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Elderly Patients with IBD: Management Strategies and Care

Dr. Buch:
This is *GI Insights* on ReachMD, and I'm Dr. Peter Buch. Joining us today to discuss management of inflammatory bowel disease, IBD, in the elderly is Dr. David Hudesman. Dr. Hudesman is a Professor of Medicine and Co-director of NYU Langone's Inflammatory Bowel Disease Center.

Welcome to the program, Dr. Hudesman.

Dr. Hudesman:
Thank you so much. Happy to be here.

Dr. Buch:
Pleasure to have you. To start us off, Dr. Hudesman, what are some challenges that arise when diagnosing the elderly with IBD?

Dr. Hudesman:
So there's been an increase in the elderly IBD population, and it's estimated that probably about a third of our overall IBD population will soon be over the age of 60. And some of that is the aging population, and the second part is there's a second, smaller peak of new diagnoses, maybe about 15 percent of them that occur right around that age of 60. And so what makes a little more difficult diagnosing and managing these patients is there's different factors to consider, things like polypharmacy, things like biological versus chronological age, how fit these patients are versus how frail they are, and talking about different types of other comorbidities and side effects of medications.

Dr. Buch:
And let's get into some specific therapies. What are the preferred medications to treat ulcerative colitis in the elderly?

Dr. Hudesman:
So I think the most important thing is when we're initially approaching a patient with ulcerative colitis or, for that matter, Crohn's disease that's elderly, is we want to approach it the same general way. We want to pick effective medication. And what some recent data has shown is there's this hesitation to prescribe certain biologics in patients with both ulcerative colitis and Crohn's because of their age and fear of complications, and what you see is, specifically with ulcerative colitis, you see more mesalamine scripts and more steroid and prednisone scripts, and we know prednisone has plenty of its own side effects and less scripts of effective therapies, such as biologics and small molecules. And some of the recent data has shown that active disease, so active inflammation, is associated with more adverse outcomes in the elderly, not really these other comorbidities, so delaying appropriate treatment with the biologic, with a small molecule it can lead to more complications.

So I like to approach the patient the same way. Somebody with more moderate ulcerative colitis, this is when I like to start a therapy that's more targeted, so something like vedolizumab or an anti-integrin, ustekinumab, or mirikizumab, or IL-12/23 or IL-23 inhibitors. And now we have a couple of S1P receptor modulators, both ozanimod and entrezimod, on the market. So in the more moderate patient, I think these are all good options. When we're talking about a more severe patient, that's when I really rely on infliximab or one of our JAK inhibitors, like upadacitinib.

Now specifically when speaking about the elderly, that's when we need to take into account other comorbidities, how fit these patients are, and that could help narrow down what's the right medication for this specific patient.

Dr. Buch:

Thank you. And honing down specifically here, are there any special precautions when considering ozanimod in elderly patients?

Dr. Hudesman:
So for ozanimod, one of our S1P receptor modulators, and this medication modulates both receptors S1P1 and S1P5, is we need to do certain screening tests before starting. And one of that's a baseline EKG. But again, this is a screening test, so this is really looking for any types of severe bradycardias, sinus blocks, and heart blocks, and so forth. So if your patient does not have that, there's no reason not to start this therapy.

The other things we like to do in the elderly population that's important with these S1P receptor modulators is to screen for different types of eye conditions, like glaucoma, so that I do for all my patients over the age of 50 before starting the S1P receptor modulators. And then lastly, really again, polypharmacy could be a big issue with our elderly population, so looking what possible drug-drug interactions there are with an S1P receptor modulator and other therapies these patients might be on.

Dr. Buch:
And for those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. David Hudesman about treating IBD in the elderly.

So, Dr. Hudesman, what can you tell us about the preferred medications to treat Crohn's disease in the elderly?

Dr. Hudesman:
So I would say, similar to ulcerative colitis, we want to pick effective treatments. And there was an older concept that as you get older, your disease may burn out, your Crohn's disease may burn out, and you might not need therapies. And really, the data hasn't really shown that. So again, the biggest risk for this elderly population is active inflammation, and that's associated with adverse outcomes, infections, serious adverse events, hospitalizations.

