued the study treatment but returned for their safety follow-up visit were considered to have completed study participation. ^dPatients who were not in clinical response at week 12 as determined using Interactive Web Response System data and received treatment at week 12. COVID, coronavirus; IV, intravenous; N, total population; n, subset; SC, subcutaneous.

of patients in the guselkumab 200 mg (61.4% [62/101]; adjusted treatment difference 33.6 [20.9, 46.3], $P < .001$) and 400 mg (60.7% [65/107]; adjusted treatment difference 33.1 [20.8, 45.4], $P < .001$) groups achieved the primary endpoint of clinical response compared with the placebo group (27.6% [29/105]) (Figure 2). Similarly, greater proportions of guselkumab-treated patients than placebo-treated patients achieved the major secondary endpoints at week 12 (clinical remission, symptomatic remission, endoscopic improvement, histo-endoscopic mucosal improvement, and endoscopic normalization) (Figure 2). No apparent guselkumab dose response was observed for any of these endpoints.

Among the 148 patients with a history of inadequate response/intolerance to prior advanced therapy, 75 (50.7%) had prior inadequate response/intolerance to only 1 advanced therapy class, 73 (49.3%) to ≥ 2 advanced therapy classes, 133 (89.9%) to ≥ 1 TNF- α antagonist, 78 (52.7%) to vedolizumab, and 31 (20.9%) to tofacitinib

(Table 1). Among the 165 patients without a history of inadequate response/intolerance to advanced therapy, 154 (93.3%) were advanced therapy naïve and 11 (6.7%) were advanced therapy experienced. In both subgroups of patients without (Supplementary Figure 2A) or with (Supplementary Figure 2B) a history of inadequate response/intolerance to advanced UC therapy, greater proportions of guselkumab-treated than placebo-treated patients achieved the clinical endpoints at week 12. Within these subgroups, achievement of the clinical endpoints at week 12 was similar between the guselkumab 200-mg and 400-mg treatment groups.

Efficacy through week 12. Efficacy was observed at the earliest time points assessed. Starting at week 2, greater proportions of guselkumab-treated vs placebo-treated patients achieved symptomatic response (Figure 3A). At week 12, 65.3%, 66.4%, and 37.1% of patients in the guselkumab 200-mg and 400-mg and placebo groups, respectively, achieved symptomatic response (both nominal $P < .001$).

Table 1. Patient Demographics and Baseline UC Disease Characteristics (Primary Efficacy Population)

	Guselkumab			Total (N = 313)
	Placebo (N = 105)	200 mg IV (N = 101)	400 mg IV (N = 107)	
Age, y, mean (SD)	41.2 (15.05)	43.3 (14.28)	40.4 (13.84)	41.6 (14.40)
Female, n (%)	39 (37.1)	41 (40.6)	48 (44.9)	128 (40.9)
Race, n (%)				
Asian	24 (22.9)	23 (22.8)	27 (25.2)	74 (23.6)
Black or African American	1 (1.0)	1 (1.0)	1 (0.9)	3 (1.0)
White	77 (73.3)	73 (72.3)	74 (69.2)	224 (71.6)
Not reported/multiple	3 (2.9)	4 (4.0)	5 (4.7)	12 (3.8)
Weight, kg, mean (SD)	68.8 (16.30)	70.3 (16.50)	71.7 (18.58)	70.3 (17.16)
Disease duration, y, mean (SD)	7.7 (7.16)	7.0 (6.00)	7.9 (7.15)	7.6 (6.79)
Extensive UC, n (%)	46 (43.8)	48 (47.5)	59 (55.1)	153 (48.9)
Mayo score, mean (SD)	9.0 (1.31)	9.2 (1.29)	9.3 (1.35)	9.2 (1.32)
Modified Mayo score, mean (SD)	6.9 (1.06)	7.0 (1.06)	7.0 (0.99)	7.0 (1.04)
Modified Mayo score 7–9 (severe), n (%)	69 (65.7)	71 (70.3)	78 (72.9)	218 (69.6)
Partial Mayo score, mean (SD)	6.3 (1.14)	6.6 (1.15)	6.5 (1.23)	6.5 (1.18)
Endoscopy subscore of 3 (severe), n (%)	75 (71.4)	66 (65.3)	78 (72.9)	219 (70.0)
Geboes total score, n	101	99	103	303
Mean (SD)	12.3 (5.35)	12.8 (4.64)	13.1 (4.50)	12.7 (4.84)
Geboes high activity subscore (0–10), ^a n	101	99	103	303
Mean (SD)	5.4 (3.29)	5.6 (2.99)	5.7 (2.96)	5.6 (3.08)
Extraintestinal manifestation present, ^b n (%)	13 (12.4)	15 (14.9)	22 (20.6)	50 (16.0)
CRP, n	105	99	104	308
Median (IQR), mg/L	4.9 (1.4; 10.8)	4.3 (1.6; 17.8)	4.4 (1.9; 8.8)	4.6 (1.6; 11.3)
Abnormal (>3 mg/L), n/n (%)	64/105 (61.0)	63/99 (63.6)	66/104 (63.5)	193/308 (62.7)
Fecal calprotectin, n	91	95	101	287
Median (IQR), mg/kg	1457.0 (749.0; 3054.0)	1667.0 (771.0; 2859.0)	1578.0 (811.0; 2860.0)	1564.0 (767.0; 2860.0)
Abnormal (>250 mg/kg), n/n (%)	81/91 (89.0)	85/95 (89.5)	91/101 (90.1)	257/287 (89.5)
Albumin, g/L, median (IQR)	43.0 (41.0; 46.0)	43.0 (40.0; 45.0)	43.0 (40.0; 46.0)	43.0 (41.0; 46.0)
IBDQ total score (32–224), n	101	99	104	304
Mean (SD)	124.8 (31.91)	125.5 (30.63)	124.2 (34.11)	124.8 (32.18)
PROMIS-Fatigue SF-7a, n	101	99	104	304
Mean (SD)	56.9 (9.7)	56.7 (8.9)	56.8 (8.2)	56.8 (8.9)
Receiving corticosteroids, immunosuppressants, or aminosalicylates for UC treatment at baseline, n (%)	95 (90.5)	92 (91.1)	96 (89.7)	283 (90.4)
Oral corticosteroids	40 (38.1)	41 (40.6)	44 (41.1)	125 (39.9)
Immunosuppressants	17 (16.2)	25 (24.8)	27 (25.2)	69 (22.0)
Oral aminosalicylates	79 (75.2)	74 (73.3)	89 (83.2)	242 (77.3)
No history of inadequate response/intolerance to advanced therapies, ^c n (%)	54 (51.4)	55 (54.5)	56 (52.3)	165 (52.7)
Advanced therapy naïve, n/n (%)	51/54 (94.4)	52/55 (94.5)	51/56 (91.1)	154/165 (93.3)
Advanced therapy experienced, n/n (%)	3/54 (5.6)	3/55 (5.5)	5/56 (8.9)	11/165 (6.7)

Table 1. Continued

	Guselkumab			
	Placebo (N = 105)	200 mg IV (N = 101)	400 mg IV (N = 107)	Total (N = 313)
History of inadequate response/intolerance to ≥ 1 UC advanced therapy, ^c n (%)	51 (48.6)	46 (45.5)	51 (47.7)	148 (47.3)
≥ 1 TNF- α antagonist, n/n (%)	46/51 (90.2)	41/46 (89.1)	46/51 (90.2)	133/148 (89.9)
Vedolizumab, n/n (%)	29/51 (56.9)	22/46 (47.8)	27/51 (52.9)	78/148 (52.7)
Tofacitinib, n/n (%)	15/51 (29.4)	10/46 (21.7)	6/51 (11.8)	31/148 (20.9)
1 advanced therapy class, n/n (%)	23/51 (45.1)	27/46 (58.7)	25/51 (49.0)	75/148 (50.7)
≥ 2 advanced therapy classes, n/n (%)	28/51 (54.9)	19/46 (41.3)	26/51 (51.0)	73/148 (49.3)

NOTE. Unless otherwise noted, the denominators used to calculate proportions of patients were those listed in the heading for each treatment group.

IQR, interquartile range; N, total population; n, subset; SD, standard deviation.

^aThe continuous histology score was derived as the sum of Geboes Grades 3, 4, and 5 that defined histologic improvement.

^bExtraintestinal manifestations assessed were arthritis/arthralgia, aphthous stomatitis, erythema nodosum, iritis/uveitis, primary sclerosing cholangitis, and pyoderma gangrenosum.

^cAdvanced therapy refers to TNF- α antagonists, vedolizumab, and/or tofacitinib.

The mean decrease from baseline in partial Mayo score was greater in the guselkumab groups vs the placebo group at week 4, the earliest time point assessed for this endpoint, and continued through week 12 (Figure 3B). At week 12, the mean decrease from baseline in partial Mayo score was 3.51 in the guselkumab 200-mg group and 3.44 in the 400-mg group compared with 1.40 in the placebo group (both nominal $P < .001$). In addition, greater proportions of

guselkumab-treated vs placebo-treated patients achieved a stool frequency subscore of 0 or 1 (Figure 3C) or a rectal bleeding subscore of 0 (Figure 3D) through week 12. At week 12, in the guselkumab 200-mg and 400-mg and placebo groups, respectively, 57.4%, 57.0%, and 27.6% (both nominal $P < .001$) achieved a stool frequency subscore of 0 or 1 and 67.3%, 56.1%, and 34.3% (nominal $P < .001$ and $P = .002$, respectively) achieved a rectal bleeding subscore of 0.

