BÖLÜM 31

GERİATRİ VE CROHN HASTALIĞI

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GİRİŞ

İnflamatuvar barsak hastalığı (İBH) görülme sıklığı tüm dünyada artmaktadır. İBH en sık Kuzey Avrupa, Kuzey Amerika ve Birleşik Krallık'ta görülmekteyken Çin, Güney Kore, Güney Afrika gibi batı tarzı yaşam tarzının yaygınlaştığı bölgelerde de sıklığı giderek artmaktadır. İtalya'da yapılan epidemiyolojik bir çalışmada 2001-2006 yıllarında 6.7/100.000 olan İBH insidansının 2016-2021 yıllarında 18/100.000'e yükseldiği ve %169 oranında bir artış olduğu gösterilmiştir. Ayrıca Crohn hastalığı (CH)'ndaki artışın ülseratif kolit (ÜK)'ten daha fazla olduğu da saptanmıştır (%121'e karşı %73) (1).

Dünya Sağlık Örgütü verilerine göre beklenen insan ömrü 2000 yılında 66.8 yılken 2019 yılında 73.3 yıla yükselmiştir (2). 2020 yılında Türkiye İstatistik Kurumu'nun yayınladığı verilere göre Türkiye'de 2013-2015 döneminde erkeklerde 75,3 yıl olan beklenen yaşam süresi, 2017-2019 döneminde 75,9 yıla, kadınlarda ise 80,7 yıldan 81,3 yıla yükselmiştir (3).

İBH her yaşta görülmekte birlikte en sık 15-30 yaş aralığında tanı konur. 50-80 yaş arasında ikinci bir pik yaptığını gösteren çalışmalar da mevcuttur (4, 5). European Crohn's and Colitis Organisation (ECCO) yaşlı-başlangıçlı İBH'nı (elderly-onset) hastalığın 60 yaş veya üzerinde başlaması olarak tanımlamıştır (6).

İBH sıklığının ve geriatrik nüfusun artması geriatrik İBH hasta grubunda hızlı bir artışa neden olmaktadır. İBH popülasyonunun %25-35'i 60 yaşın üzerindedir (7, 8). Yaşlı İBH hastalarında hastalığın seyri, tedavi etkinliği, tedavinin olası yan etkileri ve en önemlisi hastaların yaşam kalitesinin etkilenme derecesi genç hastalara göre farklılık göstermektedir.

Geriatrik grupta mevcut yaygın komorbiditeler (özellikle malignite ve enfeksiyona yatkınlık) yaşlı hastaları immünsüpresyon komplikasyonlarına karşı daha savunmasız hale getirebilir (9). Gözlemsel çalışmalar yaşlı hastalarda anti-TNF ile tedavide enfeksiyon riskinin ve tiyopürinlerle lenfoma riskinin belirgin şekilde daha yüksek olduğunu göstermektedir (10, 11). Cerrahi tedaviler de komorbiditeler nedeniyle yüksek riskli oluşturmaktadır. Ayrıca ÜK'te genç yaşta hastalık başlangıcı olanlarla yaşlı-başlangıçlı hastalar arasında mortalite açısından fark bulunmazken CH'nda yaşlı grupta mortalite artmaktadır (genç: 1, orta yaş:5.6 ve yaşlı 33/10.000 kişi-yılı) (12).

Artan yaşlı İBH popülasyonu, ilaç etkileşim-

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ve yan etkilerden korkulması nedeniyle özellikle immunsupresif veya biyolojik tedavilerden kaçınılması kılavuz önerilerinin oluşturulmasını güçleştirmektedir. Geriatrik gruptaki hastalarda ayırıcı tanıda yaşlı hastalarda daha sık görülen malignite ve iskemik kolit gibi morbiditesi ve mortalitesi yüksek hastaların dikkatle incelenmesi gerekmektedir. Tedavi seçiminde hastaların komorbiditeleri, ilaçları, malignite riski gibi faktörler göz önüne alınarak karar verilmelidir. Bu hastaların takibinde işlem ve sedasyon komplikasyonları hasta ile paylaşılarak birlikte karar verilmelidir. Sonuç olarak geriatrik gruptaki İBH tanı, tedavi ve takibi dikkatli bir yaklaşımı gerektirmektedir ve bu grupta daha fazla çalışmaya ihtiyaç duyulmaktadır.

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