ORIGINAL

SHORT- AND LONG-TERM EFFECTIVENESS OF RISANKIZUMAB IN CROHN'S DISEASE: RESULTS IN REAL-WORLD CLINICAL PRACTICE IN TWO TERTIARY HOSPITALS IN MÁLAGA.

Gutiérrez Martínez F[1], García Fuentes E[1,3], Olmedo Martín R[2], Fernández Castañer A[3], Rodríguez González F[3], VanDussen Martos JV[3], Alcaín Martínez G[1], Toro Ortiz JP[1], Romero Cara P[2], Amo Trillo VM[2], Mostazo Torres J[2], López Gómez C[1,3], Camargo Camero R[1]

[1]CLINICAL MANAGEMENT UNIT OF DIGESTIVE SYSTEM, VIRGEN DE LA VICTORIA UNIVERSITY HOSPITAL, MÁLAGA.

[2]CLINICAL MANAGEMENT UNIT OF DIGESTIVE SYSTEM, REGIONAL UNIVERSITY HOSPITAL, MÁLAGA.

[3]BIOMEDICAL RESEARCH INSTITUTE OF MÁLAGA AND NANOMEDICINE PLATFORM, IBIMA BIONAND PLATFORM, MÁLAGA.

Abstract

Introduction: The therapeutic arsenal for Inflammatory Bowel Disease (IBD) has grown in recent years. Interleukin-23 (IL-23) p19 subunit inhibitors represent an emerging therapy for these patients. Risankizumab is an IL-23 inhibitor approved for the treatment of patients with moderate to severe Crohn's disease (CD).

Objectives: To evaluate the effectiveness, survival, and short- and long-term safety of risankizumab in patients with Crohn's disease (CD).

Methods: Retrospective, multicenter, observational study of Crohn's disease patients from the Virgen de la Victoria University Hospital and the Regional University Hospital of Málaga treated with risankizumab. The primary endpoint was the clinical remission rate, calculated using the Harvey Bradshaw (HBI) clinical index.

Results: A total of 51 patients were included. Clinical remission rates at 12, 26, and 52 weeks were 43.1%, 45.1%, and 49%, respectively. The median duration of treatment was 18 months, with a 12-month survival rate of 84% and a 24-month survival rate of 75%.

Fernando Gutiérrez Martínez
Virgen de la Victoria University Hospital, Malaga.
fernando-gutma@hotmail.com

Gutiérrez Martínez F, García Fuentes E, Olmedo Martín R, Fernández Castañer A, Rodríguez González F, VanDussen Martos JV et al. Short- and long-term effectiveness of risankizumab in Crohn's disease: Results in real-world clinical practice in two tertiary hospitals in Malaga. RAPD 2026;49(2):43-49. DOI: 10.37352/2026492.1

Only one patient experienced treatment-related side effects requiring discontinuation.

Conclusion: In this cohort of patients from routine clinical practice, risakizumab treatment was effective in inducing and maintaining remission, with a good safety profile.

Keywords: Crohn's disease, Risankizumab, Effectiveness.

Introducción

Interleukin-23 (IL-23) inhibitors represent one of the emerging advanced therapies for the treatment of inflammatory bowel disease (IBD) in patients who have shown an inadequate response, loss of response, or intolerance to conventional or biologic therapy. These drugs bind to the p19 subunit of IL-23, thereby inhibiting IL-23-dependent cellular signaling and the subsequent release of proinflammatory cytokines[1].

The IL-23 inhibitors approved for the treatment of Crohn's disease (CD) are guselkumab, mirikizumab, and risankizumab.

Focusing on risankizumab, the pivotal study supporting its approval for CD consists of two induction trials (ADVANCE and MOTIVATE) and one maintenance trial (FORTIFY). These studies reported clinical remission rates of 45% and 42% after 12 weeks of treatment and 52% after 52 weeks[2,3].

The objective of this study was to evaluate the effectiveness of risankizumab in patients with CD.

