Réseau de Cancérologie d'Aquitaine

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Réseau d'Oncologie - Hématologie du Limousin

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UCOG Limousin

Unité de Coordination en Onco-Gériatrie Poitou-Charentes

1ère rencontre d'oncogériatrie en Nouvelle-Aquitaine

Vendredi 16 mars 2018 de 9h30 à 16h

ANGOULEME

B BRAUN SHARING EXPERTISE

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PRISE EN CHARGE CHIRURGICALE DES CANCERS GYNECOLOGIQUES DU SUJET AGE

Dr Cédric Nadeau
Chirurgien gynécologue (CHU de Poitiers)

Angoulême, le 16 mars 2018

1ère Rencontre d'Oncogériatrie Nouvelle Aquitaine

- Agée ou fragile?
- Quels objectifs?
- Quels moyens?
- Quelles limites?

- Toute la problématique tient là.
- Méthode chirurgicale et médecine

Agées?

Age civique vs physiologique

Notion de fragilité

Capacité à recevoir un traitement a visée curatrice

Pertinence d’un tel traitement

Choisir l'objectif avec la patiente et sa famille

- N'oublions pas: 85 ans, aucune donnée de survie dans les essais (c'est pas faisable!!)
- Où et comment vie la patiente
- Quel est son entourage
- Que veut-elle: qu'accepte-t-elle de subir comme traitement? Ou que ne veut-elle surtout pas subir ou vivre?
- Est elle curable?
- Est-elle opérable techniquement?
- Est-elle capable de recevoir de la chimiothérapie ou de la radiothérapie?

Geste chirurgical

- La chirurgie n'a d'intérêt que si elle apporte un soulagement durable ou participe à une chance de guérison
- Parfois extensive pour être complète
- Limite physiologique en termes de tolérance
  - Bas débit per opératoire
  - Dénutrition et comorbidités
  - Sarcopénie
- Vont à l'encontre d'une récupération rapide et complète

Geste chirurgical

- Nécessité d'une évaluation pré opératoire précise pour déterminer et dépister les fragilités qui sont le seul frein technique à la prise en charge
- Comorbidités
- Si possible intervention gériatrique correctrice pré opératoire
- Scores de dépistage:
  - FOG: validé pour population au-delà de 75 ans
  - G8: validé pour population au-delà de 70 ans

Chimiothérapie

- Inutile d'opérer si on ne fait pas de chimiothérapie ou de radiothérapie alors qu'ils sont nécessaires au contrôle de la maladie en intention curatrice
- Quel programme adjuvant (ou néo adjuvant)
- Intérêt +++ de la discussion en RCP pré opératoire avec un avis gériatrique et un plan d'intervention programmé par les gériatres
- Etude EWOC-1: ovaire chimio adjuvante
  - Patientes fragiles, comparait 3 schémas
  - Pas encore publiée

Réhabilitation

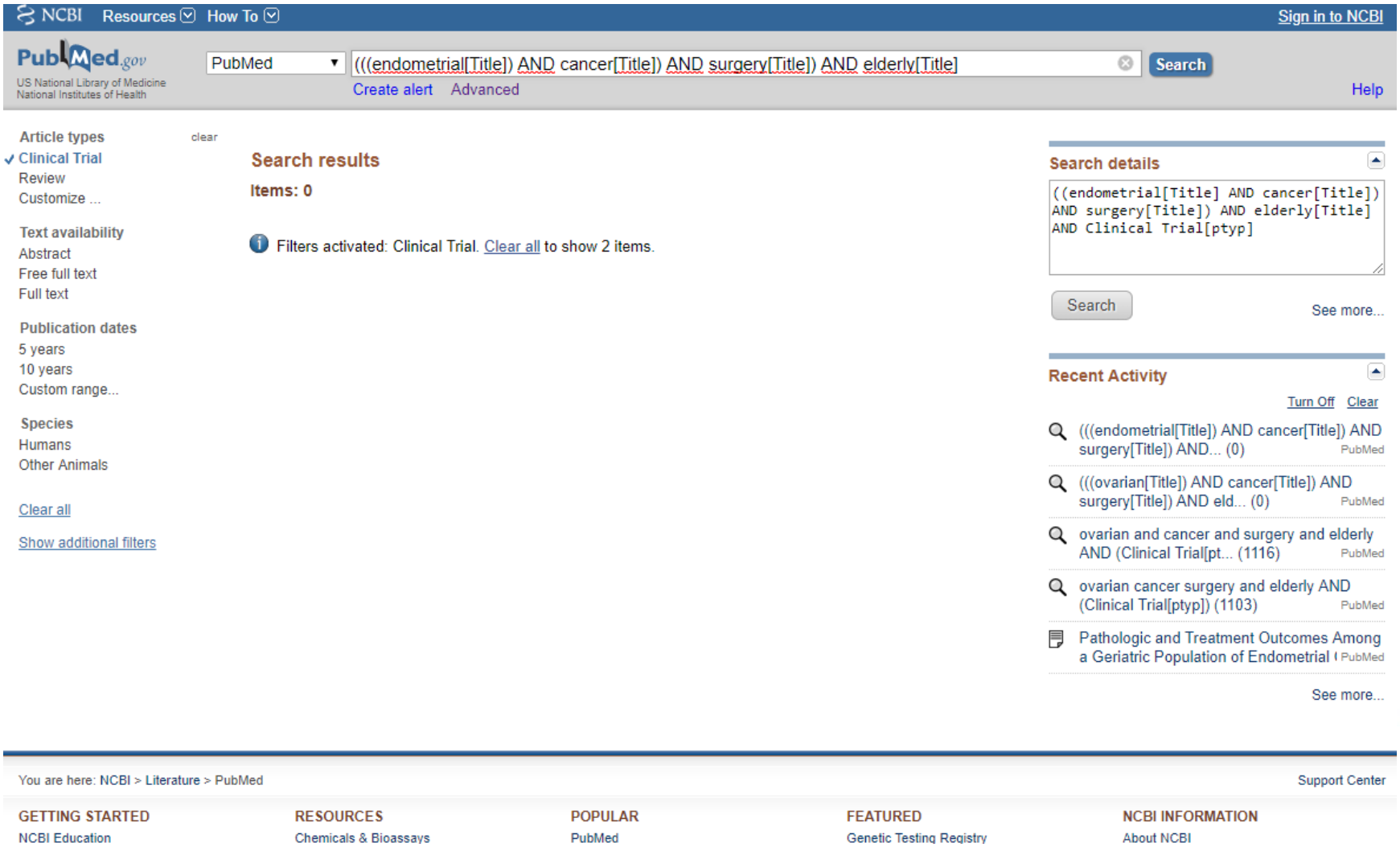
- Patientes nécessitant une mobilisation active en termes de réhabilitation
  - Kiné pré et post opératoire pour la prévention des complications pulmonaires, la reverticalisation
- Nutrition: vigilance en péri opératoire
- Sortie de l'hôpital: dépendance transitoire: organiser en amont si possible les SSR, EHPAD et autres soutiens à domicile

