

Gastric cancer in the elderly patient

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Abstract. The incidence of gastric cancer is increasing in elderly patients, unlike what it's being observed in the younger patients. The aim of this study is to evaluate the impact of the age on the resectability, resection type (R0-R1-2), morbidity, mortality and survival rate. The higher mortality observed in the elderly patients, the discussed role of an extended lymphadenectomy and the poor survival rate, would lead to a surgical approach which mostly tends to the palliation of the symptoms than the obtainment of a curative resection. But, on the other hand, the impossibility of making chemotherapy in most of the over 75 year old patients, lead us to a R0 surgery treatment.

Key words: Gastric cancer, elderly patient

Background and aim

The incidence of gastric cancer is increasing in elderly patients, unlike what it's being observed in the younger patients. The aim of this study is to evaluate the impact of the age on the resectability, resection type (R0-R1-2), morbidity, mortality and survival rate.

Methods

Since 1998 we treated surgically 112 patients for gastric cancer, 99 of which were resected. All of them underwent a total gastrectomy and most of them (61.6%) (61 pts) had a D2 lymphadenectomy, the remaining patients a D1 or a D3. In order to answer our questions we analysed our data dividing the resected patients in 3 groups: group 1 (G1) up to 64 years: 41 patients (41.4%); Group 2 (G2) from 65 to 74 years: 39 patients (39.4%); Group 3 (G3) above 75 years: 19 patients (19.2%) (10 M - 9 F).

Results

Most of the patients (81.8%) (81 pts) had an advanced disease at the time of the diagnosis, and only the 18.2% (18 patients) were affected an early cancer: G1: 19.5% (8 pts); G2: 20.5% (8 pts); G3: 10.5% (2 pts). The resectability observed (88.4%) (99/112 patients) didn't show any significant differences among the 3 groups of patients, just as the nodes metastasis (74.7%) and the curative resection. This last one, all in all made in the 82.8% (82 patients) of the cases gave the following results; G1: 82.9% (34 patients); G2: 84.6% (33 patients); G3: 78.9% (15 patients) (ns). Morbidity was 23.2% (23 patients) without showing a significant prevalence in none of the groups except that for the lung infections which resulted significantly higher in the G3 patients compared to the G1-G2 ones ($p < 0.05$). Total mortality was 2.0% (2/99 M; 1 G2 patient, 1G3 patient). In all the groups of patients the most common location of the tumour was lower and the intestinal type. The 5 year survival rate was 53.5% (53 patients) and resulted significantly lower in the elderly patients than

in the Group 1 (G1: 63.4% (26 pts); G2: 48.7% (19 pts); G3: 42.1% (8 pts) (G1 vs G3 $p < 0.05$). No difference in the survival rate was observed in the 3 groups of patients according to the lymphadenectomy extension (D1-D2-D3) and to the N and R parameters; in the N0 patients it was 76.7%, ($p < 0.001$ vs N+), while in the R0 it was 59.5% ($p < 0.05$ vs R1-2).

Discussion

The prevalence in the male sex seem to subdue significantly with the age, so that the relation M/F in the over 75 year old patients is near to be pair. In the old patients the suitable treatment is surgery, with unsatisfactory results especially for the stage of the disease, resectability didn't result lower than the group

G1, the advanced age is considered to be a negative prognostic factor. The extension of the lymphadenectomy doesn't seem to improve the long time results, and even, in some studies such a procedure goes along with an increment of mortality and morbidity.

Conclusions

The higher mortality observed in the elderly patients, the discussed role of an extended lymphadenectomy and the poor survival rate, would lead to a surgical approach which mostly tends to the palliation of the symptoms than the obtainment of a curative resection. But, on the other hand, the impossibility of making chemotherapy in most of the over 75 year old patients, lead us to a R0 surgery treatment.