1303 POSTER

Renal insufficiency in elderly cancer patients: International Society of Geriatric Oncology (SIOG) clinical practice recommendations.

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Background: Elderly cancer patients commonly have renal function decline. This warrants particular caution during the administration of renally-excreted cancer drugs or those with established nephrotoxicity.
Design: A SIOG taskforce 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: Prior to drug therapy, the assessment and optimization of hydration status and evaluation of renal function is required. Serum creatinine (SCr) alone is insufficient as a means of evaluating renal function, and creatinine clearance (CrCl) should at least be calculated in every patient by the aMDRD or Cockcroft-Gault equations. In the extremes of obesity and cachexia and at very high and low creatinine values, no single tool is really accurate. In these patients, the best estimate of GFR is provided by direct methods such as 51Cr-EDTA or inulin measurement. Within each drug class, preference may be given to agents less likely to be influenced by renal clearance, which are minimally nephrotoxic, or for which appropriate methods of prevention for renal toxicity exist. Co-administration of known nephrotoxic drugs should be avoided or minimized.
Conclusions: Future trials should be designed to present data in a way that allows evaluation of the contribution of renal function to toxicity and efficacy.

1304 POSTER

Knowledge and attitudes towards cancer in an old age sample

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Background: Cancer incidence increases with advancing age. However is in this group where more barriers towards screening, early diagnosis and treatment are found.
Material and Methods: 425 old individuals (⩾65 years old) were approached through a non-profit foundation devoted to elderly with a 72-items self-administered test on cancer information.
Results: 370 valid interviews were included in this preliminary study. Mean age: 74.68 (Sd 6.65). Summary of main results: *Prevention and early diagnosis*: Although a 53.5% believe that cancer can be prevented, 94% do not know the European Code against Cancer but have a correct knowledge of some of its recommendations (smoking 96.1%, excessive alcohol intake 91.8%, too long exposure to sunbath 91.8%), while those concerning diet and avoiding overweight are known only by 47.6% and 40.5% respectively. 74.5% believe that cancer may be early diagnosed, but only 44% know the PSA test, and 31.3% stated that breast cancer may be early detected. *Knowledge*: 66% believe that cancer do not increases with age, 59.7% stated that it can be cured, 8.5% believe that cancer is a contagious disease and 7% that it is a punishment for something bad you have done. *Treatment*: Cancer treatment is considered worse than cancer itself by 55.9%. 56% and 31.4% believe that mastectomy and prostatectomy respectively are the only way to cure breast and prostate cancer. Most feared treatment is chemotherapy (54.6%), which is qualified as dangerous by 59%, adjective which is given to radiotherapy by 51%. Alopecia following chemotherapy is considered not reversible by 17.4% and vomiting unavoidable by 30.2%. *Research*: 4.2% know the meaning of "'randomization", 23.1% "placebo" and 31.1% "clinical trial". *Information, attitudes and support*: 68% confirm that a cancer patient needs psychological support, and 85.1% that positive attitude is crucial to survive cancer. In case of having cancer: 80.9% would prefer to be fully informed, however 51.3% are not sure they would want receive any treatment.
– Gender comparison (54.6% women, 45.4% men) showed statistically significant differences in stating prostatectomy is necessary to cure prostate cancer (27.95% men, 22% women, $p < 0.003$), that cancer treatment is worse than cancer itself (34.04% women, 22.08% men, $p < 0.0001$) and in believing in the chance of early diagnosis of breast, prostate and colon cancer (men say 'yes' more frequently).
– Having had cancer in the past (18%) did not yield much difference in results, except in believing that cancer can be cured (71.85% in cancer survivors, 57.25% who have not a cancer antecedent, $p < 0.039$), in believing that a cancer patient need psychological support (62.5% who have had cancer, 69.75% having no history of cancer, $p < 0.013$) and in having suffered depression and anxiety (more frequently in those having had cancer, $p_{depression} < 0.045$; $p_{anxiety} < 0.0005$).

Conclusions: This is a preliminary report which gives information on the need of increasing cancer education programs targeted to old people.

1305 POSTER

SIOG (International Society of Geriatric Oncology) prostate cancer guidelines proposals in senior adult men

