



TO EVALUATE GYNAECOLOGICAL MALIGNANCY AMONG GERIATRIC AGE GROUP (≥ 65 years), MANAGEMENT AND OUTCOME OF TREATMENT

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ABSTRACT

Introduction:- Increasing number of elderly population is a known contributing factor for the increasing rate of cancer incidence worldwide. Gynaecological cancers are constituting about 30% of the total cancers among women in India. Surgery is in many instances, the cornerstone for treatment of cancer patients at any age. However because the prevalence of comorbidity increases with age, serious concern often exists as to feasibility of surgery in geriatric patients

Aim and Objective: The aim is to study distribution of gynaecological malignancy among geriatric patients undergone surgery and evaluate feasibility and outcome of surgery in this age group.

Materials and Methods: A retrospective study of 35 cases of gynaecological malignancies in geriatrics, Age, symptom, clinical findings, investigations and Performance status was evaluated, by ECOG performance level (Eastern Cooperative Oncology Group). Patients were divided into groups of either early or advanced stage of disease. Preoperative anaesthetic evaluation, surgery assessment, complication and recovery were evaluated.

Results: In our study the average age of patients was 69.57 years. Distribution of gynaecological malignancy according to age, 31.4% of the elderly group have ovarian tumour, 31.4% uterine corpus, 8.5% cervical and 28.5% vulvar cancer. The mean duration of hospital stay was 19 days (range 9-32 days). In whole series complications occurred were in acceptable level, not related with increasing age.

Conclusion: This study demonstrates that in specialized units, primary surgery for gynaecologic malignancies in elderly women can be carried out with very low morbidity and mortality.

KEYWORDS : Gynaecologic malignancies, ECOG performance level

INTRODUCTION

Gynaecological cancers have increased in India and are estimated to be around 182,602 by the year 2020 constituting about 30% of the total cancers among women in India. Among these cancer of the uterine cervix followed by ovary and corpus uteri are the major contributors.

Global improvements in health care and an increased life expectancy have led to a significant increase in the number of geriatric population^[1]. Gynaecologic malignancy occurs frequently among elderly women^[2]. Thus the gynaecologic oncologist will face an increasing proportion of geriatric patients in the near future. Surgery, at any age, is the principal treatment for these patients^[3]. However, the physical and emotional stress that is required for surgical treatment is limited by patient's functional reserve, decreasing with age and further deteriorating due to associated comorbid illnesses^[3]. Hence, in the past serious concern often exists as to the feasibility of surgical treatment in geriatric patients.

Recently, however, due to new developments in anaesthesiology, perioperative care, and surgical techniques, the exclusion criteria for surgery in elderly patients have been reduced and the operative safety has been increased^[3].

Several studies claim that elderly women with gynaecologic malignancy are treated less aggressively than younger patients. On the other hand, recent data demonstrates that elderly woman who underwent radical pelvic surgery, tolerate it very well^[4,5].

The aim of current study is to evaluate surgical feasibility among geriatrics with gynaecologic malignancy, to study distribution of gynaecological malignancy in this age group and the outcome in terms of operative morbidity.

MATERIALS AND METHODS:

A retrospective study of 35 cases of gynaecological malignancies in geriatrics, that underwent surgery in a department of obstetrics and gynaecology, Late Shri Lakhiram Agrawal Memorial Medical College Raigarh. Age, height and weight, Body mass index (BMI), symptoms and clinical findings evaluated according to related cancer. Investigations such as haemogram, renal and liver function tests, x-ray

chest were carried out. Imaging like Ultrasonography, CT scan and MRI were carried out according to indication. We sent tumour marker like CA-125 in case of CA ovary for diagnostic purpose, as geriatric patients are considered high risk, additional workups were carried out included 2DECHO, PFT (pulmonary function test).

Performance status evaluated, by ECOG performance level (Eastern Cooperative Oncology Group). These scales and criteria are used to assess how a patient's disease is progressing, assess how the disease affects the daily living abilities of the patient, and determine appropriate treatment and prognosis. Before surgery, the risk of anaesthesia was evaluated by the Standard Physical Status Classification System of American Society of Anaesthesiologists (ASA). Due to heterogeneity of tumour types different surgical procedure performed included exploratory laparotomy (ca ovary), staging laparotomy (ca ovary, ca endometrium), radical hysterectomy (ca cervix), and radical vulvectomy (ca vulva).

In patients having technically unresectable tumours, 2 to 4 cycles of neoadjuvant chemotherapy were given before surgery (interval laparotomy).

Surgical characteristics assessed on following parameters: duration of surgery, any intraoperative injuries or complications, average blood loss, number of ICU admission, duration of hospital stay.

Recovery period were evaluated in terms of: return of bowel function, ambulation, primary wound healing. Adjuvant treatment was considered after final histopathology and required proper risk assessment.

Statistical analysis: The data from the cases and control groups were compared by using Student's t-test using SPSS (Statistical Package for Social Science) software, version 3.5. P values < 0.001 were considered to indicate statistical significance.

