Glioblastoma in the Elderly: The Impact of Advanced Age on Treatment and Survival

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Abstract

Objective To evaluate the effects of combined treatments on the outcome and survival of elderly (≥ 65 years) patients with glioblastoma as compared with younger ones.

Material and Methods Fifty consecutive elderly (≥ 65 years) patients (group A) who underwent complete or subtotal (> 80%) resection of brain glioblastoma followed by irradiation and chemotherapy with temozolomide between 2004 and 2009 were retrospectively reviewed and compared with 50 glioblastoma patients aged < 65 years, treated in the same period (group B). Patient sex, tumor location, size and side, combined treatments, reoperation, progression-free survival, and overall survival were compared in the two groups by using the Kaplan-Meyer method.

Results There were no significant differences between the two groups for tumor location, size and side, and Ki-67 Li. Forty-four of 50 group B patients were treated by the Stupp protocol, whereas all group A patients underwent irradiation and adjuvant temozolomide. Second-line chemotherapy was administrated in 32% of group A and 76% of group B cases, and reoperation was performed in 16% and 36%, respectively. The median survival of the overall series of 100 patients was 15.6 months. Group A patients (≥ 65 years) had a median survival of 14.5 months, significantly lower than group B cases (17 months) (p = 0.02).

Keywords ► glioblastoma ► age ► elderly ► surgery

Conclusion Elderly patients with glioblastoma may benefit from combined treatments, including surgery, radiotherapy, and chemotherapy. Although younger patients do survive longer than older ones, the difference of survival is less significant if several criteria of selection to surgery, such as good Karnofsky performance status (KPS), largely resectable tumor, and no significant comorbidity, are respected.

Introduction

Glioblastoma is the most common primary brain tumor in adults, with a peak incidence between 65 and 74 years; because of the higher median age of the general population, an increased incidence in older patients (up to 20% after 80 years) has been reported.

In spite of the advancements in imaging, surgical techniques, and adjuvant treatments, the prognosis of glioblastoma remains dismal. The two clinical parameters that are widely accepted as indicators of prolonged survival include a favorable (≥ 70) Karnofsky performance status (KPS) and younger patient age at time of diagnosis.
For these reasons, the age threshold between younger and adult patients, the management of glioblastoma in the elderly, and the influence of advanced age on outcome are still controversial.

The present report discusses the effect of combined treatments and the factors affecting the survival of elderly (≥ 65 years) patients with glioblastoma as compared with younger ones. Its aim is also to determine whether combined treatments are advisable in older patients.

Material and Methods

Study Design
Fifty consecutive patients aged ≥ 65 years with newly diagnosed supratentorial glioblastoma, treated at the Neurosurgical Clinic of the “Federico II” University of Naples between 2004 and 2009, were reviewed (Group A). The data were compared with those of a group of 50 patients < 65 years treated in the same period (Group B).

The inclusion criteria were a KPS > 70, complete or subtotal (> 80%) surgical resection, completed radiotherapy, and adjuvant and/or concomitant chemotherapy with temozolomide. Patients with multicentric tumors and gliomatosis, those who underwent biopsy or limited resection, those who died for unrelated conditions, and those lost to follow-up were excluded. Patients with significant comorbidities, including recent heart infarction, cardiac insufficiency, and kidney failure, were also excluded.

Neuroradiological Assessment
Magnetic resonance (MR) studies before and after contrast administration were obtained preoperatively in all patients. Spectroscopic sequences were also performed in 63 cases. The volume of the initial tumor was defined by measuring the three main tumor diameters.

All patients were studied by computed tomography (CT) scan within 72 hours after surgery. MR before and after contrast administration was performed 1 month postoperatively. The residual tumor was defined as contrast enhancement and calculated as percentage of the initial tumor volume.

Treatments
All 100 patients underwent complete or subtotal (>80%) tumor resection. Locoregional chemotherapy with carmustine was used in the last 35 patients.

Adjuvant radiotherapy was administered in all patients with a total dose ranging between 54 and 60 Gy, with daily doses of 2 Gy. Temozolomide was used as concomitant and adjuvant therapy according to the Stupp protocol (44 cases), or as adjuvant therapy only (56 cases). Adjuvant temozolomide was administered at doses of 300 mg/daily for 5 days every 28 days for at least 6 months or until progression. Second-line chemotherapy with fotemustine or irinotecan was used at the tumor progression in 44 patients.

