

Addressing the challenges of cancer care in older adults: The unique benefits of oncogeriatric evaluation and management



Afrontando los desafíos de la atención del cáncer en adultos mayores: los beneficios únicos de la evaluación y manejo oncogeriatra

Dear Editor,

Age is the single major risk factor for most cancers, including hematological malignancies, with population aging posing a growing concern worldwide. In Europe, the median age at diagnosis for hematological malignancies is 69 years; incidence increases with age, reaching a maximum at 75–99 years.¹ Survival for patients aged 75 years and older with hematological malignancies is generally poor, particularly for those with acute leukemias. The incidence of solid tumors also increases with age, with the presence of frailty, malnutrition and comorbidities associating a higher risk for mortality in elderly patients diagnosed with cancer.² Understanding outcome variability, treatment challenges, and the impact of frailty and comorbidities among older patients is of utmost importance if we are to manage the burden of cancer in the aging population correctly.³

Along with the aging population, the increasing cost of oncological treatments is another major challenge that healthcare systems face today. Strategies developed to minimize the impact of these challenges include promoting the use of generic and biosimilar medications, negotiating drug prices, evaluating the cost–benefit profile of different treatments, promoting the prevention and early diagnosis of cancer, and optimizing access to therapy. The judicious use of digital health tools merits special attention, as studies demonstrate improved cancer care outcomes and reduced costs⁴; digital health interventions for older patients with cancer have shown to improve clinical outcomes⁵ and increase access to care, especially in patients with reduced mobility. A careful design, taking care to bridge the “digital divide”, is vital to the success of digital health interventions for geriatric patients.

In the context of population aging and budget constraints, geriatric oncology could be the key to addressing the unique challenges presented by cancer treatment in older patients, and fundamental to patients' quality of life and survival.⁶ Geriatric oncology focuses on cancer treatment in older people and uses comprehensive geriatric assessment to develop personalized treatment plans tailored to patients' individual needs. The Community of Madrid's Plan for the Attention of Frailty and Healthy Aging⁷ prioritizes the early detection of frailty in those clinical processes in which frailty could reduce treatment tolerance or put patients at risk for functional decline. Unfortunately, the widespread implementation of geriatric oncology programs is yet to be achieved, despite multiple arguments which justify the benefits of such an approach.⁸

- Geriatric oncology programs permit personalized care by developing individualized treatment plans depending on each patient's needs, thus avoiding unnecessary treatments and ensuring that patients receive an appropriate and effective treatment according to their health status and therapeutic tolerance.
- Geriatric oncology programs (GOPs) reduce direct spending on oncology treatments, as well as costs associated with ineffective therapy and avoidable side effects.
- GOPs improve patients' quality of life through comprehensive care and geriatric evaluation, which reduce the morbidity and mortality associated with cancer in older patients.

- GOPs increase access to care by implementing technological advances such as telemedicine to provide support for patients with limited mobility.
- GOPs address the aging population. With the increase in life expectancy, the incidence of cancer in older people is expected to rise, highlighting the need to ensure that older patients receive appropriate and personalized treatment.
- GOPs contribute to healthcare system sustainability by reducing cancer treatment-associated costs in older patients.

Multiple publications underline the need for implementing geriatric programs for older patients with cancer, demonstrating the efficacy of comprehensive geriatric evaluation for these patients though outcomes such as improved quality of life, reduced healthcare spending, and reduced prescription of unnecessary oncology treatments.⁹

Some countries, such as France and the UK,¹⁰ have modified cancer care policies in patients over 70 to include comprehensive geriatric evaluation and personalized care, with results including improved quality of life and reduced direct healthcare spending.

In summary, there are overwhelming arguments to convince healthcare services of the need for geriatric oncology programs. Healthcare managers cannot ignore this need if the sustainable improvement of cancer care in older adults is truly a priority. Geriatric oncology offers a personalized model of care tailored to the needs of each patient, reducing spending on oncology treatment, improving patients' quality of life, providing solutions to address population aging, and contributing to the sustainability of the healthcare system.

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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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