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RESPONSE TO LETTER

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

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Dear editor

We thank Drs. Kosar and Majid Hashemzadeh for their thoughtful comments on our recent article.[1,2] Their letter underscores important perspectives on recurrence risk, variability in international guidelines, frailty progression, and emerging approaches to geriatric care.

In our cohort of patients aged ≥75 years, the incidence of recurrent biliary events (RBE) was 8.6% with RBE-related mortality of 0.7%. These relatively low rates may reflect the advanced age of the cohort, the shorter feasible follow-up period, and our stricter definition that required clinically verified events.

We agree that frailty is dynamic, consistent with longitudinal data showing frequent transitions from robust or prefrail to frail in older adults. Our study was not intended to argue against laparoscopic cholecystectomy (LC) in operable patients but to provide evidence that, in those at prohibitive surgical risk, a wait-and-see strategy can be safe.

We concur that dietary modification may serve as a pragmatic adjunct in reducing the risk of recurrent biliary events. In our practice, dietary advice was routinely provided not only to patients managed non-operatively but also to those who underwent LC, as recurrent CBD stones were still observed in 3.8% of cases in our cohort. This underscores the value of comprehensive management strategies that extend beyond the surgical decision itself.

We acknowledge that limited follow-up due to reluctance of older patients to attend hospital visits was a challenge in our study. We agree that models such as Hospital at Home or virtual wards are promising strategies to improve adherence and enhance patient-centered care, and their integration into future research would provide more accurate long-term outcome data.

In conclusion, our findings suggest that a wait-and-see strategy can be a safe and pragmatic option in carefully selected high-risk geriatric patients. The decision to proceed with LC should be guided by surgical risk, functional status, and patient preferences.

Disclosure

The author reports no conflicts of interest in this communication.

References

1. Prapasajchavet W, Viriyaroj V, Yodying H, Rookkachart T, Sathornviriyapong S, Boonsinsukh T. Delayed cholecystectomy after ERCP in geriatric patients: balancing surgical risk and recurrence prevention — a retrospective study. *Clin Interv Aging*. 2025;20:1517. doi:10.2147/CIA.S538539
2. Hashemzadeh K, Hashemzadeh M. Individualising post-ERCP management in the geriatric patients with comorbidities [Letter]. *Clin Interv Aging*. 2025;20:1693–1694.

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