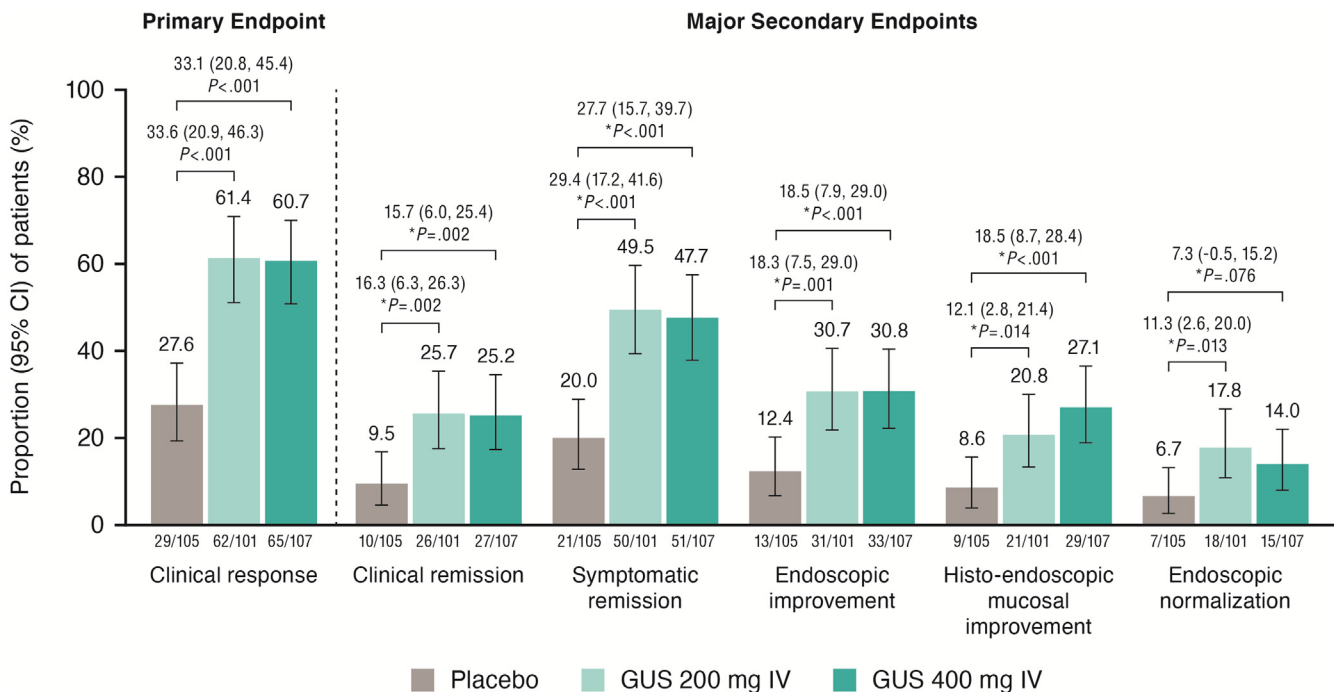


Figure 2. The primary endpoint of clinical response at week 12 and the major secondary endpoints of clinical remission, symptomatic remission, endoscopic improvement, histo-endoscopic mucosal improvement, and endoscopic normalization all at week 12 (P values for major secondary endpoints are nominal). *Denotes nominal P values. Primary efficacy population. All P values are based on the Cochran-Mantel-Haenszel chi-square test. The adjusted treatment difference and confidence intervals were based on the Wald statistic with Cochran-Mantel-Haenszel weight. CI, confidence interval; GUS, guselkumab.

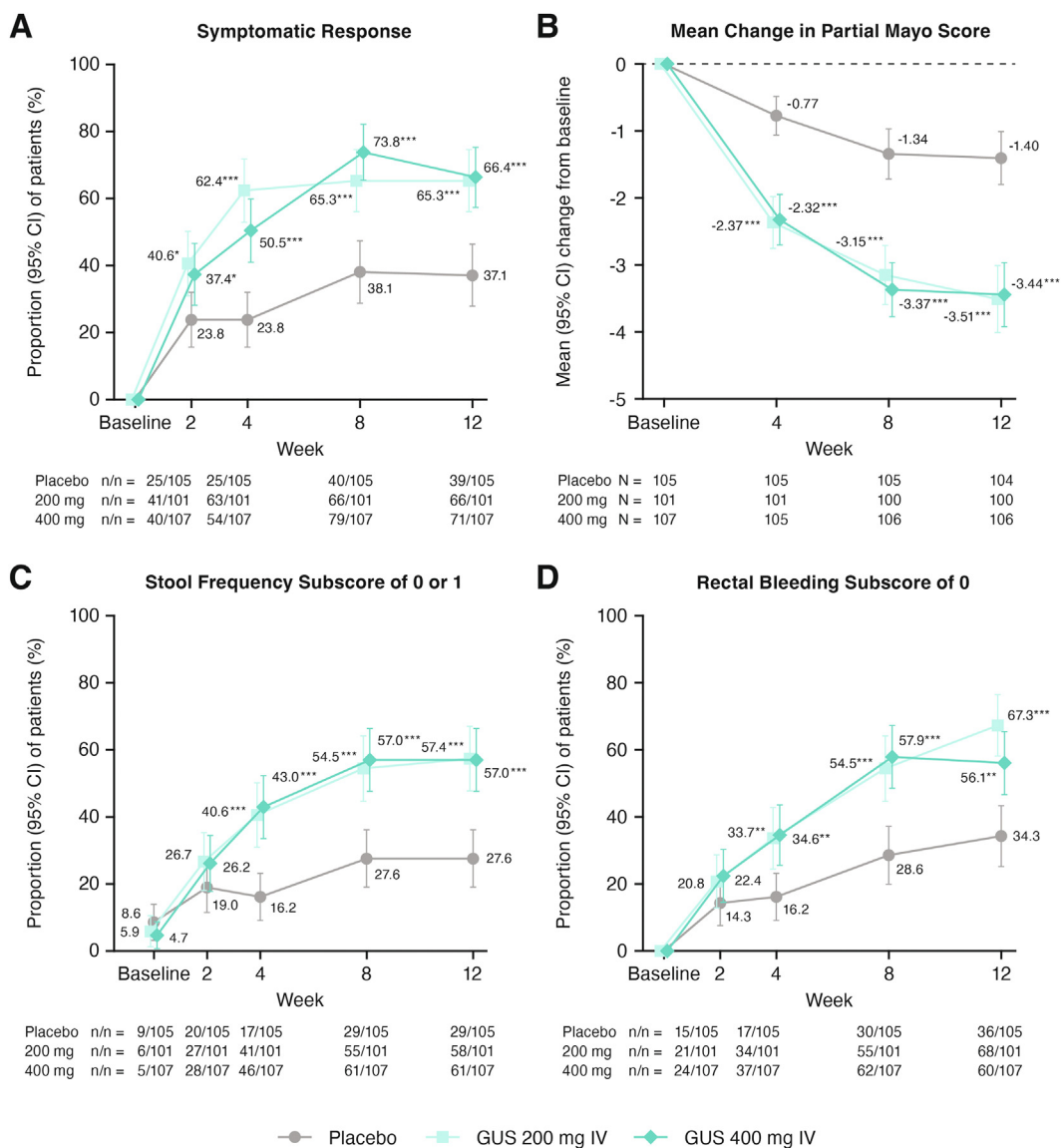


Figure 3. Symptomatic response (post hoc) (A), partial Mayo score (B), stool frequency subscore of 0 or 1 (C), and rectal bleeding subscore of 0 (D) through week 12. Primary efficacy population. All *P* values are nominal and were based on MMRM for partial Mayo score and Cochran-Mantel-Haenszel chi-square test for all other endpoints: **P* < .05, ***P* < .01, ****P* < .001. For partial Mayo score, MMRM was used to account for missing data under the assumption of missing at random. The first post-baseline measurement of physician’s global assessment was at week 4. For stool frequency and rectal bleeding subscores and symptomatic response, patients with a missing score at the designated time point (stool frequency and/or rectal bleeding for symptomatic response) were considered not to have met the endpoint. CI, confidence interval; GUS, guselkumab; MMRM, mixed-effect model for repeated measures. N, total population; n, subset.

Inflammatory biomarker assessments. At baseline, the median concentrations of serum CRP and fecal calprotectin were comparable across treatment groups (Table 1). At the earliest time point assessed (week 4) and continuing through week 12, greater median reductions from baseline in levels of CRP and fecal calprotectin were observed in the guselkumab groups compared with the placebo group (Supplementary Figure 3A and B). At week 12, median CRP levels were reduced by 2.31 mg/L in the guselkumab 200-mg group and 1.06 mg/L in the 400-mg group compared with an increase of 0.06 mg/L in the placebo group (both nominal *P* < .001). Median fecal calprotectin concentrations

were reduced by 745.00 mg/kg in the guselkumab 200-mg group and 558.50 mg/kg in the 400-mg group compared with 0.00 mg/kg in the placebo group (both nominal *P* < .001).

Among patients with abnormal levels of CRP (>3 mg/L) at baseline (range: 61.0%–63.6%) (Table 1), greater proportions of patients in the guselkumab groups achieved CRP normalization (≤3 mg/L) compared with placebo as early as the first post-baseline measurement at week 4 continuing through week 12. At week 12, among patients with abnormal CRP at baseline, 50.8% of patients in the guselkumab 200-mg group and 37.9% in the guselkumab 400-mg

group achieved CRP normalization (≤ 3 mg/L) compared with 18.8% in the placebo group (nominal $P < .001$ and $P = .012$, respectively). Among patients with abnormal fecal calprotectin levels (>250 mg/kg) at baseline (range: 89.0%–90.1%) (Table 1), greater proportions of patients in the guselkumab groups than in the placebo group achieved fecal calprotectin normalization (≤ 250 mg/kg) at week 12 (34.1% and 31.9% in the guselkumab 200-mg and 400-mg groups, respectively; 9.9% in the placebo group; both nominal $P < .001$).