- **Travaux pour chercher à dépister le risque chirurgical notamment dans l'ovaire**
  - A preoperative personalized risk assessment calculator for **elderly ovarian cancer** patients undergoing primary cytoreductive **surgery**.Barber EL et al. Gynecol Oncol. (2015)

Problème

de la définition de l'âge: certains essais classent elderly à partir de 60 ans…

de la description de cette population spécifique dans les stratégies thérapeutiques, quant à la chirurgie…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Int J Gynecol Cancer. 2015 Nov;25(9):1652-5. doi: 10.1097/IGC.0000000000000545.

Endometrial Cancer Surgery for Elderly Women--The Early Postoperative Period.

Peled Y[1], Aviram A, Perlman P, Krissi H, Ben-Haroush A, Levavi H, Sabah G, Eitan R.

Author information

Abstract

OBJECTIVE: The aim of this study was to examine the early postoperative period and assess whether elderly patients recuperate differently than do their younger counterparts after surgery for endometrial cancer.

METHODS: This retrospective chart review comprised all women older than 75 years who underwent laparotomy for endometrial cancer staging at our center from January 2005 through December 2010 and a consecutive control group of women younger than 74 years. Parameters included demographic variables, surgical procedure/findings, postoperative morbidity, and pathology.

RESULTS: Ninety patients older than 75 years and 88 younger patients were identified. The elderly patients had a statistically significant prolonged wait for bowel movement (5.9 vs 3.1 days, P = 0.002) and ambulated later (4.1 vs 1.1 days, P < 0.001). Postoperative hospital stay was similar in both groups (5.8 vs 4.2 days, P = 0.37). Early postoperative complications (fever, bowel, wound, eventration, cardiopulmonary) occurred at a similar rate in both groups.

CONCLUSIONS: Elderly patients after laparotomy for endometrial cancer staging ambulated later and recovered bowel function later than did the younger patients. This did not translate into prolonged hospital stay or excessive complications. Earlier intervention with physical therapy and stool softeners can possibly close this gap in recovery.

PMID: 26332393 DOI: 10.1097/IGC.0000000000000545

[Indexed for MEDLINE]

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Surgical management of early-stage endometrial cancer in the elderly: is lap [Gynecol Oncol. 2001]

Comparative outcomes in older and younger women undergoing [Am J Obstet Gynecol. 2016]

Comparative Surgical Outcomes for Endometrial Cancer Patients 65 Years [Ann Surg Oncol. 2015]

Review Endometrial cancer in elderly women: Which disease, which st [Eur J Surg Oncol. 2016]

Review Laparoscopy versus laparotomy for the managemer [Cochrane Database Syst Rev. 2012]

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Gynecol Oncol. 2008 Oct;111(1):35-40. doi: 10.1016/j.ygyno.2008.06.026. Epub 2008 Aug 15.

The impact of surgery on survival of elderly women with endometrial cancer in the SEER program from 1992-2002.

Ahmed A[1], Zamba G, DeGeest K, Lynch CF.

