CGA IN DAILY PRACTICE

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Introduction

• It is becoming evident that selected elderly cancer patients may benefit from a Comprehensive Geriatric Assessment (CGA) and geriatric interventions. In daily practice, barriers to perform CGA are time, costs, and each of well-defined procedure to interpret and apply for information.

• This work was carried out from 2004 to 2006 at the Rovigo General Hospital. The Rovigo province is located in the south of the Veneto Region in the north of Italy. It is a vast rural area with an elderly index very high.

• In 2003 we started a program devoted to senior cancer adult, in collaboration with prof. Monfardini.
Introduction 2

• Objective of the program

• Perform elderly evaluation to patients aged 70 + ys according to the guidelines and perform different treatments in accordance with the evaluation.

• Know better the medical and social conditions of elderly cancer patients of our area.
The elderly index for Rovigo area is about double the index for Veneto and the whole of Italy index.

<table>
<thead>
<tr>
<th></th>
<th>Rovigo</th>
<th>Veneto</th>
<th>Italy</th>
</tr>
</thead>
<tbody>
<tr>
<td>elderly Index</td>
<td>203,6</td>
<td>138,2</td>
<td>139,9</td>
</tr>
<tr>
<td>dependence index</td>
<td>50,2</td>
<td>49,4</td>
<td>51,1</td>
</tr>
<tr>
<td>elderly dependence index</td>
<td>33,7</td>
<td>28,7</td>
<td>29,8</td>
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</table>

ISTAT DATA 1-1-2006
THE NUMBER OF ELDERLY PEOPLE IS PARTICULARLY HIGH IN OUR PROVINCE. THE GREATER ELDERLY INDEX IS LOCATED PREVALENTLY IN THE WEST.
The incidence of cancer is slightly growing.

For males, the incidence trend is +0.35% per year.

For females, the incidence trend is +1% per year.

The incidence of cancer is slightly growing.
all cancers incidence trend in pts aged > 70  VCR 2007

Globally no difference in the incidence trend of cancer between Veneto Region and Rovigo area
work organization

OUTPATIENT CLINIC

SECRETARIAT

• nurse

GERIATRICIAN

ONCOLOGIST

discussion

• treatment strategy
• letter for patient
• letter for the primary care physician
comprehensive geriatric assessment

- Function: PS; ADL; IADL
- Co-morbidity: Conditions/severity
- Cognition: Folstein’s MMS
- Emotional: GDS
- Pharmacy: Polypharmacy; drug interactions
- Nutrition: MNA
- Geriatric Syndromes
a) Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)
b) Comorbidity (Related to life expectancy and stress)
c) Mental status Related to life expectancy and dependence (Folstein Mini-Mental Status)
d) Geriatric Depression Scale (GDS)
e) Nutritional Status Reversible (MNA) Risk of drug interactions
f) Polypharmacy (Related to survival)
g) Geriatric syndromes (Delirium, dementia, depression, falls, incontinence spontaneous bone fractures, neglect and abuse, failure to thrive)
h) Social support related to the patient’s ability to receive treatment
   • does the patient live alone or in a family or adult living facility?
   • is there a person the patient identifies as a caregiver?
   • is the caregiver able to use the phone to provide transportation in case of emergency? Can the caregiver ensure patient nutrition?
### Diagnosis

<table>
<thead>
<tr>
<th>TUMOR</th>
<th>N°</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>colo-rectal</td>
<td>82</td>
<td>38</td>
</tr>
<tr>
<td>stomach</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>breast</td>
<td>32</td>
<td>15</td>
</tr>
<tr>
<td>lung</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>hematol</td>
<td>43</td>
<td>20</td>
</tr>
<tr>
<td>others</td>
<td>43</td>
<td>20</td>
</tr>
<tr>
<td><strong>total</strong></td>
<td><strong>216</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Great prevalence of GI cancers
On completion of the evaluation the patient was located according to this scheme and a treatment was planned.

Balducci L Oncologie 2007 modified
Of the patients classified as frails at first examination 50% need further evaluation.
As in other studies, the group of patients + 85 years are not well represented.

Demographic data sex

**M/F balanced**

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by A. Bononi
The great majority of Patients attended for a primary school
The number of patients living alone rises with age.
The social support is not considered high priority for elderly patients with cancer.
The caregiver is usually a family member living near the patient.
There are no differences between age and nutritional status but there is a tendency for a slight rise of abnormality in the +85 group (40%).
The distance from hospital is frequently more than 10 Km. This may create problems for patient treatment.
PS 0-1 is more frequent in 70-75 age group. P< 0.05
Patients in group 70-75 Ys show little dependence on ADL. P<0.05
IADL dependences are incongruous with previous tests because in the group 70-75 years four or more dependencies have been found in about 50% of patients.
Comorbidities are equally distributed between age groups.
Cognitive disorders increase with age. Between 76-85+ years, 30-40% of the patients had problems.
The number of drugs per day is in inverse relation with age. In the group 85+ more than 60% of patients take 0-3 drugs a day.
The frailty increases with age.

P<0.05
The Treatment between Groups classified according CGA is highly statistically different. $P < 0.001$
Conclusions 1

1) Our experience was extremely positive. The collaboration with other specialists in a multidisciplinary team was very gratifying.

2) The stratification of patients was sometimes difficult because of particular clinical geriatric peculiarities (analyzed by L. Friend: Jama 1998).

3) In patients aged 70-75 year old dependences are better detected by IADL than by PS and ADL. In daily practice this subset should be carefully evaluated.
Conclusions 2

4) In the age bracket 76-85 years we have found a great number of frail patients (46%). These subgroups often live alone, without social support and without a care giver, despite their need of support.

5) Frequently the accurate classification of frail patients required further evaluation.

6) CGA in daily clinical practice was time consuming but was helpful in differentiating tailored treatments for oncogeriatric patients.
Conclusions 3

7) We have recently started a rapid evaluation process according to NCCN guidelines. It is too early to evaluate this experience.

8) The main problem is the identification of the real frail patients who still remain not candidates for classical oncologic treatments. Symptoms related to cancer cachexia are often confounding; combined geriatric and oncologic expertise may help properly select patients.
Rapid validated screening

- **Screen**
  - **Negative**
  - **Positive**
    - **Confirmatory tests**
Medical Oncology Unit
Dir. F. Pasini MD

The Oncogeriatric team
A.Bononi Medical Oncology
S.Baldan Geriatrician
G.Bellucco Psychologist
G.Bregola Pharmacist
M.Gusella Pharmacology
Death does not arrive with old age
But with forgetfulness

G.G. Marquez
thanks for your attention