Health-related quality of life at week 12. At week 12, greater proportions of patients in the guselkumab 200- and 400-mg groups compared with the placebo group had improvement in health-related quality of life (HRQoL) as assessed with the IBDQ (Supplementary Figure 4). IBDQ remission was achieved by 52.5% and 55.1% of patients in the guselkumab 200- and 400-mg groups, respectively, compared with 26.7% in the placebo group (both nominal $P < .001$). A clinically meaningful improvement in total IBDQ score was achieved by 71.3% and 73.8% of patients in the guselkumab 200- and 400-mg groups, respectively, compared with 48.6% in the placebo group (both nominal $P < .001$). In addition, 67.3% and 72.0% of patients in the guselkumab 200- and 400-mg groups, respectively, achieved a >20 -point improvement in total IBDQ score compared with 40.0% of patients in the placebo group (both nominal $P < .001$). The mean (standard deviation) increase from baseline in total IBDQ score (indicative of improvement) was greater in patients in the guselkumab 200- and 400-mg groups (40.8 [32.9] and 44.6 [37.6], respectively) compared with the placebo group (17.8 [34.7]; both nominal $P < .001$).

Fatigue response as measured by PROMIS-Fatigue SF-7a was also greater at week 12 with guselkumab compared with placebo (44.6% [nominal $P = .026$] and 40.2% [nominal $P = .101$] in the guselkumab 200-mg and 400-mg groups, respectively, vs 29.5% in the placebo group) (Supplementary Figure 4). At week 12, mean (standard deviation) decrease from baseline in PROMIS-Fatigue SF-7a score was 6.3 (9.6; nominal $P = .009$) and 7.1 (9.7; nominal $P < .001$) in the guselkumab 200- and 400-mg groups, respectively, and 3.1 (7.8) in the placebo group.

Clinical response at week 24 by baseline randomization group among week-12 clinical nonresponders. Among guselkumab week-12 clinical nonresponders (based on electronic case report form) who received SC guselkumab treatment, 54.3% (19 of 35) in the guselkumab 200 mg IV \rightarrow guselkumab 200 mg SC group and 50.0% (19 of 38) in the guselkumab 400 mg IV \rightarrow guselkumab 200 mg SC group achieved a clinical response at week 24 (Figure 4). Cumulatively, clinical response at induction week 12 or 24 was achieved by 80.2% (81 of 101) of patients initially randomized to guselkumab 200 mg IV and 78.5% (84 of 107) initially randomized to guselkumab 400 mg IV. In both subgroups of patients without (Supplementary Figure 5A) and with (Supplementary Figure 5B) a history of inadequate response/intolerance to advanced therapy, substantial proportions of guselkumab week-12 clinical nonresponders achieved a clinical response at week 24.

Among patients randomized to placebo who were week-12 clinical nonresponders and received guselkumab 200 mg IV at weeks 12, 16, and 20, 65.2% (43 of 66) achieved clinical response at week 24 (Supplementary Figure 6), which is similar to the proportion of patients randomized to guselkumab 200 mg IV who achieved clinical response at week 12 (61.4%) (Figure 2). Moreover, the results for the other clinical endpoints in the placebo IV \rightarrow guselkumab 200 mg IV group at week 24 were also generally similar to those reported for the guselkumab 200-mg and 400-mg IV groups at week 12 (Supplementary Figure 6 and Figure 2).

Safety

In the primary safety population, through week 12, the proportions of patients who experienced 1 or more AE were comparable among treatment groups (44.6% in the guselkumab 200-mg group, 49.5% in the 400-mg group, and 56.2% in the placebo group) (Table 2). Serious AEs occurred at a low frequency (1.0% in the guselkumab 200-mg group, 2.8% in the 400-mg group, and 5.7% in the placebo group). The proportions of participants who experienced 1 or more infections were 13.9% in the guselkumab 200-mg group, 9.3% in the 400-mg group, and 12.4% in the placebo group. Two patients in the placebo group reported serious infections (one was receiving corticosteroids); no serious infections were reported in either guselkumab group through week 12. The most frequently reported AEs were anemia, headache, and COVID-19.

AEs leading to discontinuation of therapy were not greater in either guselkumab group compared with the placebo group. No patient discontinued study treatment due to COVID-19 infection; however, 1 patient terminated study participation before week 12 due to COVID-19-related reasons. No cases of active tuberculosis, opportunistic infections, or death were reported. No antibodies to guselkumab were observed at any time through week 12, and no cases of anaphylaxis or serum-sickness-like reactions were reported.

The safety results for all treated patients regardless of baseline modified Mayo score were consistent with the results in the primary safety population (Supplementary Table 1). In this population, 1 case of malignancy was reported with a baseline modified Mayo score of 4. On study day 15, a patient in the IV guselkumab 200-mg group with a medical history of treated basal cell carcinoma had their annual dermatology examination. An excisional biopsy was performed on a skin nodule known to have existed before randomization. The excised nodule was diagnosed as basal cell carcinoma. Safety in week-12 clinical nonresponders who received additional guselkumab administered subcutaneously was consistent with safety through week 12 (Supplementary Table 2).

Discussion

This study in patients with moderately to severely active UC demonstrates that, compared with placebo, guselkumab IV induction treatment resulted in significantly higher clinical response rates at week 12. Guselkumab induction

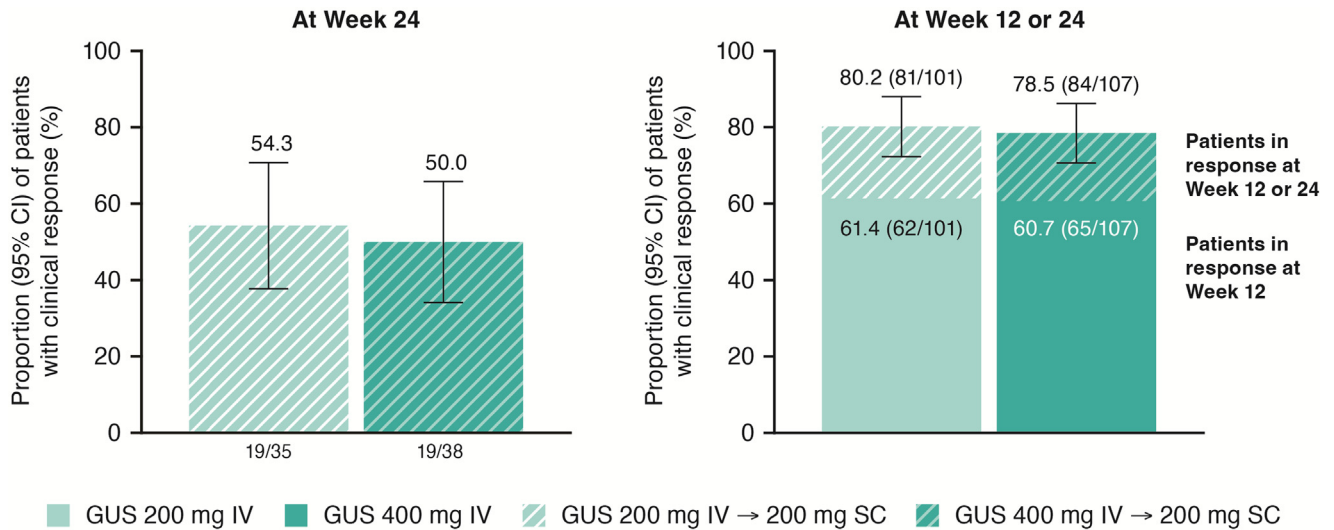


Figure 4. Clinical response at week 24 among week-12 clinical nonresponders to guselkumab and cumulative clinical response at weeks 12 or 24 among patients randomized to guselkumab. Primary efficacy population. Patients missing 1 or more modified Mayo subscore (stool frequency, rectal bleeding, or endoscopy) pertaining to this endpoint at the designated time point were considered not to have achieved clinical response. CI, confidence interval; GUS, guselkumab.

therapy also resulted in higher rates of achievement for all major secondary endpoints at week 12 compared with placebo. The efficacy of guselkumab was observed among

patients with and without a prior inadequate response/intolerance to advanced UC therapies. Consistent with results from previous trials in patients with UC,^{28,30,31} patients

Table 2. Overall Summary of AEs through Week 12 (Primary Safety Population)

	Placebo IV (N = 105)	Guselkumab		
		200 mg IV (N = 101)	400 mg IV (N = 107)	Combined (N = 208)
Average duration of follow-up, wk	12.1	12.1	12.2	12.2
Average exposure (number of administrations)	2.9	3.0	3.0	3.0
Patients with ≥1, n (%)				
AE	59 (56.2)	45 (44.6)	53 (49.5)	98 (47.1)
AE within 1 h of infusion	2 (1.9)	2 (2.0)	0	2 (1.0)
Serious AE	6 (5.7)	1 (1.0)	3 (2.8)	4 (1.9)
Death	0	0	0	0
Discontinuation for AE	3 (2.9)	1 (1.0)	0	1 (0.5)
Malignancy	0	0	0	0
Infection ^a	13 (12.4)	14 (13.9)	10 (9.3)	24 (11.5)
Serious infection	2 (1.9)	0	0	0
Most frequent AEs, ^b n (%)				
Anemia	10 (9.5)	7 (6.9)	8 (7.5)	15 (7.2)
Headache	7 (6.7)	3 (3.0)	6 (5.6)	9 (4.3)
COVID-19 infection	4 (3.8)	6 (5.9)	2 (1.9)	8 (3.8)
Abdominal pain	2 (1.9)	4 (4.0)	3 (2.8)	7 (3.4)
Arthralgia	2 (1.9)	2 (2.0)	4 (3.7)	6 (2.9)
Colitis ulcerative	6 (5.7)	1 (1.0)	4 (3.7)	5 (2.4)
Diarrhea	2 (1.9)	3 (3.0)	1 (0.9)	4 (1.9)
Lymphopenia	5 (4.8)	1 (1.0)	2 (1.9)	3 (1.4)
Pyrexia	4 (3.8)	2 (2.0)	1 (0.9)	3 (1.4)

N, total population; n, subset.