Methodology

Design and study population

We conducted a retrospective, multicenter observational study that included patients diagnosed with CD aged 18 years or older who were being followed at the Virgen de la Victoria Hospital (HVV) and the Regional University Hospital (HRU) in Málaga and who initiated treatment with risankizumab between November 2023 and October 2024. Patients with ulcerative colitis or unclassified colitis were excluded. Data were obtained by reviewing the medical records of participating patients using an anonymous database created for this purpose.

The primary objective of the study was to analyze remission rates and clinical response at 12, 26, and 52 weeks after initiating treatment with risankizumab. Clinical response was defined as a decrease of ≥3 points in the Harvey-Bradshaw Index (HBI), and clinical remission was defined as an HBI score of ≤4. Biological remission was assessed by measuring fecal calprotectin (FCP) using an enzyme-linked immunosorbent assay (ELISA).

Biological remission was defined as FCP values <250 µg/dL.

Corticosteroid-free clinical remission was defined as an HBI score of ≤4, along with the absence of a need to introduce corticosteroids (systemic or topical) during treatment with risankizumab. For patients who started risankizumab and were previously on active corticosteroid therapy, corticosteroid-free clinical remission was defined as the ability to discontinue corticosteroids within 12 weeks.

Statistical Analysis

Qualitative variables were presented as absolute values and percentages, while quantitative variables were presented as medians and interquartile ranges (IQR).

Statistical comparisons of clinical markers (HBI) and biomarkers (FCP) were performed using the Wilcoxon test. A p-value ≤ 0.05 was considered statistically significant. Qualitative variables were compared using the chi-square test. Drug persistence was calculated using Kaplan–Meier curves. IBM SPSS Statistics was used for the statistical analysis of the data.

Results

Demographic and Clinical Variables

A total of 51 patients were included in the study, 15 from the HVV and 36 from the HRU. Table 1 summarizes the clinical and demographic characteristics, and figure 1 shows the patient flow.

Analysis of Clinical Remission

Table 2 shows the median HBI score at 12, 26, and 52 weeks after the start of treatment. Figure 2 illustrates the rates of remission and clinical response, both with and without concomitant corticosteroid therapy.

The median baseline HBI score for patients was 8 (IQR 6–12), decreasing to 6 (IQR 4–9) at week 12 ($p < 0.001$), to 5 (IQR 0–3) at week 26 ($p < 0.001$), and to 4 (IQR 3–7) at week 52 ($p < 0.001$).

DOI: 10.37352/2026492.1

	Risankizumab
Baseline characteristics	(Patients n=51)
Age (years), median (IQR)	50
Gender, n (%):	
Man	20 (39.2)
Women	31 (60.8)
Smokers, n (%)	9 (17.6)
Duration of disease (years), median (IQR):	13 (7–23)
Extent, n (%)	
Ileal	30 (58.8)
Colonic	3 (5.9)
Ileocolitis	16 (31.4)
High-grade involvement	2 (3.9)
Pattern of involvement, n (%)	
Inflammatory	16 (31.4)
Stenosing	23 (45.1)
Fistulizing	12 (23.5)
Perianal disease, n (%)	13 (25.5)
Previous surgeries, n (%)	27 (52.9)
MEI	
Rheumatology, n (%)	4 (7.8)
Dermatology, n (%)	5 (9.8)
Ophthalmology, n (%)	0 (0)
Hepatobiliary, n (%)	0 (0)
Hematologic, n (%)	0 (0)
Bone, n (%)	1 (2)
Total, n (%)	10 (19.6)
Previous anti-TNF treatment, n (%)	44 (86.3)
Previous treatments, n (%)	
Infliximab	31 (60.8)
Adalimumab	28 (54.9)
Ustekinumab	38 (74.5)
Vedolizumab	11 (21.6)
Upadacitinib	5 (9.8)
Number of previous biologics/small molecules, n (%)	
0	1 (2)
1	11 (21.6)
2	20 (39.2)
3	14 (27.5)
≥4	5 (9.8)
IQR: Interquartile range n: Number EIM: Extraintestinal manifestations Spa: Spondyloarthropathies	

