

side effects were: fatigue in 7 pts (28%) and local chest wall pain in 2 pts (8%). No clinically symptomatic pneumonitis was observed. One pts (4%) developed rib fracture. Subjective symptoms of increased dyspnoea during follow up occurred in 2 pts (8%). Asymptomatic radiation induced lung fibrosis was detected in 9 pts (36%).

Conclusion: SBRT with SRTS in octogenarians appears to be a safe and minimally invasive modality for treating pts with medically inoperable stage I NSCLC. Despite the significant presence of medical comorbidity (Charlson score ≥ 4 in 40% of pts), curative SBRT, with doses of >100 Gy BED, achieved high local control with minimal toxicity. Longer FU will be required to fully establish toxicity as well as probability of local failure.

4003

ORAL

Age is Nothing but a Number – Management of Breast Cancer in the Elderly

R.L. Harries¹, G. Kugathasan¹, E.A. Jones¹, N. Faulkner¹, K.F. Gomez¹.

¹ Nevill Hall Hospital, Oncoplastic Breast Unit, Abergavenny, United Kingdom

Background: Breast cancer is becoming more prevalent in an older cohort of patients. Some clinicians can occasionally be guilty of basing treatment decisions on biological age in conjunction with pre-morbid states and predicted life expectancy, such that surgery and, even chemotherapy or radiotherapy are not offered as first line treatment options in the elderly. The aim of our study was to assess treatment options provided for patients over the age of 75 years with breast cancer at a single institution.

Materials and Methods: A retrospective review of a prospectively maintained database of patients diagnosed with breast cancer aged over 75 years at time of diagnosis at a single institution over a 3-year period (December 2003– November 2006) was undertaken. Only symptomatic and invasive cancers were included in the study.

Results: 57 patients with invasive breast cancer were reviewed. The median follow-up period was 3 years. 28 patients underwent surgery as their primary treatment and 29 underwent primary hormonal therapy. 89.6% of this group received Aromatase Inhibitors as their primary hormone treatment. The median age in the surgical group of patients was 80.3 years (Range 75–85) compared to 85.2 years (Range 77–96) in the primary hormone group. 96.4% of the patients had Oestrogen positive (ER) tumours. There was no difference in American Society of Anaesthesiology (ASA) status between the two groups. 72.4% of patients who underwent surgery were alive at 3 years, compared to only 28.5% of patients in the primary hormone group. The lymph node involvement was fairly evenly matched in both groups; however 28% of the primary hormone group had distant metastatic disease at the time of diagnosis compared to 0% in the surgical group.

Conclusions: Our results show that if an elderly patient has symptomatic breast cancer but does not have distant metastases, and is fit to undergo an anaesthetic, then primary surgery should be recommended by the local multi-disciplinary team as the treatment of choice. Primary hormone treatment in the elderly should be reserved for those patients with metastatic disease or if the patient chooses this option. The chronological age of the patient should not be a primary factor in the decision making process.

4004

ORAL

Evaluating the Perioperative Risk of Gastric Cancer Patients Over 80 Years Old Retrospective Analysis Using the POSSUM and E-PASS Scoring System

T. Iwase¹, N. Takiguchi¹, H. Yamamoto¹, M. Miyazaki². ¹Chiba Cancer Center, Department of Surgery, Chiba, Japan; ²Chiba Graduate School of Medicine, Department of General Surgery, Chiba, Japan

Background: It is well known that the surgical risk for an elderly person is much greater than that for younger patients, and that in such cases, the surgical risk should be evaluated preoperatively. Although many studies of perioperative risk analysis using predictive risk scores for elderly patient have been reported, there are still very few studies evaluating risk analysis in an extremely elderly patient group such as those over 80 years old (y.o.). In this study, we applied POSSUM and E-PASS, which are known to be useful predictive perioperative risk score systems for assessing perioperative risk, and attempted to evaluate perioperative risk and patient outcomes.

Material and Methods: Between May 2006 and August 2010, 898 patients underwent gastric cancer surgery at our institute and 63 of these patients were over 80 y.o. For this evaluation, we applied the Physiologic and Operative Severity Score for the enUmeration of Mortality and morbidity (POSSUM) and Estimation of Physiologic Ability and Surgical Stress (E-PASS), which was developed for evaluating perioperative risk in Japan. Moreover, the duration of hospital stay was also evaluated.

