Physiological Changes and Comorbidities Associated with Aging: Relation to Risk of Cancer Therapy Toxicity

Supriya Mohile, MD, MS
Associate Professor of Medicine
University of Rochester

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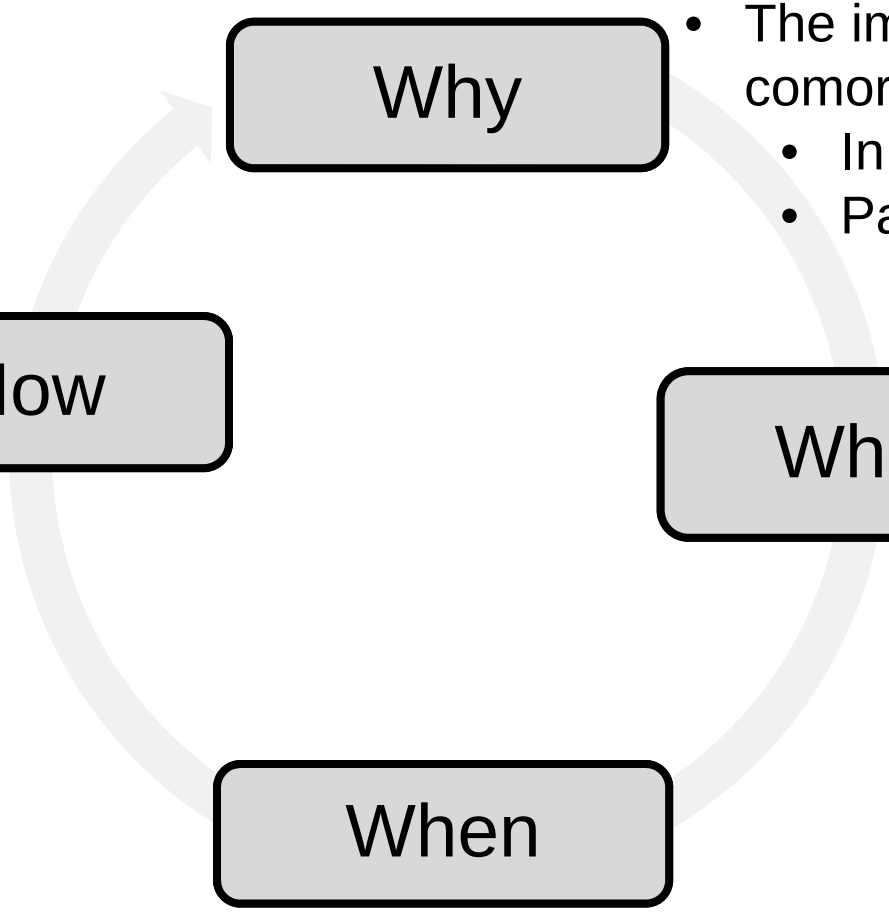
CANCER & AGING RESEARCH GROUP

Aging and Cancer

- Comorbidity and Aging
- Pharmacology of Anti-Neoplastic Agents in the Elderly
- Toxicity of Anti-Neoplastic Agents in the Elderly (Examples)

Comorbidity Measures – *what is the what?*



- The importance of comorbid conditions
  - In general
  - Particular to cancer

- Definitions of comorbidity
- Generic vs. disease-specific

- Situations in which it may be important to measure comorbidity

- Commonly used comorbidity indices
- Index choice based on study characteristics

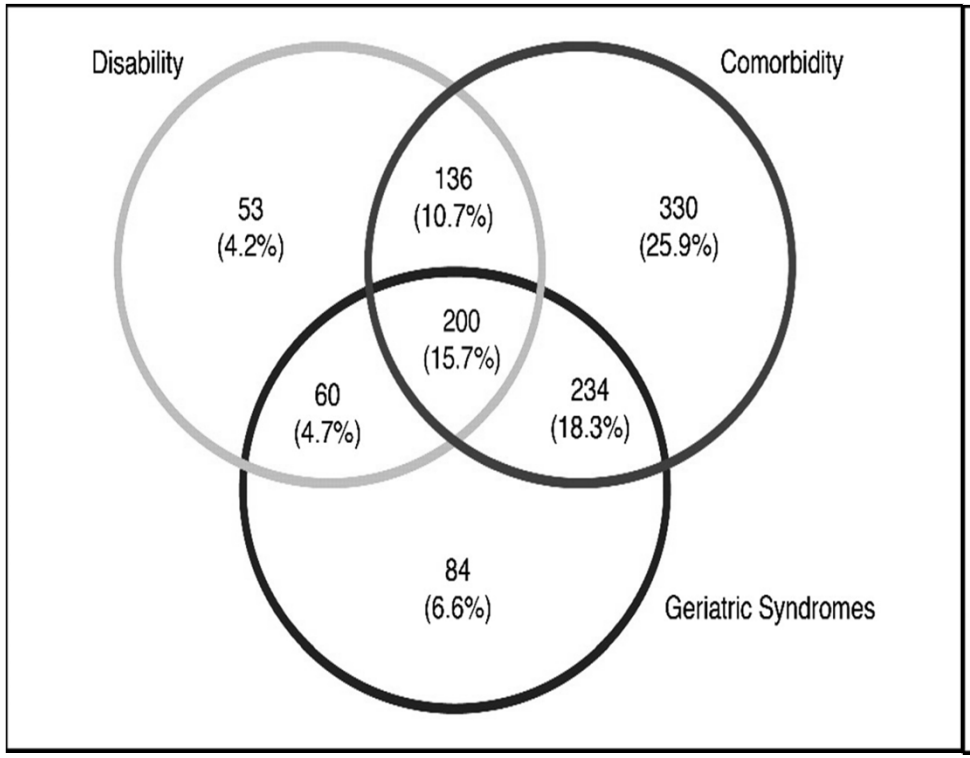
Comorbidity in Cancer

- A coexisting medical condition that exists along with an index condition that has implications for an outcome
- No gold standard for measurement
- Particular importance in cancer
  - Confounder or mediator of effect
  - Outcome of interest
  - Distinguish from toxicity

