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Characteristics of late-onset IBD

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Abstract

Introduction: Inflammatory bowel disease (IBD) primarily affects adults, with a peak incidence between 20–30 years. A second, less frequent peak occurs between 50–70 years. Late-onset IBD, diagnosed after age 60, represents a distinct entity with potential comorbidities and unique clinical features. This study aimed to analyze the epidemiological, clinical, therapeutic, and disease course characteristics of IBD in late-onset IBD patients.

Materials and Methods: We conducted a single-center, retrospective, descriptive study over six years (July 2018–July 2025). Among 465 IBD patients followed at our center, 20 were diagnosed after age 60. Both sexes with documented Crohn's disease (CD) or ulcerative colitis (UC) were included. Epidemiological, clinical, therapeutic, and disease course data were collected.

Results: Of the 20 patients (4.4%), 11 had UC (55%), 7 had CD (35%), and 2 (10%) had indeterminate colitis. The mean age at diagnosis was 69 years [60–82], with a female-to-male ratio of 1.2. Twelve patients (60%) had at least one comorbidity. UC was pancolonic in 28%, left-sided in 36%, and distal in 36%. CD was ileal in 28.5%, ileocolonic in 28.5%, and colonic in 42.8%, with stricturing phenotype in 43%, inflammatory in 43%, and fistulizing in 14%. Extra-intestinal manifestations occurred in six patients (30%). Maintenance therapy included aminosalicylates for UC (100%), immunosuppressants (57.1%), and anti-TNF therapy (42.9%) for CD. Three patients (15%) underwent surgery. Remission was maintained in 18 patients (90%).

Conclusion: Late-onset IBD is a distinct entity, often presenting with no family history, frequent comorbidities, milder clinical features, and good response to medical therapy. Reduced use of immunosuppressants and biologics reflects disease profile and age-related considerations. Prospective studies on larger cohorts are needed to optimize management in this growing population.

Keywords: Late-onset IBD; Epidemiology; Clinical Features; Therapeutics; Disease course

1. Introduction

Inflammatory bowel disease (IBD) primarily occurs in adults, with a peak incidence between 20 and 30 years. A second, less frequent peak is observed between 50 and 70 years.

Late-onset IBD, defined by a diagnosis made after the age of 60, includes Crohn's disease (CD) and ulcerative colitis (UC). These cases represent a distinct entity affecting a population often vulnerable, with comorbidities and potentially at risk for a more severe disease course.

The aim of this study was to analyze the epidemiological, clinical, therapeutic, and disease course characteristics of IBD in this age group.

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2. Materials and methods

This is a single-center, retrospective, descriptive study conducted over six years, from July 2018 to July 2025. Among 465 patients followed for IBD in our center, 20 were older than 60 years at the time of diagnosis. Patients of both sexes with documented CD or UC diagnosed after age 60 were included. Epidemiological, clinical, therapeutic, and disease course data were collected for each patient.

3. Results

Among the 20 patients included (4.4%), 11 had UC (55%), 7 had CD (35%), and 2 (10%) had indeterminate colitis (IC). The mean age at diagnosis was 69 years [60–82], with a female-to-male ratio of 1.2. Two patients (10%) were smokers, and 12 (60%) had at least one comorbidity: 6 with diabetes, 2 with heart disease, and 4 with hypertension. No patient reported a family history of IBD.

Regarding disease location, UC was pancolonic (E3) in 3 cases (28%), left-sided (E2) in 4 cases (36%), and distal (E1) in 4 cases (36%) (Figure 1).

CD was ileal (L1) in 2 cases (28.5%), ileocolonic (L3) in 2 cases (28.5%), and colonic (L2) in 3 cases (42.9%), with one patient presenting ano-perineal lesions (anal fistula) (14%). CD phenotypes were structuring (B2) in 3 cases (43%), inflammatory (B1) in 3 cases (43%), and fistulizing (B3) in 1 case (14%) (Figure 2A; 2B).