Table 1. ***Demographic and clinical variables.***

DOI: 10.37352/2026492.1

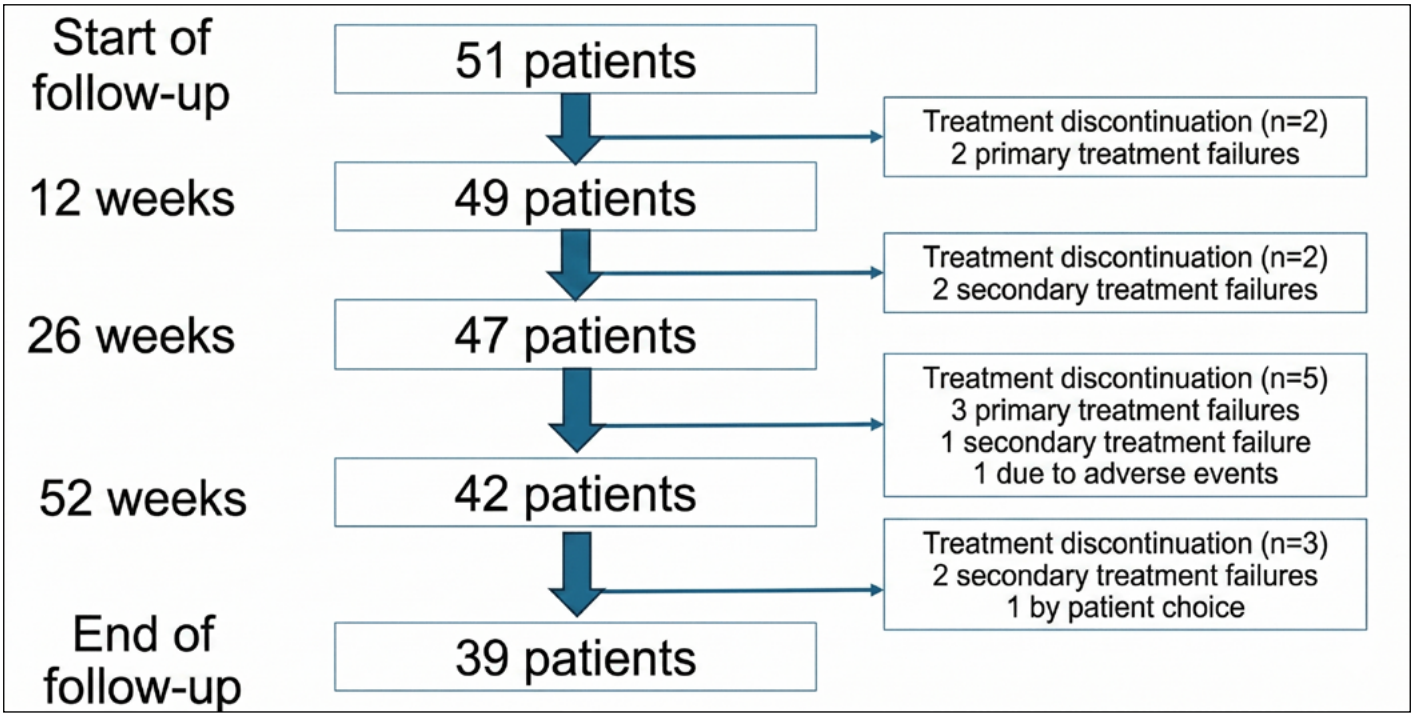


Figure 1. ***Patient flow.***

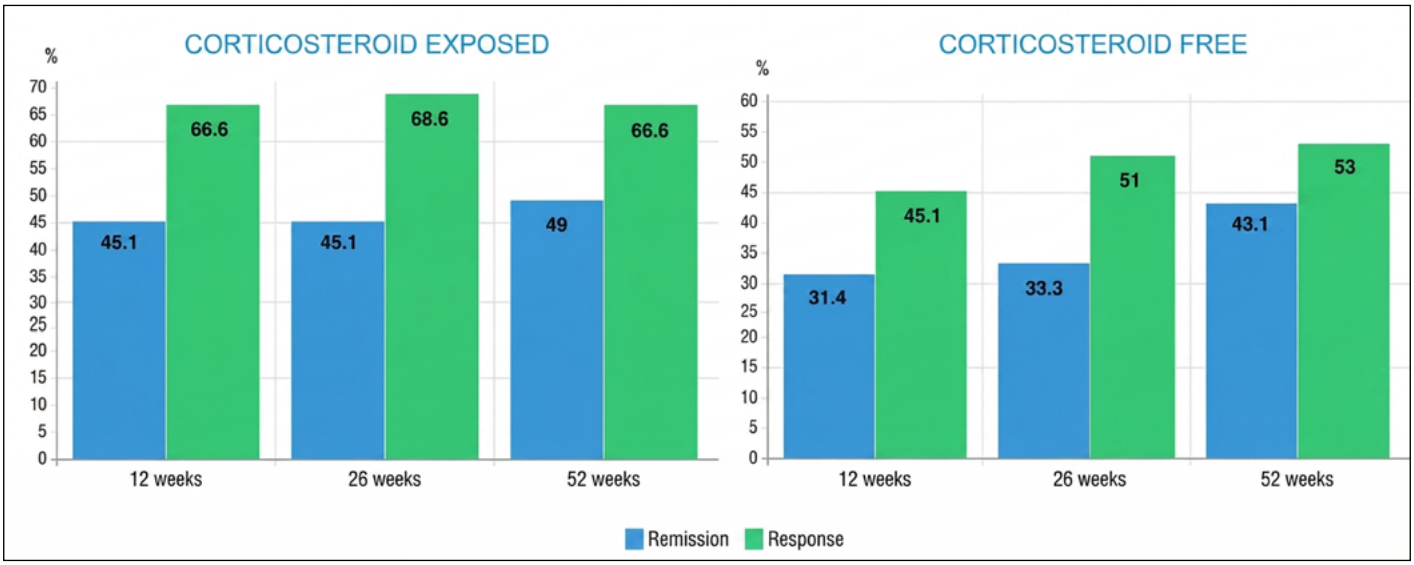


Figure 2. ***Remission and short-, medium-, and long-term clinical response in patients exposed to corticosteroids (A) and in corticosteroid-free patients (B).***

Baseline HBI, median (IQR) [n]	8 (6-12) [n=51]
HBI 12 w, median (IQR) [n]	6 (4-9) [n=51]
HBI 26 w, median (IQR) [n]	5 (3-8) [n=49]
HBI 52 w, median (IQR) [n]	4 (3-7) [n=47]
HBI: Harvey-Bradshaw Index; w: weeks	

Table 2. ***Scores on clinical indices.***

From the 51 patients included at the start of follow-up, at 12 weeks, 66.6% (34/51) achieved a clinical response and 45.1% (23/51) achieved remission. Of the patients who achieved remission, 31.4% (16/51) did so without corticosteroids.

At 26 weeks, 68.6% (35/51) achieved a clinical response. Remission was achieved by 45.1% of patients (23/51), of whom 33.3% (17/51) achieved it without corticosteroids.

66.6% (34/51) responded after 52 weeks of treatment. Of these patients, 49% (25/51) achieved clinical remission,

DOI: 10.37352/2026492.1

and 43.1% (22/51) did so without the need for corticosteroid therapy.

The risankizumab maintenance regimen was intensified in 10 patients who had shown an incomplete response. In all cases, the dosing interval was shortened from 360 mg subcutaneously every 8 weeks to every 6 weeks. The median time to initiation of the intensified regimen was 9.5 months (IQR 6–14). 30% of the patients who received intensified treatment (3 out of 10) experienced a clinical response following this change.

