Surely you have by now realised how many older patients you are dealing with in your busy clinical practice. If you have an interest in optimising your performance and tailoring your treatment plan to every individual patient according to his/her frailty, rather than to the mere chronological age, you are welcome to join forces with SIOG!

The International Society of Geriatric Oncology is 11 years old. During the first decade we have established the role for Geriatric Oncology. We have investigated how to appraise fitness to undergo medical or surgical treatments. We have looked into the toxicity of different chemotherapeutic compounds and the prevalence of surgical complications, specifically for older patients.

Several cancer sites have been taken into account, the available literature has been reviewed by the experts in the field and recommendations have been published to inform the medical community.

This has been the target of our Task Forces and more of them have been recently established such as anaesthesiology and radiotherapy in the elderly.

An active network of National Representatives has been set in place, to facilitate worldwide communication and the first Asian meeting on Geriatric Oncology took place in Malaysia (January 2011). This proves the commitment of SIOG to divulge its unique knowledge and involve clinicians worldwide. Our yearly congress took place in Paris (November 2011), with over 450 delegates in attendance from 35 different countries.

The Journal of Geriatric Oncology, an entirely dedicated peer-reviewed journal, has been created under the editorial lead of Arti Hurria.

SIOG is delighted to share all this with you and we look forward to a fruitful cooperation.

Welcome on board!

Riccardo A. Audisio, SIOG President
St Helens Hospital, Liverpool, UK
The 11th meeting of the International Society of Geriatric Oncology (SIOG) was held in Paris on the 4th and 5th of November, 2011. Founded in the year 2000, SIOG is dedicated to the education of physicians about the care of the older cancer patient. The Society has a number of activities, in particular task forces which have published important position statements about various aspects of Geriatric Oncology care: chemotherapy, renal dysfunction, surgery, geriatric assessment, as well as tumour specific recommendations or guidelines.

Of note, SIOG has also endorsed the mission to support efforts in research in elderly cancer patients; this was the specific purpose of a “brainstorming” satellite symposium on “new methodology in clinical cancer research in geriatric oncology” held in Saint-Cloud (France), on the day before the meeting, under the transatlantic joined umbrella of SIOG, the European Organization of Research and Treatment of Cancer (EORTC, Brussels, Belgium) and the Cancer And Leukemia Group B (USA).

The 11th meeting welcomed over 400 attendees from 27 countries with a broad range of specialties. The scientific program was structured so that clinicians with varying interests can benefit and attend complementary sessions. It encompassed basic science of aging, review of therapeutic modalities (surgery, radiation therapy, medical oncology and geriatrics), and disease specific sessions (gastrointestinal, urology, breast, ovary, head and neck, and haematological malignancies). There were educational sessions, proffered paper presentations and poster sessions. Earlier sessions of the society were primarily focused on organizational and tutorial issues.

The opening session provided updates in the fields of geriatrics, surgery, medical oncology and radiotherapy, focusing on key data produced between 2009 and 2011 and underlining clearly the current stakes of geriatric oncology. It was followed by a provocative educational session addressing the HOWs, PROs and CONs for treating tumours considered as “difficult” in general and consequently even more tricky in elderly: sarcomas, brain, pancreas and hepato-biliary tumours. This session was a unique opportunity to demonstrate the need to fight widely - although wrongly - accepted ideas in order to not deny elderly patients the access to adequate treatment able to provide substantial benefit, sometimes of same magnitude as in younger patients. The main difficulty stays in the “quavering” balance between both frequent under- and over-treatment!!

This meeting showed a marked increase in the presentation of data from a wide variety of investigator initiated studies. It included a large number of presentations on geriatric assessment instruments utilized in various clinical settings, from preoperative assessment and screening tools as the Gröningen frailty index and the French G8, to scores allowing prediction of treatments toxicity as the one developed by the Cancer and Aging Research Group and the CRASH program from the University of South Florida. Although unable to contend that some of these scores would prevail on others for a similar endpoint, the presentations showed that there is increasing experience with these various instruments and that the time

(continued on page 4)
1st Announcement / Call for Abstracts

Geriatric Oncology: Cancer in Senior Adults

12th Meeting of the International Society of Geriatric Oncology
October 25-27, 2012
Manchester, UK

Scientific Chair:
Riccardo Audisio, Liverpool, UK

SIOG (International Society of Geriatric Oncology)
President: Riccardo Audisio, Liverpool, UK
Past President: Martine Extermann, Tampa, USA
Executive Director: Matti Aapro, Genolier, Switzerland

For more information, please visit: www.siog.org
11th SIOG Meeting Highlights (continued)

is coming to investigate how the information they generate can be used to choose adequate interventions. These measures are specific for the clinical settings in which they were developed and for the question addressed. There may indeed not be a one-fits-all instrument. There will be need for prospective validation in various clinical settings. However it is clear that great strides have been made. The small number of geriatricians mandate that oncologists need to familiarize themselves with some of these instruments to assess their patients.

