

Should we establish standards of care for management of elderly patients with inflammatory bowel disease?

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Elderly patients with inflammatory bowel disease (IBD) have poorer outcomes than their younger counterparts with increased inpatient mortality rates, infection rates, lymphoma rates (1), and intolerance to immunosuppressive agents or tumour necrosis factor inhibitors (TNFi) (2). These may lead to hesitancy in prescribing effective immunosuppressive drugs and TNFi to elderly patients, especially in individuals with comorbid conditions. Overuse of corticosteroids, however, has significant deleterious effects in elderly patients including osteoporosis, hypertension, diabetes, ocular complications, infections and postsurgical complications. Some elderly patients with IBD may also have very indolent disease and it is important not to overtreat them.

Several studies, including the report by Stepaniuk et al (3) in the current issue of the *Journal* (pages 273-277), have clearly shown that elderly patients receive less TNFi and less immunosuppressive drugs than their younger counterparts with IBD (4). While whether such undertreatment contributes to poorer outcome and complications in elderly patients still requires robust evidence, it is also of concern that elderly patients may be treated and monitored less rigorously and objective end points, such as mucosal healing, may never be reached. Introduction of newer therapies, such as the integrin inhibitor vedolizumab, may offer potentially certain safety advantages. TNFi may also be considered in this population as monotherapy rather than combination therapy in the presence of comorbid conditions such as chronic obstructive airways disease. Rapid control of more severe disease is essential to prevent increased morbidity and complications in elderly individuals.

Several areas of management of IBD in elderly patients require specific attention (Box 1). These include establishment of diagnosis by robust exclusion of several conditions such as colon cancer, infections, especially *Clostridium difficile*, ischemic colitis, diverticular colitis and angiodysplasia. Monitoring by regular use of C-reactive protein, fecal calprotectin, complete blood count and liver function tests is necessary to avoid the necessity of frequent invasive investigations and avoid hematological or other complications. Transabdominal ultrasonography for distal ileal Crohn disease may be a very useful noninvasive monitoring modality because it is well tolerated. Endoscopic surveillance to detect dysplasia may be especially challenging in elderly patients due to the high prevalence of diverticular disease and polypoid lesions leading to difficulty in deciding on local endoscopic resection strategies (5) versus panproctocolectomy with potentially increased morbidity. It is also important to vaccinate elderly patients against common infective preventable diseases and be aware of the high incidence of herpes zoster. The use of steroid-sparing agents, such as azathioprine, methotrexate and TNFi, is important in elderly patients to avoid excessive use of steroids in moderate to severe IBD and ensure mucosal healing. Finally, inpatients need careful prophylaxis against thromboembolism, vigilance against nosocomial infections and surgery if required in a timely manner before advanced disease, poor nutrition and infections lead to postoperative complications and poor outcome including mortality. Elderly patients are often troubled by fecal incontinence after pouch surgery and a permanent ileostomy is often a preferred approach. However, elderly

patients with adequate sphincter function may do well after pouch surgery. Multidisciplinary management of these elderly patients is especially important given the comorbid conditions that are often present.

While there are many guidelines and an increasing number of standards of care to optimize management of IBD, there are no specific guidelines for comprehensive management of elderly patients with IBD. This appears to be an omission that requires attention by national and international organizations. Many of the issues in the elderly population also require further generation of evidence because these patients form only a small fraction of patients in clinical trials.

BOX 1

Specific issues influencing management of IBD in elderly patients

Differential diagnosis: Distinguish among ischemic colitis, colon cancer, diverticular colitis, *Clostridium difficile*, lymphocytic colitis, angiodysplasia.

Management: Variation in care compared with nonelderly patients, especially lower use of immunosuppressive drugs and TNFi. Risk for poor control of disease.

Complications: Increased risk for infections, lymphoma, herpes zoster, mortality after surgery. Fecal incontinence after ileal-pouch anal anastomosis.

Dysplasia surveillance: Increased prevalence of colonic polypoid lesions and challenge to determine local resection versus panproctocolectomy.

Challenges to therapy: Comorbid conditions such as heart failure, diabetes, hypertension, chronic obstructive lung disease, concurrent or previous malignancy, drug interactions, thromboembolism and osteoporosis.

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