I TRATTAMENTI INTEGRATI NELL'ANZIANO

Grazia Acquaviva

UO RADIOTERAPIA
AOOR PAPARDO-PIEMONTE

Giardini Naxos, 26 Ottobre 2013

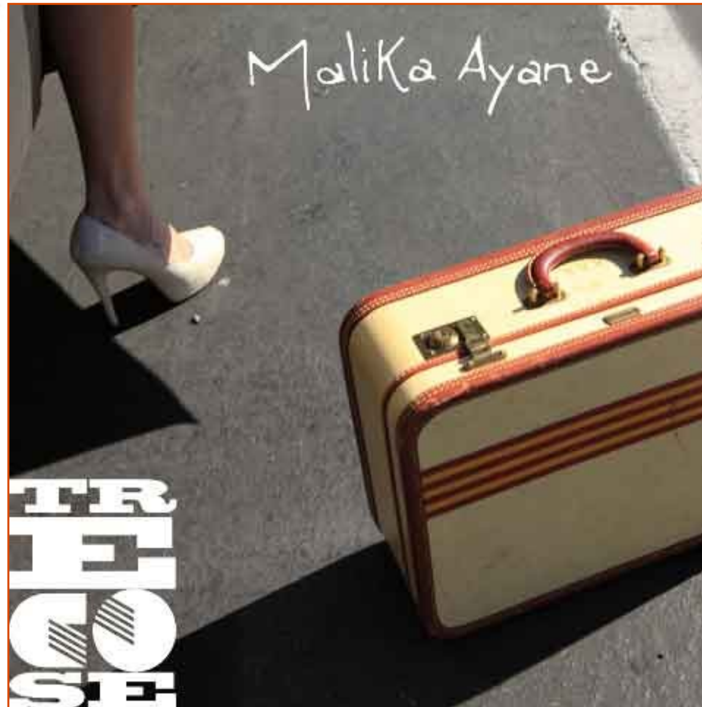
INCIDENZA

15%

165.000 in età > 65-74 aa
75.000 in età >75 aa

American Cancer Society	CANCRO/ETA'	
	MASCHI	FEMMINE
0-39 aa	1.6 %	1.9 %
40-59 aa	8.2 %	9.2 %
60-79 aa	33.7 %	22.2 %

… 3 COSE DA DIRE…



CHI

SE

COME

CHI SONO GLI ANZIANI ?

- GIOVANE: 65-75 aa
- “VERO”: 76-85 aa
- GRANDE: > 85 aa

OBIETTIVO

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NCCN

Senior Adult Oncology

VERSION I.2014

AIRO

- RADIO-ONCOLOGO
- CHIRURGO
- ONCOLOGO MEDICO
- MEDICO GERIATRA
- PSICOLOGO

ASPETTATIVA DI VITA

MORBIDITA'

MORTALITA'

XXIII CONGRESSO AIRO
Giardini Naxos - Taormina, 26-29 ottobre

VALUTAZIONE

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Does the patient have risk factors for adverse outcomes from cancer treatment?

- Comorbidities[e]
  - cardiovascular disease[f]
  - renal insufficiency[g]
  - neuropathy
  - anemia
  - osteoporosis
    - See NCCN Bone Health Task Force
  - GI problems
  - diabetes
  - lung disease
  - hearing or vision loss
  - prior cancer diagnosis and treatment
  - chronic infections
  - decubitus or pressure ulcers
- Geriatric syndromes[e]
  - functional dependency (ADL, IADL)
  - mobility problems
  - falls
  - dementia
  - delirium
  - depression
  - nutritional deficiency
  - polypharmacy
- Socioeconomic issues
  - poor living conditions
  - no caregiver or limited social support
  - low income
  - transportation barriers/access problems
  - under-insurance and/or high out-of-pocket costs for medications

VULNERABLE

See special considerations for patients able to tolerate treatment (SAO-3) and (SAO-B)

ALGORITMO DECISIONALE

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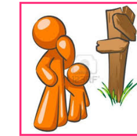

APPROACH TO DECISION MAKING IN THE OLDER ADULT

Is the patient at moderate or high risk of ding or suffering from cancer considering his or her overall life expectancy?