There were also data presented on disease specific clinical trials as well as a number of studies of quality of life, issues of cognitive impairment and symptom burden.

A definite highlight of the meeting was the excellent proffered papers covering a broad range of topics but demonstrating the increased worldwide enthusiasm for interest in geriatric oncology. This 11th meeting in Paris provided an opportunity for an interaction among investigators around the globe to stimulate further study.

The Society presented the Calabresi award to Dr. Beena Devi to recognize her contribution to Geriatric Oncology over the past year, particularly in organizing the successful First Asian Congress on Cancer in the Older Patient, held in January 2011 in Kuching. Importantly, the Society’s next President was elected: Dr. Arti Hurria of the City of Hope, Duarte, USA. Dr. Hurria is also the Editor-in-Chief of the Journal of Geriatric Oncology.

On the occasion of the 11th SIOG meeting held on November 4-5 in Paris, Carine Bellera and colleagues won the 2011 BJ Kennedy Award for the Best Poster for their research study titled “Prognostic Factors of Loss of Autonomy in Older Patients with Cancer Receiving First Line Chemotherapy.” The investigators examined prognostic factors of the loss of autonomy in 364 older patients with cancer (any stage) receiving first line chemotherapy. Loss of autonomy was defined as a decrease of 0.5 or more points on the Activities of Daily Living (ADL, scored 0 to 6) scale between the beginning of treatment and the second cycle. Prognostic factors for loss of autonomy were identified from the baseline clinical variables, biological variables (age, sex, performance status, BMI, weight loss, tumour stage and localization, albumin, CRP, haemoglobin levels, leucocyte and platelet counts, creatinine clearance), and the pre-treatment geriatric assessment data, which included an evaluation of comorbidity (Cumulative Illness Rating Scale-Geriatric), functional status (Instrumental Activities of Daily Living - IADL - scale and the Get up and Go test), nutritional status (Mini Nutritional Assessment), cognition (Mini-Mental Status exam), and psychological status (Geriatric Depression Scale). Patients completely dependent at baseline (ADL score of 0) were excluded. A total of 299 patients were evaluable and 50 experienced loss of autonomy. Loss of autonomy was significantly associated with an increased risk of death (RR 1.5, 95% CI 1.08-2.14). In the multivariate model, a low score of the Geriatric Depression Scale (OR 2.4, p=0.01, 95% CI 1.23-4.66) and the need for assistance with IADL (OR 3.0, p=0.027, 95% CI 1.13-9.09) were independently associated with an increased risk of loss of autonomy. This research suggests that an assessment of psychological and functional status may identify patients at risk for loss of autonomy and decreased survival.
Cancer awareness through education in Sarawak, Malaysia by Beena Devi

Education empowers individuals. The concept of empowerment of the community was the theme that we worked on for cancer awareness in Sarawak, Malaysia. Sarawak is a large state over 750 km along the northeast coastline of Borneo with a population of 2 millions in 1993. At that time, we had numerous issues in relation to cancer diagnosis and presentation. More than 80% of the top five cancers presented in late stage. Lack of knowledge of common cancer symptoms and cancer treatment in the community, both public as well as for professionals, was prevalent. The state had no palliative care service and the system of drug delivery to the rural areas was poorly organised. There was shortage of manpower and funds for cancer management.

We decided to focus on educating the health staff and the community on the common cancer symptoms and palliative care. Hence we began the Early Cancer surveillance program to train health staff in recognising the common symptoms for breast, cervix and nasopharyngeal cancers (being the commonest cancers). Simultaneously, the same staff was trained in palliative care. We reorganised the system of drug delivery. In 2006, we published our results that revealed that downstaging was achieved for the two female cancers but not for nasopharynx. Due to this program, we were able to establish that Bidayuhs (one native group) have the highest incidence of nasopharyngeal cancer in the world. Our model of palliative care was published and selected by UICC as a model of palliative care in LMC countries with limited resources.

Due to the interesting findings that we have observed in nasopharyngeal cancer, we have found >50 families with family history of nasopharyngeal cancer with one large family pedigree with 26 cases being the largest in the world. We are collaborating with IARC (International Agency for Research on Cancer/WHO), Lyon, France and NIH, USA on this project. From a competitive research grant from GSKERI (Ethnic research initiative) for breast cancer we were able to establish that triple negative breast cancer was the highest amongst natives (35%) and HER2 breast cancer was the highest in the Malays (23%). This finding has now led to collaborative research with NIH, USA.