^aInfections as assessed by the investigator.

^bOccurred in at least 3% of patients in any treatment group.

without a history of an inadequate response/intolerance to advanced therapy had higher clinical response percentages than those with this history. Clinical efficacy based on symptomatic response was evident as early as week 2 (first timepoint assessed), and reductions in serum levels of inflammatory biomarkers were observed as early as week 4 (first timepoint assessed). In addition, the efficacy of the guselkumab doses tested in this study, 200 mg and 400 mg, was similar across all endpoints at week 12, and no dose-related differences in clinical outcomes were noted.

Improvements in HRQoL, patient-reported symptom outcomes, and fatigue were also greater in the guselkumab groups compared with the placebo group at week 12. Fatigue is a common symptom experienced by patients with IBD.³² In a qualitative patient interview study conducted on patients with UC (N = 11), fatigue was ranked as the second or third most important symptom by 1 patient each.³³ Chronic fatigue may be associated with psychological comorbidity, sleep disturbances, anemia, micronutrient deficiencies,³² and pain³⁴ and could substantially affect the HRQoL in patients with IBD.

In this study, additional treatment with guselkumab 200 mg administered SC in patients who did not respond to guselkumab 200- or 400-mg IV induction therapy at week 12 allowed more than half of the week-12 guselkumab clinical nonresponders to achieve clinical response at week 24. The clinical benefit of additional guselkumab treatment administered SC in patients who did not respond to guselkumab at week 12 was similar regardless of the IV guselkumab induction dose received at weeks 0, 4, and 8, suggesting that there was no incremental benefit with the higher dose. Overall, approximately 80% of patients randomized to receive IV guselkumab (200 mg or 400 mg) achieved clinical response at week 12 or 24. Efficacy with extended treatment was also observed in the subgroups of patients with or without a history of inadequate response/intolerance to advanced therapy. Data from this patient cohort suggest that the efficacy of guselkumab increases over time.

Overall, both guselkumab doses were well tolerated in this study, as reflected in the low discontinuation rate and the generally comparable rates of AEs in guselkumab and placebo groups. Moreover, the safety results in this study were consistent with the known safety profile of guselkumab in the approved indications of plaque psoriasis and psoriatic arthritis.

Although this trial was conducted during the COVID-19 pandemic, COVID-19 did not significantly affect the ability to monitor and conduct the trial according to the protocol or the integrity of the efficacy or safety results. There were no treatment discontinuations because of COVID-19 infection, and rates of infection were comparable among treatment groups.

While this study was being conducted, guselkumab efficacy in UC was demonstrated in a Phase 2a, proof-of-concept, double-blind study of guselkumab monotherapy and combination therapy with the TNF- α antagonist, golimumab, in patients with moderately to severely active UC who were naïve to TNF- α antagonists and had an inadequate response/intolerance to corticosteroids or

immunosuppressants (NCT03662542).¹⁸ In this study, guselkumab plus golimumab combination therapy resulted in greater clinical response and remission rates through week 38 than either agent alone, with similar AE rates. Collectively, these results in UC as well as the previously published results demonstrating guselkumab efficacy and safety in Crohn's disease²¹ provide clinical proof-of-concept for guselkumab in IBD.

The unique molecular properties of guselkumab may play a role in its efficacy in IBD. Guselkumab neutralizes IL-23 with high affinity and potency and has been shown to bind to CD64 (high-affinity Fc gamma receptor 1 [Fc γ R1]) on human inflammatory monocytes.³⁵ Guselkumab bound to CD64 on human inflammatory monocytes can still bind and neutralize IL-23, and this process does not induce myeloid cell activation (ie, cytokine production).³⁶ CD64⁺ mononuclear phagocytes are enriched in inflamed tissue in IBD and serve as the predominant source of IL-23.^{37,38} Therefore, guselkumab may be enriched within the inflamed tissue microenvironment by binding to CD64, neutralizing IL-23 at its cellular source,³⁹ and suppressing immune activation at the critical "myeloid/T-cell" interface. The relevance of the findings from these in vitro studies to clinical outcomes in patients with IBD are being investigated.

The collection of data in a treat-through, blinded fashion in this study helps in the understanding of the therapeutic benefit of additional guselkumab treatment administered subcutaneously in patients with UC who did not initially achieve clinical response to IV guselkumab at week 12. This study had a broad patient population with high disease burden and treatment refractoriness, including a substantial subpopulation with both disease refractory to ≥ 2 advanced therapies and severe endoscopic disease (ie, baseline Mayo endoscopy subscore of 3). However, patients with isolated proctitis were excluded, which limits the generalizability of the findings. Another limitation of this study is that only the primary endpoint was multiplicity controlled. The major secondary endpoints were not sufficiently powered for interim analysis due to sample size. Although other endpoints were prespecified, they may be subject to type 1 error and should be interpreted with caution. The efficacy and safety of guselkumab induction and maintenance therapy in a larger patient population will be evaluated in Phase 3 (NCT04033445).

In conclusion, guselkumab induction therapy at 200 mg and 400 mg in patients with moderately to severely active UC demonstrated superior efficacy compared with placebo at week 12. Greater proportions of guselkumab-treated compared with placebo-treated patients achieved clinical and HRQoL endpoints with consistent results among patients with or without prior inadequate response/intolerance to advanced therapy. Furthermore, week-12 IV guselkumab clinical nonresponders benefited from additional guselkumab treatment administered subcutaneously during the uncontrolled study period. The safety results were consistent with the known and favorable safety profile of guselkumab in approved indications, and the efficacy and safety of guselkumab were comparable at both doses. Larger

Phase 3 studies of guselkumab in patients with UC are warranted.

Supplementary Material

Note: To access the supplementary material accompanying this article, visit the online version of *Gastroenterology* at www.gastrojournal.org, and at <https://doi.org/10.1053/j.gastro.2023.08.038>.

References

- Danese S, Fiocchi C. Ulcerative colitis. *N Engl J Med* 2011;365:1713–1725.
- Ordás I, Eckmann L, Talamini M, et al. Ulcerative colitis. *Lancet* 2012;380:1606–1619.
- Ungaro R, Mehandru S, Allen PB, et al. Ulcerative colitis. *Lancet* 2017;389:1756–1770.
- Simponi (golimumab) [prescribing information]. Horsham, PA: Janssen Biotech, Inc.; 2019.
- Remicade (infliximab) [prescribing information]. Horsham, PA: Janssen Biotech, Inc.; 2021.
- Humira (adalimumab) [prescribing information]. North Chicago, IL: AbbVie Inc.; 2021.
- Stelara (ustekinumab) [prescribing information]. Horsham, PA: Janssen Biotech, Inc.; 2020.
- Entyvio (vedolizumab) [prescribing information]. Lexington, MA: Takeda Pharmaceuticals USA, Inc.; 2022.
- Xeljanz (tofacitinib) [prescribing information]. New York, NY: Pfizer Inc.; 2022.
- Rinvoq (upadacitinib) [prescribing information]. North Chicago, IL: AbbVie Inc.; 2022.
- Zeposia (ozanimod) [prescribing information]. Summit, NJ: Celgene Corporation; 2022.
- Vieujean S, D'Amico F, Netter P, et al. Landscape of new drugs and targets in inflammatory bowel disease. *United European Gastroenterol J* 2022;10:1129–1166.
- Raine T, Danese S. Breaking through the therapeutic ceiling: what will it take? *Gastroenterology* 2022;162:1507–1511.
- Alsoud D, Verstockt B, Fiocchi C, et al. Breaking the therapeutic ceiling in drug development in ulcerative colitis. *Lancet Gastroenterol Hepatol* 2021;6:589–595.
- Revés J, Ungaro RC, Torres J. Unmet needs in inflammatory bowel disease. *Curr Res Pharmacol Drug Discov* 2021;2:100070.
- D'Haens G, Kobayashi T, Morris N, et al. Efficacy and safety of mirikizumab as induction therapy in patients with moderately to severely active ulcerative colitis: results from the phase 3 LUCENT-1 study [abstract OP26]. *J Crohns Colitis* 2022;16(Suppl 1):i028–i029.
- Dubinsky MC, Irving PM, Li X, et al. Efficacy and safety of mirikizumab as maintenance therapy in patients with moderately to severely active ulcerative colitis: results from the phase 3 LUCENT-2 study [abstract 867e]. *Gastroenterology* 2022;162(Suppl 1):S1393–S1394.
- Feagan BG, Sands BE, Sandborn WJ, et al. Guselkumab plus golimumab combination therapy versus guselkumab or golimumab monotherapy in patients with ulcerative colitis (VEGA): a randomised, double-blind, controlled, phase 2, proof-of-concept trial. *Lancet Gastroenterol Hepatol* 2023;8:307–320.
- D'Haens G, Panaccione R, Baert F, et al. Risankizumab as induction therapy for Crohn's disease: results from the phase 3 ADVANCE and MOTIVATE induction trials. *Lancet* 2022;399:2015–2030.
- Ferrante M, Panaccione R, Baert F, et al. Risankizumab as maintenance therapy for moderately to severely active Crohn's disease: results from the multicentre, randomised, double-blind, placebo-controlled, withdrawal phase 3 FORTIFY maintenance trial. *Lancet* 2022;399:2031–2046.
- Sandborn WJ, D'Haens GR, Reinisch W, et al. Guselkumab for the treatment of Crohn's disease: induction results from the phase 2 GALAXI-1 study. *Gastroenterology* 2022;162:1650–1664.e8.
- Chiricozzi A, Costanzo A, Fargnoli MC, et al. Guselkumab: an anti-IL-23 antibody for the treatment of moderate-to-severe plaque psoriasis. *Eur J Dermatol* 2021;31:3–16.
- Boehncke WH, Brembilla NC, Nissen MJ. Guselkumab: the first selective IL-23 inhibitor for active psoriatic arthritis in adults. *Expert Rev Clin Immunol* 2021;17:5–13.
- Food and Drug Administration. Guidance for Industry. Ulcerative colitis: developing drugs for treatment; 2022. Available at: <https://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM515143.pdf>. Accessed January 18, 2023.
- Geboes K, Riddell R, Ost A, et al. A reproducible grading scale for histological assessment of inflammation in ulcerative colitis. *Gut* 2000;47:404–409.
- Irvine EJ. Development and subsequent refinement of the inflammatory bowel disease questionnaire: a quality-of-life instrument for adult patients with inflammatory bowel disease. *J Pediatr Gastroenterol Nutr* 1999;28:S23–S27.
- Higgins PDR, Schwartz M, Mapili J, et al. Patient defined dichotomous end points for remission and clinical improvement in ulcerative colitis. *Gut* 2005;54:782–788.
- Sands BE, Sandborn WJ, Panaccione R, et al. Ustekinumab as induction and maintenance therapy for ulcerative colitis. *N Engl J Med* 2019;381:1201–1214.
- Sandborn WJ, Ferrante M, Bhandari BR, et al. Efficacy and safety of mirikizumab in a randomized phase 2 study of patients with ulcerative colitis. *Gastroenterology* 2020;158:537–549.e10.
- Feagan BG, Rutgeerts P, Sands BE, et al. GEMINI 1 Study Group. Vedolizumab as induction and maintenance therapy for ulcerative colitis. *N Engl J Med* 2013;369:699–710.
- Danese S, Vermeire S, Zhou W, et al. Upadacitinib as induction and maintenance therapy for moderately to severely active ulcerative colitis: results from three phase 3, multicentre, double-blind, randomised trials. *Lancet* 2022;399:2113–2128.
- Borren NZ, van der Woude CJ, Ananthakrishnan AN. Fatigue in IBD: epidemiology, pathophysiology and management. *Nat Rev Gastroenterol Hepatol* 2019;16:247–259.

