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ORAL

Evaluation of the G8 Questionnaire as a Screening Tool for Frailty in Older Cancer Patients (pts)

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Background: Frailty is an important factor to be considered in the senior cancer patient (pt). The Comprehensive Geriatric Assessment (CGA) is considered to be the gold standard to evaluate frailty in this pt population but its routine use in clinical practice is difficult. Therefore, screening instruments are needed to identify cancer pts who can be treated according to standard guidelines or are in need for a full CGA with geriatric interventions. The G8 questionnaire is a short and simple screening tool and was compared with the CGA to distinguish fit from unfit pts.

Materials and Methods: Eligible pts were evaluated by the G8 questionnaire [score range: 0 (poor score) to 17 (good score)] and a full CGA to discriminate fit from unfit pts. The CGA evaluated function, mobility, nutrition, co-morbidity, cognition, depression and social support. Pts were considered unfit (vulnerable or frail) if there was more than 1 deficit within the CGA. Cut-off point used for the G8 questionnaire was a G8 score ≤ 14 for unfit pts. ROC analysis was used to evaluate the overall performance of the G8 questionnaire compared to the CGA.

Results: 135 cancer pts were recruited from two sites in Belgium. Median age was 77 years old (range 66–97 years). Most prevalent types of cancer were urological cancers (22%), head and neck cancers (21%), cancer of the digestive system (17%), breast cancer (16%) and lung cancer (13%). According to the CGA, 44% of patients were considered unfit. The G8 questionnaire screened 75% of the patients as unfit with a sensitivity of 92% (95% confidence interval [CI]: 82–97%), a specificity of 39% (95% CI: 28–51%), a positive predictive value of 55% (95% CI: 44–64%) and a negative predictive value of 85% (95% CI: 68–95%). 62% of the pts were correctly classified. The Area Under the ROC Curve (AUC) was 0.85 (Standard error 0.03; 95% CI: 0.78–0.90).

Conclusions: Overall the G8 questionnaire had a good ability (AUC=0.85) to discriminate fit from unfit patients in our sample compared to the CGA. For a cut-off point G8 score ≤ 14 the sensitivity was very high, but unfortunately the specificity or the probability to correctly identify fit patients was poor.

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ORAL

Comorbid Cardiovascular Diseases in Patients With Metastatic Colorectal Cancer

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Background: Currently, data regarding the prevalence of cardiovascular comorbidities in patients with metastatic colorectal cancer (mCRC) are limited. This study determined the rate of comorbid cardiovascular diseases in patients with mCRC, as comorbidities may impact treatment decisions, prognoses, and quality of care.

Methods: From the PHARMO Record Linkage System (RLS), including among other things, drug dispensing and hospitalization records of approximately 3.2 million residents in the Netherlands, all patients with a primary or secondary hospital discharge code for CRC and distant metastasis between 2000 and 2008 were selected and defined as patients with mCRC. The first discharge diagnosis defining metastases served as the index date. Prevalent cardiovascular comorbidities were assessed during the 12 months prior to the index date and patients were required to be registered in the PHARMO RLS during this period to be included in the study cohort. Cardiovascular comorbidities were captured using both cardiovascular drug use and hospital admission data, i.e. information on drugs dispensed for the treatment of cardiovascular diseases in the outpatient setting and primary and secondary hospital discharge diagnoses in the hospital admission database.

Results: A total of 2,964 patients with mCRC were included in the analysis. Mean ($\pm$ standard deviation) age at diagnosis was 68 (± 12) years and 53% were male. Overall, cardiovascular comorbidities were observed in 52% of the patients. Of all patients identified by drug use (n=1,479), the most commonly used agents were antithrombotic agents (54%), followed by beta blocking agents (46%), and agents acting on the renin-angiotensin system (45%). Of the patients who were hospitalized for cardiovascular comorbidities during the year prior to index date (n=297), about one-third was hospitalized for cardiac dysrhythmia (39%), followed by congestive heart failure (19%) and hypertension (18%).

Conclusions: Cardiovascular comorbidities are commonly seen in patients with mCRC, which might be explained by the high mean age at diagnosis. Consideration of these conditions should be an integral part of the treatment strategy in individual patients with mCRC.

**Poster Presentations (Mon, 26 Sep, 14:00–16:30)
Cancer in the Older Patient**

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POSTER

Characteristics of Gastrointestinal Cancer Patients Older Than 65 Years of Age: Single Cancer Center Experience

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Background: Aging is one of the important risk factor for increased incidence of cancer. Molecular changes and insufficient immunity associated with aging results in increased susceptibility for many carcinogens to tissues especially to gastrointestinal system (GIS). Pharmacological and pharmacodynamical changes of chemotherapies associated with aging together with co-morbidities mostly seen in this older age group makes the treatment of GIS cancers unique. In the presenting retrospective study basic characteristics and differences of treatment of the GIS cancers in older age group were evaluated.

Materials and Methods: Between february 2009 and July 2010, three hundred and thirty six patients who were histopathologically diagnosed with GIS cancer evaluated retrospectively. One hundred and eighty six patients older than 65 years of age were of our main interest.

Results: Median age of our elderly patient group was 73 years (Range: 65–86). Eighty (43%) patients were women and 106 (57%) were men. Localisations of the GIS cancers were colo-rectal, gastric, pancreaticobiliary system and primary liver as an incidences of 78 (41.9%), 52 (%28), 37 (19.9%) and 9 (4.8%) respectively. In this older age group gastric and pancreaticobiliary system and hepatocellular cancers were the common cancer types in men than in women [36 (33.9%), 21 (19.8%) and 7 (6.6%) respectively]. In contrast colo-rectal cancer was the most common cancer type in women in elderly. The stage of GIS cancers in this age group were mostly advanced stage [stage IV, III, II and I were 84 (45.2%), 41 (22%), 49 (26.3%), and 12 (6.5%) respectively]. In older patient groups 73 (39.2%) of patients were not received any chemotherapy. Reasons were refusing to chemotherapy, low performance status, no indication to chemotherapy in 63 (86.3%), 4 (5.4%), 6 (8.2%) of patients respectively. Although 113 (60.8%) of patients received chemotherapy, 40 (35.3%) of patients were received inferior chemotherapy regimens rather than standart protocols.

Conclusion: Cancers of GIS are mostly diagnosed in advanced stage in older age patients since fatigue, debility and anorexia are common symptoms in both GIS cancers and senility. Thus screening programs and close monitoring of the symptomatic patients are important. There is a higher tendency to less treat and to deny chemotherapy in elderly. But treatment of GIS cancers gives as good results as in young adults even in elderly, if there was no associated co-morbidities. Physiological conditions and co-morbidities are more reliable factors to decide treatment strategies rather than chronological age. Assessment of good performance status by some tests like treadmill may be helpful before planning chemotherapy in this age group. Elderly patients who are in a good performance status should be encouraged for receiving chemotherapy.

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POSTER

Less Adjuvant Chemotherapy for Elderly Patients With Stage III Colon Cancer in the Netherlands

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Background: We described to what extent patients with colon cancer aged ≥ 75 years were treated with adjuvant chemotherapy and the impact on survival in the Netherlands 1997–2009.