So there was a recent data looking at using anti-TNFs in this patient population, and there was actually, active disease patients did better with anti-TNFs, and there were less of these complications than if you were cycling steroids. So similarly, I try to approach my patients the same way. In somebody with more moderate disease, perhaps an inflammatory phenotype, so no strictures or no fistulas, I like to start with a more targeted therapy like ustekinumab or risankizumab or IL12/23 or IL-23 inhibitors. And in a more complex disease, more severe disease, maybe deeper ileal ulcerations, any penetrating complications, that's when I use our anti-TNFs, and I really rely on infliximab and adalimumab.

I also think it's important when discussing therapies, especially with Crohn's disease, is that surgery, and possibly early surgery, should not be thought of as a last-line therapy, and sometimes it makes sense in our older population, depending on the comorbidities, to move to surgery a little bit sooner. And we've had some recent data. There was a trial called the LIR!C trial, which actually looked at patients without strictures, without fistulas, going for either starting on infliximab or an anti-TNF or going to a small bowel resection, and primary outcomes was quality of life; but when they specifically looked at the elderly population, all of the outcomes trended better towards the surgery arm. I'm not saying I'm recommending surgery for all of my patients, but I think delaying surgery and waiting for that patient to get more malnourished, worsening frailty will increase complications.

Dr. Buch:
Really appreciate that information about that LIR!C trial. So let's move on to this now. What are the health maintenance considerations for all patients with IBD? But are there any differences for the elderly?

Dr. Hudesman:
Yes. So for all of our patients with IBD, whether we're starting a patient on our biologic or any biologic or small molecule, first really is vaccinations. And if we're giving a patient a therapy that potentially could increase their risk of infections, we should do our best to vaccinate our patients. So flu vaccines I recommend for my patients, giving a pneumonia vaccine, whether Prevnar or Pneumovax 20, patients specifically on JAK inhibitors in TNFs, and I'm doing this more and more across the board for biologics, giving the Shingrix vaccine for shingles. So I think vaccinating across the board is extremely important to discuss with our patients.

Any of our patients, and this is specifically for the elderly as well, that's had disease for a while, that's been on more than three months of prednisone, at least 10 milligrams or more, really should get a bone density to screen for osteopenia or osteoporosis. I recommend yearly dermatology screenings, full-body skin screenings for patients on any biologic therapy. And then again, specifically for this older population, I wouldn't necessarily call this health maintenance, but going through all of their different medications, as I mentioned earlier is extremely important.

Dr. Buch:
And a very important aspect to this field is understanding the research that is specific for the elderly. What are the next steps in IBD

research as far as you are concerned?

Dr. Hudesman:
So I think there's two major buckets. I think first is better data with our medications. So if you look at our clinical trials, the median age at almost all the clinical trials, whether it's for a biologic or small molecule, is in the mid-40s. So we need better data. Do these therapies possibly work better or worse in our elderly population? There's some recent literature that was interesting that actually showed that elderly patients were more likely to develop antibodies to anti-TNFs, especially infliximab, and that we should be either monitoring drug levels or considering combination therapy in these patients. So there has been some differences that have been found, so we need more targeted trials or at least real-world evidence for our elderly population.

The second thing that I think is extremely important, I touched on surgery for the elderly. And I think there's been emerging data showing that surgery is a very good option for these patients, but what we don't do well is how do we risk-stratify our patients for surgery and move away from chronological age to biological age. And there's been some recent data, some with my colleague, Dr. Adam Faye at NYU, who's looking at frailty and looking at something called sarcopenia, so essentially looking at muscle mass or loss of muscle mass and function. And patients with worsening frailty and worsening cases of sarcopenia had higher perioperative and postop complications, including readmissions, infections, and sepsis. So I think really honing into this concept of frailty and sarcopenia and maybe making a predictive model around surgery, and then with the goal of trying to optimize these factories before sending an elderly patient for surgery will be extremely important moving forward.

Dr. Buch:
What an excellent review on this very important topic. I want to thank my guest, Dr. David Hudesman, for sharing his insights.

Dr. Hudesman, thanks for joining us today.

Dr. Hudesman:
Thanks so much for having me.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit *GI Insights* on reachmd.com, where you can Be Part of the Knowledge. Thanks for listening, and looking forward to learning with you next time.