Author information

Abstract

OBJECTIVES: Few population-based studies have evaluated surgical treatment and outcomes in elderly patients with endometrial cancer. The National Cancer Institute's SEER, Surveillance, Epidemiology and End Results, Program provides a database to examine this issue. The objective of this study was to determine the extent to which elderly women with endometrial cancer receive surgical treatment and to evaluate the impact of surgery on survival.

METHODS: Data were obtained from the SEER registries for expanded races from 1992-2002. The inclusion criteria were women ages 50 to 95 with pathologically confirmed endometrial cancer. Cases with multiple primaries were excluded. The data were examined with respect to histology, radiotherapy use, extent of surgery and FIGO stage. The survival data were analyzed using a Cox proportional hazard model. Chi-squared tests were used to examine the extent to which elderly women with endometrial cancer receive surgical treatment, hysterectomy at minimum. Endometrial cancer-specific mortality was analyzed.

RESULTS: 27,517 women were analyzed with 94% of the cohort receiving surgical treatments. There is a significant trend that suggests elderly women, aged 65+ years at time of endometrial cancer diagnosis, received surgical treatment less often than younger women (p<0.001). The age-adjusted hazard of death was reduced with surgical intervention. After adjustment for stage at diagnosis, histology, and radiotherapy, the hazard ratios for endometrial cancer-specific mortality were decreased when surgery was undertaken.

CONCLUSIONS: In this population-based study, the poor prognosis associated with advanced age may be in part associated with the decreased frequency of surgical treatment. The reasons need to be further investigated. Continued efforts should be directed at providing surgical treatment for elderly patients with endometrial cancer.

PMID: 18707756 DOI: 10.1016/j.ygyno.2008.06.026

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The prognostic significance of age in surgically staged patients with Type I [Gynecol Oncol. 2012]

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Associations between etiologic factors and mortality after endometrial [Gynecol Oncol. 2015]

Int J Gynecol Cancer. 2017 May;27(4):730-737. doi: 10.1097/IGC.0000000000000947.

Pathologic and Treatment Outcomes Among a Geriatric Population of Endometrial CancerPatients: An NRG Oncology/Gynecologic Oncology Group Ancillary Data Analysis of LAP2.

Bishop EA[1], Java JJ, Moore KN, Walker JL.

Author information

Abstract

OBJECTIVES:

Elderly endometrial cancer patients have worse disease-specific survival than their younger counterparts, but the cause for this discrepancy is unknown. The goal of this analysis is to compare outcomes by age in a fully staged elderly endometrial cancer population.

METHODS/MATERIALS:

This is an analysis of patients on Gynecologic Oncology Group Study (GOG) LAP2, which included clinically early stage endometrial cancer patients randomized to laparotomy versus laparoscopy for surgical staging. Patients were divided into risk groups based on criteria defined by GOG protocol 99. Differences in outcomes and adjuvant therapy were assessed within these risk groups.

RESULTS:

LAP2 included 715 patients 70 years or older. With increasing age, worse tumor characteristics were seen. Older patients received similar rates of adjuvant therapy when stratified by stage. Patients 70 years or older had significantly worse progression-free survival and overall survival, and on multivariate analysis, older age and high-risk uterine factors were predictors of progression-free survival and overall survival, whereas stage and lymph node metastases were not. When patients were divided into GOG protocol 99 risk categories, most of those who met the high-intermediate risk criteria did so based on age above 70 years and grade 2 to 3 disease. These patients had low risk of recurrence (3.3%) compared with those who met the criteria by age above 70 years and all 3 uterine factors (20.9%).

CONCLUSIONS:

In early stage endometrial cancer, patients 70 years or older who undergo similar surgical management and adjuvant therapy, age and tumor characteristics independently predict recurrence. Most patients older than 70 years meet the high-intermediate risk criteria for recurrence based on age and 1 other uterine risk factor, and our results suggest that these patients are at low risk for recurrence.


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Eur J Surg Oncol. 2011 Jun;37(6):537-42. doi: 10.1016/j.ejso.2011.03.136. Epub 2011 Apr 21.

Ovarian cancer in the elderly: impact of surgery on morbidity and survival.

Chéreau E[1], Ballester M, Selle F, Rouzier R, Daraï E.

Author information

Abstract

BACKGROUND: Elderly ovarian cancer patients often undergo non-optimal surgery due to their age despite of the high risk of recurrence. The aim of this study was to determine if more postoperative complications occurred in patients over 70 years and to compare extent of surgery with younger patients.

MATERIALS AND METHODS: Between 2001 and 2009, 172 patients with ovarian cancer were included. We compared patient characteristics, surgical course, postoperative complications and outcome for patients under and over 70 years.

RESULTS: 143 patients were under 70 years and 29 over. There were no difference between the two groups for tumors characteristics, time of surgery, FIGO stage, standard surgical procedures and rate of optimal resection. Patients over 70 years had less peritoneal surgery ($p < 0.001$) especially diaphragmatic surgery ($p = 0.006$), pelvic ($p = 0.02$) and para-aortic ($p = 0.003$) lymphadenectomy. There was no difference in the occurrence of per- or post-operative complications and patients over 70 years had shorter duration of hospitalization ($p = 0.04$). There was no difference between the two groups for disease-free survival (DFS) ($p = 0.08$) but overall survival (OS) was better in patients under 70 years ($p = 0.002$).

