Geriatric oncology: cancer in senior adults

8th Meeting of the International Society of Geriatric Oncology
8–10 November, 2007, Madrid, Spain

***Ulrich Wedding*[1] & *Jean-Pierre Droz*[2†]**

†Author for correspondence

[1]Universitätsklinikum Jena, Department of Hematology/Oncology Bachstraße 18, 07740 Jena, Germany.

Tel.: +49 364 193 4904; Fax: +49 364 193 4902;

E-mail: ulrich.wedding@med.uni-jena.de

[2]Lyon-RTH Laennec School of Medicine, Centre Leon Berard, 28 rue laennec, 69008, Lyon, France.

Tel.: +33 478 782 867; Fax: +33 478 782 716; E-mail: droz@lyon.fnclcc.fr

The International Society of Geriatric Oncology (SIOG) [101], founded in New York, USA in 2000, holds its annual congress either in Europe or in North America. The objective of the meeting is to bring together geriatricians, medical oncologists, radiation oncologists, surgeons and all health professionals involved in the management of senior adult patients. The attendance is composed of all these specialists concerned with the treatment of cancer in senior adults. This year, the meeting took place in Madrid, Spain. It was chaired by Professor G Perez Manga (Spain); the Scientific Committee was coordinated by Ulrich Wedding (the University of Jena, Germany, and current chair of the European Organisation for Research and Treatment of Cancer [EORTC] Task Force in the Elderly). The meeting was organized around plenary sessions, parallel sessions and poster displays, as well as oral presentations. The sessions focused on the management of different diseases, but also on specific topics such as a review of the latest achievements in the care of senior adults, the organization of different Senior Adult Programs, recent advances in surgery and radiation oncology in senior adults, the specificity of clinical trials in senior adults and an update of SIOG recommendations. T Estape (Spain) reported the results of a sociological survey of senior adult patients with cancer: she showed that the level of knowledge of elderly patients regarding cancer is rather good. The patients know that early diagnosis is possible, that cure of their cancer may be achievable and that clinical research is important; they want to have access to supportive care and want to be told the truth. All these information justify the activity of geriatric oncology.

Key presentations

A Hurria, a well recognized Medical Oncologist and Geriatrician and Director of the Cancer and Aging Research Program at the City of Hope in California, USA, gave an overview of the most recent achievements in geriatric oncology from the medical oncology side. The amount of literature covering the field has clearly increased over the last few years.

Breast cancer

An update of the Early Breast Cancer Trialists' data was published that included 305 women aged 70 years and older treated with single-agent adjuvant chemotherapy, and 1224 treated with polychemotherapy for whom 10 years of breast cancer mortality rates are reported. Results were not significantly different for recurrence or for breast cancer-related mortality. Owing to the small number of patients treated within clinical trials, data from registries are interesting. Giordano *et al.* reported from the Surveillance Epidemiology and End Results (SEER) database data from 41,930 women aged 65 years and older. Chemotherapy was associated with a significant reduction in mortality among older women with estrogen-receptor (ER)-negative and lymph-node (LN)-positive breast cancer. Elkin *et al.* reported similar results. Chemotherapy use decreased with increasing age. A survival benefit from adjuvant chemotherapy was seen in older women with hormone-receptor-negative breast cancer. The difficulty is to balance between benefit and toxicity. Toxicity rates increase in elderly patients with adjuvant chemotherapy of breast cancer. As Hyman Muss, Medical Oncologist from the Vermont Cancer Center, USA, pointed out, even healthy older patients who met the strict eligibility criteria for these trials had a higher rate of hematologic toxicity and treatment-related deaths than younger patients, but no increase in nonhematologic toxicity. Patt *et al.* demonstrated a small but real increase in acute myeloid leukemia after adjuvant chemotherapy for breast cancer in older women. Pinder *et al.* demonstrated that women aged 66–70 years who received adjuvant anthracyclines had significantly higher rates of chronic heart failure (CHF), but not those aged 71–80 years. Within the coming years, reports from recent adjuvant trials are awaited; CALGB 49907 closed accrual and the ICE trial is still recruiting, but others, such as the Chemotherapy Adjuvant Studies for Women at Advanced Age (CASA) trial, had to close accrual early, due to poor recruitment.