Twenty-six patients underwent reoperation for tumor regrowth.

Follow-Up
In all patients clinical examination and postcontrast MR were performed 1 month after surgery, one month to 45 days after the end of the radiotherapy, and then every 3 months.

The data of the whole series were reviewed in December 2011 (follow-up of at least 2 years). For patients lost to follow-up, the family was contacted by phone. Patients who were still alive at last contact were surveyed for survival analysis.

Bias Identification
Several factors affecting the outcome and survival were stratified into patients ≥ 65 years and patients < 65 years. These include sex, tumor location and side, tumor size, type of adjuvant treatment, K−67 Li, progression-free survival (PFS), reoperation, and overall survival.

Statistical Analysis
The statistical analysis was performed by using the Kaplan-Meyer method. A value < 0.05 was considered as significant.

Results (Table 1)
The 100 patients of the overall series were 62 males and 38 females, ranging in age between 24 and 80 years (median age 61 years).

The two groups (≥ 65 years and < 65 years) did not show significant differences in patient sex, tumor location and side, tumor size, and K−67/MIB-1 Li. Forty-four of 50 patients of Group B underwent irradiation with 60 Gy and concomitant temozolomide (75 mg/day) and adjuvant temozolomide (Stupp protocol). Six patients of Group B and all of Group A underwent irradiation with 54 to 60 Gy and adjuvant temozolomide.

The treatments at tumor progression were as follows: second-line chemotherapy with fotemustine or irinotecan was administrated in 44 patients, 16 (32%) of Group A and 38 (76%) of Group B. Among 26 patients undergoing reoperation after an interval of 7 to 40 months from the initial surgery, 8 (16%) belonged to Group A and 18 (36%) to Group B. Thus, the overall frequency of the treatments at progression was higher in younger than in elderly patients.

The medial PFS of the overall series was 10 months, and the overall median survival was 15.6 months. The stratification of the outcome and survival according to the age was as follows: in Group A (≥ 65 years) the median PFS was 8.4 months. In Group B (≤ 65 years) did not show significant differences in patient sex, tumor location and side, tumor size, and K−67 Li. Among 26 patients undergoing reoperation after an interval of 7 to 40 months from the initial surgery, 8 (16%) belonged to Group A and 18 (36%) to Group B. Thus, the overall frequency of the treatments at progression was higher in younger than in elderly patients.

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who survived more than 5 years belong to this group. The overall median survival of this group was 17 months.

The difference of PFS and overall median survival between the two groups is statistically significant ($p = 0.02$).

**Discussion**

Advanced patient age is a recognized factor of poor survival in patients with glioblastoma. However, the incidence of malignant gliomas in the elderly population is very high. Thus, the treatment modalities and the outcome of this age group are still discussed and remain controversial.

This retrospective study analyzes the outcome and survival in two groups of younger and older glioblastoma patients. Only three recent reports have compared the outcome of younger and elderly patients harboring brain glioblastoma (Table 2).

The age limit to consider a patient as elderly is variably defined, ranging in the literature studies from 60 to 70 years. Despite the limited postoperative survival of patients with glioblastoma, even older individuals are expected to live long enough to benefit from the treatments. We think that 65 years may be considered an appropriate age limit.

In the reported series, the older age group often includes patients with different concomitant pathologies and different surgical risk. In our study we have excluded patients with significant comorbidities, which may influence survival. This could be a reason for a less significant difference of survival between younger and older patient in our series (Table 2).

In this study several factors have been correlated with the outcome and survival of younger patients versus elderly patients with glioblastoma. There were no significant differences for tumor location, size, and proliferation index evaluated by Ki-67 Li MIB-1. The values of MIB-1 are rather variable in most series on glioblastoma and are unable to differentiate glioblastoma from anaplastic astrocytoma. However, it seems to correlate with the survival of patients with glioblastoma but not with their age at diagnosis.

The significance of the type of surgery (complete resection, incomplete resection, and biopsy) was the focus in five series. The completeness of the tumor resection was associated with significantly better median survival (5.7 to 17.3 months) than was incomplete resection (7 to 11 months) and biopsy (2.2 to 3.6 months). These data confirm that complete resection of the enhancing tumor must be performed, when possible, in elderly patients as well as for the whole population of patients with newly diagnosed glioblastoma.