Six patients (30%) had extra-intestinal manifestations: 1 erythema nodosum, 2 ankylosing spondylitis, and 3 peripheral arthritis (Table 2).

Regarding maintenance therapy, all UC patients were on aminosalicylates (100%). Among CD patients, 4 (57.1%) were on immunosuppressants (azathioprine) and 3 (42.9%) received anti-TNF therapy (infliximab). Two patients (10%) with indeterminate colitis were in remission without treatment (Table 3).

Three patients (15%) underwent surgery: 2 emergently for severe acute inaugural colitis, receiving subtotal colectomy with ileorectal anastomosis, and 1 for ileal fistulas occurring later, undergoing ileocecal resection with ileocolic anastomosis (Table 4).

Remission was maintained in 18 cases (90%) (Table 5).

Table 1 Demographic and Clinical Characteristics of Late-Onset IBD patients

Baseline characteristics	N (%) or Value
Number of patients	20 (4.4%)
Age, years	69 (60-82)
Sex (F/M)	11/9
Crohn's Disease (CD)	7 (35%)
Ulcerative Colitis (UC)	11 (55%)
Indeterminate Colitis (IC)	2 (10%)
Comorbidities	12 (60%)
– Diabetes	6 (30%)
– Hypertension	4 (20%)
– Heart disease	2 (10%)
Toxic habits	
– Smoking	2 (10%)
– Alcohol	0