- No → Symptom management/supportive care SEE NCCN Guidelines for Palliative Care
- Yes ↓

Does this patients have decision-making capacity?
Patients must have the ability to:
- Understand the relevant information about proposed diagnostic tests or treatments
- Appreciate their situation (including their underlying values and current medical situation)
- Use reason to make a decision
- Communicate their choice

- No → Obtain information from:
  - > Patient's proxy
  - > Advanced directive
  - > Living will
  - > Health care power of attorney
  - > Clinician's documentation
  - > Consider consult from ethics committee or social worker or consider Pallitive Care
- Yes ↓

Assess the patients' goal and value regarding the management of his or her cancer
Are the patient's goals and values consistent with wanting anticancer therapy?

- No → Symptom management/ supportive care
- Yes → Assessment of Risk Factor

FATTORI PROGNOSTICI

STATO COGNITIVO DEL PAZIENTE
RPA

COMPLIANCE

CALO PONDERALE > 5% IN MENO DI 6 MESI

BMI <22 kg/m2 rappresenta un fattore mortalità

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....SE...

- *CHIRURGIA: American Geriatrics Society Tack Force*

  American College of Surgeons
- *RADIOTERAPIA*
- *CHEMIO-TARGETED TERAPIA*
- *TERAPIA DI SUPPORTO*

TAILORED THERAPY

…RACCOMANDAZIONI…

NCCN **Senior Adult Oncology VERSION I.2014**

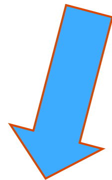
Surgery	• In general, age is not the primary consideration for surgical risk • Emergency surgery carries increased risk of complications. • Assess physiologic status • American Geriatrics Society Task Force and American College of Surgeons provided general guidelines for older adults undergoing surgery. These guidelines can be applied to older cancer patients undergoing surgery. • There are data suggest that an increased need for functional assistance pre-surgery (measured by ADL, IALD and PS) predict postoperative complications, extended hospital stay, and 6-month mortality in older patients undergoing cancer surgery. • Impaired cognitive status is a risk factor for postoperative complications, prolonged lenght of stay, and 6-month overall mortality postoperatively. • In patients undergoing general surgery i. Older age is a risk factor for postoperative delirium ii. Delirium is a risk factor for functional decline. Preventive measures exist for delirium i. Yale Delirium Prevention Trial and Hospitalized Elder Life Program ii. National Institute for Health and Clinical Excellence Guideline for Prevention of Delirium

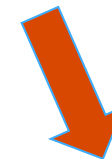
Systemic Therapy	• Chemoterapy toxixity risk can be predicted by parameters that are tipically included in a Comprenhensive Geriatric Assessment. These tools are awaiting additional validation. ✓ Chemotherapy Risk Assessment Scale for High-Age Patients score ✓ Cancer and Aging Research Group Chemo Toxicity Calculator

.....LIMITAZIONI....

LA TERAPIA DI SCELTA E' INFLUENZATA DALL'IMPATTO DELLA TOSSICITA' TRATTAMENTO-CORRELATA

Radiation Therapy	• USE CAUTION WITH CONCURRENT CHEMORADIATION THERAPY; DOSE MODIFICATION OF CHEMOTHERAPY MAY BE NECESSARY • NUTRITIONAL SUPPORT AND PAIN CONTROL ARE NEEDED IF RADIATION THERAPY-INDUCED MUCOSITIS IS PRESENT