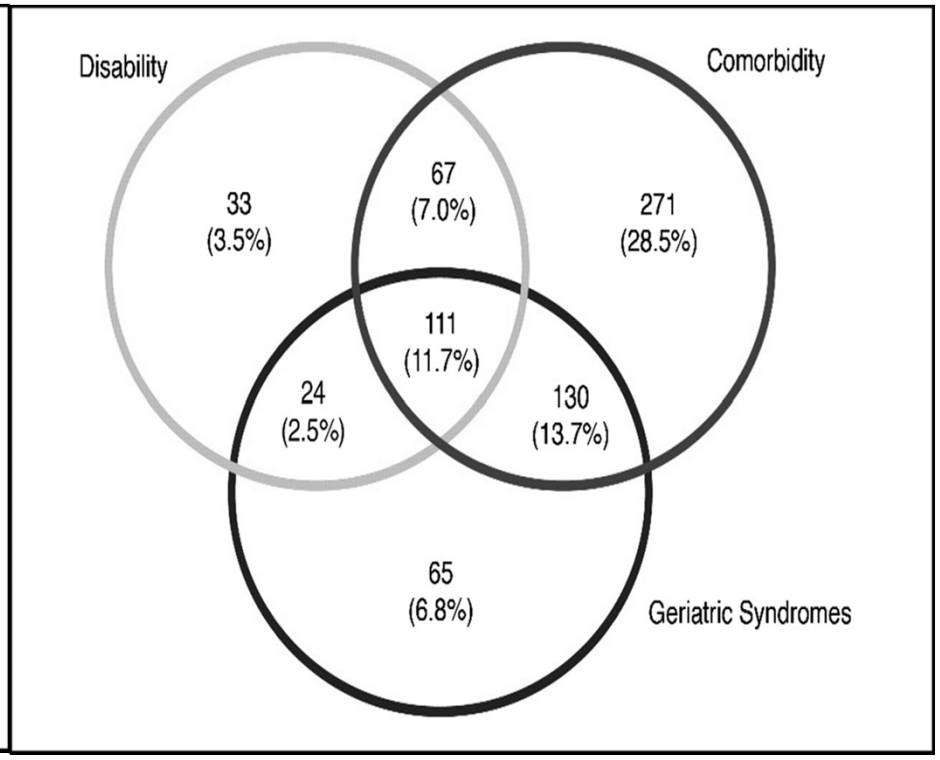
Sorensen HT. Clin Epi 2013:5 (suppl1):1-2.
Ritchie CS. J Oncol Practice 2011;7:371-4.

