30

THE MANAGEMENT OF RECTAL CANCER IN OLDER PATIENTS IN ENGLAND - A RETROSPECTIVE POPULATION BASED STUDY A PATIENTS DIAGNOSED BETWEEN APRIL 2009 AND DECEMBER 2014

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Background This study sought to examine the use of radical treatment for rectal cancer (neoadjuvant radiotherapy and major surgical resection) and the associated outcomes across the English National Health Service (NHS) in relation to age.
Materials and Methods Data for all patients diagnosed with a first primary rectal cancer between 1st April 2009 and 31st December 2014 were included. Data from multiple sources including cancer registration data and Hospital Episode Statistics (HES) data, which were compiled as part of the Bowel Cancer Intelligence UK (BCI UK) hub, were used to obtain information about patient and tumour characteristics, treatments and outcomes. Patients were divided into three groups in relation to their age at the time of diagnosis; <70, 70-79 and ≥80. Descriptive analyses were undertaken to assess the variation in treatment and outcomes. Multilevel binary logistic regression models were used to assess the factors associated with the receipt of a major surgical resection, with patients clustered within NHS trusts.
Results. In total, 52,922 people were diagnosed with a first primary rectal cancer in England over the study period. Of these, 11,924 (22.4%) were aged 80 or over at the time of diagnosis. The proportion undergoing a major resection decreased with age, falling from 66.5% amongst those aged under 70 to 31.7% amongst those aged 80 and over. The use of neoadjuvant radiotherapy decreased with age, with 48.3% of those aged under 70 receiving pre-operative radiotherapy compared to 26.5% of those aged 80 and over. Stoma creation rates were similar across all age groups. However the proportion of patients having their stoma closed within 18 months fell with age, from 66.3% amongst those aged <70 to 32.4% amongst those aged ≥80.
Deaths within 30 days of a major surgical resection increased with age, from 1.0% to 5.5%. The rate of returns to theatre were consistent between age groups (11.0%, 11.6% and 10.2% respectively). The rate of 30-day post-operative mortality was lower amongst those who received neoadjuvant radiotherapy than those who did not across all age groups (1.6% versus 2.6%).
After adjustment for case-mix factors significant variation in operative rates for the oldest patients between NHS trusts in England remained. Results from adjusted logistic regression models showed no significant difference in 30-day post-operative mortality, length of stay or emergency readmission amongst those aged 80 and over between trusts with high and low operative rates.
Conclusions. This study demonstrates that older patients with rectal cancer were less likely than younger patients to receive potentially curative treatment. However those who did receive potentially curative treatment for rectal cancer demonstrated outcomes comparable to those of their younger counterparts, suggesting that they have been well selected.
Conflict of interest: No conflict of interest.

31

COMPREHENSIVE MULTIDISCIPLINARY CARE PROGRAM FOR ELDERLY COLORECTAL CANCER PATIENTS: "FROM PREHABILITATION TO INDEPENDENCE"

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Background: We implemented a multidisciplinary pre- and rehabilitation program for elderly patients (≥75 years of age) in a single center consisting of prehabilitation, laparoscopic surgery and early rehabilitation with the intention to lower 1-year overall mortality.
Methods: In this study we compared all patients that underwent elective surgery for stage I-III colorectal cancer before and during development and after implementation of the program (2010-2011, 2012-2013 and 2014-2015) Primary endpoint was 1-year overall mortality, the secondary endpoint was complication rates.
Results: Eighty-six patients were included in the intervention cohort and compared to 63 patients in 2010-2011 and 75 patients in 2012-2013. Patient characteristics were comparable; median age in the study cohort was 80.6. Seventy-three patients (85%) participated in the program, 54 (74%) of whom followed a prehabilitation program and 46 (63%) of whom were discharged to a rehabilitation center. Laparoscopic surgery increased over the years from 70% to 83% in the study cohort. There was a trend in lower 1-year overall mortality: 11% versus 4% (p=0.06). There was a significant reduction in cardiac complications and the number of patients with a prolonged length of stay (p<0.01).
Conclusions: Multidisciplinary care for elderly colorectal cancer patients that includes prehabilitation and rehabilitation is feasible and may contribute to lower complications and reduced length of stay. This study did not show a clear benefit of implementing a comprehensive care program including both prehabilitation and rehabilitation. Dedicated multidisciplinary care seems the key attributer to favorable outcomes of CRC surgery in elderly patients.
Conflict of interest: No conflict of interest.

32

THE AXILLARY SURVEY STUDY (AXISS) ON AXILLARY TREATMENT IN CLINICALLY NEGATIVE/SENTINEL NODE POSITIVE BREAST CANCER PATIENTS

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Background. Axillary lymph node dissection (ALND) is, for the time being, still the gold standard in the axillary treatment of breast cancer. Multiple studies, including the Z0011 trial, the AMAROS trial and the IBCSG 23-01 trial, have shown that in selected sentinel node positive patients the ALND could safely be omitted. However, there is some discussion internationally on whether the results of these studies should be implemented in clinical practice and to what extent. As a result, axillary treatment regimens differ internationally in patients with clinically negative/sentinel node positive breast cancer. Therefore, we have conducted this international survey to gain insight in the axillary treatment in these breast cancer patients.
Materials and methods. This international survey was distributed using an online tool between September 2016 and July 2017. The survey contains 26 questions based on various hypothetical propositions on axillary treatment plans (axillary lymph node dissection, axillary radiotherapy, no axillary treatment) in patients with clinically node negative/sentinel node positive breast cancer who are not treated with neoadjuvant chemotherapy.
Results. A total of 272 participants completed the survey. These respondents are employed in 48 different countries worldwide. Eighty percent were surgical oncologists with 67.3% having more than 10 years of experience. During axillary work-up, 90% specialists rely on axillary ultrasound of which 73% also perform fine needle aspiration of a morphologically suspicious axillary lymph node. Sixty-five percent tend to replace the ALND with axillary radiotherapy in patients with macrometastases or refrain from the ALND in micrometastatic disease. However, this decision may also be influenced by several patient and tumor characteristics, as well as a patient's preference.