



Geriatric oncology

GERIATRIC ONCOLOGY: CURRENT STATE OF THE SCIENCE

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Since *Cancer Forum* first focused on geriatric oncology in 2008, our understanding of the needs of this growing population has expanded, along with the evidence base to support and optimise the level and quality of cancer care provided to older Australians. With the leadership of groups such as the International Society of Geriatric Oncology (SIOG) and the Cancer and Aging Research Group, there has been a steady increase in the awareness of the needs of older people with cancer globally. Within Australia, the Clinical Oncology Society of Australia's Geriatric Oncology Interest Group is fostering the development of the field in a truly multidisciplinary fashion. Input from all disciplines engaging in cancer care is required to facilitate the necessary development in research, education and service delivery.

This forum brings together expertise from a wide range of clinical specialties and disciplines. It provides an overview of the challenges of providing cancer care to an older, heterogeneous population with variable physiological functioning, rates of comorbidity and needs, and identifies opportunities to further refine their cancer care for this cohort. Rather than inventing new services, many of these articles detail strategies for utilising the expertise within existing cancer, primary or aged care services to provide appropriate care and support to older people with cancer.

In 2011, SIOG developed a document highlighting the main priorities for education, clinical practice and research in geriatric oncology around the globe.¹ This included a call for the development of specific geriatric oncology training programs. Gaining dual certification in geriatrics and medical oncology or palliative care remains an arduous process, and only a small group of physicians have attained the title of geriatric oncologist.² While it is unrealistic to suggest that a dual-trained clinician will manage all older adults with cancer, these specialists will be able to drive academic geriatric oncology programs that other centres can learn from. The development of a streamlined dual-training program will be required to expedite this process. In the meantime, much of the routine care of older adults with cancer will fall on clinicians in oncology clinics, who

will need to harness the expertise of existing oncology and geriatric multidisciplinary teams to address the unmet needs of this population. As the number of older people with cancer and some degree of cognitive impairment is predicted to increase in line with population ageing, the article by Soo is a reminder of the importance and complexity of assessing cognition on clinical decision making in this population.³ This article calls for early identification to facilitate appropriate decision-making and interventions to reduce the effects of cognitive impairment on patients and their caregivers. It provides clinicians with insights into the various cognitive screening methods and cognitive impairment management strategies, and the action required. If a clinician suspects a patient may have cognitive impairment, a more detailed assessment is required. This is one area where collaboration with a geriatrician and/or aged care assessment team is vital.

Ideally, geriatric screening and assessment ought to be available for older people with cancer at the point of entry. However, determining which screening and geriatric assessment tool is most appropriate continues to be a contested space. The article by McCarthy et al details a two-step pragmatic screening and assessment approach that is being tested in a large metropolitan cancer centre in Australia, and provides insights as to what might be realistically possible using existing resources.⁴ While the search for the 'best' assessment tool is ongoing, these authors remind us that identifying the best method of assessment is often a complex process that needs to be tailored to the needs of the patients and the clinical context.

Determining optimal treatment regimens for older adults with cancer is also challenging, as fewer older people are included in clinical trials and current data of geriatric assessment variables fails to resolve the specific difficulties involved in determining if a patient is fit enough to receive chemotherapy. In the absence of robust clinical trial data, empirical age-related dose reductions are frequent in clinical practice. Gibbs and colleagues examine the literature relating to chemotherapy outcomes for the

treatment of colorectal cancer in older adults and make some suggestions about which group of older people appear to benefit from chemotherapy for this disease.⁵ Although we do have some data regarding the efficacy and toxicity of this treatment in older adults, more research is needed to advance evidence-based clinical decision making in this area.

Not surprisingly, studies that inform clinicians of the optimal management of frail patients are one of the priority research areas. The amount of dedicated geriatric oncology research is increasing worldwide, yet there is much work yet to be done. Determining the effect of a geriatric assessment and guided intervention, the best screening and assessment tools for clinical practice, and how to design clinical trials specifically for older adults with cancer are some of the key research questions yet to be answered. Our international colleagues, Mohile and Hurria, provide a framework detailing the geriatric-oncology research priorities for current investigators in the field.⁶

Given the prevalence of comorbid conditions in ageing populations and the enduring relationship many older people have with their general practitioner (GP), Mitchell's article details the importance of primary care input throughout the cancer journey.⁷ While it can be difficult to engage primary care clinicians in day-to-day cancer management, there are key situations where the role of the GP is paramount. The GP is a vital member of the multidisciplinary management team, however finding ways to improve their participation in the decision making process is challenging. Technological advances such as video conferencing via Skype into multi-disciplinary meetings will hopefully improve this situation.

Nurses and allied health professionals have a significant role to play in identifying and proactively addressing the unmet needs of older people and their care-givers, which is explored in the article by Prouse and Phillips.⁸ They suggest a range of practical strategies that could be readily implemented by all cancer care services as the first step to addressing the practical and emotional needs of older people with cancer. They also pay attention to the supportive care needs of the care-givers, who themselves are also often older and frequently have their own health concerns. In addition to this contribution, the perspective of the pharmacist and dietician are provided in separate papers by Lees and Findlay et al.^{9,10}

Being aware of the prescribed and over the counter medications being used by older people takes on increasing importance when cancer treatment is required. Lees provides an overview of the poly-pharmacy issues and details four steps to enable cancer care clinicians to effectively manage and identify potential drug-drug interactions. Findlay calls for routine screening to identify older people at risk of malnutrition, using validated tools, and suggests practical strategies for the multidisciplinary team to adopt to ensure that those at risk of malnutrition have timely access to nutritional support from a dietician. These articles reinforce the importance of input from specialist members of the multidisciplinary team.

As Mitchell notes, the management of cancer in older adults should be "...similar but different" to the care of younger patients. Adequate geriatric assessment is required to guide appropriate treatment. The principle of geriatric oncology is to individualise management to provide the appropriate level of treatment and supportive care that the older person and their carer requires. This can be a difficult and time consuming process, however as all of the articles in this issue demonstrate, with dedication, rigour and teamwork, we can work together to optimise the patient's treatment and ensure that their cancer care journey and that of their care-givers is as smooth as possible.

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