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Colorectal Cancer down Staging in Geriatric Oncology

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Abstract

Colorectal cancer presentations are often seen with an isolated metastatic spread to the liver. These lesions may be amenable to surgical resection through hemihepatectomy or hepatic metastasectomy and in the skilled hands of a hepatobiliary surgeon, achieve down staging. This becomes a curative management for such patients. While there is evidence through surgical trials in younger patients, geriatric population has not been studied. It is only recently that patients of advanced age are being offered more complex management plans in cancer care. A case of Mr AC, who at the age of 86 years, presents with colorectal cancer and 3 FDG avid liver metastases on PET scan. Despite a number of comorbidities including CABG in 1995, he undergoes right laparoscopic hemicolectomy in April 2014. After discussions with colorectal and hepato-biliary surgical teams, he is offered quasi-neoadjuvant chemotherapy with modified FOLFOX in order to undergo right hemi-hepatectomy. This is followed by adjuvant chemotherapy with CAPIRI. Patient has been on active surveillance since, with no recurrence of his malignancy. He leads an active life playing competitive Bocce, and has been to Italy twice to visit his family.

Keywords: chemotherapy; Colorectal cancer; PET scan

Introduction

This case demonstrates that in selected cases, with fit geriatric patients and multidisciplinary care provision, colorectal down staging with surgical procedures to the liver may provide the patient a potential cure of their malignancy. Colorectal cancer (CRC) is one of the most common cancers worldwide, and its incidence is increasing. The choice of treatment is based on several factors, including stage at presentation, location, and the conditions of the patient. Current treatment in general for CRC includes surgery for CRC stage I or II; surgery followed by adjuvant chemotherapy for stage III colon cancer; and in cases of metastatic CRC (mCRC), systemic chemotherapy alone or in combination with targeted biologics. mCRC requires multidisciplinary management, where surgical resection of metastatic disease is considered wherever possible. The treatment of rectal cancer includes surgery alone in stage I or short-course radiotherapy or chemoradiotherapy with surgical resection followed by adjuvant chemotherapy in selected stage II and III patients. Approximately 60% of CRC patients are > 70 years of age at the time of diagnosis, and 43% are > 75. These proportions will likely continue to increase in the near future. Many of these older patients will have problems of frailty and comorbidity that demand careful patient assessment, and, if necessary, individualized treatment approaches. Aging may be defined as a progressive decline in the functional reserve of multiple organ systems. This process is highly individualized, and poorly reflected in chronological age. The treatment of cancer should be based on the assessment of the physiological age, the patient's life expectancy, and tolerance to treatment [4]. Older patients risk being undertreated, and, therefore, presenting a worse oncologic outcome. If they are over treated, however, there is an increased risk of morbidity and mortality. The challenge in this group of patients comes from the physiological heterogeneity of the older patient population, with frequent discrepancies between physiological and chronological age, coupled with the of coexisting medical conditions and psychological and social care issues. The treatment of those at the upper extreme of life often presents significant clinical dilemmas. A critical appraisal is needed of the costs and benefits of treatment, and a better selection of patients who can benefit from available therapies is warranted. There is a paucity of controlled trials including this group of patients, and, therefore, evidence-based decision-making is difficult. Many elderly patients will benefit from radical treatment approaches, but others will not, and in some cases, non-operative "palliative" management should be offered, even though the cancer is "curable".

This review aims to focus on the existing evidence to aid in the decision-making process for treatment of CRC in elderly patients. Go to: GERIATRIC ASSESSMENT The patient's biological age should ideally be established through a comprehensive geriatric assessment in order to aid therapeutic decisions. There is a paucity of clinical trial data in these patients who, in many cases, have poor functional reserves, major comorbidities, and frailty. In older patients, functional levels vary widely- from robust and able to tolerate cancer treatments to frail and unable to tolerate even minor interventions without life-threatening consequences. At either end of this spectrum, treatment decisions are clear, but the identification of individuals at risk for functional decline and frailty, where interventions or treatment

modifications are needed, is where geriatrics could have the biggest impact on oncology. By distinguishing the fit from the vulnerable older patients, treatment can be adjusted to maximize its effectiveness, avoid complications, and better meet the individual requirements of the older patient. When choosing between various treatment options, quality of life and function may be at least as important for the elderly as the cancerspecific or surgical outcome. The main difficulty for individualizing treatment in elderly patients is the capacity to evaluate vulnerability to treatment. Several aspects should be taken into account, which include: (1) an estimation of lifeexpectancy based on functional evaluation and co-morbidities; (2) an estimation of the risk of cancer-related morbidity: a: Tumor stage at diagnosis; b: Risk of recurrence and tumor progression; and c: Tumor aggressiveness; (3) an evaluation of the conditions that could interfere in the cancer treatment and tolerance; a Comprehensive Geriatric Assessment (CGA), which includes: a: undernutrition (recent loss of > 5% weight/body mass index ; b: polypharmacy (more than 10 medications); c: social isolation; d: depression; e: cognitive disorder; f: risk of falls; g: side effects of neoplasia: sensory deterioration, urinary incontinence, sexual dysfunction; h: comorbidities (number and severity of co-existing illnesses); and (4) an evaluation of the goals of the patient (what the patient expects from treatment).