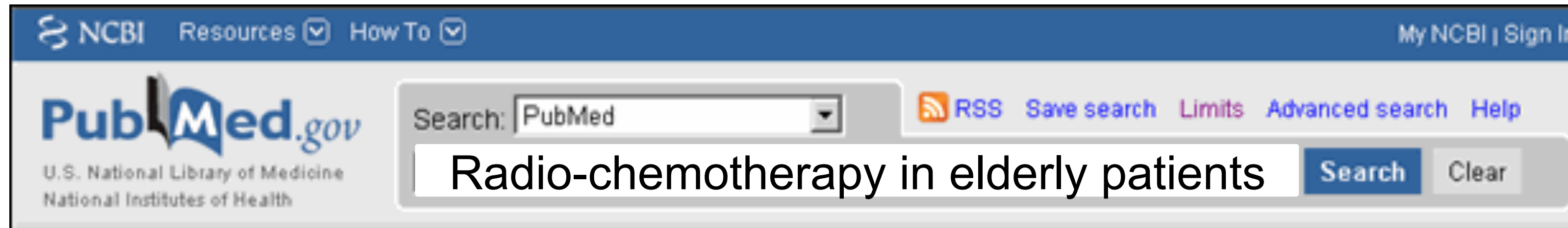


TECNICHE SPECIALI

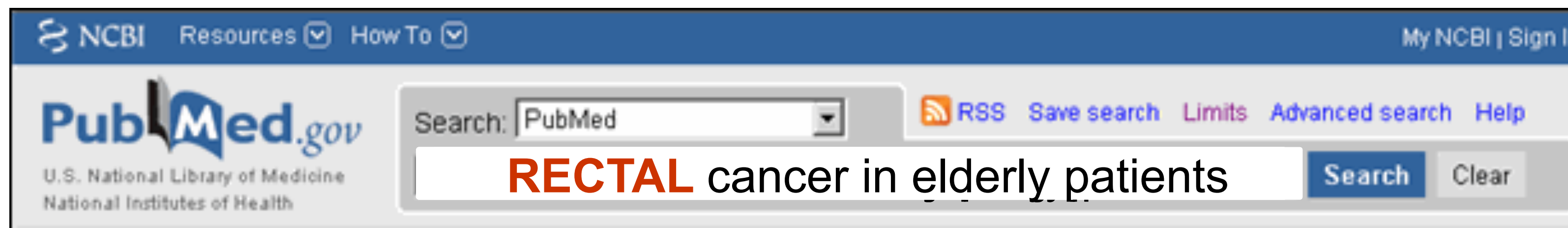
MODIFICA DI DOSE

TERAPIA DI SUPPORTO

...COME...



POCHI GLI STUDI PROSPETTICI COINVOLGENTI QUESTO SETTING DI PAZIENTI



GLIOBLASTOMA MULTIFORME

ETA'
KPS
RPA

APPROCCIO INTEGRATO:

- CHIRURGIA
- RADIOTERAPIA
- CHEMIOTERAPIA

OS	2 aa	3 aa	4 aa	5 aa
RT+CT	27 %	16 %	12 %	9.8 %
RT	11 %	4 %	3 %	2 %

Abbreviated course of radiation therapy in older patients with glioblastoma multiforme: a prospective randomized clinical trial. J Clin Oncol. 2004 Roa W et al.

n. 100	60 Gy/2 Gy	40 Gy/15 fz (3 w)
Sopravvivenza media	5.1 mesi	5.6 mesi
Sopravvivenza a 6 mesi	44.7%	41 %
USO DI CORTISONICI	49%	23%

Deficit neurologici radioindotti:
- ***Alte dosi***
- ***Larghi campi***
- ***Co-morbidità***

Interruzione del trattamento 30% frazionamento standard
Interruzione del trattamento 10 % ipofrazionata

STUDIO AVAglio:
Aa 84
PFS > 4 MESI

HNSCC LOCALMENTE AVANZATO

PIGNON, 2008: CHEMIOTERAPIA DI INDUZIONE VS RADIO-CHEMIOTERAPIA CONCOMITANTE *(MACH-NC)*

n. 17346

The benefit of concomitant chemotherapy was confirmed and was greater than the benefit of induction chemotherapy

BONNER 2010: RT+/- CETUXIMAB

	RT+ CETUXIMAB	RT
OS	49 MESI	29.3 MESI
OS a 5 aa	45.6 %	36.4%

OS > in pz con rush cutaneo G2 vs G1

QUALI FARMACI?

- *DERIVATI DEL PLATINO*
- *5-FU e DERIVATI*

MACHTAY M, 2008: FATTORI ASSOCIATI A TOSSICITA' TARDIVA

- Older age
- Advanced T-stage
- Larynx/hypopharynx primary site
- Neck dissection after CCRT

Strahlenther Onkol. 2012 Nguyen NP
Impact of intensity-modulated and image-guided radiotherapy on elderly patients undergoing chemoradiation for locally advanced head and neck cancer.

Compared to younger patients, elderly patients with locally advanced head and neck cancer tolerated chemoradiation with IMRT and IGRT well, and should not be denied curative treatment based solely on age.