Since pain is the most common symptom in cancer patients, we did a survey study amongst doctors in Sarawak to establish the baseline knowledge in cancer pain management. In 2000, we were the first department in Malaysia to monitor pain as the 5th Vital Sign. In 2008, we introduced massage as complementary therapy for pain management. In 2009, our department was accredited and we became the first ESMO Designated Centre for integrated oncology and palliative care in South East Asia. In 2011, we were as ESMO Partner centre.

For the elderly patients, we did a retrospective study (2005-08) on 1500 elderly patients >65 years. Our results revealed that >70% present in late stage and that colorectal cancer was the highest for the Chinese and Head & Neck for the natives. One of the main reasons for late presentation was due to the cultural practice in the older patients to use Chinese herbal medicine and the dependency on the children to take them to see a doctor.
In 2008, we introduced the Groningen Frailty Index as a pre-treatment assessment tool in a busy oncology clinic. Our results revealed that the study was feasible in a multi-ethnic society and this tool was more useful than ECOG performance status.

In January of 2011, we held the first Asian Congress on Older Patients under the auspices of SIOG and it was a huge success with 500 delegates with a positive feedback that such congresses should be held in Asia in the future.

Over a period of 18 years, the manpower and budget for the department has increased 4-6 fold. Our patient number has doubled. We have been able to maintain the downstaging effect of the two female cancers. In addition we are collaborating with IARC, Lyon, NIH (USA), INCTR (International Network for Cancer Treatment and Research – Brussels, Belgium), FNCA (Forum for Nuclear Co-operation in Asia – Japan) and NUS (National University of Singapore) for various studies. We feel that our theme of empowering the community with knowledge has led to great strides in our research work.

The SIOG 10 priorities are a hit! By Martine Extermann

Dear SIOG members,

You all received one or several copies of the SIOG 10 Priorities monograph. We also sent or gave copies to numerous national and international organizations, as well as local political authorities. The reception has been enthusiastic: this really seems to have answered a need. So I am sharing with you some examples as feedback.

- The UICC has posted the 10 Priorities on its website and our president, Riccardo Audisio, represented SIOG at UICC’s World Cancer Leaders’ Summit. [http://www.uicc.org/membership/uicc-member-siog-defines-top-10-priorities-development-geriatric-oncology-worldwide](http://www.uicc.org/membership/uicc-member-siog-defines-top-10-priorities-development-geriatric-oncology-worldwide)

- ASCO’s president, Dr Michael Link, sent us a wonderful letter. Extract: “On behalf of the American Society of Clinical Oncology, please let me congratulate you, the authors and the entire SIOG organization on compiling the Ten Priorities Initiative document. No doubt the report will not only serve SIOG and its current and future leaders, but also significantly advance the practice of geriatric oncology and improve outcomes for elderly cancer patients around the world.” This triggered an exchange about ASCO initiatives in geriatric oncology. We are linking the ASCO geriatric oncology curriculum to the SIOG website.

- Our Swiss national representative, Gilbert Zulian, sent them to the Federal Counselor (“Minister”) in charge of the Department of the Interior, and received a personal response. An extract: “…the number of cancers in the elderly will increase in the next few years… Early information about the consequences for the health system and about the challenges for the institutions concerned, health professionals, and research, is very important in elaborating possible solutions.” (translation mine).

- One member can make a difference! James and Maggie Clarkson, SIOG members who are community radiation oncologists in Pascagoula, Mississippi, triggered an excellent opportunity to present the SIOG 10 Priorities at an international conference. The Clarksons have an NIH grant at their site to reach underserved populations. When they received their copy of the SIOG 10 Priorities, they prompted Dr Wong, at the NIH, to invite me to present the 10 Priorities at an NIH symposium at the annual conference of ASTRO, the American Society of Therapeutic Radiation Oncology.

- Reinhardt Stauder, our Austrian national representative, suggested that the 10 priorities should be translated in as many languages as possible. He did a German translation. Follow the example: we will post the translations on the SIOG website as they come.

- A scientific article based on the 10 priorities was published in the Journal of Geriatric Oncology. [http://www.geriatriconcology.net/article/S1879-4068(11)00042-7/abstract](http://www.geriatriconcology.net/article/S1879-4068(11)00042-7/abstract). Cite it at will!

