Recommendaions
NCCN, SIOG, SoFOG, etc.

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HÔPITAL RENÉ HUGUENIN

Au 1er janvier 2010, le Centre René Huguenin devient l'Hôpital René Huguenin, un établissement de soins, d'enseignement et de recherche de l'Institut Curie
Guidelines

• Meta-Analyses
• Trials

• Evolving consensus
  – Saint-Gallen
  – NIH
  – NCCN
  – GEPOG/SoFOG
• Wedding U. Elderly patients have become the leading drug consumers: it's high time to properly evaluate new drugs within the real targeted population. J Clin Oncol 24:62-3, 2006 (no abstract available)
<table>
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| Rigorous screening to exclude patients at unacceptably high cardiac risk (level 1a) | Comprehensive patient history  
Current signs or history of CHF  
Cardiovascular comorbidity (i.e., hypertension, diabetes or coronary artery disease)  
Prior exposure to anthracyclines for this or previous malignancy (level 1a) |
| Not exceeding the recommended upper cumulative dose (level 1a) | Reduction in maximum cumulative dose (level 5)  
Use of continuous infusion (level 1a)  
Epirubicin (level 1a)  
Doxorubicin (level 1b, elderly: level 5)  
Liposomal anthracycline formulations (level 1b, elderly: level 5)  
Sequential administration of conventional anthracyclines and trastuzumab in HER2-positive breast cancer (level 1b, elderly: level 5) |
| Regular monitoring of cardiac function, signs and symptoms (level 1a) | Measure of LVEF by ultrasound (preferred, level 5) or MUGA scan*, every two to three cycles of anthracyclines (level 1a)  
Special attention noted if drop in LVEF exceeds 10%, even if remaining within normal range (level 5) |
| Cardiovascular risk reduction interventions (level 1a) | Long-term follow-up (level 1a)  
Early management of dysfunction (level 1a)  
Lifestyle modifications (i.e., smoking cessation, regular exercise, weight loss where appropriate) (level 1a)  
Beta blockers and ACE inhibitors (level 1a)  
Reduced lipid levels (level 1a) |

CHF, congestive heart failure; MUGA, multiple uptake gated acquisition; ACE, angiotensin-converting enzyme.  
*Use the same method through the follow-up.  

**Anthracycline cardiotoxicity in the elderly cancer patient: a SIOG expert position paper**  
M. Aapro¹, C. Bernard-Martí², E. G. C. Brain³, G. Batist⁴, F. Erdkamp⁵, K. Krzemieniacki⁶, P. Leonardi⁷, A. Lluch⁸, S. Monfardini⁹, M. Rybicki¹⁰, P. Stubbe-yann⁴ & U. Wedding¹¹
Management of prostate cancer in older men: recommendations of a working group of the International Society of Geriatric Oncology

- **G1** = “fit”
  - No abnormality
  - CIRSG
    - grade ≤ 2
  - (I)ADL normal
  - MNA normal
  - **Standard treatment**

- **G2** “vulnérable” (reversible)
  - CIRSG
    - ≥ 1 grade 3
  - ≥ 1 IADL
  - Risk for denutrition
    - 17 ≤ MNA < 24
  - **Standard treatment ± geriatric intervention**

- **G3** “fragile” (non reversible)
  - CIRSG
    - ≥ 2 grade 3 or
    - ≥ 1 grade 4
  - ≥ 1 ADL
  - Severe denutrition
    - MNA < 17
  - Cognitive impairment
    - 15 < MMSE ≤ 24
  - Desorption, confusion
  - **Symptomatic treatment ± specific actions**

- **G4**
  - Dependence, dementia
  - Major comorbidities
  - Terminal
  - **Palliative treatment**
APPROACH TO DECISION MAKING IN THE OLDER ADULT

Does this patient have a life expectancy that puts him or her at moderate or high risk of dying or suffering from cancer during the lifetime?\textsuperscript{a}

Yes

No

Symptom management/supportive care

See NCCN Supportive Care Guidelines

Obtain information from patient’s proxy. Consider consult from ethics committee in patient without decision making capacity.

Does this patient have decision-making capacity?\textsuperscript{b}

Yes

No

Symptom management/supportive care

See NCCN Supportive Care Guidelines

Are the patient goals and values consistent with wanting cancer treatment?\textsuperscript{c}

Yes

Assessment of Risk Factors (See SAO-2)

No

Note: All recommendations are category 2A unless otherwise indicated.

Clinical Trials: NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged.

\textsuperscript{a}See histograms for age-specific life expectancy (SAO-A).

