8th ESO
Arab and Southern European Countries
Masterclass in Clinical Oncology

23-27 January 2020
Limassol, Cyprus

Chairs: M.S. Aapro, CH - N. Pavlidis, GR
Co-chairs: J. Gligorov, FR - S. Khatib, JO
Host Chair: D. Papamichael, CY
HOW DO I MANAGE ELDERLY PATIENTS

Matti S. Aapro
Cancer Center
Genolier
Switzerland
ABOUT ELDERLY PATIENTS

A few key messages

Matti S. Aapro
Cancer Center
Genolier
Switzerland
Dr Aapro is a consultant for Accord, Amgen, BMS, Celgene, Fresenius, G1, GSK, Helsinn, JnJ Novartis, Merck, Merck Serono, Pfizer, Pierre Fabre, Roche, Sandoz, Teva, Vifor and has received honoraria for lectures at symposia of Accord, Amgen, Bayer Schering, Biocon, Cephalon, Dr Reed, Fresenius, GSK, Helsinn, Hospira, Ipsen, JnJ OrthoBiotech, Kyowa Hakko Kirin, Merck, Merck Serono, Mundipharma, Novartis, Pfizer, Pierre Fabre, Roche, Sandoz, Sanofi, Taiho, Teva, Vifor.
A siesta menu

Why geriatrics?
Some issues
How to evaluate these patients
Some further data
What can/should be done
Welcome to SIOG
A siesta menu

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Welcome to SIOG
The worldwide population is aging

60 years or older

80 years or older

The challenge?
An ageing population, a decreasing workforce

2010
4 people working for every person over 65

2060
2 people working for every person over 65

Heavy burden on the younger generations to pay for the welfare system and find ways to care for elderly

A challenge? Really?:
An ageing population, a decreasing workforce

Heavy burden on the younger generations to pay for the welfare system and find ways to care for elderly

4 people working for every person over 65

2 people working for every person over 65

This population aging is clearly reflected here.
WHAT WAS THIS CURVE?
SUCCESS OF CRUISE SHIPS!
The elderly are not all crippled…

Ursula Andress at age 26 (1962)

Ursula Andress aged 74 (2010)
Maybe she is on a cruise!
(at age 83 now, and probably not malnourished)
A siesta menu

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Welcome to SIOG
You had lunch not long ago. What is a frequent issue in the elderly?
Prevalence of malnutrition
5-30% in those living by themselves
up to 70% in those residing in protected homes

Naeim, Aapro et al, J Clin Oncol 2014
Anaemia in the elderly is not « normal »

A healthy elderly is NOT ANAEMIC

Iron, vit B12 and folate deficiencies are frequent

Naeim, Aapro et al, J Clin Oncol 2014
Supportive Care Considerations for Older Adults With Cancer

Arash Naeim, Matti Aapro, Rashmi Subbarao, and Lodovico Balducci

Abstract

The treatment of cancer presents specific concerns that are unique to the growing demographic of elderly patients. Because the incidence of cancer is strongly correlated with aging, the expansion of supportive care and other age-appropriate therapies will be of great importance as the population of elderly patients with cancer increases in the coming years.

Elderly patients are especially likely to experience febrile neutropenia, complications from chemotherapy-induced nausea, anemia, osteoporosis (especially in patients diagnosed with breast or prostate cancer), depression, insomnia, and fatigue. These issues are often complicated by other chronic conditions related to age, such as diabetes and cardiac disease.

For many patients, symptoms may be addressed both through lifestyle management and pharmaceutical approaches. Therefore, the key to improving quality of life for the elderly patient with cancer is an awareness of their specific needs and a familiarity with emergent treatment options.

J Clin Oncol 32:2627-2634. © 2014 by American Society of Clinical Oncology
Early recognition of malnutrition and cachexia in the cancer patient: a position paper of a European School of Oncology Task Force

M. Aapro¹, J. Arends², F. Bozzetti³, K. Fearon⁴, S. M. Grunberg⁵, J. Herrstedt⁶, J. Hopkinson⁷, N. Jacquelin-Ravel¹, A. Jatoi⁸, S. Kaasa⁹ & F. Strasser¹⁰

