

# UCSF Colitis and Crohn's Disease Center Town Hall: IBD and Aging



# Agenda

630-640 pm: Updates

640-710 pm: IBD and Aging

710-730 pm: Wrap up and Questions

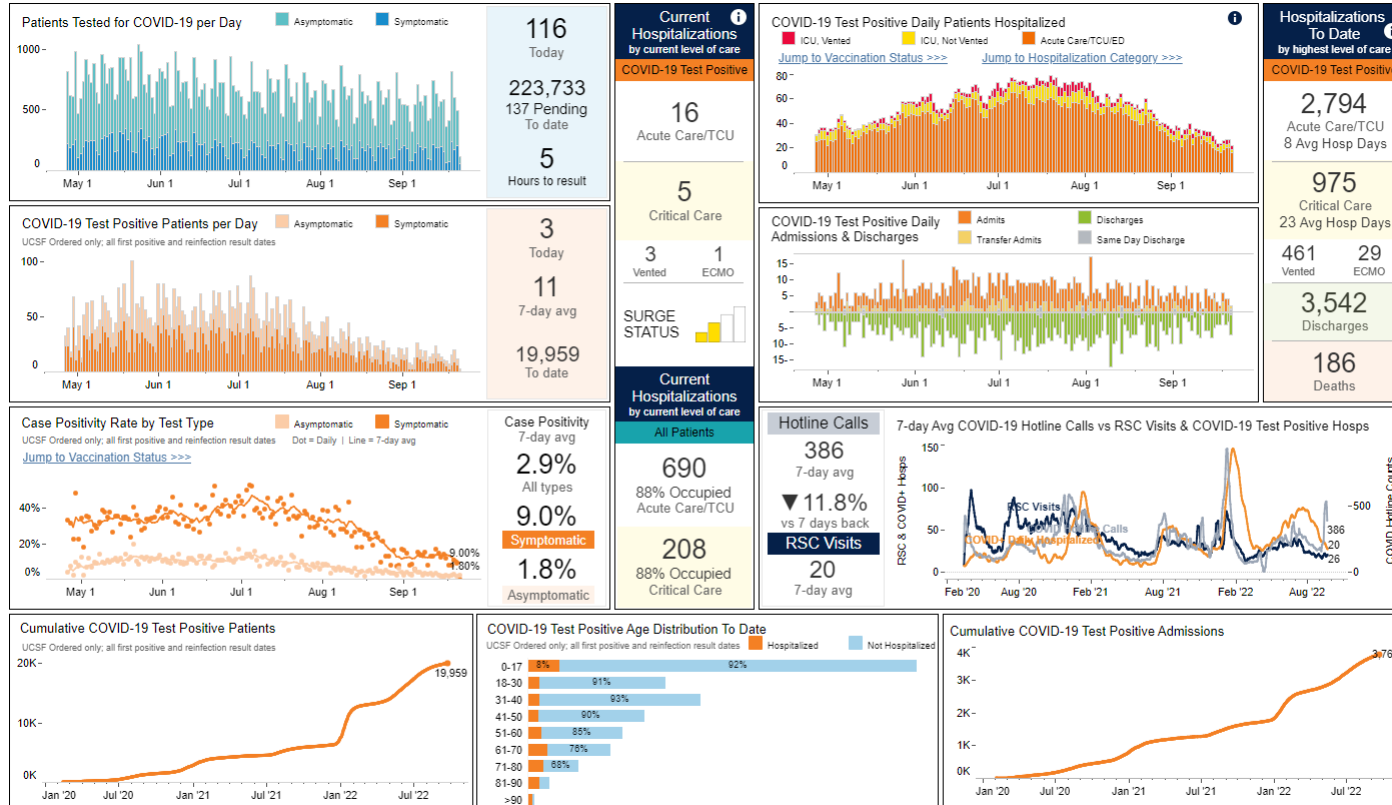
## Notes:

- You can ask a question anonymously or use or name
- You can upvote questions that are interesting to you

COVID

---

# COVID AT UCSF



**Bivalent** target two strains of COVID-19:

- original strain (2020)
- Omicron subvariants BA.4 and BA.5


**Recommend:**

- **Bivalent vaccine >2 months after infection/booster**

**Table 2. Immunization Schedule for Persons 18 Years of Age**

Type	Recipient Age	Product*	For Most People		Those Who ARE Moderately or Severely Immunocompromised	
			Doses	Interval Between Doses†	Doses	Interval Between Doses
mRNA vaccine	18 years and older	MONOVALENT Moderna Red vial cap with a blue-bordered label	Primary series: Monovalent			
			Dose 1 to 2	At least 4–8 weeks‡	Dose 1 to 2	At least 4 weeks
		Dose 2 to 3			At least 4 weeks	
		BIVALENT Moderna Blue cap with gray bordered label	Booster dose: Bivalent			
	Dose 2 to 3		At least 8 weeks (2 months)	Dose 3 to 4	At least 8 weeks (2 months)	
	18 years and older	MONOVALENT Pfizer-BioNTech Gray vial cap with gray-bordered label	Primary series: Monovalent			
Dose 1 to 2			At least 3–8 weeks‡	Dose 1 to 2	At least 3 weeks	
		Dose 2 to 3		At least 4 weeks		
BIVALENT Pfizer-BioNTech: Gray vial cap with gray-bordered label		Booster dose: Bivalent				
	Dose 2 to 3	At least 8 weeks (2 months)	Dose 3 to 4	At least 8 weeks (2 months)		
Protein subunit vaccine	12 years and older	MONOVALENT Novavax	Dose 1 to 2	At least 3–8 weeks‡	Dose 1 to 2	At least 3 weeks
		Booster dose: Bivalent				
		Moderna or Pfizer-BioNTech bivalent COVID-19 vaccine should be used for the booster dose.	Dose 2 to 3	At least 8 weeks (2 months)	Dose 2 to 3	At least 8 weeks (2 months)
Adenovirus vector vaccine	18 years and older	MONOVALENT Janssen	Janssen COVID-19 vaccine is authorized for use in certain limited situations due to safety considerations. <sup>5</sup>			
		Moderna or Pfizer-BioNTech bivalent COVID-19 vaccine should be used for the booster dose.	Booster dose: Bivalent			
			Administer a single booster dose at least 8 weeks (2 months) after the previous dose.			