Analysis of Biological Remission

Biological remission, defined as an FCP < 250, was achieved in 11 patients (21.56%) at both 12 and 26 weeks ($p < 0.05$), and in a total of 12 patients (23.52%) at 52 weeks ($p < 0.001$) (Figura 3).

Treatment persistence

The persistence curve for risankizumab is shown in Figure 4.

The median treatment duration was 18 months (IQR 14–20), with treatment persistence at 12 months of 84% and 75% at 24 months. A total of 12 patients (23.5%) discontinued risankizumab during follow-up. The reasons for discontinuation were: primary failure in 5 patients (41.6%), secondary failure in another 5 (41.6%), adverse effects in 1 (8.3%), and 1 case of a patient who voluntarily decided to discontinue treatment (8.3%). The median time to discontinuation was 10 months (IQR 6–13.5).

Treatment Safety

17.6% of patients (9/51) reported adverse events during treatment with risankizumab, most of which were mild (headache, rhinitis, dizziness, etc.). Only 5.8% (3/51) experienced a serious adverse event: (a) urinary tract infection, (b) pneumonia, and (c) a neoplastic disease (small intestine adenocarcinoma), the latter being the only patient in the study who permanently discontinued treatment due to an adverse event, although this cannot be directly attributed to the drug.

Discussion

Risankizumab is a drug recently added to the therapeutic arsenal for CD, so references in the literature regarding it are scarce. This study evaluated the efficacy and safety of risankizumab treatment in patients with CD refractory to other therapies in real-world clinical practice at two tertiary care hospitals in the city of Málaga.

