

How Age Affects MPN Symptoms and Treatment Options

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Annette:

My name is Annette. I have PV. I've heard quite a few times, you've indicated with age, would you be more aggressive with the treatment with a certain age as opposed to another age even if the symptoms and the patient is feeling the same whether you're 40 or whether you're 60?

Jeff Folloder:

Great question, great question.

Dr. Moliterno:

That really is a perfect question. And, you know, for instance in PVNR Hopkins cohort, we've made a diagnosis in as young as a 5-year-old girl, JAK2 positive PV and as old as a 96-year-old woman. So right. Same disease entity but clearly very different issues, right? So what's going to be good for a 5-year-old girl in her development and like how many decades of disease versus someone older, right, is really different.

Age plays a lot into our risk assessment because age, unfortunately, carries a lot of vascular risk. So if you looked at thrombotic risk for the whole population whether you have a disease or not, but venous thrombosis, arterial thrombosis, cardiovascular disease, stroke; these are all age-dependent entities.

And so when put on, well we're trying to assess vascular risk in, in PV, ET or MF, we listen to age very carefully. Now I, that being said, I know there are some guidelines, or some position papers out there that say, oh if you're 60 and you have a high blood count, then you have to go, once you hit 60, you have to go on myelosuppressive therapy to lower your platelets.

And that, patients always joke with me, well I was 59 and I didn't need chemotherapy, now I'm 60, and I need chemotherapy. And I don't think we, either of us practice that way or even 70 or 80. You know I've had some 85-year-olds who had ET for forever, and their platelets are over a million, and they are coming to my clinic because their last hematologist fired them because they said either you take hydroxyurea (Hydrea), or you have to leave my clinic.

And they are like fine, I'll go to Hopkins, and Dr. Moliterno will tolerate this. But I understand they're right, you know, if they, if they haven't had an event and they're feeling well, we will just proceed. So that's how age, you know, their age is

purported. It is a known risk factor, and we don't, no one wants anything bad to happen to our patients. So that's why age plays such a key assessment tool.

Dr. Stein:

If I could also, I'll be very brief, age doesn't necessarily define you, there are patients who are 40 who have 65-year-old blood vessels and patients who are 65 who may have the vasculature of a 40-year-old. So we, this is what we don't necessarily like about the guidance we get worldwide about what we're supposed to with our prescriptions.

Age reproducibly increases vascular risk, but we'd like it to be more, a little more personalized, individualized when we're prescribing therapy but not, I have a handful of patients who I've met when they're 58, 59 and we've had, they've had their 60th birthday and come in and they are no different than they were when they were 58.

So this is the part where we are looking to more personalized approaches to preventing thrombosis. Age does impact treatment, and I think it must be said that if we're thinking about myelofibrosis and if we're thinking about stem cell transplant, this is where age can play a major role. Perhaps this some, is a risk worth taking in a younger patient, perhaps it's too risky in an older patient.

So we don't like to base our decisions entirely on age, but there are some circumstances where we must, and I think the same comes from hydroxyurea. If you're a younger patient who must be on such a therapy, perhaps if we're looking at logically or very realistically, hydroxyurea could be a medication you're on for 25 years.

There might be consequences to being on it for that long. So age, we don't like it to, it's not the only thing we use to make treatment decisions and we don't, we really want to look at the whole person, the individual.

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