There are many other examples I could cite. In short, this document is a frank success. Keep sharing it and using it in your discussions with your colleagues, your funding agencies, and your authorities. SIOG will keep track of the worldwide progress on these priorities and give you regular updates.
PENCIL YOUR AGENDA

Advances and Perspectives in Geriatric Oncology
presented by Demetris Papamichael

This international symposium will take place in Athens on the 17th and 18th of February, 2012. It is jointly organised by the Hellenic Society of Medical Oncology and the Senior Adult Oncology Program at Lee Moffit Cancer Centre and Research Institute, Tampa, Florida.

The objective of this forthcoming event is to provide an international forum for discussion of current and emerging concepts in the management of cancer in senior adults. An international faculty representing various specialties involved in cancer care and research has been brought together aiming at covering a wide spectrum of issues relating to clinical and research aspects of Geriatric Oncology.

The Symposium will feature round table discussions, presentation and discussion of challenging cases, invited lectures as well as poster presentation and discussion. A number of meet the expert sessions will also be featured.

Topics of the meeting will include: biology of aging and cancer, breast cancer, colorectal cancer, clinical research issues in geriatric oncology, health economics, geriatric assessment, lung cancer, prostate cancer and supportive care.

Detailed info: www.geriatriconcology-greece.com

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Book of Geriatric Oncology in Portuguese

Under the initiative of Theodora Karnakis, a SIOG National Representative for Brazil, as well as Rafael Kaliks, Auro del Giglio and Wilson Jacob-Filho, a book of geriatric oncology in Portuguese was published this year with the support of Roche:

Oncogeriatra – Uma Abordagem Multidisciplinar


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SIOG in Paris with a new booth!

SIOG is a UICC member
Since the SIOG meeting in Berlin in 2009, geriatric oncology activity in Australia has been formalized and the profile of the discipline continues to grow. The Clinical Oncological Society of Australia (COSA) geriatric oncology interest group now has a formal structure, and a programme of 3 monthly meetings of the executive has commenced. The interest group has 82 members who receive regular emails regarding the activities of the group. The group meets annually at the COSA annual scientific meeting. With the assistance of COSA the interest group held a successful forum on geriatric assessment in oncology in 2010, which was well attended. Catherine Terret was a keynote speaker at this meeting and provided very useful advice for our group.

The formation of a combined geriatric oncology training programme is an aim of the group and we will need to lobby training bodies to facilitate the recognition of the specialty. There are currently 4 dual-trained physicians in geriatric oncology in Australia but unfortunately only one is working in the geriatric oncology field (at the Royal Adelaide hospital). Funding constraints limit practice in most situations and a case needs to be made for combined management.

A number of projects have been running around the country. The Royal Adelaide Hospital geriatric oncology clinic in South Australia remains the only funded, stand-alone multidisciplinary team to manage patients on a day to day basis. A pilot programme of routine screening for supportive care needs in all patients over the age of 70 has commenced at Border Medical Oncology in Albury-Wodonga and the results of this effort were presented at SIOG 2011. The COSA interest groups members also conducted an audit of geriatric oncology assessment in several Australian centres. Results of this audit were presented at the SIOG 2011 meeting. The audit facilitated collaboration between interested clinicians and also confirmed the well-known fact that geriatric assessment is rarely performed in older patients with cancer in Australia. A research subcommittee of the COSA geriatric oncology interest group has been formed and will work towards the aim of conducting clinical trials in this area. Clinical trials designed to capture older patients are underway in a number of tumour types and the interest group encourages participation in these. Research in geriatric oncology service provision is occurring at the Royal Adelaide hospital, Border Medical Oncology and at the Princes Alexandra hospital in Brisbane. A workshop was held at the NHMRC clinical trials centre at the University of Sydney that led to the formulation of ideas for a possible randomized trial of geriatric assessment in the Australian clinical context.

The COSA geriatric oncology interest group looks forward to possible future collaborations with SIOG and recognises the importance of the society in improving the care of older patients with cancer around the globe.
The UICC World Summit by Riccardo A. Audisio

The UICC World Summit of cancer leaders took place on November 17-18, 2011 in Dublin, Ireland. It was a pleasure to represent SIOG during this event and to show our commitment to global cancer control and contributing to a thought-provoking and productive discussion on priority actions needed to move From Resolution To Action. The day before the Summit we attended a number of side events in which participants heard and gave insight into specific topics such as the issue of cancer in low- and middle-income countries, the GAPRI programme (Global Access to Pain Relief Initiative: a joint programme of UICC and ACS), and working in partnership with the private sector.

