

## Influence of age and comorbidity on outcome and compliance to RT

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presentation will summarize the biological changes associated with increasing age and will emphasize the large individual variation observed. Clinical studies of the sensitivity and tolerance of normal tissue in elderly patients will be reviewed and the role of co-morbidities will be discussed. Furthermore, the available data on survival outcome of standard treatment protocols for different tumour entities will be considered. The bulk of the current evidence seriously questions the common practice of excluding cancer patients from study protocols solely on the basis of their chronological age

#### **SP-0341 Influence of age and comorbidity on outcome and compliance to RT**

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##### **Abstract text**

Head and neck cancer (HNC) patients are often long term users of tobacco and/or alcohol. Besides the carcinogenic effect of these substances they also lead to other chronic diseases and thus contributes to a high prevalence of comorbidities among HNC patients. Due to demographic changes the general population becomes older and consequently more HNC patients may suffer from comorbidity. Severe comorbidity may impact on prognosis for HNC patients and may impact treatment decision, compliance and subsequent outcome. This talk will focus on comorbidity and age in HNC patients and the impact on survival. Data will be presented from different studies including large population based study from the DAHANCA group. These studies show that comorbidity is common among HNC patients and is a negative prognostic factor for overall survival. Comorbidity also have a negative impact on cancer specific survival, while age does not. Therefore, critical assessment of comorbidity can significantly improve the decision-making proces for clinicians and may influence and improve patient outcome.

#### **SP-0342 From geriatric assessment in radiation oncology to interventions: experience from the PIVOG trial**

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##### **Abstract text**

The demographic development in Europe e. g. in Germany leads to increasing need of adapted care concepts for elderly cancer patients. General principles (e. g. "go-go, slow-go, no-go" for very fit, quite fit and unfit elderly patients, respectively) are difficult to translate into clinical treatment recommendations for individual patients. Maintaining quality of life is highly important for elderly cancer patients. Its measurement, however, has only become possible recently with established of normal reference values for elderly age groups (e. g. for the EORTC QLQ-C30 questionnaire) and the validation of an elderly- specific instrument (QLQ-ELD 14; Wheelwright et al., Br J Cancer 2013).

Using these tools, we could show in an observational study of n=50 very elderly (>80 years old) cancer patients undergoing radiotherapy, that general and elderly-specific quality of life remained stable from beginning to end of radiotherapy, but deteriorated in several domains, including physical function, role function and family support by 6 months after treatment (Kaufmann et al., Support Care Cancer 2015). A possible explanation was the good access to supportive treatment during radiotherapy, but lack thereof after treatment.

We interpreted this as a need to develop an intervention to stabilize quality of life of elderly cancer patients after

the end end of treatment and developed a complex intervention containing (a) a clinically feasible comprehensive geriatric assesemtn (CGA) before the start of cancer treatment and (b) regular telephone contact with an oncology nurse during the first six months after treatment to counsel patients on the management of symptoms and provide additional ressources of care. This intervention was pilot tested in n=100 elderly patients over 70 years with at least one comorbidity and / or one functional impairment in the PIVOG trial (Patient-centered Interdisciplinary Care Concept for Geriatric Oncology Patients; Schmidt et al., J Geriat Oncol 2017). The geriatric assessment was feasible and took on average one hour. The nurse-led telephone contact was well accepted (used by 79% of patients, mean 7.8 calls per patient, mean duration 14 minutes). In the primary endpoint, global quality of life at 6-month follow-up, mean scores were stabilized compared to baseline. Clinically relevant improvement and deterioration were seen in 35% and 28% of patients, respectively, no change in 37%. Details on the experience with specific elements of the geriatric assessment and development in subscales of quality of life will be presented. Ongoing work is focussed on developing the complex intervention for evaluation in a randomized trial, on physical exercise to improve or stabilize physical function in elderly cancer patients and on the implementation of electronic patient-reported outcome measurement in geriatric oncology using the CHES platform.

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#### **Debate: Which is the best brachytherapy technique to deliver partial breast irradiation? Pitfalls, results and current recommendations**

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#### **SP-0343 Postoperative multicatheter brachytherapy**

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##### **Abstract text**

Whatever the breast brachytherapy indication (boost, APBI for primary or APBrI for salvage irradiation), breast brachytherapy can be performed intra or post-operatively. We listed the different point which can be positively or negatively impacted if the implant is performed intra or postoperatively. Regarding breast brachytherapy applicators, in case of intra-operative implant, both multicatheter and balloon devices (single or multilumen) can be used, while in case of postoperative implant multicatheter brachy is the only one possible technique. For patient comfort regarding to anesthesia, in case of intra-op implant, the patient is under general anesthesia which is more comfortable compare to a local one in a postoperative implant. Regarding to "Vectors in place" duration, in case of intra-operative implant, before starting the irradiation, it is warranted to obtain the full postoperative pathological report which takes between 5 to 8 days plus 4 to 5 more days for the treatment itself for a total duration ranged between 10 to 15 days (patient discomfort, risk of local infection and/or pain). However, in case of post-operative implant, the "Vectors in place" duration is reduced to the treatment duration itself plus/minus the delay between the implant and the first day of irradiation. For brachytherapist comfort regarding to anesthesia in case of intra-op implant, surgeon and brachytherapist can work together, with a full visibility of the tumor bed and the clip position. No pressure due to potential patient pain. In case of post-operative implant, it is sometimes difficult to perform the implant when the patient is not totally relaxed, obliging the brachytherapist to do the implant in a shorter time (potential stress). In terms of organization, in case of intra-operative implant, the brachytherapist must be available at the time of the