Conclusions: The answers obtained from those two surveys by geriatricians and oncologists showed an increase in the number of elderly patients with cancer treated and the difficulty in the management of complex oncogeriatric patient. The mutual request is for a more active collaboration. The majority of respondents, in both specialties request the availability of more knowledge by training course and the development of common intervention protocols.

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Drugs prescribed for elderly oncologic patients hospitalized in the geriatric oncology unit of Institut Jules Bordet: Polypharmacy and impact of clinical pharmacist

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Purpose of the Study: STOPP and START lists are used to disclaim potential inappropriate medications (PIMs) prescribed at home in older persons. The main objective of this study was to measure the impact of clinical pharmacist on the number of PIMs in a Geriatric Oncology Unit.

Methods: Prospective study in consecutive elderly (≥70 yrs) patients admitted to a geriatric oncology unit in a cancer center from July 2011 to April 2012. PIMs were identified by a clinical pharmacist using the STOPP and START lists. The number of PIMs was compared from the admission to the discharge of the patient, after clinical pharmacist interventions. Polymedication was defined as the use of ≥5 drugs.

Results: Ninety one elderly oncologic patients were included in the study. The mean age was 78.10 ± 9.92 years (60.4% female). Screening geriatric profile was: ISAR score at 3.4 ± 1.6/6, G8 score at 11.3 ± 2.9/17, and Charlson index at 1.7 ± 2.13/37. Polymedication was found in 14 persons (16.3%) compared to 17 PIMs at the hospitalization discharge (p = 0.001). There was also a significant lower score for discharge START (mean = 0.10) compared to admission START (mean = 0.49; p < 0.001). The top three PIMs according to the START list were: calcium and vitamin D supplements (60%), antipsychotics in the presence of moderate–severe depressive symptoms (6%) and angiotensin converting enzyme inhibitors with chronic heart failure (5%). The top three according to the STOPP list were: calcium channel blockers with chronic constipation (15.4%), regular opioids in patients with chronic constipation without concurrent use of laxatives (15.4%) and the presence of duplicate drug class prescription (15.4%).

Conclusion: Polymedication was common in hospitalized elderly cancer patients. Most of them had an abnormal geriatric profile. The screening tools START and STOPP with multidisciplinary assessment by the oncogeriatric team, including a clinical pharmacist allowed identifying PIMs and changing prescriptions for elderly oncologic patients.

Introduction and aims: Although it is strongly recommended that ECP receive a CGA before any treatment decision, there is no consensus about the best form of multidimensional evaluation.1 Recently, the MPI has been validated as a strong predictor of 6 and 12-month mortality in independent cohorts of elderly hospitalized patients with acute or re-emerging chronic diseases. The MPI derives from 8 geriatric items related to functional, cognitive and nutritional conditions, comorbidities, pressure score risk, medications and social aspects. The aim of the present observational, prospective study was to firstly ascertain the prognostic value of the MPI at 6 and 12-months in ECP.

Patients and methods: Patients aged ≥70 yrs admitted to our Program of Geriatric Oncology with a recent histologically confirmed diagnosis of locally advanced or metastatic solid cancer were enrolled if able to sign the informed consent and available to receive a CGA. The CGA was administered by the medical oncologist, geriatrician and psychologist at the time of the first oncological visit and included ADLs, IADLs, Short Portable Mental Status Questionnaire, Mini Mental Status Examination (MMSE), Cumulative Illness Rating Scale-Comorbidity Index and Severity Index (CIRS-SI), Mini Nutritional Assessment, Exton Smith Scale, the number of drugs for concomitant diseases, household composition, the Geriatric Depression Scale (GDS) and the Visual Numeric Scale. The MPI score was calculated and interpreted as reported by Pilotta et al.2

Results: Between 17th April 2008 and 19th April 2010 one hundred-sixty patients, 88 females (55%), mean age 79.4 ± 5.7 years (range 69–93), entered the study. The overall mortality rate was 34.4% (55 patients) at 6-months and 46.9% (75 patients) at 12-months. Ninety-six patients (60%) had a low MPI, 48 (30%) a moderate MPI and 16 (10%) a severe MPI. Fig. 1 shows the age- and sex-adjusted survival curves for the three subgroups with low, moderate and severe MPI scores; high MPI scores were significantly associated with higher mortality rate than lower MPI scores (p < 0.0001). A high MPI was associated with a HR of 8.094 (95%CI 3.749–17.475, p < 0.0001) at 6-months compared to 5.655 (95%CI 2.866–11.158, p < 0.0001) at 12-months. When the MPI was considered as a continuous variable, any increase by 0.2 units was associated with a 2.347-fold increase in mortality risk at 6-months and a 2.051-fold increase at 12-months. The age- and sex-adjusted AUC of ROC curve for MPI score were 0.81 (95%CI, 0.74–0.88) and 0.78 (95%CI, 0.71–0.85), respectively, at 6- and 12-months of follow-up. A regression model adjusted for age, sex,