¹Clinique de Genolier, Genolier, Switzerland; ²Tumor Biology Center, Albert Ludwig's University, Freiburg, Germany; ³Department of Medicine and Surgery, University of Milan, Milan, Italy; ⁴School of Clinical Sciences and Community Health, University of Edinburgh, Royal Infirmary, Edinburgh, UK; ⁵Hematology/Oncology Division, University of Vermont College of Medicine, Burlington, VT, USA; ⁶Department of Oncology, Odense University Hospital, Odense, Denmark; ⁷School of Healthcare Sciences, Cardiff University, Cardiff, UK; ⁸Department of Oncology, Mayo Clinic, Rochester, MN, USA; ⁹Faculty of Medicine, Norwegian University of Science and Technology, Trondheim, Norway; ¹⁰Department of Internal Medicine, Kantonsspital, St Gallen, Switzerland
Malnutrition in the elderly: A narrative review

E. Agarwal, M. Miller, A. Yaxley, E. Isenring

School of Exercise and Nutrition Science, Queensland University of Technology, Victoria Park Road, Kelvin Grove, Queensland 4059, Australia
Nutrition and Dietetics, Flinders University, Adelaide, Australia
Centre for Dietetics Research, University of Queensland, Brisbane, Australia
Princess Alexandra Hospital, Brisbane, Australia
Tell me about consequences of malnutrition, lack of exercise.
Shown by
Hans Wildiers

Shown by
Riccardo Audisio
Malnutrition and lack of exercise  

**Correlations and Consequences**

- Vitamin D and calcium deficiencies, leading to osteopenia and osteoporosis, which can be limiting factors in breast and prostate cancer treatment.
- Recovery from the stress of surgery and tolerance of some radiation therapy treatments are better in well nourished patients.

Ref: ESO position paper  
Aapro et al AnnOnc 2014
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What is the life expectancy of a US or Japanese older patient?

A male patient, no special comorbidities, aged 75 will live

a) 5 years
b) 9 years
c) 14 years
Life expectancy in senior adults: a large variability reflecting health status variability

G-8 geriatric screening tool

<table>
<thead>
<tr>
<th>Question</th>
<th>Score Options</th>
</tr>
</thead>
</table>
| Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? | 0 = severe decrease  
1 = moderate decrease  
3 = no decrease |
| Weight loss during the last 3 months?                                    | 0 = > 3kg; 1 = does not know  
2 = between 1 and 3kg; 3 = none |
| Mobility?                                                                | 0 = bed or chair bound;  
1 = able to get out of bed or chair but does not go out; |
| Neuropsychological problems?                                             | 0 = severe dementia /depression  
1 = mild dementia  
2 = no psychological problems |
| BMI (weight in kg/height in m$^2$)                                       | 0 = BMI <19; 1 = BMI 19 to <21  
2 = BMI 21 to <23; 3 = BMI ≥ 23 |
| Takes more than 3 prescription drugs per day?                           | 0 = yes; 1 = no |
| In comparison with other people of the same age, how does the patient consider his health status? | 0 = not as good; 0.5 = does not know;  
1 = as good; 2 = better |
| Age                                                                      | 0 = >85 yr; 1 = 80-85 yr; 2 = <80 yr |
| **Total score**                                                          | 0-17                           |
Strong prognostic value of G8 for OS

Prospective non interventional study in 937 patients aged 70 or older

Kenis C et al, J Clin Oncol 2014; 32: 19-26
Assessing the Older Patient for Cancer Treatment

- Fitness does not mean you can all do the same exercise, does it?

Shown by Audisio, SIOG 2003
SO TO PREDICT FOR TOXICITY YOU HAVE 2 TOOLS
## Predictive Model for Toxicity From Chemotherapy

<table>
<thead>
<tr>
<th>Risk Factors for Grade 3-5 Toxicity</th>
<th>OR (95% CI)</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &gt; 73</td>
<td>1.2 (1.2-2.7)</td>
<td>2</td>
</tr>
<tr>
<td>GI/GU cancer</td>
<td>2.2 (1.4-3.3)</td>
<td>3</td>
</tr>
<tr>
<td>Standard dose</td>
<td>2.1 (1.3-3.5)</td>
<td>3</td>
</tr>
<tr>
<td>Polychemotherapy</td>
<td>1.8 (1.1-2.7)</td>
<td>2</td>
</tr>
<tr>
<td>Hemoglobin (male: &lt;11, female: &lt;10)</td>
<td>2.2 (1.1-4.3)</td>
<td>3</td>
</tr>
<tr>
<td>Creatinine clearance &lt;34</td>
<td>2.5 (1.2-5.6)</td>
<td>3</td>
</tr>
<tr>
<td>1 or more falls in last 6 months</td>
<td>2.3 (1.3-3.9)</td>
<td>3</td>
</tr>
<tr>
<td>Hearing impairment (fair or worse)</td>
<td>1.6 (1.0-2.6)</td>
<td>2</td>
</tr>
<tr>
<td>Limited in walking 1 block</td>
<td>1.8 (1.1-3.1)</td>
<td>2</td>
</tr>
<tr>
<td>Assistance required in medication intake</td>
<td>1.4 (0.6-3.1)</td>
<td>1</td>
</tr>
<tr>
<td>Decreased social activity</td>
<td>1.3 (0.9-2.0)</td>
<td>1</td>
</tr>
</tbody>
</table>
Predictors of Toxicity From Cancer Therapy