\textsuperscript{b}Sessums LL, Zembruska H, Jackson JL. Does this patient have medical decision-making capacity? JAMA 2011;306:420-427.

\textsuperscript{c}Harrington SE, Smith TJ. The role of chemotherapy at the end of life: when is enough, enough? JAMA 2008;299:2667-2678.
ASSESSMENT OF RISK FACTORS

Does the patient have risk factors for adverse outcomes from cancer treatment?

- Comorbidities
  - congestive heart failure (CHF)
  - renal insufficiency
  - neuropathy
  - anemia
  - osteoporosis
  - GI problems
  - diabetes
  - lung disease
  - hearing or vision loss
- Geriatric Syndromes
  - functional dependency (ADL, IADL)
  - mobility problems
  - falls
  - dementia
  - delirium
  - depression
  - nutritional deficiency
  - polypharmacy
- Socioeconomic Issues
  - poor living conditions
  - no caregiver
  - low income
  - no transportation
  - lack of prescription drug coverage

Treat as recommended in disease specific treatment guidelines
See Disease-Specific Issues Related to Age (SAO-B)
and NCCN Guidelines for Treatment of Cancer by Site

Symptom management/supportive care
See NCCN Supportive Care Guidelines

Are the risk factors modifiable?

- Yes
  - Consider alternate treatment options to reduce toxicity
  - No
    - Treat risk factors
      - See special considerations for patients able to tolerate treatment (SAO-3)

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*See Comprehensive Geriatric Assessment (SAO-C).*

*The Panel recommends calculation of creatinine clearance to assess renal function for all patients.*

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SPECIAL CONSIDERATIONS FOR PATIENTS ABLE TO TOLERATE TREATMENT

Chemotherapy
- Consider alternative regimens with non-neurotoxic drugs
- Monitor hearing loss and avoid neurotoxic agents if significant hearing loss present
- Monitor cerebellar function if high dose cytarabine
- Monitor for peripheral neuropathy

Neurotoxicity
- Symptomatic or asymptomatic CHF
  - Caution with use of anthracyclines, consider alternative treatment
  - Caution with use of trastuzumab (among patients with a normal ejection fraction, risk factors for CHF include receipt of an anthracycline-based regimen, baseline LVEF of 50-54%, and on hypertensive medicines)

Cardiac toxicity
- Calculate creatinine clearance to assess renal function
- Adjust dose for glomerular filtration rate (GFR) to reduce systemic toxicity

Renal toxicity
- Prophylactic colony stimulating factors when dose intensity required for response or cure

Bone marrow suppression
- Decreased dose of chemotherapy if palliation is the goal

Falls
- Consider PT evaluation in patient with history/risk of falls

Diarrhea
- Consider early aggressive rehydration
- Management with octreotide if oral preparations are ineffective

Constipation
- See NCCN Palliative Care Guidelines

Nausea/vomiting
- See NCCN Antiemesis Guidelines

Mucositis
- Early hospitalization in patients who develop dysphagia/diarrhea
- Nutritional support
- See NCCN Task Force: Prevention and Management of Mucositis in Cancer Care

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Senior Adult Oncology

Upper, middle, and lower quartiles of life expectancy for women and men at selected ages.

A) Life Expectancy for Women
- Top 25th Percentile
- 50th Percentile
- Lowest 25th Percentile

For example, a 75 year old woman in average health is likely to live 12 years; if she is in excellent health, she is likely to live at least 17 years; if she is in poor health, she is likely to live less than 7 years.

B) Life Expectancy for Men

Reprinted and adapted with permission from Walter LC, Ovbiageje KE. Cancer screening in elderly patients. JAMA 2001;285:2750-2756.

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NCCN disease-specific

- Bladder
- Breast
- CNS
- CRC
- H&N
- Kidney
- MM
- NSCLC
- Prostate
GEPOG/SoFOG

- Metastatic CRC
- A taste of "CGA »
- Patient involvement
- Social measures + denutrition / comorbidities

- Fit: local treatment for liver M+ whenever possible with preop chemo; clinical trials
- Intermediate: radiofrequency; evaluate potential resection w/ preop assessment; monochemo
- Fragile: symptomatic treatment
National French Recommendations for Chemotherapy

- **Summary of previous recommendations**
  - Validated regimens
    - 4 AC
    - 6 CMF
  - Options: TC
    - 4 TC > 4 AC
      - Post hoc sub group analysis in a randomized trial, n ~ 80

- **Sequential regimen**
  - No data

- **Reassuring data for safety profile of**
  - TC: grade B
  - MC (liposomal doxorubicin): grade C

- **Systematically discuss primary prophylaxis w/ GCSF**
  - Expert agreement