AZATHIOPRINE IN THE ELDERLY

Introduction
Anogenital granulomatosis (AGG) is a recently recognised cause of genital lymphoedema and an association of CD with AGG has been noted in previous case reports. It presents with genital erythema and swelling, and flares are frequently misdiagnosed as cellulitis. We present a large case series.

Methods
Patients were identified from referrals to the regional Lymphoedema Service at St George’s Hospital after failure of antibiotics and topical steroids to improve symptoms. Demographic, clinical and endoscopic finding were correlated in patients with histological features of AGG in patients.

Results
Sixteen patients (15 male, 1 female; aged 34.8 ± 15.0 yr (mean ± s.d.)), were referred with AGG. 14 of 16 patients initially presented with genital swelling whilst 2 others presented with buttock swelling. Swelling of additional sites was noted in several patients (mons pubis – 25% of patients; natal cleft – 25%; peri-anally – 19%; buttocks – 12.5%). Although initially intermittent (15/16 patients), genital swelling was typically well established and irreversible by the time of presentation to the Lymphoedema Clinic. Flares involved erythema and deterioration of swelling which failed to return to baseline. Established swelling was associated with an increased risk of cellulitis in addition to the non-cellulitic flares.

Histological examination of the affected areas demonstrated dermal (and one case of intra-lymphatic) non-caseating granulomas in 12 patients with the remainder diagnosed clinically. Gastroenterology review, including colonoscopy, confirmed a diagnosis of Crohn’s disease in 37.5% of patients.

Treatment of AGG has proven difficult. Initial treatment with compression garments and prednisolone showed a reduction (but not elimination) of scrotal and penile shaft swelling in 9/11 patients. Antibiotics reduced the frequency of flares in only 3/11 patients. Steroid-sparing immunosuppression was successful in 4/11 patients. Antibiotics reduced the frequency of flares in only 3/11 patients. Myelosupression (1); joint pain (1); infection (1); and general malaise (1). The mean duration of AZA use in these patients was 34 days (Range 3–89). 13 (52%) tolerated the drug well with one of this group having the drug actively withdrawn at 701 days in complete clinical, endoscopic and histological remission. There were four deaths (16%). Two died in the group intolerant of AZA (84 year old died of stroke 888 days after 13 days of AZA; 82 year old died in the community 140 days after 5 days of AZA). Two people died in the AZA treated group (83 year old died in the community on day 1476 of AZA; 79 year old died following cardiac arrest on day 212 of AZA).

Conclusion
Our data demonstrate that AZA is an effective treatment in the elderly. It appears to be less well tolerated than in the general population with 48% intolerant of the drug within 3 months. Within the limitations of this study it appears to be safe. The increased incidence of drug intolerance in this population group may suggest that low-dose azathioprine and allopurinol co-therapy should be considered first-line therapy in this group. A further study to clarify this is required.

Disclosure of Interest None Declared.

REFERENCES
3 Gordon et al. Int J STD AIDS. 2013;Epub

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