Why should the Italian geriatrician be interested in elderly-onset inflammatory rheumatic diseases?

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Abstract

Inflammatory rheumatic diseases (IRDs) may onset in patients over 65 years old, and some of them are absent in younger subjects. As the over-65-year-old population is growing, IRD prevalence is consequently increasing. As for today, incorporating a comprehensive assessment in IRD management is rare, contrary to what happens in other areas of medicine. This brief communication stresses the main reasons why the Italian geriatrician should grow their interest in IRDs.

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Introduction

The umbrella term "inflammatory rheumatic diseases" (IRDs) defines a cluster of conditions extremely diversified in diagnosis, prognosis, and therapeutic approaches, whose common denominator is an anyway induced inflammation, whether it is an autoinflammation or whether is an immune-mediated inflammation. As of today, more than 100 different IRDs have been identified. Some IRDs may be onset in the elderly (Table 1). As the over-65-year-old population is growing, IRD's prevalence is consequently increasing. It is estimated to double in the near future.[1,2]

Age and inflammatory rheumatic diseases

Several IRDs can present differently between elderly and younger patients. For example, the first manifestation of elderly-onset rheumatoid arthritis (EORA) can be an acute involvement of the shoulder joints without the classic involvement of the joints of wrists and hands. On the contrary, an acute involvement of the shoulder joints is very uncommon in young or middle-aged patients with rheumatoid arthritis. An acute involvement of the shoulder girdle is common in patients with polymyalgia rheumatica (PMR). PMR and EORA are estimated to be the most common IRDs in the elderly, and differential diagnosis between these two diseases is not always straightforward in everyday clinical practice.[3] In the elderly-onset Sjögren's syndrome, the occurrence of a seronegative subset is common, as well as systemic manifestations not related to sicca syndrome. These findings can favor diagnostic errors and delays.[4,5] Some IRDs are absent in young subjects. PMR, for example, is altogether absent in the under-50-year-old population.[6] Similarly, primary gout is absent in female subjects before menopause, and symptomatic calcium pyrophosphate deposition (CPPD) disease is absent in young and middle-aged subjects (unless it is a familial and genetically determined CPPD disease).[7]

Additionally, the physiological age-related impairment of various organs and apparatus, along with comorbidity and polypharmacology, complicate the therapeutic management of elderly patients with IRDs, forcing "compromise" solutions and so hampering higher treatment goals. Finally, the onset of drug-induced IRDs must always be taken into account.[8]

Elderly patient with inflammatory rheumatic diseases in the rheumatologic assessment

Rheumatologists take great care in applying the guidelines proposed by rheumatologic scientific societies or experts' opinions. However, older patients are underrepresented in the majority of

clinical trials, and the current clinical practice guidelines are mainly focused on healthy middle-aged patients. Furthermore, geriatricians are often not included in rheumatology expert groups. This means that the geriatricians' point of view and experience are typically disregarded.

Additionally, the social environment, educational level, and functional needs of individual patients are not captured by traditional rheumatologic examination, despite having a potentially strong clinical impact, especially on medication adherence. Finally, assessment of the risk of falls is rarely carried out by the rheumatologist.

The geriatrician and the patient with elderly-onset inflammatory rheumatic diseases

Without a doubt, the geriatrician's multidimensional and holistic vision would help to better manage the older patient with IRDs. In a 1993 editorial, Boyer emphasized how geriatric rheumatology was a "much needed subspeciality".[9] In 2005, Danish clinicians wrote about their gerontorheumatological outpatient service in Nijmegen, where age-related psychosocial and cultural issues were routinely assessed. IRDs were diagnosed in about 20% of patients over 75 years of age. Almost all patients had a positive experience, so much so that they intended to recommend this service to other patients of their age with similar clinical problems.[10] A similar age-friendly approach has been proposed in the United States.[11]

After more than 30 years, this plea is largely unheeded in Italy, where geriatric rheumatology clinics can be counted on the fingers of one hand, and they are almost always headed by a rheumatologist. This could be due to the fact that the Italian geriatricians' interest in rheumatic diseases is still low, and typically confined to osteoarthritis and osteoporosis. The presence of many orthogeriatric clinics would confirm this. In addition, geriatric congresses often include sessions on orthogeriatrics. This means that geriatrician skills can be fully integrated into IRD management if the will is there.

