En quoi la prise en charge gériatrique est-elle primordiale en hématologie ?

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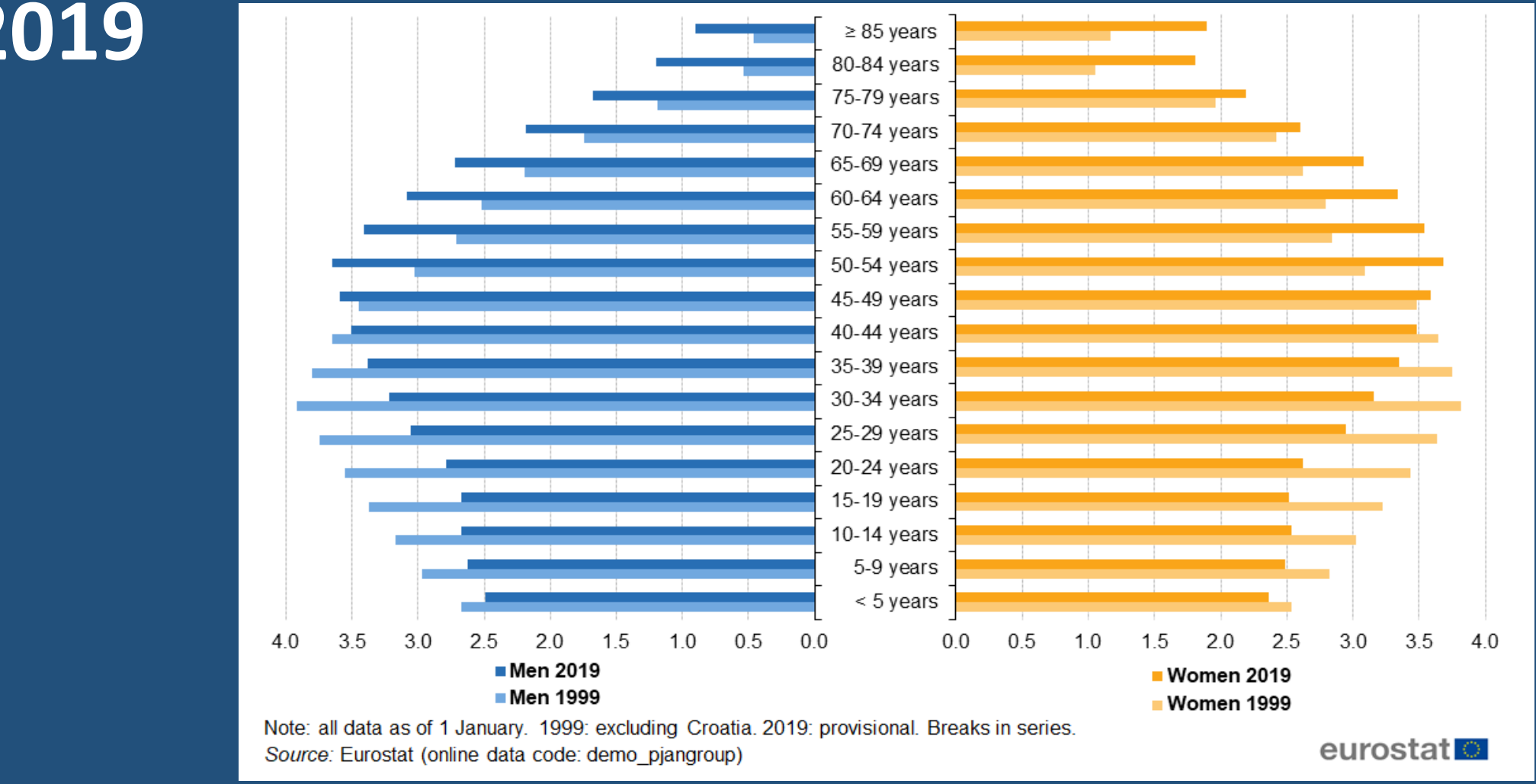
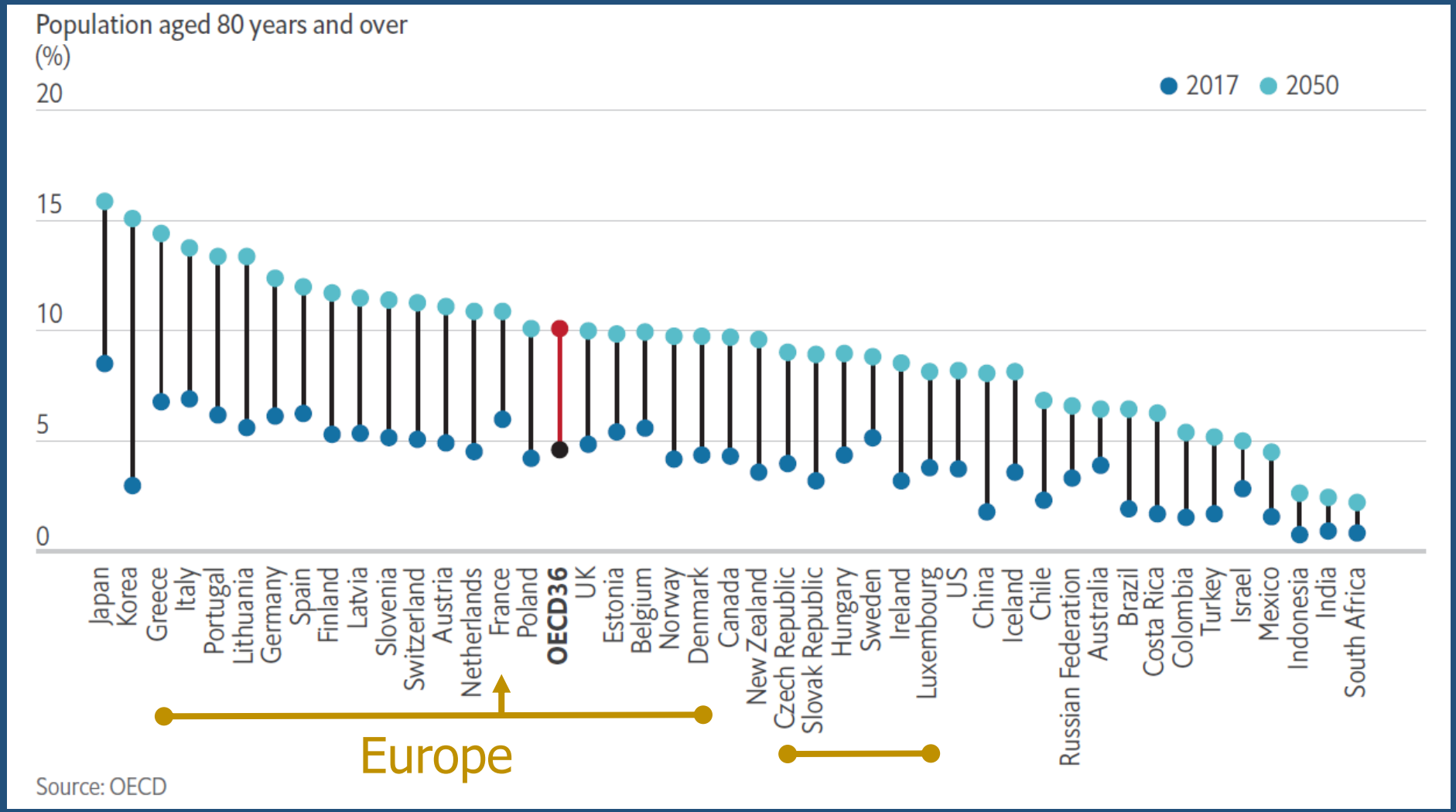
Le vieillissement de la population est déjà visible en 2019



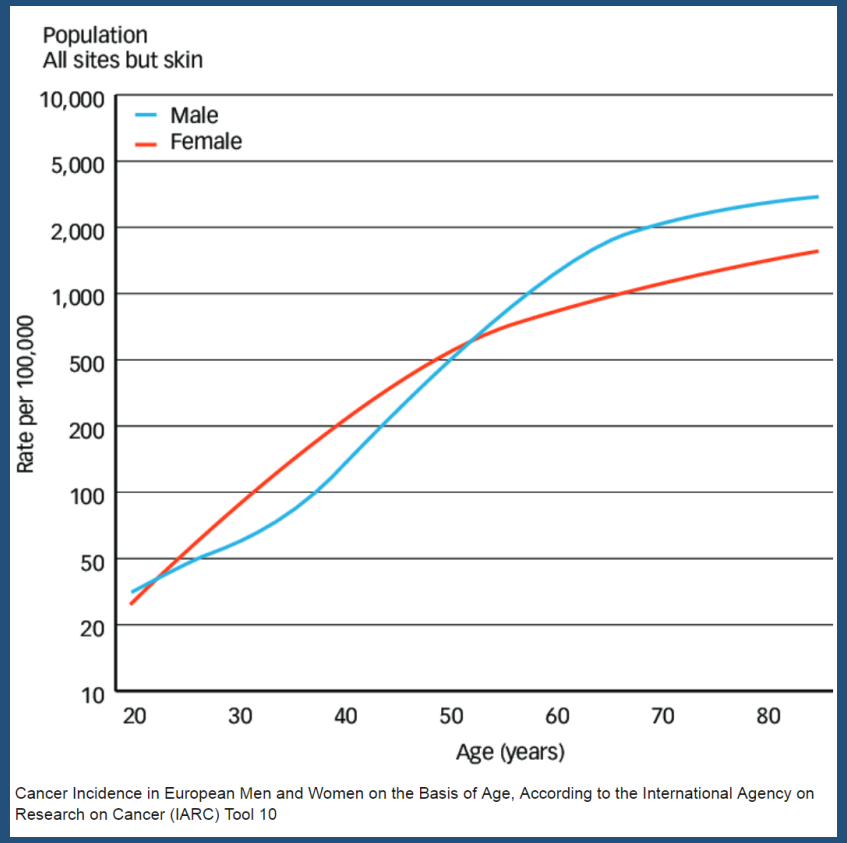
Population structure by five-year age groups and sex, EU-27, 1999 and 2019
(% share of total population)

Le vieillissement de la population est déjà visible en 2019 et le sera encore plus en 2050

La proportion d'adultes de plus de 80 ans va augmenter au moins d'un facteur 2

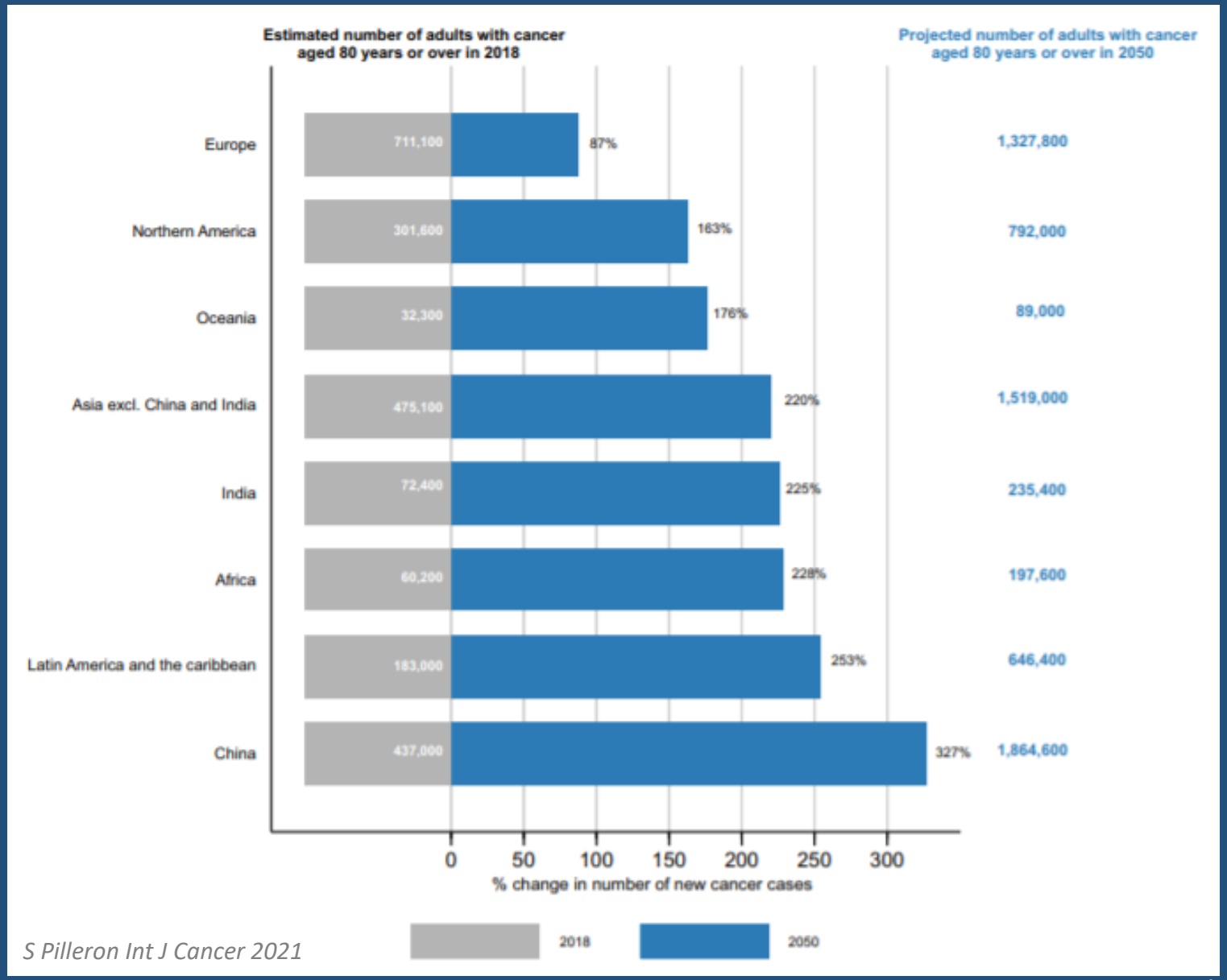


Le nombre de patients âgés avec cancer va augmenter



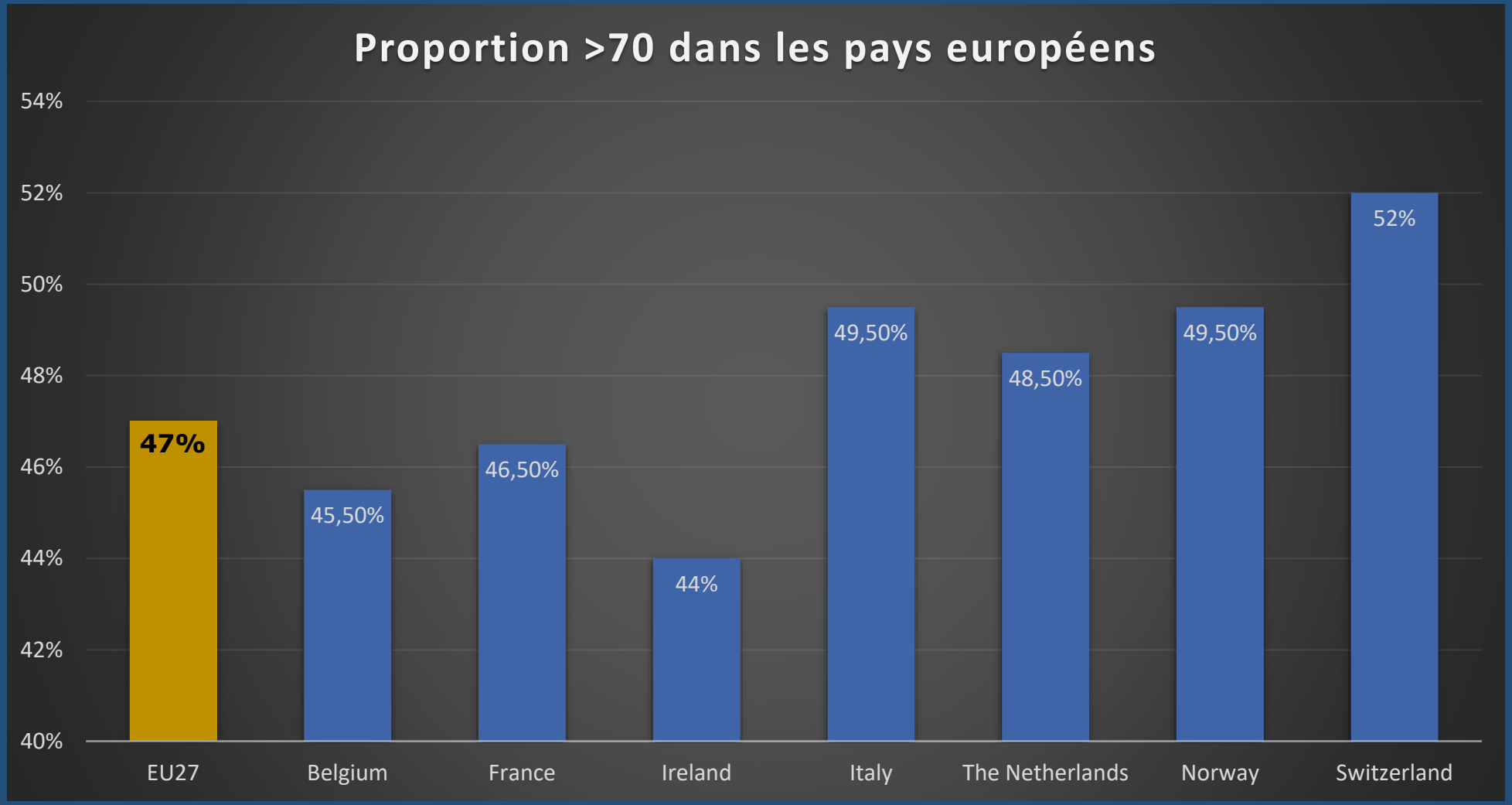
Cancer Incidence in European Men and Women on the Basis of Age, According to the International Agency on Research on Cancer (IARC) Tool 10

