

Pazienti fragili: valutazione e trattamento

Annamaria Ferrero

SCDU Ginecologia AO Ordine Mauriziano, Torino

Frailty

- a state of vulnerability to poor resolution of homeostasis following a stress
- an increased risk of of adverse outcomes



More than half of older cancer patients have pre-frailty or frailty with an increased risk of:
> chemotherapy intolerance
> postoperative complications
> mortality

Gynaecological cancer in elderly patients

- Women aged 65 and above the fastest-growing population
- Rising incidence of malignancies

Ovarian cancer

- Incidence increases with age to reach a peak during the 7th decade of life
- One third of patients are aged 70 or older

Endometrial cancer

- Mean age at diagnosis 68 years
- More aggressive disease (FIGO stage, histological type and grade) in the elderly with
- higher rate of recurrence (13% vs 5%)
- higher 5-years cancer-specific mortality (95% vs 82%)





Health Care Delivery for the Older Adult with Cancer: Where do we go from here?

ASCO20 Virtual Education Program BJ Kennedy Award and Lecture August 8, 2020

#ASCO20

Andrew E. Chapman DO, FACP Chief of Cancer Services, Sidney Kimmel Cancer Center/Jefferson Health Co-Director, Jefferson Senior Adult Oncology Center

Sidney Kimmel Cancer Center Jefferson Health_® | NCI – designated

ASCO20 Virtual PRESENTED AT: EDUCATION PROGRAM

PRESENTED BY: Slides are the property of the author

Andrew E. Chapman DO, FACP Co-Director, Jefferson Senior Adult Oncology Center

Challenge #1 Geriatric Oncology Program Development A call to action!

- All Academic Medical Centers
- All NCI Designated Cancer Centers
- All Health System Leaders

ASCO20 Virtual

EDUCATION PROGRAM

PRESENTED AT:

If you have a Geriatric Oncology Program- <u>Thank You</u> If you don't have a Geriatric Oncology Program- <u>Can we turn on the</u> <u>lights, Please?</u>



 #ASCO20
 Andrew E. Chapman DO, FACP

 Slides are the property of the author, permission required for reuse.
 PRESENTED BY:
 Chief of Cancer Services, Sidney Kimmel Cancer Center/Jefferson Health

Challenge # 2 Workforce Expansion

- All Health Care Professionals
 - Is it not time to require Geriatric/Geriatric Oncology core competency education and training for <u>all</u> healthcare professionals to receive/maintain licensure if they care for older adults with cancer?

All Caregivers

Is it not time to alleviate caregiver burden and stress by providing the necessary education and skills to care for all older adults with cancer?

Develop, Implement, Integrate, Disseminate!

T. HSU JGO 7/1/20



PRESENTED AT: ASCO 20 Virtual

#ASCOZO Slides are the property of the author, permission required for reuse. Andrew E. Chapman DO, FACP PRESENTED BY: Chief of Cancer Services, Sidney Kimmel Cancer Center/Jefferson Health Co-Director, Jefferson Senior Adult Oncology Center

Challenge # 3 Tailoring Care Delivery for the Older Adult with Cancer

Unique vulnerabilities, needs, and goals
 Further unmasked by COVID 19

Value Based Care Programs

Value measured by the unique needs of the older adult

Survivorship Care Programs

Late effects of cancer/cancer therapy in the older adult

Is it not time that all treatment for cancer in the older adult be individualized to address their unique vulnerabilities, and meet their relevant needs/goals?

As we build Value Based and Survivorship Care Programs, is it not time to tailor these programs to specifically address the older adult with cancer?

PRESENTED AT:

ASCO20 Virtual EDUCATION PROGRAM Slides are the property of the author, permission required for reuse. Andrew E. Chapman DO, FACP PRESENTED BY: Chief of Cancer Services, Sidney Kimmel Cancer Center/Jefferson Health Co-Director, Jefferson Senior Adult Oncology Center

Challenge # 4 Geriatric Assessment

Geriatric Assessment for all older adults with cancer prior to starting active treatment for their disease.