**Table 1** Distribution of clinicopathological features, treatments, and survival between younger and elderly patients in the present study

<table>
<thead>
<tr>
<th></th>
<th>Overall series</th>
<th>Group A ≥ 65 years</th>
<th>Group B &lt; 65 years</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>38</td>
<td>18 (36%)</td>
<td>20 (40%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>M</td>
<td>62</td>
<td>32 (64%)</td>
<td>30 (60%)</td>
<td></td>
</tr>
<tr>
<td><strong>Tumor location</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frontal</td>
<td>28</td>
<td>16 (32%)</td>
<td>12 (24%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Temporal</td>
<td>36</td>
<td>16 (32%)</td>
<td>20 (40%)</td>
<td></td>
</tr>
<tr>
<td>Parietal</td>
<td>26</td>
<td>12 (24%)</td>
<td>14 (28%)</td>
<td></td>
</tr>
<tr>
<td>Occipital</td>
<td>10</td>
<td>6 (12%)</td>
<td>4 (8%)</td>
<td></td>
</tr>
<tr>
<td><strong>Side</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left</td>
<td>52</td>
<td>20 (40%)</td>
<td>28 (56%)</td>
<td>n.s.</td>
</tr>
<tr>
<td>Right</td>
<td>48</td>
<td>30 (60%)</td>
<td>22 (44%)</td>
<td></td>
</tr>
<tr>
<td><strong>Size (median)</strong></td>
<td>34.0 cm³</td>
<td>35.7 cm³</td>
<td>32.2 cm³</td>
<td>n.s.</td>
</tr>
<tr>
<td><strong>Ki-67 Li (median)</strong></td>
<td>26%</td>
<td>24%</td>
<td>28%</td>
<td>n.s.</td>
</tr>
<tr>
<td><strong>Adjuvant treatments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Locoregional carmustine therapy</td>
<td>35</td>
<td>21 (60%)</td>
<td>14 (40%)</td>
<td></td>
</tr>
<tr>
<td>RT + concomitant and adjuvant TMZ (Stupp protocol)</td>
<td>44</td>
<td>–</td>
<td>44 (88%)</td>
<td></td>
</tr>
<tr>
<td>RT + adjuvant TMZ</td>
<td>56</td>
<td>50 (100%)</td>
<td>6 (12%)</td>
<td></td>
</tr>
<tr>
<td>Second-line chemotherapy</td>
<td>44</td>
<td>16 (32%)</td>
<td>38 (76%)</td>
<td></td>
</tr>
<tr>
<td><strong>Reoperation</strong></td>
<td>26</td>
<td>8 (16%)</td>
<td>18 (36%)</td>
<td></td>
</tr>
<tr>
<td><strong>PFS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall median survival</td>
<td>10 months</td>
<td>8.4 months</td>
<td>11.7 months</td>
<td>0.02</td>
</tr>
<tr>
<td>Dead patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall survival</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alive patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: F, female; M, male; n.s., not significant; PFS, progression-free survival; RT, radiotherapy; TMZ, temozolomide.
Glioblastoma multiforme. To this end, fluorescence-guided resection with 5-aminolevulinic acid (ALA) may be helpful.

The type of combined treatments is a key factor for the outcome. In nine series of elderly patients treated with variable entity of surgical resection (complete or incomplete), radiotherapy with variable radiation doses and chemotherapy in the pretemozolomide era, the median survival ranged from 4.2 to 13 months, with only one series reporting a median survival of more than 1 year. On the other hand, in seven series of elderly patients treated by complete or subtotal surgical resection, radiotherapy with 60 Gy, and adjuvant temozolomide, median survival ranged from 11 to 16.3 months, with only one series reporting a median survival of less than 1 year.

The data from these studies confirm that radical surgical resection followed by a full course of radiotherapy and adjuvant temozolomide is the best treatment for elderly glioblastoma patients with good prognostic factors. We obtained in our series a median survival of 14.5 months. The combined treatment provides significant benefit over the survival compared with radiotherapy alone and significantly improves the time to progression compared with radiotherapy plus standard chemotherapy.