# Treatment and Prevention

Treatment	Who	When	How
<a href="#">Nirmatrelvir with Ritonavi (Paxlovid)</a>  <i>Antiviral</i>	Adults; children 12 years and older	Start as soon as possible; must begin within 5 days of when symptoms start	Taken at home by mouth (orally)

- **Evusheld:** (tixagevimab plus cilgavimab) adults and children ages >12 years
- Two monoclonal antibodies provided together
  - 2 separate consecutive intramuscular (IM) injections at office or healthcare facility
- Moderately or severely immunocompromised or severely allergic to COVID-19 vaccines
  - High dose long-term steroids, combination biologics
  - No antibody response to COVID vaccine

## Evusheld:

- Undetectable covid Ab despite vaccine

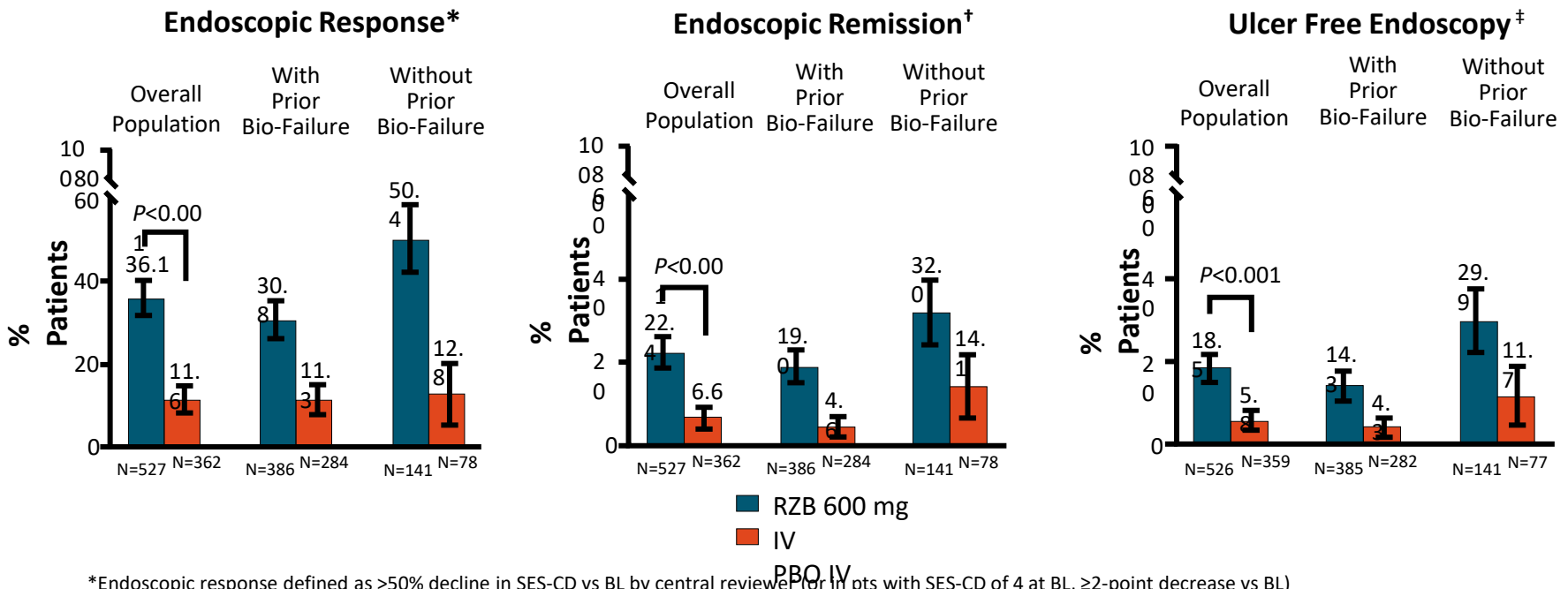
## Paxlovid:

- Trial was in unvaccinated
- Recommended in older patients, immune compromised

# New Therapy

---

# Risankizumab: Moderate to severe Crohn's Disease Induction Endoscopic Outcomes at Week 12



\*Endoscopic response defined as >50% decline in SES-CD vs BL by central reviewer (or in pts with SES-CD of 4 at BL, ≥2-point decrease vs BL)

<sup>†</sup>Endoscopic remission defined as SES-CD ≤4 with ≥2-point decrease vs BL, and no subscore ≥2 for any variable by central reviewer

<sup>‡</sup>Ulcer-free endoscopy defined as SES-CD ulcerated surface subscore of 0 in pts with BL subscore ≥1 by central reviewer



# Medications

Crohns Disease	Ulcerative Colitis
	Mesalamine
Budesonide (entocort)	Budesonide (uceris)
Azathioprine/6mp/MTX	Azathioprine/6mp/MTX
Biologics: <ul style="list-style-type: none"> <li>• Anti-TNF: Infliximab, adalimumab, certolizumab</li> <li>• Anti-Integrin: Vedolizumab, natalizumab</li> <li>• Anit-IL12: Ustekinumab, <b>Risankizumab</b></li> </ul>	Biologics: <ul style="list-style-type: none"> <li>• Anti-TNF: Infliximab, golimumab, adalimumab</li> <li>• Anti-Integrin: Vedolizumab</li> <li>• Anti-IL23: Ustekinumab</li> </ul>
Jak inhibitors: none	Jak inhibitors: <ul style="list-style-type: none"> <li>• Tofacitinib</li> <li>• <b>Upadacitinib</b></li> </ul>
	S1P: <ul style="list-style-type: none"> <li>• <b>Ozanimod</b></li> </ul>

# IBD Chat

---

# IBD CHAT

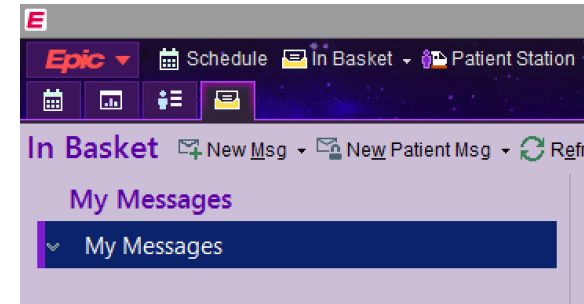
1) Notification sent via text/email

2) Patient enrolls and begins interacting with chat

3) Responses trigger alerts



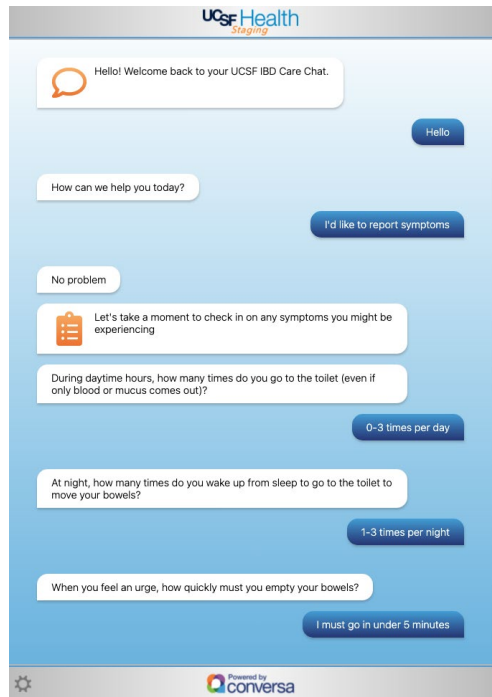
4) Forwarded to pooled EHR in-basket



5) Action taken within EHR

## Modules

- i. Housekeeping
- ii. Symptom Monitoring: HBI/SCCAI score
- iii. Lab Reminders
- iv. Goodbye