Is this not standard of care yet?

Coming Soon: 1) Gap Assessment Tool 2) How-To Guide

PRESENTED AT:



ASCO20 Virtual EDUCATION PROGRAM Slides are the prop

#ASCO20 Slides are the property of the author, permission required for reuse. Andrew E. Chapman DO, FACP PRESENTED BY: Chief of Cancer Services, Sidney Kimmel Cancer Center/Jefferson Health Co-Director, Jefferson Senior Adult Oncology Center

<u>Geriatric Assessment-driven IN</u>tervention (GAIN) on chemotherapy toxicity in older adults with cancer: a randomized controlled trial

Daneng Li, Can-Lan Sun, Heeyoung Kim, Vincent Chung, Marianna Koczywas, Marwan Fakih, Joseph Chao, Leana Chien, Kemeberly Charles, Simone Fernandes Dos Santos Hughes, Monica Trent, Elsa Roberts, Enrique Soto Perez De Celis, Reena Jayani, Vani Katheria, Jeanine Moreno, Cindy Kelly, Mina Sedrak, Arti Hurria, William Dale

City of Hope, Duarte, CA



Center for Cancer and Aging

This work was supported by the Unihealth Foundation, the Hearst Foundation, and City of Hope's Center for Cancer and Aging.



ASCO20 Slides are the property of the author, permission required for reuse.

PRESENTED BY: Daneng Li, MD



- Primary endpoints:
 - Incidence of grade 3-5 chemo toxicity (NCI CTCAE 4.0)
- Secondary endpoints:
 - Advance directive completion
 - Unplanned hospitalizations
- Emergency room visits
- Average length of stay (ALOS)

NCT02517034



#ASCO20 Slides are the property of the author, permission required for reuse.



PRESENTED BY:

ides are the property of the author.

permission required for reuse

PRESENTED AT:

ANNUAL MEETING

Daneng Li, MD

Results: Primary Endpoint

Incidence of Grade 3-5 Chemotherapy-Related Toxicity





#ASCO20 Slides are the property of the author, permission required for reuse.

PRESENTED BY: Daneng Li, MD

COMPREHENSIVE GERIATRIC ASSESSMENT (CGA)

➤ Functional status:

- Assessment of ability to perform activities of daily living (ADL)
- Assessment of instrumental activities of daily living (IADL)
- Assessment of mobility using the Gait Speed or Timed Up and Go (TUG)
- Cognitive function: The Mini Mental State (MMS)
- Comorbidities & geriatric syndromes (e.g. dementia, delirium, falls, osteoporosis, urinary incontinence)
- Polypharmacy

Social support

- Psychological status: Geriatric Depression Scale (GDS)
- Nutritional status: Mini Nutritional Assessment (MNA)
- **PROS** CONS Multiple indicators to Time consuming to determine prognosis, risks administer and evaluate and benefits associated with cancer in the elderly It provides the basis for Should be administered by a initiating interventions to geriatrician improve outcomes Not suitable for use in clinical More objective and reproducible than practice unstructured physician estimates
- Owusu C et al, Clin Pract 2014; Balducci L et al,. Surg Oncol. 2010

G8

7 questions derived from Mini Nutritional Assessment (MNA) and age:

- Food intake
- Weight loss
- Body Mass Index
- Mobility
- Neuropsychological status
- Number of medications
- Self-rated health
- Age < 80, 80-85, > 85



Vulnerable Elders Survey–13 (VES-13)

- A 13 question self-administered tool developed in 2001 to predict functional decline and mortality among older patients.
- It can be administered in 5 minutes
- 4 groups of questions:
 - Age
 - Self-perceived health
 - Difficulties to perform six specific activities (crouching or kneeling, carrying heavy objects, extending arms above shoulder level, handling small objects, walking for 500 meters, doing heavy housework)
 - Difficulties to perform daily living tasks due to health concerns (shopping, managing money, walking across the room, doing light housework, bathing and showering).





