suggest that this is the case in Hodgkin's disease and acute leukaemia. In non-Hodgkin's lymphoma, for example, the complete response rates with aggressive chemotherapy are equal in patients over and under 60 years old. The survival of the older patients is less, however, because of deaths unrelated to the lymphoma or its treatment.[8] Overall response rates to chemotherapy in small cell lung cancer are also similar in younger and older patients, and age has not been found to be an adverse prognostic factor.[9] Survival rates are similar in older patients despite the dose intensity often being less and despite them having a greater number of comorbid conditions.

Some cancers may behave differently in the elderly and warrant different treatment approaches from those in younger patients. In breast cancer for example, the risk of local recurrence after lumpectomy declines with age. This may decrease the need for postoperative radiotherapy in older women. In the Oxford meta-analysis adjuvant chemotherapy was associated with decreasing survival benefit with increasing age particularly in the over 70 age group.[10] Individual older women at high risk of recurrence, however, may obtain some benefit from adjuvant systemic therapy.

Conclusion

In most cancers the elderly will respond as well as their younger counterparts provided the chemotherapy can be given safely. This may depend on physiological changes in organ function, particularly renal and hepatic function. Deteriorating organ function will make adverse effects and therefore an adverse impact on quality of life more likely.

Elderly patients should be given the option of chemotherapy for responsive advanced cancers. As with younger patients they make their decision balancing any predicted positive outcome against the treatment's adverse effects that, even if temporary, will impact upon their quality of life.

REFERENCES

1. Olver IN. Commentary on chemotherapy. Monash Bioethics Review. 1996;15 Suppl:17-21.
2. Spiegelhalter DJ, Gore SM, Fitzpatrick R, Fletcher AE, Jones DR, Cox DR. Quality of life measures in health care. III: Resource allocation. Br Med J 1992;305:1205-9.
3. Coates A. Who shall decide? [editorial]. Eur J Cancer 1995;31A:1917-8.
4. Extermann M, Overcash J, Lyman GH, Parr J, Balducci L. Comorbidity and functional status are independent in older cancer patients. J Clin Oncol 1998;16:1582-7.
5. Bonaventura A. Complications of cytotoxic therapy. Aust Prescr 1995;18:65-7, 105-7.
6. Antiemetic Subcommittee of the Multinational Association of Supportive Care in Cancer (MASCC). Prevention of chemotherapy- and radiotherapy-induced emesis: results of Perugia Consensus Conference. Ann Oncol 1998;9:811-9.
7. Giamarellou H. Empiric therapy for infections in the febrile, neutropenic, compromised host. Med Clin North Am 1995;79:559-80.
8. Greil R. Prognosis and management strategies of lymphatic neoplasias in the elderly. I. Aggressive non-Hodgkin's lymphomas. Oncology 1998;55:189-217.
9. Siu LL, Shepherd FA, Murray N, Feld R, Pater J, Zee B. Influence of age on the treatment of limited-stage small-cell lung cancer. J Clin Oncol 1996;14:821-8.
10. Wazer DE, Erban JK, Robert NJ, Smith TJ, Marchant DJ, Schmid C, et al. Breast conservation in elderly women for clinically negative axillary lymph nodes without axillary dissection. Cancer 1994;74:878-83.

Self-test questions

The following statements are either true or false (answers on page 87)

5. In general, the efficacy of chemotherapy is reduced in the elderly.
6. The physiological changes of ageing may require increased doses of chemotherapy to be given.

Chemotherapy for elderly patients: a personal experience

Editor's note:

'Snow' Partridge was 81 years old when he developed a small cell carcinoma of unknown primary. He was treated with six cycles of cisplatin and etoposide.

AP: *How did you find out you had cancer?*

SP: I noticed a small lump at the front of my neck. I did not think much about it, but about a month later I mentioned it to my general practitioner when I consulted her about another problem. My doctor sent me for a biopsy.

