



PERSONAL VIEWPOINT

Cancer in older people: a tale of two disciplinesC. B. Steer,¹ G. M. Marx,² N. Singhal,³ M. McJannett,⁴ D. Goldstein⁵ and R. Prowse³¹Border Medical Oncology, Wodonga, ²Sydney Haematology and Oncology Clinic, Hornsby, ³Royal Adelaide Hospital, Adelaide, South Australia, ⁴Clinical Oncological Society of Australia, and ⁵Prince of Wales Hospital, Sydney, New South Wales, Australia**Key words**

cancer, geriatrics, oncology, older people.

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Abstract

Management of cancer in the elderly presents an unprecedented challenge in Australia with the proportion of the population aged over 65 years set to double over the next four decades. Despite the complex healthcare needs of the older patient with cancer, there is currently little communication or cooperation between the fields of oncology and geriatrics. Improved interdisciplinary communication would facilitate care that is framed within current oncology practice while taking account of physiological age, complex comorbidities, risk of adverse events and pharmacological interactions as well as the implications of cognitive impairment on suitability for treatment and consent. An important first step has been taken towards the development of a strategic, focused and collaborative approach to the management of cancer in older people through a national interdisciplinary workshop convened by the Clinical Oncological Society of Australia in April 2008. Engagement and commitment of both oncology and geriatric disciplines is now critical to ensure that momentum is not lost in progressing this important and growing area of healthcare.

Introduction

National and international media coverage suggests that cancer is predominantly a disease of the younger generation. In fact, the reverse is true. In 2003, the median age of patients diagnosed with cancer in Australia was 67.8 years (Dr Mark Short, unpublished analysis, AIHW, 2007) with 44% of patients aged over 70 at diagnosis.¹ Cancer is one of the three leading causes of death in Australians aged 65 and over and represents a major burden to the health system, representing 11% of hospitalizations in this age group.² The reality is that, with the number of Australians aged over 65 set to double to one-quarter of the population over the next 35 years,³ the Australian healthcare system is facing an unprecedented challenge in how to manage cancer in its ageing population.

Planning and delivery of appropriate cancer care for older patients present a number of challenges. The increased likelihood of comorbidities in this age group is associated with an increased potential for treatment side-effects and drug interactions, only some of which can be predicted.⁴ Current guidelines suggest three categories of older patients: (i) 'young old' patients aged 65–75 years; (ii) 'old' patients aged 76–85 years and (iii) 'oldest old' patients aged 85 years and over.⁵ These groups represent a significant burden of disease accounting for 25%, 23% and 8% of all cancer cases in Australia respectively.² However, management options should not be determined solely on the basis of age.⁶ An alternative approach groups patients as a function of health: (i) healthy, independent patients; (ii) patients with moderate impairment and (iii) frail patients with major functional impairment and/or complex comorbidity.^{5,7}

It is important to recognize the wide differences that exist between chronological and physiological age. Triaging is essential to ensure that healthy active individuals have access to the full range of treatment options while frail patients with multiple comorbidities receive care

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appropriate to their needs.⁸ There is growing evidence that fit older patients tolerate conventional cancer therapy as well as their younger counterparts.⁹ Ongoing improvements in treatments and supportive care will only serve to increase the number of patients who are eligible for treatment, and an inability to quantify risk and plan care accordingly may result in inferior outcomes.⁵

The need for an interdisciplinary approach

The question of where responsibility for management of older patients with cancer lies is not straightforward. Given the median age of cancer patients in Australia, it could be said that all oncologists outside paediatrics are specialists in cancer in older people by default. Yet many current care providers lack the resources to manage the complex needs of these patients.^{10–13} Conversely, within geriatrics, management of comorbidities, assessment of polypharmacy and an understanding of cognitive impairment issues are central to everyday care. However, many geriatricians have only a limited knowledge of current oncology practice. Although patients could benefit from input from both areas of healthcare, there is currently little or no cross-over between the two disciplines. An interdisciplinary approach would facilitate delivery of best practice cancer care that considers physiological age, complex comorbidities, risk of adverse events and pharmacological interactions as well as the implications of cognitive impairment on suitability for treatment. Valuable lessons may be drawn from other interdisciplinary services, such as emergency medicine, intensive care and orthopaedics, that combine geriatric assessment and services with acute care.^{14–16}

