Vinorelbine and prednisone in frail elderly patients with intermediate-high grade non-Hodgkin’s lymphomas

Monfardini et al. [1] should be praised for their study on 30 frail elderly patients with unfavorable non-Hodgkin’s lymphoma (NHL) treated with vinorelbine and prednisone, because it is difficult to perform a clinical trial in such a difficult group of patients. Unfortunately, this non-toxic combination showed a modest activity, with a complete remission (CR) rate of only 10%. From March 2000 to June 2005, within the G.O.L. (Gruppo Oncoematologico Linfomi), a cooperative study group in North Italy, we treated 32 frail patients with aggressive NHL and with superimposable characteristics to those of Monfardini et al., i.e. age ≥80 years in 12 of 32 (37%) and age ≥70 and dependence on one or more activities of daily living in 20 of 32 (63%) patients. The significant difference of our treatment strategy was to also give to these frail patients a potentially active and curative chemotherapy regimen for aggressive diffuse large-cell NHL, i.e. CHOP in those without severe cardiac comorbidities, CEOP (epirubicin instead of doxorubicin), in those with moderate cardiac comorbidities, or CVP in those with severe cardiac comorbidities. The use of prophylactic granulocyte colony-stimulating factor (G-CSF) was mandatory from days 5 to 15 in all patients. Moreover, 17 of our patients were also treated with rituximab. The reasons why 15 patients did not receive rituximab were as follows: CD20 negativity in three patients, T-cell subtype in three patients and rituximab–CHOP (R-CHOP) still not an accepted treatment at the time of the enrollment into the study in nine patients.

CR was obtained in 25 of 32 (78%) of the patients with two of 32 (6%) obtaining only a partial remission. There were no differences in CR rate among patients treated with rituximab versus those who did not receive rituximab (76% versus 80%). The toxicity was quite acceptable and with 138 cycles of chemotherapy administered, grade 4 hematological toxicity was observed in only three (10%) patients and no toxic death occurred. The addition of rituximab did not increase the toxicity of chemotherapy. After a median follow-up of 20 months, there were only five of 25 (20%) relapses, while 25 of 32 (78%) patients are still alive. Seven out of 32 patients (22%) have died: four patients of NHL progression, two of pulmonary embolism (one patient before starting chemotherapy and one patient after a femoral neck fracture) and one of acute renal failure not related to the treatment.

In conclusion, our experience shows that also in frail patients with aggressive NHL, the aim of the treatment should be the control of the aggressive lymphoma with a CHOP-like regimen, modified according to possible cardiac comorbidities, with mandatory prophylactic G-CSF therapy and including rituximab in those who are eligible, taking into consideration the recent data of the British Columbia Group confirming the superiority of R-CHOP in elderly patients [2]. The comparison between the CR rate of Monfardini et al.’s study (10%) versus our study (72%) in a superimposable group of frail patients with aggressive NHL strongly supports our treatment strategy.

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