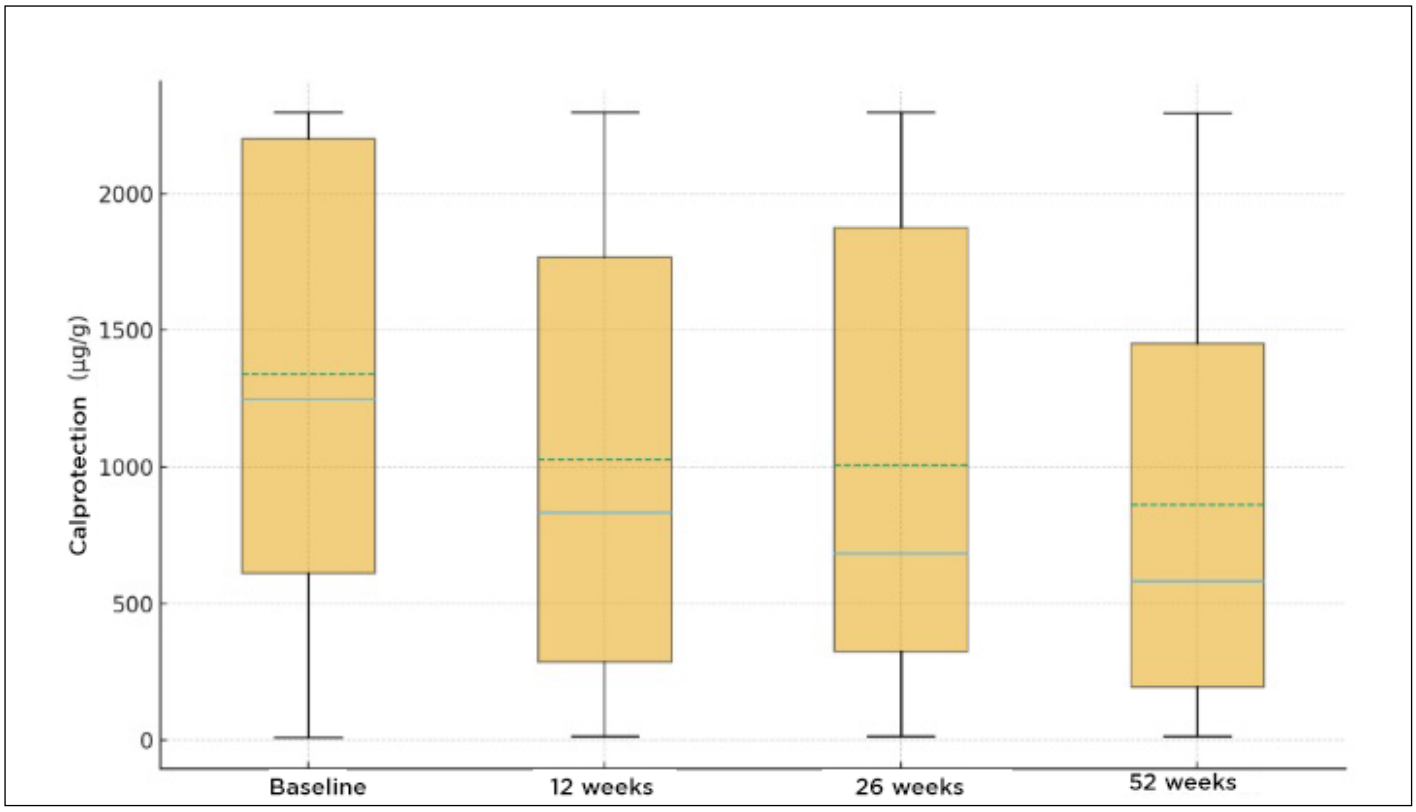


Figure 3. ***Box plots of the FCP at the four evaluation time points.***

DOI: 10.37352/2026492.1

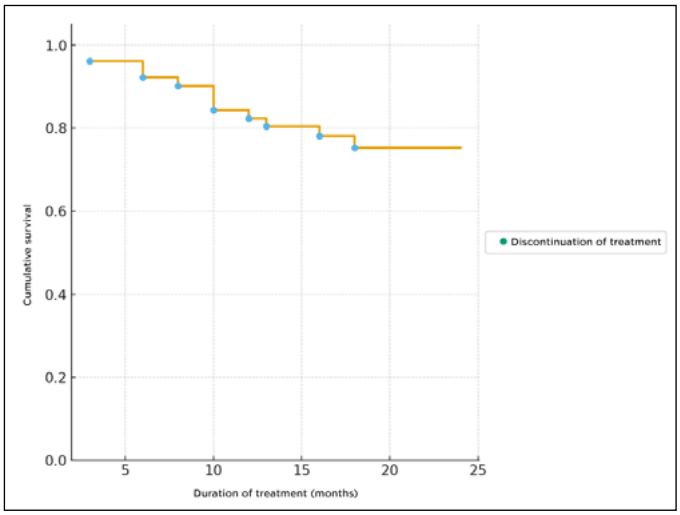


Figure 4. ***Treatment persistence curve.***

The clinical remission rates observed at weeks 12 and 52 were virtually identical to those reported in the pivotal studies (45% and 42% at 12 weeks and 52% at 52 weeks)[2,3], and are also consistent with the major real-world studies published to date, which, like our study, included a highly refractory population[4-8].

Our mid- and long-term results show that risankizumab is effective in maintaining the response over time, with a treatment persistence rate at one year of 84%, data that are consistent with other real-world studies[9-11].

Normalization of FCP was achieved in approximately 1 in 4 patients following induction in our study, findings equivalent to a post-hoc analysis of the pivotal risankizumab study[12].

A favorable safety profile was observed, with a rate of serious adverse events below 6%, a figure similar to that reported in the pivotal studies[2,3] and the main real-world studies[6,7].

The study's limitations stemmed from its retrospective observational nature, small sample size, and the absence of systematic endoscopic evaluation and imaging parameters (ultrasound or enteric MRI) to assess treatment response.

In conclusion, risankizumab is an effective treatment for patients with Crohn's disease who are refractory to other advanced therapies in real-world clinical practice, with a good long-term treatment persistence rate and an acceptable safety profile.

