and family) of good end of life care. Currently the physician may ‘inadvertently fall into the trap of prognostic paralysis’ [1]. The clinical question ‘would I be surprised if this patient died within the next year?’ has been advocated as a useful prompt for care planning, discussion with the patient and family, and in decision making [4]. COPD is a chronic incurable disease, and many patients with COPD will eventually die of their condition. Our current therapies, even when used, targeted and directed skilfully, cannot prevent this in every patient, and there will come a time for many when continued active care is intrusive and futile. The decision as to when this time has come is not purely a medical one and should be arrived at jointly by patient, family and physician (or multidisciplinary team). Nonetheless, accurate prognostic information is a vital element in informing this decision.

**ERCP in the elderly: more than just the age factor**

**SIR**—We read with interest the article by Köklü et al. looking at the safety of endoscopic retrograde cholangiopancreatography (ERCP) in the elderly Turkish population [1]. They prospectively compared the characteristics and outcomes of patients undergoing ERCP for the first time. They showed that therapeutic ERCP is safe and the complication rates were comparable between the elderly (>70 years old) and the younger group. Before generalizing their results, one has to remember that this study was conducted in a high volume referral centre where the standard practices are likely to be different from those of lower volume centres.

There are several issues that require further clarification. First, what was the general health status of their patients? The number of co-morbid conditions, severity of patients’ acute illnesses at presentation and time of ERCP are particularly important. Secondly, the stone clearance rate in this study was quite high with use of the biliary mechanical lithotripter (BML) in only five procedures. Are the stones commonly encountered in their practice small? Thirdly, as stated by the authors, the rate of pre-cut sphincterotomy performed (49.5%) is very high. Although pre-cut sphincterotomy has been shown to be safe, it is generally not recommended by experts [2]. There are many centres that do not perform pre-cutting or only resort to pre-cutting if conventional approaches have failed. Hence the risk of complications is likely to be higher. Finally, the duration of follow-up, limited to 30 days, may not be long enough, as some cases of incomplete clearance of a stone may only become apparent later.

We recently reported our own experience of ERCP in the elderly (>80 years) population [3]. Seventy-one per cent of our patients had significant co-morbid conditions and 52% were dependent on others for their activities of daily living. Compared with the Köklü et al. study, our patients were much older and perhaps sicker. The stones encountered were generally big, and BML or stent placements were commonly used. We also showed that ERCP in the elderly is safe. However, complications do occur, and these were mainly related to sedation. This is in line with the findings of endoscopic studies undertaken in elderly patients. Significant complications occurred in 3.5% (n = 5): bleeding (n = 1), cholangitis (n = 2), perforation in a patient with previous Billroth II surgery, and one death probably contributed to by the procedure. Although retrospective, similar to others [4,5], our study assessed the existing standard practices of the particular centres. Hence these results are more generalisable, reflecting the current and perhaps the changing practice of ERCP among the ageing population. Finally, one has to bear in mind that there are other factors apart from the age of patients that can affect the outcomes of ERCP.

doi:10.1093/ageing/afj077

Reply

SIR—We thank Chong et al. for their interest in our manuscript. Further discussion will clarify the points they emphasized.

Percutaneous and surgical approaches are two alternative therapeutic options for endoscopic retrograde cholangiopancreatography (ERCP). Percutaneous transhepatic cholangiography (PTC) may be therapeutic in some cases; however, it may be only palliative in the remaining cases. Moreover, it has potential risks for liver injury. Surgery is the least preferred approach in the elderly. As stated by Chong et al., surgery has increased morbidity and mortality risks in those cases with co-morbid diseases [1]. Obviously, therapeutic ERCP is the best method for those patients. As shown by Chong et al., complications are mainly related to sedation rather than ERCP procedures. Therefore, we prefer to use low doses for pre-medication [2].

Although we did not measure the size of the biliary stones, we certainly removed large ones, especially in the elderly. In our own experience, the main facilitative factor was the frequent presence of diverticulae in the elderly patients. Peridiverticular papillas are less resistant even in partial endoscopic sphincterotomy. Although stones held by a basket seemed unremovable at first sight, they could be removed easily in those patients. Besides, a higher ERCP frequency may be related to large diameter sphincterotomy practices. Nevertheless, impaction is much more important than the size regarding stone extraction [3]. Stones wider than the common bile duct are problematic in the elderly as they are in younger people.

In fact, pre-cut sphincterotomy is frequently preferred in our centre. Although some authors find it hazardous, recent studies demonstrate that early pre-cut papillotomy does not carry more risks than persistent attempts [4,5]. Pre-cut papillotomy is not more dangerous than repeated pancreatic cannulation and papillary damage in expert hands. We also demonstrated that issue in a previous study [6].

The ‘. . .incomplete clearance of a stone may only become apparent later’ estimation is purely speculative. Moreover, in the long term, it is not always possible to determine whether a biliary stone was formed recently or is a residual stone. Nonetheless, patients who have undergone previous endoscopic sphincterotomy may have a new stone, especially those who have a wider duct. Therefore, the elderly with peripapillary diverticula may be at higher risks for new stone formation.

SEYFETTIN KÖKLÜ1,*, ERKAN PARLAK2, OSMAN YÜKSEL3, BURHAN ŞAHIN2
1Department of Gastroenterology, Ankara Education and Research Hospital, Ankara, Turkey
2Department of Gastroenterology, Türkiye Yüksek İhtisas Hospital, Ankara, Turkey
3Department of Gastroenterology, Numune Hospital, Ankara, Turkey
*To whom correspondence should be addressed at: Karargahtepe mahallesi, Kumrulu sokak, 18/1, Keçiören, Ankara, Turkey Tel: (+90) 312 3612568 Fax: (+90) 312 3124120 Email: gskoklu@yahoo.com


doi:10.1093/ageing/afj078