33. Nag A, Romero B. Development and content validation of patient-reported outcomes tools for ulcerative colitis and Crohn's disease in adults with moderate-to-severe disease. *Health Qual Life Outcomes* 2022;20:75.
34. Jelsness-Jørgensen LP, Frigstad SO, Moum B, et al. Pain may be an important factor to consider in inflammatory bowel disease patients troubled by fatigue. *United European Gastroenterol J* 2017;5:687–693.
35. Krueger JG, Eyerich K, Greving C, et al. Differentiation of therapeutic antibodies targeting IL-23 [poster]. Presented at the Society for Investigative Dermatology 2022 annual meeting; Portland, OR; May 18–21, 2022.
36. Eyerich K, Krueger JG, Greving C, et al. Differentiation of therapeutic antibodies targeting interleukin-23 [abstract 047]. *J Invest Dermatol* 2022;142:S188.
37. Chapuy L, Bsat M, Sarkizova S, et al. Two distinct colonic CD14⁺ subsets characterized by single-cell RNA profiling in Crohn's disease. *Mucosal Immunol* 2019;12:703–719.
38. **Chapuy L, Bsat M, Rubio M, et al.** IL-12 and mucosal CD14⁺ monocyte-like cells induce IL-8 in colonic memory CD4⁺ T cells of patients with ulcerative colitis but not Crohn's disease. *J Crohns Colitis* 2020;14:79–95.
39. Atreya R, Abreu MT, Krueger JG, et al. Guselkumab, an IL-23p19 subunit-specific monoclonal antibody, binds CD64⁺ myeloid cells and potently neutralises IL-23 produced from the same cells [abstract]. *J Crohns Colitis* 2023;17(suppl 1):i634–i635.

Author names in bold designate shared co-first authorship.

Received April 27, 2023. Accepted August 16, 2023.

Correspondence

Address correspondence to: Axel Dignass, MD, PhD, Department of Medicine I, Agaplesion Markus Hospital, Goethe University, Wilhelm-Epsteinstr. 4, 60431 Frankfurt am Main, Germany. e-mail: Axel.Dignass@agaplesion.de.

Acknowledgments

Laurent Peyrin-Biroulet and Jessica R. Allegretti contributed equally to this article. The current affiliation of William J. Sandborn is Ventyx Biosciences, Inc., Encinitas, California. Medical writing support was provided by Holly Capasso-Harris, PhD, and Shereen D'Cruz, PhD, of Certara Synchrogenix, under the direction of the authors in accordance with Good Publication Practice guidelines (Ann Intern Med 2022;175:1298–1304) and was funded by Janssen Scientific Affairs, LLC.

The QUASAR Study Group Members include Orest Abrahamovych,¹ Halyna Afanasieva,² Lilia Aitova,³ Engin Altintas,⁴ Romain Altwegg,⁵ Pavel Andreev,⁶ Kazuki Aomatsu,⁷ Monika Augustyn,⁸ Paola Balestrieri,⁹ Jakob Begun,¹⁰ Luciana Brunatto,¹¹ Diego Bulgheroni,¹¹ Elena Bunkova,¹² Mercedes Cabello,¹³ Qian Cao,¹⁴ Flavio Caprioli,¹⁵ Rute Cerqueira,¹⁶ Baili Chen,¹⁷ Chou-Chen Chen,¹⁸ Chou-Pin Chen,¹⁸ Cheng-Tang Chiu,¹⁹ Chang Hwan Choi,²⁰ Michele Cicala,⁹ Olena Datsenko,²¹ Pieter Dewint,²² Eugeni Domenech,²³ Joris Dutré,²⁴ George Duvall,²⁵ Juan Fernandez,²⁶ Rafal Filip,²⁷ Ronald Fogel,²⁸ Sharlye Fowler,²⁹ Toshimitsu Fujii,³⁰ Masayuki Fukata,³¹ Yohei Furumoto,³² Antonio Gasbarrini,³³ Beata Gawdis-Wojnarska,³⁴ Cyrielle Gilletta,³⁵ Paolo Gionchetti,³⁶ Eran Goldin,³⁷ Aleksandr Golovchenko,³⁸ Maciej Gonciarz,³⁹ Can Gonen,⁴⁰ Gaston Gonzalez Segura,⁴¹ Oleksii Gridnyev,⁴² Tibor Gyokeres,⁴³ Xavier Hébuterne,⁴⁴ Charlotte Hedin,⁴⁵ Per Hellström,⁴⁶ Ida Norimi Hilmi,⁴⁷ Ivo Horny,⁴⁸ Gyula Horvat,⁴⁹ Namiko Hoshi,⁵⁰ Ludek Hrdlicka,⁵¹ Shunji Ishihara,⁵² Olha Ivanishyn,⁵³ Byung Ik Jang,⁵⁴ Odey Junior,⁵⁵ Takashi Kagaya,⁵⁶ Shuji Kanmura,⁵⁷ Marina Karakina,⁵⁸ Nakai Katsuhiko,⁵⁹ Jaroslaw Kierkus,⁶⁰ Hyo Jong Kim,⁶¹ Tae-Oh Kim,⁶² Young-Ho Kim,⁶³ Gyula G. Kiss,⁶⁴ Jochen Klaus,⁶⁵ Dariusz Kleczkowski,⁶⁶ Maria Klopocka,⁶⁷ Taku Kobayashi,⁶⁸ Iwona Kobielsz-Gembala,⁶⁹ Ja Seol Koo,⁷⁰ Adam Kopon,⁷¹ Tetiana Kravchenko,⁷² Masatoshi Kudo,⁷³ Kwang An Kwon,⁷⁴ Paula Lago,⁷⁵ David Laharie,⁷⁶ Ian Lawrence,⁷⁷ Jaroslaw Leszczyszyn,⁷⁸ Yan Li,⁷⁹ Milan Lukas,⁸⁰ Christian Maaser,⁸¹ Atsuo Maemoto,⁸² Hiroyuki Marusawa,⁸³ Matthew McBride,⁸⁴ Shoba Mendu,⁸⁵ Pal Miheller,⁸⁶ Hideharu Miyabayashi,⁸⁷ Wolfgang Mohl,⁸⁸ Gregory Moore,⁸⁹ Satoshi Motoya,⁹⁰ Narayanachar Murali,⁹¹ Mohammed Naem,⁹² Koichi

