

# Komorbidity

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# Classification of CLL patients by fitness

## 'Go go'

- Completely independent
- No co-morbidity
- Normal life expectancy

→ Aggressive chemotherapy

## 'Slow go'

- Some co-morbidity
  - Impaired organ function
  - Reduced performance status
- Less aggressive approach

## 'No go'

- Severely handicapped
- High co-morbidity
- Reduced life expectancy

→ Palliative care

# Decision tree for elderly patients with CLL

**Diagnosis and staging**  
**Stage 0-II: observation until treatment necessary**  
**Stage III-IV: individual patient assessment**



**Fit patients**  
•Immunochemotherapy as for younger patients (R-FC/FC)

**Less fit patients**  
•Adapted purine analogues ±R  
•Alemtuzumab for 17p-deletion  
•Alkylating agents (chlorambucil, bendamustine)

**Frail or unsuitable for chemotherapy**  
•Supportive care

# Factors affecting the choice of fludarabine

- Renal insufficiency: debate exists
  - CrCl 30–70 ml/min: SmPC mandates reduced dose
- Autoimmune haemolysis
  - During previous exposure to fludarabine
  - *De novo* autoimmune haemolysis?
- Other contraindications
  - Cardiac insufficiency
  - Neurological disorders (pre-existing central nervous system disorders or peripheral neuropathy)

# Instruments designed to detect and quantify co-morbidity

Three scales are potentially applicable to haematological oncology:

1. The Sorrow version of the Charlson Index (CI) rates 19 diseases  
and can generate an age/co-morbidity index
2. The Cumulative Illness Rating Scale (CIRS) rates 13 body systems on a 5-point pathophysiology severity scale
3. The Index of Co-Existing Disease (ICED) measures disease severity of 14 categories of diseases and assesses disability

# Patient characteristics: Geriatric assessment versus oncology

Oncology

Geriatric medicine

Age

Functional status (e.g. ADL, iADL, aADL)

Performance  
status

Depression (e.g. geriatric depression scale)

Dementia (e.g. mini-mental status exam)

Mobility (e.g. timed up and go)

Nutrition (e.g. mini nutritional assessment)

Social situation

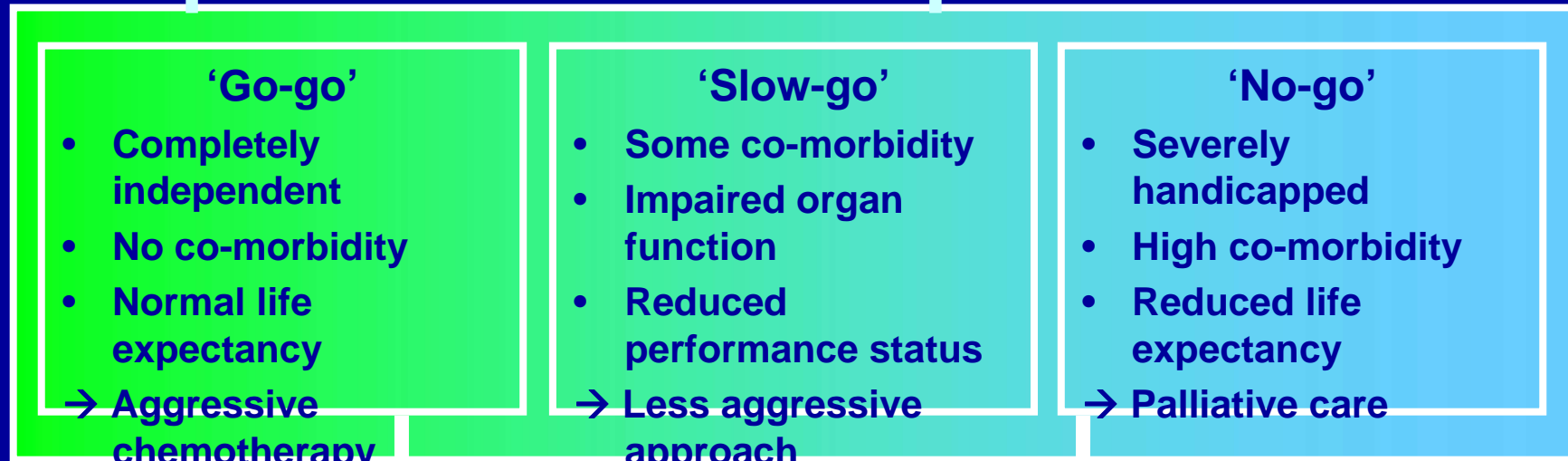
Co-morbidity (e.g. Charlson score and polypharmacy)

# GCLLSG trials in CLL: Co-morbidities

## Measurement of co-morbidity: Cumulative Illness Rating Scale (CIRS)

CIRS: Please insert the appropriate grade of illness/impairment:		
Organ system	If illness/impairment present, please specify:	Score
Heart		<input type="checkbox"/>
Blood pressure		<input type="checkbox"/>
Vascular		<input type="checkbox"/>
Respiratory		<input type="checkbox"/>
Ear/nose/throat		<input type="checkbox"/>
Upper gastrointestinal		<input type="checkbox"/>
Lower gastrointestinal		<input type="checkbox"/>
Liver		<input type="checkbox"/>
Renal		<input type="checkbox"/>
Genitourinary		<input type="checkbox"/>
Musculoskeletal		<input type="checkbox"/>
Endocrine/metabolic		<input type="checkbox"/>
Neurological		<input type="checkbox"/>
Psychiatric		<input type="checkbox"/>
		Total Score: <input type="checkbox"/> <input type="checkbox"/>

# Other MabThera plus chemo combinations may allow therapy to be adapted to individual patients' needs



MabThera-FC is the standard of care

MabThera-chemo is the standard of care?  
e.g. MabThera-HDMP,  
MabThera-FC-'lite',  
MabThera-PC,  
MabThera plus  
bendamustine/chlorambucil

# MabThera-FC-‘lite’: An option for unfit patients

- Maintain efficacy by increasing the MabThera dose
  - MabThera: 500 mg/m<sup>2</sup> q14d x 6 (375 mg/m<sup>2</sup> in cycle 1)
  - MabThera maintenance q3mo (500 mg/m<sup>2</sup>)
- Reduce toxicity by reducing the dose of fludarabine and cyclophosphamide
  - F: 20 mg/m<sup>2</sup>
  - C: 150 mg/m<sup>2</sup>