Available online at www.sciencedirect.com ScienceDirect

Estimating the risk of chemotherapy toxicity in older patients with cancer: The role of the Vulnerable Elders Survey-13 (VES-13)

CrossMark

J Geriatric Oncology 2015

- 648 patients **≥66** years, 287 (44.3%) vulnerable
- solid or hematological cancers • (33 endometrial and 63 ovarian)

Table 4 - Treatment compliance and toxicity.				
Variable	VES-13 < 3	$V\!ES13\geq 3$	Overall ^a	p-Value ^{a a}
Dose reduction (first cycle) — n (%)	50 (13.9)	37 (12.9)	87 (13.4)	0.722 ^b
Dose reduction — n (%)	131 (36.4)	120 (41.8)	251 (38.8)	0.160 ^b
Unknown	1	-	1	
Cause of dose reduction — n (%)				0.788°
Toxicity	70 (53.8)	61 (50.8)	131 (52.4)	
Acute event	1 (0.8)	-(0.0)	1 (0.4)	
Medical decision	42 (32.2)	41 (34.2)	83 (33.2)	
Subject decision	6 (4.6)	3 (2.5)	9 (3.6)	
Progression	10 (7.7)	14 (11.7)	24 (9.6)	
Death	1 (0.8)	1 (0.8)	2 (0.8)	
Unknown	1	-	1	
Treatment interruption — n (%)	106 (29.4)	86 (30.0)	192 (29.6)	0.868 ^b
Cause of treatment interruption — n (%)				0.025°
Toxicity	33 (31.1)	23 (26.7)	56 (29.2)	
Acute event	1 (0.9)	2 (2.3)	3 (1.6)	
Medical decision	17 (16.0)	3 (3.5)	20 (10.4)	
Subject decision	16 (15.1)	12 (14.0)	28 (14.6)	
Progression	36 (34.0)	44 (51.2)	80 (41.7)	
Death	2 (1.9)	2 (2.3)	4 (2.1)	
Other	1 (0.9)	-(0.0)	1 (0.5)	
Grades 3-4 hematological toxicity — n (%)	75 (20.8)	101 (35.2)	176 (27.2)	
Grades 3–4 non hematological toxicity — n (%)	39 (10.8)	53 (18.5)	92 (14.2)	

Can Vulnerable Elders Survey – 13 (VES-13) predict the impact of frailty on chemotherapy in elderly patients with gynaecological malignancies?

Ferrero A et al, IGCS 2016; Medicine 2018

- 84 patients \geq 70 years, 36 (42.9%) vulnerable •
- ovarian, endometrial and cervical cancers

CHEMOTHERAPYY		VES	5-13	Tetel	n Value	
		< 3	≥ 3	Total	p-value	
Тур	e of treatment:				p = 0.07	
-	Combination chemotherapy	39 (62.9%)	23 (37.1%)	62		
-	Single-agent chemotherapy	9 (40.9%)	13 (59.1%)	22		
Res	ponse to treatment:				p = 0.001	
-	CR (complete response)	20 (83.3%)	4 (16.7%)	24		
-	PR (partial response)	16 (42.1%)	22 (57.9%)	38		
-	SD (stable disease)	7 (87.5%)	1 (12.5%)	8		
-	PD (progression disease)	5 (35.7%)	9 (64.3%)	14		
Reco	urrence of disease	28 (57.1%)	21 (42.9%)	49	p = 1	
Thre	ombocytopenia	3 (18.7%)	13 (81.3%)	16	p = 0.0005	
Ana	emia	2 (18.2%)	9 (81.8%)	11	p = 0.005	
Neutropenia		24 (55.8%)	19 (44.2%)	43	p = 0.58	
Sup	portive care:					
-	Transfusion	2 (25%)	6 (75%)	8	p = 0.05	
-	G-CSF	10 (37%)	17 (63%)	27	p = 0.01	
-	ESA	1 (100%)	- (0%)	1	p = 0.38	
Non	-hematological toxicity:					
-	Neuropathy	4 (28.6%)	10 (71.4%)	14	P = 0.017	
-	Renal toxicity	2 (18.2%)	9 (81.8%)	11	p = 0.005	
-	Arthralgia/myalgia	3 (14.3%)	18 (85.7%)	21	p = 0.0001	
-	Asthenia	2 (7.4%)	25 (95.6%)	27	p = 0.0001	
Dos	e reduction	4 (33.3%)	8 (66.7%)	12	p = 0.07	
Dela	γ	23 (48.9%)	24 (51.1%)	47	p = 0.08	
Disc	ontinuation	6 (31.6%)	13 (68.4%)	19	p = 0.01	