CONCLUSION: Elderly ovarian cancer patients undergo less extensive surgery and have lower OS despite similar postoperative morbidity, optimal resection and DFS. OS decrease could be explained by difference in the management of recurrences.

PMID: 21511424 DOI: 10.1016/j.ejso.2011.03.136

[Indexed for MEDLINE]

MeSH terms

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Int J Gynecol Cancer. 2010 Jan;20(1):34-40. doi: 10.1111/IGC.0b013e3181c10c04.

Primary radical surgery in elderly patients with epithelial ovarian cancer: analysis of surgical outcome and long-term survival.

Fotopoulou C[1], Savvatis K, Steinhagen-Thiessen E, Bahra M, Lichtenegger W, Sehouli J.

Author information

Abstract

OBJECTIVE: Geriatric population life expectancy is increasing and so is the incidence of epithelial ovarian cancer (EOC) in elderly women. The aim of our study was to determine the impact of radical cytoreductive surgery, the cornerstone of clinical management in primary EOC, in this population with special regard to the associated morbidity.

METHODS: Through a pooled data analysis, cancer-related patient characteristics, intraoperative tumor pattern, and surgical and clinical outcomes were evaluated according to a validated documentation data collection tool. Kaplan-Meier curves were calculated for overall survival (OS). The Cox regression analysis was performed to identify independent predictors of mortality.

RESULTS: One hundred one EOC patients older than 69 years (mean [SD] age, 75.54 [4.49] years) were evaluated. The mean (SD) follow-up period was 22.63 (22.92) months. Advanced International Federation of Gynecology and Obstetrics stage III (60.4%) was the most common tumor stage. A complete tumor resection was achieved in 45 patients (44.6%) with an associated complication rate of 40.6%. The postoperative mortality was 6%. The mean OS was 47.29 months (95% confidence interval, 36.24-58.34). The multivariate analysis identified age older than 75 years, incomplete tumor resection, and absence of adjuvant chemotherapy to negatively affect OS.

CONCLUSIONS: Radical surgery for primary EOC obtaining complete tumor resection is associated with a significantly prolonged OS in elderly patients (> or =70 years). The increased postoperative morbidity must be considered, underlining the high requirement for special interdisciplinary postoperative management in this special collective.

PMID: 20130501 DOI: 10.1111/IGC.0b013e3181c10c04

[Indexed for MEDLINE]

PROADAPT-ovaire / EWOC-2

70 years old
Stage III-IV ovarian cancer
Initial diagnosis

Planed primary or interval surgery

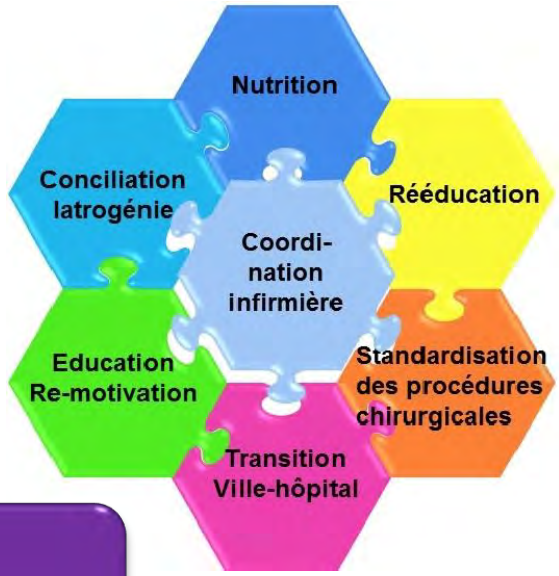
Non vulnerable patients (GVS < 3)

