

Angioectasias in the elderly: Interpreting the data by Pérez-Cuadrado Robles et al.

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We are pleased to discuss the issues mentioned in the letter to the Editor by Pérez-Cuadrado Robles et al.¹ regarding our manuscript entitled “Predictors and characteristics of angioectasias in patients with obscure gastrointestinal bleeding identified by video capsule endoscopy.”²

We agree that our data is limited by its retrospective monocentric design and that a prospective trial is more accurate and valuable in detecting clinical predictors. In addition, we consent that discriminating between P1 or P2 lesions is not easy and, therefore, misinterpretation in our data cannot be fully excluded.

Our data consists of (clinically relevant) patients with obscure gastrointestinal bleeding only, while clinically more irrelevant patients, without gastrointestinal bleeding, are not included. Thus, a conclusion about the clinical relevance of angioectasias in patients without obscure gastrointestinal bleeding or about the incidence of these vascular lesions in general or in any subgroup of patients cannot be drawn from our data. As we already pointed out in the discussion part of the manuscript, in patients with obscure gastrointestinal bleeding and the positive finding of angioectasias, and at the same time the absence of any other possible bleeding sources, angioectasias have to be regarded as the most probable source and therefore are of distinct clinical relevance as these angioectasias should be treated. On the other hand, we would not primarily treat angioectasias in case of a more probable gastrointestinal bleeding source or without any signs of gastrointestinal bleeding.

It would be of great clinical relevance to be able to define the bleeding potential of small bowel angioectasias to be able to treat them a priori – before the occurrence of angioectasia bleeding or to estimate the bleeding probability in cases of ambiguous angioectasia bleeding. However, as Pérez-Cuadrado Robles et al. pointed out, this would be a practically almost impossible and time-consuming task, considering the need for video capsule endoscopy in many “healthy” individuals without any signs of obscure gastrointestinal bleeding to screen for these angioectasias, and considering the “waiting period” until bleeding of these lesions occurs.

Pérez-Cuadrado Robles et al. discussed that the incidence of vascular lesions may be underestimated in young patients,³ where the bleeding potential may be lower compared to older patients. We agree with this conclusion, which is actually supported by our data as it shows that patients >65 years with angioectasias have a higher risk for obscure gastrointestinal bleeding than patients <65 years. Also, Yung et al. and Zhang et al. showed that the incidence of angioectasias is lower in younger patients with obscure gastrointestinal bleeding.^{3,5} Again, at this point we want to indicate that our data, as well as those of the latter studies, did not define clinical predictors for angioectasias in general, but only in patients with obscure gastrointestinal bleeding.

Naturally, multivariate analysis does not fully eliminate age to be a confounding factor and actually different data did not identify advanced age as an independent risk factor for angioectasias in multivariate analysis.⁵ Therefore, as already discussed in our manuscript, factors such as an increased prevalence of concomitant diseases or medication intake could be a reason for a higher angioectasia bleeding potential in the elderly. However, as specific comorbidities and medication intake were not identified as independent risk factors for angioectasias in our data, we believe that age itself should still be considered as an important risk factor. The exact pathogenesis for angioectasias in older patients, however, is yet to be clarified.

References

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