Frailty Index

Deficit	Assigned points
1 Needhalo organing meals	No = 0 Vec = 1
 Need help preparing means Need help feeding upwork 	$N_0 = 0$, $T_{es} = 1$
2. Need help descript yourself	$N_0 = 0$, $T_{es} = 1$
 Need help using the toilet 	$N_0 = 0$, $T_{es} = 1$
 Need help using the tonet Meed help with housekeeping 	$N_0 = 0, Tes = 1$
6. Meed help slimbing string	$N_0 = 0, T_{es} = 1$
7. Need help bathing	$N_0 = 0, T_{es} = 1$
8. Need help walking	$N_0 = 0, Tes = 1$
0. Need help using transportation	$N_0 = 0, T_{es} = 1$
10 Need help using transportation	$N_0 = 0, T_{es} = 1$
11 Need help managing medications	$N_0 = 0, Tes = 1$
12 Depend on assistius devices (walker cane atc.)	$N_0 = 0, T_{es} = 1$
or other neonle to perform activities of daily life	$N_0 = 0, T_{es} = 1$
13 Dependent on device for normal breathing	$N_0 = 0$ Vec = 1
14. Climb 2 flights of stairs without sect	No can't do at all $= 1$
rectanto 2 ingres of starts without rest	Ves with difficulty $= 0.5$
	Ves with no difficulty $= 0$
15 Myocardial infunction	$N_0 = 0$ Ves = 1
16 Diabetes	$N_0 = 0, Y_{es} = 1$
17. Peripheral vascular disease	$N_0 = 0$, $Y_{es} = 1$
18. Cerebrovascular disease	$N_0 = 0$, $Y_{es} = 1$
19. Dementia	$N_0 = 0$, $Y_{es} = 1$
20. Chronic obstructive pulmonary disease	No = 0, $Yes = 1$
21. Pepticulcer	No = 0, $Yes = 1$
22. Hemiplegia /paraplegia	No = 0, Yes = 1
23. Renal disease	No = 0, Yes = 1
24. Moderate/severe liver disease	No = 0, $Yes = 1$
25. Rheumatologic disease	No = 0, Yes = 1
26. Hypertension	No = 0, Yes = 1
27. Hyperlipidemia	No = 0, $Yes = 1$
28. Body mass index	Underweight/obese $= 1$
-	Overweight $= 0.5$
	Normal = 0
29. Depression	No = 0, Yes = 1
30, Anemia	No = 0, Yes = 1

mFl

1	Chronic obstructive pulmonary disease or
	recent pneumonia
2	Congestive heart failure
3	Myocardial infarction
4	Percutaneous coronary intervention, previous cardiac surgery, or angina
5	Diabetes mellitus
6	Hypertension requiring medication
7	Peripheral vascular disease or ischemic rest pain
8	Impaired sensorium
9	Transient ischemic attack or cerebrovascular accident
10	Cerebrovascular accident with neurological deficit
11	Functional status, such as functional status measured in the 30 d before surgery
Derive	d from the Concilient Study of Health and Asias
Derive Frailty	ed from the Canadian Study of Health and Aging

