



Is STRIDE II achievable in everyday clinical practice?

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Slovenian journal of gastroenterology / Gastroenterolog 2025; supplement 2: 11–12

Keywords: Crohn's disease, ulcerative colitis, STRIDE II, treat-to-target

INTRODUCTION

In 2015, the Selecting Therapeutic Targets in Inflammatory Bowel Disease (STRIDE) initiative proposed evidence- and consensus-based treatment targets to support treat-to-target strategies in clinical practice. The updated STRIDE-II recommendations, published in 2021, comprise 13 recommendations that incorporate time-dependent treatment goals and drug-specific time points (1). STRIDE-II reflects advances in therapeutic approaches and growing evidence that achieving more ambitious targets—such as endoscopic healing, absence of IBD-related disability, and normalization of quality of life—improves long-term outcomes (2). Nonetheless, concerns have been raised regarding the validity, applicability, and daily clinical impact of these recommendations (1).

DISCUSSION

The framework of STRIDE II defines short-, intermediate-, and long-term treatment goals, with scheduled reassessment of disease activity against predefined targets serving as the basis for therapeutic decisions. The consensus targets combine clinical and patient-reported remission, biomarker normalization, and endoscopic healing. While endoscopic healing is endorsed, it may not be appropriate or achievable for all patients (3). Despite its aim to

harmonize standards of care, adherence to STRIDE-II in real-world practice remains suboptimal (1). Ambitious targets such as mucosal or histological healing are often difficult to achieve with current therapeutic options, and some proposed measurement tools (clinical assessments, patient reported outcomes (PROs), biomarkers, imaging, histology) lack validation, are resource-intensive, or are not widely accessible. In addition, the generalization of treatment goals across the heterogeneous IBD population may not be appropriate, particularly in elderly patients or those with multiple therapeutic failures. Further obstacles include limited access to trained specialists, advanced imaging, and innovative therapies, as well as financial and time constraints in daily practice (1).

Real-world studies indicate that objective data for IBD evaluation, as required by STRIDE-II, are frequently unavailable, limiting guideline application and reducing the likelihood of achieving recommended endpoints such as mucosal healing. This has led to suggestions that some STRIDE-II targets may be overly stringent or insufficiently evidence-based, supporting calls for the definition of less stringent or alternative goals in selected patient subgroups (1). Improved patient stratification and identification of predictors of therapeutic response are considered essential to enhance the effectiveness of treat-to-target strategies (2).

Key challenges for implementation include:

- establishing a uniform definition of mucosal healing,
- demonstrating the long-term benefits and risk-benefit ratio of treat-to-target strategies in randomized controlled trials (particularly in ulcerative colitis),
- developing cost- and time-efficient monitoring tools (e.g. intestinal ultrasound, with potential targets such as transmural healing),
- refining patient stratification strategies (e.g. asymptomatic, geriatric, paediatric, comorbid populations),
- identifying predictors of response to guide first-line therapy selection,
- updating recommendations with emerging therapies and new treatment targets,
- improving early diagnosis and intervention, and
- ensuring feasibility of implementation in low-resource healthcare settings (2).

Currently, the most important long-term achievable targets remain clinical remission, endoscopic healing, restoration of quality of life, and absence of disability. Symptom control is regarded as the immediate goal, while serum and fecal biomarkers are considered feasible medium-term targets. Deep remission, defined as the combination of clinical, endoscopic, histological, and transmural healing, remains aspirational for most patients with currently available therapies. Transmural healing in Crohn's disease and histological healing in ulcerative colitis are increasingly recognized as adjunctive measures of treatment response. However, individualized decision-making remains necessary, and clinical choices may diverge from the suggested algorithm depending on patient-specific circumstances (4).

CONCLUSION

STRIDE-II provides a structured framework for treat-to-target management in IBD, but its integration into daily clinical practice faces significant challenges. These include limited resources, variable uptake, and insufficient validation of some endpoints. To enhance applicability, models of care that are cost-effective, scalable, and adaptable to both high- and low-resource settings are needed. Incorporating non-invasive monitoring tools, such as point-of-care intestinal ultrasound, may improve feasibility. Patient engagement and clinician education are critical for successful adoption. Addressing these barriers is essential to realize the full potential of the treat-to-target approach in IBD care (3).

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