# IBD Chat

- Expedited Chat (skip a month)
- Videos (drug therapy, pregnancy, older patients, pediatrics, pregnancy, etc)
- Flowsheets in mychart

# IBD Clinical Trials

---

# Clinical Trials

- **MOSAIC**: Outpatient IV steroids for severe ulcerative colitis
- **Diet** (Seamus) intervention for mild to moderate ulcerative colitis
- **PIANO Registry**: Pregnancy and IBD ([piano@ucsf.edu](mailto:piano@ucsf.edu))

Coming soon:

- Combination therapy
- Oral molecules
  
- Contact: Karan Bhatia: [Karan.Bhatia@ucsf.edu](mailto:Karan.Bhatia@ucsf.edu)



University of California  
San Francisco

# IBD and the Elderly

UCSF IBD Town Hall

September 28, 2022

Kendall Beck, MD

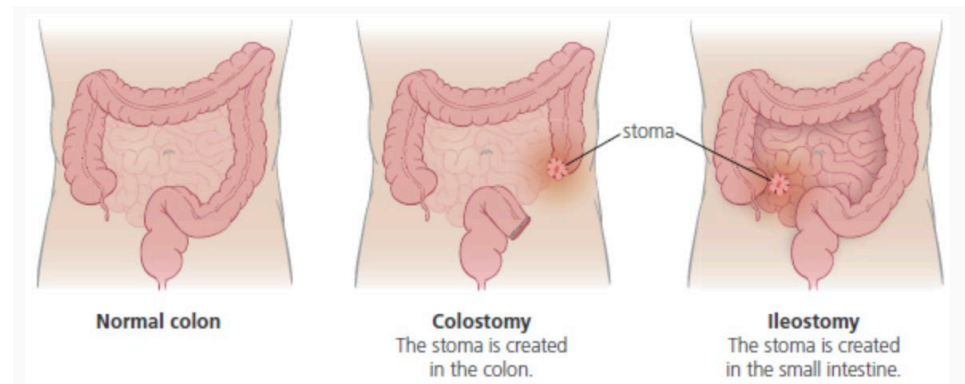
# Objectives

- Case presentation
- IBD demographics
- Making the diagnosis of IBD in an elderly patient
- Treatment considerations for elderly patients
  - Medical
  - Surgical
- Healthcare maintenance topics
- Recently published IBD and elderly care pathway



# Case presentation

- 78 yo W with Crohn's disease, diagnosed in 1985 who had a colectomy (colon removed) and ileostomy
- Admitted to hospital with diarrhea, kidney injury, abnormal heart rhythm, and partial bowel blockage after taking anti-diarrheal agents
- Has not been on any Crohn's medicines, or seen by gastroenterologist in 7 years.



# Case presentation

- Last time she had her bowel looked at was an ileoscopy in 2011 with very mild inflammation

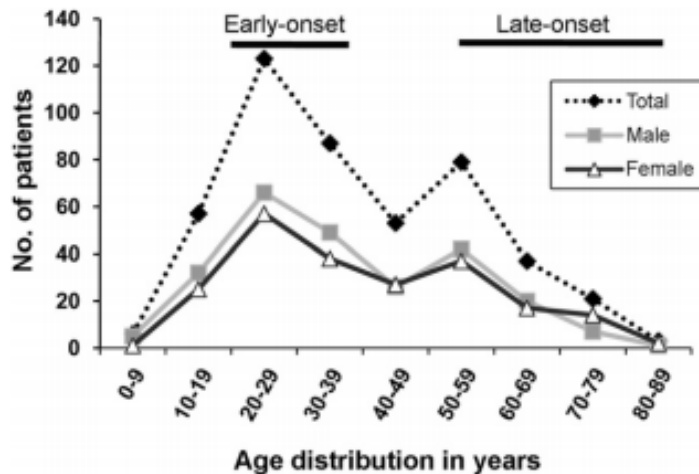
Hospital:

- Fecal calprotectin (stool inflammation test) recommended
  - 405 (normal < 150)
- Due to hesitancy to undergo procedure, and partner's medical issues, ileoscopy was done 11 months later
  - Inflammation with ulcers in the ileum, consistent with active Crohn's disease of the ileum →



# Demographics, Diagnosis, & Prognosis

# Demographics

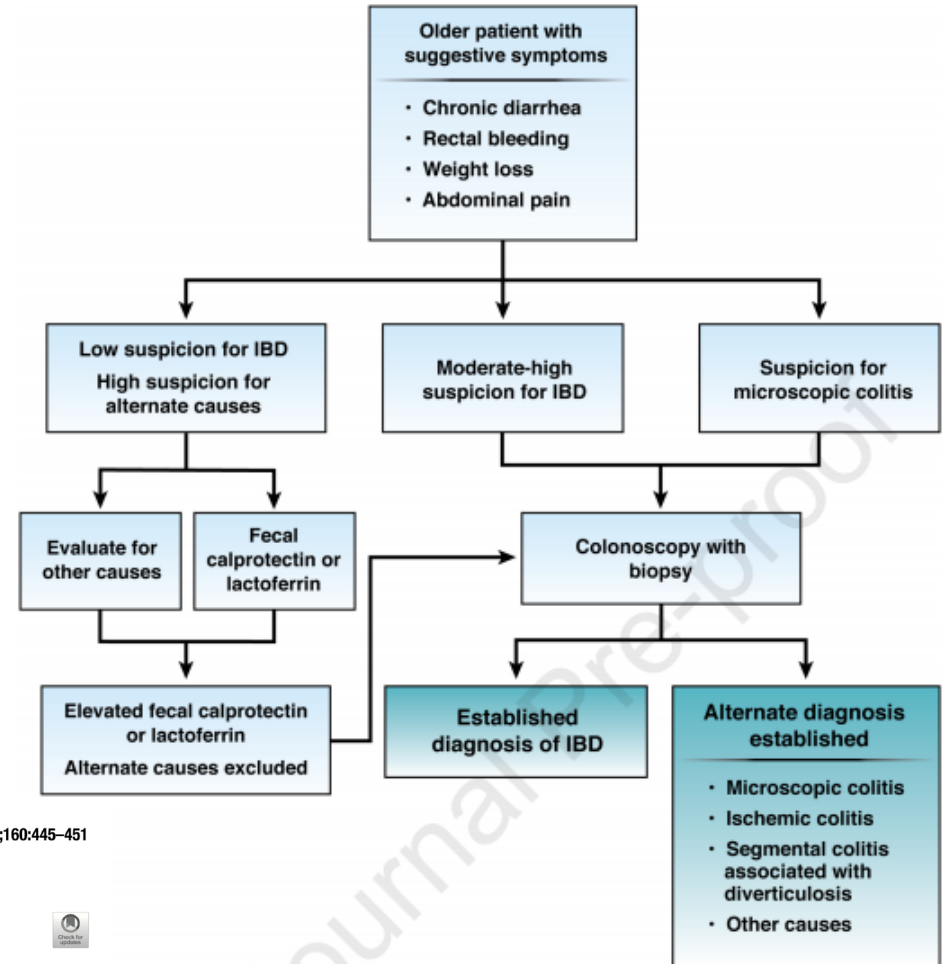


- Elderly defined as > age 60
- 1/160 elderly people have IBD (new diagnoses, and aging IBD population)
- **Bimodal** distribution of IBD diagnoses
- ~15% of new IBD diagnoses are made in the elderly
- Elderly patients comprise very small portion of clinical trials subjects or pharmcovigilance data