D'environ un facteur 2
en Europe
et encore plus dans les autres continents



S Pilleron Int J Cancer 2021

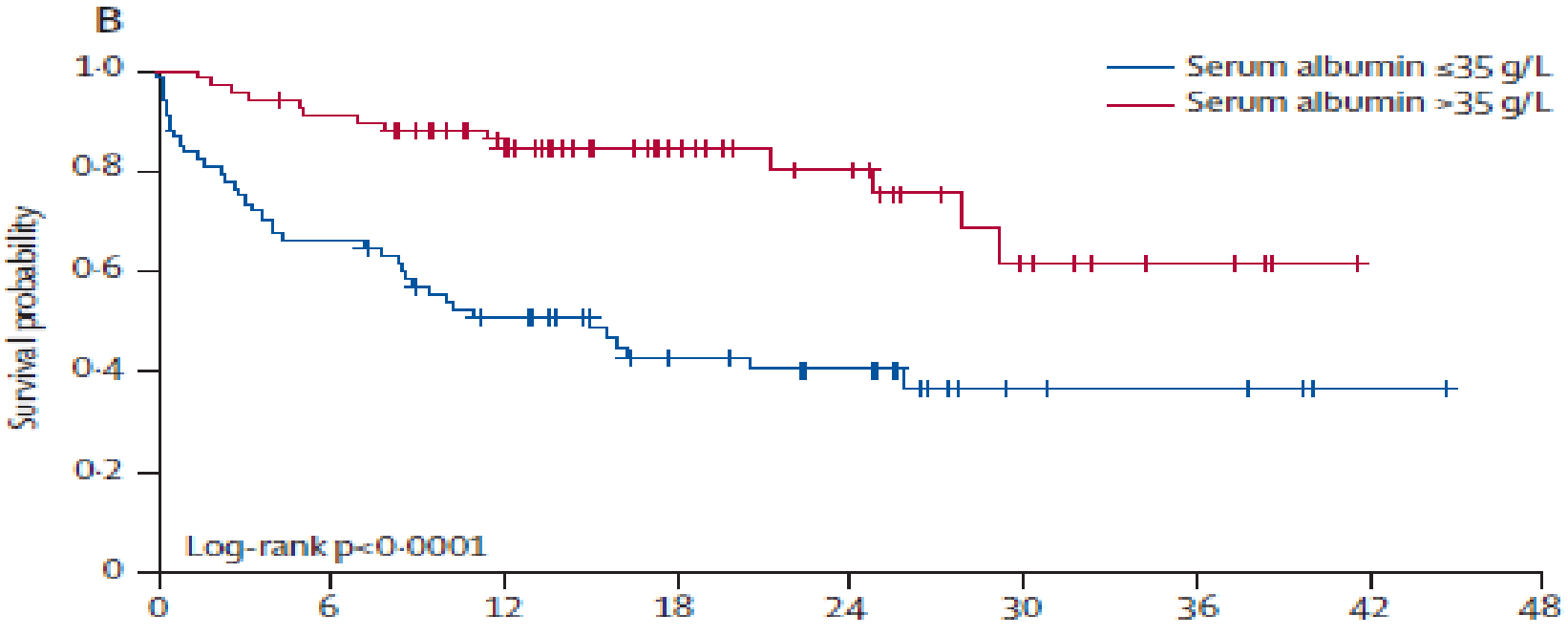
A peu près 50% de nos patients âgés ont >70 ans



Une prise en charge gériatrique est primordiale pour les patients âgés avec une hémopathie maligne

Parce qu'une partie des déterminants du pronostic est gériatrique

Le pronostic est en partie gériatrique

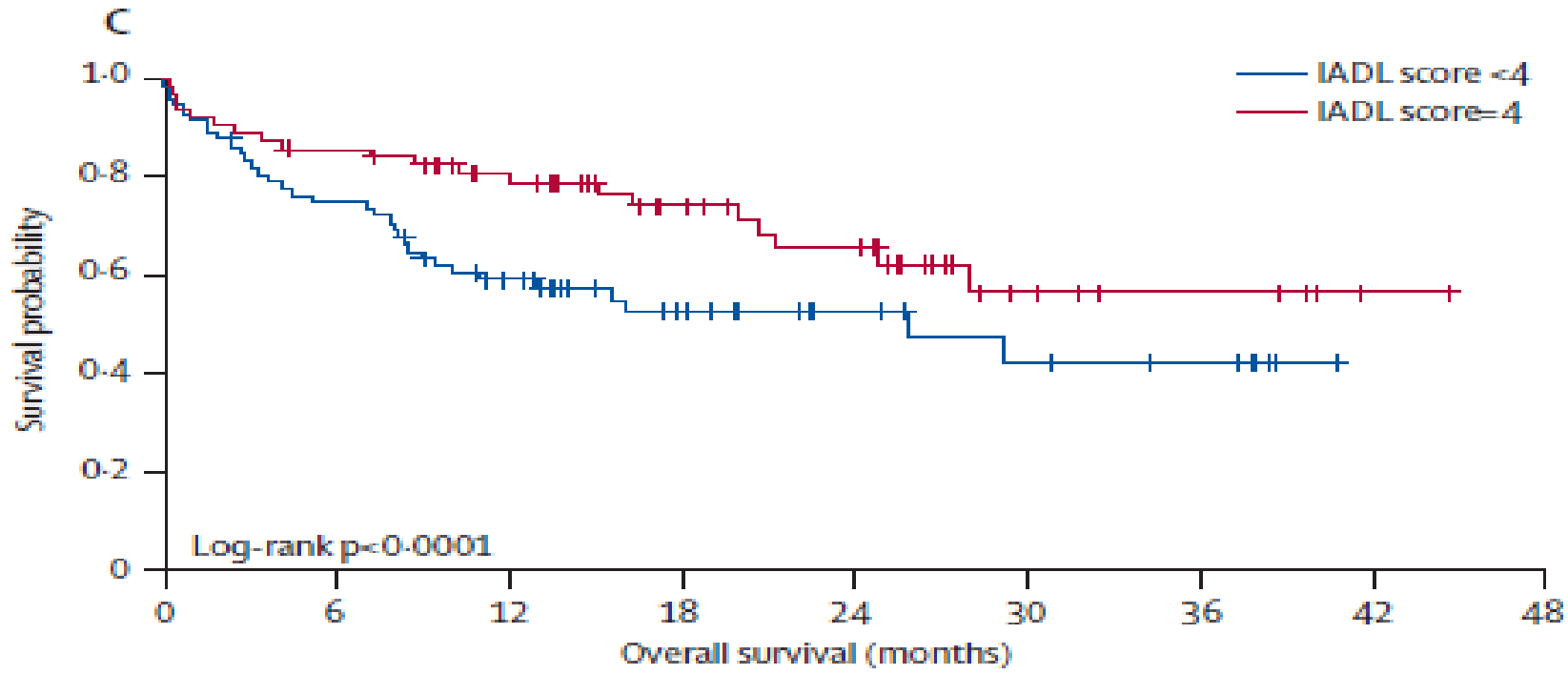


Number at risk									
Serum albumin ≤35 g/L	68	45	32	19	15	5	4	1	0
Serum albumin >35 g/L	68	61	46	26	18	8	4	0	0

	Event	Censored	Median survival (95% CI)
Serum albumin ≤35 g/L	39 (57%)	29 (43%)	15·11 (8·51–NA)
Serum albumin >35 g/L	14 (21%)	54 (79%)	NA (29·14–NA)

F Peyrade. Lancet Oncol 2011

Le pronostic est en partie gériatrique

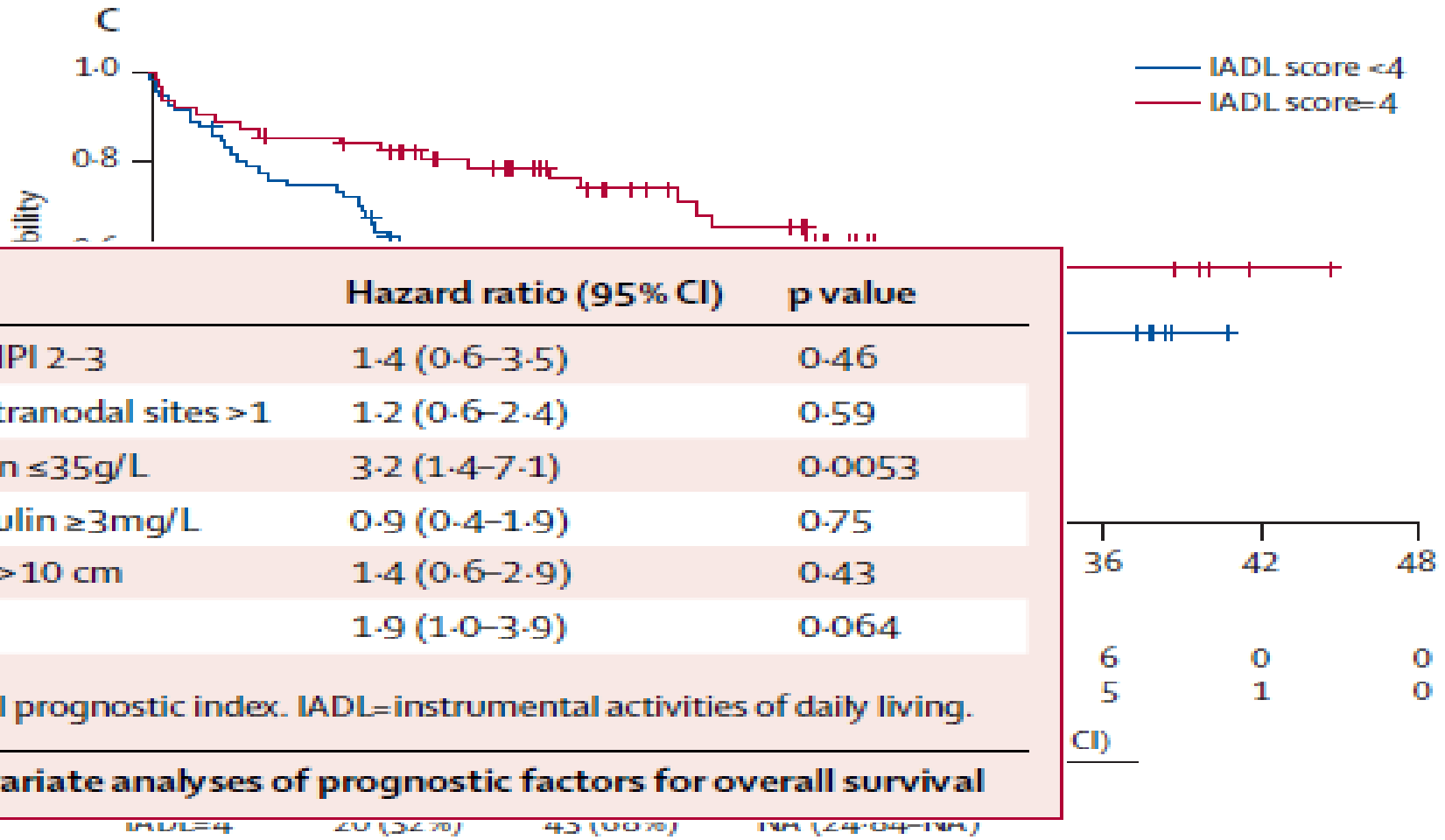


Number at risk									
IADL score <4	72	53	37	21	13	8	6	0	0
IADL score=4	63	53	42	29	23	8	5	1	0

	Event	Censored	Median survival (95% CI)
IADL<4	34 (47%)	38 (53%)	25·82 (10·05–NA)
IADL=4	20 (32%)	43 (68%)	NA (24·84–NA)

F Peyrade. Lancet Oncol 2011

Le pronostic est en partie gériatrique



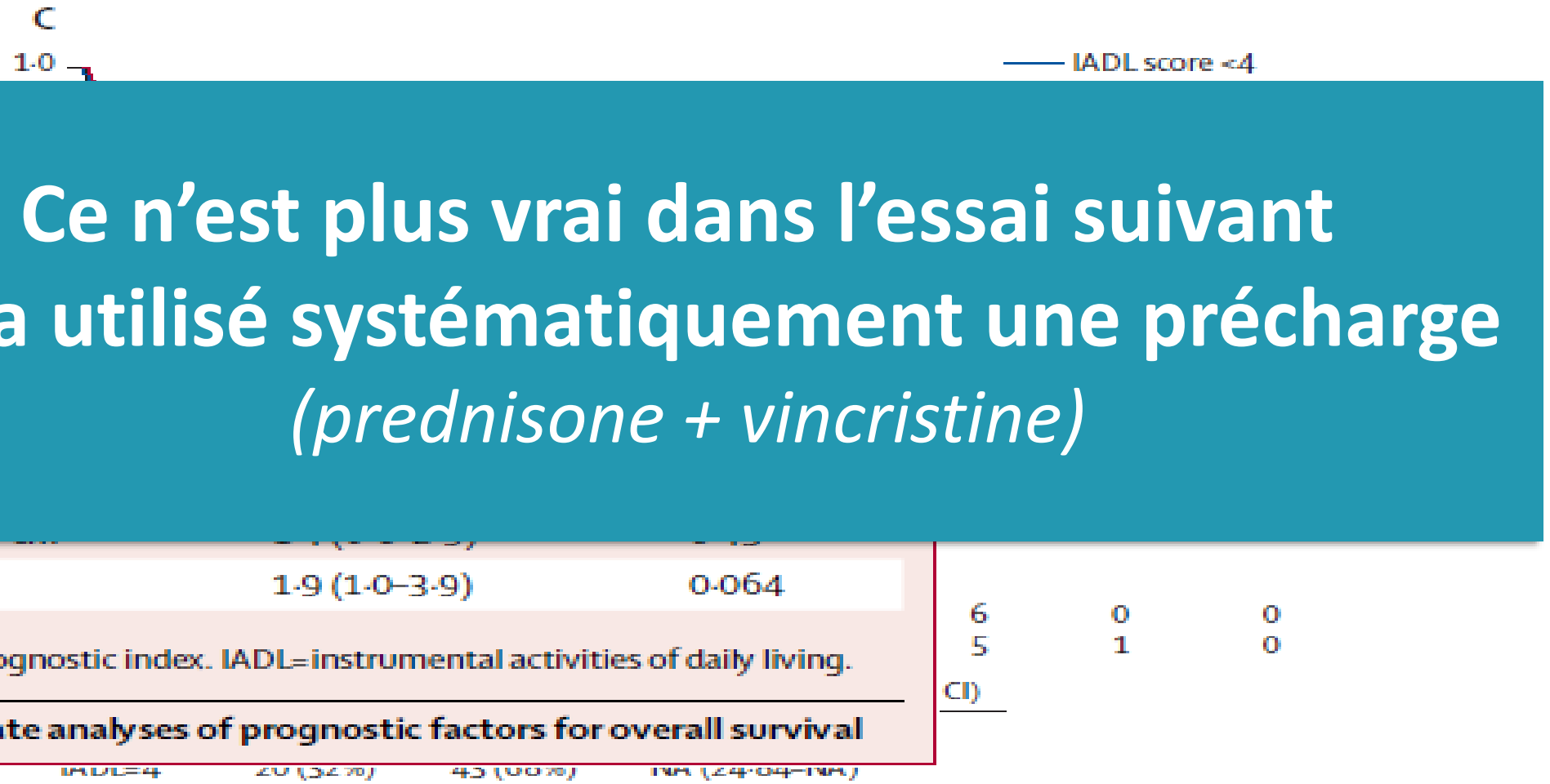
	Hazard ratio (95% CI)	p value
Age-adjusted IPI 2–3	1·4 (0·6–3·5)	0·46
Number of extranodal sites >1	1·2 (0·6–2·4)	0·59
Serum albumin ≤35g/L	3·2 (1·4–7·1)	0·0053
β2-microglobulin ≥3mg/L	0·9 (0·4–1·9)	0·75
Tumour mass >10 cm	1·4 (0·6–2·9)	0·43
IADL score <4	1·9 (1·0–3·9)	0·064

IPI=international prognostic index. IADL=instrumental activities of daily living.