Results: As patient background, there were 41 males, 22 females, aged 82.5 ± 2.4 year old. Twenty-one patients had perioperative complications, such as aspiration pneumonia, wound infection, leakage, cerebral infarction, delirium and others. In POSSUM, there were significant differences in Hb (complication group = 10.7 ± 2.6 vs. non complication group = 12.5 ± 1.8), Physiologic Score (25.4 ± 5.1 vs. 23.7 ± 5.1), Predictive morbidity rate (-2.16 ± 0.67 vs. -2.51 ± 0.73), and Predictive mortality rate (0.03 ± 0.81 vs. -0.40 ± 0.89) between the complication group and non-complication group ($p < 0.05$). In E-PASS, there were no significant differences between the two groups. For those with a hospital stay over 30 days, there were significant differences in Physiologic Score, Predictive morbidity rate, Predictive mortality rate in POSSUM. There was no relationship between the predictive risk rate and complication group in E-PASS. Moreover, there was no relationship between predictive risk rate and CRS (Comprehensive risk score) in E-PASS. On comparison of the frequency and extent of lymph node dissection by age group, patients over 80 y.o. underwent D1 or D0 dissection significantly more frequently than patients under 80 y.o. (40.5% vs. 65.1%).

Conclusion: In this study, POSSUM was more sensitive for predicting perioperative risk. When analyzing the results of predictive morbidity rate in E-PASS, patients over 80 y.o. underwent D1 or D0 dissection more frequently than patients under 80 y.o. group in our center. It is considered that the surgeon's selection of surgical methods strongly influences the clinical outcome.

4005

ORAL

A Retrospective Audit of Adjuvant Chemotherapy Offered Elderly Patients for Colorectal Cancer

G. Faust¹, A. Osman², S. Porter². ¹Northampton General Hospital, Department of Oncology, Northampton, United Kingdom; ²University Hospitals of Leicester NHS Trust, Department of Oncology, Leicester, United Kingdom

Background: This retrospective audit assesses the management & outcome of elderly (≥ 75 years old) patients over a 5 year period after undergoing resection of a colorectal primary.

Method: All cases of elderly patients having undergone curative resection for a colorectal primary, between 1.7.2004 & 30.6.08, at University Hospitals of Leicester NHS Trust, for a Dukes' B or C tumour were reviewed. Data was collected from sources including electronic databases, notes & community physicians. Criteria for exclusion from analysis included metastatic disease at presentation, neoadjuvant (chemo) radiotherapy, endoscopic resection & death prior to surgery.

Results: 328 pts (167 male) were analysed, median age 80.8 yrs (Range 75–95) & 142 Dukes' C cancer. 88 (27%) were referred to oncology for consideration of adjuvant chemotherapy & of these 43 received chemotherapy (38 Dukes' C). For pts reviewed in oncology, those receiving chemotherapy had a significantly better initial PS than those who didn't (age was NS). Of those 45 reviewed by oncology but who did not receive chemotherapy, patient choice was the main factor for patients who did not want treatment (100%), whilst co-morbidities (50%) & disease status (27%) influenced oncologists' opinion in not offering treatment.

The type of chemotherapy administered was weekly 5-FU (20 (46%) pts), capecitabine (20 (46%) pts) & FOLFOX-4 (3 (7%) pts). Of these 24 patients experienced no $\geq G3$ toxicity, 5 had 1 $\geq G3$ toxicity whilst 14 had 2 or more $\geq G3$ toxicities (capecitabine was the main causative agent). The majority of $\geq G3$ toxicities experienced were diarrhoea & PPE. Multiple G1 & G2 toxicities were documented including diarrhoea, lethargy & conjunctivitis. Treatment completion rate was 65% for 5-FU, 55% capecitabine & 0% FOLFOX-4. Overall survival was significantly different between those who received chemotherapy & those that didn't (4.07 vs 3.27 yrs, $p = 0.045$), however time to recurrence was not significantly different. OS from time of recurrence was poor in both groups – 189d & 110d respectively (NS).

Conclusions: In our elderly population those with better PS & Dukes' C rather than B cancer were more likely to be offered & receive chemotherapy. Patient choice & co-morbidities were the main reasons for not receiving adjuvant treatment. Weekly 5-FU was seemingly better tolerated than either capecitabine or FOLFOX-4. Chemotherapy did influence OS but not TTP. After recurrence, life expectancy in this group is poor at 3 to 6 mths.