

^c Fundacion Jimenez Diaz University Hospital, Health Research Institute IIS-FJD, Madrid, Spain

^d Hospital La Fe, Spain

* Corresponding author.

E-mail address: fmperomingo@salud.madrid.org (J. Martínez-Peromingo).

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Reflecting on oncogeriatrics: What can be done to promote the integration of the comprehensive geriatric assessment in the oncology practice?



Reflexión sobre oncogeriatría: ¿qué puede hacerse para promover la integración de la evaluación geriátrica integral en la práctica de la oncología?

Dear Editor,

The comprehensive geriatric assessment (CGA), the core of geriatric medicine, is defined as a multidimensional interdisciplinary diagnostic process intended to determine a frail older person's medical, psychosocial and functional capabilities and limitations in order to develop an individualized overall plan for treatment and long-term follow-up.¹ In the oncogeriatrics setting, CGA also represents the core of the decision-making process because it not only identifies which older adults are resilient enough to tolerate intensive oncologic treatments or which are frail/vulnerable (and so at high risk of treatment toxicity), but it is also used to estimate life expectancy.² As a result of this, incorporating the CGA in the oncology clinic when treating older adults with cancer is recommended by scientific societies, such as the International Society of Geriatric Oncology (SIOG) and the American Society of Clinical Oncology (ASCO).^{3,4} Furthermore, CGA-centered interventions are starting to draw the attention of the scientific community, as they appear to potentially change oncologic treatment plans and outcomes without compromising overall survival.^{5,6}

Albeit these recommendations and scientific evidence, it appears to be difficult for cancer care providers to include CGA or geriatric assessment (GA) tools in their daily practice. It has been described how the use of these tools appears to be low in the oncogeriatric setting, mainly when professionals are not aware of the guidelines.⁷ Furthermore, in a recent survey carried out in the United States and addressed to community oncologists, it was observed that almost 60% of the respondents did not regularly use a validated GA tool in their daily practice,⁸ and the most frequently reported reason for not applying them was lack of time.^{7,8} However, the 'time consuming' argument has to be stopped,⁹ as we shouldn't be potentially exposing older adults with cancer to an increased risk of developing treatment-related complications, or not offering them individualized treatment plans, just because of a 'time matter'.

One possible solution to confront this matter would be to incorporate a geriatrician to every oncology clinic to assure that every older adult with cancer receives a CGA. However, this option is currently unrealistic, as Girones et al. showed how – in a survey addressed to Spanish medical oncologists in which a hundred and fifty-four different national centers were represented – only 48% of them had a geriatrics discipline among their workforce.¹⁰ A SIOG expert consensus statement considered that to assure an adequate assessment of older patients with cancer, the use of screening tools

would be useful to select those who would benefit the most from a multidisciplinary team assessment that would eventually lead to a personalized intervention plan.¹¹ And although this is sensible and of extreme importance, the issue still remains with those oncology clinics that don't have a geriatrician available to lend a hand with these assessments.

Considering this geriatrician shortage, we not only think that integrating geriatric oncology in the medical and nursing curricula and supporting specific training programs is necessary,¹¹ we also think that it is time to *really* start promoting interdisciplinary teamwork nationwide. It seems essential to build bridges between scientific societies – both national and international – so that action guides, consensus statements and strategic plans regarding geriatric oncology include all healthcare professionals involved in the field. These 'bridges' could also lead to the development of multidisciplinary research projects that will not only encourage interdisciplinary teamwork, but also the inclusion of outcomes traditionally forgotten on research studies but of great importance to the older population (such as functionality or quality of life).

Thankfully this approach seems feasible, as geriatricians are very aware of the importance of team-working to provide the best care possible for patients.¹² However, and as geriatric oncology appears to have developed considerably in the last few years, it seems imperative to first assess what the situation of our country is. We need to update the already available evidence¹⁰ and to get to know what is being done nationwide: we need to know how older adults with cancer are being assessed, if the use of CGA is common, what validated tools are being used, how many oncologists work with multidisciplinary teams that include a geriatrician... and so on. Because if we want to find a way to integrate CGA in the oncogeriatrics practice and develop other action plans to assure an improvement in the care of older adults with cancer, we first need to know what the magnitude of the issue is.

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Nicolás M. González-Senac^{a,b,*}, Myriam Rodríguez-Couso^c

^a *Geriatrics Department, Hospital General Universitario Gregorio Marañón, Madrid, Spain*

^b *Instituto de Investigación Sanitaria Hospital General Universitario Gregorio Marañón, Madrid, Spain*

^c *Geriatrics Department, Hospital Universitario Fundación Jiménez Díaz, Madrid, Spain*

* Corresponding author.

E-mail address: nic.gsenac@gmail.com (N.M. González-Senac).

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