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NSCLC LOCALMENTE AVANZATO

RAO

LANGER 2002 RT+ CT	
Pz > 65 aa	Sopravvivenza mediana
CT+RT	22.4 mesi
CT+ RT bid	16.4 mesi
CT seq RT	10.8 mesi

SCHILD 2003 RT+ CT		
OS	2 aa	5 aa
Pz < 65 aa	39 %	18 %
Pz > 65 aa	36 %	13 %

APPROCCIO COMBINATO >TOSSICITA'

QUALI FARMACI
DERIVATI DEL PLATINO VNR

RADIOTERAPIA
IMRT-IGRT
VMAT
INF

CA MAMMARIO

DISSEZIONE CAVO ASCELLARE: OPZIONALE!!!!

OMISSIONE RT?

FATTORI PROGNOSTICI FAVOREVOLI
UNFIT

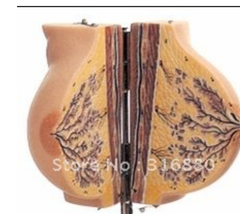
ALTERNATIVE

IPOFRAZIONAMENTI:

✓ONTARIO TRIAL: 42.4 Gy/2.65 Gy

✓ FAST TRIALIST GROUP

- >50 aa
- N0
- RE +; RPg +; c-erbB2 3+;
- 5.7 Gy o 6 Gy fz per 5 sett



CA RETTO-LARC

✓RADIO-CHEMIOTERAPIA PREOPERATORIA:
DOWNSTAGING
SPHINCTER- SAVING

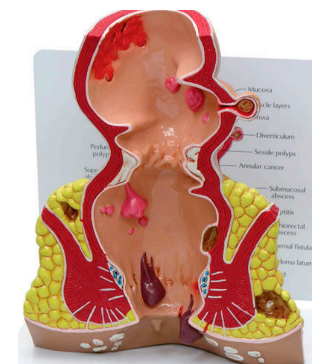
***T**otal **M**esorectal **E**xcision*

- COMPLICANZE PERIOPERATORIE
- MORTALITA' NON CANCRO CORRELATA PERIOPERATORIA PRIMI 6 MESI-

✓TOSSICITA' GASTROINTESTINALE

✓BREAKS

✓ IMRT-IGRT



CA CERVICE LOCALMENTE AVANZATO

RADIOCHEMIOTERAPIA CONCOMITANTE GOLD STANDARD

RT-CT ANZIANI VS GIOVANI
RISULTATI SOVRAPPONIBILI CANCER-SPECIFIC SURVIVAL
OS > NEI GIOVANI
RISULATI SOVRAPPONIBILI TOSSICITA'

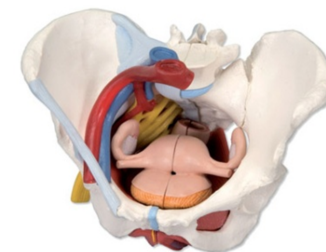
Int J Gynecol Cancer. 2008, 18: 95-103
Chemoradiation for invasive cervical cancer in elderly patients: outcomes and morbidity.
Goodheart M et al

ETA' NON E' UNA VARIABILE SIGNIFICATIVA

Radiother Oncol,2000; 56-9-15.
Radiotherapy in the management of cervical cancer in elderly patients
Lindergaard JC et al.

HPV MENO VIRULENTI

Cancer Res. 2006; 66: 423-28
Age-related changes of the cervix influence human papillomavirus type distribution
PE Caste et al



CA VESCICA MUSCOLO-INVASIVO

CISTECTOMIA RADICALE

TURB- RADIOTERAPIA-CHEMIOTERAPIA:
OS A 5 AA: 48-65%
75-80% LUNGO SOPRAVVIVENTI: QdV !!!

J Natl Compr Canc Netw. 2013 Aug 1;11(8):952-60.
Trimodality bladder preservation therapy for muscle-invasive bladder cancer.
Chen RC, Shipley WU, Efstathiou JA, Zietman AL.

DERIVATI DEL PLATINO

New England Journal Of Meidicine, 2012; 366:1477-88
Radiotherapy with or without chemotherapy in muscle-invasive Bladder cancer
James N et al

CONCLUSIONI

IL PAZIENTE ANZIANO NON DEVE ESSERE ESCLUSO APRIORISTICAMENTE DAL MIGLIOR TRATTAMENTO ONCOLOGICO ATTUABILE

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L'ANIMA NASCE VECCHIA, MA RINGIOVANISCE.
E' LA COMMEDIA DELLA VITA.
IL CORPO NASCE GIOVANE E INVECCHIA.
E' LA TRAGEDIA DELLA VITA.

(OSCAR WILDE)

GRAZIE

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