R

n=292

Common care

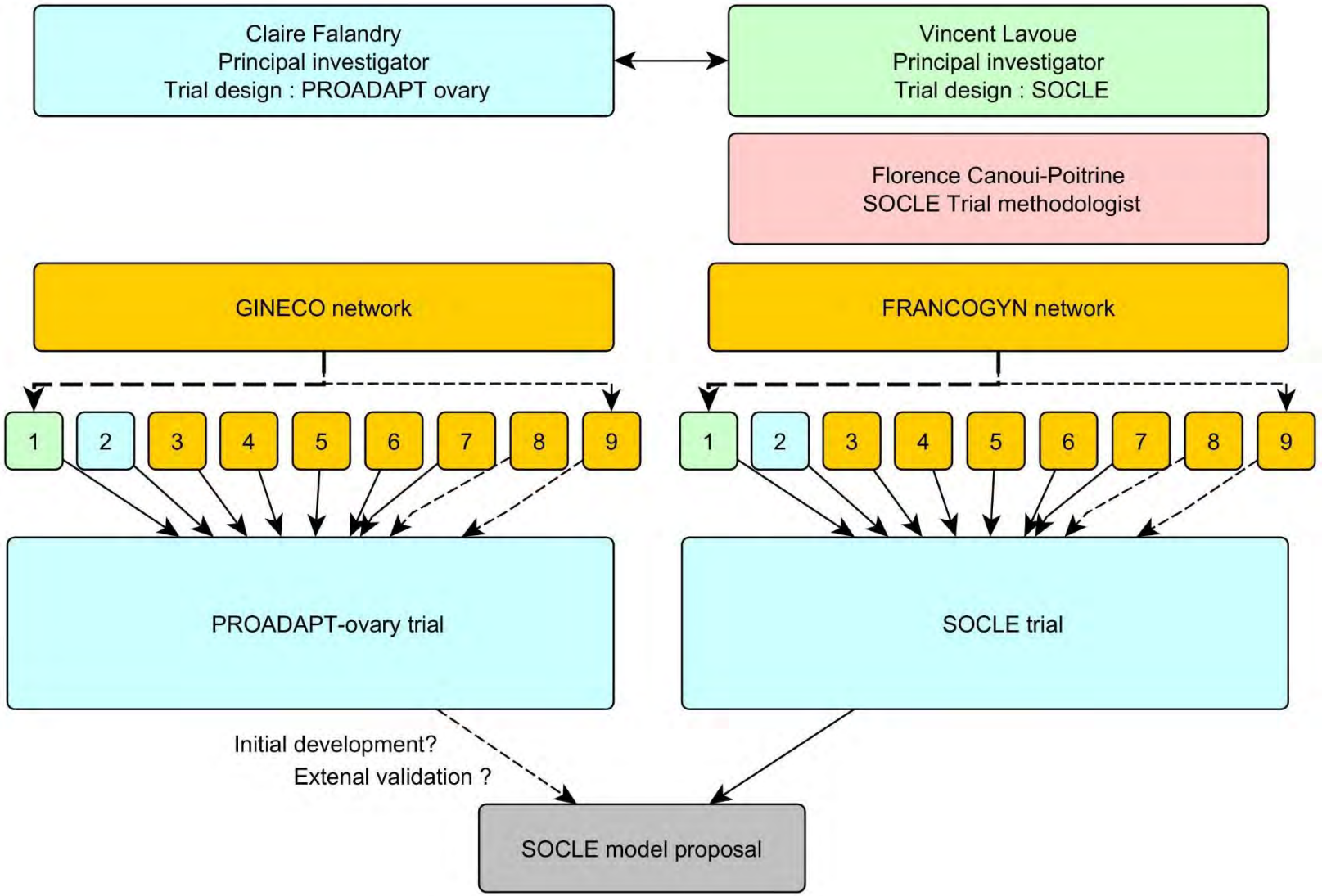
Multidomain standardized intervention



Perspective 1

- **Collaboration GINECO-chir/FRANCOGYN**
  - **PHRC-K 2017 porté par Vincent Lavoué : SOCLE-01**

    Création d'un score simplifié prédictif de complications majeures chez les patientes âgées opérées pour un cancer de l'endomètre à haut risque ou avancé ou un cancer de l'ovaire.


Claire Falandry
Principal investigator
Trial design : PROADAPT ovary
Vincent Lavoue
Principal investigator
Trial design : SOCLE
Florence Canoui-Poitrine
SOCLE Trial methodologist
GINECO network
FRANCOGYN network
1
2
3
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PROADAPT-ovary trial
SOCLE trial
Initial development?
Extenal validation ?
SOCLE model proposal

Au final

- La chirurgie doit être la même quelque soit l'âge
- Seules les comorbidités et les fragilités liées à l'âge doivent les moduler
- Discussion pluridisciplinaire pré thérapeutique +++
- Et avant tout avec la patiente