Comorbidity ≠Disability ≠ Geriatric Syndromes

Colorectal Cancer



Breast Cancer



Koroukian, S. M. et al. *J Clin Oncol*; 24:2304-2310 2006

Multimorbidity

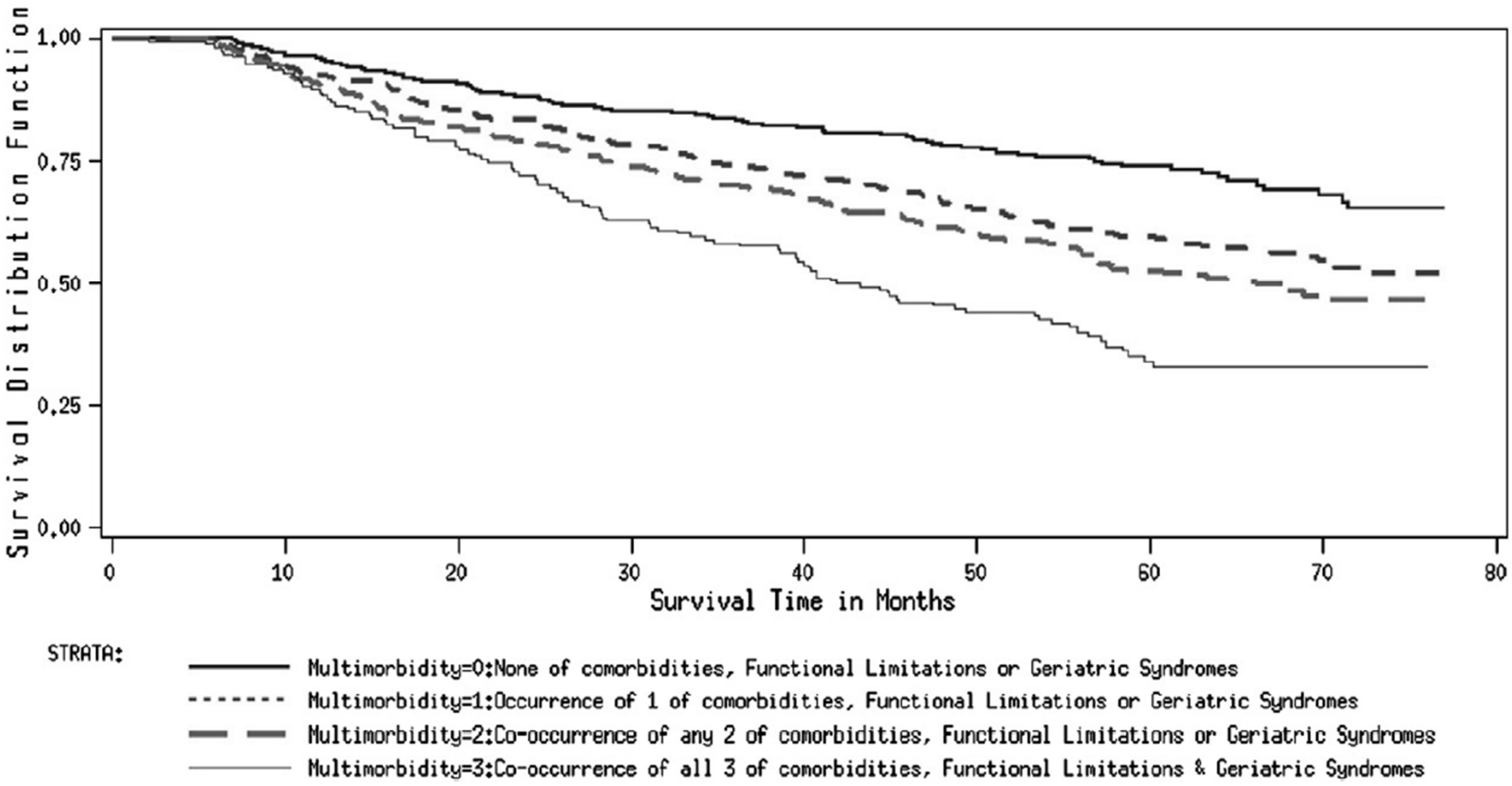
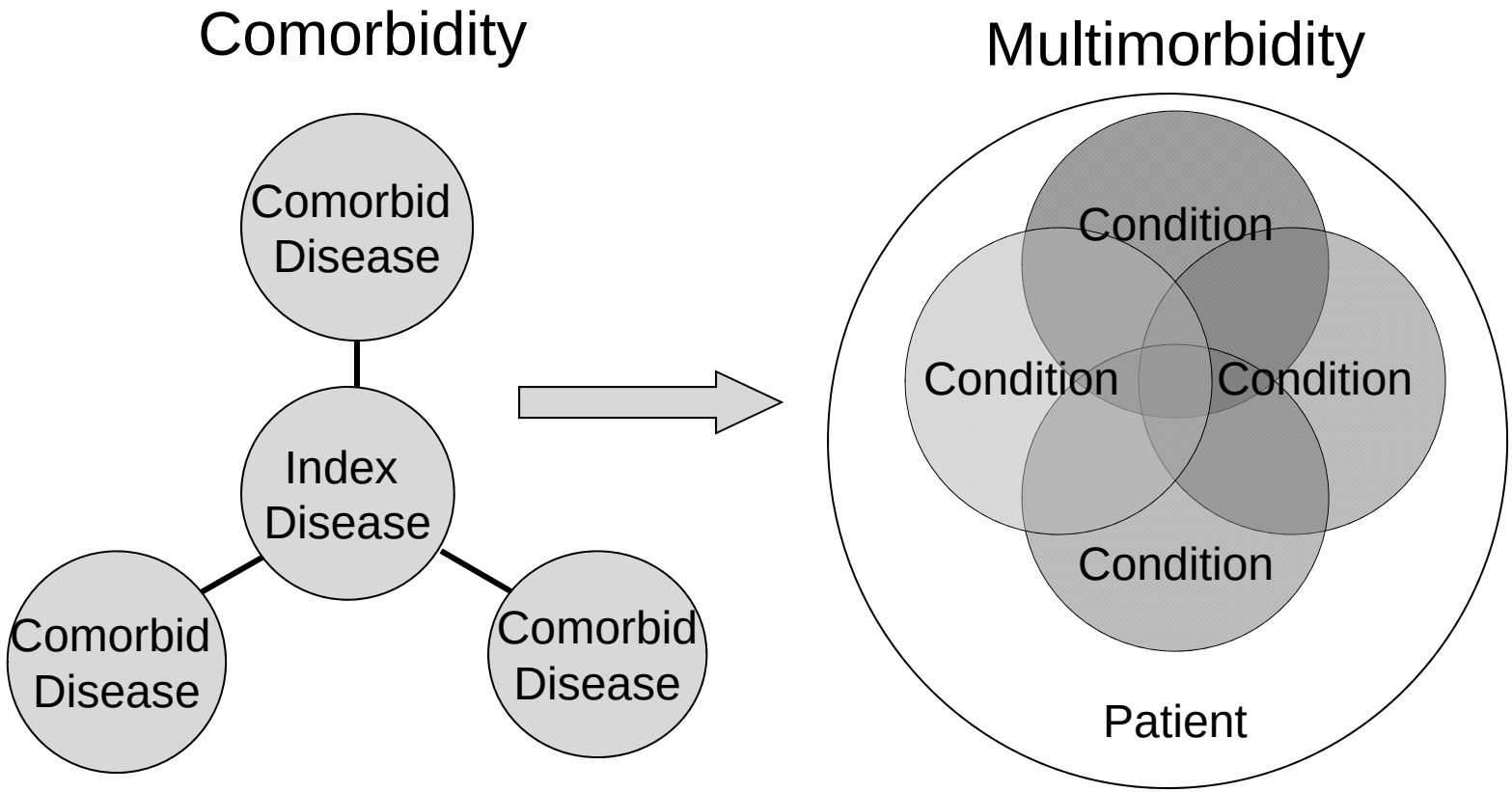


Fig. 1 – Overall survival by Multimorbidity. Log-Rank chi-square = 58.3 p < 0.0001.

Koroukian S, et al. J Geriatr Oncol 2011;2:200-8.

More than half of people 65 and older have 3+ chronic conditions



Boyd, CM, Fortin M. Public Health Reviews, 2011.

Importance of Multimorbidity

Brendan Smialowski (NY Times)

- *Increased risk of*:
  - Death
  - Institutionalization
  - Increased utilization of healthcare resources
  - Decreased quality of life
  - Higher rates of adverse effects of treatment or interventions
- *Almost all existing "guidelines" have single disease focus*
- *Best approaches to decision-making and clinical management of older adults with multimorbidity* ***remain unclear***

AGS Expert Panel on the Care of Older Adults with Multimorbidity. J Am Geriatr Soc 2012;60:1957-68

AGS

Comorbidity Assessed in PMH

- Charlson Comorbidity Scale; Cumulative Illness Rating Scale-Geriatric (European)
- Extermann et al. JCO 1998;16(4):1542.
- Standardized scoring
- May be self-administered
- Public Domain
- Demonstrated predictive value for hospitalization, mortality

Table 1 – Selected list of comorbidity scales discussed in this article organized by scale type.