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Background: Prostate cancer incidence increases with age, with a median age at diagnosis of 68 years. Due to the increased life expectancy, prostate cancer represents a major problem of public health. Management of prostate cancer in senior adult men represents a major challenge for the future. No specific guideline has previously been published on the management of prostate cancer in older men (>70 years). The SIOG has developed a proposal of recommendations in this setting.
Methods: A systematic bibliographical search focused on screening, diagnostic procedures, treatment options for localized, locally advanced prostate cancer and metastatic disease in senior adults has be done. Specific aspects of the geriatric approach were emphasized, as evaluation of health status (nutritional, cognitive, thymic, physical and psycho-social evaluations) and screening for vulnerability and frailty. Attention was drawn on consequences of androgen deprivation and complications of local treatment, mainly incontinence. The collected material has been reviewed and discussed by a scientific panel including urologists, radiation oncologists, medical oncologists and geriatricians from both Europe and North America.
Results: The consensus has been to use either EAU or NCCN clinical recommendations for prostate cancer treatment. They are adapted to health status evaluation based on Instrumental Activity daily Living (IADL) activities, comorbidities evaluation by CISR-G, screenig of dementia. Patients in group 1 (no abnormality) are likely to receive the same treatment as younger patients, patients in group 2 (one impairement in IADL, one non-controled comorbidity) will receive standard treatmant after medical intervention, patients in group 3 (major IADL or cognitive impairement, several non-controled comorbidities) will receive adapted treatment, patients in group 4 (dependant) will receive only symptomatic palliative treatment.
Conclusions: Treatment will be adapted to health status. Specific prospective studies in senior adult men with prostate cancer are warranted.

1306 POSTER

An attempt to correlate "Comprehensive Geriatric Assessment" (CGA), treatment assignment and clinical outcome in elderly cancer patients: results of a phase II open study

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Background: To assess the correlation of the different CGA categories with different treatment administered and clinical outcome. The ultimate goal was to verify whether an appropriate treatment given to elderly cancer patients according to their CGA category could translate into a better clinical outcome, i.e. objective clinical response, performance status (ECOG PS), and toxicity. Phase II open, prospective non randomized study.
Patients and Methods: 114 elderly cancer patients hospitalized at Department of Medical Oncology, University of Cagliari, Italy. Patients were assigned to 3 different CGA categories: fit, intermediate and frail. Therefore, an appropriate treatment was administered and the clinical outcome was assessed. All patients underwent CGA evaluation. The clinical outcome after 3 month treatment was defined as objective clinical response, ECOG PS and toxicity. The difference of clinical outcome variables between the CGA categories were assessed by ANOVA test. Moreover, the correlation of clinical response with CGA category, ECOG PS, stage and dose intensity was evaluated by Spearman's t test.

Results: A better clinical response was observed in fit patients as compared both to intermediate and frail patients. Treatment toxicity was significantly worse for intermediate patients as compared to fit and frail patients. The correlation analysis showed a significant direct correlation between clinical response, CGA category and dose intensity; then, the multivariate regression analysis showed that the only independent predictive variables of clinical response were CGA category at baseline and dose intensity.
Conclusions: The main conclusion of our study is that the CGA category is the only true independent variable predictive of clinical outcome, as the other variables (dose intensity and ECOG PS) are correlated to it. The most relevant interest of the study is the new approach in the use of CGA.

1307 POSTER

First-line chemotherapy with sequential administration of gemcitabine followed by docetaxel in elderly advanced non-small-cell lung cancer (NSCLC) patients: a multicenter phase II study

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Background: Single-agent chemotherapy (gemcitabine or vinorelbine) is currently the standard treatment for elderly advanced NSCLC patients. The combination of gemcitabine+docetaxel was active but not well tolerated in this subset. Modified schedule of docetaxel (37.5 mg/m^2 on day 1 and 8 every 3 weeks) resulted active and well tolerated in pre-treated elderly advanced NSCLC patients. Aim of this study was to evaluate the activity and the toxicity of a sequential regimen of gemcitabine followed by docetaxel in elderly advanced NSCLC patients.
Materials and Methods: Chemo-naive elderly patients (>70 years old) with histologically or cytologically confirmed stage IIIB (positive pleural effusion or metastatic supraclavear lymph nodes) or IV NSCLC and a performance status (PS) 0−2 were treated with gemcitabine 1200 mg/m^2 on Day 1 and 8 every 3 weeks for 3 cycles followed by, in case of no progressive disease, docetaxel 37.5 mg/m^2 on Day 1 and 8 every 3 weeks for further 3 cycles.
Results: Fifty-six patients were enrolled into the study: 46 men and 10 women; 13 stage IIIB and 43 stage IV; 7 PS 0, 38 PS1, 11 PS2; median age was 75 years (range 70−84). The median number of major comorbidities was 2.
All the patients were evaluable for toxicity and 45 were evaluable for response. Toxicity was mild; afebrile grade 3−4 neutropenia was observed in 4 patients (7.1%) and grade 3 thrombocytopenia in 2 patients (3.6%); no grade 3−4 anaemia was observed. Non-haematological grade 3−4 toxicities were: fatigue in 5 patients (8.9%), diarrhoea in 1 patient (1.8%) and mucositis in 2 patients (3.6%). Nine of the 45 evaluable patients showed a partial response (20%, 95% CI 9.6−34.6%), 17 had a stable disease (37.8%) and 19 a progression (42.2%). Five patients had a conversion from stable disease to partial response by docetaxel.
Conclusion: Sequential chemotherapy with gemcitabine and docetaxel seems active and well tolerated in elderly advanced NSCLC patients. Further data will be presented at the meeting.
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1308 POSTER

Liver surgery for elderly in the new millennium: is it feasible?

