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ORIGINAL ARTICLE

# Optimal oncologic treatment of rectal cancer in patients over 75 years old: Results of a strategy based on oncogeriatric evaluation

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## KEYWORDS

Aged;  
Colorectal surgery;  
Geriatric assessment;  
Rectal neoplasms

## Summary

**Background:** Few data are available on the management of elderly rectal cancer patients, and especially on the ability to provide optimal oncological treatment. The aim of this study was to determine the feasibility and results of multimodality treatment for rectal cancer in patients 75 years and older after simplified comprehensive geriatric assessment (CGA) according to Balducci score.

**Methods:** We reviewed the charts of elderly patients who underwent surgery for localized middle or low rectal cancer. Patients were classified into three CGA groups depending on their functional reserve, comorbidities, geriatric syndromes, and life expectancy.

**Results:** Neoadjuvant therapy was discussed for 27 patients (47%), but only 56% of them were treated, including 8, 7, and 1 patient from CGA groups 1, 2, and 3, respectively. Fifty-three patients (93%) underwent sphincter-preserving surgical resection and four patients underwent abdominoperineal resection (7%). Postoperative complications were observed in 21 patients (37%). The postoperative complication rate was correlated non-significantly with age (< 85 years: 40.6%; ≥ 85 years: 57.1%;  $P=0.3$ ), and with the CGA ( $P=0.64$ ). In total, 10 patients

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(18%) had definitive colostomy, including five anastomotic leakages (9%), and one incontinence (2%). The total rate of sphincter preservation was 82% ( $n=47$ ). The risk of secondary definitive colonic stoma formation was not correlated with CGA (group 1: 14%; group 2/3: 16%;  $P=0.8$ ). Estimated OS at five years was 52%.

**Conclusions:** After routine geriatric assessment, elderly rectal cancer patients have good rates of sphincter conservation and acceptable morbidity/mortality.

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## Introduction

The populations of Western countries are ageing, and as a result of longer life expectancies, a growing number amongst the older population will be diagnosed with a cancer [1]. Colorectal cancer (CRC) is the most frequent type of cancer and the second most common cause of cancer-related deaths in Europe [2]. Forty percent of patients are 75 years or older at the time of diagnosis [3], with rectal cancer accounting for up to 30% of colorectal cancers [4].

Optimal surgical treatment remains the cornerstone of effective treatment. This treatment includes a combination of neoadjuvant chemoradiotherapy (CRT) for locally advanced cancers of the middle or lower rectum followed by total mesorectal excision (TME) [5–8].

Considering the prevalence of rectal cancer, especially in the elder population, many studies have shown that elderly patients are less likely to be offered optimal diagnosis [9] and treatment for rectal cancer [10–14,43]. When surgery is planned, CRT is less often used and non-restorative surgical procedures are undertaken [13]. However, the reasons for sub-standard or sub-optimal treatment of the elderly with rectal cancer remain unclear.

Elderly people are a heterogeneous group of patients, with individual status ranging from fit to very frail; therefore, a Comprehensive Geriatric Assessment (CGA) would help oncologists to better select patients who can benefit from optimal treatment and identify those at high risk [15,16]. The majority of published studies on elderly CRC patients have included patients older than 70 or 75 years but fewer data are available on older patients.

The aim of this study was to determine the feasibility and results of multimodality treatment for rectal cancer in patients 75 years and older after simplified Comprehensive Geriatric Assessment (CGA) according to Balducci score.

## Material and methods

### Study design

In this study, we reviewed the records of all patients operated on in our center for rectal cancer from January 2002 to April 2014. The following data were recorded and analyzed: medical history, age, gender, tumor grade and localization, clinical presentation, ASA score, neoadjuvant treatment, surgery, postoperative morbidity and mortality, and pathological findings, including TNM staging, adjuvant chemotherapy, tumor recurrence, date, and cause of death. Geriatric assessments were also collected to analyze their respective impact on the therapeutic decisions. Data were

collected in an electronic database that was registered with the French National Data Protection Agency (*Comité national informatique et liberté*).

### Patients

All consecutive patients who underwent rectal resection with intent to cure were included in this study. Patients with metastatic disease, with endoscopic resection (uT1 or uTis), or operated on in an emergency were excluded from this study. Preoperative tumor assessment included digital examination, complete colonoscopy, endorectal ultrasound, liver and chest CT-scan, and pelvic MRI.

### Oncogeriatric assessment

Taking into consideration the frailty of this population, all of our patients aged of 75 years or older had undergone an oncogeriatric evaluation preoperatively which was used as a guideline to tailoring the medical and surgical management for each patient. Since the development of the mobile geriatric team in our institute in 2004 (consists of a specialized nurse and a senior geriatrician), further development of the service have been introduced to include an oncogeriatric assessment for patients requiring aggressive medical or surgical treatment decided in multidisciplinary team meeting (MDT) [17]. Patients were seen either by the mobile team if they happen to be hospitalized as inpatients or in consultation organized by the treating physician in the hospital. Preoperatively, patients were assessed according to a simplified Comprehensive Geriatric Assessment (CGA) score adapted by Balducci et al. in 2000 [15] (Fig. 1). Patients were classified into three different categories depending on their functional reserve, comorbidities, geriatric syndromes and life expectancy.

### Preoperative treatment

The indications for neoadjuvant therapy were discussed for all patients during MDT meetings. Preoperative chemoradiotherapy or radiotherapy alone was offered to patients with uT3, uT4, or N+ lower or mid-rectal cancer as assessed according to the endorectal ultrasound and MRI findings [7].

### Surgery

All patients underwent partial or complete total mesorectal excision (TME) [18]. Patients undergoing an anterior resection with a colo-anal anastomosis had a diverting ileostomy created. The perineal step of abdomino-perineal resection was performed as previously described [19]. Surgical

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