Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/gi-insights/evaluating-treating-ibd-in-the-elderly/13318/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Evaluating & Treating IBD in the Elderly

Dr. Buch:
Inflammatory bowel disease in the elderly compared to IBD in younger patients is characterized by a different disease course and increased risk of mortality. So how can we achieve better outcomes for our elderly patients?

Welcome to *GI Insights* on ReachMD. I'm your host Dr. Peter Buch, and joining me today to talk about IBD in the elderly is Dr. Benjamin Cohen, who's the Co-Section Head and Clinical Director for Inflammatory Bowel Disease at the Cleveland Clinic. He's published extensively on IBD and is a leader in IBD education.

Dr. Cohen, thanks so much for joining us today.

Dr. Cohen:
Thanks for having me. I'm excited to talk about this important topic.

Dr. Buch:
To start us off, Dr. Cohen, can you please compare the clinical presentation of ulcerative colitis and Crohn's disease in the elderly versus the presentation in younger patients?

Dr. Cohen:
Sure. So most IBD patients are diagnosed in their third and fourth decade of life, but there's data that shows a second peak between the ages of 50 and 70, and up to 20% of patients from some data from Denmark can have their index diagnosis after the age of 60. And this diagnosis in later-onset IBD can be challenging for clinicians, and it may be delayed while they're investigating or treating other comorbidities in that patient group, and as many as 60% of patients with Crohn's can be initially misdiagnosed, which is 4-fold increase from even younger patients, and there's been delays in diagnosis compared to younger patients when looking at historical data.

Part of the reason for this can be in elderly-onset IBD, the symptoms may be a little more subtle. There may be less severe diarrhea, less rectal bleeding, and abdominal pain. In Crohn's disease, it can be more likely to present with a non-stricturing and non-fistulizing phenotype. And the disease course in elderly-onset IBD tends to be a little more stable and less progressive.

Both younger onset and older onset IBD are similar in terms of the presence of extraintestinal manifestations, but I think part of the challenge here is you have to consider that there are some potential mimicked diseases in the older population, so the differential has to include things like infectious colitis, NSAID-induced enterocolitis, ischemic colitis, segmental colitis associated with diverticulosis, radiation colitis, and even microscopic colitis in this patient group.

Dr. Buch:
With that background in mind, let's talk about hospital treatments and medications for these patients. Should we be concerned about the use of anti-TNF medications in the elderly?

Dr. Cohen:
So I think the biggest medication to be concerned about in the elderly is actually use of systemic corticosteroids. I mean, these have been associated with serious side effects, including hypertension, hyperglycemia, delirium, bone loss, glaucoma, cataracts, and even cardiovascular effects, so our focus should be really treating the patient in front of us and getting their disease under control and putting them on steroid-sparing medications. And even Medicare data suggested low rates of use of steroids during therapy, such as anti-TNF drugs in older patients.

Now there are some safety considerations associated with anti-TNF drugs, but they are generally very safe. I think some of the limitations in the elderly may be that they can't be used in patients with severe cardiomyopathy or heart failure. There is a small increased risk of certain malignancies, such as lymphoma, which we know can be of increased incidence in elderly patients. But in general, I think the data has shown a 2- to 3-fold increase in lymphoma in patients on anti-TNF irrespective of age, but it's a very low absolute risk, even in the elderly, so I think we have to think about what the patient is presenting with. If they have an indication that suggests that they should be an anti-TNF therapy, whether it be perianal disease, fistulizing disease, certain extraintestinal manifestations that may be more likely to respond to an anti-TNF drug, I would have no hesitation in treating them. You don't want to undertreat them. But if all things are equal, you may think about using some of the other advanced therapies with different safety profiles.

Dr. Buch:
Which is a perfect segue to our next question, Dr. Cohen. Should we be using more vedolizumab and ustekinumab in the elderly because of the safety profile?

Dr. Cohen:
Yes, I think vedolizumab and ustekinumab are attractive because of their safety profiles. Vedolizumab is an anti-integrin molecule and has some gut selectivity associated with it that makes it attractive in terms of not having the risks of lymphomas or other malignancies or systemic infections, and ustekinumab, in the time we've had it has had a very similar safety profile to vedolizumab. So again, it goes back to the point I made earlier where if everything were equal and you have a patient in whom you think any of the available options would be equally efficacious for the patient, then I may select a drug like vedolizumab or ustekinumab preferentially because of safety, but the other thing I would caution is that, with a lot of these drugs, we don't have great data in terms of the safety and efficacy in older patients because these patients may be excluded from clinical trials, either due to age or comorbidities, so much of what we know is based on retrospective real world data, so we may learn things in the future, and it's important that we actually put a focus on collecting real world data on older patients so that we can understand better if there's a reason to use one of these drugs preferentially. But long story short, you want to pick the right drug for the patient based on their disease presentation and their comorbidities, and I think that's how you should focus your care.