Family history of IBD	0

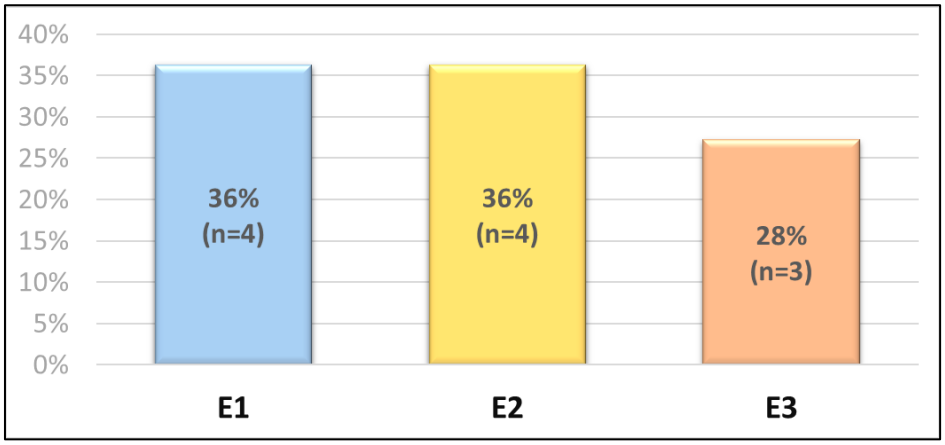

Figure 1 Distribution of UC by Disease Location

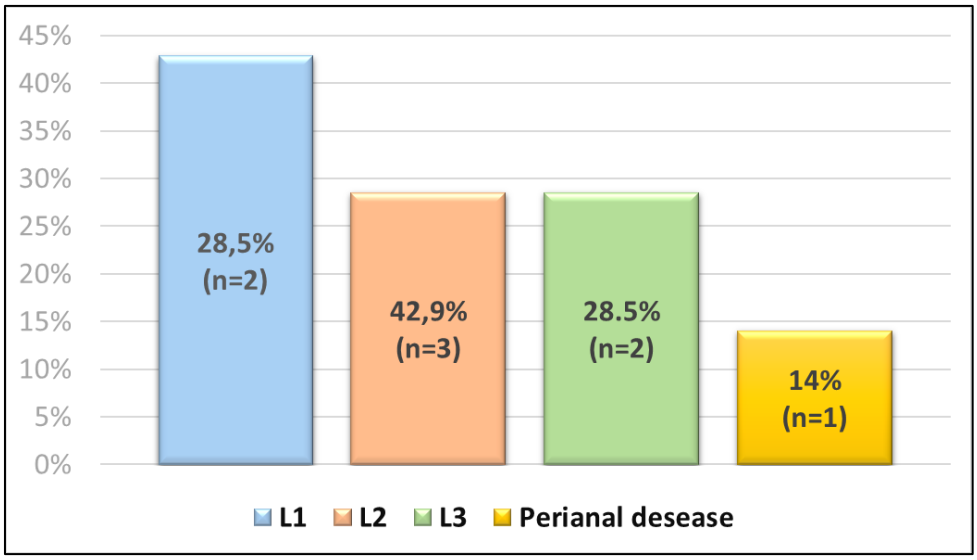

Figure 2A Distribution of CD by Location and Perianal Involvement

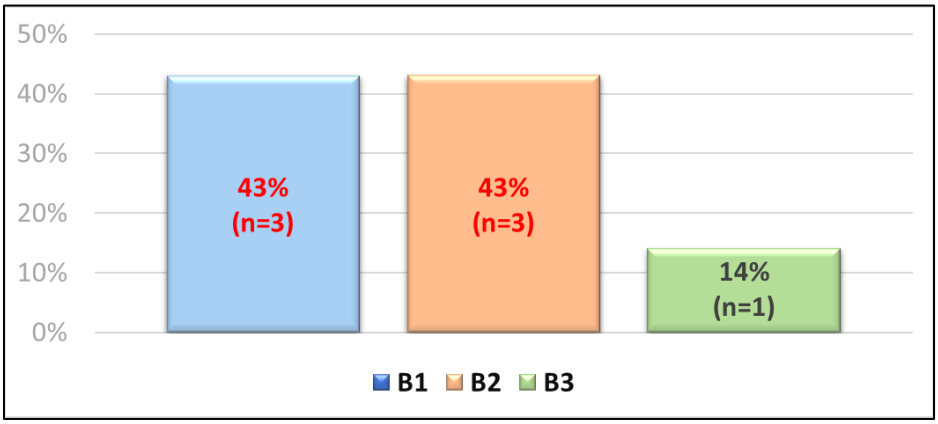

Figure 2B Distribution of CD Phenotypes

Table 2 Extra-Intestinal Manifestations in Late-Onset IBD Patients

Extra-Intestinal Manifestations	**N (%)**
Erythema nodosum	1 (5%)
Ankylosing spondylitis	2 (10%)
Peripheral arthritis	3 (15%)
Total	6 (30%)

Table 3 Maintenance Therapy in Late-Onset IBD Patients

Therapy	**UC patients N (%)**	**CD patients N (%)**	**IC patients N (%)**
Aminosalicylates	11 (100%)	–	0 (0%)
Immunosuppressants (AZA)	–	4 (57.1%)	0 (0%)
Anti-TNF (Infliximab)	–	3 (42.9%)	0 (0%)

Table 4 Surgical Interventions in Late-Onset IBD Patients

Surgical interventions	**N (%)**
Subtotal colectomy with ileorectal anastomosis	2 (10%)
Ileocecal resection with ileocolic anastomosis	1 (5%)
Total	3 (15%)

Table 5 Clinical Remission Outcomes

Outcome	N (%)
Remission maintained	18 (90%)
2 relapses per year	2 (10%)
Total	20 (100%)

4. Discussion

Although IBD is primarily diagnosed in young adults, it increasingly affects older individuals. Currently, approximately one-quarter to one-third of IBD patients are over 60 years. This demographic trend includes two distinct profiles: patients with longstanding disease reaching advanced age and those with late-onset IBD [1].
Definitions of "late-onset" vary, but most studies consider age 60 as the threshold. This subgroup represents approximately 10–20% of new diagnoses, a proportion expected to grow with population aging, raising specific diagnostic, therapeutic, and prognostic challenges [1].

