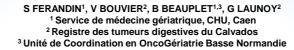






# Comparison of epidemiological characteristics and management of ColoRectal Cancer according to age, from 2005 to 2010 in Calvados.







# **Introduction:**

- 45% ColoRectal Cancers (CRC) occur after 75 years and colonoscopy is the gold standard diagnostic examination.
- Authors reports less realization of colonoscopy among elderly people.
- We supposed that CRC were diagnosed at more advanced stages in this population, with more complications, that could explain also less access to cancer treatments.
- The aim of this study was to compare epidemiological characteristics and management of CRC related to age.

# Material and method:

- Retrospective study from 2005 to 2010 on Calvados Digestive Tumors
- Including patients with CRC older than 50 years.
- Comparison criteria:
- 1. Age, sexe
- 2. Tumor location
- 3. Symptoms at the discovery and presence of complications
- 4. Histological confirmation
- 5. Colonoscopy and additional examinations
- 6. Stage at diagnosis
- Cancer treatments
- 8. Impact of comorbidities
- Statistical analysis: Chi 2 test, Fisher exact test

# Results:

1/More women are affected after 75 years (p<0,0001)

	50-74 years	≥ 75 years	Total
Men	715 (63%)	421 (37%)	1136
Women	488 (47%)	553 (53%)	1041
Total	1203	974	2177

#### 2/More location in the right colon after 75 years (p<0,0001) 50-74 yrs ≥75Vrs



Right Colon ■ Left Colon and RSJ Unknown



3/ We notice further deterioration of general condition (15% vs 7%) and iron deficiency anemia (26% vs 9%) in the older subgroup (p <0.0001). There were no difference between the 2 subgroups for transit disorders, abdominal pain and gastrointestinal bleeding. Older subjects suffered more complications (16% vs 10%) as occlusion, sub-occlusion and perforation (p < 0.0001).

4/Less histological confirmation (90% vs 99%) in elderly (p <0.0001) whether on primary tumor or metastasis.

5/ Less complete colonoscopy in over 75 years(p<0,0001):

# Colonoscopy in 50-74 years subgroup



in 75years and over



No difference between subgroups for CT scan but less pelvic RMI (p = 0.0016) and endoscopic ultrasound (p = 0.0002) in rectal location after 75 years.

6 / No more advanced stage (III and IV) at diagnosis in elderly.

	Stage I	Stage II	Stage III	Stage IV	No surgery	Unknown
50-74 years	257 (22%)	245 (22%)	261 (23%)	329 (29%)	21 (2%)	23 (2%)
≥75 years	132 (13%)	285 (27%)	200 (19%)	326 (31%)	83 (8%)	15 (1%)

# 7/ Treatment:

- Fewer curative resection tumor in elderly (65% vs 72%, p <0.0001); and more colostomies (p <0.001)
- Less chemotherapy (p < 0.0001)
- Less radiotherapy (p = 0.0009)

8/ More comorbidities in elderly according to Charlson Comorbidity Index (CCI)

Charlson Comorbidity Index	0	1	2	3	≥4
50-74 years	558 (59%)	173 (19%)	133 (14%)	38 (4%)	38 (4%)
≥75 years	383 (44%)	256 (29%)	132 (15%)	51 (6%)	49 (6%)

- ◆ No influence of CCI on surgical resection (p = 0.14 in 50-74yrs, p = 0.82 after75 yrs)
- **◆ No influence of CCI on radiotherapy** (p = 0.22 in 50-74yrs, p = 0.08 after 75 yrs)
- ▼ Influence of CCI on chemotherapy (p <0.001 in 50-74yrs, p = 0.0003 after 75 yrs)
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# **Conclusion:**

- There is a lack of information on clinical and geriatric status. Consequently, the integration of G8 ONCODAGE score is planned in the registration form to assess its impact on treatment.
- More complications at diagnosis, poor performance status and iron deficiency anemia should explain suboptimal treatment, specially surgical tumor resection, that is not influenced by CCI