Dr. Buch:
Thank you. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Benjamin Cohen about inflammatory bowel disease in the elderly.

So Dr. Cohen, if we continue focusing on the available treatments, should early surgery be considered for the elderly with ulcerative colitis?

Dr. Cohen:
Yes, I think it's an interesting concept. The risk of surgery in older patients has been around 20% at 5 years in Crohn's and around 10% in ulcerative colitis at 5 years from population-based studies. There have been a few studies that have looked at whether the risk of surgery is more or less in the elderly population. I don't think there's been a convincing signal either way for it. The concept you're talking about would be whether earlier elective surgical intervention may be preferentially pursued to avoid side effects of long-term medical therapy. And again, I think you have to talk with your patient and understand sort of what their risk/benefit decision-making would look like because it may be different for different patients, so you want to understand their comorbidities. If there's somebody who may be higher risk from being on an immunosuppressive therapy of some kind, maybe surgery would be the right answer for them, but in other patients, they may prefer to be on medical therapy than go through a surgery. Older patients are at increased risk of postoperative complications, so it's not a trivial decision.

Dr. Buch:
Let's circle back to this topic. How concerned are you about the infection risk in elderly patients with IBD?

Dr. Cohen:
Age is definitely a risk factor for infections. Ashwin Ananthakrishnan has published on the higher likelihood of infection-related hospitalizations in older IBD patients and their higher risk for complications related to their infections. So I think the key point is that we have to be vigilant with preventative measures, so vaccinating all patients but definitely older patients for influenza yearly, pneumococcal infections. In the era of COVID, we have to make sure everybody is getting their COVID vaccinations and getting boosted based on the more recent data. And additionally in this patient group, we worry about varicella zoster, especially with some of the newer JAK inhibitors because we can see higher rates of shingles infections, so we want to make sure our older patients are vaccinated for that because there can be a lot of morbidity associated with those infections. And I think we shouldn't necessarily just look at age as the only indicator. Age is really just a number. I think the emerging metric to look at is frailty, and that's more of the predictor of poor outcomes. You can have an older patient who's very fit, very active and in good condition, and you can have somebody who's a little bit younger who's more frail, and that person is going to be at higher risk for infections and complications related to those infections.

Dr. Buch:
Thank you. How would you think about thrombotic risk in the elderly patients with IBD?

Dr. Cohen:
Yeah, this is another important topic. Older patients are, generally speaking, going to be at higher risk for venous thromboembolism. That could be due to any number of reasons. It could be that they're less active. It could be due to comorbid conditions. And then when you superimpose IBD on top, that can elevate their risk more. We know that, in particular, active ulcerative colitis is a significant risk factor across all age groups for venous thromboembolism, and then active Crohn's disease as well, and probably higher if you're talking about Crohn's/colitis, so I think number one is you want to control active disease. In terms of IBD risk, that's going to be the biggest thing you can do to decrease their risk of venous thromboembolism. So going back to the points we discussed before, it's really choosing the right medications for the right patient and getting their disease under control.

Now some of the newer medicines that have come out have had some thrombotic risk associated with them. The biggest one in the last couple years are the JAK inhibitors where there's a FDA warning on those drugs due to some findings of increased risk of pulmonary embolism in older patients with rheumatoid arthritis treated with JAK inhibitors who had also cardiovascular risk factors, so that's led to some warnings even in the IBD population, but I think it's important to note that we haven't actually seen that signal in the data of IBD patients for increased thrombotic risk, but it's important that we be aware of it. It's important that we minimize risk factors for patients. And again, the biggest risk factor for venous thromboembolism is going to be active disease, so we want to treat their disease.

Dr. Buch:
Before we conclude, Dr. Cohen, is there anything else you would like to share with our audience today?

Dr. Cohen:
I think the biggest thing is to not undertreat our older patients with IBD. We don't want to leave them on corticosteroids, which is going to put them at higher risk. We want to use effective therapies appropriately and treat the patient in front of you, not necessarily worrying about their age. We have to treat their disease and that will make a big difference in their quality of life. And we have to be conscious of the different risk factors that there are in older patients and address them and educate the patients about the appropriate therapies.

Dr. Buch:
Those are all great takeaways. And I really want to thank my guest, Dr. Benjamin Cohen, for sharing his insights. Dr. Cohen, it was great speaking with you today.

Dr. Cohen:
Thank you so much, and I enjoy listening to your podcast, and I think you really disseminate a lot of important information out into the medical community, so we appreciate it.

Dr. Buch:
Thank you kindly, sir. For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in the series, visit ReachMD.com/GIInsights where you can Be Part of the Knowledge. Thanks for listening and see you next time.