Lung cancer

Former trials confirmed that in patients aged 70 years and older with advanced NSCLC, single-agent chemotherapy

10.2217/1745509X.4.1.25 © 2008 Future Medicine Ltd ISSN 1745-509X

plus best supportive care (BSC) performed better than BSC alone. The MILES 2P trial demonstrated the feasibility of a cisplatin plus gemcitabine combination in patients with good performance status, this combination should be compared with single-agent treatment in this group of patients. Peep *et al.* retrospectively analyzed the data of the National Cancer Institute of Canada and Intergroup Study JBR.10, and compared the results for patients aged younger and older than 65 years. They concluded that despite elderly patients' receiving less chemotherapy, adjuvant vinorelbine and cisplatin improves survival in patients over 65 years of age with acceptable toxicity. Adjuvant chemotherapy should not be withheld from elderly patients.

Colorectal carcinoma

Goldberg *et al.* analyzed patients' age as a factor for toxicity of the oxaliplatin plus fluorouracil (FOLFOX) regimen. Hematological toxicity was significantly higher in patients aged 70 years and older, but nonhematological toxicity did not increase. Effectiveness was not different between younger and older patients. But only a selected number of elderly patients were included, with only 123 (3%) of 3725 patients being 75 years and older. Scappaticci *et al.* reported an increased risk of the development of arterial thromboembolic events in those aged 65 years and over following a prior arterial thromboembolic event.

Geriatric oncology program organization

JH Cohen chaired a session dedicated to the organization of geriatric oncology programs. There are clearly different approaches to these programs, depending on whether geriatricians are involved (which is not frequent), whether the study is aimed to screen vulnerability or frailty, as done in Tampa (FL, USA) or, conversely, to propose both cancer treatment and geriatric intervention (program developed in Lyon, France). Another approach is the management of patients within an interdisciplinary approach, which means that all professionals are involved (experience of the Monteregie network in Quebec, Canada). These experiences will help to delineate the best possible organization for the future.

Guidelines

Guidelines for cancer treatment are generally established by cancer societies or specialty-oriented societies. Until now, very little information has been available regarding senior adults with cancer, therefore no specific recommendations have been proposed in the past. It is only recently that such guidelines have been developed and have begun to be implemented. However, there is a gap in our knowledge about some tumors, such as prostate cancer, and others, such as renal cancer. A presentation of proposals for guidelines in both localized and advanced-stage prostate cancer was made at the meeting: recommendations include a very practical screening of vulnerability using comorbidity score, evaluation of geriatric syndromes and dependency screening. A review by J Bellmunt (Spain) showed that a chemotherapy drug such as docetaxel is as active in senior adults as it is in younger patients and its administration is feasible; a decision tree has now been proposed. Conversely, no data are available on the use of targeted drugs in senior adults with renal cancer, and guidelines are therefore extremely difficult to establish. It was thus concluded that specific trials should be conducted to address this question.

Regarding the use of biphosphonates in senior adult patients, guidelines have been developed by the SIOG and these were presented by JJ Body (Belgium). Biphosphonates are recommended to prevent skeletal-related events and to provide pain relief in patients with bone metastases. Zoledronic acid, ibandronate and pamidronate are active in this domain, regardless of the necessity to adapt treatment to creatinine clearance, to increase hydration and to screen and prevent dental side effects.

More recently developed guidelines from the SIOG cover the topic of adjustment of dosing in elderly cancer patients with renal insufficiency who are treated with chemotherapy, in breast cancer patients and, as reported during the meeting, for treatment of metastatic colorectal carcinoma.

Surgery

The knowledge on surgery in senior adults is growing rapidly. An important trial should be published soon: the Physician-based Assessment and Counseling for Exercise (PACE) protocol, presented by R Audisio (UK), is a validated tool used preoperatively to assess 30-day morbidity and mortality rates and duration of hospital stay. This 20-min procedure includes various screening tools. The most important items assessed are the Brief Fatigue Index and the Instrumental Activity of Daily Living (IADL) Index. The PACE will soon be available as a facility on the internet. B van Leeuwen (The Netherlands) reviewed the surgery of colorectal cancers; the major conclusion was that emergency surgery might yield the same results as elective surgical procedures. K Oda (Japan) showed that elective surgery is applicable in gastric and colorectal cancers in patients over 80 years of age: there is no mortality and a morbidity rate of 28%; even changes in IADL are transient.

