

# Treatment may need to be modified for elderly brain cancer patients

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Glioblastoma, the most common and aggressive type of brain tumor, accounts for a majority of the brain tumors seen in patients 65 years or older. This segment of the population is growing faster than any other age group and not surprisingly, the incidence of glioblastoma in older adults is on the rise. Because survival in older patients tends to be short and they have a higher risk of suffering debilitating side effects from therapy, physicians are unsure how to manage their treatment. A new study examining the patterns of treatment in older patients with glioblastoma was published in *Annals of Neurology*, the official journal of the American Neurological Association.

Led by Lauren E. Abrey of the Memorial Sloan-Kettering Cancer Center in New York, researchers used data from the Surveillance, Epidemiology, and End Results (SEER) cancer registry to gather information on 4,137 on patients who were at least 65 years old and were diagnosed with glioblastoma between 1994 and 2002. They evaluated the associations of demographic characteristics (age, gender, race, marital status and residence in a metropolitan versus non-metropolitan county) and co-existing health conditions with the probability of undergoing surgery, radiation and chemotherapy to treat the tumor.

The results showed that 61 percent of the patients underwent surgery, and that black patients had surgery less often than white patients. Radiation was performed in 65 percent of patients, while only 10 percent underwent chemotherapy. Patients who were older, unmarried and had additional health issues were less likely to receive radiation or

chemotherapy within three months of diagnosis. The median survival for elderly patients was only four months.

The study showed that age was the most significant factor in predicting whether a patient received treatment, with older age associated with lower odds of undergoing surgery, radiation or chemotherapy. The authors attribute this to the fact that physicians may be concerned about increased toxic side effects or complications from treatment in elderly patients. "Another possibility is that elderly patients may decline more invasive and aggressive treatments because therapies are only palliative and may prolong life only for a short time," the authors note, although the study did not evaluate this aspect. Although the reasons for the difference in surgery rates between blacks and whites are not clear, the authors speculate that blacks may have been more likely to have health conditions that made them poor candidates for surgery or may be more averse to having surgery than whites.

The study highlights the need for a better understanding of how patients, families and physicians make treatment decisions for elderly glioblastoma patients. "Specific interventions for elderly glioblastoma patients deserve further study, especially for those with identifiable risk of being under-treated such as black and unmarried individuals," the authors state. For example, they note that a shorter three-week course of radiation seems to be as effective as the usual six-week course and that temozolimide, an oral chemotherapeutic drug, seems to be well tolerated in older glioblastoma patients. They conclude: "Further investigations into the role of biology, molecular determinants of response to therapy and more effective and less toxic therapies are required for elderly glioblastoma patients."

Source: Wiley

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