# Diagnosis of IBD in elderly

## ■ Elderly less likely to have IBD:

- Colorectal cancer
- Ischemic colitis (lack of blood flow)
- Diverticulitis
- Ibuprofen changes
- Radiation colitis (from prior cancer therapy)
- Microscopic colitis



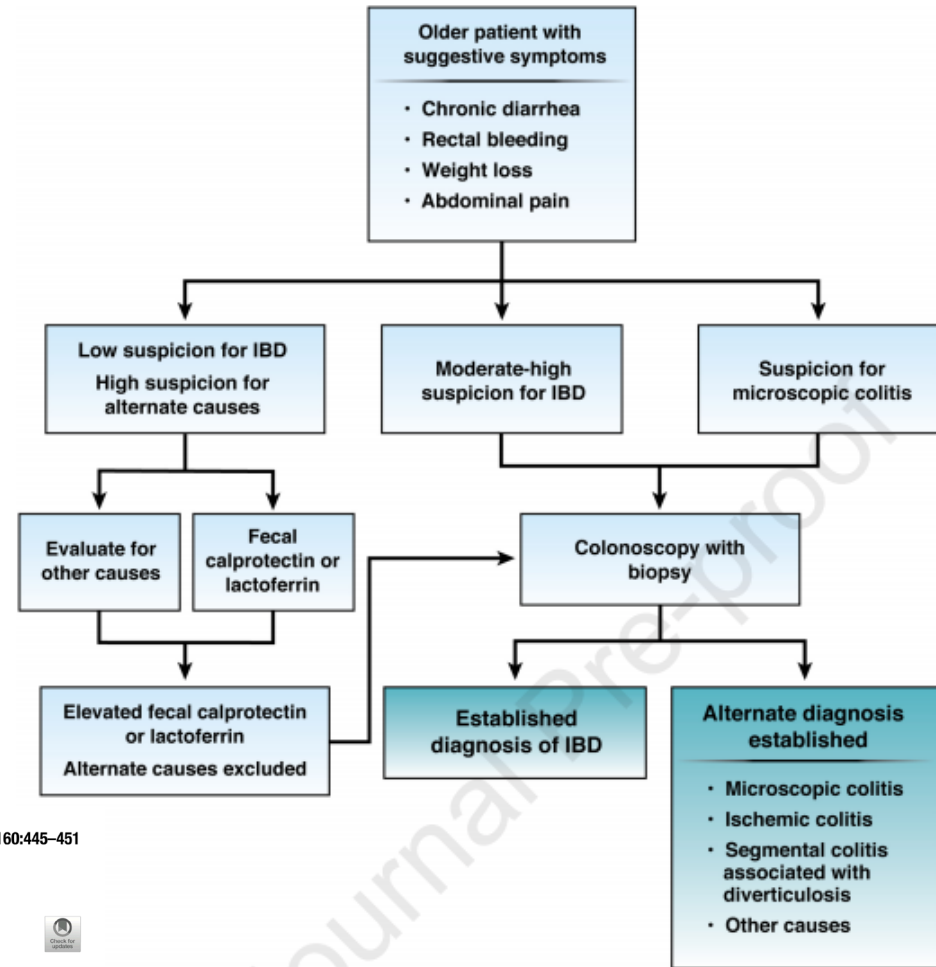
Gastroenterology 2021;160:445-451

## AGA Clinical Practice Update on Management of Inflammatory Bowel Disease in Elderly Patients: Expert Review

Ashwin N. Ananthakrishnan,<sup>1</sup> Geoffrey C. Nguyen,<sup>2</sup> and Charles N. Bernstein<sup>3</sup>

# Diagnosis of IBD in elderly

- Procedures and anesthesia carry more risk in elderly
- Diagnostic tests: blood count, stool test for infection, fecal calprotectin to confirm inflammation
- CT scan to rule out other diagnosis
- Colonoscopy only if other tests make IBD likely, or the diagnosis is not made by the other tests



Gastroenterology 2021;160:445-451

## AGA Clinical Practice Update on Management of Inflammatory Bowel Disease in Elderly Patients: Expert Review

Ashwin N. Ananthakrishnan,<sup>1</sup> Geoffrey C. Nguyen,<sup>2</sup> and Charles N. Bernstein<sup>3</sup>

# Expected course of disease

Elderly (> 50) with new onset IBD are more likely to have...

- Only the colon involved in Crohn's Disease (44%)
  - Elderly less likely to have perianal Crohn's, abscess, fistula
- Left sided ulcerative colitis (rather than whole colon) (40%)
- Less severe
- Better outcomes suggested by some studies, but not all
  - Fewer older onset IBD given biologic drugs
  - Similar need for surgery for CD, more UC pts had surgery

Original Article

## **Systematic Review and Meta-analysis: Phenotype and Clinical Outcomes of Older-onset Inflammatory Bowel Disease**

Ashwin N. Ananthakrishnan,<sup>a,\*</sup> Hai Yun Shi,<sup>b,†</sup> Whitney Tang,<sup>b</sup>  
Cindy C. Y. Law,<sup>c</sup> Joseph J. Y. Sung,<sup>b</sup> Francis K. L. Chan,<sup>b</sup> Siew C. Ng<sup>b,\*</sup>



# Expected course of disease

Elderly (> 60) with new onset IBD are...