The involvement of young geriatricians is crucial. However, young Italian geriatricians are already lagging because their educational choices focus on some topics and ignore others, thus missing the full picture.[12]

Inflammatory rheumatic diseases as a potential area for collaboration between geriatricians and rheumatologists

IRDs may be an area for fruitful collaboration between geriatricians and rheumatologists. First, the relationship between IRDs and geriatric syndromes is bidirectional, and high levels of circulating inflammatory cytokines are identified as a common basis. As the published literature highlights, identification and proper management of IRDs can help improve frailty, cognitive functions, risk of falls, and other geriatric syndromes. On the other hand, IRD prognosis and response to anti-rheumatic therapies are worse in elderly patients with concomitant geriatric syndromes.[13-15] Consequently, IRD management can benefit from a multidimensional approach [such as the Comprehensive Geriatric Assessment (CGA)]. The usefulness of CGA in tailoring therapies has been documented in a wide range of diseases of elderly patients: older patients who are categorized as "fit" can be treated the same as non-elderly patients. On the contrary, treatment in elderly patients categorized as "frail" should be uncoupled from strict criteria.[16]

Secondly, what most matters to the elderly patient with IRDs is commonly assessed through scales not always valid for the elderly. Finally, palliative and end-of-life care in geriatric rheumatology is still no man's land. Implementation of advanced care planning through shared guidelines is necessary, especially in patients where IRDs are the most impactful condition.[17]

The geriatrician can make an irreplaceable contribution to all these points, also detecting early signs and symptoms of IRDs and promptly referring a patient to the rheumatologist.

Recently, during the 2024 American Geriatrics Society annual scientific meeting, *ad hoc* sessions highlighted the need and, indeed, the urgency for an age-friendly care model in rheumatology. Specifically, the importance of the Geriatric 5Ms in assessing older patients with rheumatic diseases was discussed. Consequently, the use of evidence-based and patient-centered care was proposed as the standard of care.[18] The Geriatric 5Ms was set up by Tinetti *et al.* in 2017. According to the Geriatric 5Ms, Mind, Mobility, Medications, Multicomplexity, and Matters most to me are areas identified as key to care for the elderly.[19] The Geriatric 5Ms represents an example of CGA. The coming years will show us what steps have been taken to establish working partnerships. To the best of my knowledge, similar *ad hoc* sessions are still lacking in Italy.

A 3-step approach

All prior points lead to the proposal of a 3-step approach (Figure 1).

Firstly, there is still a strong need for strengthening knowledge of IRDs among geriatricians. Indeed, it is not possible to recognize what we do not know. Consequently, *ad hoc* sessions in geriatric congresses should be increasingly organized.

Incorporating geriatric assessment is the next step, as already happens in other areas of medicine. This means, for example, assessing the risk of falls, social context, cognitive functions, and what matters most to the individual patient, in addition to the traditional rheumatologic approach. Consequently, *ad hoc* sessions in rheumatology congresses should be increasingly organized. Moreover, the

Table 1. Common elderly-onset inflammatory rheumatic diseases.

Gout
Other crystal-related arthropathies (namely, crystal pyrophosphate deposition disease)
Elderly-onset rheumatoid arthritis
Polymyalgia rheumatica
Vasculitides
Spondylarthritis
Remitting seronegative symmetrical synovitis with pitting edema
Connective tissue disorders

Figure 1. Geriatrician and inflammatory rheumatic diseases: a 3-step approach.

inclusion of elderly patients in rheumatologic clinical trials must be implemented.

Lastly, collaborative initiatives between scientific societies of rheumatology and geriatrics must be carried out. As for today, partnership work is rare.

Conclusions

In conclusion, this short communication stresses the main reasons why geriatricians should be interested in IRDs.

A cultural change seems necessary to engage geriatricians in the identification of such complex and epidemiologically relevant diseases, achieving closer collaboration between geriatricians and rheumatologists. Are the *Società Italiana di Geriatria Ospedale e Territorio* (SIGOT) and its young board (SIGOT Young) ready to take up this challenge?

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