The role of the geriatrician in the multidisciplinary approach of treating older patients with cancer

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Would you recommend conventional induction therapy trying to achieve complete remission?

Woman, 90 years old
Diabetes mellitus
Recent diagnosis of acute myeloid leukaemia
Age per se is not a good predictor of outcomes

- Age is a risk factor of a higher mortality and morbidity
- However, if multivariate analysis considering comorbidity and functional status is performed, age will not predict mortality and morbidity for most diseases
Why is age still considered a major risk factor?

- Decision biased by ageism
- Undertreatment
- Error reinforced
- Worse results
MEDICAL decision making

Life expectancy
Morbidity/complications
Quality of life

Life expectancy
Is cure possible?
Morbidity/complications
Quality of life

NO TREATMENT

EACH TREATMENT OPTION
Life expectancy

Age, gender

Comorbidity

Functional status

Stage of disease to be treated

Life expectancy
2 Upper, Middle, and Lower Quartiles of Life Expectancy for Women and Men at Selected Ages

Data from Life Tables of the United States

The main influence of age on decision making is usually in the form of ageism

Influence of comorbidity

Causes of death in women with breast cancer

Number of associated diseases

- None
- One
- Two
- Three or more

Legend:
- Cancer dead
- Non-cancer dead
Predictors of mortality
6 months after hospital admission
## Predictors of long term mortality

10 years after hospital admission

- Admission due to cancer, infection or neuropsychiatric condition.
- Dependent for Instrumental ADL.
- Cognitive impairment.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Hazard ratio</th>
<th>CI 95%</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer related admission</td>
<td>4.30</td>
<td>(2.65 – 6.98)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Neuropsychiatric admission</td>
<td>1.94</td>
<td>(1.18 – 3.20)</td>
<td>0.009</td>
</tr>
<tr>
<td>Infection on admission</td>
<td>1.70</td>
<td>(1.22 – 2.36)</td>
<td>0.002</td>
</tr>
<tr>
<td>Mental impairment</td>
<td>1.19</td>
<td>(1.05 – 1.35)</td>
<td>0.008</td>
</tr>
<tr>
<td>Able to perform IADLs</td>
<td>0.83</td>
<td>(0.77 – 0.89)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
Geriatric assessment is needed in older cancer patients to detect unknown problems, to improve functional status and, possibly to improve survival.

Task Force on CGA of the SIOG. Crit Rev Oncol Hematol 2005
OUR AIM: TO HELP PATIENTS

To treat... or not to treat?
MEDICAL decision making

- **Never** based on age or prejudice
- **Objectively** consider every factor: life expectancy, life with/without treatment, quality of life
- The **patient** will make the decision
- **Individualization**
- Team work
Multidisciplinary work seems to be a good idea

But many things need to be sorted out
What are the functions and roles of each member of the team?
Comprehensive geriatric assessment: a meta-analysis of controlled trials

Andreas E Stuck, Albert L Siu, G Darryl Wieland, John Adams, Laurence Z Rubenstein


Effectiveness of acute geriatric units on functional decline, living at home, and case fatality among older patients admitted to hospital for acute medical disorders: meta-analysis

Juan J Baután, consultant geriatrician,1 Francisco M Suárez-García, geriatrician,2 Jesús López-Arrieta, consultant geriatrician,3 Leocadio Rodríguez-Mañas, chief of department,4 Fernando Rodríguez-Artalejo, professor of preventive medicine and public health5,6

BMJ 2009;338:b50
Comprehensive geriatric assessment

Clinical data

Physical function

Mental function

Socioeconomic aspects
Evolution of geriatric assessment

a still evolving tool

Geriatric assessment comes in many sizes and shapes.

Robert Kane
Adaptation of assessment


Formal geriatric assessment.

An imperative for the older person with cancer

Roche RJ, Forman WB, Rhyne RL.


“...results underline the need of a formal comprehensive geriatric assessment that includes measures of cognition, mood, and physical function in older cancer patients.”
What do geriatricians bring to the team?

- Comprehensive patient-centered vision.
- Experience in complex patients with multiple diseases, drugs, complications.
- Experience in assessment.
- Able to appreciate life expectancy, quality of life, functional and social issues.
- Team work with other specialists/professionals.
What may be the role of geriatricians?

- Support **decision** making on treatment options in the most complex
- Help in the treatment of **comorbid** diseases
- Play a role in adapting complex **drug treatments** to reduce ADR
- Provide help in reducing the **functional** (physical and mental) and **social** impact of cancer and cancer treatment
- Help treating physician in managing **ethical** problems
- Deliver **end of life care**
I Am a Geriatrician

How often have I been asked over the past 30 years, "What is a geriatrician?" I cannot count the times and the ways that I have tried to answer this question. But clearly, even as the field has grown and matured, the public continues to have at best a vague idea of what a geriatrician is and does and why. In this essay, I attempt to capture the essence of my various attempts to respond to this query (e.g., "I", from my friends and neighbors, who still do not understand what I do. I hope that my answer is factually informative while emphasizing that the real magnetic force bonding me to the field is my love for the patients we serve, each with an old lives tale to share.

I am a geriatrician. I specialize in the medical, psychological, and social care of old people.

How old is old? Perhaps 75 for starters, 85 as an average, ever 90, 95, 100, and older.

I love old people. I love old people. I love old people. I enjoy respect and admire them. They inspire me. I have survived the trials of youth and middle age and learned from those trials and all of their experiences and have so much to teach me about life and what it means to age. They have given so much and have so much to give in return.

How do you get to be a geriatrician? Finish medical school to become a doctor; of course. Curves of residency to become an internist or a family.

generalist skilled in diagnosis and treatment of the vast array of medical problems of adults. Finally, I or more years in a geriatrics fellowship to become a specialist in the management of the special problems of old people. This is tremendously demanding, because it is in reality, the medical problems of the elderly are complex and progressive.

In addition, diseases commonly interact to produce an atypical or nonspecific presentation, making any specific diagnosis obscure. The limited reserves and resiliency of the old person increase the risk of weight loss and malnutrition, dehydration, and bad reactions to drugs and medical and surgical procedures. The complex web of these factors frequently producessome orall of the geriatric syndromes that perhaps are now new to our specialty: confusion, falls and fractures, urinary incontinence, depression, and dementia, to name just a few. Perhaps my most typical patient is the old-fashioned picture of frailty, a man—or more often a woman—who lives on the razor's edge between independence and triggering a tragic cascade of diseases, disabilities, and complications that all too often prove irreversible.

So, as a geriatrician, I am by definition an expert in subslety and complexity. I am acutely aware of the interaction between physical, psychological, and social factors that affects the lives of each of my elderly patients. Because the care of my patients is so demanding and so complicated, I often work with family members and other professionals who contribute to the care of my patients and to orchestrate the best care as their primary physician.

Our team includes nurses, social workers, rehabilitation therapists, psychologists, and spiritual counselors, and frequently others.

As a geriatrician, I have also come to terms with the reality that most of my sick old patients are unlikely to recover completely. Hence, by training, it becomes their task to keep them functioning despite the their decreased potential for recovery.

My inspiration and my passion will always come from my older patients. One day I hope to be like them; when that day comes, I hope that my doctor will be a geriatrician.

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REFERENCE

"It is surprising with what little studying can a physician practice medicine, although it is not surprising how bad he can do it."

William Osler