The O-6-methylguanine-DNA methyltransferase (MGMT) promoter methylation is an important prognostic marker and has been consistently associated with newly diagnosed glioblastoma. However, its value in elderly patients is still unclear. Two studies have shown that MGMT methylation is a favorable prognostic factor associated with significantly improved median survival in elderly patients. On the other hand, two other studies did not show statistically significant correlation. Further prospective studies are required to define the role of MGMT methylation as a prognostic marker and to determine its predictive value for responsiveness to temozolomide in elderly patients.

The opportunity of an aggressive treatment for tumor recurrence in the elderly is still debated. In a literature review by Barbagallo et al, the rate of reoperation for glioblastoma ranged from 10 to 30% and varied with patient age. Some studies reported significantly lower rate of reoperation for glioblastoma recurrence with advanced age (16% in older versus 36% in younger patients of our series). However, repeated surgery for recurrence seems to also be associated with improved survival in elderly patients, particularly if combined with other postoperative salvage treatment modalities.

The difference of median survival between younger and elderly patients was less significant. In our series the overall survival of both groups was slightly higher than most literature data, and the difference between younger and older patients was less significant (p = 0.02). This is due to the patient selection (KPS > 70, complete or subtotal tumor resection, complete adjuvant treatments, exclusion of cases with significant comorbidities).

Several molecular genetic features were found to be associated with the age and outcome of patients with glioblastoma. There is evidence of a relationship between epidermal growth factor receptor (EGFR) overexpression and better prognosis in the older age group and different prognostic significance of alterations of p53, 1p, and 16 in

Table 2 Differences of survival between younger and elderly patients in the present and other studies

<table>
<thead>
<tr>
<th>Author</th>
<th>No. of pts</th>
<th>Age limit</th>
<th>Survival (younger, elderly)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stark et al (2007)</td>
<td>345</td>
<td>60 years</td>
<td>14 months, 8.4 months</td>
<td>0.0001</td>
</tr>
<tr>
<td>Stummer et al (2008)</td>
<td>243</td>
<td>60 years</td>
<td>14 months, 11 months</td>
<td>0.0090</td>
</tr>
<tr>
<td>Casartelli et al (2009)</td>
<td>196</td>
<td>64 years</td>
<td>13.6 months, 9.1 months</td>
<td>0.002</td>
</tr>
<tr>
<td>Present series</td>
<td>100</td>
<td>65 years</td>
<td>17 months, 14.5 months</td>
<td>0.02</td>
</tr>
</tbody>
</table>

Table 3 Survival of elderly patients with glioblastoma after complete or subtotal (≥ 80%) resection, RT, and TMZ

<table>
<thead>
<tr>
<th>Author</th>
<th>No. of pts</th>
<th>Age limit</th>
<th>Median survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stark et al (2007)</td>
<td>123</td>
<td>≥ 60 years</td>
<td>15 months</td>
</tr>
<tr>
<td>Stummer et al (2008)</td>
<td>50</td>
<td>≥ 60 years</td>
<td>13.8 months</td>
</tr>
<tr>
<td>Combs et al (2008)</td>
<td>43</td>
<td>≥ 65 years</td>
<td>11 months</td>
</tr>
<tr>
<td>Brandes et al (2009)</td>
<td>58</td>
<td>≥ 65 years</td>
<td>13.7 months</td>
</tr>
<tr>
<td>Gerstner et al (2009)</td>
<td>35</td>
<td>≥ 70 years</td>
<td>16.2 months</td>
</tr>
<tr>
<td>Minniti et al (2010)</td>
<td>83</td>
<td>≥ 70 years</td>
<td>15.3 months</td>
</tr>
<tr>
<td>Ewelt et al (2010)</td>
<td>35</td>
<td>≥ 65 years</td>
<td>15 months</td>
</tr>
<tr>
<td>Present series</td>
<td>50</td>
<td>≥ 65 years</td>
<td>14.5 months</td>
</tr>
</tbody>
</table>
different age groups. This may suggest different tumorigenic pathways of glioblastoma with age.

Conclusions

Elderly patients may benefit for an as radical as possible surgical resection of brain glioblastoma followed by radiotherapy and adjuvant chemotherapy with temozolomide. This combined treatment should be reserved to patients with good KPS, no significant comorbidity, and largely resectable tumors. In this way, the difference of survival between older and younger patients is less significant.

Conflict of Interest
None

References

