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Platinum Priority – Review – Prostate Cancer

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Management of Prostate Cancer in Elderly Patients: Recommendations of a Task Force of the International Society of Geriatric Oncology

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Abstract

Context: Prostate cancer is the most frequent male cancer. Since the median age of diagnosis is 66 yr, many patients require both geriatric and urologic evaluation if treatment is to be tailored to individual circumstances including comorbidities and frailty.

Objective: To update the 2014 International Society of Geriatric Oncology (SIOG) guidelines on prostate cancer in men aged >70 yr. The update includes new material on health status evaluation and the treatment of localised, advanced, and castrate-resistant disease.

Data acquisition: A multidisciplinary SIOG task force reviewed pertinent articles published during 2013–2016 using search terms relevant to prostate cancer, the elderly, geriatric evaluation, local treatments, and castration-refractory/resistant disease. Each member of the group proposed modifications to the previous guidelines. These were collated and circulated. The final manuscript reflects the expert consensus.

Data synthesis: Elderly patients should be managed according to their individual health status and not according to age. Fit elderly patients should receive the same treatment as younger patients on the basis of international recommendations. At the initial evaluation, screening for cognitive impairment is mandatory to establish patient competence in making decisions. Initial evaluation of health status should use the validated G8 screening tool. Abnormal scores on the G8 should lead to a simplified geriatric assessment that evaluates comorbid conditions (using the Cumulative Illness Score Rating–Geriatrics scale), dependence (Activities of Daily Living) and nutritional status (via estimation of weight loss). When patients are frail or disabled or have severe comorbidities, a comprehensive geriatric assessment is needed. This may suggest additional geriatric interventions.

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Conclusions: Advances in geriatric evaluation and treatments for localised and advanced disease are contributing to more appropriate management of elderly patients with prostate cancer. A better understanding of the role of active surveillance for less aggressive disease is also contributing to the individualisation of care.

Patient summary: Many men with prostate cancer are elderly. In the physically fit, treatment should be the same as in younger patients. However, some elderly prostate cancer patients are frail and have other medical problems. Treatment in the individual patient should be based on health status and patient preference.

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1. Introduction

Prostate cancer is the most frequent male cancer in developed countries [1] and is also common in less developed countries. The median age at diagnosis is 66 yr, and 69% of deaths occur in men aged ≥ 75 yr. Since incidence and mortality rise steeply with age, the prostate cancer burden will increase with exponential ageing of the population.

The current paper, which focuses on men aged >70 yr, updates existing International Society of Geriatric Oncology (SIOG) guidelines for the management of elderly prostate cancer patients [2–4]. Issues considered include the risks of both overtreatment and undertreatment and the importance of assessing overall health status, comorbidities, and cognitive function in personalising management. Previously published SIOG guidelines on prostate cancer [3,4] argued that age alone should not preclude effective treatment. Since 2014, the SIOG recommendations have been fully endorsed by the European Association of Urology (EAU) and are now referred to as the EAU/ESTRO/SIOG guidelines [5,6].

The most important new features of these updated guidelines are: (1) the introduction of initial screening for cognitive function; (2) the rewording of health status classification to align with terms currently used in the geriatric literature; (3) consideration of the most important advances in the treatment of advanced prostate cancer and their implications for elderly patients; and (4) a recommendation for the early introduction of palliative management.

Choice of therapy should not be based on chronological aging, which proceeds at the same pace for all, but on biological aging and health status, which differ greatly from one person to another. In the USA, a 70-yr-old man in the healthiest 25% of his peers can expect to live 18 yr, while for the frailest 25% life expectancy is only 7 yr [7]. Evaluation of health status is therefore vital to appropriate management. Assessment of social situation is also important and can usefully include whether or not a family care-giver is present, of course, is patient preference, both in relation to the goals of therapy and the means of attaining them.

The gold standard for evaluating health status is the Comprehensive Geriatric Assessment (CGA) [8]. This includes data on demographic, social, functional, nutritional, cognitive, and mental health status; and the presence of comorbidities and geriatric syndromes. It predicts survival and chemotherapy toxicity, identifies reversible conditions, and reflects patients' capacity to make decisions as well as

their values and treatment goals [9]. Although relatively simple, the Activities of Daily Living (ADL) measure of dependency has been used to determine the need for social and healthcare interventions and has prognostic value. Aside from prostate cancer itself, comorbidity is the strongest predictor of death among men with localised disease [10]. The Cumulative Illness Score Rating-Geriatrics (CISR-G) [11] is used to assess comorbidity. In this context, it is helpful to ascertain the stage and potential reversibility of the condition, its history, and the risk of acute organ failure.

However, a CGA is time-consuming and requires specialist staff. Moreover, it is probably needed in only a minority of patients. A rational approach is to screen all patients to identify those who need further assessment. This further assessment can take the form of a simplified geriatric evaluation or a full CGA.

2. Evaluation of health status

Evaluation of health status involves a stepwise process starting with screening using the G8 and mini-COGTM [12]. This is followed, where indicated, by a simplified geriatric assessment and then, again when indicated, by full geriatric assessment, particularly when complex geriatric interventions are needed.

2.1. G8 screening

In a comprehensive review of tools to establish the need for CGA, the G8 (Table 1) was the most robust [8,13]. Thus, a rational approach is to screen with the G8 scale, which was developed specifically for older cancer patients and can be completed in less than 5 min [13]. Its eight components cover food intake, weight loss, body mass index, mobility, neuropsychological problems, polypharmacy, self-perceived health status and age.

In a prospective noninterventive study of almost a thousand men aged ≥ 70 yr, an abnormal score on the G8 (≤ 14 on a scale from 0 to 17) strongly predicted mortality over 3 yr and hence a need for full assessment [13]. Following studies showing that the G8 is a good way of identifying patients requiring a CGA, the European Organisation for Research and Treatment of Cancer (EORTC) made G8 screening compulsory for all patients aged ≥ 70 yr included in the organisation's trials. It is also recommended in EAU guidelines.

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