■ mFl ≥ 4 = high

Validated in several surgical specialties

Kumar, Gynaecol Oncol 2017; Uppal, Gynaecol Oncol 2015

Measurement and validation of frailty as a predictor of outcomes in women undergoing major gynaecological surgery

EM George,^a WM Burke,^{a,b,c} JY Hou,^{a,b,c} AI Tergas,^{a,b,c,d} L Chen,^a AI Neugut,^{b,c,d,e} CV Ananth,^{a,d} DL Hershman,^{b,c,d,e} JD Wright^{a,b,c}

- 66105 hysterectomies from 2008 to 2012
- mFI increases wound complications by 11.4%, severe complications by 22.0% and overall complications by 11.0%
- Mortality increased in patients with a higher frailty index (from 0.06% to 3.2%, p < 0.0001)



Frailty index predicts severe complications in gynecologic oncology patients $\stackrel{\diamond}{\approx}$



Shitanshu Uppal ^{a,*}, Elena Igwe ^b, Laurel W. Rice ^a, Ryan J. Spencer ^a, Stephen L. Rose ^a

- 6551 patients with gynaecological malignacies
- Increased rates of Clavien IV/V complications according to mFI scores of 0, 1, 2, 3 and ≥4 (p=0.001)

Ovarian Cancer in Elderly Patients

Patterns of Care and Treatment Outcomes According to Age and

Modified Frailty Index

Annamaria Ferrero, MD,* Luca Fuso, MD,* Elisa Tripodi, MD,* Roberta Tana, MD,† Alberto Daniele, MD,* Valentina Zanfagnin, MD,* Stefania Perotto, MD,* and Angiolo Gadducci, MD† Int J Gynecol Cancer 2017

Methods: Treatments of 78 patients analyzed according to:

- 1) age group categories: 70 to 75 years versus older
- 2) mFl < 4 (low frailty) versus \geq 4 (high frailty)

Results:

- Co-morbidities more frequent in the high frailty group
- Performance Status different only according to mFI
- More patients older than 75 years underwent none or only explorative surgical approach (55.3 vs 20%, p=0.003)
- Postoperative complications prevalent in high-frailty patients (23.5% vs 4.3%; p=0.03)
- No differences in chemotherapy toxicity except more hospital recovery in the high-frailty cohort
- Median survival time in favour of younger patients (98 versus 30 months) and less-frailty patients (56 vs 27 months)

Development of a frailty questionnaire

- mFl
- VES 13
- G8
- Frialty deficit Index

- 20 items selected and merged, focused on:
- patient's inability to perform activities of daily life
- coexistance of comorbidites
- ✓ Pilot feasibility study
- ✓ Validation prospective study

Development and clinical application of a tool to identify f in elderly patients with gynecological cancers

A. Ferrero¹, M. Villa¹, D. Attianese¹, M. Coppo¹, M. Borghese¹, E. Badellino¹, L. Fuso¹, N. Biglia¹

Academic Department Gynaecology and Obstetrics - Mauriziano Hospital, Torino, Italy

Objectives. Aim of this prospective study is the development and clinical application of a tool to identify frailty in patients > 70 years old affected by either ovarian or endometrial cancer.

Methods. The tool consists of 20 items combining comorbidities and functional aspects. After identifying a cut off to establish frailty, differences in terms of surgical complications and chemotherapy toxicities were verified. 52 patients were evaluated before treatment's at the diagnosis or at the first recurrence.

Results.

- A cut off > 4 resulted the best in terms of specificity and sensibility (Sp 100 %, Sn 77,6 %).
- 36% of patients resulted frail.
- Frailty was associated with longer hospitalization after surgery.



 No differences occurred in the incidence of postoperative adverse events.

