The Geriatric Oncology Clinic: Similarities and Differences To A Comprehensive Oncology Clinic

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Why So Much Hype About Geriatrics?

Current and Future Anticipation……..

- Greater than 50% of patients diagnosed with cancer today are ≥ 65 years of age
- This number will continue to increase as world ages
- Exponential growth is expected
- Less evidence on how to treat geriatric patients as this age group is under-represented in clinical trials
- Heterogeneity in the aging process
- Cancer biology may present differently in older adults
- Age-related variations in treatment and outcomes
- Under- or over-treatment is common

Korc-Grodzicki B, Downey RJ, Shahrokni A, et al. (2014). *J Clin Oncol, 24,* 2647-53.

Why Is Geriatric Assessment Important?

Chronological age is a poor descriptor of aging

Requires a systematic, evidence-based assessment

Comprehensive Geriatric Assessment (CGA)

- Systematic
- Multidimensional
- Interdisciplinary
- Diagnostic process

OUTCOME: coordinated and integrative team

Wildiers H, Heeren P, Puts Martine, et al. (2014). *J Clin Oncol, 24,* 2595-03

Rationale for Geriatric Assessment

- Detection of unidentified problems
- Risks for which targeted interventions can be applied
- Prediction of adverse outcomes
- Better estimation of residual life expectancy
- Estimation of lethality of cancer
- Provide a comprehensive health assessment
- Will guide targeted geriatric interventions

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Information Gained Beyond H&P

Age-related problems

- Fatigue (37%)
- Nutritional issues (38%)
- Functional impairments (40%)

Predict potential toxicity/adverse effects of treatment

Estimate life expectancy

Influence or improve treatment decisions

Enables targeted interventions

- Can improve quality of life
- Compliance with therapy

Systematic process to appraise objective health

- Multi-morbidity
- Functional status

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Reliability of Geriatric Assessment to Predict Oncology Treatment-Related Complications?

Two large, prospective studies

Cancer & Aging Research Group (CARG)

Chemotherapy Risk Assessment Scale for High-Age Patients (CRASH)

Geriatric assessment items are predictive (independent of classic oncologic predictors) of:

- Risk of severe treatment-related toxicities
- Modifications of therapeutic approach (e.g. dose, regimen) with adaptations or interventions

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Geriatric Assessment & Overall Survival

Geriatric assessment items independently predict overall survival:

- Increased risk of death from other causes
- Increased risk of death due to less aggressive treatment
- Death resulting from complication of cancer treatment

Prognostic models for geriatric oncology are needed!!

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Impact of Geriatric Assessment on Treatment Decisions?

Geriatric assessment can affect treatment decisions:

- Overtreatment, or more frequently under-treatment
- Decrease or increase treatment intensity
- Tailor treatment
- Trigger geriatric interventions to improve outcomes
- Integration of assessment findings into treatment decisions

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Domains of Geriatric Assessment

Important domains include:

- Functional status
- Fatigue
- Comorbidity
- Cognition
- Mental health status
- Social support
- Nutrition
- Geriatric syndromes
  - Dementia
  - Delirium
  - Falls
  - Incontinence
  - Spontaneous fractures
  - Neglect or abuse
  - Failure to thrive
  - Constipation
  - Pressure ulcers
  - Sarcopenia
  - Polypharmacy
  - Osteoporosis

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How To Organize Geriatric Clinics

Geriatric oncology unit

- Specific ward caring for geriatric patients
- Allows centralization of geriatric expertise and treatment options
- Potential patient withdrawal from familiar treating oncologist
- General oncologists may not refer due to financial issues
- Only limited number of patients can be reached
- General geriatric oncologists are not the same as site-specific providers

Geriatric Consultation Team

- Patients remain under supervision of treating oncologists
- Can reach large majority of older patients with cancer
- Interaction with oncologists and geriatric team is possible
- Decentralization has logistic and practical issues
- Low compliance of oncologists to recommended actions
- Geriatric assessment results may be unknown during decision-making
- Patients needing referrals may encounter waiting lists

Organization of Geriatric Clinic (cont.)

What if geriatric expertise is not nearby?

- Stand-alone clinic in comprehensive cancer center without geriatric department
- Hospital-affiliated practices
- Private practices
- Urban vs. rural

Patients remain under treating oncologist

- Validated methods can be used to target high risk patients
- Introduce geriatric care
- Large majority of geriatric patients can be reached

No gold standard exists – Research needed!!!!

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Clinic at The Ohio State University

Geriatric clinic at The Ohio State University

Stephanie Spielman Comprehensive Breast Center

- Specific clinic at breast center in medical oncology area
- Team of breast medical oncologist & geriatric NP
- Appointments by scheduler (based on age) or referrals
- Recommendation that ***all*** geriatric patients seen
- Patient returned to surgical oncologist / kept for treatmt
  - History & physical
    - Constitutional
    - Head – dizzy, headaches
    - Eyes – vision changes/deficits
    - Ears – hearing loss
    - Respiratory
    - Cardiac

Gastrointestinal – appetite, gut

Genitourinary - incontinence

Neurological – stroke, TIAs

Musculoskeletal – falls, exercise

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Comprehensive Geriatric Assessment:

- Numerical pain rating scale
- Timed Up and Go
- Grip strength
- Katz Index of Independence in Activities of Daily Living
- Lawton Instrumental Activities of Daily Living
- Mini nutritional assessment
- Mini cognitive assessment (recall, draw clock)
- Geriatric depression scale
- Charleson comorbidity scale
- Falls
- Impression based on results

Concerns About Surgical Intervention

Surgery is the most effective cancer-ablative therapy and the best modality to treat solid tumors.

- Complication rates
- Mortality
- Length of hospital stay
- Intensive care unit admissions

ALL can increase with age….offsets oncologic advantage

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Surgical Considerations

- Aging population with increasing cancer risks
- Persons may not have been considered in past
- Often used to, or still do have age ‘cut-offs’ for surgery
- Decisions made with little personal evidence
- Effective surgery requires safe performance

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Preop Evaluation of Syndromes

- Frailty, e.g. a state of reduced physiologic reserve
- Functional limitations
- Falls risk stratification
- Cognitive limitations
- Malnutrition
- Comorbidities
- Polypharmacy
- Social support

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Postoperative Concerns

- Adequate perioperative risk stratification
- Assessment of functional status
- Oncologic prognostication

Geriatric Assessment May Prevent…

- Postoperative delirium
- Functional decline
- Falls
- Additional long-term comorbid conditions
- Need for institutionalization

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Final Guidelines

Treatment of senior oncology patients should focus on:

- Enhancement of functional capacity
- Preoperative ‘prehabilitation’
- Perioperative care
- One-year outcomes after surgery

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