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CROHN'S & COLITIS FOUNDATION

Managing Inflammatory Bowel Diseases in the Elderly Population (Those After the Age of 60)

The incidence of Inflammatory Bowel Diseases (IBD) is increasing worldwide and as our population ages, we will be caring for a growing number of IBD patients who are transitioning into advanced age. Although the peak incidence of IBD is between ages 20-39 years, a second peak is recognized between ages 50-70. (Molodecky, Soon, Rabi, et al. 2012; Katz, Pardi, 2011)

The debilitating effects of IBD compounded with age-related decrements in health and functional capacity, make medical management of older patients distinctly challenging to clinicians.

TIP #1: Compare the important clinically different presentations in the elderly to the younger patient. (Nimmons, Limdi, 2016. Gisbert, Chaparro, 2014)

Crohn's Disease

- Diagnosis is delayed in older individuals with a mean time delay of 6 years compared to 2 years in younger individuals
- More colonic involvement and inflammatory disease with lower frequency of fistulas and strictures
- Presents with less bleeding and abdominal pain
- First episode is more severe compared to the younger individual
- Change in disease behavior is less progressive in the elderly

Ulcerative Colitis

- Left-sided or extensive disease more common than isolated proctitis
- Presents with less diarrhea, abdominal pain, and weight loss
- Disease behavior more likely to remain stable

Both

- Extraintestinal manifestations are less
- Less likely to have family history of IBD
- Higher risk of non-Hodgkin's lymphoma with thiopurines
- Higher risk of non-melanomatous skin cancer with anti-TNF therapy

TIP #2: Recognize barriers for the delay in diagnosis in the elderly. (Harper, McAuliffe,Beeken, 1986)

- Disinclination to seek medical advice
- Lack of access to specialist healthcare
- An initial misdiagnosis compared to younger patients
- Higher prevalence of conditions mimicking and confused with IBD in the elderly. This prevalence may affect the true incidence of IBD assessed.
    - Complicated diverticular disease (diverticulitis and diverticular bleeding)
    - Radiation colitis
    - Non-steroidal anti-inflammatory intestinal injury

- Ischemic colitis
- Infective colitis

TIP #3: Identify complex management challenges in the elderly. (Roman, Munoz, 2011. Charpentier, Salleron, Savoye, et al. 2014.)

- Clinical co-morbidities
- Polypharmacy
- Social issues
- Mismatch between chronological and biological age (functional status)
- Currently no consensus guidelines to manage the elderly
- Patients' over the age of 65 frequently excluded from clinical studies may limit evidence-based decision making

TIP #4: Recognize that elderly patients are hospitalized more than younger patients, with worse outcomes. (Ananthakrishnan, Binion, 2009. Bassi, Dodd, et al. 2004. Odes, Vardi, et al. 2006. Loftus, 2002)

- More ill
- More malnourished
- Anemic/higher transfusion requirements
- Hypovolemic
- Longer post-op hospital stay especially after surgery

TIP #5: Identify crucial considerations in the therapy of IBD in the elderly. (van Duin, Mohanty, et al. 2007. Drey, Kaiser, 2011. Gavazzi, Krause 2002. Stallmach, Hagel, et al. 2011. Cross, Wilson et al. 2005. MacLaughlin, Raehi, et al. 2005)

- Immune function declines with age
  - Malnutrition also accentuates decline in immune function
- Treatment with immunosuppressive medications increases risk of opportunistic infection and possibly even malignancy
- Polypharmacy is common and may impact adherence and thus, clinical outcomes
- Age-related conditions
- Home circumstances
- Impaired mobility
- Impaired memory
- Consequent need for practical support

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