Type	Index	Items and rating	How constructed
Summative			
	Elixhauser	30 dichotomous conditions	Length of stay, total charges, and in-hospital mortality of hospitalized patients
Weighted			
	Charlson Comorbidity Index (CCI)	19 conditions weighted 1 to 6	1 year mortality in hospitalized internal medicine patients
	NCI Comorbidity Index	16 conditions weighted by empirically derived weights	2 year non-cancer mortality in prostate, breast, lung, and colorectal cancer patients
Systems based			
	Cumulative Illness Rating Scale (CIRS)	13 or 14 organ system categories, each rated 0–4	Comprehensive listing of conditions weighted by physician's judgement, unclear original population used to derive
	Kaplan–Feinstein Index (KFI)	12 conditions, each rated 0–3	Survival in 188 male patients with diabetes
	Index of Coexistent Disease (ICED)	Disease severity sub-index: 14 diseases (rated 0–4). Functional severity sub-index: 12 conditions (rated 0–2). Total: 0–3	Anticipated outcomes 2 years after hospitalization in breast cancer patients
Cancer-specific			
	Washington University Head and Neck Comorbidity (WUHNCI)	7 conditions, each rated 0–4	5-year survival in patients with head and neck cancer
	Hematopoietic cell transplantation-comorbidity index (HCT-CI)	17 conditions, each rated 0–3	2-year non-relapse mortality in patients undergoing HCT

Categories of Comorbidities

Terminal

- Dementia, class IV CHF, end-stage COPD

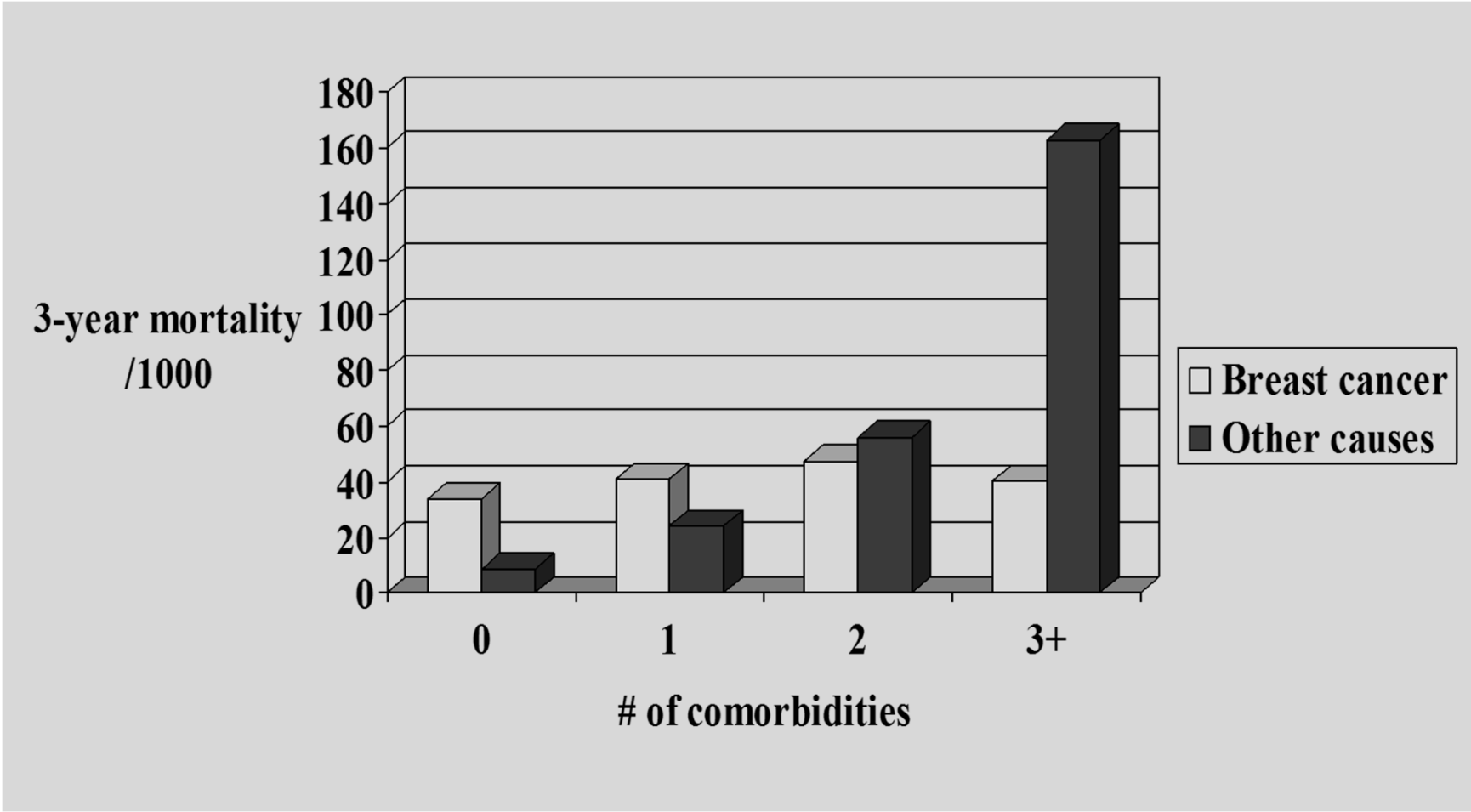
Function-limiting, possible life-limiting

- stroke, severe COPD, PVD, OA, vision impairment, depression, urinary incontinence