1ère Rencontre d'Oncogériatrie Nouvelle Aquitaine

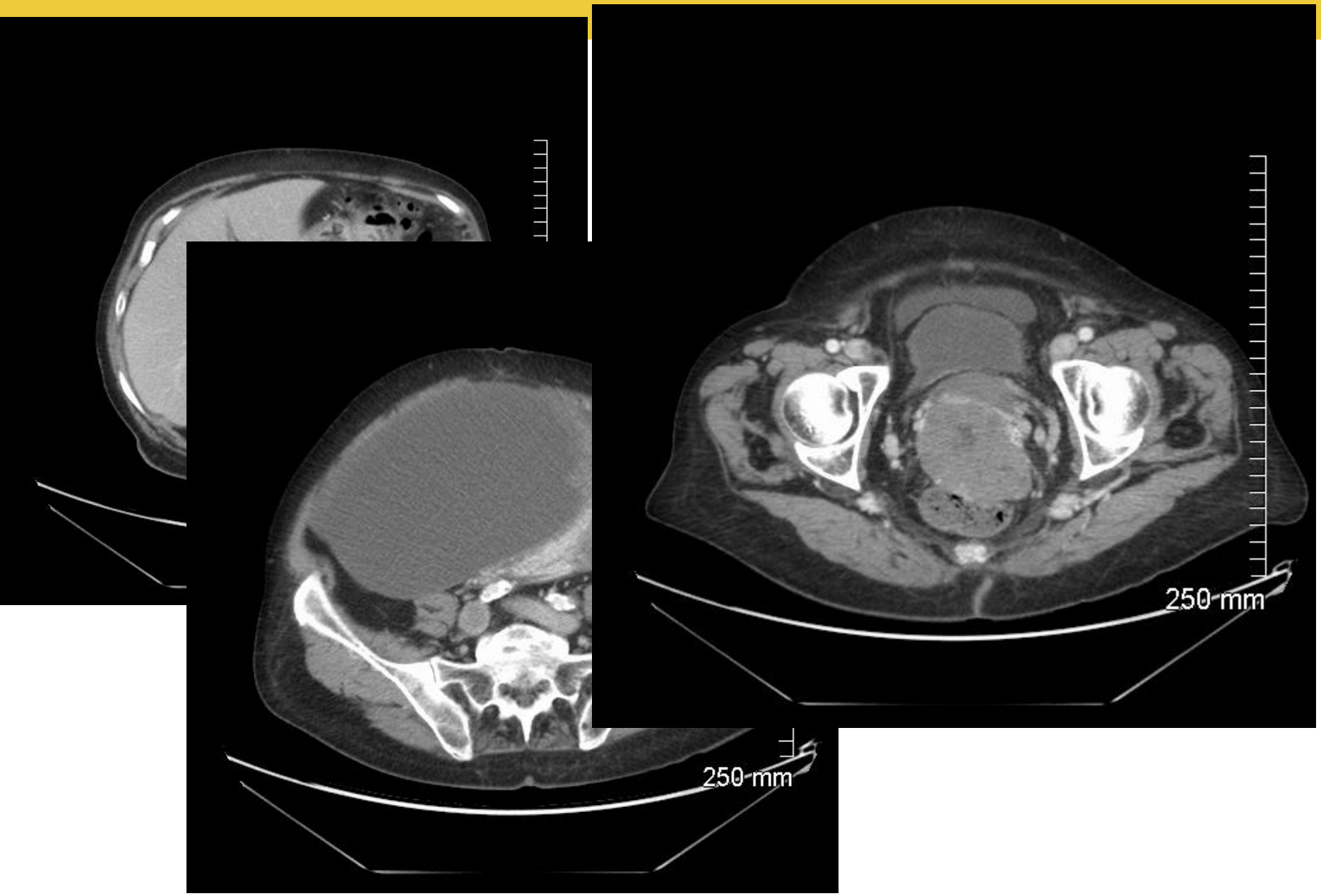
- 80 ans
- 2 phlébites octobre et décembre 2012
- Mange moins: -15 kg en quelques mois (depuis l'été 2012)
- Par ailleurs HTA, active et autonome, famille nombreuse et très présente
- Masse abdomino pelvienne avec ulcération de la partie postérieure haute du vagin

Angoulême, le 16 mars 2018

1ère Rencontre d'Oncogériatrie Nouvelle Aquitaine

- Biopsie par voie vaginale de l'ulcération:
  - Images de carcinome peu différencié compatible avec une tumeur de type carcinome à cellules transitionnelles non Brenner dans l'hypothèse d'une origine ovarienne primitive
- TDM: volumineuse masse kystique et solide ovarienne droite de 27 cm de grand axe, masse du douglas solide de 6cm, « adénopathies » centimétriques latéro aortiques, ascite modérée, macrocarcinose omentale?
- Biologie: albuminémie à 32g/L, créat à 64µM, CA125 à 2639 UI/L

1ère Rencontre d'Oncogériatrie Nouvelle Aquitaine



1ère Rencontre d'Oncogériatrie Nouvelle Aquitaine

- J'appelle l'oncologue….
- J'appelle l'oncogériatre car score FOG à 2 (aide pour les courses et perte de poids > 10% avec alb < 35)
- L'oncogériatre après bilan complet me dit: renutrition et par la suite OK PEC active car très bon état général
- L'oncologue me dit: OK pour un petit carbo taxol hebdo…