ITEMS

Walking across the room Loss of appetite Self-care (bathing, dressing) Doing light houseworks Shopping for personal items Going-out indipendently Receiving functional and psychological help Taking more than 3 drugs per day Rating own health status Body Mass Index (BMI)

Chronic lung disease Previous stroke or percutaneous procedure Beart failure Diabetes meilitus Peripheral vascular disease Chronic kidney disease Hypertension Peripheral neuropathy Cognitive decline Cerebrovascular accident with sequelae

- Compliance to chemotherapy was better in the fit group.
- Hematological and non-hematological advers event were more prevalent in the frail group.

Conclusions. Our tool seems to effectively stratify elderly patients with gynecological cancers according to frailty, in order to choose the best treatment for frail women and avoid undertreatment in fit ones.





Pazienti fragili: valutazione e trattamento



Contents lists available at ScienceDirect

Gynecologic Oncology

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

GYNECOLOGIC ONCOLOGY

Gynecologic Oncology 153 (2019) 616-624

Early treatment modifications improve chemotherapy adherence in ovarian cancer patients ≥70 years

Thorsten Heilmann ^{a,*}, Jacobus Pfisterer ^b, Antje Marie Hempel ^a, Sandra Saß ^c, Jürgen Hedderich ^d, Eric Pujade-Lauraine ^e, Philipp Harter ^f, Andreas du Bois ^f, Felix Hilpert ^{a,g}

- 3333 patients with advanced ovarian cancer
- 3 phase III trials of the AGO & GINECO study groups
- Retrospective analyses for age-specific prognostic and toxicity parameters.
- 359 (10%) patients aged ≥70 years

Results:

- Lower quality of treatment
- Less cycles of platinum/taxane-based chemotherapies in elderly patients
- Lower OS in elderly patients with ≤4 cycles of chemotherapy (18.4months vs 30.9months)





GINECO has developed a Geriatric Vulnerability Score (GVS) to discriminate vulnerable from fit older patients ⁽¹⁾

GVS items

- Activity of Daily Living (ADL-Katz) score < 6</p>
- Instrumental Activities of Daily Living (IADL-Lawton) score < 25</p>
- Hospital Anxiety and Depression score (HADS) > 14
- Albuminemia < 35g/L</p>
- Lymphocyte count < 1G/L</p>

$GVS = \Sigma$ scores

GVS > 3 defines vulnerable older patients (> 70 years old)

(1) Falandry et al. Development of a geriatric vulnerability score in elderly patients with advanced ovarian cancer treated with first-line carboplatin: a GINECO prospective trial Annals Oncol 2013



#ASCO19 Slides are the property of the author, permission required for reuse.

PRESENTED BY:

EWOC-1: A randomized trial to evaluate the feasibility of three different first-line chemotherapy regimens for vulnerable elderly women with ovarian cancer (OC): A GCIG-ENGOT-GINECO study

EWOC-1 design

Eligibility criteria

- Age > 70yrs
- Histologically or cytologically proven epithelial cancer of the ovary, fallopian tube, and primary peritoneum
- FIGO stage III or IV
- No clinically relevant organ dysfunction
- Life expectancy > 3 months

Stratification parameters:

PRESENTED AT:

- Country

- Initial debulking surgery outcome Randomisation according minimization

2019 ASCC

lides are the property of the author,





PRESENTED BY: C FALANDRY

- Completed 6 cyles (primary endpoint):
- ARM A: 26 (65%)
- ARM B: 19 (47,5%)
- ARM C: 24 (60%)

Same results in most vulnerable patients (GVS 4 e 5)





Even vulnerable older ovarian cancer patients should be offered a Carboplatin-Paclitaxel regimen

Safety and Efficacy of Extended Bevacizumab Therapy in Elderly (Q70 Years) Versus Younger Patients Treated for Newly Diagnosed Ovarian Cancer in the International ROSiA Study Frederic Selle, Nicoletta Colombo, Jacob Korach, Cesar Mendiola, Andres Cardona, Youssef Ghazi, and Amit M. Oza

