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Editorial

Is the Long-term Disease Course of Elderly-Onset Ulcerative Colitis Different from That of Non-Elderly-Onset Ulcerative Colitis?

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See "Clinical Characteristics and Long-term Prognosis of Elderly-Onset Ulcerative Colitis in a Population-Based Cohort in the Songpa-Kangdong District of Seoul, Korea" by Sang Hyoung Park, et al. on page 742, Vol. 15, No. 5, 2021

Inflammatory bowel disease (IBD), composed of Crohn's disease (CD) and ulcerative colitis (UC), becomes a global disease as the incidence of IBD has been increasing in newly industrialized countries like Asia where IBD was rare in the past.[1] UC is more prevalent than CD and it occurs in a wide range of ages from the 20s to 60s. Therefore, the number of elderly patients with UC is rising accordingly.

The proportion of elderly-onset UC (EOUC) which was defined as UC diagnosed in those aged 60 years or older was 14.2% to 23% in Western countries.[2,3] That of EOUC in East Asia is reportedly lower ranging between 9.9% and 14.6%.[4] The elderly with UC have peculiar features compared with the young patients. First, frequent comorbidities may prevent the use of immunosuppressants in concerns of adverse events such as infection and malignancy.[5] This practice pattern may negatively affect the disease outcomes. Second, the relatively immunodeficient state in the elderly may attenuate aberrant immune response probably leading to an improved disease course. Considering that the aging population is growing, it is required to better understand clinical courses of these patients.

The natural course and clinical characteristics of patients with EOUC have yet to be concluded. The Dutch population-based study reported that EOUC patients have a higher hospitalization rate[2] while a systematic review and meta-analysis of population-based cohorts showed that EOUC patients have a similar risk of colectomy as patients with non-EOUC.[6] Corticosteroid use was similar but with lower use of immunomodulatory and anti-tumor necrosis factor agents. In Asia, a Japanese nationwide survey study reported that EOUC patients had a more severe disease activity, a higher proportion of IBD-related surgery, and a higher rate of corticosteroid use.[7] In contrast, a cohort study in Hong Kong reported that the disease severity, corticosteroid or immunomodulator use, and colectomy rate were similar in EOUC and non-EOUC patients.[8] However, these Asian studies had limitations in that they used only data from the referral hospital or that they excluded patients with mild disease.

In the current issue, Park *et al.*[9] reported data comparing clinical characteristics and long-term disease course of EOUC with those of non-EOUC in a well-established population-based cohort in Korea. This cohort study included 99 patients with EOUC and 866 patients with non-EOUC between 1986 and 2015. This study showed that cumulative risk of medication use was comparable between groups (p=0.091 for corticosteroids, p=0.794 for thiopurines, and p=0.095 for anti-tumor necrosis factor agents). Also, the cumulative risks of disease outcomes were similar between patients with EOUC and non-EOUC (11.9% vs 18.1% for hospitalization [p=0.240], and 2.3% vs 1.8% for colectomy [p=0.977]) at 10 years after diagnosis. These results suggest that the long-term disease course of patients with EOUC was similar to that of non-EOUC.

The strength of this study would be a well-organized population-based cohort with long-term follow-up period (median 104.5 months). Despite the limitation of the study (the lack of baseline data such as activity, laboratory results

and comorbidities), the results are of importance in understanding the natural course and clinical characteristics of Asian EOUC patients.

Meanwhile, it is necessary to consider cancer occurrence and mortality as age-related issues in patients diagnosed with UC over 60 years. In a French population-based study, there was no increased risk of developing colorectal cancer in EOUC patients. However, the risk of developing lymphoproliferative and myeloproliferative disorders was high, which was unrelated to thiopurine exposure.[10] A 50-year nationwide register-based cohort study in Sweden reported increased all-cause mortality (hazard ratio, 1.4; 95% confidence interval, 1.4 to 1.4) in EOUC patients compared to the general population.[3] But the hazard ratio for various causes of death in EOUC and non-EOUC patients was similar. Currently, data on cancer and mortality in EOUC patients in the Asian population are lacking. The research on this issue with optimal monitoring and management strategies for EOUC patients is warranted in the future.

CONFLICTS OF INTEREST

No potential conflict of interest relevant to this article was reported.

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