

## Preface



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*Guest Editor*

No organ in the body is so misunderstood, so slandered and maltreated as the colon.

—Sir Arthur Hurst, 1935

It is estimated that by the year 2030 there will be 27 million people age 65 years and older. This growing population's livelihood is often complicated by underlying age related changes, polypharmacy, chronic medical conditions, psychosocial stressors resulting from loss of bodily functions (incontinence, inability to walk or live at home), or loss of a spouse or child. Oftentimes, these ailments are further compounded by loss of memory. In older patients with poor cognition it is extremely difficult for the healthcare provider to obtain a good history, and in turn reach the crux of the problem. It is because of this important fact that all older adults should be screened for memory loss using instruments such as the Saint Louis University Mental Status Examination [1]. Older patients should also be screened for depression, along with screening for erectile dysfunction, problems related to appetite, incontinence, as well as other assessments needed to provide a complete comprehensive geriatric evaluation.

In regards to the gastrointestinal (GI) function, aging has a relatively small effect because of the large, efficient reserve of the GI tract. Changes that do occur in the GI tract usually go unnoticed unless severe stress is placed on the gut. In contrast, aging is associated with an increased prevalence of several GI disorders, including those induced by drugs (*eg*, gastrointestinal bleeding caused by nonsteroidal anti-inflammatory drugs),

anorexia of aging, development of constipation, diarrhea or fecal incontinence, and postprandial hypotension. In the next few decades, it is expected that there will be a rise in prevalence of both hepatitis B and C. Therefore, more in depth research will be necessary to evaluate the treatment of chronic hepatitis.

One of the most relevant progressions in the geriatric population, that needs a through evaluation, is the physiologic anorexia of aging that causes weight loss and possibly cachexia. The first stride is to properly differentiate physiologic anorexia from pathologic undernutrition. The etiology of anorexia of aging has not been fully defined, but there are some probable causes, such as decreased sense of smell and taste, reduced palatability of food, alteration of GI function, age related hormonal changes, and an increase in the level of cytokines [2]. It is also clear that anorexia of aging places older persons at a higher risk of having a severe decrease in food intake, and is further worsened by special diets [3]. In this population, the magnitude of any problem they face can easily enhance the likelihood of malnutrition. It is therefore important to be familiar with some of the common causes of geriatric malnutrition, such as poverty, shopping and preparation of food, limited transport or social support, presence of depression or dementia, alcoholism, and chronic medical conditions, to name a few.

Fecal incontinence is one the most devastating conditions an older person may face. In the nursing home population alone, fecal incontinence is nearly 50%. Along with urinary incontinence, it makes up one of the leading causes of nursing home placement. At this time, fecal incontinence is an underreported and undervalued problem in older adults. Although fecal incontinence is more common in women than in men, the difference does begin to narrow with the increase of age. Some of the risk factors that lead to the development of fecal incontinence include dementia, physical disability, and fecal impaction. Treatment options include medical or conservative therapy. Surgical options may also be explored, based on the availability of surgical expertise in selected older adults [4].

Constipation is very common in older adults and accounts for increased physician office visits and hospital admissions. There is no agreement on the definition of constipation, regarding what patients perceive as constipation and what physicians traditionally view as constipation. The etiology of constipation is multifactorial, and when left untreated, results in complications, such as impaction, fecal incontinence, obstruction of the bowel, perforation of the colon, and even death. Laxative use also increases with age; at times multiple agents are used to relieve symptoms of constipation. Currently, the most commonly used laxative is stool softener; however stool softener does lack efficacy. It appears that osmotic laxatives are effective in older adults and well tolerated. Psyllium, a bulk laxative, is also effective, and while there is limited evidence for stimulants, dioctyl sulfosuccinate is also used in the treatment of constipation. There is a clear need for a large-scale trial to examine an appropriate cost-effective approach to the management of

constipation in older persons, in particular in the nursing home where the problem is of paramount importance [5].

Although the specialty of geriatrics involves many different areas of awareness, this issue of geriatric gastroenterology offers a comprehensive review for some of the most significant concerns that impact the lives of older persons. The authors have done an exemplary job in addressing the most recent information about physiologic changes, disease presentation, and management issues in the ever-growing geriatric population. I hope this issue will serve as a resource for those clinicians who are involved in the care of older persons.

Finally, I would like to thank all the authors who made invaluable contributions to this issue.

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