Literature reports a higher incidence of UC than CD in the elderly [2]. A recent review also highlighted faster growth of late-onset IBD incidence in women compared to men between 1990 and 2021 [3]. Our results are consistent, showing a slight female predominance and higher UC frequency in our elderly cohort.

Clinical presentation in older patients is generally similar to younger adults, with common features including weight loss, abdominal pain, anemia, and diarrhea. Absence of family history is also more frequent in this population [4].

A survey conducted by the World Gastroenterology Organization reported a higher frequency of rectitis in elderly UC patients compared to younger patients. The EPIMAD registry, on the other hand, identified left-sided colitis as the

predominant location, followed by rectitis and extensive colitis [6]. A Hungarian study also highlighted that elderly CD patients more often had colonic involvement, while UC tended to localize preferentially in the left colon. These findings were corroborated by a Canadian study, which demonstrated a predominance of colonic involvement in late-onset CD and more extensive involvement in elderly-onset UC [7]. A systematic review reported that most patients with late-onset CD had an inflammatory phenotype. Higher prevalence of isolated colonic involvement and perianal disease has also been described in late-onset CD [8].

Observations from our study show predominant colonic involvement in CD and distal or left-sided localization in UC, which is generally consistent with trends reported in the literature. However, we found an equal distribution between inflammatory and stricturing forms of CD. This difference could be explained by geographic variations, sample size, or factors specific to the studied population.

Extra-intestinal manifestations are generally less frequent in the elderly, although some studies report similar rates to younger patients [6,9].

Therapeutic strategies in elderly IBD patients are strongly influenced by concerns about adverse effects, particularly infections and malignancies. The basic principles of IBD management remain the same as in other age groups: induce and maintain remission, prevent disease- or treatment-related complications, and improve quality of life. Treatment choice depends on disease location and severity, disease behavior (inflammatory, stricturing, fistulizing), presence of extra-intestinal manifestations, and associated comorbidities. Thus, although therapeutic goals are similar to those in younger patients, management in the elderly requires additional precautions and individualized decision-making [6].

The review by Nimmons and Limdi emphasizes that aminosalicylates remain the treatment of choice for elderly UC patients due to their favorable safety and tolerance profile. For CD, the use of immunosuppressants such as azathioprine and anti-TNF biologics is approached more cautiously in this population due to the increased risk of infections and age-related complications [6]. In our study, all UC patients received aminosalicylates, 4 CD patients were on azathioprine, and 3 received biologic therapy, reflecting an individualized therapeutic approach that balances expected benefits and risks.

The literature reports less frequent use of surgery in elderly IBD patients compared to younger individuals, particularly in UC where medical management is often preferred. Several studies indicate that late-onset CD often presents milder forms, but a notable proportion of patients may still require surgery, especially for complications such as fistulas or severe acute colitis [1,10]. This is consistent with our series, in which 15% of patients required surgical intervention, the majority emergently for severe inaugural acute colitis, while one patient underwent surgery for ileal fistulas occurring during disease progression. These findings highlight the importance of careful follow-up and tailored management to prevent and optimally manage surgical complications in the elderly.

Clinical outcomes in our series were generally favorable, with a high remission rate of 90%. These results confirm that, despite advanced age, appropriate management can often effectively control the disease. This trend aligns with the literature, where late-onset IBD generally exhibits a milder course and better prognosis compared to early-onset forms [6].

5. Conclusion

Late-onset IBD represents a distinct entity, characterized by absence of family history, high prevalence of comorbidities, often milder clinical presentation, and good response to medical therapy in most cases. Reduced use of immunosuppressants and biologics reflects both a milder disease profile and the need to tailor therapy to age-related considerations.

Prospective studies on larger cohorts are needed to better define optimal management strategies in this growing population.

Compliance with ethical standards

Disclosure of conflict of interest

All authors declare that they have no conflicts of interest related to this manuscript.

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