How much geriatrics can an oncologist do?
The real world...

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What do patients expect of an oncologist?

- To perform the diagnosis
- To define the stage of the tumor
- To give the best treatment adapted to general status, with the least toxicity
- To organize follow up during the course of the disease
- To give the maximal chance of cure and to extend life if possible...
- To explain disease and treatment, to give information
- To take into account his social condition or psychological status
- Best supportive care if necessary
What do patients expect of a geriatrician?

- To treat diseases and symptoms due to age
- To centralize information from other physicians, to bring together all results of different exams
What do elderly patients expect of a physician?

- The same than before,
- but for some patients to take into account more quality of life & toxicity of treatments, than the true increase of life span.
In the Real World...

- Time of a visit with an oncologist: 15 minutes!
- Time necessary for a geriatric assessment: 1 Hour!!

...Just Impossible!

The biggest disease of the brain it is to think
So what is better to do?

- To screen patients and then to address them to a geriatrician.
- To do “short- assessment” yourself.
- To participate in clinical research in order to define the best test to perform...for example in France with “the G8 screening test”.

SIOG 2011- Paris
## A short assessment?

<table>
<thead>
<tr>
<th>For each patient</th>
<th>And...for elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Weight</td>
<td>• BMI</td>
</tr>
<tr>
<td>• Comorbidity</td>
<td>• ADL, IADL</td>
</tr>
<tr>
<td>• Medication</td>
<td>• Cognitive function</td>
</tr>
<tr>
<td>• PS</td>
<td>• Emotional status</td>
</tr>
<tr>
<td>• Disease history</td>
<td>• falls</td>
</tr>
<tr>
<td>• Physical examination</td>
<td>• Albumin, vit D...</td>
</tr>
<tr>
<td>• Biology</td>
<td></td>
</tr>
<tr>
<td>• Tumor assessment</td>
<td></td>
</tr>
<tr>
<td>• Social condition</td>
<td></td>
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</table>
How many and which items of ADL and IADL are necessary for screening?

Roehrig et al., CROH, 2007; 62 (2): 164-171

- Of 327 elderly patients (age ≥ 60 y) with 27.9% had limitations in ADL and 36% in IADL.
- Data were entered in a forward selection model.

- 4 out of 10 items of ADL identified 95.3% of patients with limitations in ADL (Barthel index).
- 2 out of 8 items of IADL identified 97.4% of patients with limitations in IADL (Lawton).
How many and which items of ADL and IADL are necessary for screening?

The combined use of these 6 items recognized 98.5% of patients with limitations in ADL or IADL score.

- walk upstairs and downstairs
- urine continence
- walking in a corridor
- having a bath or a shower
- shopping
- food preparation
Or use a simple screening test > 70

- To identify the proportion of patients who are fit and where complete CGA would not identify relevant “age-related problems”

- And to focus the efforts on the smaller group where the yield of geriatric assessment will be larger.
The G8 screening tool

- Screening tool validated in a French prospective trial of 1668 consecutive patients to select elderly patients with cancer who may benefit from the geriatric oncology approach. (Oncodage)

- With a cut-off score of 14/17, G8 had a 90% sensitivity and a 60% specificity (Soubeyran et al, JCO 2008; 26 (suppl 20- abstr 20568))

- But we don’t know whether intervention could improve outcome in screened patients.
<table>
<thead>
<tr>
<th>Items</th>
<th>Possible answers</th>
<th>Score</th>
</tr>
</thead>
</table>
| Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties? | 0: severe reduction in food intake  
1: moderate reduction in food intake  
2: normal food intake |       |
| Weight loss during the last 3 months?                                | 0: weight loss >3kg  
1: does not know  
2: weight loss between 1 and 3 kg  
3: no weight loss |       |
| Mobility                                                              | 0: bed or chair bound  
1: able to get out of bed/chair but does not go out  
2: goes out |       |
| Neuropsychological problems                                          | 0: severe dementia or depression  
1: mild dementia or depression  
2: no psychological problems |       |
| Body Mass Index (weight in kg/height in m2)                          | 0: BMI less than 19  
1: BMI 19 to less than 21  
2: BMI 21 to less than 23  
3: BMI 23 or greater |       |
| Takes more than 3 medications per day                                | 0: yes  
1: no |       |
| In comparison with other people of the same age, how does the patient consider his/her health status? | 0: not as good  
0,5: does not know  
1: as good  
2: better |       |
| Age                                                                   | 0: >85  
1: 80-85  
2: <80 |       |
The VES 13

- The Vulnerable elders survey 13: 
  Saliba et al., JAGS 2001; 49(12): 1691-9

- a self-administration questionnaire
- 12 items for functional capacity, physical status and patient’s perception of his health and one question for age. Cut off ≥ 3
- designed for identifying community-dwelling vulnerable older people, defined as persons age 65 and older at increased risk of death or functional decline
The VES 13

- Validated in prostate cancer population who receive androgen ablation (N: 50):
  
  *Mohile SG et al. Cancer 2007, 109: 802-810*

with this conclusion

“current results indicated that the brief VES-13 performed nearly as well as a conventional CGA in detecting geriatric impairment in this population.”
VES 13 in daily practice?

- S. Monfardini, *J Clin Oncol* 28:15s, 2010 (suppl; abstr 9114)
- 150 breast cancer patients aged ≥70 years underwent both CGA and VES-13.
- At CGA patients were divided into fit, vulnerable and frail.
- 95 patients (63.3%) were able to complete VES-13 autonomously.
- 8 patients (5.3%) required help.
- In 47 cases (31.4%) the questionnaire was completely administered by a research nurse.
VES 13 in daily practice?

- 25.9% of elderly patients with favourable VES-13 score were vulnerable/frail at full CGA.
- 34.8% of patients with unfavourable VES-13 were fit.
- The negative and positive predictive values being 74.1% and 65.2%, respectively.
- Sensibility and specificity of VES-13 to uncover vulnerability/frailty at full CGA were 68% and 71%, respectively.

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Other tool

*Hurria et al., Cancer 2005; 104 (9): 1998-2005*

- A self administered cancer-specific tool
- Assessment of functional status, comorbidity, cognition, psychological status, social functioning and support and nutritional status
- Mean time to completion: 27 min
- 78 % complete the test without assistance
- Being validated in the clinical trials by CALGB

To long in daily practice?
Conclusion

- Make your own experience with one tool...or not
- Work in association with nurses and geriatricians
- Don’t forget that your main goal is to offer the most appropriate cancer treatment.
- As an oncologist we just have to be aware of the geriatric data that may influence our decision making.
1st Announcement
Geriatric Oncology: Cancer in Senior Adults
12th Meeting of the International Society of Geriatric Oncology
October 25-27, 2012
Manchester, UK