I was told that the biopsy was 'positive' and I was referred to a surgeon. The surgeon recommended that I have the lump removed so I had an operation. After the operation I was referred to an oncologist. I had to have scans of my whole body.

AP: *How did you feel when you were told you had cancer?*

SP: I do not know what kind of cancer I had. I knew that cancer was serious so I was slightly alarmed by the diagnosis.

AP: *Were you told what choices you had for treating your cancer?*

SP: I was not given a choice of treatment. The oncologist advised me to have chemotherapy to 'clear up any nasties'. I decided to take the oncologist's advice.

AP: *Before you had your treatment, what did you think it would be like?*

SP: I knew other people who had been given chemotherapy. They had felt crook all the time and had problems with vomiting. I knew it would not be pleasant, however I coped well with chemotherapy.

I did not know what I was treated with, but my treatment was for three days every three weeks. This was repeated six times. I had blood tests before each treatment and I had to stay in hospital for two nights each time.

AP: *What adverse effects did you have?*

SP: The doctors and nurses were very good – they told me what side effects to expect and what I could do about them. I only vomited twice, but all my hair fell out after the second treatment. I think I coped well. Apart from a couple of days when I overdid things, I did not feel too unwell.

AP: *Were you relieved when the treatment was completed?*

SP: I hoped the treatment was curing the cancer but I was pleased when the chemotherapy was over. I felt more lively and my hair grew back.

It is now nearly two years since I finished treatment. I am still playing golf and a few sets of tennis.

AP: *Would you make the same choice if you had to make the decision about being treated again?*

SP: I would have chemotherapy again if the doctors advised it.

AP: *Do you have any advice to help elderly people with cancer decide about having or continuing treatment?*

SP: It would be a bit rough to say that old people with cancer should not be treated. I think if you are reasonably fit you should go for the treatment. If you are advised to have chemotherapy, think positively and go for it.

Dental implications

Prepared by Associate Professor R.G. Woods of the Australian Dental Association

Chemotherapy for elderly patients with advanced cancer: is it worth it? (page 80)

The oral adverse effects of chemotherapy may complicate dental treatment in patients with cancer.[1] Systemic adverse effects, for instance immunosuppression, are likely to complicate endodontic treatment or surgery. Taking a pre-treatment medical history is essential to obtain information about the drugs being used to treat the cancer. You should also ask if the patient has had radiotherapy, particularly in the region of the head and neck.

Dental treatment needs to be planned with care. The risks of post-operative infection and delayed wound healing should be minimised. This could include antibiotic surgical prophylaxis. An increased risk of infection from periodontal disease and its treatment should be anticipated. Stomatitis may occur with or without oral ulceration and may be relieved by topical steroid therapy (triamcinolone).

Where possible, a comprehensive oral and dental examination should be made and any infection treated before chemotherapy begins. Following chemotherapy provision should be made for dentate patients, to have a regular preventive dentistry program to minimise the need for invasive dental treatment.

Dental management of any patient, young or old, can be complicated by chemotherapy. Where there is any doubt concerning the effects of medication used or precautions needed, dentists should discuss the case with the patient's oncologist.

REFERENCE

1. Bonaventura A. Complications of cytotoxic therapy. Aust Prescr 1995;18:68.

International success

In June Dr John Dowden, the Editor of *Australian Prescriber*, received an outstanding service award from the Drug Information Association (DIA). The presentation ceremony took place at this year's annual meeting of the DIA in California. Dr Dowden accepted the award in front of an audience of approximately 7000 people in the San Diego Convention Centre.

While the award is primarily for Dr Dowden's work with the South-west Asia-Pacific Steering Committee of the DIA, it reflects well on *Australian Prescriber*. The journal is an important source of independent drug information in Australasia. The Executive Editorial Board congratulates the Editor on his award.

For more information about the DIA follow the Links from the *Australian Prescriber* web site at *www.australianprescriber.com*