- More likely to have stricture pattern for Crohn's (24 vs 13%)
- Less likely to use steroids, advanced drugs like anti-TNF
- More hospitalization (66 vs 49%)
- More cancers (14 vs 0.5%)
- More surgery for UC (8.3 vs 5.1%)
  - ?due to less medication use

***More important to consider individual disease rather than trends when determining management strategies***



ORIGINAL ARTICLE | [Free Access](#) |

Phenotype and natural history of elderly onset inflammatory bowel disease: a multicentre, case-control study

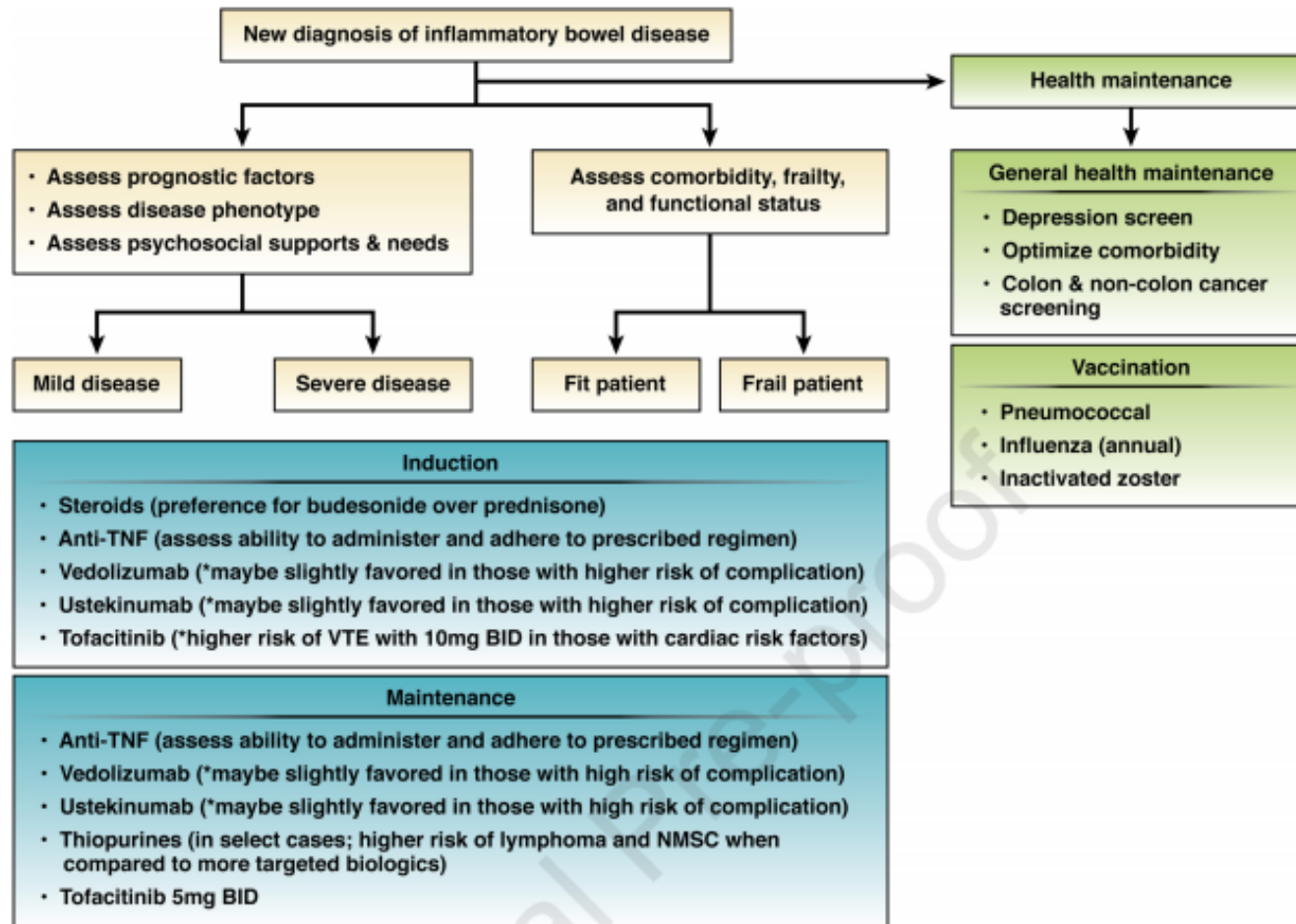
M. Mañosa , M. Calafat, R. de Francisco, C. García, M. J. Casanova, P. Huelín, M. Calvo, J. Tosca, L. Fernández-Salazar, C. Arajol, Y. Zabana, G. Bastida, J. Hinojosa, L. Márquez ... See all authors 



# Management

# Management of IBD in elderly

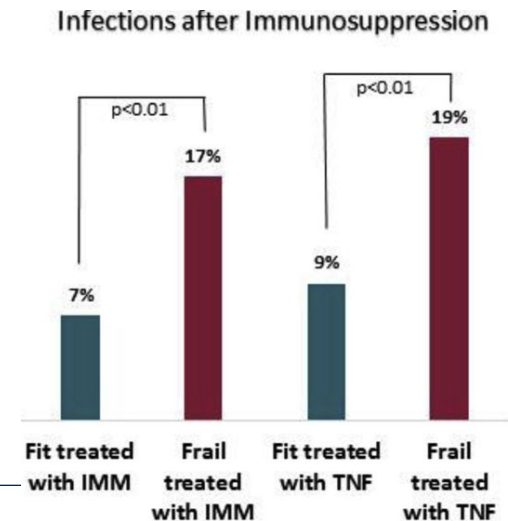
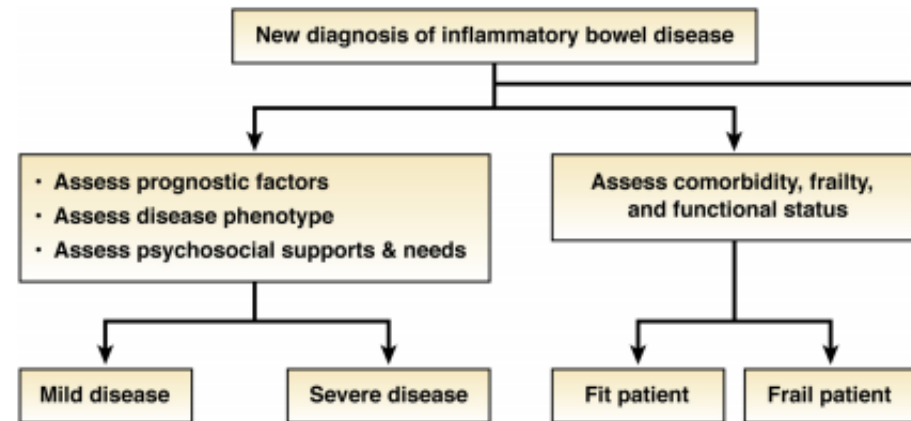
## General principles



