SIOG 2017 - Abstract Submission

Track 2: Haem malignancies in the elderly and basic science

Other

O06

MAJOR IMPACT OF MILD COGNITIVE IMPAIRMENT (MCI) AND INFLAMMATORY STATUS IN OLDER PATIENTS RECEIVING CHEMOTHERAPY FOR HEMATOLOGICAL MALIGNANCIES

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I submit my abstract to be considered for the following award: None

Introduction: Patients “clinically fit” to receive chemotherapy for a malignant hemopathy, are a heterogeneous population covering fit and vulnerable patients. Patients with geriatric syndromes and/or irreversible comorbidities are usually excluded from standard dose chemotherapy. Major progresses have been achieved to identify older patients who should be treated with standard dose of chemotherapy. However, a reliable “frailty score” remains urgently needed to better define the vulnerable population that does not benefit from chemotherapy. In the literature, two clinical (Mild Cognitive Impairment (MCI) and gastro-duodenal ulcer) and two biological (low hemoglobin level and IL-6 level) factors are frequently correlated with poor overall survival (OS) and/or chemotherapy-related toxicity.

Objectives: To establish the reliability of a simple clinico-biological tool for the screening of vulnerable patients with malignant hemopathies presenting unacceptable chemotherapy-related toxicity or disappointing results defined as a poor OS (<6 months).

Methods: This prospective multicentric study was conducted in the institute Jules Bordet (Brussels) and in the University Hospitals of Leuven (Leuven). A Comprehensive Geriatric Assessment (CGA) was performed to 269 consecutive patients (65-90yrs) with malignant hemopathies admitted to receive chemotherapy. A screening tool composed of 0 to 4 of the prognostic factors (MCI [Mini Mental State Examination], presence of gastro-duodenal ulcer [Charlson Comorbidity Index], anemia [hemoglobin level] and IL-6 level [CRP]) was studied in our population. Univariate and multivariate Cox proportional hazards model were used to predict OS.

Results: Two hundred and thirteen patients were evaluable for the clinico-biological tool (NHL, n=126; CLL, n=23; MM, n=29; AML, n=18; ALL, n=5; LMMC, n=8, MDS, n=4). Eighty-four percent had a more favorable prognosis (NHL, CLL or MM) and fifty-four percent had a first diagnosis of cancer. A “frailty” scoring system (range 0-4 items) was developed, based on our predictive factors for poor survival: Mild Cognitive Impairment (MCI) (MMSE<27, n=65), duodenal ulcer (n=24), anemia (HB<11g/dl, n=99) and CRP≥2mg/l, (n=167). The population was stratified into 3 groups: fit (score=0-1, n=90), vulnerable (score= 2, n=82) and “frail” (score= 3 or 4, n=41). The one-year OS was 77% in fit, 62% in vulnerable (hazard ratio (HR)=1.83; 95% CI=1.05-3.19; P=.033) and 39% in “frail” patients (HR=3.90; 95% CI=2.18-6.98; P<.001) with a median survival of 3 months.

Conclusion: In our selected population of patients referred to receive chemotherapy for malignant hemopathies, our “frailty score” helps clinician to predict a poor OS. This “frailty score” detects unsuspected “frail” patients who may benefit from palliative care. Further prospective analyses in a larger cohort of malignant hemopathies are ongoing to validate this score.

Disclosure of Interest: None Declared

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