Table 3: **Multivariate analyses of prognostic factors for overall survival**

F Peyrade. Lancet Oncol 2011

Le pronostic est en partie gériatrique



Ce n'est plus vrai dans l'essai suivant qui a utilisé systématiquement une précharge *(prednisone + vincristine)*

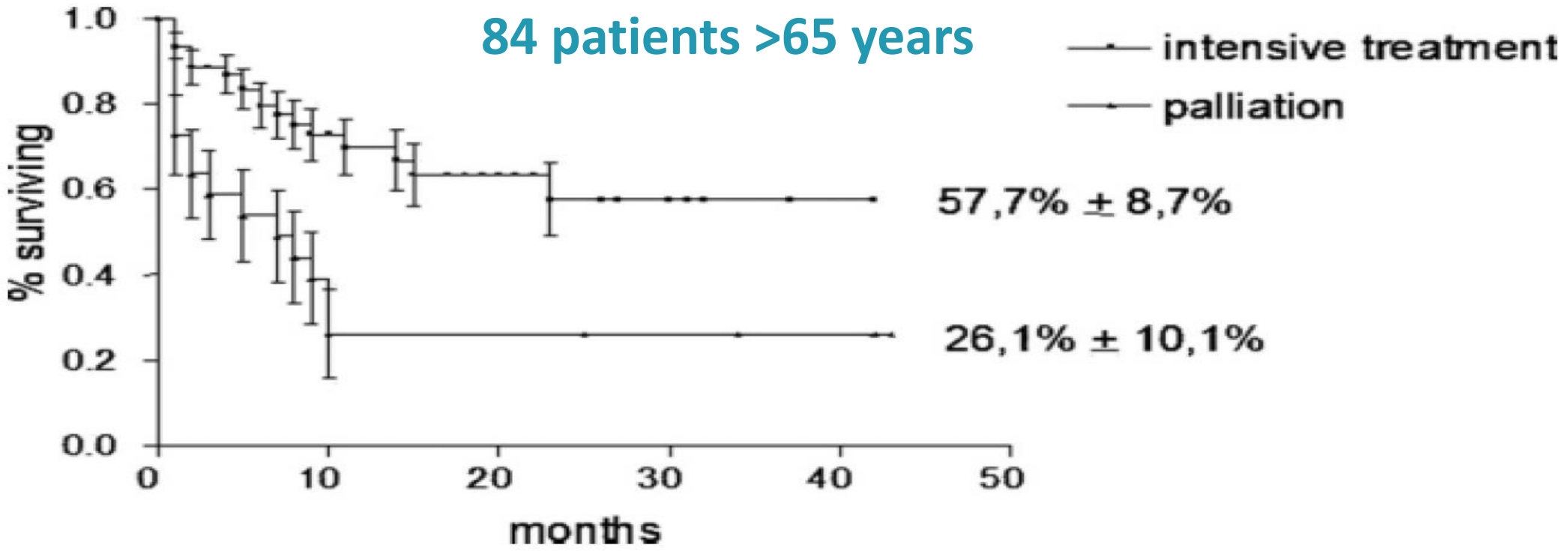
Age-ad		
Numbe		
Serum		
β2-mic		
Tumou		
IADL score <4	1·9 (1·0–3·9)	0·064

IPI=international prognostic index. IADL=instrumental activities of daily living.

Table 3: **Multivariate analyses of prognostic factors for overall survival**

F Peyrade. Lancet Oncol 2011

Le pronostic est en partie gériatrique



A Tucci. Cancer 2009

Le pronostic est en partie gériatrique

Comprehensive Geriatric Assessment

Fit

Age <80

Independent (ADL 6)

<3 grade 3 comorbidities

No grade 4 comorbidity

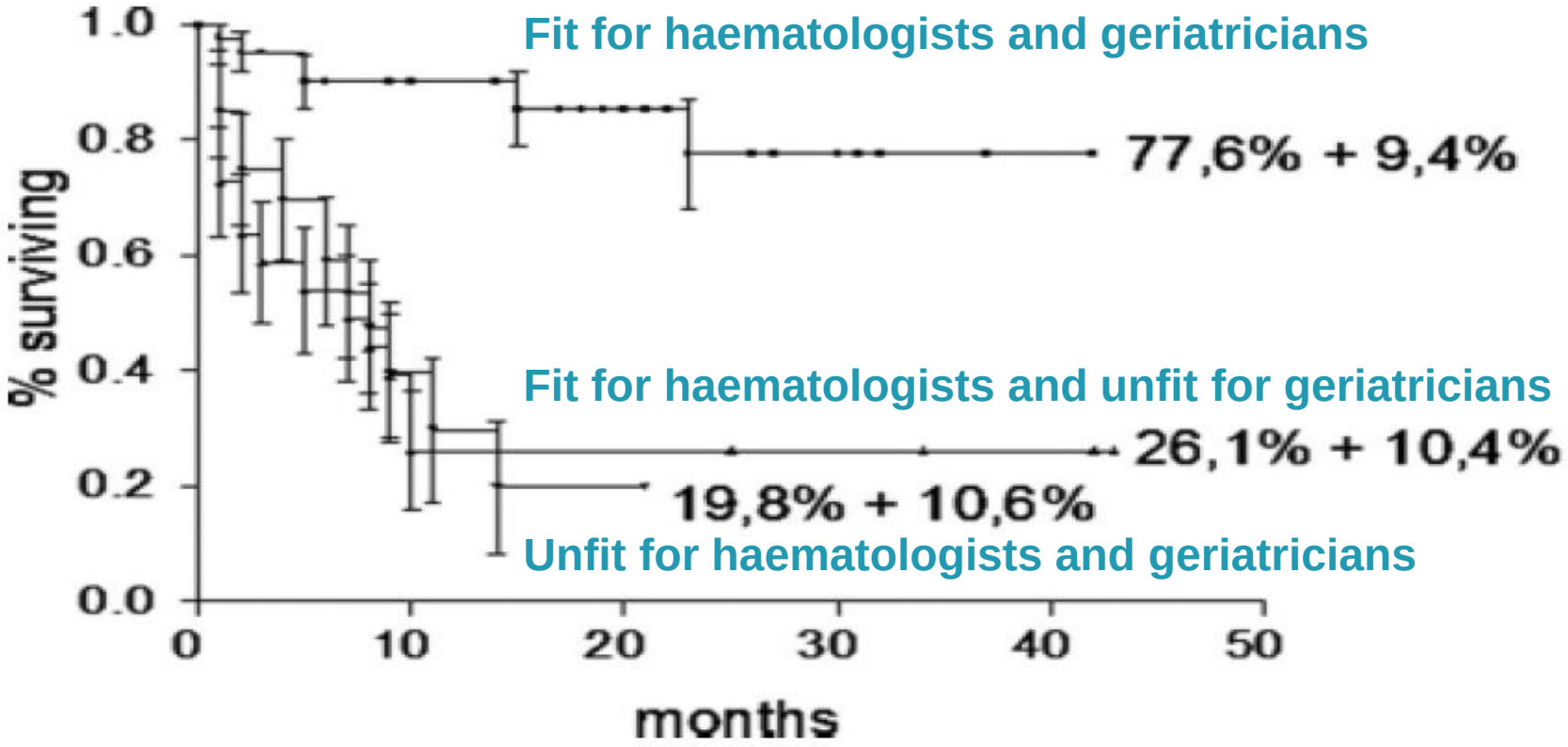
No geriatric syndrome

Fragile

All other patients

A Tucci. Cancer 2009

Le pronostic est en partie gériatrique



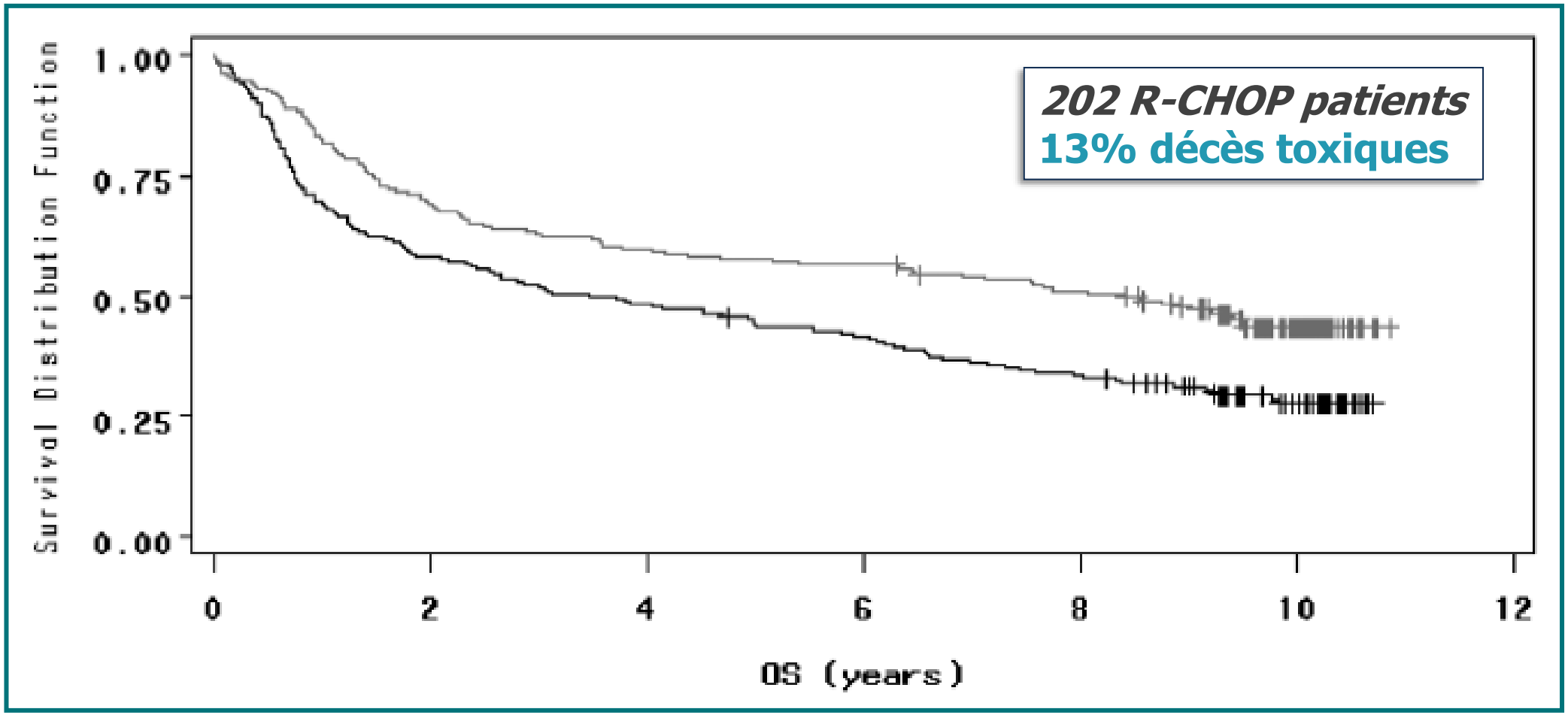
A Tucci. Cancer 2009

Une prise en charge gériatrique est primordiale pour les patients âgés avec une hémopathie maligne

Parce que, sans évaluation, on ne contrôlera pas les risques

Guérison possible et trop de décès toxiques

R-CHOP for fit patients



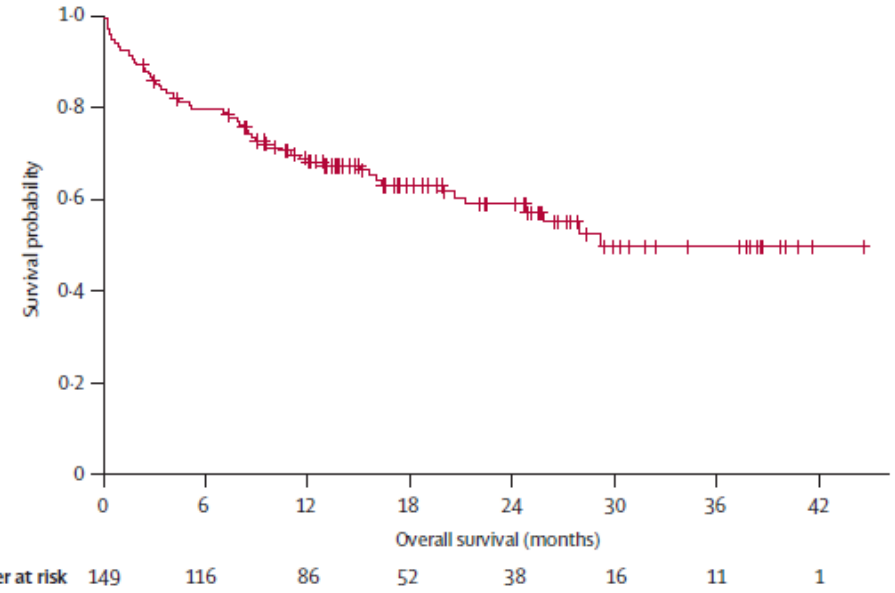
Coiffier B, Blood 2010

Guérison possible et trop de décès toxiques

R-miniCHOP patients de plus de 80 ans …

R-miniCHOP
phase II
Fit/*Unfit DLBCL > 80*
149 patients
R-MiniCHOP
62% CR-CRu

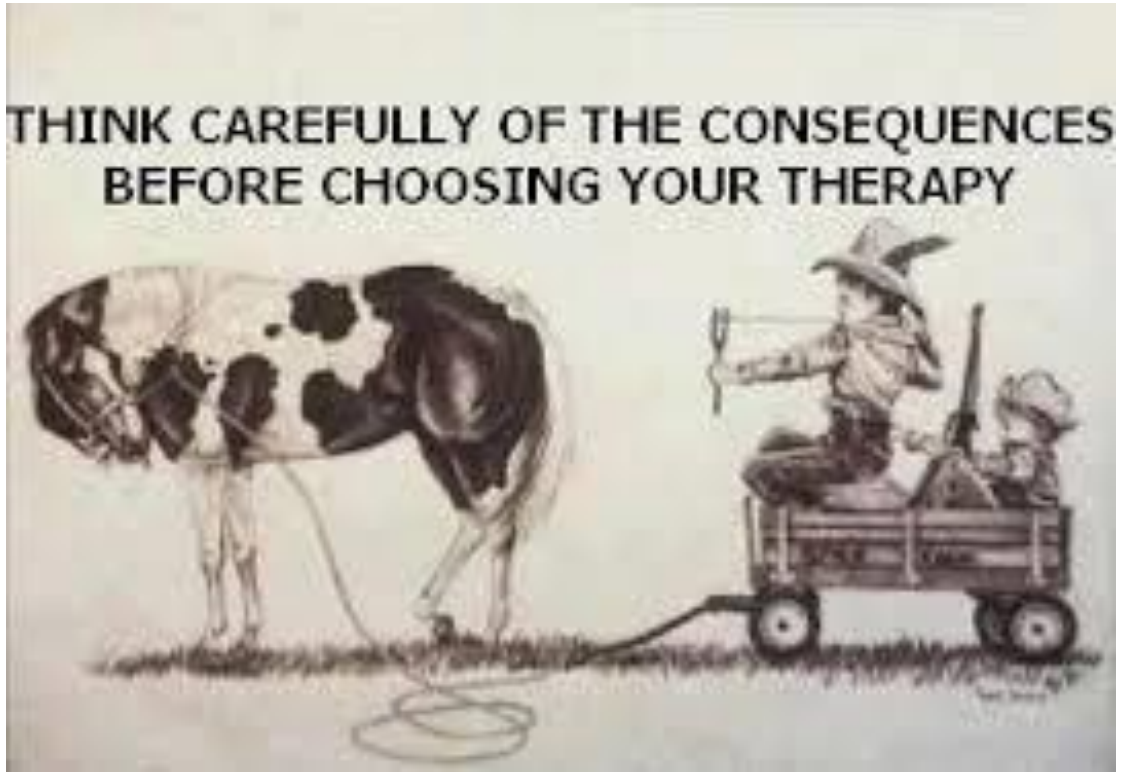
	Patients (n=149)
Men	51 (34%)
Age (years)	83 (80–95)
Performance status	
0	27 (18%)
1	72 (48%)
2	50 (34%)
Ann Arbor stage	
I	13 (9%)
II	24 (16%)
III	35 (23%)
IV	77 (52%)
Tumour mass ≥10 cm	30 (20%)
>1 extranodal sites	55 (37%)
LDH concentration >618 U/L	102 (68%)
B symptoms*	49 (33%)
β2-microglobulin ≥3 mg/L	82/112 (73%
Serum albumin <35 g/L	69/137 (50%
IPI	
0–1	13 (9%)
2	31 (21%)
3	46 (31%)
4–5	59 (40%)



12 décès toxiques (8%)
13 décès ni liés au LNH, ni liés au traitement (8.7%)

F Peyrade. Lancet Oncol 2011

Une prise en charge gériatrique est primordiale pour les patients âgés avec une hémopathie maligne



Parce que les traitements changent et les risques avec eux

Nouvelles toxicités

Rituximab lenalidomide

Table 3. Adverse Events during the Treatment Period in the Safety Population.