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Background: Hepatic resections for primary and metastatic tumours are performed with increasing frequency and the limits extending. However, the safety and feasibility of liver surgery in elderly patients is still under debate. The aim of this study was to evaluate the feasibility and outcome of liver resections in the elderly (70 years and older).
Materials & Methods: Between January 1, 1997 and January 1, 2007 a consecutive series of 194 patients underwent 214 liver resections. The group of patients under 70 years served as control group (paediatric patients were excluded). Primary outcome was mortality. Secondary outcomes were complications, hospital length of stay and readmissions.
Results: Forty six elderly patients with a median age of 75 years (range 70−88) underwent partial liver resection. Both groups matched for gender and major/minor resections. Mortality rate was higher in the elderly group compared to the control group [2/46 (4 per cent) versus 1/166 (0.6 per cent)] but within the range reported in literature. Also, complication rates were higher in the elderly [19/46 (41 per cent) versus 50/166 (30 per cent)]. The median length of hospital stay was 9 days (range 4−82) in the elderly versus 8 days (range 3−81) in the control group. There were 4 re-admissions (9 per cent) in the elderly group compared to 27 (16 per cent) in the control group. None of these differences between the groups were statistically significant.
Conclusion: Hepatic resection can be performed in elderly patients of 70 years and older with an acceptable morbidity and mortality.

1309 POSTER

Care of elderly patients with cancer: place of geriatric intervention

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Background: A standardized geriatric evaluation is essential for the multidisciplinary discussion of elderly patients with gastrointestinal cancer. A geriatric as well as an oncological evaluation are mandatory to offer to these patients the best therapeutic option and improve their prognosis as well as their quality of life. A Geriatric Intervention Team (GIT) composed by nurses and geriatrician is working in our hospital. One of its function is to evaluate elderly patients with digestive neoplasms in collaboration with the Digestive Oncology unit (DOU).
Methods: The Mini Mental State Examination, the mini-Geriatric Depression Scale and the Get up and go timed test were used for the geriatric evaluation.
Results: GIT was solicited for 124 pts over a 3-year period. Their mean age was 79.1±6.3 years (65−96), 45% were men. The neoplasic localizations were: colorectal (53%), pancreatic (17%), esophagus (11%), hepatic carcinoma (7%) and other (12%). There was a clear prevalence of cognitive disorders identified by the Folstein MMSE. Among 65 workable files (complete MMSE), 61% of the patients had an abnormal (<26). The observation of a time and/or space disorientation was noticed in 30% of the cases. The mini-GDS used to detect depression, was positive in 43% of the evaluations. The Timed Get Up and Go Test was used to evaluate the walking capacity self-sufficiency and the risk of falls. It was superior to 20 seconds in 40% of cases. For 77 geriatrics evaluation, the GIT was solicited before the decision of the best treatment to choose. In this population, we can clearly identify 3 clusters of patients: well-matched patients (34%) who received chimiotherapy; intermediate patients (26%) who needed a new geriatric assessment before decision; and frailed patients (40%) who received only palliative treatment. In the second group, after geriatrician intervention, 60% of patients finally received a chemotherapy.
Conclusions: These results show the benefit of a close collaboration between geriatricians and oncologist. In the daily management of elderly patients, alteration are at least detected in 55% of patients by geriatric assessment. Moreover, the GIT is allow to securely classify the patients between the 3 categories and help to decision in the intermediate group.

1310 POSTER

A phase II study with cisplatin (cddp) and gemcitabine (gem) in elderly patients with advanced non-small cell lung cancer

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Background: The incidence of Non-Small Cell Lung Cancer (NSCLC) is increasing among the elderly representing about 30% of NSCLC patients over 70 years-old. Monochemotherapy is actually considered a standard approach in the elderly. The aim of this study was to evaluate the efficacy and tolerability of a modified schedule with CDDP-GEM in elderly pts with advanced NSCLC. On the basis of our previous experience of a dose-finding study we have decided to conduct this phase II trial to test the schedule at the dosage we have demonstrated to be tolerable in this special setting of patients.
Methods: Between June 2004 and December 2006, 30 pts were included in the study. Median age was 72 (range 70−75). Male/female 27/3 (90%/10%); 77% of patients were stage IV at diagnosis and three patients presented with brain metastasis. Treatment consisted of CDDP 35 mg/m^2 on days 1 and 8 and GEM 1250 mg/m^2 on days 1 and 8 every 21 days.
Results: a total of 115 cycles were administered with a median of 5 cycles per patient. The most relevant WHO toxicities were: neutropenia grade III/IV in 6 (20%) pts and grade I/II in 10 (33%) pts. We experienced no episode of treatment related deaths. Anemia was a major cause of haematological toxicity with 9 pts affected by grade II anemia. 6 pts (20%) experienced grade III/IV platelets reduction. Non-hematological toxicities