The Summit itself was a great success and a positive feedback was received on the quality of speakers and the format used. The day provided an opportunity to hear from key experts and advocates from around the world who are contributing to increasing the visibility of cancer control within the international policy arena, and to discover what the Political Declaration of the UN High-level Meeting on NCDs (Non Communicable Diseases) means from different perspectives.

The announcement session in the afternoon underscored the importance of committing to concrete actions and effective interventions to reduce the global cancer burden. We were urged to consider how to become involved in one of these initiatives that were showcased. Following the UN High-level Meeting on NCDs and now the World Cancer Leaders’ Summit, we enter a year in which there is much work to be done to ensure that momentum is not lost and that the commitments made at these two landmark events are implemented.

Please find available for download the final list of participants for your perusal. All speakers’ presentations will be uploaded on the website soon as well as the Summary Report on the UICC website, www.uicc.org/events/wcls2011. We were encouraged to share these materials with other stakeholders who are also engaged in global cancer control. The next meeting will take place in Montreal, Canada, on August 27, 2012, followed immediately by the World Cancer Congress.

Differences between Norway and the US - A Transatlantic Research, Clinical, and Personal Experience by Siri Kristjansson, MD, PhD

With a clinical background from geriatric medicine and a research interest in geriatric oncology, family reasons brought me to Southern California from Norway in 2009-2011. By chance we ended up living about a 1-hour drive from City of Hope Comprehensive Cancer Center (COH), where Arti Hurria and her cancer and aging research team were located. Thanks to the SIOG meeting in Berlin in 2009 I got in touch with Dr Hurria, and she generously invited me to join her team in California. I made some reflections regarding differences between our two countries – and to start with the conclusion: There are large cultural differences between Norway and the US.

Healthcare is perceived very differently in Norway compared to the US, and for a native Norwegian growing up in a socialized country it is very difficult to accept the American way of thinking. In Norway, free health care is a basic human right for all citizens. If you are hospitalized in Norway, you never see a bill, and traditionally the best doctors have worked
Siri Kristjansson (continued)

in the public hospitals. However, the differences between our two countries are not only about health care, the main issue lies much deeper. To simplify, I think a main distinction is whether or not you believe that the state can or should take care of you. For example, I find that Americans are more willing to help others thorough charity – but they want to choose whom to help. In Norway, people are less willing to contribute, because they pay their taxes and find that they have done their part already. There are advantages and disadvantages with both systems – but I must admit I felt very safe being covered by the health insurance of the State of Norway during my stay in the US.

Arti Hurria invited me to participate in her outpatient breast cancer clinic at COH, and that was a great experience. The hospital team was well organized and more efficient than I am used to from Norway. And the patients impressed me: they made an effort to make conversation with me even though they were facing a diagnosis and treatment for cancer. I also found that family members were very involved with their sick relatives. In the hospital setting, another big difference between our countries was visible: In Norway, you don’t need to sign a single form when you see a doctor or are admitted to the hospital. The amount of paperwork and number of forms to sign in the US, in all kinds of settings, is immense. After a while I got used to signing forms on a daily basis, but it was a relief to return to Norway in that respect.

The organization of the research team at COH was also very efficient and impressive. When I did a clinical research study in Norway, I collected all the data myself, and it is uncommon to have clinical research assistants (CRAs). The organization at COH with a team including CRAs that can collect data for different studies is in my opinion a much better way of organizing clinical research. The use of teleconferencing with colleagues across the US was also an inspiring way of collaborating efficiently. An advantage regarding research in Norway is that the consent forms can still fit 1-2 pages, and the process to get a study approved ethically is less cumbersome because it is still handled by clinicians rather than lawyers. I find that research has a higher status in the US than in Norway.

I am impressed with one more thing from the US: Americans work hard, and they work a lot. We like our 5 weeks of vacation and 9 months paid maternity leave. But again, we expect the state to provide those things for us (plus we have a lot of oil), while Americans seem to rely more on themselves.

The Key Meeting in Geriatric Oncology by Matti Aapro

It all started with Balducci, Rosso and Polivtka. They organized the first meeting on geriatric oncology and following their pioneering efforts we came to the conclusion that there was space for a society dedicated to geriatric oncology. The logo is a Roman coin which shows a younger and an older face, the symbol of continuity as our society is working with all those interested in this growing area. The recent meeting in Paris was a success with the presence of the majority of the leaders in this specialized area of oncology. There were participants from 27 countries, a demonstration that this question is of importance worldwide. This is also attested by the fact that all main societies in geriatrics, hematology and oncology now have specific sessions dedicated to questions on aging and cancer. But a forum during which all the "aficionados" can meet and exchange their experience over three days is provided only by the yearly SIOG meeting. Welcome to Manchester in 2012.