The United Kingdom is typical of a developed country in that it has an aging population. The over 85s are one of the fastest growing groups. Physical frailty and diminished mental capacity are common. Gastrointestinal disorders including colonic tumours are more common with advancing age. Colorectal cancer is the second commonest cause of cancer deaths in the UK. The risk of developing the disease increases considerably after the age of 50.

There are several ways to visualise the colon. Colonoscopy is the most accurate method with the advantage that biopsy specimens can be taken from suspicious lesions and precancerous polyps excised. However, colonoscopy may be uncomfortable for the patient, usually entails intravenous sedation, and has a perforation rate of up to 0.5%. Mortality may approach 0.1%. The risks are thought to be higher in the elderly population. Colonoscopy is particularly useful for patients aged 50–70 years. However, there is less information on its benefit in the very old.

The aim of this study is to evaluate the use of colonoscopy in patients aged at least 85 years in the setting of a district general hospital. Should a patient’s age in itself cause us to modify our approach to the investigation and treatment of bowel disease?
identified an explanation for their symptoms underwent a barium enema. Midazolam (median 4 mg, range 0–12) and pethidine (median 50 mg, range 0–100) were used as premedications. No major complications such as perforation or bleeding occurred.

Table 2 summarises the commonest findings. For some patients, several abnormalities were recorded.

A normal colon was found in 65 (30%) of the 219 cases that had had a complete examination. Colonoscopy identified a problem that explained the patient’s symptoms in 116 (37%) cases.

Polyps were found in 45 (14.2%) cases and a malignant tumour in 28 (8.8%). All except two of these were adenomatous polyps on histological examination. The presenting symptoms for those in whom a malignant tumour was found were anaemia (53%), diarrhoea (17%) rectal bleeding (17%), and others (13%). Of these patients, 19 (68%) went on to have a curative resection.

DISCUSSION

Life expectancy in the UK continues to increase and advancing age is an important risk factor for the development of colorectal cancer. There is more than a 10-fold increase in the risk of developing colorectal cancer in people aged over 65 compared with younger people. That the percentage of patients above 85 years of age seen in the clinic and undergoing colonoscopy is similar suggest that we do not deny patients access to colonoscopy on the grounds of age alone.

In our elderly population the yield of polyps and malignancy of 14.2% and 8.8% respectively was higher than for an average risk population with non-specific large bowel symptoms, of about 5.8% and 0.4%. Our study suggests that colonoscopy in the very old is as safe as in the younger patients but may be technically more challenging as shown by a lower overall completion rate. Although our complication rates are comparable to those from previous studies, our failure to complete in many was attributable to the higher incidence of severe diverticular disease with increasing age. Difficulties with bowel preparation resulting in a poorly prepared colon contributed too. Our study supports the findings of a recent prospective study of colonoscopy practice in the UK, which found that there is an inverse relation between caecal intubation rate and increasing age and that it was considerably reduced in the presence of a stricture. However, our results also support the notion we have previously put forward that bowel preparation in elderly patients is not unsafe although the 21% “inadequate bowel preparation” score we report here is disappointing, as it is higher than in previous studies in older age groups. The risk associated with bowel preparation of clinically significant electrolyte disturbance seems very low even if fluid balance disturbances are commoner in this age group as we have suggested elsewhere. The most common presentation for patients who were found to have colorectal cancer was anaemia, often an incidental finding in clinic or in primary care. Many of these patients may not have any gastrointestinal symptoms. Anaemia is but one of several presentations that may be appropriately and helpfully investigated by colonoscopy, even in, or especially in the elderly population.

CONCLUSION

The absence of significant complications and a comparatively high yield of colonic malignancies and polyps reinforces the value of colonoscopy as a diagnostic tool even after 85 years of age. Increasing age alone should not preclude a patient from having a colonoscopy. Our study supports the view set by the National Service Framework, which states that it is appropriate to provide health services, at least in the field of diagnostic colonoscopy regardless of patient age, on the basis of clinical need alone.

**Table 2 Common findings on colonoscopy**

<table>
<thead>
<tr>
<th>Findings</th>
<th>Patients Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diverticular disease</td>
<td>152 (41.1)</td>
</tr>
<tr>
<td>Polyps</td>
<td>45 (14.2)</td>
</tr>
<tr>
<td>Colorectal cancer</td>
<td>28 (8.9)</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>13 (4.1)</td>
</tr>
<tr>
<td>Angiodysplasia</td>
<td>7 (2.2)</td>
</tr>
<tr>
<td>Normal</td>
<td>78 (24.7)</td>
</tr>
</tbody>
</table>

**REFERENCES**

Colonoscopy in the very old: why bother?

K K Y Yoong and T Heymann

Postgrad Med J 2005 81: 196-197
doi: 10.1136/pgmj.2004.023374

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