# Management of IBD in elderly

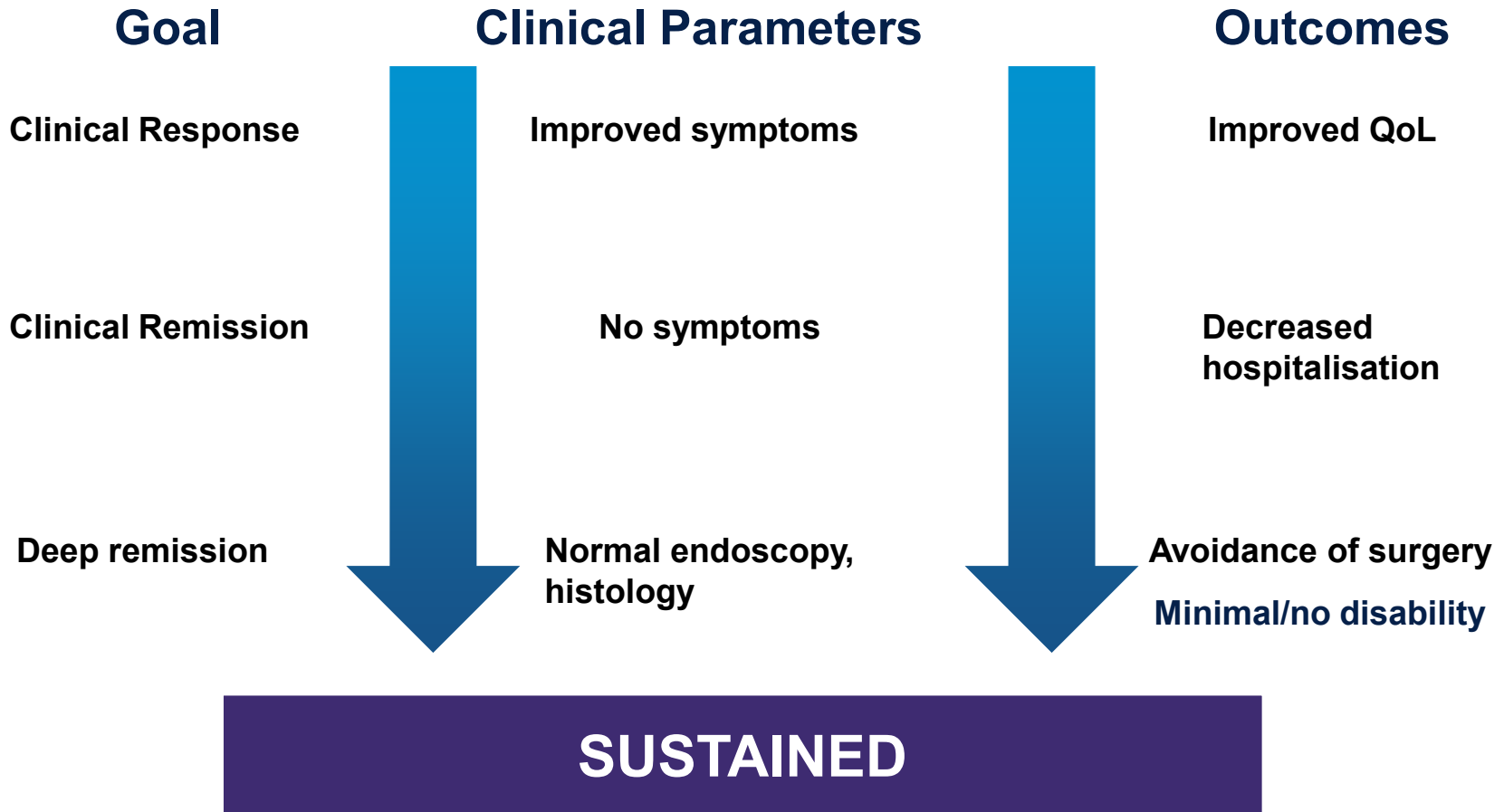
## General principles

- Multidisciplinary – involve all providers
- At risk for polypharmacy – complication from large number of medications
- More medical illnesses
- Depression and mental health
- Physical and cognitive function
  - Treatment-related complications
  - May need help making and getting to appointments and taking medications
  - Nutrition and physical therapy interventions
  - *Pre-treatment physical decline (frailty) associated with risk of infections with anti-TNF medications, surgery*
    - 19% frail vs 9% fit developed infection



# Goals of Therapy for IBD:

*Sustained Deep Remission*



QoL=quality of life

Modified from Panaccione R. Presented at: European Crohn's and Colitis Organization (ECCO) Fifth Annual Congress. Prague, Czech Republic; February 2010

# Management of IBD in elderly

## General principles

- Similar principle to choosing medication as in younger patients
  - *Age does not change how well drugs work*
- *Exception:*
  - More safety concerns
  - Higher risk of other medical problems that can increase side effects
    - *Very little safety data*
  - May have a harder time giving injections to self

***Therapy should not be delayed or steroid therapy prolonged out of concerns for treatment-associated risks***

# General Principles

- More recent diagnosis with early, aggressive disease
  - Early biologic use had less hospitalization
  - Biologic use associated with lower rates (UC OR 0.8 and Crohn's 0.7)
- Young (Age < 40)**  
**Pan-colitis**  
**Deep ulcers**  
**H/o hospitalization**  
**Steroid dependent**  
**High CRP**  
**C. diff or CMV infection**

***2020 AGA UC Guidelines suggest using biologic agents early rather than gradual step up***

# Management of IBD in elderly

## Medication summary

### Anti-TNF (IFX, ADA, GOL, CZA)

- IV and SQ options
- Fastest onset
- Most data
- High immunogenicity
- Good for systemic involvement
- Infection, lymphoma risk, skin CA

### JAK-inhibitor – tofacitinib

- Oral drug, not a biologic
- Rapid onset – as early as 3 days
- Newest novel FDA approved therapy
- Joint involvement
- Safety concerns: Shingles, NMSC, VTE
  - Black Box warning for VTE
- Contraindicated in pregnancy

### Anti-integrin – vedolizumab

- IV (SQ coming)
- Slowest onset (up to 6 months)
- Low immunogenicity
- Gut selective, good safety profile
- Not good for systemic involvement

### Anti- IL 12/23 – ustekinumab

- IV x 1, then SQ Q8 wks
- A little slower onset than anti-TNF
- Better for anti-TNF failure
- Low immunogenicity
- Good safety profile
- Good for skin involvement

### S1P1 – Ozanimod

- Oral
- No immunogenicity
- Approved for UC, Multiple Sclerosis
- Requires safety monitoring
- Works best for moderate severity

# Management of IBD in elderly

## Pharmacologic considerations

### Induction

- **Steroids (preference for budesonide over prednisone)**
- **Anti-TNF (assess ability to administer and adhere to prescribed regimen)**
- **Vedolizumab (\*maybe slightly favored in those with higher risk of complication)**
- **Ustekinumab (\*maybe slightly favored in those with higher risk of complication)**
- **Tofacitinib (\*higher risk of VTE with 10mg BID in those with cardiac risk factors)**



