

Cancer in the Elderly

Poster presentations (Tue, 25 Sep, 09:00–12:00)

Cancer in the elderly

1300

POSTER

Chemotherapy in elderly patients with renal insufficiency. Recommendations of the International Society of Geriatric Oncology (SIOG)

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Background: The elderly comprise the largest group of patients with cancer. They have a high incidence of significant comorbid illnesses which can affect the choice and dosing of chemotherapy. Elderly cancer patients commonly have a physiologic decline in renal function in addition to comorbid illness which can further exacerbate renal insufficiency. This warrants particular caution during the administration of renally-excreted cancer drugs or those with established nephrotoxicity.

Materials: An expert taskforce of the International Society of Geriatric Oncology was formed to discuss treatment recommendations for this group of patients regarding (1) the appropriate evaluation of renal function in such patients and (2) the dosage adjustment requirements for a number of anticancer drugs commonly used.

Results: The recommended dosing adjustment schedules for cancer drugs in this population of elderly cancer patients with altered renal function will be presented. Dosing adjustments have been made for drugs in current use which have recommendations in renal insufficiency and the elderly, focusing on drugs which are renally eliminated or are known to be nephrotoxic. Recommendations are based on pharmacokinetic and/or pharmacodynamic data when available in the international literature. The taskforce recommends that before initiating therapy, some form of geriatric assessment should be conducted that includes evaluation of comorbidities and polypharmacy, hydration status and renal function (using available formulae). Serum creatinine should not be used as the sole assessment of renal function. Within each drug class, it is sensible to use agents which are less likely to be influenced by renal clearance. Pharmacokinetic and pharmacodynamic data of anticancer agents in the elderly are needed in order to maximize efficacy whilst avoiding unacceptable toxicity. Recommendations regarding the use of biologics in renal insufficiency will also be discussed.

Conclusions: Future trials should be designed to specifically study the pharmacokinetics/pharmacodynamics of anticancer drugs in cancer patients with impaired renal function. Such studies are mandatory to optimize drug therapy in those patients by appropriate adjustment of dosages according to renal function. The practice recommendations will be updated to the latest available evidence by the time of the meeting

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POSTER

Surgical risk prediction with PACE (Preoperative Assessment of Cancer in the Elderly)

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Background: The prevalence of co-morbidities & frailty in elderly patients enhances the risk of treatment-related complications. This may interfere in offering optimal cancer management. A tool to predict postoperative short-term outcomes could facilitate optimisation of treatment.

Aim: A compilation of validated questionnaires (PACE) is assessed for 30-day postoperative outcomes (morbidity, mortality and hospital stay).

Material and Methods: An international series of elderly (>70 years) receiving elective cancer surgery recruited (July 2003 – December 2005). A 20-min interview (co-morbidities, IADL, ADL, GDS, BFI, PS, MMS) assessed health status; ASA, POSSUM and P POSSUM used to assess surgical risk. Postoperative outcomes were correlated against such components.

Results: 460 pts (mean age 76.9 yrs; range 70–95 yrs) were recruited. 83.0% had >1 co-morbidities. Hypertension (53.6%), heart disease (21%), vascular disease (14.4%), arthritis (19.2%), digestive diseases (22%) & diabetes (12%) were the most common. Surgery was for breast (47.0%), gastro-intestinal (31.7%) or genitor-urinary cancer (15.4%). Complications affected 171 pts (37.8%) with 45pts having at least one major complication (10.2%). 16 patients died (3.5%). Median hospital stay 5 days (IQR 2–70 days).

Dependency on ADL (RR 1.41), IADL (RR 1.43), fatigue/BFI (RR 1.52) & impaired PS (RR 1.64) associated with increase in risk for “any” morbidity. Similarly, dependency on ADL (RR 1.87), IADL (RR 1.65), fatigue/BFI (RR 1.24) and impaired PS (RR 1.97), depression on GDS (RR 1.69), abnormal ASA (RR 1.96) associated with increase risk for “major” complications.

Abnormal PACE components entered into forward stepwise Cox regression model, moderate to severe BFI (RR = 1.46, 95% CI = 1.18 to 2.13) & dependent IADL (RR = 1.36, 95% CI = 1.04 to 2.05) best described occurrence of any morbidity. Morbidity proportionately increased with increase in abnormal pace components; 0 factors (27%); 1 factor (36.5%) and 2 factor (68.2%).

Dependency on ADL (RR = 2.01), IADL (RR = 1.58) & impaired PS (RR = 1.64) predict the occurrence of a prolonged hospital stay. Dependency on ADL (RR = 2.00, 95% CI = 1.37 to 2.92) best described the extended hospital stay on multivariate forward stepwise Cox regression model. No PACE significantly predicted mortality due to the small number of events (3.6%).

Conclusions: PACE components (BFI & dependent IADL) predicts any 30-day morbidity. ADL associates with extended hospital stay. Functional health evaluation using PACE compliments treatment titration for elderly.

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POSTER

Updated International Society of Geriatric Oncology (SIOG) recommendations for the use of bisphosphonates in elderly cancer patients with bone metastases

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Background: The use of bisphosphonates to prevent skeletal-related events (SREs) in elderly patients warrants special consideration, due to frequently impaired renal function and use of several concomitant drugs. Moreover, elderly patients suffer often from osteoporosis and cancer treatments can lead to further bone loss.

Methods: A SIOG expert task force reviewed information from the literature (in PubMed) on bisphosphonates in elderly patients with bone metastases. Additional pertinent data were obtained from the manufacturers.

Results: Bisphosphonates are recommended in the elderly with bone metastases to prevent SREs. Intravenous formulations are preferred for the treatment of hypercalcemia and severe bone pain. It is recognized that zoledronic acid, ibandronate, and pamidronate can effectively contribute in relieving metastatic bone pain. The efficacy of bisphosphonates for the prevention of SREs has been demonstrated for all three of them and for clodronate in breast cancer. However, for other solid tumors, a significant reduction in SREs has only been shown for zoledronic acid. Available data, although quite limited, do not appear to indicate that elderly patients are at increased risk of nephrotoxicity due to bisphosphonates. However, creatinine clearance should be monitored initially in every patient, and an agent with minimal or no renal toxicity should be used where evidence of similar efficacy is available. The assessment and optimization of hydration status is recommended. Due to the risk from osteonecrosis of the jaw, routine oral examination and treatment of dental problems by a dental team is recommended before starting bisphosphonates.

Conclusions: Physicians should choose the most appropriate bisphosphonate. Safety precautions are particularly important in elderly patients. Further research is needed in elderly patients. These guidelines will be updated to include literature until June 2007.