RESULTS: In our study the average age of patients was 69.57 years. Table 1 shows the distribution of patients by age, tumour site, stage of disease, obesity, presence of associated diseases and ASA physical status classes

Table 1 Distribution of patients in the study

Sno.	Characteristics	NO (%)
1	Age(year)	69.57(65-85)
2	Stage	
	Early	21(60)
	Advanced	14(40)
3	History	
	Obesity	12(34.28)
	Comorbidity	22(62.85)
	Preop: chemotherapy	4(11.42)
4	ASA physical status	
	Class II	16(45.71)
	Class III	6(17.14)

Distribution of gynaecological malignancy according to age, 31.4% of the elderly group have ovarian tumour, 31.4% uterine corpus, 8.5% cervical and 28.5% vulvar cancer. Overall, 4 patients (11.42%) were given pre-operative treatments in form of chemotherapy. Table 2 shows distribution of different gynaecological malignancy

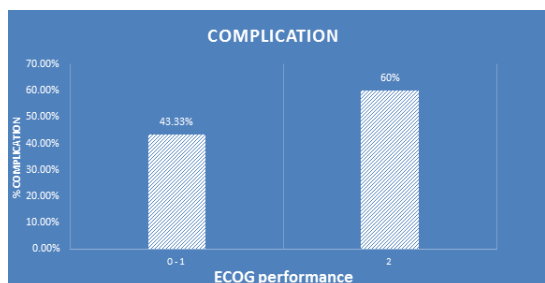
TABLE 2. Distribution of patients according to histopathological subtypes and stage

Subtypes	NO(%)	Stage				
		Stage I	Stage II	Stage III	Stage IV	Unstage
CA ovary	11	3	2	2	-	4
Serous cyst adenocarcinoma	3(27.27)	1	1	-	-	1
Mucinous cyst adenocarcinoma	4(36.36)	1	-	2	-	1
Endometrioid carcinoma	2(5.71)	1	1	-	-	-
undifferentiated carcinoma	2(5.71)	-	-	-	-	2
CA endometrium	11	8	2	1	-	-
Endometrioid	5(45.45)	4	1	-	-	-
Serous	1(9.09)	-	1	-	-	-
Mixed type	3(27.27)	3	-	-	-	-
MMMT	1(9.09)	1	-	-	-	-
Adenocarcinoma	1(9.09)	-	-	1	-	-
CA cervix	3	2	-	1	-	-
Squamous cell	3(100)	2	-	1	-	-
CA vulva	10	7	1	2	-	-
Squamous cell	10(100)	7	1	2	-	-

There were 22 patients (62.85%) having one or more associated comorbid illness. This higher rate of systemic diseases is and may be the cause for common belief that perioperative morbidity and mortality supported by previous reports rates are higher in elderly patients.

Eighty-six percentage (30) patients have good performance status (0-1). Only 14% have poor performance status. If, however same patient was analysed according to their initial ECOG performance level, there is significant correlation between poor performance status and major complication related to treatment.

Figure 1. Correlation between ECOG performance status and complication rate



Given the heterogeneous nature of the series, several types of operations were performed. In present study total 11 cases of ca ovary and most of them undergone radical surgical procedure along with

lymphadenectomy. In patients with ca endometrium, 20% (7) had staging laparotomy with lymphadenectomy. One patient had undergone total abdominal hysterectomy and bilateral salpingo-oophorectomy, with omental sampling. In two patients only performed TAH and BSO.

In case of ca cervix one patient had undergone radical hysterectomy with B/L PLND, one patient had radical hysterectomy. One case became inoperable. This data suggested advanced stage disease with poor surgical resectability and less prevalence of early stage cervical cancer in this age group.

Regarding ca vulva eight patients undergone radical vulvectomy with bilateral lymphadenectomy and in two patients only radical vulvectomy were performed.

In our study average operative time was 174 minutes and average blood loss was approximate 175 ml. One patient had small rent in external iliac artery during surgery which was repaired and in one patient encountered difficulty during bladder dissection. One ICU admission required of patient suspected of pulmonary embolism on third postoperative day, managed with anticoagulants. There was decrease in intraoperative injuries and intraoperative complication in our study, compared with the study of Tomasso Susini et al.⁶

The mean duration of hospital stay was 19 days (range 9-32 days), showed prolong hospital stay required in this age group than general population.

In the present study, febrile morbidity occurred in 6 patients (17.14%). Wound dehiscence was reported in 4 (11.42%) of patients. Four (11.42%) patients who developed breathlessness were managed by medical therapy. One who developed paralytic ileus in postoperative period was treated conservatively. In 1 patient, we had suspected pulmonary embolism was treated with anticoagulant therapy and had complete remission. No patient died peri-operatively or postoperatively in whole series.

In whole series complications occurred were in acceptable level, not related with increasing age. Advances of new surgical techniques and improvement in the field of peri-operative care results in poor complication rate.

In the present study 28 (80%) patient have early return of bowel function within 2-3 days and remaining 7 patients have poor tolerance to fluids, this may be related to anaesthetic complication or drug induced, resulted in delayed recovery of bowel function.

Twenty-seven percent (77%) patients were mobilized early, resulted in early recovery in post-operative period. Eight patients whom delayed ambulation allowed were actually with vulvar cancer having radical vulvectomy with bilateral groin lymphadenectomy, to provide time for healing of groin flap. In these patient's leg stockings provided and allowed distal limb exercise to prevent DVT along with DVT prophylaxis.

Thirty-one (88%) patients have primary wound healing, remaining four have some wound complication required secondary intervention

DISCUSSION AND CONCLUSION:

This study demonstrates that in specialized units, primary surgery for gynaecologic malignancies in elderly women can be carried out with very low morbidity and mortality and suggests that biologic age, which equates the performance status and general fitness for anaesthesia; is a much more important indicator of surgical risk than chronological age.

Our findings support the conclusions of other studies that optimal patient care should depend on good medical and surgical judgment and individualization of treatment and not on age^[2,6,7].

Improving clinical outcome and preserving quality of life both must be priorities in elderly cancer patients. Elderly patients with gynaecologic cancer withstand radical surgery almost equal to younger patients^[2].

Knowledge about the surgical management of older cancer patients is rapidly expanding. As the field of geriatric oncology evolves, guidelines will ultimately assist in these difficult decisions^[1]. Cancer in the elderly is progressively developing into a sub-specialty on its own

and a team approach towards management is obviously the way forward.

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