Ovarian Cancer in the Elderly: Further Considerations

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This article reviews the following: 21st Century Challenge of Ovarian Cancer in the Elderly: A Personal Perspective

Piver gives his perspective on the management of epithelial ovarian cancer in the elderly. This subject has been dealt with previously by numerous authors, with a general consensus that advancing age is an independent negative prognostic factor when multivariate statistics are applied to the multiple parameters affecting outcome. How much of the poor outcome is due to intrinsic biologic factors vs less aggressive surgical and medical therapy remains unclear. Piver’s manuscript deals primarily with the operative and medical management of ovarian cancer in the elderly. However, ample data suggest that age-related biologic differences exist.

In a retrospective analysis of more than 2,000 patients from four Gynecologic Oncology Group (GOG) studies performed prior to the taxane era, Thigpen showed that advanced age was an independent and negative prognostic factor that could not be overcome by more aggressive debulking surgery.[1] A similar retrospective study of primary therapy in the taxane era was reported by Winter and again showed advanced age to have a negative effect on outcome irrespective of residual tumor volume.[2] Conversely, a recent retrospective analysis from a single institution showed similar rates of clinical complete response, platinum sensitivity at 6 months, progression-free survival and overall survival for patients < 65 and > 65 years old.[3]

Proper Staging
The first part of Piver’s paper deals with the definition of elderly, and as the author notes, it is clear that ovarian cancer is primarily a disease of the elderly with a peak incidence in the 6th decade of life. Piver next reviews the history of surgical management of early disease, noting correctly that too many patients still have suboptimal staging in the hands of nongynecologic oncologists.

Over the past 3 decades, proper staging has produced an improvement in survival for stage I disease, which is more likely related to greater homogeneity in stage than to any real improvement in treatment of the disease. With proper staging there remains some doubt, however, as to the benefit of adjuvant chemotherapy. Conversely, recent data suggest that adjuvant therapy may benefit the apparent stage I patient who is incompletely staged and possibly a cryptic stage III patient.[4] What Piver fails to mention is that true early ovarian cancer is a rare entity accounting for approximately 20% of all presentations and is exceedingly more uncommon in the elderly patient. Almost always, then, management of ovarian cancer in the elderly is management of advanced disease.

Aggressive Management
Piver next turns his attention to the management of advanced disease in the elderly, suggesting that the poorer outcome is largely due to less aggressive surgical and medical therapy as well as existing comorbidities. However, the author omits entirely the major role likely played by biology, which may trump management issues in this population, as noted above. Further, aggressive debulking surgery in the elderly (particularly with bowel resection) has been associated with serious and often fatal complications when postoperative adjuvant therapy follows the procedure too closely. This was noted in a recently completed GOG study of five different combination regimens built around the paclitaxel/carboplatin backbone (GOG 182).

A significant amount of the literature is devoted to the use of intraperitoneal therapy. Piver notes that this type of therapy has not been adopted by many in the United States. Indeed, even fewer are using the technique in Europe, and even the biggest proponents of this therapy admit that for the
first year after therapy there is a significant decrement in quality of life. At the current time it would seem prudent to withhold aggressive intraperitoneal therapy from all but the most vigorous elderly patients.

**Comprehensive Geriatric Assessment**

Piver proposes a modification of the comprehensive geriatric assessment described by Balducci. This tool was originally used to differentiate elderly patients who could be treated with combination chemotherapy vs monotherapy vs symptom management only. Piver extends this tool to differentiate patients who would be candidates for standard (aggressive) debulking surgery, modified surgery, or only chemotherapy/symptom management. Although Piver does not define the modified surgery, one would assume it eliminates extensive retroperitoneal node dissection and aggressive upper abdominal debulking. Though this seems a reasonable approach to surgical management, no prospective study has defined the specifics of surgical management nor the outcomes for the three proposed groups.

**Neoadjuvant Chemotherapy**

In his review, Piver does not consider neoadjuvant chemotherapy, which is more popular in Europe than the United States. Elderly patients can tolerate standard intravenous chemotherapy and frequently have major tumor cytoreduction with this approach. Perhaps the patient with an excellent response to neoadjuvant chemotherapy would identify the best candidate for standard surgical management. A recently completed randomized study conducted by the European Organisation for Research and Treatment of Cancer (EORTC) compares standard debulking followed by chemotherapy vs neoadjuvant chemotherapy followed by surgery. Perhaps cohort analysis of the elderly patients in this study may shed additional light on how best to manage the elderly patient with advanced ovarian cancer.

**References:**


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