Geriatric Assessments Could Fine-Tune Cancer Care for Older Adults

Oncologists say that the care of older adults with cancer needs to be improved, and this new guideline may kickstart a positive change.

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In a move to improve cancer care for older adults, the American Society of Clinical Oncology is recommending that all patients age 65 and older receive a geriatric assessment when considering or undergoing chemotherapy.

The goal is to better identify which patients can tolerate intensive chemotherapy, and which patients may need modified treatment regimens because of underlying conditions, such as cognitive impairment, that often go undetected by oncologists.

Fewer than 25 percent of older cancer patients currently get these assessments, which evaluate a person's functioning (what he can and cannot do), psychological status, nutrition, cognition, social circumstances and other, coexisting medical conditions, and which can predict the potential toxicity of chemotherapy.

The new guideline, ASCO's first in the field of "geriatric oncology," may have significant potential to change medical practice. "These recommendations will capture the attention of oncologists, I think, and that will be incredibly valuable," said Corinne Leach, strategic director of cancer and aging research at the American Cancer Society.

They recognize a shifting demographic reality for cancer specialists, who are treating increasingly older patients as life spans lengthen across the globe. In the U.S., 60 percent of patients newly diagnosed with cancer (an estimated 1.7 million people this year) are age 65 or older, as are more than 60 percent of cancer survivors.

Yet evidence about how best to treat older adults with cancer is weak because older adults are underrepresented in clinical trials. And most oncologists have received little training in how to manage older patients' unique vulnerabilities.

When researchers asked 305 community oncologists about evaluating older patients, 89 percent acknowledged "the care of older adults with cancer needs to be improved," according to a recently published study. Fewer than 25 percent said they were "very confident" they could

identify dementia or accurately assess a patient's functioning or risk of falling — factors associated with poorer outcomes for cancer treatment.

Still, resistance to change is evident. "We're all inundated with trying to keep up with new standards of care, and I doubt there will be any broad acceptance of the rigor called for in this guideline," said Frederick Schnell, MD, medical director of the Community Oncology Alliance.

The burden on physicians shouldn't be significant, however: The streamlined assessments recommended in the ASCO guideline take only about 20 minutes to complete. Patients fill out surveys during most of that time; about five minutes is required for a nurse or physician assistant to administer several brief tests.

The assessment can identify people at increased risk of experiencing serious side effects from chemotherapy — infections, fatigue, diarrhea, dehydration and other problems that affect more than half of older patients. Physicians can then take steps to address these vulnerabilities such as prescribing physical therapy for an older patient with muscle weakness or ordering a nutritional consultation for someone who has become malnourished. Also, they can alter chemotherapy regimens to minimize the potential for harm.

Currently, most oncologists decide whether older patients can benefit from chemotherapy by using the "eyeball test," an assessment that relies primarily on their experience and judgment. "This isn't enough to understand factors that put older adults at risk; it takes a deeper dive," said Arti Hurria, MD, director of the Center for Cancer and Aging, professor of medical oncology and therapeutics research at City of Hope, a comprehensive cancer center in Duarte, Calif., and co-chair of the panel that produced the new guidelines.

An oncologist walking into a room in a busy clinic might find an older patient already on the exam table, for instance, and miss the fact that she needed assistance getting out of a chair and getting into a gown — important signs of functional impairment that could be aggravated by chemotherapy, Hurria said. Or, "a very pleasant older patient might smile kindly at you and agree with everything you're saying, and she might not have understood a thing you said" because of undetected cognitive impairment that could worsen and interfere with treatment, she explained.

William Dale, MD, PhD, a geriatrician and Arthur M. Coppola Family Chair in Supportive Care Medicine at City of Hope and another co-chair of the guideline panel, tells of an 83-year-old woman whom he saw several years ago, with lung cancer metastasized to her brain. Her family requested a consultation because she'd become withdrawn and forgetful — a sign of accelerating cognitive impairment, they suspected.

Should she have chemotherapy and whole brain radiation, or would that worsen her memory lapses, the patient and family wondered?

One result stood out when Dale ordered a geriatric assessment: This older woman wasn't cognitively impaired, she was psychologically distressed. "She wasn't eating, she wasn't interacting with other people, she appeared not to want treatment, but all this was due to

depression," Dale recalled. With counseling, the patient decided to undergo chemotherapy and radiation treatment, which he called "remarkably successful."

Just as genetic tests are being used to personalize care for older cancer patients, geriatric assessments can be employed for this purpose — at considerably less expense, said Supriya Gupta Mohile, MD, editor-in-chief of the Journal of Geriatric Oncology and director of geriatric oncology at the James Wilmot Cancer Institute at the University of Rochester.

She tells of a 78-year-old man with invasive bladder cancer who came in for a consultation. From the medical chart, she learned the patient had hypertension, diabetes and depression, all reasonably well-controlled. From a geriatric assessment, she discovered that he lived alone, had cognitive impairment, relied on his daughter to deliver meals and was at high risk of falling.

"The patient and his daughter were worried about his safety at home, his cognition getting worse, and fatigue and how that might affect his ability to function," Mohile said. "His goal was to stay independent, at home, and not be hospitalized or go to rehabilitation."

The standard of care for this condition was three to four months of chemotherapy before surgery, but Mohile recommended that the older patient skip chemotherapy and have surgery immediately after reviewing the geriatric assessment with her patient and his family.

Every older patient considering chemotherapy should request an evaluation of this kind, even if your physician doesn't offer it, said Heidi Klepin, MD, associate professor of hematology and oncology at Wake Forest School of Medicine in North Carolina. "Ask for your doctor to consider your ability to do the things you most care about doing and for care to be individualized to your unique circumstances."

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