	Ag	ge≥70 Year	rs (n = 121)	Age <70 Years (n = 900)				
Patients, %	All Grades	Grade 3	Grade 4	Grade 5	All Grades	Grade 3	Grade 4	Grade
Any AE of special interest	92.6	52.1	13.2	2.5	89.3	37.9	13.7	0.3
Hypertension	60.3	39.7	1.7	0	54.4	22.0	0.4	0
Neutropenia and associated complications	52.1	18.2	9.9	0.8	50.7	18.2	11.1	0
Thrombocytopenia	41.3	9.1	1.7	0	34.7	8.0	1.7	0
Bleeding	33.1	0.8	0	0.8*	38.9	0.4	0.1	0.1
Proteinuria	31.4	2.5	0	0	31.2	4.0	0	0
Thromboembolic events	14.0	5.0	0.8	1.7^{\dagger}	5.8	1.4	0.8	0.1
Arterial	5.0‡	1.7	0	0.8	2.4	0.7	0.2	0.1
Venous	9.9 [‡]	3.3	0.8	0.8	3.3	0.8	0.6	0
Gastrointestinal perforation	4.1	1.7	1.7	0	2.0	0.8	0.2	0.1
Wound-healing complication	1.7	0	0	0	3.3	0.4	0	0
Congestive heart failure	1.7	0	0	0.8 [§]	0.1	0	0.1	0
Fistula/abscess	0.8	0.8	0	0	0.8	0.2	0.1	0
PRES	1.7	0	0.8	0	0	0	0	0

^{\dagger}Venous embolism (n = 1) and disseminated intravascular coagulation (n = 1).

[‡]One patient had an ATE and a VTE.

§Congestive cardiac failure.

AE, adverse event; PRES, posterior reversible encephalopathy syndrome.





	Age <70 years (n=900)	Age ≥70 years (n=121)
Median PFS, months	25.6	23.7
(95% CI)	(23.7–28.4)	(18.6–27.9)





Contents lists available at ScienceDirect Gynecologic Oncology

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



CrossMan

Tolerance and toxicity of the PARP inhibitor olaparib in older women with epithelial ovarian cancer

Lauren E. Dockery^{a,*}, William P. Tew^b, Kai Ding^a, Kathleen N. Moore^a

398 patients \geq 65 years, stratified into age groups by 5 year increments, compared to those <65

- \checkmark No differences in dose reductions and dose interruption
- ✓ No myelodysplastic syndrome (MDS) or acute myeloid leukemia (AML) in any of the older cohorts
- ✓ No significant differences in toxicities across age groups

	<65 years		65-69 years		70-74 years		≥75 years		p-value
	n = 320		n = 38		n = 23		n = 17		
n (%)	Any AE	≥3	Any AE	≥3	Any AE	≥3	Any AE	≥3	G 3/4 toxicity
Nausea	223 (70)	7(2)	16 (42)	1(3)	12 (52)	1(4)	13 (76)	0	0.69
Anemia	84(26)	40(13)	14 (37)	5(13)	5 (22)	2(9)	7(41)	4 (24)	0,70
Fatigue	183 (57)	22(7)	25 (66)	2(5)	14 (61)	2(9)	11 (65)	4 (24)	0.31
MDS/AML	1 (0.3)		0		0		0		

Specific toxicities by age group. Any grade adverse event versus grade ≥ 3.

