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Meeting Highlight

Lung Cancer in the Elderly

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In Western countries, the population over the age of 65 years is increasing and these elderly people have the highest risk and highest incidence of cancer. In the U.S.A., 52% of tumours are diagnosed in people over the age of 65 years. Lung cancer is the most common malignancy worldwide and is marked by high mortality. It frequency occurs in the elderly, with half the diagnosed cases occurring in patients over the age of 65 years. As such, a meeting was held in June 1997, dedicated to lung cancer in the elderly, under the auspices of the EORTC Lung Cancer Cooperative Group and the EORTC Study Group on Neoplasia in the Elderly and with the collaboration of the European School of Oncology. The aims were to review critically the available results in treatment and supportive care, and to evaluate the problems and limitations due to co-morbidity.

Professor Kornblith (Memorial Sloan Kettering Cancer Center, New York, U.S.A.) presented an exhaustive revision of tools available for quality of life evaluation. A possible way to circumvent the lack of instruments specific for elderly cancer patients might be the integration of different tools, oriented to different end points (e.g. cancer, age, co-morbidity).

Dr Aapro (European Institute of Oncology, Milan, Italy) stressed the difficulty of diagnosis in elderly patients; early diagnosis of lung cancer is difficult at all ages, but may be still worse for elderly patients with a long history of chronic respiratory disease, which can result in cancer-induced symptoms being overlooked.

Dr Scognamiglio (National Cancer Institute of Naples, Italy) presented data on surgery in elderly patients, indicating that surgery in elderly patients with resectable neoplasia should not be ruled out, but that the decision should be based on a careful evaluation of the patient's cardio-respiratory and general conditions, on a case by case basis.

Professor Pignon (Hospital de la Timone, Marseille, France) made the same point for radiotherapy, presenting data of an EORTC retrospective study on radiotherapy in elderly patients affected by lung or oesophagial cancer—the worst toxicities were myelosupression and oesophagitis.

Dr Perrone (Clinical Trials Unit, National Cancer Institute of Naples, Italy) focused on problems faced by clinicians when deciding whether or not a clinical trial specific for elderly cancer patients should be performed. He also addressed some of the methodological issues related to conduct and analysis of such trials. As lung cancer frequently arises in elderly patients and it seems that prognosis is significantly worse for these patients as compared with younger ones, clinical trials specifically for elderly patients are probably required. Survival is a useful end-point for such trials as it is not significantly confounded by non-cancer-related mortality because of the short life expectancy.

Dr Sorio (National Cancer Institute of Aviano, Italy) introduced pharmacokinetics in the elderly, stressing that it is important to carry out pharmacokinetic trials for anti-neoplastic drugs since there may be important differences compared with a younger population, particularly for oral drugs.

Dr Repetto (National Cancer Institute of Genoa, Italy) stressed the problem of chemotherapy toleration in elderly patients and the role of supportive care. Elderly patients tolerate chemotherapy poorly because of progressive organ failure and co-morbidities. These patients are generally not considered eligible for aggressive chemotherapy. Nowadays, there are some support drugs that can reduce chemotherapy toxicity, such as haematopoietic growth factors (G-CSF, GM-CSF, erythropoietin) heart protectors, such as razoxane, and renal protectors, such as amifostine. Moreover, in clinical practice, antineoplastic drugs, such as carboplatin and idarubicine, are used which have the same therapeutic activity but less toxicity than the original drugs.

It is important for the oncological elderly patients to have good nursing support, as mentioned by Kathy Redmond (Dublin University, Department of Nursing Studies, Dublin, Ireland).

Professor Van Meerbeeck (Dijkzigt University Hospital, Rotterdam, The Netherlands) reviewed literature on small-cell lung cancer chemotherapy in the elderly. Most of the trials were retrospective and sometimes discordant. In some, worse survival in the elderly was seen and less treatment tolerability. No survival differences were pointed out in other studies. Oral etoposide is the drug frequently used in the monochemotherapy of the elderly patients with small-cell lung cancer.

Professor Yancik (Cancer Section Geriatrics Program, National Institute on Aging of Bethesda, Maryland, U.S.A.)

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introduced epidemiological data about tumours in elderly patients and in particular in lung cancer. More than two-thirds (68%) of lung cancer mortality in the United States occurs in persons over 65 years. Age-adjusted incidence rates for 1990–1994 reported by the National Cancer Institute Surveillance Epidemiology End Results (SEER) programme are 26.7 per 100 000 population for persons under age 65 years, whilst the rate is 345.9 per 100 000 population for persons 65 years and older. The epidemiology of lung cancer presents a considerable challenge to oncologists and other health professionals, especially in the context of the world's expanding populations.

Professor Coeberg (Department of Epidemiology and Biostatistic of the Erasmus University in Rotterdam, The Netherlands) highlighted the co-morbidity problem in elderly patients affected by lung carcinoma. These co-morbidities are often responsible for the exclusion of elderly patients from clinical trials and for the lack of treatment data. The more frequently reported co-morbidities in these patients are cardiovascular and chronic pulmonary diseases, both caused or enhanced by cigarette smoking.

Professor Monfardini (National Cancer Institute of Naples, Italy) underlined the need for using, in elderly cancer patients, the same assessment tools employed by the geriatricians to evaluate: (1) the type and degree of associated co-existing pathologies; (2) the conservation or deterioration of cognitive function and presence of mental depression; (3) the ability for one-self. Age-associated conditions potentially interfering with treatment administration should be evaluated in order to avoid arbitrary decisions on patient selection for enrolment in clinical trials or simply to optimise treatment. To what extent this multidimensional evaluation methodology should substitute for scales to estimate the quality of life designed for adults and not specifically for elderly patients remains to be determined.

Finally, Dr Gridelli (National Cancer Institute of Naples, Italy) discussed the problem of chemotherapy in the elderly affected by advanced non-small-cell lung cancer. A recent meta-analysis showed only a small advantage (6 weeks in median survival for chemotherapy versus best supportive care) in advanced non-small-cell lung cancer. Meta-analysis did not show data about the patient's quality life. Very few data were published in the literature about elderly patients. There are now new active drugs which are well tolerated, such as taxanes, gemcitabine and vinorelbine. Their acceptable toxicity profile allows their evaluation in the elderly. The use of these drugs in clinical practice is stimulating clinical research in this field. A multicentre randomised phase III study (ELVIS—Elderly Lung Cancer Vinorelbine Italian Study) comparing supportive care versus supportive care plus vinorelbine in elderly patients over 70 years with advanced stage IIIB–IV non-small-cell lung cancer is ongoing. The primary endpoint of the study is quality of life measured by EORTC questionnaires C30 and LC13 and 200 patients have been enrolled in 1 year.

The meeting was concluded by Professors Giaccone and Monfardini. They underlined the usefulness of the meeting and hoped that other meetings dedicated to cancer in the elderly and particularly to breast cancer, colorectal cancer and ovarian cancer would be organised in the future.

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