Tailoring Treatment in Elderly Patients

September 01, 2007
By Silvio Monfardini, MD [1] and Savina Maria Luciana Aversa, MD [2]

As noted in part 1 of this two-part article, non-Hodgkin's lymphoma is one of a few malignancies that have been increasing in incidence over the past several decades. Likewise, these disorders are more common in elderly patients, with a median age of occurrence of 65 years. Therapy in elderly patients may be affected by multiple factors, especially attendant comorbidities. The approaches to management of these patients, with either indolent or aggressive disease processes, have been based on prospective clinical trial results, many of which have included a younger patient population. Fortunately over the past decade, results of treatment trials that have targeted an older patient population have emerged. The disease incidence and treatment approaches for both follicular (part 1) and diffuse aggressive (part 2) histologies in elderly patients are reviewed, as well as the impact of aging on the care of these patients.

We have several comments regarding the paper titled, "Non-Hodgkin's Lymphoma in the Elderly," by Vicki A. Morrison. To begin with, the author reports various factors that affect the care of older cancer patients (Table 1 in part 1, August ONCOLOGY, page 1105), but she doesn't mention the possibility of using a multidimensional geriatric assessment (MGA).[1,2] In our practice, the MGA has emerged as a mandatory evaluation for guiding the elderly patient's therapeutic program. This assessment identifies the patient's problems on the basis of validated scales, such as the Activities of Daily Living (ADL) scale, the Cumulative Illness Rating Scale (CIRS), the Geriatric Depression Scale (GDS), the Mini-Mental Status Examination (MME), and on the presence of one or more geriatric syndromes. Dr. Morrison carefully reports on several studies demonstrating that the definition of elderly is variable (60, 65, or 70 years), making it difficult to clearly evaluate these trials. In fact, the criteria of inclusion for these trials were based on performance status or an empirical clinical judgment that assesses elderly individuals as patients who can be treated in the same way as younger adults (for example, able to tolerate a full-dose doxorubicin-based regimen), patients who are to be treated with an adapted approach, and patients who are too old (or with too many age-associated conditions) to be offered any treatment other than palliation or attenuated chemotherapy. From this perspective, the majority of elderly non-Hodgkin's lymphoma patients included in the trials are of the first group (ie, treated similarly to the younger patients).

'Frail' Elderly
Although approximately one-third of all cases of non-Hodgkin's lymphoma occur in patients older than 75 to 80 years of age, very few data are available concerning optimal treatment in this age group or in patients defined by geriatricians as "frail." Only one report has been published on frail patients with NHL.[3] The criteria used to define a patient as frail in this study were (1) age > 80 years, or (2) age > 70 years plus three or more comorbidities of grade 3 or at least one comorbidity of grade 4 according to the CIRS, or (3) dependence in one or more ADLs, or (4) the presence of one or more geriatric syndromes. Treatment consisted of vinorelbine at 25 mg/m² IV on days 1 and 8 and oral prednisone at a 30-mg total dose on days 1 to 8. The cycle was repeated after a 3-week interval. With this nontoxic combination regimen, only 3 (10%) of 30 patients achieved a complete remission, and these patients were considered frail because of advanced age only. Nine other patients (30%) achieved a partial remission, obtaining a transient palliation. Enrollment of frail patients in this study was difficult, but we showed that it is possible to perform a clinical study in such a population.

Looking Ahead
The next trials should be designed with consideration of the MGA to allow a more precise division of elderly patients into prognostic categories (fit, vulnerable, and frail) and to tailor the treatment so that fit elderly patients are not excluded from curable chemotherapy. Vulnerable or frail patients could receive palliation for this chemosensitive disease with nontoxic antineoplastic drugs. Nonpegylated and pegylated liposomal doxorubicin (Doxil), with reduced toxicity profiles, and rituximab (Rituxan), with only mild or moderate side effects, should be evaluated alone or in...
combination with other agents in the treatment of vulnerable or frail patients. However, other agents such as interferon or a radioimmunoconjugate should not be used in the elderly—the first because of nonhematologic toxicity (fever, asthenia, depression), the second because of myelosuppression, which may be delayed and prolonged.

Savina Maria Luciana Aversa, MD

Disclosures: The authors have no significant financial interest or other relationship with the manufacturers of any products or providers of any service mentioned in this article.

References:


Source URL: http://www.physicianspractice.com/articles/tailoring-treatment-elderly-patients

Links: