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POSTER

Predicting the Risk of Cardiovascular Comorbidity in Cancer Survivors

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Background: Preventable conditions, such as heart disease and diabetes mellitus, represent a major threat to the life of many cancer survivors (CS). However, there are limited data on how to identify CS at the greatest risk who may benefit most from prevention. Our goals were to: 1) characterize the clinical factors associated with ischemic heart disease (IHD) and congestive heart failure (CHF) among CS; and 2) develop a stratification schema for predicting the risk of cardiovascular comorbidity in CS.

Methods: CS and non-cancer controls (NCC) were identified from the U.S. National Health and Nutrition Examination Survey. Multivariate logistic regression models were constructed to determine independent clinical factors associated with an increased relative risk (RR) for cardiovascular comorbid conditions. Based on a composite scoring system that assigned 1 point for each risk factor identified, a cardiovascular risk stratification schema was devised that correlated the risk score with the prevalence of cardiovascular comorbidity in CS.

Results: A total of 2,734 CS and 23,832 NCC were included: mean age was 45.0 years (SD 17.4), 48.1% were male, and 88.6% were White in the entire cohort. Baseline characteristics were similar between CS and NCC. When compared to NCC, CS were significantly more likely to report IHD (8.5 vs. 2.9%, $p < 0.01$), CHF (7.1 vs. 2.0%, $p < 0.01$), or both (3.2% vs. 0.67%, $p < 0.01$). Based on multivariate analyses, risk factors for cardiovascular problems included: age ≥ 60 (RR 6.4, 95% CI 5.3–7.7); male gender (RR 1.8, 95% CI 1.6–2.1); racial minorities (RR 1.7, 95% CI 1.4–2.1); those who were separated or widowed (RR 2.4, 95% CI 1.8–3.4); less than high school education (RR 1.5, 95% CI 1.3–1.8); and an annual income less than \$20,000 USD (RR 1.9, 95% CI 1.6–2.3). A cardiovascular risk stratification schema for IHD and CHF in CS was developed (please see Table).

Conclusions: Independent risk factors for IHD and CHF in CS were identified. A risk stratification schema may be helpful in developing a risk-based approach to cardiovascular preventive strategies for CS.

Table: Prevalence of cardiovascular comorbidity (IHD, CHF, or both) based on risk score

Comorbidity	Score			
	≤ 2	3	4	5+
IHD	0.8%	6.4%	13.6%	19.5%
CHF	0.4%	6.2%	10.6%	16.7%
IHD and CHF	0.2%	2.2%	3.2%	9.1%

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POSTER

Treatment of Elderly Patients With Oxaliplatin – Frequency and Severity of Adverse Drug Events and Quality of Life

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Background: Although colorectal cancer (CRC) occurs most frequently in patients >65 y, elderly patients are underrepresented in clinical trials. This lack of study data causes uncertainty about the optimal cancer treatment in this population.

Material and Methods: Data were collected in the outpatient ward for cytotoxic drug administration of a secondary care clinic between 11/2009 and 04/2011. CRC patients at the beginning of an oxaliplatin-based chemotherapy (CTx) were included. Patients >65 y underwent geriatric assessment (ADL, IADL, MMSE, TU&G, MNA) before the 1st and the 12th course. Blood count and serum creatinine were obtained for all patients before every course, as well as their retrospective perception of selected symptomatic adverse drug events (ADE: nausea, vomiting, diarrhea, mucositis, alopecia, fever, infection, allergic reaction, neurotoxicity). The data were classified according to the NCI CTCAEv3.0. Also, all patients answered the EORTC QLQ-C30 before the first and every third courses of CTx.