Adverse Event	Rituximab–Lenalidomide Group (N = 507)		Rituximab–Chemotherapy Group (N = 503)	
	Any Grade	Grade 3 or 4	Any Grade	Grade 3 or 4
	number of patients (percent)			
Neutropenia*	381 (75)	160 (32)	386 (77)	252 (50)
Anemia*	333 (66)	0	446 (89)	0
Thrombocytopenia*	268 (53)	11 (2)	266 (53)	8 (2)
Cutaneous reactions†	220 (43)	36 (7)	120 (24)	5 (1)
Diarrhea	187 (37)	10 (2)	95 (19)	6 (1)
Constipation	178 (35)	1 (<1)	167 (33)	5 (1)
Rash	146 (29)	20 (4)	39 (8)	1 (<1)
Fatigue	115 (23)	1 (<1)	147 (29)	4 (<1)
Nausea	100 (20)	0	209 (42)	8 (2)
Abdominal pain	78 (15)	4 (<1)	46 (9)	4 (<1)
Myalgia	73 (14)	0	29 (6)	1 (<1)
Arthralgia	71 (14)	3 (<1)	70 (14)	1 (<1)
Peripheral edema	69 (14)	0	47 (9)	1 (<1)
Muscle spasms	68 (13)	0	21 (4)	0
Infusion-related reaction	66 (13)	7 (1)	56 (11)	1 (<1)
Upper respiratory tract infection	47 (9)	0	55 (11)	0
Vomiting	34 (7)	2 (<1)	94 (19)	7 (1)
Peripheral neuropathy	35 (7)	1 (<1)	79 (16)	3 (<1)
Tumor flare reaction	30 (6)	7 (1)	1 (< 1)	0
Leukopenia	21 (4)	8 (2)	48 (10)	30 (6)
Febrile neutropenia	11 (2)	11 (2)	34 (7)	33 (7)
Tumor lysis syndrome	7 (1)	6 (1)	5 (1)	3 (<1)
Alopecia	5 (1)	0	45 (9)	3 (<1)

F Morschhauser, NEJM 2018

Les traitements changent

Lenalidomide

- **Lenalidomide vs investigators' choice**
  - ***Relapsed/refractory patients***
  - ***254 pts, median age 68.5 (44 to 88)***
  - ***PS 2: 16% and 13%***
  - ***MIPI high 35% and 30%***
- **Better response rate** (40% vs 11%, p<0.001)
- **Better median PFS** (8.7 vs 5.2 m., P=0.004)
- **Quality of life improvements**
  - ***Physical function: 24 vs 8%, p=0.003***
- **More toxicity**
  - ***fatigue: 21 vs 5%***
  - ***diarrhea: 23 vs 10%***

M Trneny, Lancet Oncol 2016

Les traitements changent

Ibrutinib

- **Ibrutinib vs temsirolimus phase III trial**
  - ***Relapsed/refractory patients***
    - 280 pts with MCL older than 65
    - Median age 68
    - Performance status 2: 1%
    - sMIPI high: 21%
  - ***Outcome***
    - Improved PFS (14.6 vs 6.2 m.)
    - Confirmed whatever age
  - ***Better toxicity profile***

	Ibrutinib (n=139)		Temsirolimus (n=139)	
	Any grade	Grade 3 or higher	Any grade	Grade 3 or higher
Haematological				
Thrombocytopenia	25 (18%)	13 (9%)	78 (56%)	59 (42%)
Anaemia	25 (18%)	11 (8%)	60 (43%)	28 (20%)
Neutropenia	22 (16%)	18 (13%)	36 (26%)	23 (17%)
Non-haematological				
Diarrhoea	40 (29%)	4 (3%)	43 (31%)	6 (4%)
Fatigue	31 (22%)	6 (4%)	40 (29%)	10 (7%)
Cough	31 (22%)	0	31 (22%)	0
Pyrexia	23 (17%)	1 (1%)	29 (21%)	3 (2%)
Nausea	20 (14%)	0	30 (22%)	0
Peripheral oedema	18 (13%)	0	31 (22%)	3 (2%)
Epistaxis	12 (9%)	1 (1%)	33 (24%)	2 (1%)
Stomatitis	4 (3%)	0	29 (21%)	5 (4%)

Data are n (%). Rates shown are not adjusted for differences in exposure (median treatment duration was 14·4 months for ibrutinib and 3·0 months for temsirolimus).

Table 2: Common treatment-emergent adverse events (20% or more of patients) in the safety population

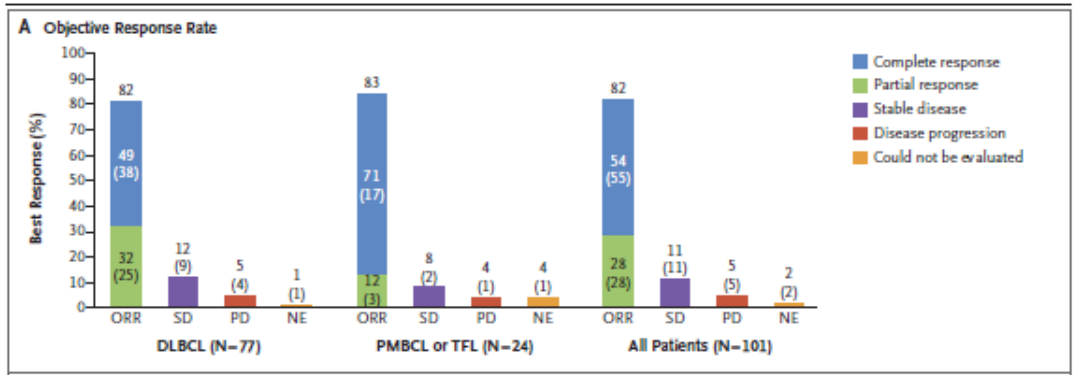
M Dreyling, Lancet 2016

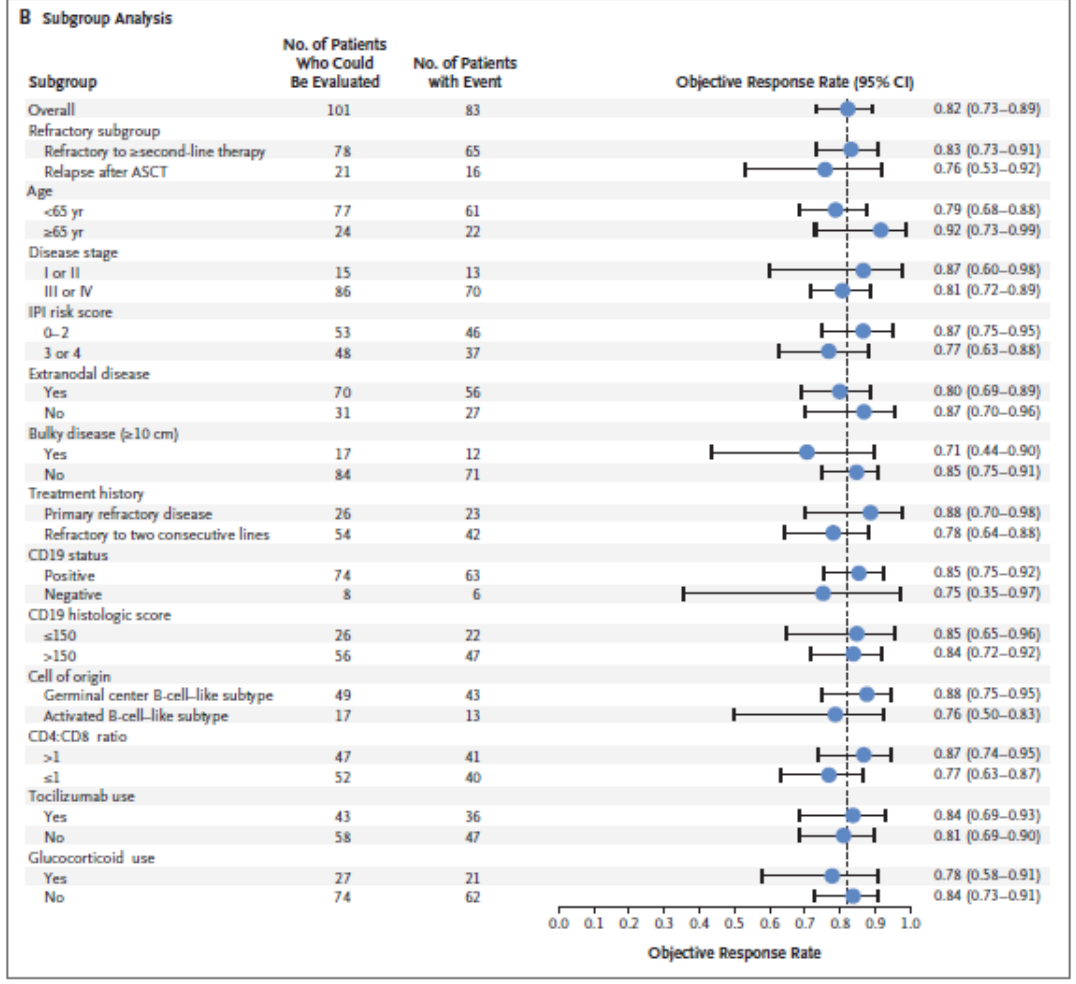
The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Axicabtagene Ciloleucel CAR T-Cell Therapy in Refractory Large B-Cell Lymphoma

Characteristics at baseline			
No. of patients	77	24	101
Disease type — no. (%)			
DLBCL	77 (100)	0	77 (76)
PMBCL	0	8 (33)	8 (8)
TFL	0	16 (67)	16 (16)
Age			
Median (range) — yr	58 (25–76)	57 (23–76)	58 (23–76)
≥65 yr — no. (%)	17 (22)	7 (29)	24 (24)
Male sex — no. (%)	50 (65)	18 (75)	68 (67)
ECOG performance-status score of 1 — no. (%)	49 (64)	10 (42)	59 (58)





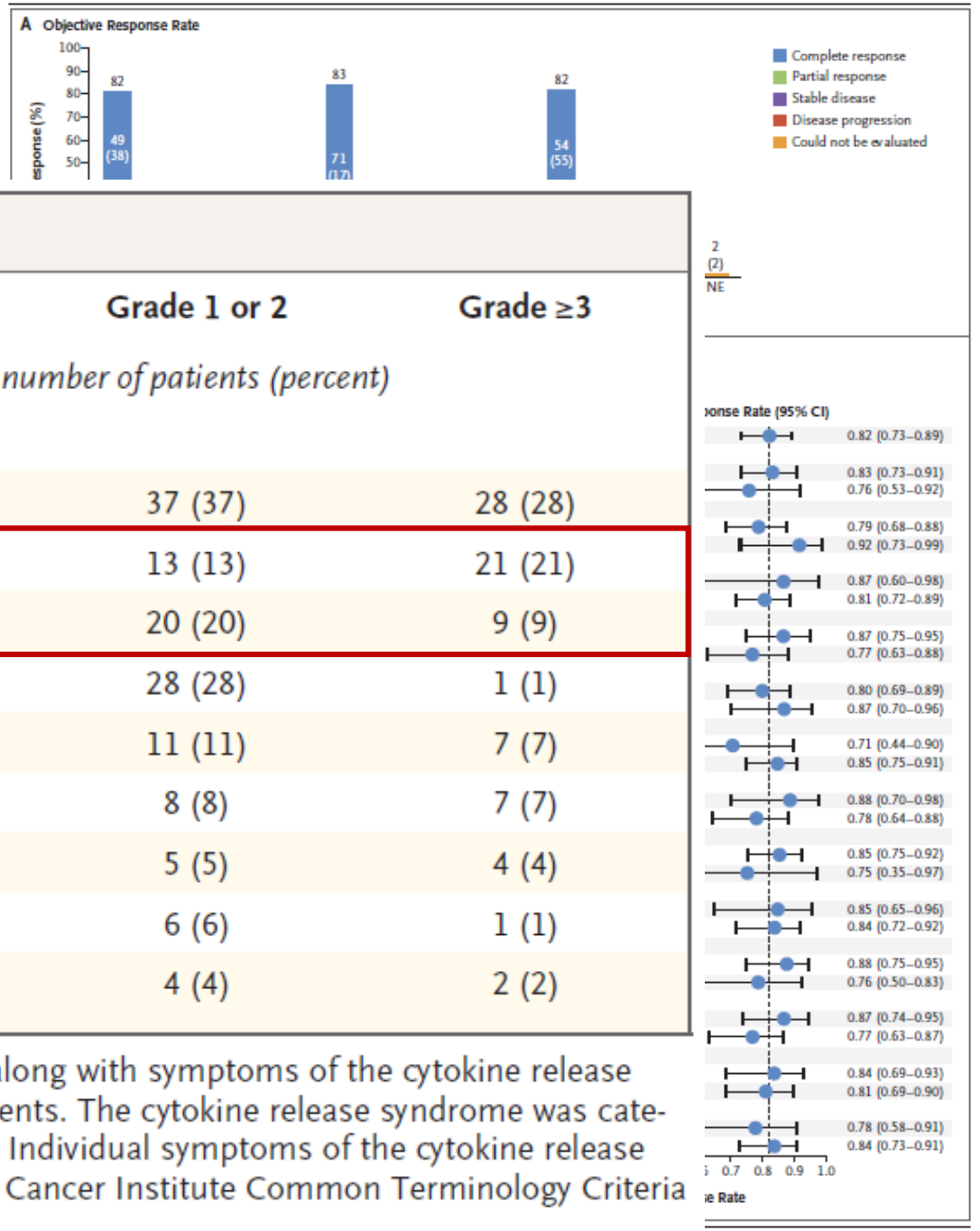
ORIGINAL ARTICLE

Axicabtagene Ciloleucel CAR T-Cell Therapy in Refractory Large B-Cell Lymphoma

Table 2. (Continued.)

Event	Any Grade	Grade 1 or 2	Grade ≥3
	number of patients (percent)		
Neurologic event			
Any	65 (64)	37 (37)	28 (28)
Encephalopathy	34 (34)	13 (13)	21 (21)
Confusional state	29 (29)	20 (20)	9 (9)
Tremor	29 (29)	28 (28)	1 (1)
Aphasia	18 (18)	11 (11)	7 (7)
Somnolence	15 (15)	8 (8)	7 (7)
Agitation	9 (9)	5 (5)	4 (4)
Memory impairment	7 (7)	6 (6)	1 (1)
Mental-status change	6 (6)	4 (4)	2 (2)

* Listed are adverse events that occurred in at least 30% of the patients, along with symptoms of the cytokine release syndrome and neurologic events that occurred in at least 5% of the patients. The cytokine release syndrome was categorized according to a modified grading system proposed by Lee et al.[24] Individual symptoms of the cytokine release syndrome and neurologic events were graded according to the National Cancer Institute Common Terminology Criteria for Adverse Events, version 4.03.