Reserve-limiting

- renal insufficiency, diabetes, COPD, stable angina

Comorbidity and prognosis: Simply adding up the number of co-existing conditions



SEER Registry. Satariano & Ragland 1994

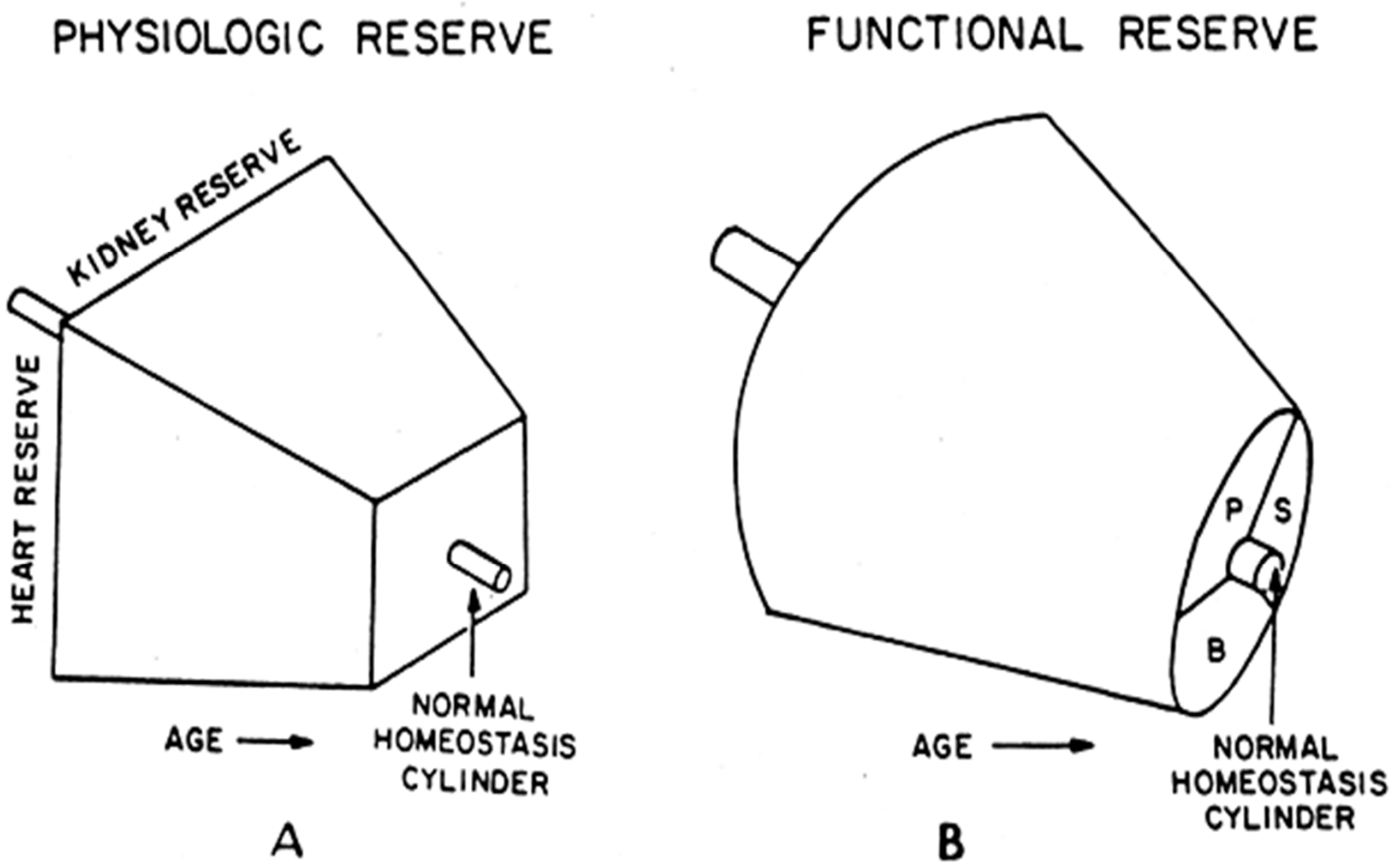


Figure 2. Functional aging. A. The Fries and Crago model of diminishing area of physiologic reserve due to the decline function. A stress to the individual that carries outside the outer envelope will result in death. (Reproduced with permiss Fries JF and Crapo LM: Vitality and Aging. Implications of the Rectangular Curve. San Francisco, W. H. Freeman, 1981, p. 3 expanded model representing the diminishing area of functional reserve due to the decline in biopsychosocial functions. Th homeostasis cylinder represents the physical and instrumental activities of daily living (see text). Death will occur when f reserves decrease to a point less than that amount required by the homeostatic cylinder or when a stress exceeds the comp functional reserves.

Pharmacologic Processes Affected by Aging

- Absorption
- Distribution
- Metabolism
- Excretion

Aging and Absorption

- Amount absorbed (*bioavailability*) is not changed
- Peak serum concentrations may be higher or lower, and delayed
- Exceptions: drugs with extensive first-pass effect (bioavailability may increase because less drug is extracted by the liver, which is smaller with reduced blood flow)
- Factors that may affect absorption
  - Reduced gastric secretion
  - Reduced gastric emptying time
  - Reduced gastrointestinal motility
  - Diminished splanchnic blood flow
  - Decreased absorption surface
  - Concomitant medications, ie. H2 blockers, antacids

Aging and Distribution

- Doubled fat content
- Decreased intracellular water
- Increased volume of distribution (Vd)
- Lowered peak concentration and prolonged terminal $t_{1/2}$
- Reduced albumin concentrations
  - (etoposide and taxanes are highly protein bound)
- Displacement of protein-bound drugs by other medications

