

studie prokázaly jeho signifikantní ekonomický přínos v porovnání s empirickým rozhodováním, nehledě na klinické dopady případné nevhodné optimalizace léčby (43, 57, 58, 67–69). V poslední době se objevují také studie, které naznačují cost-efektivnost pTDM (70).

Závěr

- Podstatou TDM je měření hladiny léčiva před jeho dalším podáním a detekce případných protilátek proti němu.
- Cílem je optimalizace léčby, aby byla bezpečná a zároveň maximálně účinná.
- V případě lumenální choroby IBD se terapeutické hladiny IFX pohybují v rozmezí 5–10 mg/l, léčba perianální choroby vyžaduje hladiny vyšší (10–20 mg/l).

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- Přidání imunosupresiva k IFX zvyšuje jeho hladinu a snižuje tvorbu antiinfliximabových protilátek.
- V současné době se nejčastěji TDM provádí při selhání terapie (reaktivní přístup), do budoucna se bude zřejmě více uplatňovat i proaktivní monitorování v období remise s cílem zabránit relapsu onemocnění.
- Při nízké hladině IFX a negativních protilátkách se léčba IFX intenzifikuje, při pozitivních protilátkách se provádí zpravidla switch – záměna za jiný a-TNF α , event. swap – záměna za biologikum s jiným mechanismem účinku. Je-li hladina IFX v době selhání terapie dostatečná, provádí se swap.
- Reaktivní monitorování farmakokinetiky je medicínsky i ekonomicky přínosné.

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