

## Cancer in the elderly: Research fails to keep up with demographic change

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Barcelona, Spain: New research showing that almost half of 13,000 patients with head and neck cancers had other health-related problems at the same time is one of the presentations in a special session at the 31st conference of the European Society for Radiotherapy and Oncology (ESTRO 31) [1] today (Friday). The session will highlight the effect of the demographic time bomb caused by an increasingly ageing population.

Dr Charlotte Rotbøl Bøje, from the Aarhus University Hospital, Aarhus, Denmark, will tell the conference that analysis of co-morbidities – other medical conditions or diseases that exist alongside an initial cancer diagnosis – in 12956 patients registered in the DAHANCA database of all Danish head and neck cancers diagnosed between 1992 and 2008 found that 44% had at least one co-morbidity.

She will say that it is essential that doctors make a proper assessment of co-morbidities when deciding on the correct [treatment](#) for elderly patients with head and neck cancer. These patients are often long-term users of tobacco and/or alcohol, which, besides having a carcinogenic effect, can also cause lung, heart and cerebrovascular disorders.

The analysis by Dr Rotbøl Bøje and her colleague Professor Jens Overgaard found that the most common co-morbidities were cerebrovascular disease (11%), chronic pulmonary disease (11%), and cardiovascular disease (10%). Increasing age was significantly associated with co-morbidities, although there was no difference between genders.

Survival rates and risk of death were also strongly associated with co-morbidities. The median age of the patients was 62; the youngest was 10 and the oldest 100. Men made up 73% of the total cohort. Information on co-morbidities was obtained from the National Patient Registry, which contains discharge diagnoses from all Danish hospital admissions and outpatient visits.

"Our analysis has shown how important it is to take a multidisciplinary approach to cancer in the elderly," says Dr Rotbøl Bøje, "particularly when recruiting them into trials. They will often have other medical conditions that need to be treated, and the design of trials needs to take this into account. We need trials that focus on both fit and frail elderly patients.

"There are some problems in treating older patients with radiotherapy, but this is not only due to their chronological age but also to the fact that there is more co-morbidity among the elderly. This can affect quality of life and can lead to treatment interruptions and hospitalisation. We believe that an accurate assessment of co-morbidities before starting treatment in elderly patients is essential in order to decide on the best and most appropriate treatment for this patient group."

In developed countries, half of all cancers already occur in patients aged 70 and over, and by 2050 the majority of older people will live in developing countries [2]. Yet the session highlighted not only the problem of co-morbidities but also how little research is conducted specifically into cancer patients over the age of 70 and the lack of clinical trials for this age group.

In another presentation, Professor David Sebag-Montefiore, from St. James's Institute of [Oncology](#), University of Leeds, Leeds, UK, will provide further evidence of the need to undertake such an assessment in older patients. "It is very clear that we need to do further research to

determine the optimal treatments for our ageing population and their associated co-morbid conditions. We need to get the balance right and avoid inappropriate under- and over-treatment," he will say.

Doctors currently rely on clinical experience, knowledge of the complete medical history of the patient, and an assessment of the severity of co-morbidities when deciding whether a patient is sufficiently fit to undergo a particular treatment. But this is not always enough, and further studies are required to help clinicians define the best way of selecting patients for specific treatment, says Professor Sebag-Montefiore.

"Although a patient's treatment should not be determined purely on the basis of age, we need to take into account the fact that things like the length of treatment, which often takes place over five to six weeks, and the travel time to cancer centres can weigh much more heavily on an older person. And although most trials do not have an upper age limit, many studies exclude patients with co-morbidities and usually the median age in such trials is significantly lower than that of the general population. So we need to design studies urgently to address these problems if we are to be able to provide the best evidence-based treatment to an [ageing population](#)," he says.

Chemotherapy also poses problems for older people, says Dr. Laura Biganzoli, from the Hospital of Prato, Istituto Toscano Tumori, Prato, Italy. "Recommendations for treatment are largely based on limited retrospective subgroup analyses from larger trials and the extrapolation of study results from younger patients. This is clearly inappropriate, since breast cancer biology differs in older patients, treatment tolerance varies, and there are the ever-present problems of co-morbidities."

Only two published studies have prospectively evaluated the role of chemotherapy in elderly breast cancer patients, and a retrospective study has found a higher risk of treatment-related deaths in older women. "In

addition to the lack of clinical trials dedicated to older patients," says Dr. Biganzoli, "we also need to design studies for those who are vulnerable and frail."

In radiotherapy under-treatment after breast conserving surgery is common, she says. "The CALGB [3] trial 9343 showed that not giving radiotherapy to women with early stage breast cancer with oestrogen receptor positive tumours who had breast conserving surgery and were taking tamoxifen had no impact on survival but was associated with an increased risk of local relapse," she says.

"The authors concluded that it was a reasonable choice to omit radiation in women in such a group of patients aged over 70. However, I believe that it is important to discuss these data with these patients and that the final decision should take into account their individual preferences."

Dr. Biganzoli's hospital unit works in close collaboration with geriatricians in order to carry out a proper pre-treatment evaluation of elderly patients. "We are also running clinical trials to identify accurate screening tools for geriatric impairment and to find biomarkers of frailty. Without the evidence these trials can provide, although we try to do our best, we are often working in the dark," Dr. Biganzoli concludes.

Prof Vincenzo Valentini, radiation oncologist at the Policlinico Universitario A. Gemelli in Rome, Italy, and President of ESTRO, said: "These three presentations underline the difficulties clinicians face when treating [elderly patients](#). Not only is there the problem of co-morbidity, but frequently the lack of trials specifically designed for older people means that results from studies including a completely different age group are extrapolated to them. This can result in their receiving inappropriate treatment – either under-treatment or unacceptable toxicity.

"Demographic change means that it has never been more important to find evidence-based treatment strategies for elderly [patients](#)."

**More information:** [1] This year the ESTRO conference is held in parallel with the World Congress of Brachytherapy, both taking place in Barcelona from May 9-13.

[2] Data from the International Society of Geriatric Oncology

[3] The Cancer and Leukaemia Group (CALGB) Co-operative Group

Provided by European Society for Radiotherapy and Oncology

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