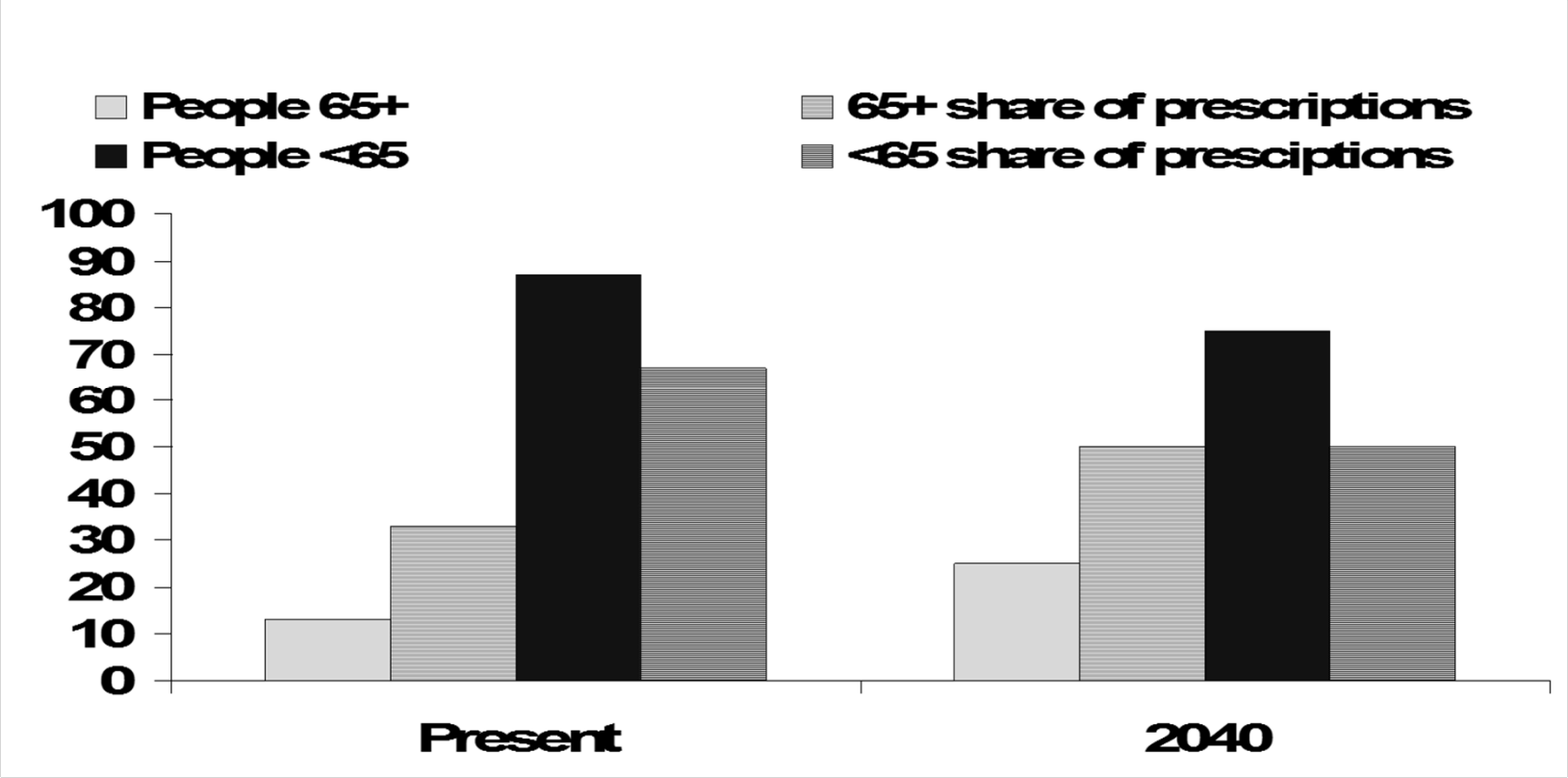
Aging and Metabolism

- Metabolic clearance of a drug by the liver may be reduced because:
  - Aging decreases liver blood flow, size, and mass, and
  - The liver is the most common site of drug metabolism

Cytochrome P-450 and Drug Interactions

- Effects of aging and clinical implications are still being researched
- CYP3A4 is involved in more than 50% of drugs on the market
- CYP3A4 is induced by rifampin, phenytoin, and carbamazepine and is inhibited by macrolide antibiotics, nefazodone, itraconazole, ketoconazole, and grapefruit juice

Polypharmacy



Now, people age 65+ are 13% of US population,
buy 33% of prescription drugs.
By 2040, will be 25% of population, will buy 50% of prescription drugs

Risk Factors for Adverse Drug Events

- 6 or more concurrent chronic conditions
- 12 or more doses of drugs/day
- 9 or more medications
- Prior adverse drug reaction
- Low body weight or low BMI
- Age 85 or older
- Estimated CrCl < 50 mL/min

Common Drug-Drug Interactions

Combination	Risk
ACE inhibitor + diuretic	Hypotension, hyperkalemia
ACE inhibitor + potassium	Hyperkalemia
Antiarrhythmic + diuretic	Electrolyte imbalance, arrhythmias
Benzodiazepine + antidepressant, antipsychotic, or benzodiazepine	Confusion, sedation, falls
Calcium channel blocker + diuretic or nitrate	Hypotension
Digitalis + antiarrhythmic	Bradycardia, arrhythmia

Before Starting a New Medication, Consider:

- Is this medication necessary?
- What are the therapeutic end points?
- Do the benefits outweigh the risks?
- Is it used to treat effects of another drug?
- Could 1 drug be used to treat 2 conditions?
- Could it interact with diseases, other drugs?
- Does patient know what it’s for, how to take it, and what ADEs to look for?

Key Concepts Regarding Drug Elimination

- **Half-life: time for serum concentration of drug to decline by 50%**
- **Clearance: volume of serum from which the drug is removed per unit of time (eg, L/hour or mL/minute)**