Nouvelles toxicités

Les conséquences des toxicités peuvent être plus graves chez les sujets âgés

Les effets secondaires sont généralement modérés mais…

- **Fatigue vs qualité de vie, indépendance et chutes**
- **Conséquences des saignements aggravées par les chutes**
- **Fibrillation auriculaire et insuffisance cardiaque**
- **Diarrhée et vomissements et déshydratation**

Une prise en charge gériatrique est primordiale pour les patients âgés avec une hémopathie maligne

Parce que, sans évaluation, on a tendance à sous-traiter

On sous-traite probablement…

- **1011 patients** ***(2003 – 2012)***
  - ***Danish National Lymphoma Registry (LYFO)***
- **Older than 75**
- **Older DLBCL undertreated**
  - ***75-79 = 83% - 80-84 = 65% - 85+ = 32%***

Bech Juul M, Eur J Cancer 2018;99:86-96

Des risques à prendre pour guérir

Place de la doxorubicin chez les patients vulnérables

67 patients	n	%
Creatinine clearance <50 ml/mn	**35**	**52**
PS 3	**32**	**48**
LVEF <50%	8	12
Comorbidities	8	12
Serum bilirubin >30 µmol/l	2	3

Abnormal	%	ONCODAGE
ADL	**39%**	15,2%
IADL	**66%**	47,9%
GDS15	**42%**	32,1%
MNA	**64%**	43,7%
MMS	**45%**	20,3%
CIRS-G grade 3-4	**42%**	41,8%

	R-COP (47 pts)	R-COPY (20 pts)
aaIPI 2-3	85%	80%
RC + RCu	**19 (40%)**	**12 (60%)**
Progression	**8 (17%)**	**1 (5%)**
Response duration CR/CRu	**15,5 m**	**38,5 m**
Febrile Neutropenia	**7 (15%)**	**7 (35%)**
Mucositis	**4 (9%)**	**3 (16%)**
Days hosp. for toxicity	**2,5 days**	**4,8 days**
Toxic deaths	4 (8,5%)	1 (5%)
Median follow-up	22,95 m	51,08 m
Median survival	20,1 m	25,4 m
2-year survival	**39,4%**	**50%**

Une prise en charge gériatrique est primordiale pour les patients âgés avec une hémopathie maligne

Parce qu'on a les moyens de mieux faire en terme de prédictions

Evaluation Gériatrique Approfondie

Domain	Assessment Tool Examples	Evidence	Intervention, examples
Functional status	ADLs (i.e. transferring, eating) IADLs (i.e. managing finances, cooking, driving)	Associated with chemotherapy toxicity, hospital admissions, functional decline, and mortality[4,41,47,56]	Aids such as motorized wheelchair Meals on wheels Physiotherapy Occupational therapy
Objective physical performance	4m gait speed, TUG; SPPB; grip strength; sarcopenia	Prediction of mortality, treatment related complications, and functional decline[57-59]	Structured exercise Assistive devices
Falls	Number of falls in previous six months	Related to chemotherapy toxicity, postoperative complications, and functional decline[23,60]	Falls prevention program
Cognitive Function	MMSE; MoCA; Mini-Cog; BOMC	Assessment of capacity for consent/treatment adherence and cognitive decline associated with treatment. Associated with poorer overall survival, chemotherapy toxicity, delirium[21,44,61]	Support during treatment trajectory Delirium prevention program Treatment reminders e.g. text messages for daily radiation therapy appointments
Mood (depression)	GDS; HADS; PHQ2/9	Assessment of psychological adjustment to treatment. Associated with postoperative complications, treatment tolerance, functional decline and mortality[46,47,56,62]	Cognitive behavioural therapy Medical therapy Counselling
Nutritional Status	MNA; BMI and weight loss combined	Associated with mortality, likelihood of treatment completion and healthcare consumption[63,64]	Dietary counselling
Comorbidity	CIRS-G; CCI; OARS comorbidity	Assessment of competing causes of mortality, survival, treatment tolerance and hospital admissions[62,65]	Referral to organ specialist
Polypharmacy	List of medications, STOPP-START; Beers criteria	Postoperative complications, chemotherapy toxicity, functional decline and mortality[66]	Geriatrician/Clinical pharmacist review of medications
Social support	Focused questions re: social support; MOS-SSS; MPSSS	Associated with cancer progression, chemotherapy toxicity, poorer survival as well as treatment adherence[67]	Home nursing Transportation assistance Buddy support schemes Referral to community/cancer support groups

Axe Horizontal (Valeur)

MNA et vitesse de marche prédisent les décès précoces

P Soubeyran, J Clin Oncol 2012; 30:1829-34

R Boulahssass, Eur J Cancer 2018; 100: 65-74

Les IADL et GDS15 sont les seuls facteurs prédictifs du déclin fonctionnel précoce

S Hoppe, J Clin Oncol 2013; 31: 3877-82

Le G8 prédit le déclin fonctionnel qui prédit les décès précoces

C Chakiba, J Ger Oncol 2019; 10: 921-5

IADL, MMS, MNA et MAX2, IADL et activités physiques prédisent les toxicités sévères

Martine Extermann, Cancer 2012;118:3377-86

Arti Hurria, J Clin Oncol 2011;29:3457-65

Une prise en charge gériatrique est primordiale pour les patients âgés avec une hémopathie maligne

Parce qu'on a les moyens de mieux faire en terme d'intervention

L'EGA est un investissement

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JOURNAL OF CLINICAL ONCOLOGY

COMMENTS AND CONTROVERSIES

Time to Stop Saying Geriatric Assessment Is Too Time Consuming

Marije E. Hamaker, *Diakonessenhuis, Utrecht, the Netherlands*
Tanya M. Wildes, *Washington University School of Medicine, St Louis, MO*
Siri Rostoft, *Oslo University Hospital and University of Oslo, Oslo, Norway*

Consommer un peu de temps au début peut permettre d'en gagner beaucoup ensuite…

Résultats

Essai INTEGERATE

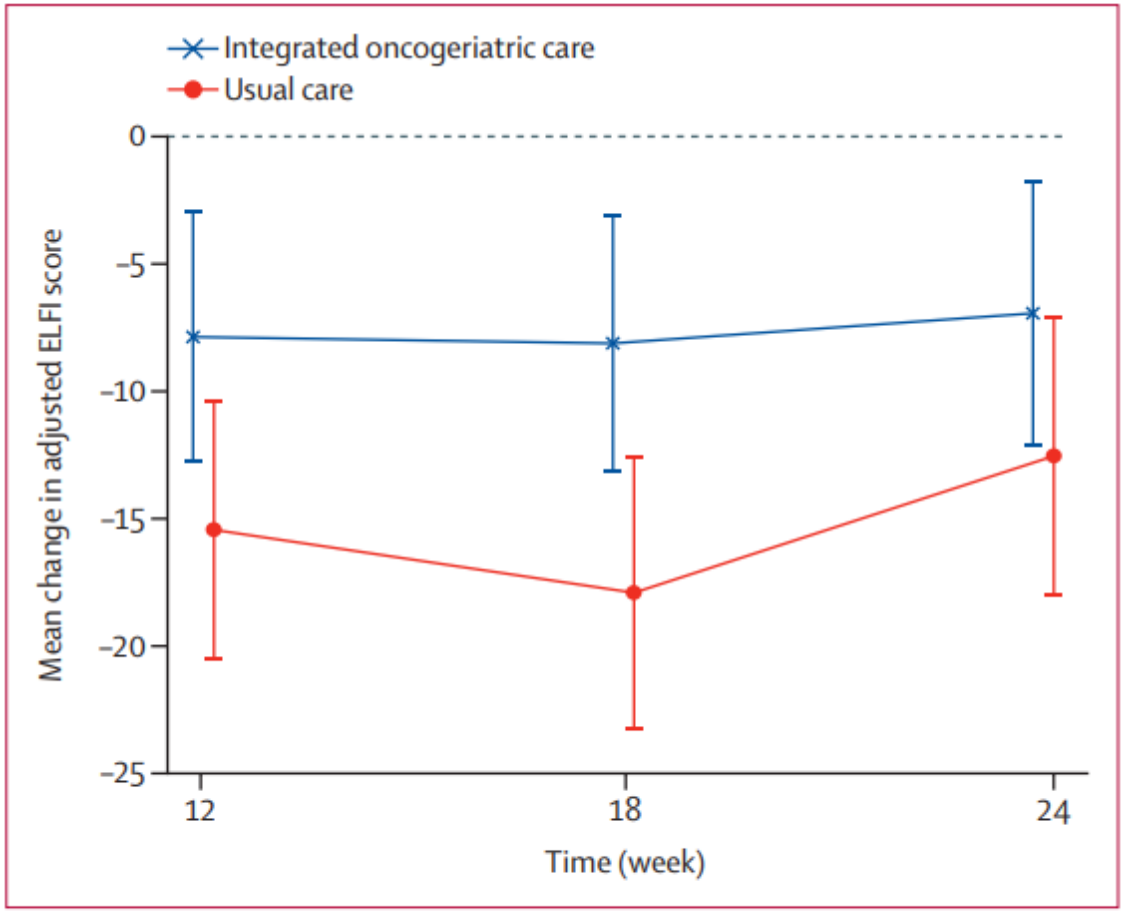


Figure 2: **Mean change in adjusted ELFI scores from baseline to 12, 18, and 24 weeks by study group in the intention-to-treat population**
Negative change indicates worsening function. ELFI=Elderly Functional Index.

Wee Kheng Soo, Madeleine T King, Alun Pope, Phillip Parente, Pēteris Dārziņš, Ian D Davis**

***Lancet Healthy Longev* 2022; 3: e617–27**

Résultats

Essai INTEGERATE

	Integrated oncogeriatric care			Usual care			Multivariate IRR* (95% CI)	p value
	n	Person-years	Incidence rate	n	Person-years	Incidence rate		
Planned hospital admission	8	28·9	0·28	5	29·2	0·17	1·53 (0·50–4·75)	0·45
Emergency presentation	46	28·9	1·59	83	29·2	2·84	0·59 (0·41–0·85)	0·0049
Unplanned hospital admission	45	28·9	1·56	80	29·2	2·73	0·60 (0·42–0·87)	0·0066
Unplanned hospital days	494	30·4	16·25	724	31·2	23·23	0·77 (0·68–0·86)	<0·0001
Acute	310	30·4	10·19	520	31·2	16·68	0·66 (0·57–0·76)	<0·0001
Rehabilitation	42	30·4	1·38	61	31·2	1·96	0·68 (0·45-1·03)	0·066
Palliative care	142	30·4	4·67	143	31·2	4·59	1·13 (0·89–1·42)	0·32

For supporting data, please refer to the time to unplanned hospital admission curve in the appendix (p 14). IRR=incidence rate ratio. *For the Poisson regression analyses, the IRRs for the effect of study group adjusted for covariates (age, sex, Eastern Cooperative Oncology Group performance status, cancer type, and treatment intent) were estimated using log-linear models for the incidence of hospital utilisation after enrolment, offset by the natural log of days at risk from enrolment until 168 days (24 weeks).

24 weeks by study group in the intention-to-treat population

Negative change indicates worsening function. ELFI=Elderly Functional Index.

Wee Kheng Soo, Madeleine T King, Alun Pope, Phillip Parente, Pēteris Dārziņš, Ian D Davis** **Lancet Healthy Longev 2022; 3: e617–27**

Essai INTEGERATE

	Integrated oncogeriatric care (n=73)	Usual care (n=77)	Univariate OR (95% CI)	p value	Multivariate OR* (95% CI)	p value
Initial reduction†	20 (27%)	29 (38%)	0·57 (0·27–1·18)	0·13	0·55 (0·24–1·26)	0·16
Subsequent reduction†	20 (27%)	19 (25%)	1·13 (0·53–2·43)	0·75	1·09 (0·50–2·39)	0·83
Subsequent escalation	4 (5%)	5 (6%)	0·83 (0·22–3·24)	1·00	0·74 (0·18–3·01)	0·67
Subsequent delay‡	11 (15%)	19 (25%)	0·54 (0·24–1·24)	0·16	0·57 (0·24–1·32)	0·19
Discontinuation of planned treatment	23 (33%)	41 (53%)	0·43 (0·22–0·83)	0·014	0·38 (0·18–0·79)	0·010
Due to toxicity	7 (10%)	27 (35%)	0·20 (0·08–0·49)	0·0013	0·18 (0·07–0·47)	0·0013
Due to progression	17 (23%)	14 (18%)	1·37 (0·62–3·02)	0·55	1·55 (0·62–3·86)	0·35

Data are n (%) unless stated otherwise. OR=odds ratio. *For the logistic regression analyses, the OR for the effect of study group adjusted for covariates (age, sex, Eastern Cooperative Oncology Group performance status, cancer type, and treatment intent) were estimated using binary logistic regression models for modification to primary systemic anticancer treatment from enrolment until 168 days (24 weeks). †Initial reduction reflects the first cycle dose reduction and subsequent reduction reflects any dose reduction that occurred in cycle two or subsequent cycles within 24 weeks. ‡Delay of more than 3 days in the start of treatment measured since the start of the previous cycle.

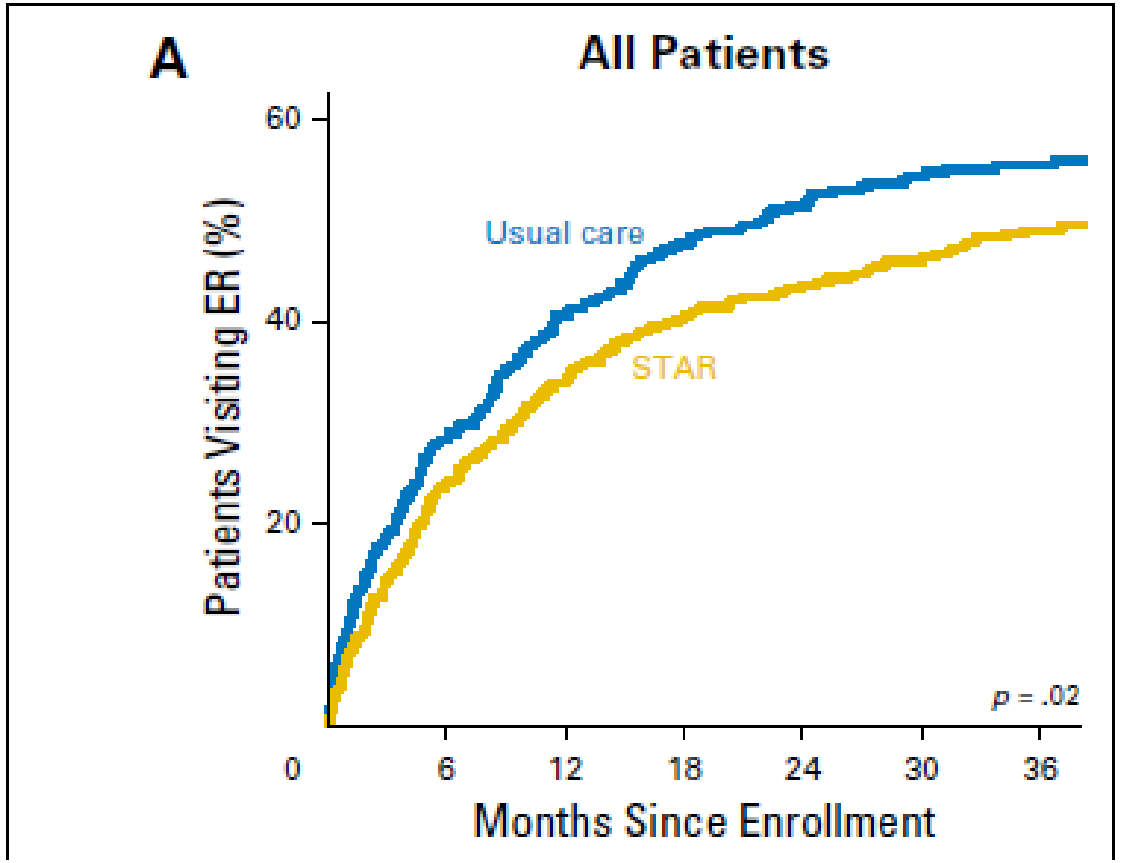
Table 4: **Chemotherapy modification by study group in the intention-to-treat population**

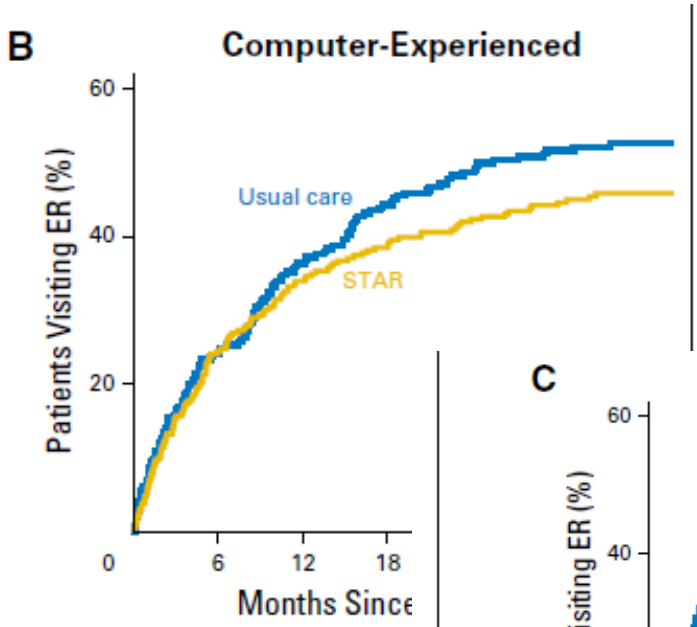
Negative change indicates worsening function. ELFI=Elderly Functional Index.

Wee Kheng Soo, Madeleine T King, Alun Pope, Phillip Parente, Pēteris Dārziņš, Ian D Davis** **Lancet Healthy Longev 2022; 3: e617–27**

Collection des PROs par outil web

Hospitalisations d'urgence





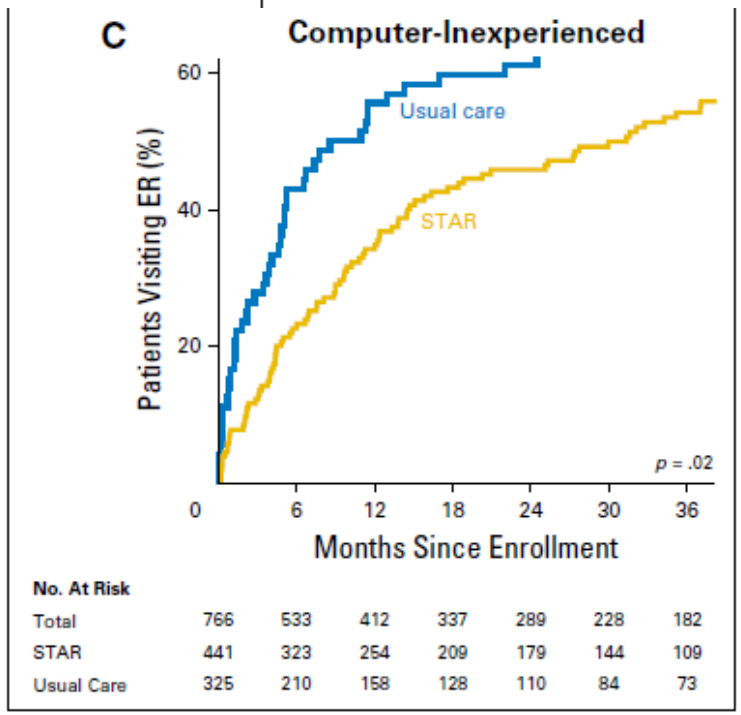


Fig 3. Cumulative incidence of emergency room (ER) visits. The incidence of patients visiting the ER is shown, with death as a competing event. (A) All patients; (B) computer-experienced patients; (C) computer-inexperienced patients. STAR, Symptom Tracking and Reporting web-based self-reporting system (study intervention).

