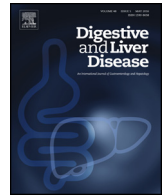




Contents lists available at ScienceDirect

Digestive and Liver Disease

journal homepage: www.elsevier.com/locate/dld



Review Article

Colorectal cancer care in elderly patients: Unsolved issues

Thomas Aparicio^{a,*}, Frederic Pamoukdjian^b, Laurent Quero^c, Sylvain Manfredi^d,
Philippe Wind^e, Elena Paillaud^f

^a Gastroenterology and Digestive Oncology Department, CHU Avicenne, APHP, Bobigny, France

^b Geriatric Department, CHU Avicenne, APHP, Bobigny, France

^c Radiotherapy Department, CHU Saint Louis, APHP, Paris, France

^d Hepato-Gastroenterology and Oncology Department, INSERM U866, CHU Dijon, Dijon, France

^e Surgery Department, CHU Avicenne, APHP, Bobigny, France

^f Geriatric Department, CHU Henri Mondor, APHP, Créteil, France

ARTICLE INFO

Article history:

Received 3 February 2016

Accepted 12 May 2016

Available online xxx

Keywords:

Adjuvant therapy

Chemotherapy

Geriatric oncology

Radiotherapy

Targeted therapy

ABSTRACT

Colorectal cancers are common in elderly patients. However, cancer screening is poorly used after 75. Elderly patients form a heterogeneous population with specific characteristics. Standards of care cannot therefore be transposed from young to elderly patients. Tumour resection is frequently performed but adjuvant chemotherapy is rarely prescribed as there are no clearly established standards of care. In a metastatic setting, recent phase III studies have demonstrated that doublet front-line chemotherapy provided no survival benefit. Moreover, several studies have established the benefit of bevacizumab in association with chemotherapy. There is a lack of evidence for the efficacy of anti-epidermal growth factor antibodies in elderly patients. Geriatric assessments could help to select the adequate treatment strategy for individual patients. Geriatric oncology is now the challenge we have to face, and more specific trials are needed.

© 2016 Editrice Gastroenterologica Italiana S.r.l. Published by Elsevier Ltd. All rights reserved.

1. Epidemiology

In Europe, the incidence of Colorectal Cancer (CRC) continues to increase. Approximately 70% of CRC occur in patients aged 65 years and older. However, the specific questions about age arise mainly after 75 years. Given the ageing of the population, the proportion of patients with CRC aged over 75 years will increase even further in the coming years. In France, the proportion of CRC in patients older than 75 years has reached 46% (<http://www.invs.sante.fr/applications/cancers/projections2010>). Moreover, life expectancy has lengthened in elderly patients. It now reaches 12 years after 75 and more than 8 years after 80 years. Elderly patients form a specific population due to comorbidities, disability and organ-specific physiological changes that have impaired their enrolment in clinical trials and thus the transposition of current guidelines established in younger patients [1–3]. The therapeutic strategy for CRC after 75 is often difficult to establish because of the lack of specific data for elderly patients. Recently, the International Society of

Geriatric Oncology published recommendations for the treatment of CRC in elderly patients [4]. Nevertheless, many issues remain unsolved and specific trials in elderly patients are urgently needed.

CRC in older patients is more often diagnosed at a later stage than in younger patients [5]. As a result, older patients more frequently require emergency and palliative surgery, which increases the risk of perioperative morbi-mortality [6]. In a review of 28 studies that enrolled 34,188 patients with colon cancer, it was reported that the resection for cure rate decreased with age (75% for 65–74 years, 73% for 75–84 years and 67% >85 years) while the rates for emergency surgery increased (15% for 65–74 years, 18% for 75–84 years and 29% >85 years) [6].

Delays in CRC diagnosis are multifactorial: older people consult later, symptoms could be atypical or poorly recognized, investigations and screening are generally organized until the age of 74.

2. Specific characteristics of elderly patients: which patients should have a geriatric assessment?

Elderly patients form a heterogeneous population. Comorbidities and disabilities become increasingly prevalent with advancing age and are associated with treatment-related side effects and poor outcomes [7–9]. Comorbidities not only compete with cancer as a cause of death but also increase the risk of cancer- or

* Corresponding author at: Service de Gastroentérologie et Cancérologie Digestive, Hôpital Avicenne, HUPSSD, 125 rue de Stalingrad, 93000 Bobigny, France. Tel.: +33 1 48 95 54 34; fax: +33 1 48 95 54 39.

E-mail address: thomas.aparicio@aphp.fr (T. Aparicio).

treatment-related complications [10]. Thus, a major issue for oncologists is to determine the risk/benefit ratio of cancer treatments in older patients. There is considerable heterogeneity among patients of the same age, so that chronological age alone provides little information. Indeed, some older people have few chronic diseases and remain autonomous. But many have geriatric conditions: comorbidities, disability, functional limitations, malnutrition, mood or cognitive impairment. Polypharmacy, a consequence of co-morbidities, increases drug interactions and side effects. All of these elements, in close interaction with the social and economic conditions, determine the health status of older persons and their autonomy.

Older patients are less likely than younger patients to receive the recommended treatment [11,12]. However, decisions concerning cancer treatment in elderly patients during multidisciplinary meetings increase the proportion of older patients treated according to recommendations [13]. There are several reasons for this difference in treatment compared with younger patients. First, older patients are less likely than younger patients to be referred to an oncologist [14] and secondly the disability of some patients and/or their poor social environment requires their hospitalization or the organization of support structures at home to administer chemotherapy. The availability of these structures or of specialized geriatric advice may be a limiting factor for optimal cancer treatment. Secondly, the fear of inducing toxicity makes practitioners reluctant to treat elderly patients conventionally, especially as their life expectancy is often limited. However, patients over 75 years have an overwhelmingly desire to be treated, even though they are less willing than younger patients to accept toxic chemotherapy for the same impact on survival [15]. Treatment to maintain a good quality of life should therefore be preferred.