Results: 18 patients (12 male, 6 female) were included and followed for a total of 207 courses. Four patients were <65 y (median: 58.7, range 45.0–64.3), 14 patients >65 y (median: 73.4, range 70.3–81.5). 15 patients were treated with FOLFIRI 4, 14 of which completed all 12 courses. One female patient (73.3 y) discontinued CTx after 6 courses due to intolerable adverse events. Of 3 patients receiving FuFOx, all discontinued after a time, for different reasons (82yo female patient: insult after a cumulative

oxaliplatin dose of 75 mg/m²; 75yo male: neurotoxicity, 820 mg/m²; 78yo female: allergic reaction, 740 mg/m²). Interestingly, dose density was higher in older patients: 86.5% of the scheduled dose, vs. 77.3% in patients <65 y. Although patients >65 y were more prone to leucopenia, fever and infections occurred in both groups to the same extent. Nephro- and neurotoxicity as well as nausea and vomiting were slightly more pronounced in patients <65 y, whereas diarrhea, alopecia and thrombopenia occurred to a greater extent in patients >65 y. Both groups showed the same extent of anemia, mucositis and allergic reactions.

Quality of life (QoL) did not change significantly in either group during CTx. By trend, patients >65 y had a higher QoL than patients <65 y.

Conclusions: Oxaliplatin-based CTx is reasonably tolerable in elderly patients and does not impair quality of life. The spectrum of ADE seems to be slightly different in younger vs. elderly patients.

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POSTER

Metastatic Renal Cell Cancer Treated With Sunitinib – Toxicity and Efficacy in the Elderly

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Background: Renal cancer accounts for 3% of adult malignancies with the highest rates observed in persons over 65 years-old. Metastatic renal cell cancer (mRCC) has a poor prognosis with 5-year survival rates $<20\%$. Sunitinib is effective in the first-line treatment of mRCC. Our purpose was to assess the toxicity and efficacy of Sunitinib in elderly mRCC patients.

Material and Methods: Retrospective cohort study of sunitinib treated patients in a single Portuguese cancer center. Elderly patients were defined as those aged ≥ 65 years (group A). Efficacy and toxicity patterns of elderly patients were compared with those of younger patients (group B) treated in the same time period.

Results: Between 2007 and 2010, 71 patients were treated with Sunitinib, of which, 53 mRCC patients in first line setting for previous treatments. Median age was 66 years, with 29 patients (55%) aged ≥ 65 . Groups A and B were comparable in terms of gender distribution, histology and proportion of prior nephrectomy. MSKCC risk scores was available in 37 patients (group A, $n = 19$). Patients distribution according to MSKCC risk scores was significantly different ($p = 0.015$). Group A tended to be more commonly in the intermediate risk group, and patients of group B tended to be more favorable or high risk patients. Median overall survival (OS) was 19 months (IC95% 15–23). Survival estimated stratified by MSKCC risk group was similar in both groups. OS according to MSKCC risk scores prognostic group for elderly patients were: favorable risk group OS 35 months; intermediate risk group OS 17 months; high risk group OS was 0.5 months. Number of treatments cycles were higher in younger patients (4 treatments vs. 8 treatments, $p = 0.008$). The toxicity profile was similar between groups (adverse events rate 89 vs 87%, $p = 0.585$), but elderly patients had a trend toward more treatment interruptions and delays.

Conclusions: Elderly patients with mRCC benefit from first line treatment with Sunitinib. However, they seem to be more prone to toxic events. This may be due to a higher prevalence of co-morbidities and impaired drug metabolism. Special attention is needed in patients at a high risk according to MSKCC prognostic score. A more tailored approach to the management of elderly mRCC patients is warranted.

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POSTER

Aromatase Inhibitors as Neoadjuvant Treatment in Elderly Patients (>70 Years) With Locally Advanced Breast Cancer: a Monoinstitutional Experience

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Background: There are scarce data on activity and tolerability of neoadjuvant treatment with aromatase inhibitors in elderly patients (pts) with locally advanced breast cancer (BC). In particular, data on surgery rate and correlation with Multidimensional Geriatric Assessment (MGA) are lacking.

Methods: Medical records of elderly (≥ 70 years) pts with locally advanced BC ($cT \geq 2$ and/or $cN \geq 1$) treated at our Institution in the years 2003–2010 were reviewed and data on age, stage, MGA classification, comorbidities, treatment, objective (clinical or radiological) response, adverse events, survival were collected. Statistical analysis was performed using Kaplan–Meier method and log-rank test.