AE = adverse event, MDS/AML = myelodysplastic syndrome/acute myeloid leukemia,



NOVA Elderly Patients Subgroup Analysis: Efficacy Progression-Free Survival in gBRCAmut Patients and non-gBRCAmut Patients Aged <70 and ≥70 Years



CI=confidence interval; gBRCAmut=germline breast cancer susceptibility gene mutation; HR=hazard ratio; PFS=progression-free survival; Data represent all randomized patients

Fabbro M., et al. Gynecolo Oncol. 2019



Contents lists available at ScienceDirect

Gynecologic Oncology

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

Gynecologic Oncology 146 (2017) 519-524

Management of elderly women with endometrial cancer Holm Eggemann ^a, Tanja Ignatov ^a, Elke Burger ^b, Serban Dan Costa ^a, Atanas Ignatov ^{a,*}

- Multicentre retrospective registry-based study
- 1550 patients with endometrial cancer.
- 676 (43.6%) patients > 70 years

Results:

- Patients <60 years more likely to receive lymphadenectomy, brachytherapy, externalbeam radiotherapy (EBRT) and systemic therapy compared with patients aged >70 years
- Rate of therapies not performed because of the physician's decision increased with patient age.
- In older than 70 years, patient refusal a very uncommon reason for failure to perform the indicated therapy

Treatment	Patients' age							
	<60 years	61-70 years	71-80 years	>81 years				
Lymphadenectomy					<0.0001			
Contraindicated	6 (42.9%)	26 (65.0%)	25 (31.6%)	20 (51.3%)				
Refused	8 (57.1%)	9 (22.5%)	8 (1 <u>0.1%</u>)	7 (17,9%)				
Not recommended	0 (0%)	5 (12.5%)	46 (58.2%)	12 (30.8%)				
Radiatio					< 0.0001			
Contraindicated	8 (17.0%)	34 (38.2%)	12 (9.0%)	12 (24.5%)				
Refused	39 (83.0%)	46 (51.7%)	10 (7.5%)	12 (24.5%)				
Not recommended	0(0%)	9 (6.2%)	111 (76.63)	25 (51.0%)				
Systemic therapy					< 0.0001			
Contraindicated	12 (18.5%)	48 (39.7%)	41 (28.3%)	29 (42.6%)				
Refused	53 (81.5%)	58 (47.9%)	19 (13.1%)	22 (32.4%)				
Not recommended	0(0%)	1. (12.4%)	85 (58.6%)	17 (25.0%)				

Reasons for failing to receive indicated treatment.



Contents lists available at ScienceDirect

Gynecologic Oncology

journal home page: www.elsevier.com/locate/ygyno



(CrossMark

Frailty in endometrial cancer

Frailty measure is more predictive of outcomes after curative therapy for endometrial cancer than traditional risk factors in women 60 and older Jane A. Driver^{a,b,c,*}, Akila N. Viswanathan^{b,c,d}

- 88 women ≥ age 60
- Median age 68.5 (range 60–88 years)
- Stage I–IV endometrial cancer
- Treated with surgery, chemotherapy and radiation

Frailty score factors:

- ECOG-PS ≥1
- BMI <20 kg/m2
- Albumin b3.5 mg/dL
- Hemoglobin b10 mg/dL
- Osteopenia/osteoporosis
- Unintentional weight loss

Results:

- 46% of frail experienced treatment delay, modification or interruption due to toxicity
- Presence of one baseline frailty factor → twices the risk of disease recurrence (HR=2.21;95% CI: 1.02–4.80).
- 3-year DFS: 77% in those with no frailty markers and 48% in those with at least one (p=0.02)
- Frailty markers predicted shortened overall survival (HR=2.34;95%CI: 1.08–5.03)

Conclusions

□ Elderly patients with gynaecological cancers:

- are under-represented in clinical trials
- are less likely to receive standard antineoplastic treatments
- may tolerate standard treatments

□ Elderly patients with gynaecological cancers:

- are an extremely heterogeneus population
- cronological age alone is a poor predictor of clinical outcomes
- fraily assessments are needed in clinical practice and clinical trials



Daniela Attianese Enrico Badellino Martina Borghese Isabella Cipullo Luca Fuso Roberta Massobrio Oscar Pezua Michela Villa

Grazie per l'attenzione