Basch E, JCO 2016

Collection des PROs par outil web

Survie globale et Qualité de vie

Table 3. Overall and Quality-Adjusted Survival at 12 Months

Patients	N	STAR (95% CI)	Usual Care (95% CI)	*P* (Univariable)*	*P* (Multivariable)*
Overall survival, % alive at 1 year					
All patients	766	75.1 (70.7 to 79.0)	68.6 (63.2 to 73.6)	.03	.05
Subgroup analysis, % alive at 1 year					
Computer inexperienced	227	74.2 (66.6 to 80.9)	59.7 (47.5 to 71.1)	.03	.02
Computer experienced	539	75.5 (70.1 to 80.4)	71.1 (65.1 to 76.7)	.25	.45
Quality-adjusted 12-month survival, months					
All patients	757†	8.7 (8.3 to 9.0)	8.0 (7.6 to 8.4)	.002	.004
Subgroup analysis, months					
Computer inexperienced	220†	8.3 (7.8 to 8.8)	7.2 (6.3 to 8.2)	.03	.02
Computer experienced	537†	8.8 (8.5 to 9.2)	8.2 (7.7 to 8.6)	.02	.046

Abbreviation: STAR, Symptom Tracking and Reporting web-based self-reporting system (study intervention).
**P* values for between-arm comparisons. Multivariable analyses controlled for age, sex, cancer type, race, and education level. For overall analyses, subgroup assignment (computer experienced or computer inexperienced) was also included as a covariate.
†Participants with missing baseline health-related quality of life scores not included in quality-adjusted survival analysis.

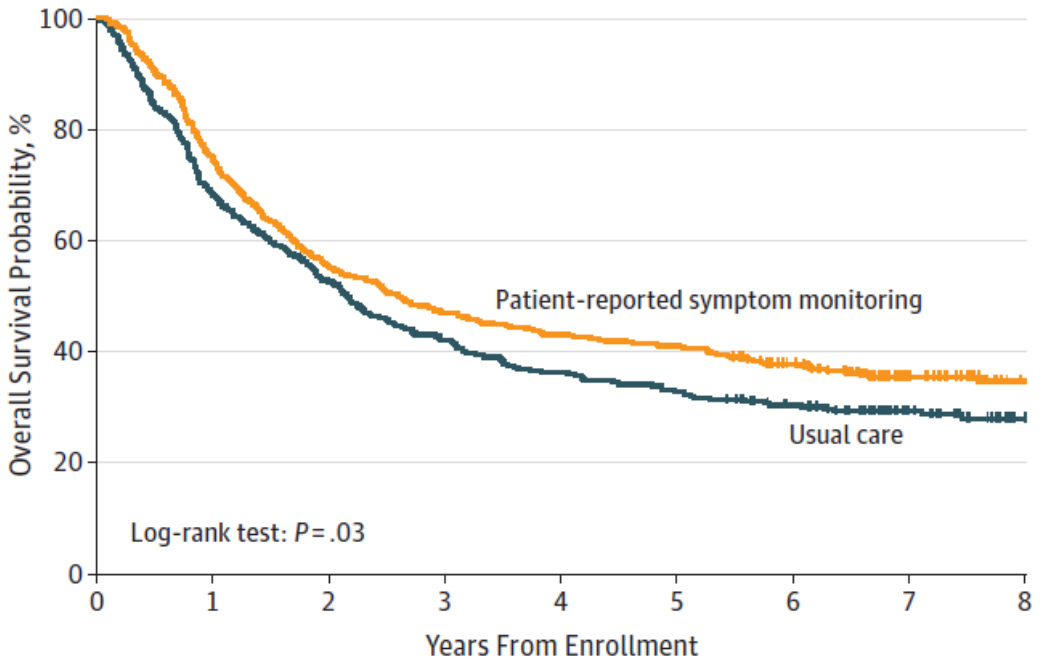
Basch E, JAMA 2017

Survie globale

Patients
Overall survival, % alive at 1 year
All patients
Subgroup analysis, % alive at 1 year
Computer inexperienced
Computer experienced
Quality-adjusted 12-month survival, months
All patients
Subgroup analysis, months
Computer inexperienced
Computer experienced

Abbreviation: STAR, Symptom Tracking and Rep
*P values for between-arm comparisons. Multi
assignment (computer experienced or computer
†Participants with missing baseline health-relate

Figure. Overall Survival Among Patients With Metastatic Cancer Assigned to Electronic Patient-Reported Symptom Monitoring During Routine Chemotherapy vs Usual Care



No. at risk									
Patient-reported symptom monitoring	441	331	244	207	190	181	148	65	33
Usual care	325	223	171	137	118	107	89	50	27

Basch E, JAMA 2017

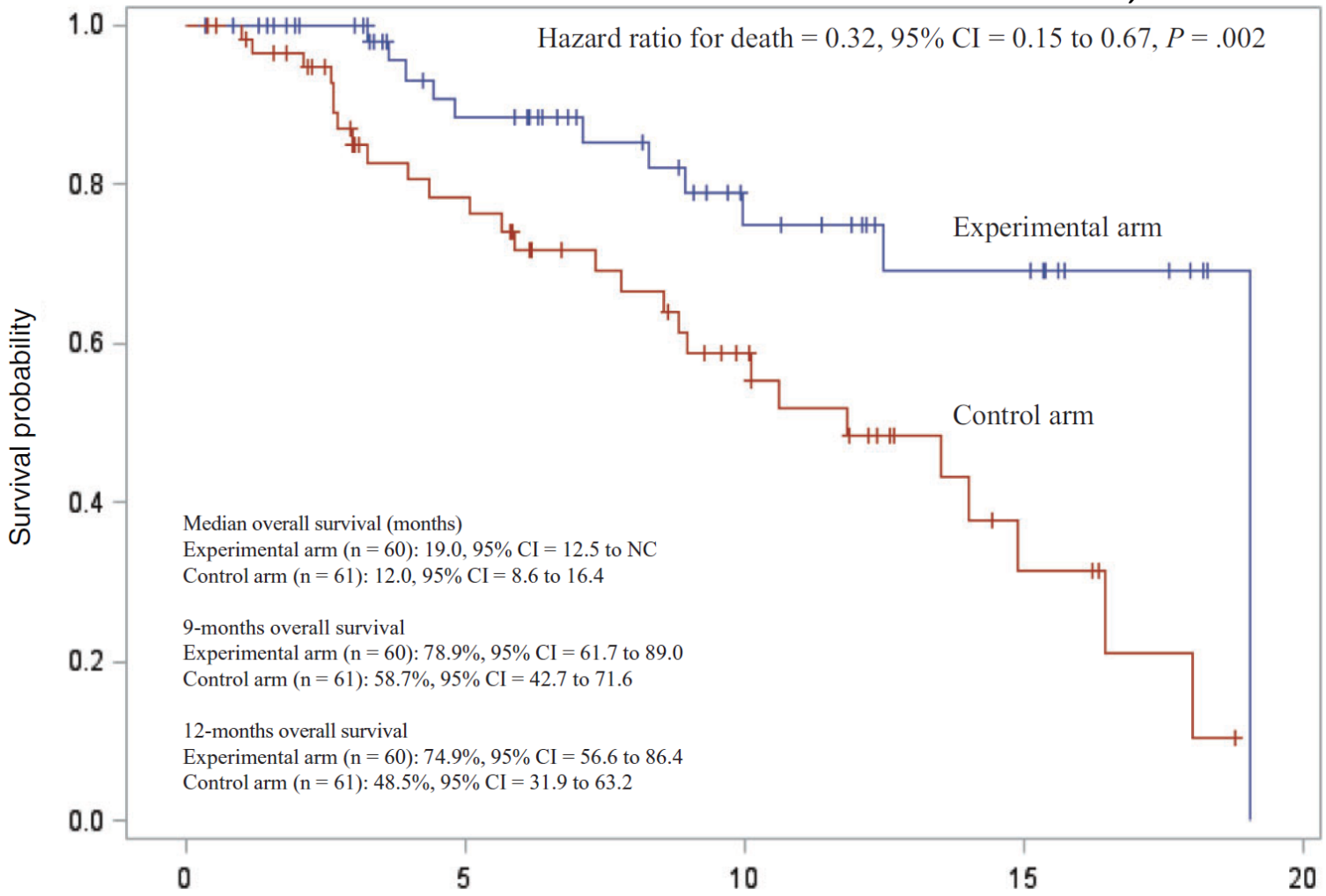
Collection des PROs par outil web

Survie globale

Denis F, JNCI 2017

Détection précoce des rechutes

Meilleur PS à la rechute



Collection des PROs par outil web

Qualité de vie

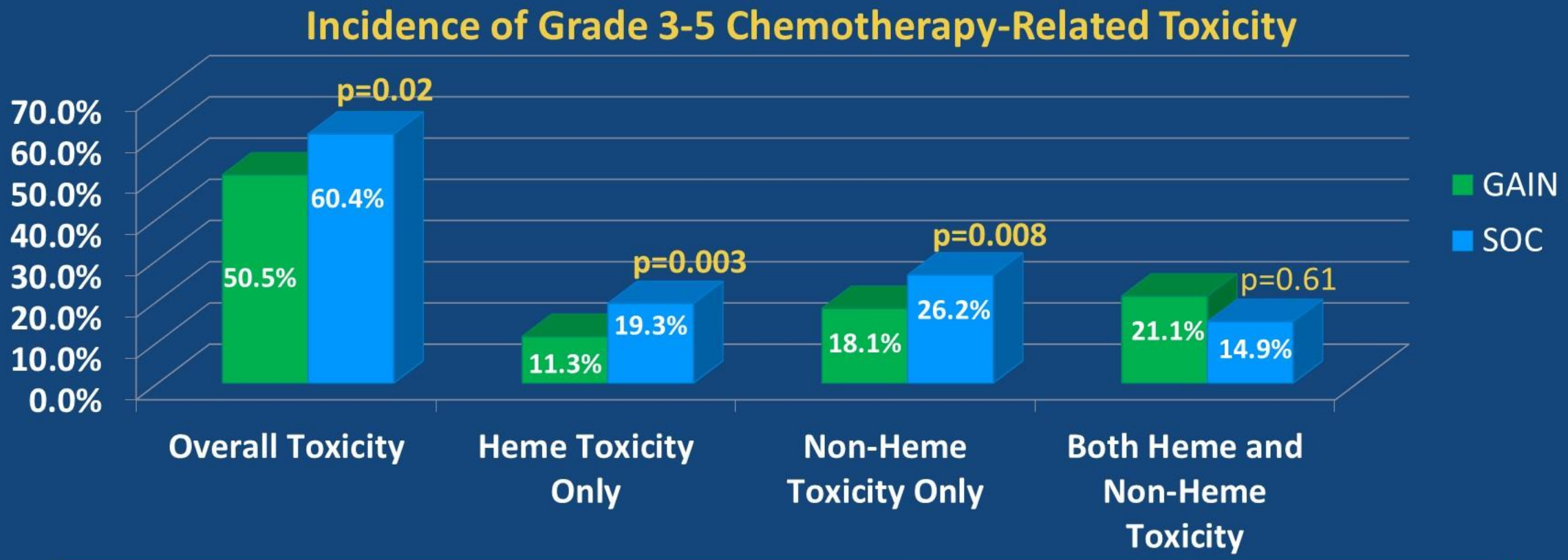
Table 4. Six-month mean changes of quality of life FACT scores from baseline*

	Control arm No. (%)	Experimental arm No. (%)	Total No. (%)	P†
Mean (SD) baseline FACT score	99.6 (16.3)	91.4 (16.2)	95,6 (16,7)	.01
6-mo evaluation/baseline*				
Improvement or stable	17 (58.6)	25 (80.6)	42 (70.0)	.04
Deterioration	12 (41.4)	6 (19.4)	18 (30.0)	

*Improvement was defined by a six-point increase between the two evaluations. Deterioration was defined by a six-point decrease between the two evaluations; stability is the intermediary situation.
†Two-sided chi-square test.

Denis F, JNCI 2017

Results: Primary Endpoint



The GAIN arm had a statistically significant reduction of 9.9% (95% CI: 1.6-18.2%, **p=0.02**) in chemo-related toxicity compared to the SOC arm

Résultats

Essai GAP70+

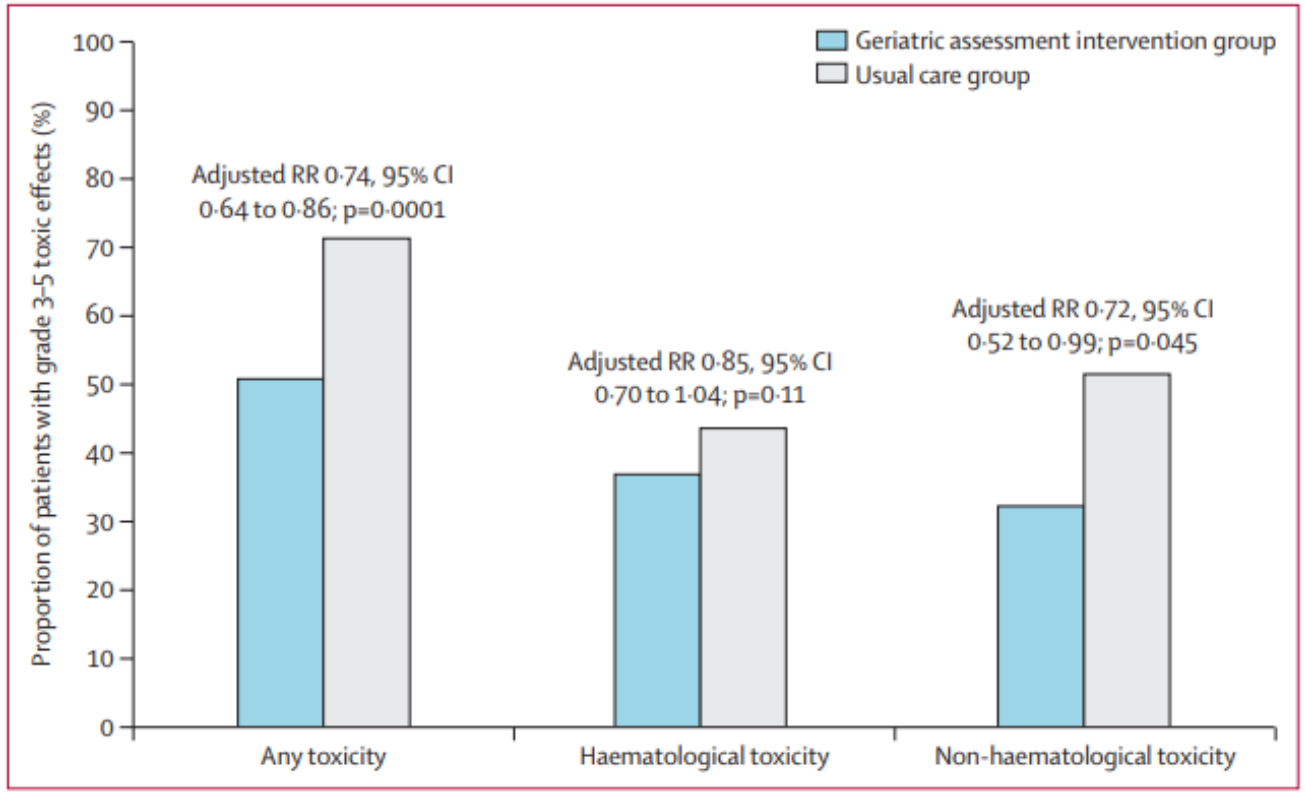


Figure 2: **Prevalence of any grade 3–5 Common Terminology Criteria for Adverse Events toxic effects over 3 months**

RR=risk ratio.

