Plenary session 1
Advancement in the field of geriatric oncology
- Update in medical oncology -

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Central Finland Health Care District
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Thank you for your attention!
Choosing relevant endpoints for older breast cancer patients in clinical trials: an overview of all current clinical trials on breast cancer treatment

- [www.clinicaltrials.gov](http://www.clinicaltrials.gov)
  - Searched Nov 10, 2013
  - Phase II, III and IV, if randomized
  - Investigating end-points of BC treatment
  - Recruiting / starting to recruit
    - Excluding studies of unknown recruitment status, reconstructive surgery, adverse effects of BC therapy, diagnostic studies, ones with no updating after Jan 1, 2012
Choosing relevant endpoints for older breast cancer patients in clinical trials: an overview of all current clinical trials on breast cancer treatment

• Primary and secondary end-points included
  • STANDARD END-POINTS
    • OS, DFS, RR, toxicity, compliance, pharmacological parameters, biological outcome parameters, health care utilisation
  • PATIENT-RELATED END-POINTS
    • QoL, functional status, cognitive functioning, cosmetic outcome
  • Study solely in older patients = lower age limit > 60 yrs
Choosing relevant endpoints for older breast cancer patients in clinical trials: an overview of all current clinical trials on breast cancer treatment

Fig. 1 Flow diagram of included trials from the clinical trial register
Choosing relevant endpoints for older breast cancer patients in clinical trials: an overview of all current clinical trials on breast cancer treatment

Only 9/463 (2 %) of all ongoing clinical trials on breast cancer treatment were specifically designed for older patients. 89 % of the studies excluded patients based on their PS
Efficacy of Targeted Therapy for Metastatic Renal Cell Carcinoma in the Elderly Patient Population

International mRCC Database Consortium

• 1381 mRCC patients treated with anti-VEGF targeted therapy from 12 centers

• 144 (10.4 %) ≥ 75 yrs (median 78; range 75 – 89)
• 1st line therapy
  • SUNITINIB = 98
  • SORAFENIB = 35
  • BEVACIZUMAB = 7
  • AZD2171 = 4 (cediranib - a pan-VEGF receptor TKI)

• Comparison between age groups ≥ 75 vs. < 75 in treatment efficacy
# Efficacy of Targeted Therapy for Metastatic Renal Cell Carcinoma in the Elderly Patient Population

### Patient Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Age, Years</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;75</td>
<td>≥75</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>73.42 (n = 906)</td>
<td>71.53 (n = 103)</td>
</tr>
<tr>
<td>Female</td>
<td>26.58 (n = 331)</td>
<td>28.47 (n = 41)</td>
</tr>
<tr>
<td>Heng Prognostic Category</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Favorable</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Intermediate</td>
<td>65</td>
<td>69</td>
</tr>
<tr>
<td>Poor</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td>Increased LDH (&gt;ULN)</td>
<td>30.59</td>
<td>30.36</td>
</tr>
<tr>
<td>Poor KPS (&lt;80)</td>
<td>28.07</td>
<td>32.35</td>
</tr>
<tr>
<td>Increased Ca (&gt;ULN)</td>
<td>11.29</td>
<td>12.4</td>
</tr>
<tr>
<td>Diagnosis to Treatment Interval (&gt;1 Year)</td>
<td>50.2</td>
<td>58.57</td>
</tr>
<tr>
<td>Increased Neutrophils (&gt;ULN)</td>
<td>15.68</td>
<td>12.12</td>
</tr>
<tr>
<td>Increased Platelet Count (&gt;ULN)</td>
<td>21.31</td>
<td>17.16</td>
</tr>
<tr>
<td>Low Hb (&lt;LLN)</td>
<td>54.75</td>
<td>61.76</td>
</tr>
<tr>
<td>Metastatic (&gt;1 Site)</td>
<td>76.13</td>
<td>70.92</td>
</tr>
<tr>
<td>Non-Clear Cell</td>
<td>10.26</td>
<td>10.69</td>
</tr>
<tr>
<td>Brain Metastases</td>
<td>8.73</td>
<td>2.84</td>
</tr>
<tr>
<td>Nephrectomy</td>
<td>79.68</td>
<td>70.92</td>
</tr>
<tr>
<td>Sarcomatoid</td>
<td>9.22</td>
<td>3.51</td>
</tr>
</tbody>
</table>

Data are presented as percentages. Numbers might not add up to total number of patients in each group because of missing data. Percentages might not add up to 100% because of rounding.