Clinical trials design

As an example of a trial specially designed for elderly cancer patients, MT Seymour from Leeds, UK, presented the data of the FOCUS-2 trial. In a 2 × 2 design, two questions should be answered in patients with first-line treatment of advanced colorectal carcinoma aged 70 years and older. Infusional 5-FU was compared with capecitabine either in combination with oxaliplatin or alone, and combination chemotherapy including oxaliplatin was compared with single-agent based chemotherapy, either as infusional 5-FU or oral capecitabine. A total of 460 patients from 62 centers were recruited, and a 117-item compromising comprehensive Geriatric Assessment (CGA) was performed, including nutritional assessment,

cognition, ADL, anxiety and depression and quality of life. The median age of patients was approximately 75 years, and roughly 30% had a poor Eastern Cooperative Oncology Group (ECOG) performance status, equal to 2. The addition of oxaliplatin to a 5-FU-based regimen tended to improve progression-free survival (HR = 0.83; p = 0.06), but worsened quality of life at 12 weeks. Fewer patients treated with capecitabine had an improvement in ADL compared with those treated with an infusional 5-FU regimen. Overall survival was not significantly different between the two groups.

A special section of the conference covered the topic of how to conduct clinical trials in elderly cancer patients. Ulrich Wedding pointed out that trials in elderly cancer patients have three aims. First, to identify by a comprehensive geriatric assessment those elderly patients who are fit and can be treated with a standard treatment, developed through trials that mainly included younger patients. Second, to identify those who are compromised and can not be treated with standard treatment either owing to increased toxicity or to no long-term benefit as other medical disorders are limiting the prognosis, and third, to identify those who are frail and should mainly be treated with supportive and palliative care. Further talks demonstrated European trial activities, for example the French GERICO trials, however the major focus was on EORTC activities. Hyman Muss spoke from the US and Cancer and Leukemia Group B (CALGB) perspective. As he pointed out, a number of trials have already finished accrual, such as the CALGB 49907 trial on adjuvant chemotherapy in elderly patients with breast cancer, or are close to reaching the planned number of patients. In her talk on ethical considerations, A Surbone, Milan, Italy, stressed the need of quality assessment regarding informed consent, the need to avoid misconception and provide the patients with all the relevant information of preliminary results of clinical trials, in elderly patients as in younger patients. In addition, she pointed out that elderly people tend to adapt to emotionally stressful events better than younger patients.

Future perspective

Different questions are under investigation. The best organization for geriatric oncology remains to be determined; it depends on the objectives of the management and on the means that can be invested in the programs. Screening tools, such as PACE, are important as they enable us to discriminate between patients who must undergo a CGA and those who only require the management of a specific health problem. Another important issue for the future is the need to increase knowledge regarding targeted drug management in the senior adult population. Finally, the role of clinical trials is essential, mainly those that are targeted specifically to senior adults and that may include some form of evaluation. Such an approach has been the object of an outstanding poster presented by B Deschler (Germany) who won the BJ Kennedy Prize award. The study included a simplified CGA in patients with myelodysplastic syndrome and acute myeloid leukemia. The CGA enabled patients to be allocated to different treatment modalities based on their health status.

Hyman Muss, received this years' honour of the Paul Calabresi Award Lecture for his numerous works on cancer in the elderly, especially elderly women.

Highlights of this conference were:

- The need to refine organization of geriatric oncology programs
- The need to develop knowledge on practical screening tools to identify patients who require a CGA
- The need to increase knowledge on targeted drugs in the senior adult population, which requires the development of specific trials
- The need for development of specific trial designs

The next meeting of the SIOG will take place in Montreal, Canada, 17–18 October, 2008.

Financial & competing interests disclosure

The authors have no relevant affiliations or financial involvement with any organization or entity with a financial interest in or financial conflict with the subject matter or materials discussed in the manuscript. This includes employment, consultancies, honoraria, stock ownership or options, expert testimony, grants or patents received or pending, or royalties

No writing assistance was utilized in the production of this manuscript.

Website

101. International Society of Geriatric Oncology www.cancerworld.org/siog