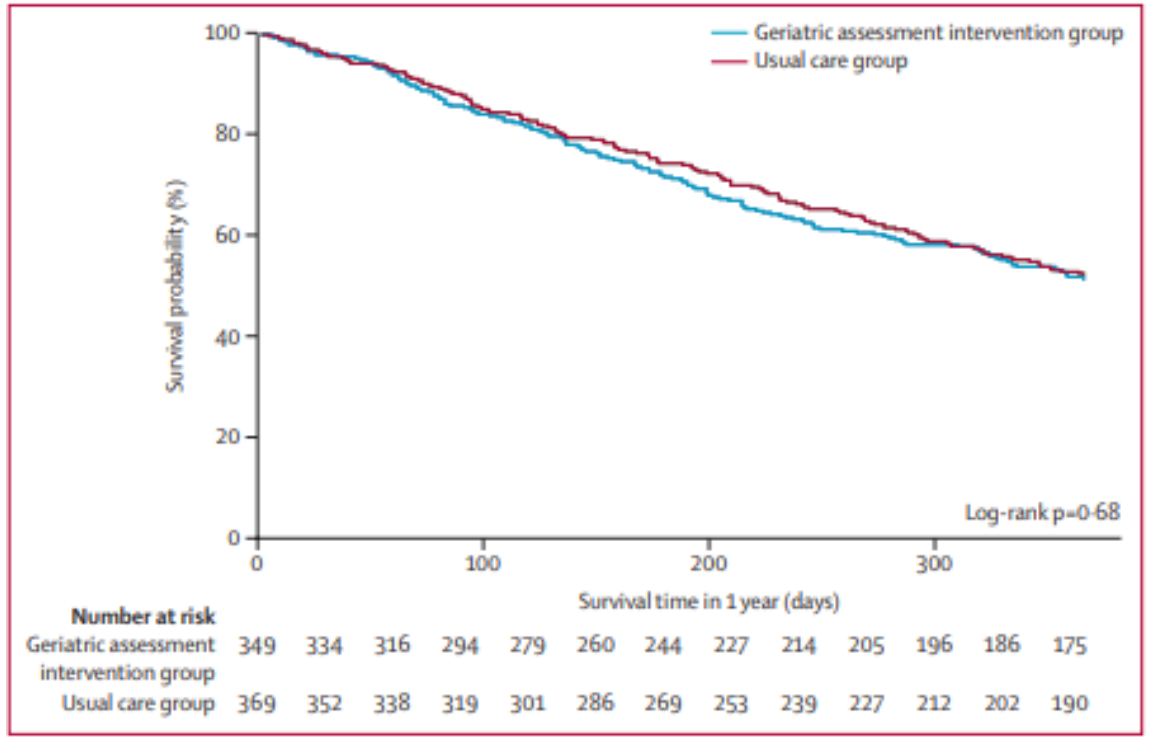


Figure 4: **Survival over 1 year by study group**

S Mohile. Lancet 2021; 398: 1894–904

Essai GAP70+

Résultats

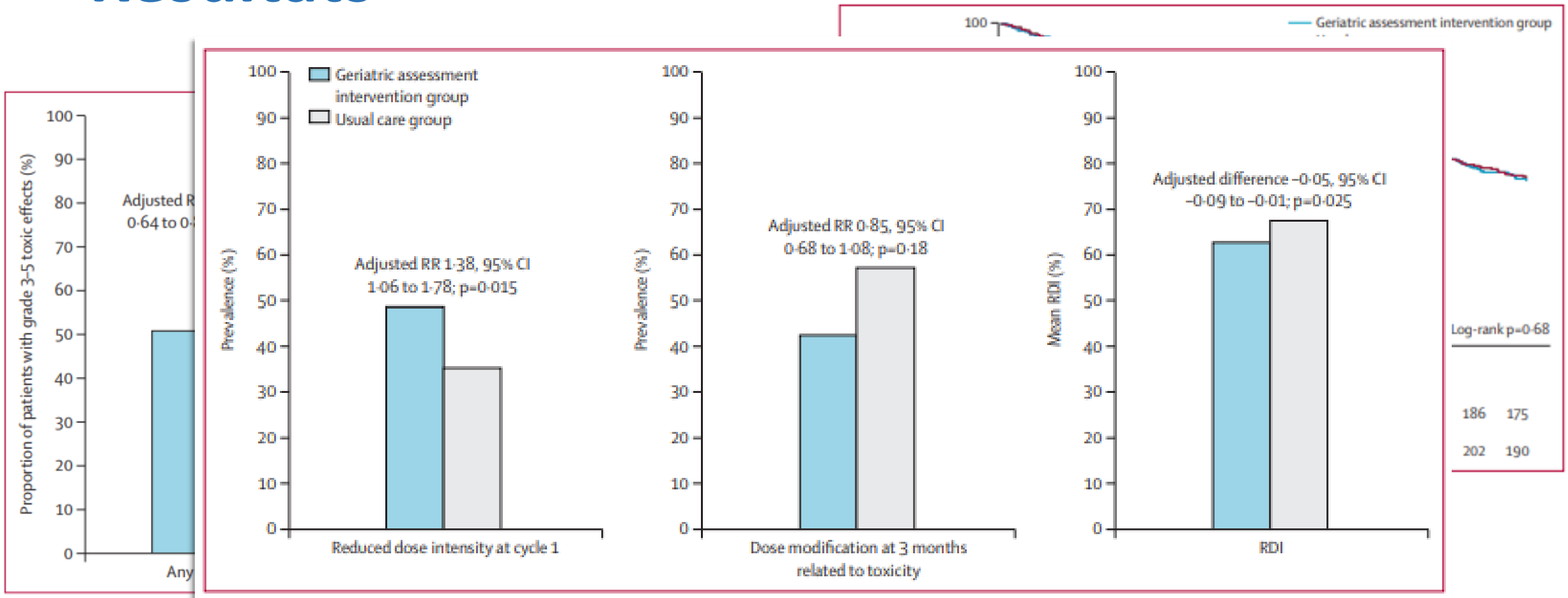


Figure 2: **Prevalence of an**
3 months
RR=risk ratio.

Figure 3: **Treatment intensity by study group**
(A) Prevalence of reduced treatment intensity at cycle 1. (B) Prevalence of dose modifications over 3 months. (C) RDI over 3 months. RDI=relative dose intensity.
RR=risk ratio.

S Mohile. *Lancet* 2021; 398: 1894–904

Une prise en charge gériatrique est primordiale pour les patients âgés avec une hémopathie maligne

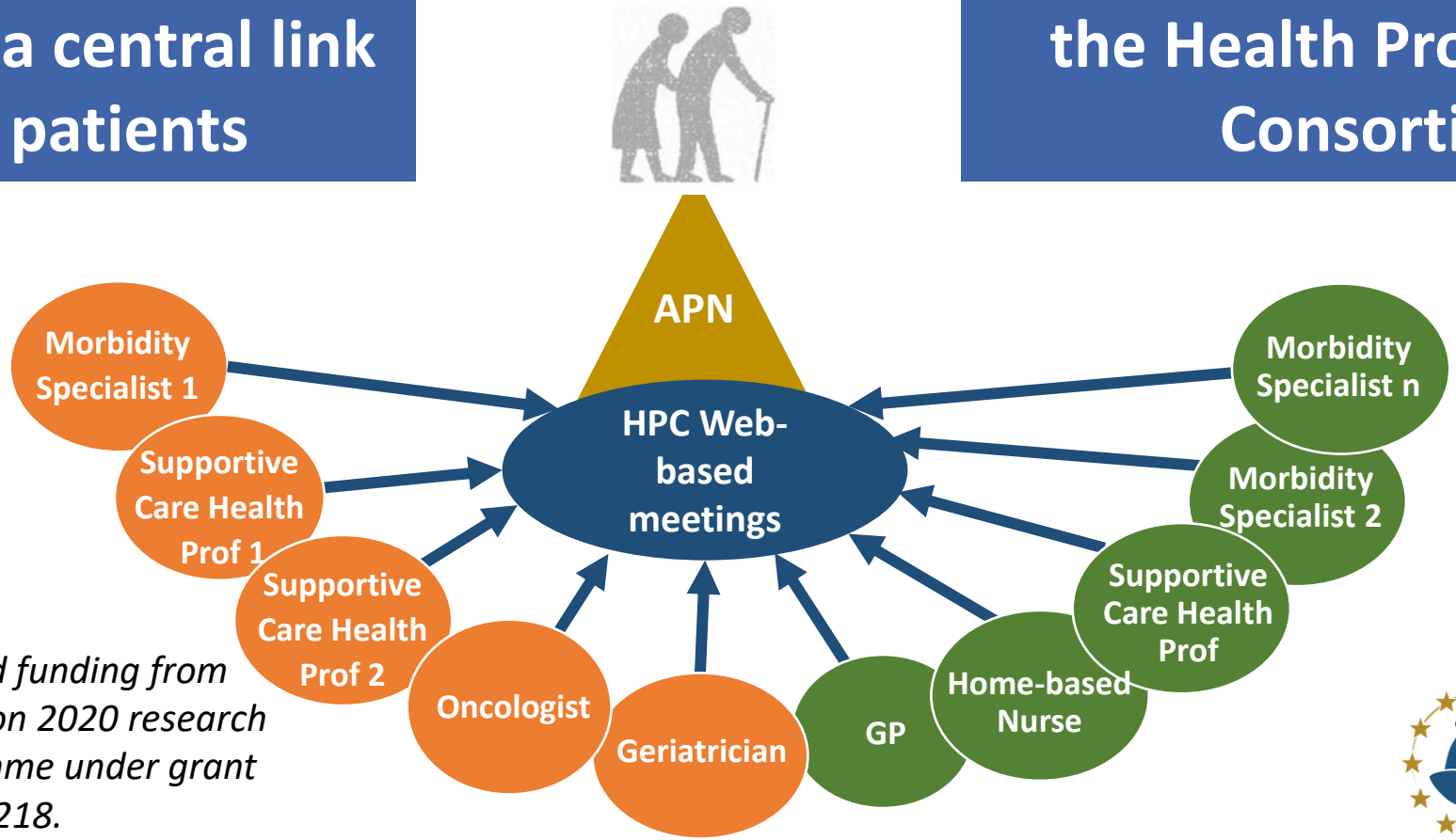
On peut encore mieux faire

GERONTE patient-centered management

Reconsider care organisation

Advanced Practice Nurse as a central link with patients

All physicians together in the Health Professional Consortium



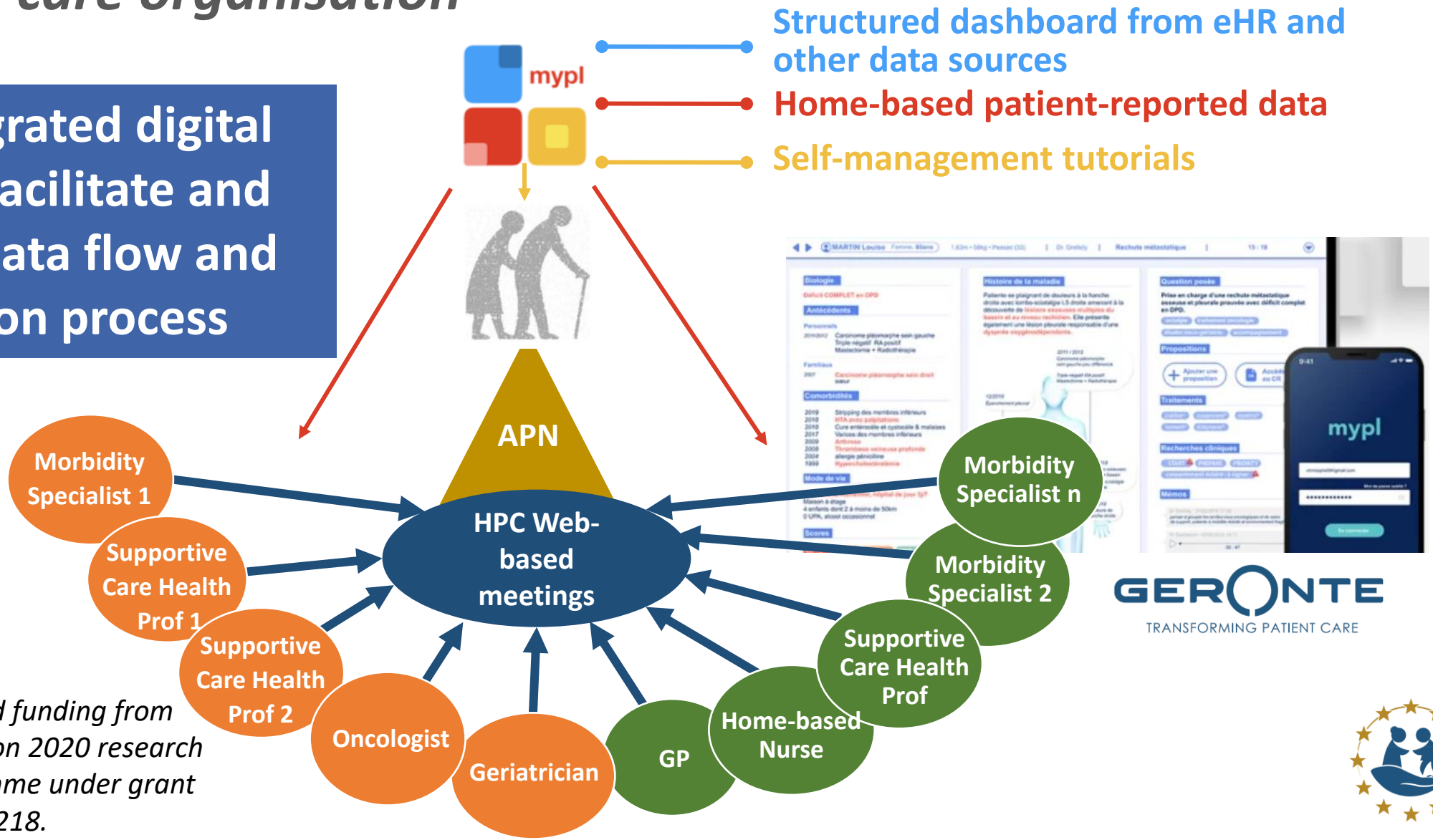
This project has received funding from European Union's Horizon 2020 research and innovation programme under grant agreement number 945218.

GERONTE
TRANSFORMING PATIENT CARE

GERONTE patient-centred management

Reconsider care organisation

An integrated digital tool to facilitate and secure data flow and decision process



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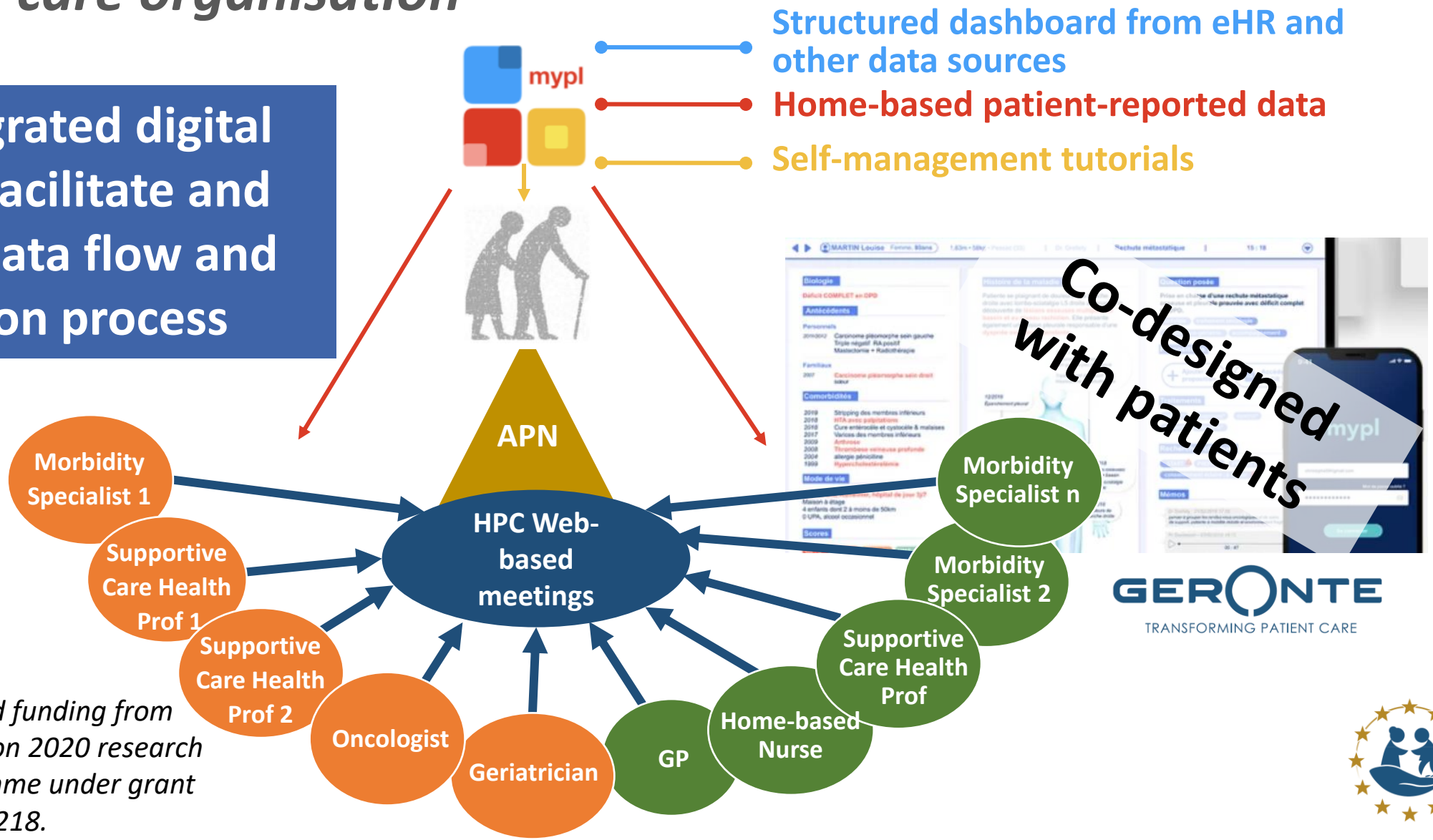