Effects of Aging on the Kidney

↓ kidney size

↓ renal blood flow

↓ number of functioning nephrons

↓ renal tubular secretion

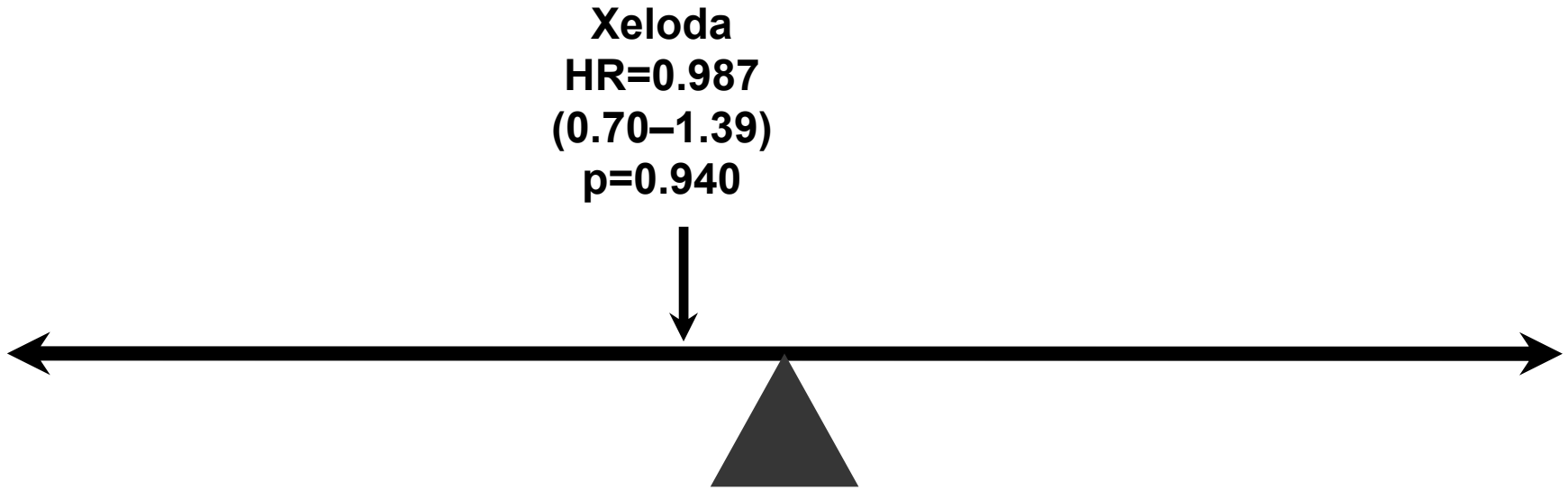
Result: Lower glomerular filtration rate

Capecitabine: Tolerability data Led to Renal Impairment Guidelines

Renal impairment	Calculated creatinine clearance (mL/min)	Starting dose (mg/m^2 twice daily)
None	>80	1,250
Mild	51–80	1,250†
Moderate	30–50	950†
Severe	<30	Contra-indicated

Poole C et al. Cancer Chemother Pharmacol 2002;49:225–34

Capecitabine Efficacy is Maintained Following Adjustments to Individual Tolerable Dose



HR = hazard ratio for disease progression in patients with versus without dose reduction

O'Shaughnessy et al

Elderly Patients With Cancer: Adapting to Renal Function

- Elderly patients are at greater risk for chemotherapy-induced toxicities
- Reluctance to give standard chemotherapy treatment often results in undertreatment
- Adapting to renal function allows safe and equipotent drug usage

Age-Related Pharmacodynamic Changes

- Toxicity differences (e.g., fluorpyrimidines)
- Tumor resistance to chemotherapy (e.g., increased incidence of MDR-1)
- Changes in sensitivity due to:
  - Anoxia of neoplastic cells
  - Reduced cell proliferation

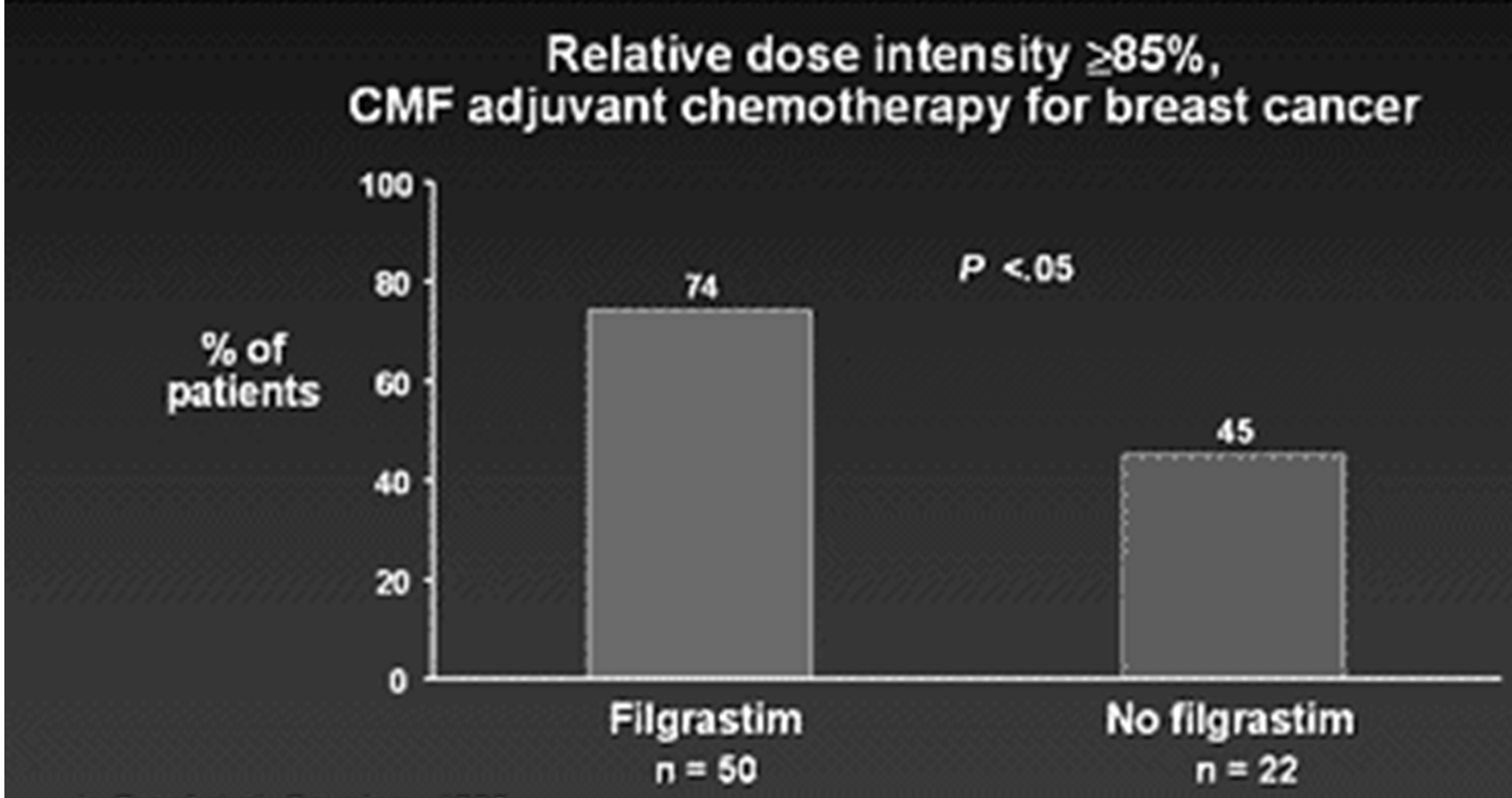
Toxicity is More Common and Severe in the Elderly