Nakajima,⁹³ Yasunari Nakamoto,⁹⁴ Stéphane Nancey,⁹⁵ Joaquim Neto,⁹⁶ Michio Onizawa,⁹⁷ Yohei Ono,⁹⁸ Yohei Ono,⁹⁹ Taro Osada,¹⁰⁰ Marina Osipenko,¹⁰¹ Danuta Owczarek,¹⁰² Bhaktasharan Patel,¹⁰³ Kamal Patel,¹⁰⁴ Elina Petrova,¹⁰⁵ Elena Poroshina,¹⁰⁶ Francisco Portela,¹⁰⁷ Lyudmyla Prystupa,¹⁰⁸ Monserrat Rivero,¹⁰⁹ Xavier Roblin,¹¹⁰ Jacek Romatowski,¹¹¹ Grazyna Rydzewska,¹¹² Simone Saibeni,¹¹³ Hirotake Sakuraba,¹¹⁴ Mark Samaan,¹¹⁵ Michael Schultz,¹¹⁶ Joerg Schulze,¹¹⁷ Shahriar Sedghi,¹¹⁸ Ursula Seidler,¹¹⁹ Sung Jae Shin,¹²⁰ Mykola Stanislavchuk,¹²¹ David Stokesberry,¹²⁴ Takayoshi Suzuki,¹²² Hiroki Taguchi,⁹⁸ Lyudmila Tankova,¹²³ Lena Thin,¹²⁴ Alexander Tkachev,¹²⁵ Leyanira Torrealba,¹²⁶ Natalia Tsarynna,¹²⁷ Zsolt Tulassay,¹²⁸ Tetsuya Ueo,¹²⁹ Ekaterina Valuyskikh,¹³⁰ Olga Vasilevska,¹³¹ Manuel Viamonte,¹³² Shu-Chen Wei,¹³³ Roni Weisshof,¹³⁴ Katarzyna Wojcik,¹³⁵ Byong Duk Ye,¹³⁶ Hsu-Heng Yen,¹³⁷ Hyuk Yoon,¹³⁸ Kosuke Yoshida,¹³⁹ Andriy Yurkiv,¹⁴⁰ Osamu Zaha,¹⁴¹ and Qiang Zhan¹⁴²; from the ¹Communal Nonprofit Enterprise of Lviv Regional Council "Lviv Regional Clinical Hospital" Lviv, Ukraine; ²Municipal Institution "Kherson City Clinical Hospital n.a. Y.Y.Karabelesh," Kherson, Ukraine; ³City Clinical Hospital # 21, Ufa, Bashkortostan, Respublika, Russian Federation; ⁴Mersin University Medical Faculty Hospital, Mersin, Turkey; ⁵Hopital Saint Eloi, Montpellier, France; ⁶NUZ Railway Clinical Hospital on Samara station of LLC "Russian Railways," Samara, Samarskaya oblast, Russian Federation; ⁷Izumiotsu Municipal Hospital, Osaka, Japan; ⁸Centrum Medyczne Plejady, Krakow, Malopolskie, Poland; ⁹Università Campus Biomedico di Roma, Roma, Roma, Italy; ¹⁰Mater Hospital, South Brisbane, Queensland, Australia; ¹¹Sanatorio Duarte Quiroz, Cordoba, Argentina; ¹²Medical University Reaviz, Multidisciplinary clinic, Samara, Samarskaya oblast, Russian Federation; ¹³Hospital NTRA. SRA. de Valme, Sevilla, Spain; ¹⁴Sir Run Run Shaw Hospital, Zhejiang University School of Medicine, Hangzhou, Zhejiang, China; ¹⁵Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico, Milano, Italy; ¹⁶Centro Hospitalar de Entre o Douro e Vouga, E.P.E. Santa Maria da Feira, Aveiro, Portugal; ¹⁷The First Affiliated Hospital, Sun Yat-sen University, Guangzhou, Guangdong, China; ¹⁸Taichung Veterans General Hospital, Taichung, Taiwan; ¹⁹Chang-Gung Memorial Hospital, Linkou Branch, Taoyuan, Taiwan; ²⁰Chung-Ang University Hospital, Seoul, Dongjagu, Republic of Korea; ²¹Communal Nonprofit Enterprise "City Clinical Hospital # 2 N.A. Prof. O.O. Shalimov," Kharkiv, Ukraine; ²²AZ Maria Middelaers, Gent, Oost-Vlaanderen, Belgium; ²³Hosp. Univ. Germans Trias i Pujol, Badalona, Catalonia, Spain; ²⁴Algemeen Ziekenhuis Jan Palfijn Merksem, Merksem, Belgium; ²⁵Tyler Research Institute, LLC, Tyler, Texas; ²⁶Harmony Medical Research Institute, Inc., Hialeah, Florida; ²⁷Centrum Medyczne Medyk, Rzeszow, Poland; ²⁸Clinical Research Institute of Michigan, LLC, Chesterfield, Michigan; ²⁹Royal University Hospital, Saskatoon, Saskatchewan, Canada; ³⁰Tokyo Medical and Dental University Hospital, Bunkyo-Ku, Tokyo, Japan; ³¹Tokyo Yamate Medical Center, Shinjuku-ku, Tokyo, Japan; ³²Tokyo Metropolitan Bokutoh Hospital, Sumida-ku, Tokyo, Japan; ³³Fondazione Policlinico Gemelli Università Cattolica, Roma, Italy; ³⁴Twoja Przyszłość - Szczecińskie Centrum Medyczne, Szczecin, Poland; ³⁵CHU Rangueil, Toulouse, France; ³⁶Policlinico Sant'Orsola Malpighi, Bologna, Italy; ³⁷Shaare Zedek Medical Center, Jerusalem, Israel; ³⁸Medical Center Ltd "Health Clinic," Department of General Therapy, Vinnytsya, Ukraine; ³⁹Wojskowy Instytut Medyczny, Warszawa, Poland; ⁴⁰Acibadem Kozyatagi Hospital, Istanbul, Turkey; ⁴¹Centro Médico Dra. De Salvo, Caba, Buenos Aires, Argentina; ⁴²SI "L.T. Maloyi National Institute of Therapy of National Academy of Medical Sciences of Ukraine," Kharkiv, Ukraine; ⁴³Magyar Honvedseg Egyszeguyi Kozpont, Budapest, Hungary; ⁴⁴CHU de Nice Hospital de l'Archev, Nice Cedex 3, France; ⁴⁵Karolinska Universitetssjukhuset, Stockholm, Sweden; ⁴⁶Uppsala University, Uppsala, Sweden; ⁴⁷University Malaya Medical Centre, Kuala Lumpur, Malaysia; ⁴⁸Nemocnice Strakonice, a.s., Strakonice, Czechia; ⁴⁹Bugat Pal Korhaz, Gyongyos, Hungary; ⁵⁰Kobe University Hospital, Kobe, Hyogo, Japan; ⁵¹ResTrial GastroEndo, s.r.o., Praha 4, Czechia; ⁵²Shimane University Hospital, Izumo, Japan; ⁵³Lviv Clinical Hospital on Railway Transport of Affiliate Healthcare Center of JSC Ukrainian Railway, Lviv, Ukraine; ⁵⁴Yeungnam University Hospital, Daegu, Daegu Gwang'yeoksi, Republic of Korea; ⁵⁵CDC - Centro Digestivo de Curitiba, Curitiba, Brazil; ⁵⁶National Hospital Organization Kanazawa Medical Center, Kanazawa, Ishikawa, Japan; ⁵⁷Kagoshima University Hospital, Kagoshima City, Kagoshima, Japan; ⁵⁸Medical Center Meditsinskie Tekhnologii, Ekaterinburg, Russian Federation; ⁵⁹Matsuda Hospital, Shizuoka, Japan; ⁶⁰WIP Warsaw IBD Point Profesor Kierkus, Warszawa, Poland; ⁶¹KyungHee University Hospital, Seoul, Republic of Korea; ⁶²Inje University Haeundae Paik Hospital, Busan, Republic of Korea; ⁶³Samsung Medical Center, Seoul, Republic of Korea; ⁶⁴Vasutegyszeguyi Nonprofit Kozhasznu Kft Debrecei Kozpont, Debrecen, Hajdú-Bihar, Hungary; ⁶⁵Universitaetsklinikum Ulm, Ulm, Baden-Württemberg, Germany; ⁶⁶Endoskopia Sp z o.o., Sopot, Pomorskie, Poland; ⁶⁷Szpital Uniwersytecki nr 2 im. dr. Jana Bizuela w Bydgoszcz, Bydgoszcz, Poland; ⁶⁸Kitasato University Kitasato Institute Hospital, Minato-ku, Tokyo, Japan; ⁶⁹Medicome Sp z o.o., Oswiecim, Poland; ⁷⁰Korea University Ansan Hospital, Gyeonggi-do, Republic of Korea; ⁷¹GASTROMED Kopon, Zmudzinski i wspolnicy SP.j., Specjalistyczne Centrum Gastrologii i Endoskopii, Torun, Poland; ⁷²Kyiv City Clinical Hospital #18, Kyiv, Ukraine; ⁷³Kindai University Hospital, Osaka-Sayama, Osaka, Japan; ⁷⁴Gachon University Gil Medical Center, Incheon, Incheon Gwang'yeoksi, Republic of Korea; ⁷⁵Centro Hospitalar do Porto, EPE, Porto, Portugal; ⁷⁶Hopital