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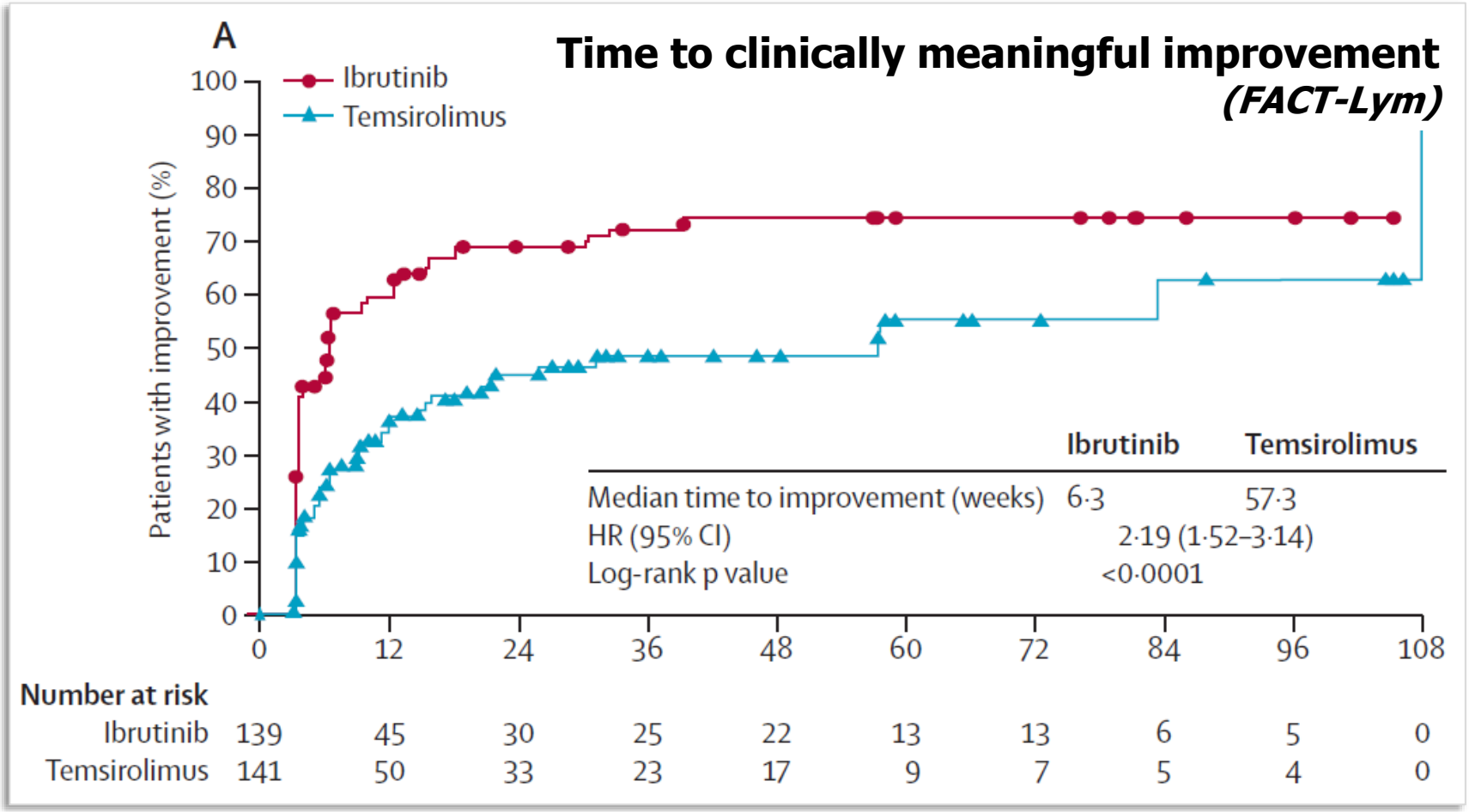
Une prise en charge gériatrique est primordiale pour les patients âgés avec une hémopathie maligne

Penser différemment ?

Un œil nouveau sur l'objectif de traitement

Nouvelles drogues : ibrutinib



M Dreyling, Lancet 2016

Un œil nouveau sur l'objectif de traitement

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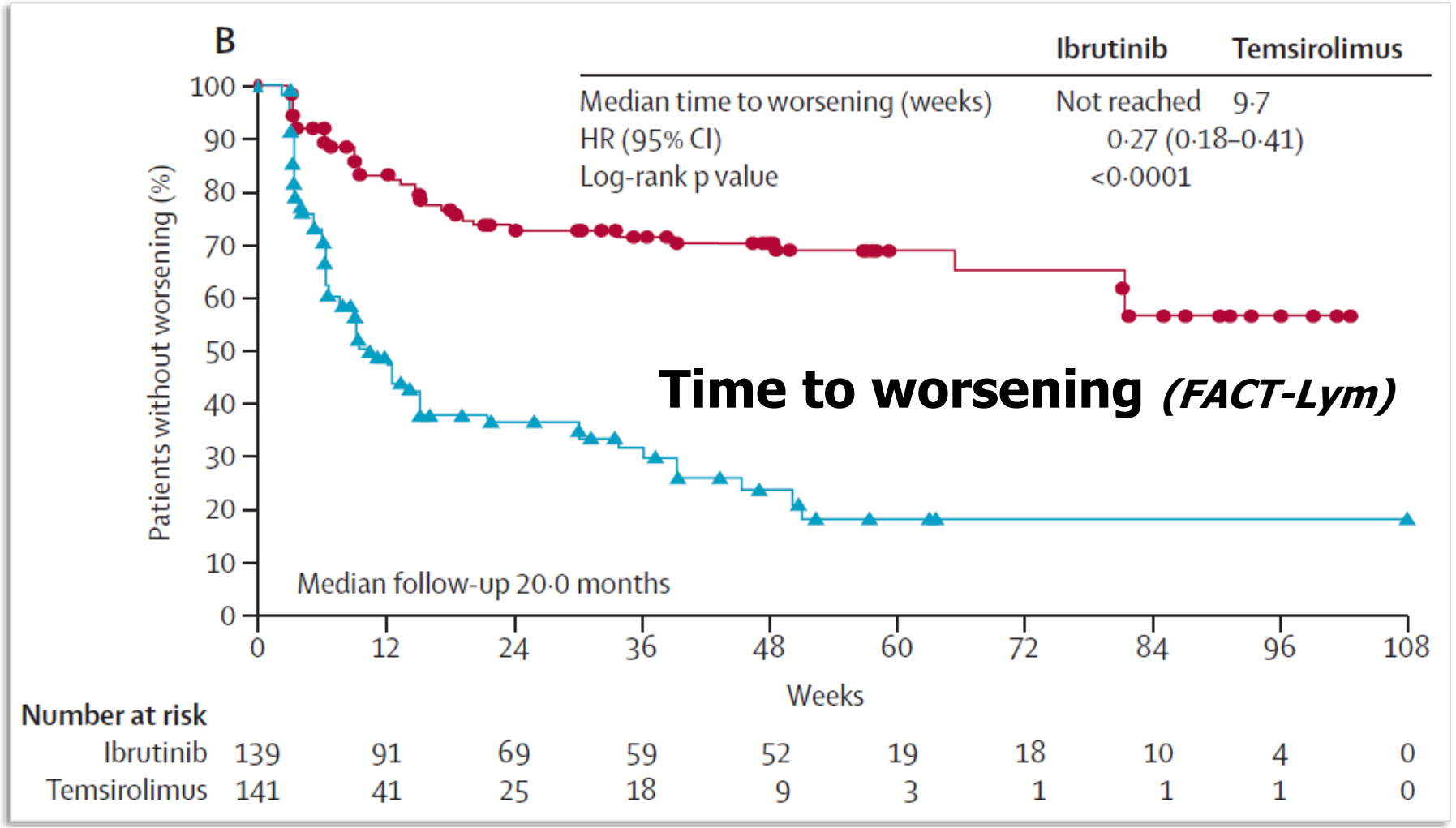
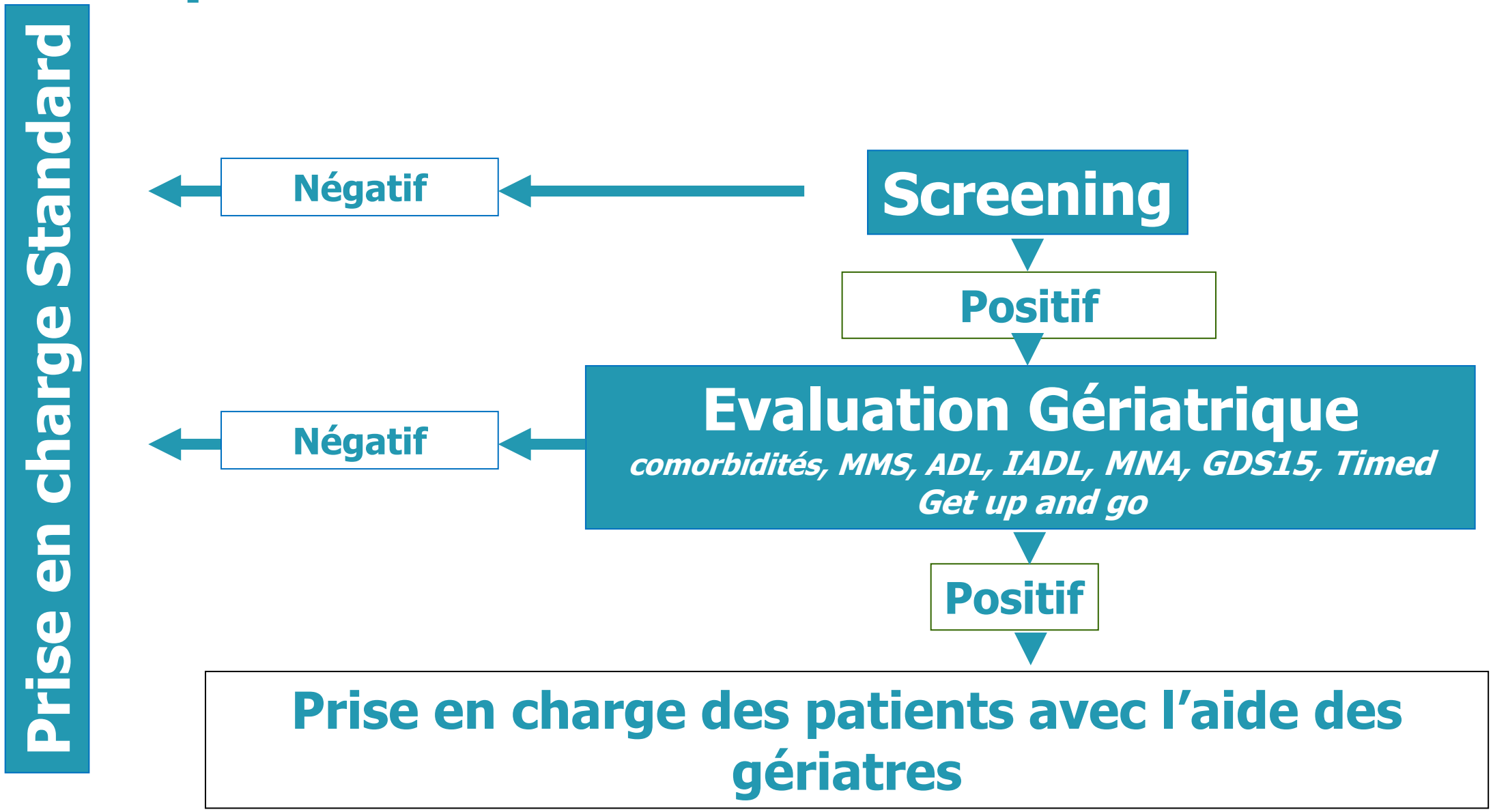


M Dreyling, Lancet 2016

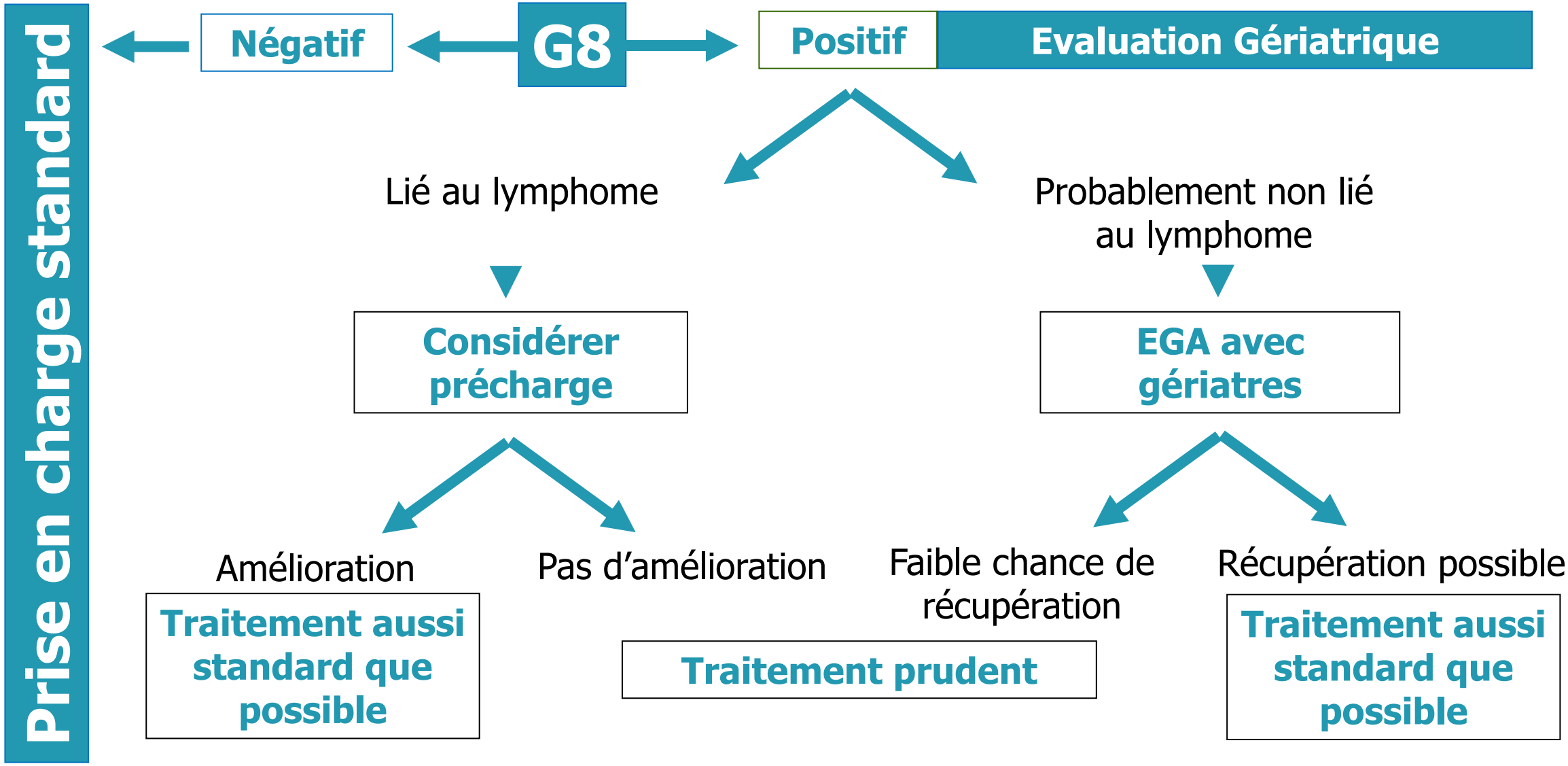
Une prise en charge gériatrique est primordiale pour les patients âgés avec une hémopathie maligne

En pratique

Classiquement…



Pour les lymphomes agressifs



Conclusions

- Le poids du terrain sur le pronostic augmente avec l'âge
- La frontière entre Bon état, Vulnérable et Fragile varie selon la maladie et le traitement
- L'évolution des traitements rend le gériatre de plus en plus utile
- Quelques toxicités et complications doivent être gérées avec les gériatres