Abbreviations: Hb = hemoglobin; KPS = Kamofsky Performance Status; LDH = lactate dehydrogenase; LLN = lower limit of normal; ULN = upper limit of normal.
Efficacy of Targeted Therapy for Metastatic Renal Cell Carcinoma in the Elderly Patient Population

Conclusions:

- Groups similar with respect to outcome
- Advanced age alone should not preclude patients from targeted therapy

Efficacy of Targeted Therapy for Metastatic Renal Cell Carcinoma in the Elderly Patient Population

Receiving 2\textsuperscript{nd} line therapy

\begin{tabular}{|c|c|c|c|}
\hline
& \textless 75 yrs & \textgreater 75 yrs & \textbf{P} \\
\hline
\textbf{Sex} & \textbf{62.75} & \textbf{71.53} & \\
\textbf{Male} & 73.42 (n = 906) & 71.53 (n = 103) & \\
\textbf{Female} & 26.58 (n = 331) & 28.47 (n = 41) & \\
\hline
\textbf{Heng Prognostic Category} & \textbf{.1779} & \textbf{.891} & \\
\textbf{Favorable} & 9 & 4 & \\
\textbf{Intermediate} & 65 & 69 & \\
\textbf{Poor} & 26 & 27 & \\
\hline
\textbf{Increased LDH (>ULN)} & \textbf{30.99} & \textbf{30.36} & \\
\textbf{Poor KPS (<80)} & 28.07 & 32.35 & \textbf{.2954} \\
\textbf{Increased Ca (>ULN)} & 11.29 & 12.4 & \textbf{.7061} \\
\hline
\textbf{Diagnosis to Treatment Interval (>1 Year)} & \textbf{50.2} & \textbf{58.57} & \textbf{.0004} \\
\hline
\textbf{Increased Neutrophil (>ULN)} & 15.68 & 12.12 & \textbf{.2829} \\
\textbf{Increased Platelet Count (>ULN)} & 21.51 & 17.16 & \textbf{.264} \\
\textbf{Low Hb (<LLN)} & \textbf{54.75} & \textbf{61.76} & \textbf{.1191} \\
\textbf{Metastatic (>1 Site)} & \textbf{76.18} & \textbf{70.92} & \textbf{.4725} \\
\textbf{Non-Clear Cell} & 10.26 & 10.69 & \textbf{.8792} \\
\hline
\textbf{Brain Metastases} & 3.83 & 2.84 & \textbf{.0128} \\
\textbf{Nephrectomy} & 79.68 & 70.92 & \textbf{.0133} \\
\textbf{Sarcomatoid} & 9.22 & 3.51 & \textbf{.0004} \\
\hline
\end{tabular}

\begin{itemize}
\item Data are presented as percentages. Numbers might not add up to total number of patients in each group because of missing data. Percentages might not add up to 100\% because of rounding.
\item Abbreviations: Hb = hemoglobin; KPS = Karnofsky Performance Status; LDH = lactate dehydrogenase; LLN = lower limit of normal; ULN = upper limit of normal.
\end{itemize}

Management of prostate cancer in older patients: updated recommendations of a working group of the International Society of Geriatric Oncology

"The consensus of the task force is that older men with prostate cancer should be managed according to their individual health status, not according to age."
Management of prostate cancer in older patients: updated recommendations of a working group of the International Society of Geriatric Oncology

Early diagnosis of prostate cancer

"The screening policy in older men with prostate cancer is controversial."
Management of prostate cancer in older patients: updated recommendations of a working group of the International Society of Geriatric Oncology

"Most guidelines do not recommend routine PSA screening in men aged 70 years or older or in any man with a life expectancy of less than 10 years."

- **NO** guideline recommends **population based** prostate cancer PSA screening
  - Based on evidence from randomised trials

- PSA test taken from an asymptomatic man is not the same as screening
  - There is absolutely no scientific evidence to support individual testing

"Patients aged 70–79 years should be considered for methods that would enable early diagnosis of individualised prostate cancer. In patients aged 80–84 years, this approach should be applied to fit patients only."

- What are these methods?? PSA is not applicable! In randomised trials the 20% reduction in PC deaths in **population based screening** is limited to age group 50 – 69 yrs

- This result cannot be extrapolated neither to opportunistic PSA testing, nor to other age groups
ERSPC

<table>
<thead>
<tr>
<th>n (age, mean)</th>
<th>182 000 (60,2 yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>82 %</td>
</tr>
<tr>
<td>Follow-up time</td>
<td>13 years</td>
</tr>
<tr>
<td>Diagnosed cancers</td>
<td>7 408 vs. 6 107</td>
</tr>
<tr>
<td>/1000 person-yrs</td>
<td>9,55 vs. 6,23 (1,57 X)</td>
</tr>
<tr>
<td>Positive screening test</td>
<td>24.2 %</td>
</tr>
<tr>
<td>Incidence</td>
<td>8,1 % vs. 6,0 %</td>
</tr>
<tr>
<td>PC Mortality</td>
<td>355 vs. 545</td>
</tr>
<tr>
<td>/1000 person-yrs</td>
<td>0,43 vs. 0,54 (- 0,11)</td>
</tr>
<tr>
<td>Relative risk reduction</td>
<td>0,79 (0,69 - 0,91) p=0,001</td>
</tr>
<tr>
<td></td>
<td>= 21 %</td>
</tr>
</tbody>
</table>

"Overdiagnosis occurs in roughly 40 % of cases detected by screening resulting in a high risk of overtreatment with unavoidable side-effects, which is a major adverse consequence of prostate cancer screening."

www.thelancet.com Published online August 7, 2014
http://dx.doi.org/10.1016/S0140-6736(14)60525-0

-Especially in fit octogenarians, the risk of introducing more harm than good with PSA testing of asymptomatic men, increases dramatically!

-Primum est, nil nocere!
Thank you for your attention!