Bibliography

1. *Agencia Española de Medicamentos y Productos Sanitarios (AEMPS). Informe de Posicionamiento Terapéutico de Risankizumab (Skirizy). Madrid: AEMPS; 2024. Disponible en: https://www.cofguadalajara.es/cofgu%5CDocumentos%5CRepositorios%5CNotas%20informativas%20AEM%5CIPT-266-Skyrizi-risankizumab.pdf*

2. *D'Haens G, Panaccione R, Baert F, Bossuyt P, Colombel JF, Danese S, et al. Risankizumab as induction therapy for Crohn's disease: results from the phase 3 ADVANCE and MOTIVATE induction trials. Lancet. 2022 May 28;399(10340):2015-2030. doi: 10.1016/S0140-6736(22)00467-6.*

3. *Ferrante M, Panaccione R, Baert F, Bossuyt P, Colombel JF, Danese S, 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 May 28;399(10340):2031-2046. doi: 10.1016/S0140-6736(22)00466-4.*

4. *Chung CS, Chang CH, Kuo CJ, Chou JW, Huang TY, Hsu WH, et al. Efficacy and safety of Risankizumab for moderate-to-severe Crohn's disease: first Asian real-world data (STAR trial).*

5. *Alzaabi MN, Swaid TK, Ahmed HA, Alahmad MA, Omar NM, Chitra Kumar KK, et al. Real-World Effectiveness of Risankizumab in Crohn's Disease: Outcome Data for an IL-23 Inhibitor from the Middle East. Crohns Colitis 360. 2025 Nov 9;7(4):otaf062. doi: 10.1093/crocol/otaf062.*

6. *Elford A, Plevris N, Constantine-Cooke N, Shah K, Faloon S, Colwill M, et al. P0832 Real-world effectiveness of risankizumab in Crohn's Disease: The UK Experience. Journal of Crohn's and Colitis. 22 de enero de 2025;19(Supplement_1):i1586-8.*

7. *Zare B, Gros B, Lal N, Dawson P, Sharma E, Dart RJ, et al. Effectiveness of risankizumab induction and maintenance therapy for refractory Crohn's disease: a real-world experience from a preapproval access programme and early access to medicines scheme. Frontline Gastroenterol. noviembre de 2024;15(6):499-506.*

8. *Zoughlami A, Abbas A, Almushir S, Zeghal M, Khan NS, Milgrom R, et al. P0978 Effectiveness of risankizumab in moderate-to-severe Crohn's Disease: A Canadian multicentric real-world study. Journal of Crohn's and Colitis. 22 de enero de 2025;19(Supplement_1):i1818-9.*

DOI: 10.37352/2026492.1

9. Fumery M, Caron B, Hébuterne X, Altwegg R, Roblin X, Stefanescu C, et al. Long-term Outcome of Risankizumab in Crohn's Disease: a Real-world GETAID Study. Clinical Gastroenterology and Hepatology. diciembre de 2024;22(12):2451-2458.e1.

10. Geeganage G, Gade A, Saraga A, Deyhim T, Zullow S, Rabinowitz LG, et al. Long-term Outcomes of Patients with Crohn's Disease Treated with Risankizumab. Inflamm Bowel Dis. 2025 Dec 1;31(12):3313-3319. doi: 10.1093/ibd/izaf162.

11. Alsoud D, Sabino J, Franchimont D, Cremer A, Busschaert J, D'Heygere F, et al. Real-world Effectiveness and Safety of Risankizumab in Patients with Moderate to Severe Multirefractory Crohn's Disease: A Belgian Multicentric Cohort Study. Inflamm Bowel Dis. 2024 Dec 5;30(12):2289-2296. doi: 10.1093/ibd/izad315.

12. Atreya R, Ferrante M, Panaccione R, Feagan B, Shchukina O, Jairath V, et al. Risankizumab Is Associated With Normalization of Biomarkers in Patients With Crohn's Disease: Results From the Phase 3 ADVANCE, MOTIVATE, and FORTIFY Studies. Journal of Crohn's and Colitis. 4 de abril de 2025;19(4):jjae164.

DOI: 10.37352/2026492.1