COP 02

SURGICAL THERAPY OF BRONCHUS CARCINOMA OF OLD PATIENTS

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Between 1973 and 1983, out of 1162 patients operated on for non-small-cell lung carcinoma, 297 (26%) were older than 65 years. Basically the determining factor for the operability is not the numerical but the biological age.
A consequent preoperative staging with special attention to the N-classification of lymph nodes in thorax as well as an exclusion of distant metastases is necessary. To clear whether there is functional operability the assessment of the respiratory reserves is essential (especially FEV_1). In combination with the sequential perfusion scintiscanning there are important indications of the operative risk. In case of high risk additional examinations - also invasive - have to be carried out.
After estimating the spread of the tumor (T) principally the possibility of surgical therapy with preservation of parts of the lung (sleevelobectomy, segmentlobectomy, wedge resection) has to be proved. If anyhow possible, the pneumonectomy should be avoided. Older patients with critical results of pulmonary function and additional risks (for example cardiac dysrhythmia, diabetes mellitus) should not be operated especially in case of a N2-stage.
As a result of the severe criterions the percentage of high-risk patients within the group of the older ones was unessential larger than in the group of the younger ones. 43% were grouped into stage I, 17% into stage II, 31% into stage III, 9% into stage IV. Regarding the operative technique smaller operations were preferred: 12% of the operations were wedge resections and segmentectomies, 76% were lobectomies and bilobectomies, only 12% were pneumonectomies. The lethality within 30 days after surgical intervention amounted to 10%. There was no difference between the long-term prognosis of the older and the younger patients.

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COP 03

SURGERY FOR GASTROINTESTINAL TUMORS: PROCEDURES AND RESULTS IN THE AGED

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Not only the aim of curation, but also the sequelae of GI-tumors as obstruction, bleeding and penetration may force the surgeon to operate on aged patients.
On gastric cancer, 128o patients were operated within the last 12 years. In patients 7o to 95 years old, operative mortality was influenced by tumor localisation, stage and risk factors (total gastrectomy: 4,o %, subtotal gastrectomy: 8,9 %). Cancers of the fundus/corpus usually give no alternative chance for palliation than removal of the tumor by gastrectomy.
Also colonic carcinomas (n=773), for palliation better should be resected (n=176, 1 year-survival: 32 %) than bypassed (n=122; 1 year survival: 5 %) even in the aged patients (>75 years old: 15,8 %). Both, colonic and rectal cancer operations, showed a dramatic drop of mortality within the last five years. 996 patients were treated on rectal cancer, 776 were operated (mortality of sphincter saving resection: 2,3 %; rectal excision: o,9 %), 18,1 % were more than 75 years old. For cryosurgery (n=22o) tumorstage was a higher risk factor than patients age (<7o years: median survival 6 months; 7o-8o years: 7 months).
Generally, quality of life remains to be better, if the tumor is removed instead of beeing bypassed. Moreover, curative treatment should be attempted.
However, bad prognosis and high risk should lead to avoid troublesome treatment in very old patients.

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COP 04

PROGNOSIS OF COLORECTAL CANCER IN PATIENTS OLDER THAN 8o YEARS

L. Braun

Between 1974-1984 767 patients with colorectal carcinoma were treated operatively at our department. 137 patients (17.9%) were older than 8o, 45 patients (5.9%) younger than 5o years. We found the following differences in these two groups (Table 1):

Table 1:	older than 8o	younger than5o
males	4o.1 %	42.2 %
T 1	5.8 %	26.7 %
T 4	13.9 %	8.9 %
N 0	58.4 %	68.9 %
N 4	12.4 %	13.3 %
M 0	81.8 %	93.3 %
palliative operation	22.6 %	8.9 %
curative operation	38.o %	6o.o %
preoperative ileus	34.3 %	6.7 %
preoperative perforation	2.2 %	2.2 %
postoperative complications	32.8 %	22.2 %
reoperations	3.6 %	4.4 %
operative mortality	19.o %	2.2 %
location right colon	22.o %	13.3 %

In 5o resp. 21 patients the operation was performed more than 5 years ago. The fate of all patients is known and analyzed (Table 2)

Table 2:	%	older than 8o mean survival	younger than 5o % survival
postoperative mortality	3o.o	-	o -
death from cancer	26.o	16.2	23.8 12.6
death from other cancer	o	-	9.5 82.o
death from other disease	34.o	33.2	4.8 65.o
surviving patients	1o.o	1oo.8	61.9 9o.5

Survival time is given in months. There is no significant difference in the death rate from colorectal cancer in these two age groups.

COP 05

CANCER OF OLD MEN - PROSTATE CANCER - MAINLY A GERIATRIC CANCER

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This tumor has a complex biology, and this fact governs diagnostics, indication and therapy. Given a live expectancy of 100 years, cancer of prostate probably would be the most frequent of all male tumors. Only 1/3 of patients die because of, 1/3 together with prostate-cancer. The group on highest risk are the 50 - 65 aged. This is why simple preventive check up in this group is of greatest value and reliability. Staging, USA System more than TNM, is the prerequisite of optimal indications. Progression is not always linear, but also erratic. G is more important than pT, but is not uniform within one tumor. Concomittant BPH has a slow down effect on NPL, which has an extra-adenomatous marginal origin. Possibly biopsy exerts activating influence. Progress in tumor marker research (RIA and PSA) is of great diagnostic value. The value of CT and Sonography is limited. Therapeutic indications have to be based upon stage and age. G 3 tumors can be prolonged, but not be cured. Radical prostatectomy, if well substantiated, continues to be the most promising method. Combined external and internal radiotherapy has similar results, but with considerable rate of complications. For 90 % of all patients palliative contrasexual hormone therapy continues to be the only therapy available. The new RH and LH analogues protect psychologically and cardiologically, but are no additional advance from a cancerological point of view, only a prolonged and expensive orchiectomy.

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