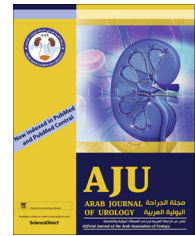




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### ORIGINAL ARTICLE

# Radical cystectomy in the elderly – Is this a safe treatment option?

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#### KEYWORDS

Bladder cancer;  
Elderly;  
Cystectomy;  
Minimally invasive;  
Laparoscopy

#### ABBREVIATIONS

CPEX, cardio-pulmonary exercise testing;  
LOS, length of stay;  
MIBC, muscle-invasive bladder cancer;  
NMIBC, non-muscle invasive disease;  
RC, radical cystectomy

**Abstract Objective:** To determine if significant differences exist in the perioperative outcomes of patients aged > 75 years treated with radical cystectomy (RC) compared to younger patients, as RC is frequently not offered to 'elderly' patients with bladder cancer because of supposed increased risks of complications.

**Patients and methods:** We retrospectively analysed prospectively collected data of all patients that underwent RC in our centre from May 2013 to June 2015. In all, 81 consecutive RCs were identified and included in our study. Patients were divided into two age groups: Group A, aged < 75 years (51 patients) and Group B, aged ≥ 75 years (30). Co-morbidities and perioperative outcomes were compared between the groups. Fisher's exact test was used for statistical analysis.

**Results:** In 68 patients RC was performed laparoscopically and the remaining 13 patients underwent open RC. The mean (range) age was 70.7 (36–85) years. There were 37 patients with muscle-invasive disease and 42 had non-muscle-invasive disease. The median hospital stay was not significantly different between the two age groups (10 vs 11 days). There was no significant difference in the preoperative Charlson co-morbidity index. The 30-day mortality rate was 4% for those aged < 75 years and 6.6% for those aged ≥ 75 years, with overall perioperative complication rates of 57% vs 66%, respectively. Most complications were minor (Clavien–Dindo Grade I–II) and there was no statistically significant difference between the two cohorts. There was also no statistically significant difference in blood transfusion rates.

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**Conclusion:** RC in patients aged  $\geq 75$  years has similar perioperative morbidity when compared with younger patients and can be offered in selected elderly patients. Thus, age should not be an absolute contraindication for RC.

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## Introduction

Bladder cancer remains the second most common urological malignancy in the Western world, with the highest incidence in the elderly population [1–4]. In the UK, it is estimated that people aged  $\geq 75$  years account for more than half of the cases of bladder cancer diagnosed each year [5]. Advances in medicine have led to increased life expectancy, thus compounding the impact of bladder cancer in the elderly population.

Radical cystectomy (RC) is considered the ‘gold standard’ treatment for muscle-invasive bladder cancer (MIBC). It is also indicated in those with high-risk and recurrent non-muscle invasive bladder cancer (NMIBC) [1]. However, RC is associated with significant morbidity and a perioperative 90-day mortality rate of up to 8% [6]. Therefore, this treatment option is not routinely offered to older patients. Some authors have reported a higher incidence of both minor and major complications in the elderly with complication rates as high as 64% [7] and prolonged postoperative hospital stay [8]. There is still considerable debate in the literature as to whether patients aged  $> 70$  years are suitable for such radical surgery [2,8,9].

Advances in minimally invasive surgical techniques have facilitated a drive to offering radical surgery to elderly patients who previously would have been treated conservatively or offered radical radiotherapy [2,9–11]. This minimally invasive approach has many advantages including reduced intraoperative blood loss and postoperative analgesic requirements, whilst facilitating earlier mobility leading to a shorter perioperative admission and possibly lower complication rates [9–12].

There are several publications comparing RC outcome in patients aged  $> 70$  years with younger patients. Articles focussing on patients aged  $> 75$  years have either reported unfavourable outcomes after such treatment [8,13] or focussed on comparing open vs minimally invasive techniques within the age cohort rather than comparing outcomes with younger patients [12,14].

The aim of the present study was to investigate whether there are any significant differences in preoperative co-morbidities, perioperative complications, length of stay (LOS), and mortality rate between patients aged  $\geq 75$  years and younger patients treated for bladder cancer by RC.

## Patients and methods

All patients that underwent open or minimally invasive (hand-assisted laparoscopic) RC in Pinderfields General Hospital between May 2013 and June 2015 were included in the study. In all, 81 consecutive patients were identified. The indication for RC was MIBC in 37 patients, high-grade and/or recurrent NMIBC in 42, one lympho-epithelial lesion, and one T3 basal cell prostate cancer.

Preoperatively, CT of the chest, abdomen and pelvis was performed to assess for evidence of metastatic disease. Additionally, all patients underwent cardiopulmonary exercise testing (CPEX) to determine their anaerobic threshold, and therefore fitness for surgery, as well as determining postoperative level of care (Level 1, 2 or 3 beds). Patients unable to perform CPEX were deemed unsuitable for surgery based on previous internal audit reviews.

All patients were enrolled on an enhanced recovery programme postoperatively. This comprises of clear fluids immediately postoperatively, free fluids and sitting out of bed on day 1, urethral drain out and mobilising on day 2, a soft diet if the patient passed flatus on day 3. Suppositories were given on day 7 if patients had opened their bowels and were passing flatus. Ureteric stents were removed on day 10. Patients were reviewed in the outpatient clinic 6 weeks after RC for clinical examination and routine blood tests. This was followed by regular outpatient visits with surveillance imaging.

Most patients had hand-assisted laparoscopic RC (68 patients) and 13 underwent open RC. All procedures were performed by two experienced surgeons (M.D. and P.W.).

Data collected included patients’ demographics, stage of disease, operative time, intraoperative blood loss and transfusion rates, LOS, Charlson co-morbidity index, perioperative complications, and 90-day postoperative mortality rate.

The Clavien–Dindo classification system was used to describe postoperative complications [15]. Grade I and II complications were classified as minor and Grade III–V were classified as major. All data were prospectively entered into a database.

Patients were divided into two cohorts based on age; Group A, patients aged  $< 75$  years (51 patients) and Group B, patients aged  $\geq 75$  years (30 patients). Fisher’s exact test was used to compare the two groups. A

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