Because elderly adults may have age-related physical and medical problems, more-severe and –complex deformities,2 poorer response to rehabilitation, greater need for postoperative medical assistance, and higher total cost of treatment,2 they present challenges for surgeons, so there is a tendency for family and doctors not to recommend even eligible patients for surgery.6 Nevertheless, with recent advances in the medical field, major surgical procedures such total hip arthroplasty (THA) and TKA can be safely performed elderly adults.2

From the experience of this case and other similar cases in octogenarians (unpublished data), the advantages of performing SBTKA rather than the two-stage total knee arthroplasty include shorter exposure to anesthesia, less time in the hospital, shorter rehabilitation and physical therapy, fewer wound complications, less surgical stress, convenience for family members, and more cost-effective treatment.6

It has been observed that, after TKA, 76% of individuals aged 85 and older could live independently and approximately one-third could drive a car.1 Hence, the quality of improvement in their lives was significantly greater, and TKA seems a valuable procedure for them. Although SBTKA cannot add years to the lives of these individuals, it can add quality to the remaining years of their lives.

When considering elderly adults for SBTKA, various factors such as age, overall health, mental function, and motivation must be considered. Older age alone should not discourage doctors and family from recommending surgery. These elderly adults, who live much longer than their counterparts, have exceptional qualities such as low probability of disease or disability, active engagement with life, and high cognitive and physical function.3

CONCLUSION

With predictable benefits of surgery, SBTKA seems a safe, effective, viable procedure for carefully selected elderly adults, provided that doctors, the individuals, and family members accept the risks. These individuals should not be deprived of potential benefits of this surgery. Biological age is more important than the chronological age of these elderly adults when considering them for SBTKA.

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SKIN LESIONS AFTER ORAL ACETYLCHOLINESTERASE INHIBITOR THERAPY: A CASE REPORT

To the Editor: Rivastigmine is an acetylcholinesterase and butrylcholinesterase inhibitor used for the symptomatic treatment of mild to moderate Alzheimer’s disease or mild to moderate Parkinson’s dementia and is given in oral or transdermal form.2 Rivastigmine is usually well tolerated and has a favorable safety profile.2 The frequency of side effects does not differ between the oral and transdermal forms.3 Approximately 10% of individuals develop more than mild skin reactions with transdermal rivastigmine therapy. Contact irritation, with mild erythema and pruritus, is most common.2 Allergic dermatitis with transdermal therapy is rare and presents with localized erythema and edema, which might spread beyond the borders of the patch.2 We report a case with recurrent allergic dermatitis with oral galantamine treatment at a site previously sensitized with a rivastigmine patch.4

CASE

A 74-year-old man was treated with rivastigmine 4.6 mg per 24-hour patch after the diagnosis of Alzheimer’s dementia with vascular lesions. After 3 months, the treatment was evaluated. He tolerated the treatment well, and he and his brother noted a positive effect, so the dose was increased to 9.5 mg per 24-hour patch. A year later, he visited the outpatient clinic with pruritus and an allergic rash far beyond the patch circumference and not round in shape on the left flank. A side effect of rivastigmine was suspected. To confirm the diagnosis, the rivastigmine treatment was discontinued, and an oral antihistaminic was prescribed. The rash disappeared in a few days. Because of

ACETYLCHOLINESTERASE INHIBITOR THERAPY:

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earlier positive clinical effects of rivastigmine, another oral acetylcholinesterase inhibitor, galantamine, was started after 1 month. Four days after initiation of galantamine treatment, he developed a rash at the previous location. Galantamine treatment was discontinued, and the rash disappeared. After 2 weeks, oral memantine, a N-methyl-D-aspartate receptor inhibitor, was initiated as an alternative treatment, and he experienced no adverse drug reactions.

DISCUSSION
A suspected side effect with a cross-reaction of acetylcholinesterase inhibitors is described in this case-report. Oral treatment with galantamine caused skin lesions similar to those from the patch with rivastigmine. According to the Naranjo algorithm, the likelihood that the adverse drug reaction was due to the suspected drug was probable. Two cases of individuals with allergic dermatitis after administration of rivastigmine patches are previously described. In one, transdermal rivastigmine was replaced with oral rivastigmine, and the rash grew. In the other, transdermal rivastigmine treatment was discontinued, and after disappearance of the rash, oral rivastigmine was administered under anesthesiological surveillance. In this case, the skin lesions reappeared at the same location, after which rivastigmine treatment was discontinued in any form. Recurrent dermatitis at a previously sensitized site after reexposure at a new site has been reported with nickel, gold, and chromate. No case reports were found of recurrent dermatitis after switching to oral therapy of a different acetylcholinesterase inhibitor, such as galantamine in this case.

Locally induced T-cells at the site of the allergic dermatitis could have caused the reappearance of the rash at the previously sensitized site with the use of a different oral acetylcholinesterase inhibitor. Allergic dermatitis is a T-cell-mediated delayed type of hypersensitivity, and even with disappearance of the skin lesions, T-cells can be detected at this site for at least 21 days after the skin rash. In this case, no skin biopsy was performed.

To the knowledge of the authors, this is the first reported case in which oral administration of galantamine lead to reappearance of an allergic dermatitis on a site that had previously been sensitized by transdermal rivastigmine. This case shows that, in the case of local side effects, sensitization can occur. Screening for recurrent local effects after switching from a patch to oral therapy of the suspected drug or to a drug from the same therapeutic drug group may be useful.

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REFERENCES

CONSTIPATION: AN UNUSUAL PRESENTATION OF UCULCERATIVE PANCOLITIS IN AN ELDERLY ADULT

To the Editor: Ulcerative colitis (UC), along with Crohn’s disease (CD), is one of the major types of inflammatory bowel disease. UC has a bimodal age distribution; the