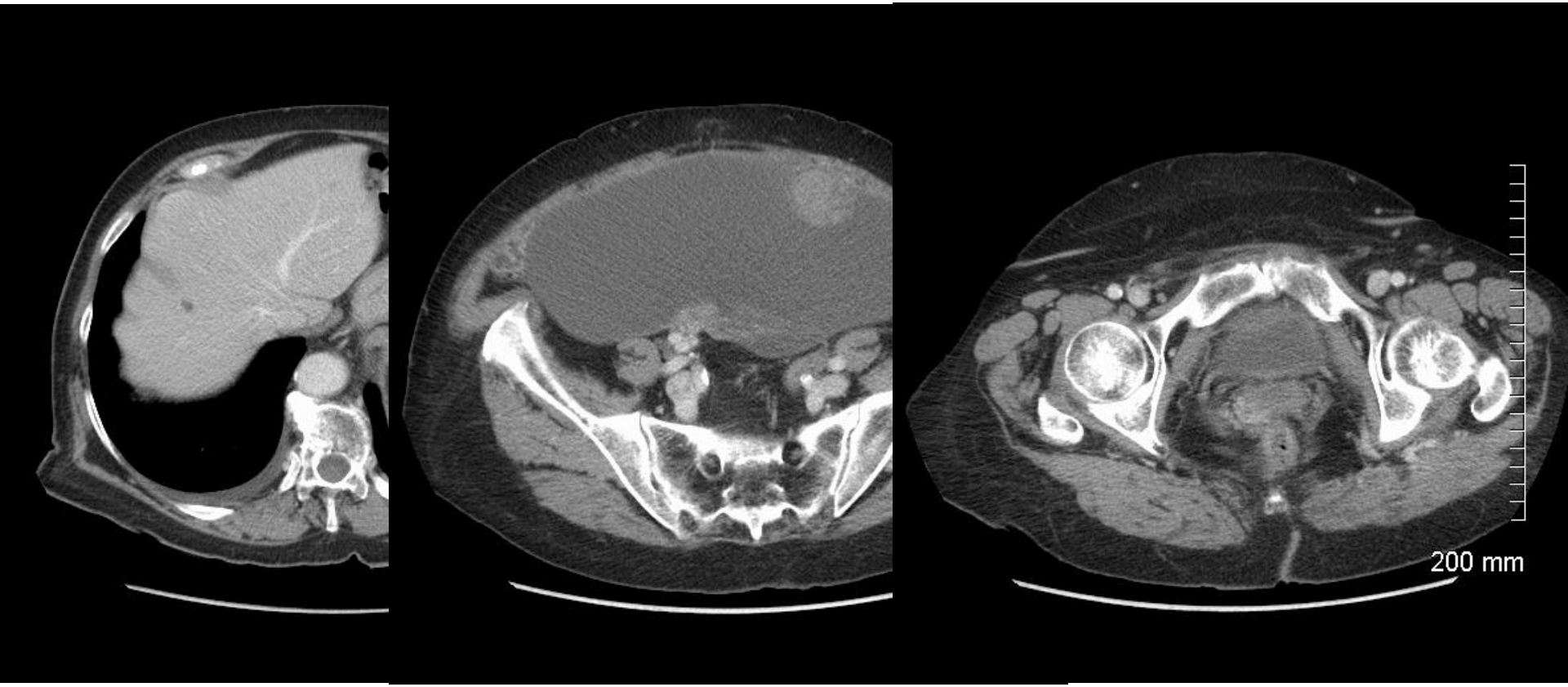
1ère Rencontre d'Oncogériatrie Nouvelle Aquitaine

- Vu le contexte: décision de chimiothérapie Néo adjuvante à doses adaptées par Carbo-Taxol Hebdomadaire
- 6 cycles sans problème!
- Réponse clinique :
  - Disparition de l'ulcération du vagin, rectum libre
  - Garde sa grosse masse kystique, pas de carcinose palpable et a repris 6 Kg
  - TDM: idem sauf masse du douglas qui a disparu, omentum RAS comme le reste du ventre

- Le marqueur est abaissé mais stable à 254 UI/L depuis plusieurs cycles

1ère Rencontre d'Oncogériatrie Nouvelle Aquitaine

- Sur le scanner et l'examen clinique:
  - Toujours la grosse boule, plus d'ulcération du vagin…



1ère Rencontre d'Oncogériatrie Nouvelle Aquitaine

- Après information, la patiente choisit d'être opérée sur mes conseils: objectif évaluation de la situation et annexectomie au minimum (enlever la tumeur de 27 cm…), résection optimale si pas d'association de gestes à haute morbidité nécessaire, sinon stop.
- Laparotomie sous et sus ombilicale sans être xypho pubienne toutefois le 24/09/2013

Chirurgie des cancers avancés de l'ovaire de la femme agée.

- HTNC et résection rectale atypique antérieure avec colpectomie postéro-supérieure en un bloc emportant la zone fibrosée correspondant à la tumeur du Douglas, omentectomie totale, tour du ventre: RAS, pas de curage
- Suites simples, sortie J7 à domicile avec aides familiales
- Aujourd'hui à 4,5 ans toujours pas de signe de rechute

