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.
This work was partly supported by the Fondazione A.R.C.O.

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