The international picture

Australia can learn much from groups in Europe and the USA, where geriatric oncology has been a priority for some years. The International Society of Geriatric Oncology has raised the profile of geriatric oncology, producing nine clinical practice guidelines to date.^{17–25} The American Society of Clinical Oncology has long recognized geriatric oncology as a subspecialty, allocating a designated track at the annual scientific meeting and producing a comprehensive curriculum document.²⁶ Individual units undertaking research and clinical programme development in this area include the Senior Adult Oncology programme at the H. Lee Moffitt Cancer Centre in Florida,²⁷ centres in Switzerland, France and Italy and the European Organisation for Research and Treatment of Cancer.²⁸ Joint geriatric and oncology

training centres around the USA act as a catalyst for awareness raising, education and research.

Assessment tools

The assessment of each individual patient is central to the delivery of appropriate cancer care in older people. The Comprehensive Geriatric Assessment (CGA) is a multidisciplinary evaluation that seeks to identify and link a patient's multiple problems, strengths and resources with a view to developing an individualized management plan.^{29,30} Underpinning the CGA are four questions requiring special consideration in older cancer patients:³¹

- 1 Is the patient going to die with or of cancer?
- 2 Is the patient going to live long enough to suffer from cancer?
- 3 Is the patient going to tolerate treatment of cancer?
- 4 How will treatment impact quality of life given other coexisting illnesses and geriatric issues?

Extensive studies using the CGA have demonstrated the high prevalence of issues/syndromes in older cancer patients.¹² Aside from selecting appropriate patients for anticancer therapy, responding to the CGA has been shown to impact positively on patient well-being, with both supportive and clinical care issues addressed through a multidisciplinary approach.^{13,14}

Adoption of the CGA into routine practice has been hindered by its complexity. There is a growing need for a concise screening questionnaire that is less time-consuming or could be self-administered. Moreover, around one-third of older patients are healthy independent individuals who will derive no benefit from the CGA.⁵ Screening on the basis of a patient's health condition would allow oncologists to differentiate between healthy older patients and those with health problems that could interfere with cancer treatment who require a more in-depth geriatric assessment.⁵ Results of studies involving other screening questionnaires are awaited with promising results shown to date.^{32,33}

The Australian picture

Despite increasing numbers and the growth of aged care services, there is currently no standardized service delivery vehicle in Australia for older cancer patients. In the absence of national guidelines and frameworks, access to appropriate care for these patients is at best inconsistent. Australia's diverse demographics present an additional challenge, with access further complicated for isolated patients and those from culturally and linguistically diverse and indigenous communities.

There are several areas for improvement as Australia works towards an integrated approach to geriatric

oncology. 'Age bias' is a fundamental issue that cannot be ignored.¹¹ Guidelines for practice would provide one avenue for standardizing approaches and ensuring that treatment options consider physiological rather than chronological age. Clinical trials represent another area for improvement. Many current trials exclude older patients and those that do include patients older than 70 years typically include only the 'fit elderly'. There is a need for trials with functional endpoints that are relevant and specific for this population. Collection and analysis of registry, outcome and health economics data for the older population will also be important in identifying and filling service delivery gaps.

Australian initiatives underway include a geriatric oncology programme at the Royal Adelaide Hospital involving a self-administered screening questionnaire and referral of complex cases to a multidisciplinary onco-geriatric team.³⁴ At the Sir Charles Gairdner Hospital in Perth, work is underway to validate a short questionnaire to screen for frailty and vulnerability in a general oncology clinic. However, wider dissemination of key messages is required to ensure that lessons learned are implemented nationally.

