

# Individualising Post-ERCP Management in the Geriatric Patients with Comorbidities [Letter]

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## Dear editor

We read *'Delayed Cholecystectomy after ERCP in Geriatric Patients: Balancing Surgical Risk and Recurrence Prevention'* with great interest.<sup>1</sup>

While this study reported a relatively low incidence of recurrent biliary events (RBE) following ERCP (8.6%) and very low RBE-related mortality (0.7%), other studies in mixed-age or younger populations report recurrence rates of approximately 12–25%.<sup>2,3</sup>

The discrepancy observed in this cohort suggests a possible age-related difference in risk profile, supporting other studies that question the universal need for routine post-ERCP laparoscopic cholecystectomy (LC) in the geriatric population. Most published studies to date have focused on younger cohorts, making this contribution valuable in highlighting an underrepresented, older population.

The findings also support evidence from Kivivuori et al, which justified a “wait-and-see” strategy in patients aged 75 years or older without a significant increase in adverse outcomes.<sup>4</sup> In contrast, SAGES, a US surgical society, advocates early cholecystectomy—often within 24–72 hours—after ERCP to minimise recurrence and readmission.<sup>5</sup> Although NICE (guiding UK practice) suggests performing LC in the first week of acute cholecystitis, it does not mandate the operation post-ERCP, leaving room for clinical judgment.<sup>6</sup> Such variation in these guidelines reflects how local resources, health system structures, and patient demographics shape practice.

An additional consideration is the natural progression of frailty. Frailty is not a static trait; it typically worsens over time. Longitudinal data show that around 30% of older adults transition from robust or prefrail to frail within five years, and more than 20% follow an increasing trajectory associated with poorer long-term outcomes.<sup>7,8</sup> This means that a patient who is fit for LC at the time of admission may not remain so a year later. If a recurrent biliary event such as pancreatitis arises after this decline, the patient may be deemed inoperable, and the opportunity for definitive treatment may be permanently lost. Thus, the index admission may represent the best—and sometimes the only—safe window to perform LC, provided comorbidity and frailty status allow. If the patient is considered too frail for definitive surgical management, other measures such as a low-fat, high-fibre diet may also play a role in reducing the rate of RBE and offer a pragmatic adjunct.

The authors also noted that follow-up was limited by the reluctance of older patients to attend hospital appointments. This reflects a broader challenge in geriatric research.

The UK health system is introducing novel models of care, such as “Hospital at Home” or “virtual wards”, which aim to deliver blood tests, consultations, and in some cases, ultrasound imaging to patients’ homes. Embedding these into future studies could improve follow-up adherence and enhance patient-centred care, which can provide more accurate long-term outcome data.

Finally, we agree with the authors that following ERCP, a non-operative approach can be reasonable in selected older patients, and clinicians should consider frailty when deciding on management rather than applying a single approach to all patients. Future work could consider diet and community-based services to guide more practical care pathways.

## Disclosure

The authors report no conflicts of interest in this communication.

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