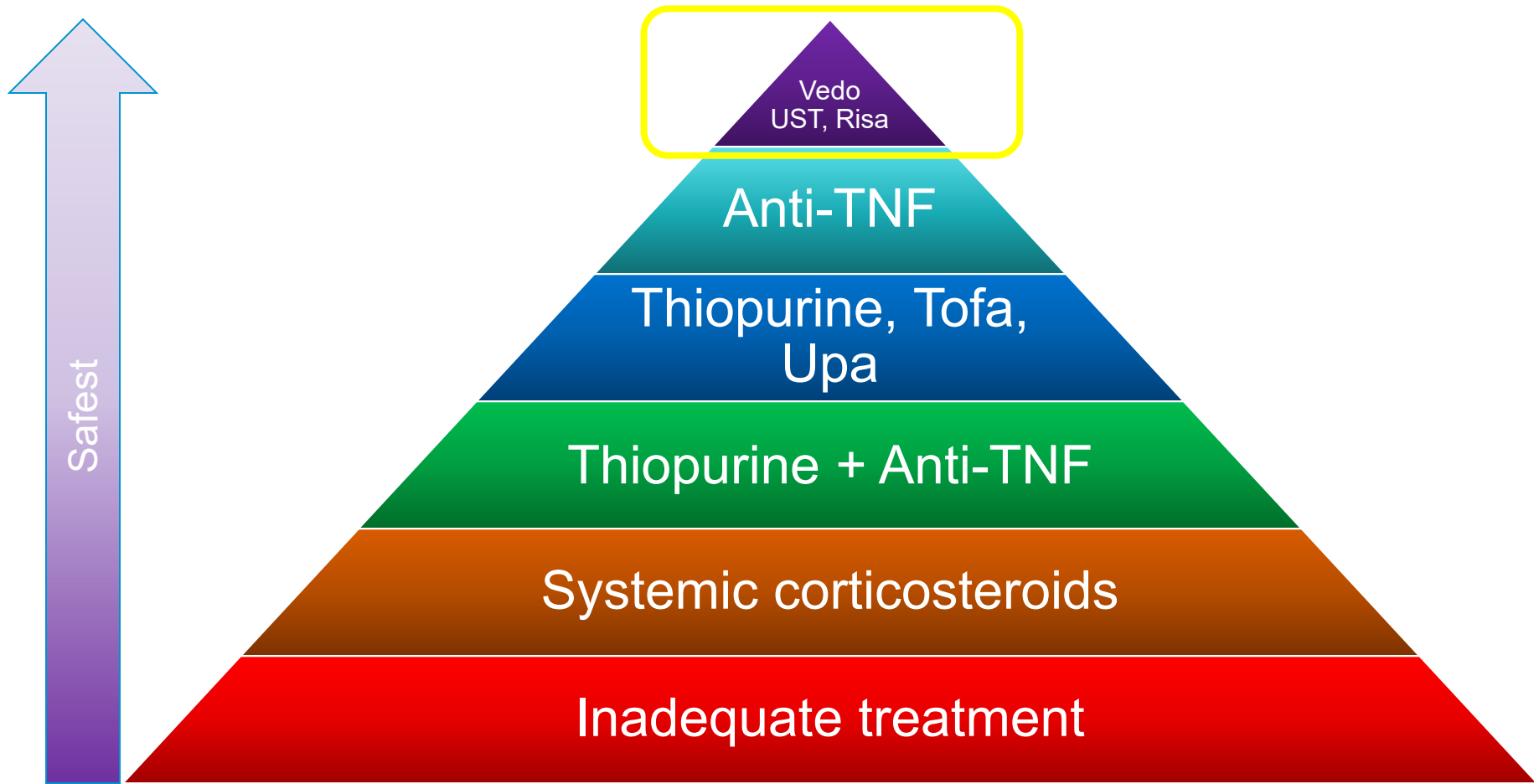
# Management of IBD in elderly

## Pharmacologic considerations

### Maintenance

- **Anti-TNF (assess ability to administer and adhere to prescribed regimen)**
- **Vedolizumab (\*maybe slightly favored in those with high risk of complication)**
- **Ustekinumab (\*maybe slightly favored in those with high risk of complication)**
- **Thiopurines (in select cases; higher risk of lymphoma and NMSC when compared to more targeted biologics)**
- **Tofacitinib 5mg BID**

# Safety Summary of IBD Medications



# Surgery

# Surgical considerations

- Complications after surgery also higher (34.5% vs 21.3%)
  - Risk of death
  - Infection, blood clot, bleeding, heart, kidney, neurologic
  - Emergency surgery associated with higher risk of death
  - Hospital stays > 30 days more likely (5% vs 1.8%)

## **Increased Postoperative Mortality and Complications Among Elderly Patients With Inflammatory Bowel Diseases: An Analysis of the National Surgical Quality Improvement Program Cohort**

Natasha Bollegala,<sup>\*</sup> Timothy D. Jackson,<sup>‡,§</sup> and Geoffrey C. Nguyen<sup>\*,§</sup>

# Surgical considerations

- No difference in complications for pouch surgery in elderly and frail UC patients except longer hospital stay
  - 2493 UC patients
  - Complications: 79.5% (age < 50) vs 79.1% (age > 60)
  - 0.8 days longer hospital stay for those > age 60
  - Frailty diagnosis did not change outcomes

Association for Academic Surgery

## Outcomes after ileoanal pouch surgery in frail and older adults

Jessica N. Cohan MD <sup>a, b</sup>  , Peter Bacchetti PhD <sup>c</sup>, Madhulika G. Varma MD <sup>a</sup>, Emily Finlayson MD, MS <sup>a, b, d</sup>

# Surgical considerations

- May have worse functional outcomes with pouch surgery
  - Age is associated with increased chance to get end ileostomy
  - But end ileostomy chances are decreasing in 61-70 age group
- Consider conditions associated with poor pouch function:
  - Obesity, pelvic radiation, anal sphincter damage or dysfunction
- Nutrition evaluation prior to surgery
- May need blood clot prevention around surgery time
- Stoma management – may have harder time managing, but studies show elderly adjust better to the stoma than younger

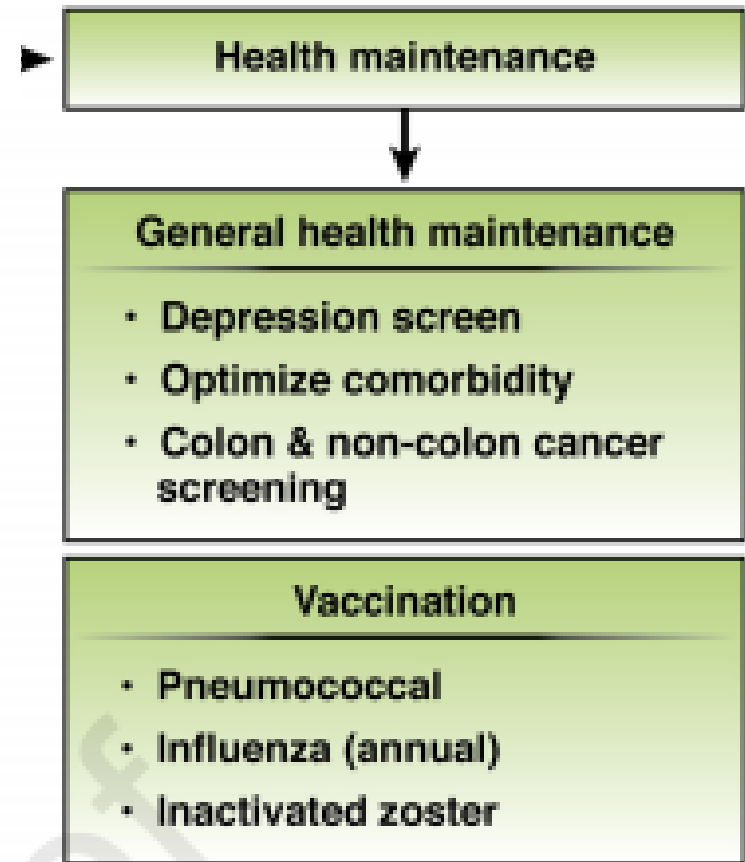
## **Impact of Patient Age on Procedure Type for Ulcerative Colitis**