Haut-Leveque, CMC Magellan, Pessac, France; ⁷⁷St John of God Subiaco Hospital, Subiaco, WA, Australia; ⁷⁸Melita Medical Sp. z o.o., Wrocław, Dolnośląskie, Poland; ⁷⁹Shengjing Hospital of China Medical University, Shenyang, Liaoning, China; ⁸⁰ISCARE a.s., Praha 7, Czechia; ⁸¹Staedtisches Klinikum Lueneburg, Lueneburg, Germany; ⁸²Sapporo Higashi Tokushukai Hospital, Sapporo, Japan; ⁸³Japanese Red Cross Osaka Hospital, Osaka, Japan; ⁸⁴Digestive Disease Specialists Inc, Oklahoma City, Oklahoma; ⁸⁵Gastroenterology Associates of Tidewater, Chesapeake, Virginia; ⁸⁶Semmelweis Egyetem, Budapest, Hungary; ⁸⁷National Hospital Organization Matsumoto Medical Center, Matsumoto, Nagano, Japan; ⁸⁸Zentrum für Gastroenterologie Saar MVZ GmbH, Saarbrücken, Germany; ⁸⁹Monash Health, Clayton, VIC, Australia; ⁹⁰Hokkaido P.W.F.A.C. Sapporo-Kosei General Hospital, Sapporo, Japan; ⁹¹Gastroenterology Associates of Orangeburg, Orangeburg, South Carolina; ⁹²Northshore Gastroenterology Research, LLC, Westlake, Ohio; ⁹³Matsushima Clinic, Kanagawa, Japan; ⁹⁴University of Fukui Hospital, Yoshida, Fukui, Japan; ⁹⁵Centre Hospitalier Lyon Sud, Pierre-Bénite, France; ⁹⁶Sociedade Campineira de Educacao e Instrucao-Hospital e Maternidade Celso Pierro, Campinas, São Paulo, Brazil; ⁹⁷Fukushima Medical University Hospital, Fukushima, Japan; ⁹⁸Imamura General Hospital, Kagoshima, Japan; ⁹⁹Kagoshima IBD Gastroenterology Clinic, Kagoshima, Japan; ¹⁰⁰Juntendo University Hospital Urayasu, Chiba, Japan; ¹⁰¹Medical Center SibNovoMed LLC, Novosibirsk, Russian Federation; ¹⁰²Centrum Medyczne Promed, Krakow, Poland; ¹⁰³Peak Gastroenterology Associates, Colorado Springs, Colorado; ¹⁰⁴St George's Hospital, London, United Kingdom and Northern Ireland; ¹⁰⁵OO MO New Hospital, Ekaterinburg, Russian Federation; ¹⁰⁶Eco-safety Ltd, Saint-Petersburg, Russian Federation; ¹⁰⁷Centro Hospitalar e Universitário de Coimbra, EPE, Coimbra, Portugal; ¹⁰⁸Sumy State University, Sumy Regional Clinical Hospital, Sumy, Ukraine; ¹⁰⁹Hosp. Univ. Marques De Valdecilla, Santander, Cantabria, Spain; ¹¹⁰CHU Saint-Etienne-Hôpital Nord, Saint-Priest en Jarez, France; ¹¹¹Gastromed Kralisz Romatowski Stachurska Sp. j., Bialystok, Poland; ¹¹²Centralny Szpital Kliniczny Mswia, Warszawa, Mazowieckie, Poland; ¹¹³Azienda Ospedaliera G. Salvini Ospedale di Rho, Rho, Milan, Italy; ¹¹⁴Hirosaki University Hospital, Hirosaki, Japan; ¹¹⁵Guy's and St Thomas' Hospital, London, United Kingdom and Northern Ireland; ¹¹⁶Dunedin Hospital, Dunedin, Otago, New Zealand; ¹¹⁷Praxisgemeinschaft Jerichow, Jerichow, Germany; ¹¹⁸Gastroenterology Associates of Central GA, Macon, Georgia; ¹¹⁹Medizinische Hochschule Hannover, Hannover, Niedersachsen, Germany; ¹²⁰Ajou University Hospital, Suwon, Gyeonggi-do, Republic of Korea; ¹²¹Vinnitsia Regional Clinical Hospital n.a. M. I. Pyrogov, Vinnitsya, Ukraine; ¹²²Tokai University Hachioji Hospital, Hachioji, Tokyo, Japan; ¹²³DCC Convex EOOD, Sofia, Bulgaria; ¹²⁴Fiona Stanley Hospital, Murdoch, WA, Australia; ¹²⁵Rostov State Medical University, Rostov-on-Don, Russian Federation; ¹²⁶Hosp. Univ. Dr. Josep Trueta, Girona, Spain; ¹²⁷Medical Center "Ok Clinic" of LLC "International Institute of Clinical Studies," Kyiv, Ukraine; ¹²⁸Semmelweis Egyetem, li. Belgyogyaszati Klinika, Budapest, Hungary; ¹²⁹Oita Red Cross Hospital, Oita, Japan; ¹³⁰LLC "Novosibirsk Gastrocentr," Novosibirsk, Russian Federation; ¹³¹Regional Clinical Hospital, Yaroslavl, Russian Federation; ¹³²Columbus Clinical Services LLC, Miami, Florida; ¹³³National Taiwan University Hospital, Taipei, Taiwan; ¹³⁴Rambam Medical Center, Haifa, HaZafon, Israel; ¹³⁵ETG Zamosc, Zamosc, Poland; ¹³⁶Asan Medical Center, Seoul, Seoul Teugbyeolsi, Republic of Korea; ¹³⁷Chang-Hua Christian Hospital, Changhua, Taiwan; ¹³⁸Seoul National University Bundang Hospital, Gyeonggi-do, Republic of Korea; ¹³⁹National Hospital Organization Tokyo Medical Center, Tokyo, Japan; ¹⁴⁰Municipal Non-profit Enterprise "Odesa Regional Clinical Hospital" Odesa Regional Council, Odesa, Ukraine; and ¹⁴¹Nakagami Hospital, Okinawa, Japan; and ¹⁴²Wuxi People's Hospital, Wuxi, Jiangsu, China

CRedit Authorship Contributions

Laurent Peyrin-Biroulet, MD, PhD (Data curation: Lead; Investigation: Lead; Methodology: Lead; Supervision: Lead; Writing – review & editing: Lead).

Jessica R. Allegretti, MD, MPH, FRCG (Investigation: Lead; Methodology: Lead; Supervision: Lead; Writing – review & editing: Lead).

David T. Rubin, MD (Investigation: Supporting; Methodology: Supporting; Supervision: Supporting; Writing – review & editing: Supporting).

Brian Bressler, MD, MS, FRCPC (Data curation: Supporting; Investigation: Supporting; Methodology: Supporting; Supervision: Supporting; Writing – review & editing: Supporting).

Matthew Germinaro, MD (Conceptualization: Lead; Data curation: Lead; Formal analysis: Supporting; Investigation: Supporting; Methodology: Supporting; Project administration: Supporting; Resources: Lead; Supervision: Supporting; Writing – original draft: Lead; Writing – review & editing: Supporting).

Kuan-Hsiang (Gary) Huang, MD, PhD (Data curation: Supporting; Formal analysis: Supporting; Investigation: Supporting; Methodology: Supporting; Project administration: Lead; Resources: Supporting; Software: Supporting; Supervision: Supporting; Visualization: Lead; Writing – original draft: Supporting; Writing – review & editing: Supporting).

Nicole Shipitofsky, PharmD (Data curation: Supporting; Formal analysis: Supporting; Investigation: Supporting; Methodology: Supporting; Project administration: Supporting; Writing – original draft: Supporting; Writing – review & editing: Supporting).

Hongyan Zhang, PhD (Conceptualization: Supporting; Data curation: Supporting; Formal analysis: Supporting; Methodology: Supporting; Project administration: Supporting; Resources: Supporting; Software: Supporting; Supervision: Supporting; Validation: Lead; Visualization: Lead; Writing – original draft: Supporting; Writing – review & editing: Supporting).

Rebecca Wilson, DrPH (Data curation: Supporting; Methodology: Supporting; Project administration: Supporting; Resources: Supporting; Software: Lead; Validation: Lead; Visualization: Supporting; Writing – original draft: Supporting; Writing – review & editing: Supporting).

Chenglong Han, MD, PhD (Formal analysis: Supporting; Methodology: Supporting; Writing – review & editing: Supporting).

Brian G. Feagan, MD, FRCPC (Conceptualization: Supporting; Investigation: Supporting; Methodology: Supporting; Supervision: Supporting; Writing – review & editing: Supporting).

William J. Sandborn, MD (Conceptualization: Supporting; Methodology: Supporting; Supervision: Supporting; Writing – review & editing: Supporting).

Julian Panés, MD, PhD (Conceptualization: Supporting; Investigation: Supporting; Methodology: Supporting; Supervision: Supporting; Writing – review & editing: Supporting).

Tadakazu Hisamatsu, MD, PhD (Investigation: Supporting; Methodology: Supporting; Supervision: Supporting; Writing – review & editing: Supporting).

Gary R. Lichtenstein, MD (Investigation: Supporting; Methodology: Supporting; Supervision: Supporting; Writing – review & editing: Supporting).

Bruce E. Sands, MD (Conceptualization: Supporting; Investigation: Supporting; Methodology: Supporting; Supervision: Supporting; Writing – review & editing: Supporting).

Axel Dignass, MD, PhD (Investigation: Supporting; Methodology: Supporting; Supervision: Supporting; Writing – review & editing: Supporting).

