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POSTER

Validation of the Barber Test as a Screening Questionnaire for Frailty in Elderly Patients

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Background: The term "frailty" is spreading in the field of Oncogeriatrics; however, there is no unanimity on the most effective methods for detecting the condition. The Barber test (BT) has traditionally been used to assess the ambulatory elderly population, but its use is not widespread in the elderly cancer patient population. The aim of this study was to validate the BT as a frailty screening questionnaire in elderly cancer patients.

Material and Methods: The BT was applied prospectively to all patients in the General Hospital de Cuenca who were older than 70 years of age and who were diagnosed with cancer between June and December 2010. Descriptive data related to the patients and their cancer histories were also collected. Using SPSS 15.0, we confirmed the reliability of this questionnaire by calculating its internal consistency (Cronbach's index, CR) and temporal stability (intraclass correlation coefficient, ICC). All patients gave their consent to participate in this study.

Results: Data were collected for a total of 86 patients. The mean age was 78.66 years (range: 70.23–91.8). Of the patients sampled, 62.4% were men (n=53). In addition, 43.5% of the patients had an Eastern Cooperative Oncology Group (ECOG) score of 1 (n=37), and 34.1% had an ECOG score of 0 (n=29). With respect to tumour status, 44.7% (n=38) had been diagnosed with gastrointestinal tumours, 23.5% (n=20) with breast and gynecological tumours and 10.6% (n=9) with a urological or prostate tumour. The average BT score was 1.31 (range: 0–5). There were 61 patients (72.6%) at risk of frailty according to the BT (score ≥1). The CR and the index of absolute agreement were 0.782. The ICC was 0.275.

Conclusions: Because the Barber test contains questions that are heterogeneously variable, its use can lead to incorrect conclusions (CR 0.782). In addition, this questionnaire lacks temporal stability (ICC 0.275). Use of the BT as a screening tool for frailty is problematic owing to its lack of reliability in the field of Oncogeriatrics. Although the BT may be useful in other patients, alternative frailty screening tools should be used for this population.

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POSTER

Feasibility of Using Groningen Frailty Index as an Assessment Tool for Cancer Treatment Decision in Elderly Patients in Sarawak, Malaysia: Preliminary Report

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Introduction: Performance status (PS) attempts to quantify patient's general well-being and helps to determine whether patient will benefit from treatment or be made worse. Most commonly used are the Karnofsky and the ECOG score, the latter quoted in WHO publications. ECOG is easy and assists making discriminations that are clinically useful. According to the criteria, patients who are fully active or have mild symptoms respond more frequently to treatment and survive longer than patients who are less active or have severe symptoms. In the Department of Radiotherapy, Oncology & Palliative care (DRO) 300 new cases in the age group (>65 years) are seen annually. In our practice, ECOG is used as a pre-treatment assessment tool. As patients >65 years tend to have other co-morbidities, that are not assessed in ECOG PS scale, we decided to test the practical feasibility of using GFI (Groningen Frailty Index) and to assess GFI quality to aid in treatment decision and to compare it to ECOG in an oncology clinic.

Method: A consecutive series of 286 patients who were ≥65 years and had no prior oncology treatment were included in this pilot study (June 2009–August 2010). For the purpose of comparing GFI and ECOG, we grouped the GFI scores 0–4 as good comparable with 0–2 for ECOG where the intent to treat is radical. For GFI scores of 5–9 (moderate) the intent to treat was palliative. While GFI scores of >10 and ECOG >3 only had best supportive care. Those who refused, did not receive adjuvant hormonal treatment, with ECOG score of 4 and GFI score of >10 were excluded.

Results: The most common cancers were: lung, colon, stomach, rectum, breast and nasopharynx. 78% (220 patients) were in advanced stage (3&4). 81% (232/286) were ECOG 0–2 and 50% (143/286) were GFI 0–4. 53% (137/266) of the patients with GFI 0–9 (eligible for radical to less radical treatment) completed treatment. While with ECOG score of 0–2, only 40%

(93/232) completed treatment. 64% (34/53) with ECOG >3 who would have only received best supportive care were treated with less radical intent based on GFI scores 5–9 and 41% (14/34) completed treatment.

Conclusion: Of the two questionnaires, GFI provided more information in assisting in treatment decision making, was more practical, took about 10 minutes and hence it is feasible to use in a busy clinic. More importantly, there was an advantage of GFI scoring over ECOG scoring for selecting those elderly patients who otherwise would be under treated.

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POSTER

Anti-androgen Therapy Suspension Following Prolonged Clinical and Biochemical Response: outcomes in a Series of Elderly Patients With Advanced Prostate Cancer

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Background: To describe the outcomes following the suspension of androgen- suppression therapy in a series of elderly patients in an advanced stage of prostate cancer and in prolonged clinical and biochemical response.

Materials and Methods: Of 371 consecutive patients with advanced prostate cancer and treated with androgen-suppression therapy, 44 older patients were defined as in stable response on the basis of the absence of noteworthy dysuria, normal prostate findings on digital rectal examination, and prostate-specific antigen values lower than 0.50 ng/ml. After suspending treatment, it was to be re-scheduled in case of onset of dysuria, evidence of a palpable lesion on digital rectal examination, or a rise in prostate specific antigen above 10 ng/ml. Progression of disease was defined as a prostate-specific antigen level increase at two subsequent measurements, and/or the appearance of new lesions, and/or evidence of progression of disease on digital rectal examination.

Results: Median age of patients was 78.5 years at the moment of therapy suspension. After a median follow-up of 93.9 months, fourteen patients (31.8%) showed progression of disease, but only 7 (15.9%) of these died. In 7 (15.9%) patients, serum testosterone levels did not exceed 0.5 ng/ml, indicating an absence of gonadal activity. The median time to progression was 138.2 months, and the median cumulative survival from the start and from the suspension of androgen-suppression therapy was 105.5 months and 64.1 months, respectively. The savings in drug costs amounted to 772,267 Euro.

Conclusions: Taking into consideration these outcomes of survival and of savings in drug costs, we can conclude that in these selected elderly patients, this treatment option could be of interest.

**Oral Presentations (Sun, 25 Sep, 09:00–10:50)
Paediatric Oncology**

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ORAL

Radiation Therapy in Childhood Low Grade Glioma (LGG) – a Subgroup Analysis Within the Scope of the German Multicenter Treatment Study HIT-LGG 1996

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Background: The HIT-LGG 1996 trial offered the first uniform treatment strategy for childhood low grade glioma (LGG) in Germany. Radiation therapy (RT) formed an integral part in the management of progressive or inoperable disease. We analysed the treatment, prognostic factors and outcome of the irradiated patients.

Material and Methods: We assessed 192 patients who underwent treatment between January 1997 and October 2006. The age at the beginning of irradiation varied from 0.7 to 18.8 years. External fractionated radiation therapy (EFRT) was administered either as a first line treatment or after the failure of primary chemotherapy. Children younger than five years