Comprehensive Geriatric assessments (CGA) evaluate a patient's functional status, mobility, comorbidities, polypharmacy, nutritional status, cognitive function, emotional status and social support [16] based on validated geriatric scales and tests. Although the term CGA may imply activity limited to assessment, it is in fact a larger clinical process including a coordinated programme of tailored geriatric interventions and follow up. A CGA is recommended before cancer treatment decisions by the SIOG [4]. CGAs reveal previously unrecognized health problems in half of the patients with cancer [17] and induce changes in cancer therapy decisions in around 20% of patients [18]. However, it is still not demonstrated that CGAs confer a survival or a quality of life benefit for patients with cancer. Two randomized studies are ongoing in France (PREPARE and EGeSOR studies) to assess these issues [19]. One recent study demonstrated that a geriatrician-delivered CGA was associated with better outcomes for older people undergoing chemotherapy. More intervention participants completed treatment as planned and required fewer treatment modifications [20].

However, the CGA is time consuming. Several screening tools are therefore used to identify frail elderly patients with cancer who are most likely to benefit from the CGA [21]. Frailty itself is predictive factor for survival in cancer patients [22]. Among these tools, the Geriatric 8 screening tool (G-8) may be the most sensitive to select patients for CGA [23]. In the Liuu et al. study, significant differences were noted in the ability of G-8 to accurately detect frailty according to tumour site. In colorectal cancer, the G-8 screening tool identified frail elderly patients with high sensitivity (90%) but low specificity (23%) [24]. Thus, relevant screening tools to assess frailty and predict morbidity must be adapted to the cancer stage, the primary site and treatment toxicities.

Predicting the toxicity of chemotherapy in elderly patient is an important challenge. A predictive score based on a cohort of elderly patients with several cancer types has been proposed. Age, gastrointestinal or genitourinary cancer, standard chemotherapy

dosing, polychemotherapy, anaemia, low creatinine clearance, hearing disability, falls, autonomy impairment, walking disability and decreased social activities have been identified as predictors for toxicities [8]. Nevertheless, these factors and others remain to be validated in the specific situation of adjuvant or metastatic settings in CRC.

In elderly patients, special attention must be paid to supportive care. Malnutrition is still not sufficiently screened for and not sufficiently managed although it is a major prognostic factor for all cancers especially for elderly patients [9]. Some geriatric syndromes, such as cognitive impairment and depressed mood, are independently associated with malnutrition in digestive cancers [25]. Thus, the nutritional management of elderly cancer patients should be multidimensional and include modifiable geriatric factors. Anaemia, frequently present, must be corrected to avoid the decompensation of other co-morbidities. Recombinant erythropoietin therapy should be used to correct chemotherapy-induced anaemia.

Thus, the direct clinical benefit of comprehensive geriatric assessment on outcomes remains an issue in elderly CRC patients and further studies are necessary to elucidate and validate rules for therapeutic decision-making.

3. Screening for colorectal cancer in the elderly: who should be screened?

Screening for CRC with the Faecal Occult Blood Test (FOBT) reduces colorectal cancer mortality [26]. Nevertheless, studies that have demonstrated the benefit of CRC screening with FOBT enrolled few or no elderly patients. In France, as in the majority of other organized mass screening programmes, the national screening programme for CRC is restricted to the population aged 50–74 years. The efficacy of CRC screening with FOBT has never been prospectively evaluated in elderly subjects [27]. The lack of diagnosis and endoscopic removal of adenoma result in more cancers in the elderly and a lower proportion of cancers diagnosed and treated early. Previous studies of colonoscopy in symptomatic and asymptomatic elderly patients have consistently shown a high prevalence of adenoma and CRC [28]. Age is a critical factor in the occurrence of adverse events related to colonoscopy. Adequate bowel preparation is more difficult to achieve in very old patients. Thus, patient selection for colonoscopy is an important challenge. The two points to be considered are the accuracy of neoplasia detection and the expected benefit considering treatment tolerance and other co-morbidities [29].

In elderly cancer patients, co-morbidities impair survival and hamper the application of standard treatment [30]. Population simulation modelling suggests that cancer screening for the elderly population in its entirety may not confer a significant survival advantage [29]. Indeed, the increasing number and severity of associated diseases adversely affect survival after the diagnosis of CRC. The evaluation of life expectancy is therefore crucial to select patients who may benefit from CRC screening. At this time, there are no prospective data concerning screening for CRC in the elderly [29]. As co-morbidities impair life expectancy, any screening strategy should take in account co-morbidities to avoid the underuse or overuse of screening [31]. Most studies have evaluated a screening strategy with recto-sigmoidoscopy or total colonoscopy, both of which could generate adverse events in patients free of CRC [32]. A first-step screening with a faecal occult blood test would allow the selection of patients who could benefit from colonoscopy. Moreover, the only data for CRC screening in the elderly were obtained from retrospective studies or simulation models.

Thus, screening CRC in elderly patients remains an issue; a real-life prospective study is needed to establish the benefit of screening.

Download English Version:

<https://daneshyari.com/en/article/5655898>

Download Persian Version:

<https://daneshyari.com/article/5655898>

[Daneshyari.com](https://daneshyari.com)