Bridging the divide

The Clinical Oncological Society of Australia (COSA) is Australia's peak national body representing cancer health professionals. In April 2008, COSA convened a 1-day interdisciplinary workshop as a first step in developing a strategic approach to managing cancer in older people in Australia. Oncology and geriatric specialists came together to identify priority issues, consider service delivery models and identify research questions relevant for the Australian context. Guidance was provided by an international expert in onco-geriatrics who shared experience and knowledge from European initiatives. Workshop outcomes provide a valuable foundation for future planning.

Participants agreed that a formal model for onco-geriatrics in Australia should consider both international experience and local issues. The need for some form of geriatric assessment for older cancer patients was recognized, with a recommendation that all cancer patients over 70 years undergo some form of geriatric assessment, in line with international guidelines.⁶ The potential role of Centres of Excellence as an avenue for research and education was discussed. Participants suggested that trialling tailored approaches at demonstration sites would provide valuable experience and data on which to base national guidelines and frameworks.

Options for facilitating functional links between oncology and geriatrics included interdisciplinary edu-

cation, joint physician training, special interest groups and joint meetings. The importance of engagement with general practitioners as key members of the multidisciplinary team was also emphasized. General practitioners are encouraged to perform routine general health assessments on all patients over the age of 75. Use of the existing Medicare item number³⁵ and careful coordination with primary healthcare providers was suggested as a way of ensuring that all patients over 75 have some form of multidisciplinary assessment.

Clinical trials involving both oncology and geriatrics could provide a catalyst to encourage interdisciplinary collaboration. In discussing options for a programme of geriatric oncology research, participants agreed on the need for a staged approach. International experience suggests that it is not sufficient to extend the age range included in existing trials,³⁶ but that trials should use specific and relevant endpoints, such as improved quality of life or improved cost-effectiveness in terms of bed days or complication rates. While it is important to not exclude fit elderly patients from clinical trials on the basis of age alone, trials in frail patients are also needed, with further research required to define optimal assessment strategies.

Implications

The 2008 workshop was an important step in acknowledging the range of issues involved in providing appropriate care for older cancer patients and highlighting the need for functional interdisciplinary collaboration between oncology and geriatrics. Embedding change into practice will take time with the success of new strategies dependent on ongoing stakeholder engagement. The importance of clinical champions and consumers in driving change cannot be underestimated.

Australia must address workforce issues if it is to meet the growing cancer burden in its ageing population. As well as recognizing geriatric oncology as a specialty, there is a need for more physicians with expertise in both disciplines. There are currently three geriatric oncology trainees in Australia. The training programme duration may need to be reviewed to encourage further uptake. Dual-trained practitioners may be best used in specialist referral centres. However, it may not be possible for all patients to be referred to such centres and options must be considered for improving care within the current service delivery framework. Recognition of the role of primary care and allied health will be important in developing a sustainable model. Telemedicine and consultation liaison services represent possible solutions to be explored.

Roadmap for the future

COSA is committed to facilitating a Special Interest Group focusing on cancer in older people. Dual-trained practitioners are well placed to provide leadership for this group. Initial action plans include definition of a valid national screening tool, a cross-sectional patterns of care study to establish current approaches to care for different categories of older patients, validation of working models for specialized clinics and development of a consensus set of recommendations on assessment of suitability for treatment.

Communication and networking will be central to the success of future programmes. Establishing links between interested specialized centres will help develop a core of expertise that cancer care facilities around the country can draw upon, while links between geriatrics, oncology and primary care will help to ensure a coordinated approach. Collaboration between COSA and the Australian and New Zealand Society for Geriatric Medicine will also be important with reciprocal presentations at annual conferences and joint symposia and workshops, providing the opportunity for ongoing dialogue.

The need for change is already apparent and will only increase with time. Australia has the opportunity to draw on international experience and make significant advances in this growing area of healthcare. It is incumbent on us as healthcare professionals to work together to find a way of ensuring optimal care for all patients with cancer, regardless of age.

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