<table>
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<th>Laboratory</th>
<th>Clinical</th>
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<tbody>
<tr>
<td>• Hemoglobin</td>
<td>• ECOG PS</td>
</tr>
<tr>
<td>• Albumin</td>
<td>• Diastolic blood pressure</td>
</tr>
<tr>
<td>• LDH</td>
<td>• Mini-Mental Examination</td>
</tr>
<tr>
<td>• Creatinine clearance</td>
<td>• Self-rated Health</td>
</tr>
<tr>
<td></td>
<td>• Mini-Nutritional Assessment</td>
</tr>
<tr>
<td></td>
<td>• CIRS-G Comorbidity</td>
</tr>
<tr>
<td></td>
<td>• IADL</td>
</tr>
</tbody>
</table>

IADL, Instrumental Activities of Daily Living.
A siesta menu

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| Age                                                                     | 0 = >85 yr; 1 = 80-85 yr; 2 = <80 yr |
Tell me about patient evaluation for mobility
“Get up and Go”

- ONLY VALID FOR PATIENTS NOT USING AN ASSISTIVE DEVICE
- Get up and walk 10ft, and return to chair

- Seconds 
  - Rating
  - <10 Freely mobile
  - <20 Mostly independent
  - 20-29 Variable mobility
  - >30 Assisted mobility

Tell me about another complicating factor
Another important point of the G-8 geriatric screening tool

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Polypharmacy Is Typical… also in Elderly Patients

Number of medications

Hansel and Gretel: The Later Years

Images and content are courtesy of Dr. Martine Extermann, Moffitt Cancer Center, 2015.
See also Whitman et al The Oncologist June 2016 vol. 21 no. 6 723-730
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Welcome to SIOG
THE PATIENT’s VOICE

- Decisions on treatment have to take into consideration the patient’s quality of life.
- Decisions on treatment have to take into consideration her decision to live longer or to have a better quality of life, perhaps dying earlier.
- Chronological age should not be the basis for treatment decisions.
- Decisions on treatment never should never be made for economic reasons.
- Individual assessment of each patient is necessary; patient /doctor communication is key to making the right decision for each patient.

From Roswitha Britz at ECCO 2015
Addressing the quality of life needs of older patients with cancer: a SIOG consensus paper and practical guide

F. Scotté¹*, P. Bossi², E. Carola³, T. Cudennec⁴, P. Dielenseger⁵, F. Gomes⁶, S. Knox⁷ & F. Strasser⁸
review

The illness trajectory of elderly cancer patients across cultures: SIOG position paper

A. Surbone1*, M. Kagawa-Singer2, G. Terret3 & L. Baider4
On behalf of the SIOG Task Force on Cultural Competence in the Elderly†

1European School of Oncology, Milan, Italy and New York University, New York, USA; 2UCLA School of Public Health and Asian American Studies Department, Los Angeles, USA; 3Centre Léon Bérard, Lyon, France; 4Hadassah University Medical Center, Jerusalem, Israel

Received 12 May 2006; accepted 26 June 2006

†Task Force Members: L. Baider, Israel; O. Brawley, US; M. Kagawa-Singer, US; M. Mori, Japan; B. Stein, Australia; A. Surbone, Italy; C. Terret, France; M. Zereu, Brasil
SIOG GUIDELINES
please go to
www.SIOG.org
Another important resource
(not because I am the co-editor...)
A siesta menu

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Welcome to SIOG
The advanced SIOG course
SIOG ANNUAL MEETING

GENEVA

OCTOBER 1 to 3, 2020

SIOG 2020
INTERNATIONAL SOCIETY OF GERIATRIC ONCOLOGY

SIOG 2020 Annual Conference
October 1, 2020 to October 3, 2020
Geneva, Switzerland
thank you