- Hematologic
- Cardiomyopathy

Hemotologic Toxicity and Age: Non-Hodgkin's Lymphoma

- Studies of patients ≥ 70 with NHL treated with CHOP or CHOP-like regimens
  - Higher incidence of grade 3, 4 neutropenia
  - Two-fold increase in neutropenic infections
  - Increased incidence of anemia and thrombocytopenia

Filgrastim Helps Maintain Chemotherapy Dose Intensity in Breast Cancer

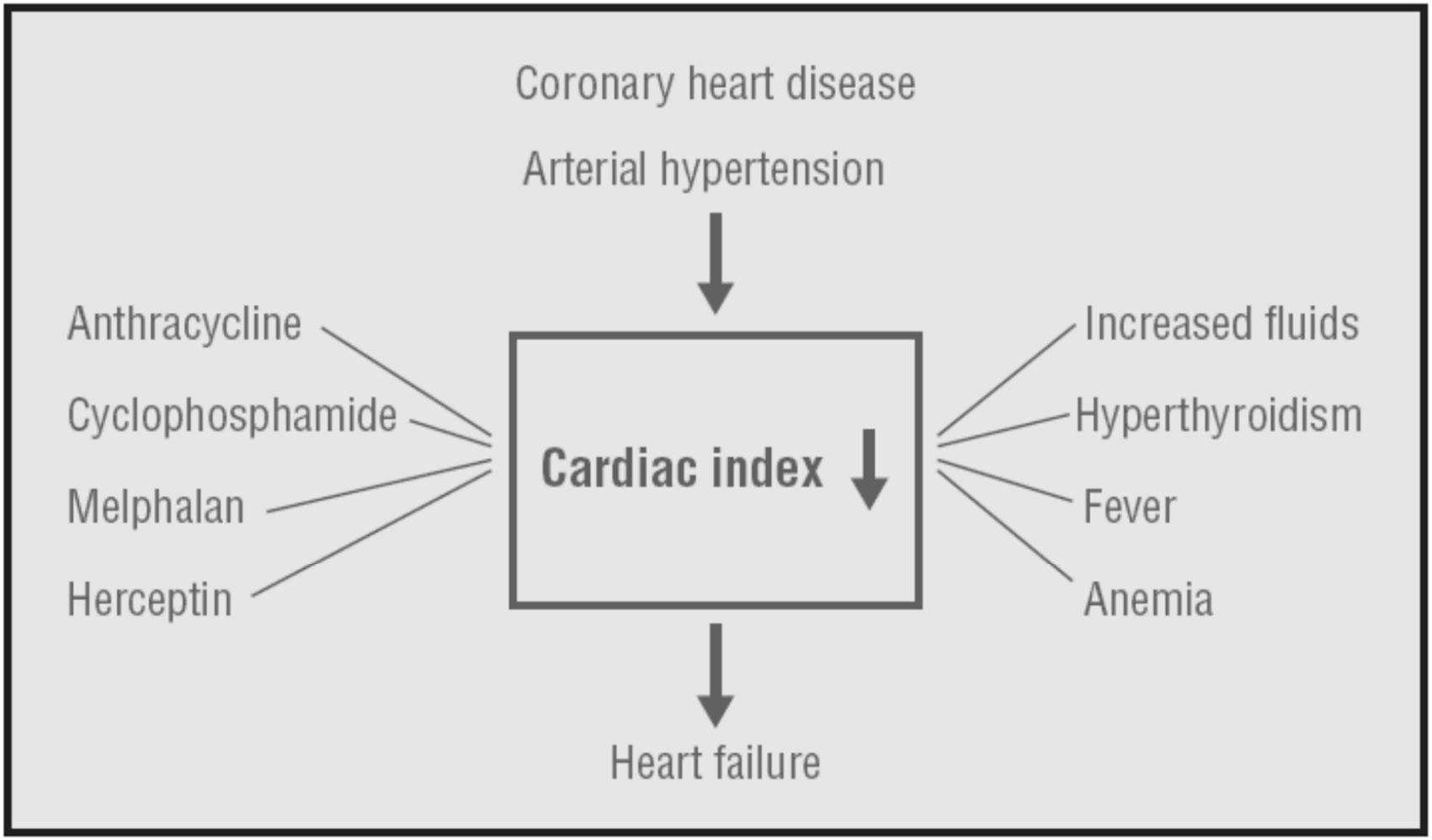


de Graaf et al. *Oncology*. 1996.

Anthracycline cardiotoxicity

- Age is a risk factor due to decreased myocardial reserve
- Alternative approaches to toxicity prevention with dose of doxorubicin $\geq$ 600 mg/m2
- MUGA scans have limited predictive value
- Myocardial damage is rare $\leq$ 300 mg/m2

Cardiac Toxicity



Prevention of Cardiotoxicity

- Cytoprotective Agents
- Alternative schedules
- Monitor LVEF and clinical symptoms
- Alternative drugs (e.g., mitoxantrone, epirubicin, liposomal anthracyclines)

Conclusion: Prevention of Toxicity

- Chemotherapy doses should be adjusted to renal function and physiology
- Successive doses should be adjusted according to toxicity
- In patients over 70 years, primary prophylaxis with hematopoietic growth factors should be considered depending on regimen
- Primary goal of treating frail patients is palliation