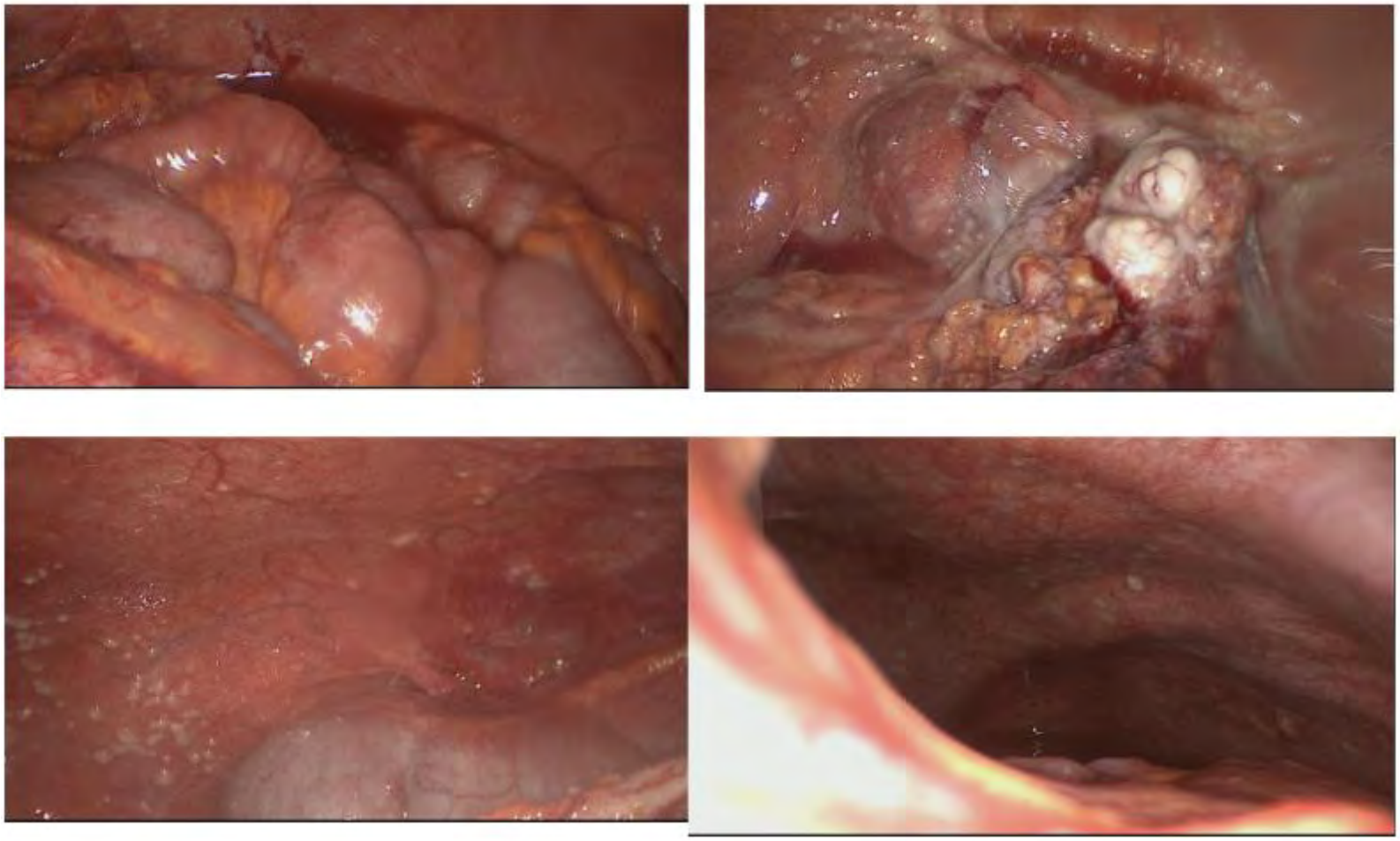
1ère Rencontre d'Oncogériatrie Nouvelle Aquitaine

- Yvette, 79 ans
- Diabète de type 2 insulino traité, AC/FA, HTA, hypothyroidie, multiples laparotomies (vésicule, prolapsus etc…)
- Préviscan, amlodipine, bisoprolol, lévothyrox, rosuvastatine, trandolapril, lantus
- 55 Kg pour 1,50m
- Ascite depuis plusieurs mois, traitée par ponctions itératives en gastro
- FOG 2/5

Chirurgie des cancers avancés de l'ovaire de la femme agée.

- Tonique, bonne impression générale, veut un traitement, mais fatiguée, ne mange presque plus
- Coelioscopie de bilan: PCI à 13, 4 régions non explorables, toutes régions visibles atteintes, pas possible de prendre une annexe, biopsie de carcinose
- Histo: séreux de haut grade
- Fièvre post opératoire, iléus, traitement médical
- Albuminémie à 23g/L, plaquettes 476000, créatininémie normale
- Prise en charge diététique avec renutrition entérale car encore capable de manger (un peu)

1ère Rencontre d'Oncogériatrie Nouvelle Aquitaine



1ère Rencontre d'Oncogériatrie Nouvelle Aquitaine

- RCP: proposition chimio première et selon évolution +/- chirurgie
- 3 cycles sans encombre, marqueur normalisé
- Cytoréduction CC0 (omentectomie totale, Hudson protégé par iléo rétablie à J15, péritonectomie pelvienne totale, pas de curage) suites simples
- Histologie: carcinosarcome ovarien
- 3 cycles de carboplatine + taxol hebdo très bien tolérés finis en janvier

- Avril suivant: vue en urgence pour insuffisance rénale aigue obstructive sur repousse tumorale pelvienne
- Décès quelques jours après

Chirurgie des cancers de la femme âgée.

- Évaluation pré thérapeutique est la clé
- FOG et G8
- Si l'opérabilité est évidente d'emblée: il faut le faire
- Dans le cas contraire discussion +++ en RCP et avec la patiente pour définir un objectif

Chirurgie des cancers de la femme âgée.

- Et bien d'autres situations ou la clé est la concertation pluridisciplinaire oncogériatrique…
- http://94.125.162.115/arcagy-organisation-et-recherche/index.php?id=1105