Conflicts of interest

The authors disclose the following: Laurent Peyrin-Biroulet has received fees from AbbVie, Adacyte, Abivax, Alimentiv, Alma Bio Therapeutics, Amgen, Applied Molecular Transport, Arena, Biogen, Bristol Myers Squibb, Celltrion, CONNECT Biopharm, Cytokine Pharma, Entera, Ferring, Fresenius Kabi, Galapagos, Genentech, Gilead, Gossamer Bio, GlaxoSmithKline, HAC-Pharma, IAG Image Analysis, InDex Pharmaceuticals, Inotrem, Janssen, Lilly, Medac, Mopac, Morphic Therapeutic, MSD, Nordic Pharma, Norgine, Novartis, OM Pharma, ONO Pharma, OSE Immunotherapeutics, Pandion Therapeutics, ParImmune, Pfizer, Prometheus Biosciences, Protagonist, Roche, Roivant, Samsung, Sandoz, Sanofi, Takeda, Theravance, Thermo Fisher, Tigenix, Tillots, Vectivbio, Ventyx, Viatrix, Vifor, and Ysopia. Jessica R. Allegretti is a consultant for AbbVie, Adiso, Bristol Myers Squibb, Ferring, Finch Therapeutics, GlaxoSmithKline, Janssen, Merck, Pfizer, Seres Therapeutics, and Roivant; is on speaker's bureaus for AbbVie, Bristol Myers Squibb, and Janssen; has received research support from Janssen, Merck, and Pfizer; and is a steering committee member and investigator for Janssen. David T. Rubin is a consultant for AbbVie, Allergan, Altrubio, Arena, Aslan Pharmaceuticals, Athos Therapeutics, Bellatrix Pharmaceuticals, Boehringer Ingelheim, Ltd., Bristol Myers Squibb, Celgene, Syneos, Connect BioPharma, Galen Atlantica, Genentech/Roche, InDex Pharmaceuticals, Ironwood Pharmaceuticals, Iterative Scopes, Janssen, Lilly, Prometheus Biosciences, Reistone, Takeda, and Techlab, Inc.; has received research funding from Takeda; and is a co-founder of Cornerstones Health, Inc. Brian Bressler is an advisor/speaker for AbbVie, Bristol Myers Squibb, Ferring, Janssen, Merck, Novartis, Organon, Pfizer, Sandoz, and Takeda; is an advisor for Alimentiv, Allergan, Amgen, AMT, Bausch Health, Bristol Myers Squibb, Celgene, Celltrion, Eupraxia Fresenius Kabi, Genentech/Roche, Gilead, Iterative Scopes, Jamp Pharma, Merck, Microbiome Insights, Mylan, Pendopharm, Protagonist, and Viatrix; has received research support from AbbVie, Amgen, Business Intelligence (BI) Pharma, Bristol Myers Squibb, Genentech/Roche, GlaxoSmithKline, Janssen, Merck, and Qu Biologic; and holds stock options in Qu Biologic. Matthew Germinaro, Kuan-Hsiang (Gary) Huang, Nicole Shipitofsky, Hongyan Zhang, Rebecca Wilson, and Chenglong Han are employees of Janssen Research & Development, LLC, a wholly owned subsidiary of Johnson & Johnson and may own stock in Johnson & Johnson. Brian G. Feagan is a consultant for AbbVie, AbolerIS, AgomAB Therapeutics, Alliantera, Amgen, AnaptysBio, Applied Molecular Transport Inc., Arena, Avoro Capital Advisors, Atomwise, BioJamp, Biora (Progenity), Boehringer Ingelheim, Boxer, Celsius Therapeutics, Celgene/BMS, Connect BioPharma, Cytokine Pharma, Disc Medicine, Duality, EcoR1 Capital, Equilibrium, Ermium, First Wave, First World Group, Galapagos, Galen Atlantica, Genentech/Roche, Gilead, Gossamer Bio, GlaxoSmithKline, Hinge Bio, Hot Spot Therapeutics, Imhotex, Immunic Therapeutics, InDex Pharmaceuticals, JAKAcademy, Janssen, Japan Tobacco Inc., Kaleido Biosciences, Landos Biopharma, Lediand, L.E.K. Consulting, LifeSci Capital, Lilly, Lument AB, Millennium, MiroBio, Morphic Therapeutic, Mylan, OM Pharma, Origo BioPharma, Orphan, Pandion Therapeutics, Pendopharm, Pfizer, PlayToKnow AG, Prometheus Therapeutics and Diagnostics, Protagonist, PTM Therapeutics, Q32 Bio, Rebiotix, REDX Pharma, Roche, Sandoz, Sanofi, Seres Therapeutics, Silverback Therapeutics, Surroze, Takeda, Teva, Thelium, Tigenix, Tillots, Ventyx Biosciences, VHSquared Ltd., Viatrix, Ysios, Ysopia, and Zealand Pharma; is a member of the speakers bureau for AbbVie, Business Intelligence (BI) Pharma, Janssen, and Takeda; has received payment for expert testimony from Morgan Lewis and Lenczner

Slaght; has received support for attending meetings and/or travel from AbbVie, Business Intelligence (BI) Pharma, Janssen, Pfizer, and Takeda; has served on a Data Safety Monitoring Board or Advisory Board at AbbVie, Amgen, AMT Pharma, AnaptysBio, Axio Research, Biora (Progenity), Boehringer Ingelheim, Celgene, EcoR1 Capital, Genentech/Roche, GlaxoSmithKline, InDex Pharmaceuticals, Janssen, Lilly, MiroBio, Morphic Therapeutic, Origo BioPharma, Pfizer, Prometheus Biosciences, REDX Pharma, Sanofi, Takeda, Teva, and Tillotts; and owns stock or stock options in Gossamer Bio, William J. Sandborn has received consulting fees from AbbVie, Abivax, Alfasigma, Alimentiv, BeiGene, Biora (Progenity), Celltrion, Forbion, Genentech/Roche, Gossamer Bio, InDex Pharmaceuticals, Prometheus Biosciences, Protagonist Therapeutics, Shoreline Biosciences, Vedanta Biosciences, Ventyx Biosciences, and Zealand Pharma; owns stock or stock options in BeiGene, Biora (Progenity), Gossamer Bio, Prometheus Biosciences, Prometheus Laboratories, Shoreline Biosciences, Ventyx Biosciences, Vimalan Biosciences, and Vivreon Gastrosciences; and is an employee at Shoreline Biosciences, and Ventyx Biosciences. Spouse is a consultant at Iveric Bio; employee at Prometheus Biosciences; and owns stock or stock options at Biora (Progenity), Iveric Bio, Prometheus Biosciences, Prometheus Laboratories, Ventyx Biosciences, and Vimalan Biosciences. Julian Panés has received grants from AbbVie and Pfizer; has received consulting fees from AbbVie, Arena, Athos, Atomwise, Biora (Progenity), Boehringer Ingelheim, Celgene, Celltrion, Ferring, Galapagos, Genentech/Roche, GlaxoSmithKline, Janssen, Mirum, Morphic Therapeutic, Origo, Pandion, Pfizer, Protagonist, Revolo, Robarts, Takeda, Theravance, and Wassermann; has received support for travel to meetings from AbbVie and Takeda, during the conduct of the study; has received payment for lectures including service on speakers bureaus from Abbott and Janssen; and has served on a Data Safety Monitoring Board or Advisory Board at Alimentiv. Takakazu Hisamatsu has received grant support from AbbVie, Daiichi-Sankyo, EA Pharma, JIMRO, Mitsubishi Tanabe Pharma Corporation, Mochida Pharmaceutical Co., Ltd., Nippon Kayaku Co., Ltd., Pfizer, and Takeda; has received consulting fees from EA Pharma, and Janssen; and has received lecture fees from AbbVie, EA Pharma, Gilead, Mitsubishi Tanabe Pharma Corporation, and Takeda. Gary R. Lichtenstein is a consultant for AbbVie, Celgene, CellCeutrix, Ferring, Gilead, Janssen Orthobiotech, Lilly, Luitpold/American Regent, Merck, Pfizer, Prometheus Laboratories, Romark, Salix Pharmaceuticals/Valeant, Shire Pharmaceuticals, Takeda, UCB, Vindico, and Virgo (stock options); and has received honoraria from American College of Gastroenterology (Associate Editor of *American Journal of Gastroenterology*), *Clinical Advances in Gastroenterology* (Associate Editor), *Gastroenterology and Hepatology* [Gastro-Hep Communications] (Editor), McMahon Publishing

(Author), SLACK, Inc (Book Royalty), Springer Science and Business Media (Editor), and Up-To-Date (Author). Bruce E. Sands is a consultant or has received speakers fees from AbbVie, Abivax, Adiso Therapeutics, Alimentiv, Amgen, Arena, Artizan Biosciences, Artugen Therapeutics, AstraZeneca, Bacainn Therapeutics, Biora (Progenity), Boehringer Ingelheim, Boston Pharmaceuticals, Bristol Myers Squibb, Caiibr, Celltrion, ClostraBio, Connect Biopharma, Cytoki Pharma, Lilly, Entera, Evommune, Ferring, Fresenius Kabi, Galapagos, Gilead, Genentech/Roche, GlaxoSmithKline, Gossamer Bio, HMP Acquisition, Imhotex, Immunic, InDex Pharmaceuticals, Innovation Pharmaceuticals, Inotrem, Ironwood Pharmaceuticals, Janssen, Johnson & Johnson, Kaleido, Kalyope, Merck, MiroBio, Morphic Therapeutic, MRM Health, OSE Immunotherapeutics, Pfizer, Progenity, Prometheus Biosciences, Prometheus Laboratories, Protagonist Therapeutics, Q32 Bio, RedHill Biopharma, Sun Pharma Global, Surrozen, Synlogic Operating Company, Takeda, Target RWE, Theravance, TLL Pharmaceutical, USWM Enterprises, Ventyx Biosciences, and Viela Bio; and owns stock options in Ventyx Biosciences. Axel Dignass has participated in clinical trials and review activities, such as data monitoring boards, statistical analysis, and endpoint committees at AbbVie, Abivax, Arena, Celgene/Bristol Myers Squibb, Falk, Gilead, Janssen, and Pfizer; has received consultancy fees from AbbVie, Amgen, Biogen, Boehringer Ingelheim, Celgene/Bristol Myers Squibb, Celltrion, Falk, Ferring, Fresenius Kabi, Galapagos, Genentech/Roche, Gilead, Janssen, Lilly, MSD, Pfizer, Pharmacosmos, Sandoz/Hexal, Takeda, Tillotts, and Vifor; and has received payment for lectures including service on speaker bureaus from AbbVie, Amgen, Biogen, Celltrion, Falk Foundation, Ferring, Galapagos, GastroToday, Gilead, High5MD, Janssen, Lilly, MSD, Pharmacosmos, Pfizer, Takeda, Tillotts, and Vifor. All QUASAR Study Group Members served as investigators for the QUASAR Phase 2b Induction Study, which was sponsored by Janssen Scientific Affairs, LLC.

Funding

This study was funded by Janssen Research and Development, LLC. Janssen Research and Development, LLC employees designed the study; collated, analyzed, and helped to interpret the data; and were involved with writing the report. All authors, including Janssen Research and Development, LLC employees, reviewed and approved the final draft of the article.

Data Availability

The data-sharing policy of Janssen Pharmaceutical Companies of Johnson & Johnson is available at <https://www.janssen.com/clinical-trials/transparency>. As noted on this site, requests for access to the study data can be submitted through the Yale Open Data Access Project site at <http://yoda.yale.edu>.