**A National Study**

# Healthcare maintenance

# Healthcare maintenance

- Higher risk for vaccine preventable diseases
  - Shingles, Flu, pneumonia
  - Low rate of appropriate vaccines
- IBD pt's often don't have a primary doctor, even elderly IBD patients
- Ensure age-appropriate cancer screening, with special attention to skin cancer
- IBD in the colon > 8 years leads to 2x risk of colorectal cancer





# Colorectal cancer screening

- Elderly onset IBD not associated with increased risk
- Patients diagnosed at older age may be diagnosed with colon cancer sooner after IBD diagnosis than younger patients
- Risk of missed colon cancer among older IBD 3x > non-IBD
- Patients age > 65, and > 80 have increasing risk of adverse events from colonoscopy
- Screening program using colonoscopy should only be used in those who will get benefits based on life expectancy, and are healthy enough to undergo colon surgery if pre-cancer or cancer is found

# Summary

- Treating elderly with IBD involves careful risk and benefit assessments
- Involving all doctors in decision making is of utmost importance
- Elderly pts more likely to have alternate diagnosis than IBD
- Colonoscopy is riskier in elderly patients
- Management guided by same principles, but must consider increased risk of side effects from drugs
- Must review healthcare maintenance topics, particularly vaccine preventable illnesses, cancer screenings/surveillance

# Thanks!

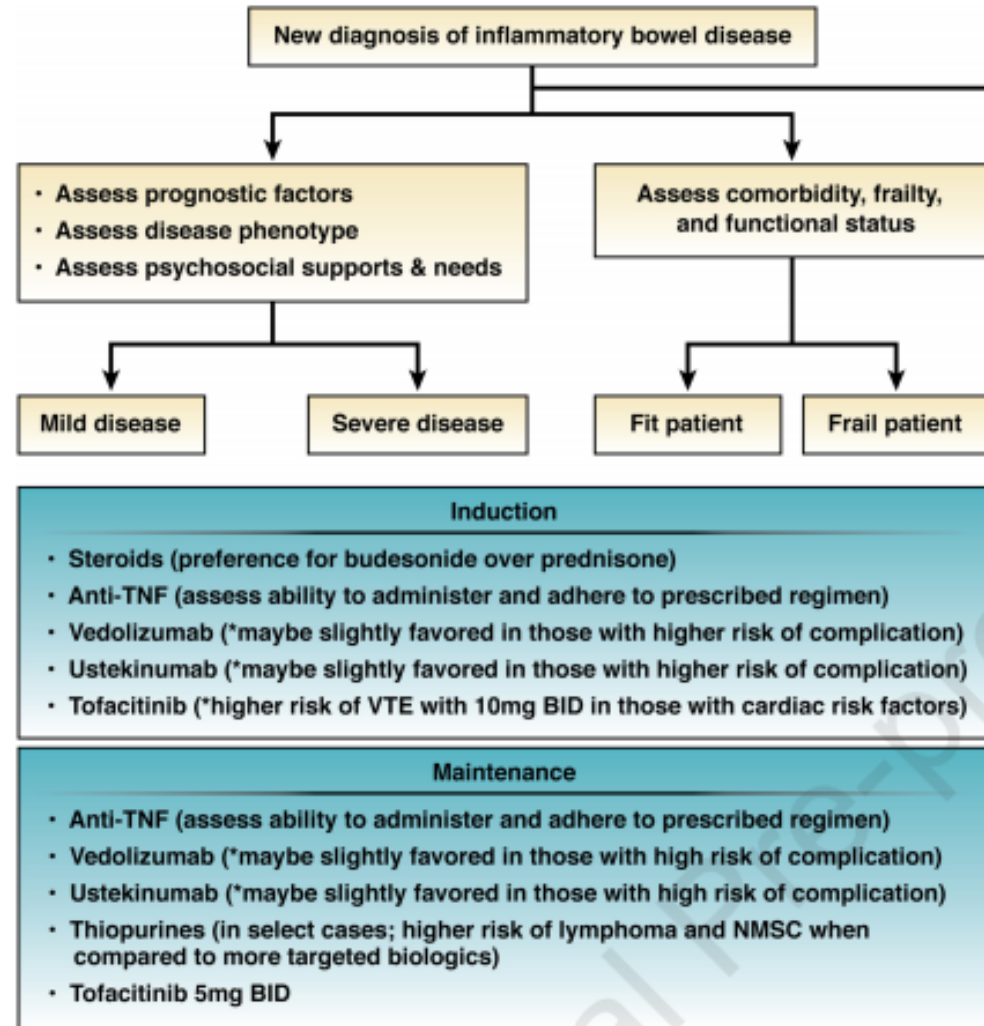
# Drug withdrawal

- No studies on withdrawal of medications specifically in the elderly

More recent studies of med withdrawal in a mixed population:

- Age did not predict recurrence of inflammation
- Age not associated with need for surgery after drug withdrawal
- In patients taking both infliximab and azathioprine, age did not predict failure of infliximab if azathioprine stopped

# Management of elderly IBD



- Treatment – case report of Edis with first Entyvio, then stelara, then reduced EF,
  - Review general principles, highlighting comprehensive review of goals and risk factors for treatment; collaborative approach with patient and PCP

- Highlight that many of the factors associated with risk in younger patients are the same
- Budesonide, vs early biologic therapy; prefer not systemic steroid
- Lower risk biologics, balance with likelihood of remission. Increased risk of VTE, fracture, infection, malignancy cardiac, zoster. Highlight any studies with risk factor profiles
- Balance 6MP IMM with risk of malignancy, slow onset
- Greater comorbidity burden, need to optimize
- Surgery consideration; highlight any studies on surgery and elderly; particularly J pouch abnormalities

- HCM
  - Vaccine schedule
  - Colorectal cancer surveillance
  - when to stop