Assessment and supportive care key in helping diverse older cancer patients and a priority at the 15th Annual Conference of SIOG, Prague, Czech Republic

In November 2015, Prague welcomed more than four hundreds oncologists, geriatricians and allied health professionals with a special interest in improving the care and treatment of older people with cancer. The occasion was the fifteenth annual conference of the International Society of Geriatric Oncology (SIOG). The theme was Geriatric Oncology and Supportive Care: A Global Approach to Advance the Science. To quote the motto of the Multinational Association for Supportive Care in Cancer (MASCC), which partnered the Prague conference, this “makes excellent cancer treatment possible”.

One of the specific concerns was polypharmacy. A typical older cancer patient has two or three comorbid conditions, each requiring two or three drugs. These are in addition to the drugs taken to combat cancer – many of which have a narrow therapeutic window – and those that support cancer treatment, such as antiemetics and antiinfectives. The dangers of adverse drug-related events are clear.

Interestingly, Franz Kafka anticipated modern concerns about polypharmacy by around a hundred years. “To write prescriptions is easy, but to communicate with people is difficult,” laments the main character in Kafka’s short story Ein Landarzt (A Country Doctor), written in 1917 in a tiny house in the precincts of Prague Castle. The Muses of medicine and literature had managed a very appropriate conjunction.

A comprehensive medication assessment that includes all the prescription drugs a patient is taking, together with all the complementary, herbal and alternative medicine products, is helpful. Among 234 elderly cancer patients assessed at the Jefferson School of Pharmacy, the mean number of medications being taken was 9, according to data presented by Ginah Nightingale (Assistant Professor, Department of Pharmacy Practice, Thomas Jefferson University, Philadelphia, USA). Up to 40% of older patients were taking inappropriate medications, in the sense that they were ineffective, unnecessary, or liable to give rise to drug-drug interactions.

Picture 1: SIOG 2015 Annual Conference – plenary session
Konference

Holly Holmes (Division Director Geriatric and Palliative Medicine, University of Texas Health Science Centre, Houston, USA) considered new data relevant to optimising blood pressure in the elderly patient. The recent SPRINT trial (published in the New England Journal of Medicine in November 2015) showed that targeting a systolic BP of 120 mmHg or less reduced mortality. Twenty-eight percent of patients enrolled were aged 75 or over, but those with diabetes (for example) were excluded, as were elderly people living in institutions. Even so, the fact that more aggressive antihypertensive treatment reduced mortality in the elderly subgroup will probably encourage more intensive intervention, with additional drugs being prescribed. This is especially so where the elderly are cared for by general physicians rather than specialists in geriatrics. This may be counterproductive since work by others (such as Benetos and colleagues published in the Journal of the American Medical Association in 2015) found higher two-year all cause mortality in nursing home residents with a systolic BP of less than 130 mmHg on combination antihypertensive medication, when compared with controls.

Hence, for robust elderly cancer patients a target of 120 or 130 mmHg may be appropriate, but harmful for the “old old” and frail.

Individualising cancer treatment

Deciding how best to treat elderly patients is difficult given the poverty of evidence. Although the majority of cancer patients are 65 years and older, few elderly patients are included in the pivotal studies of major new therapies. In the case of the adjuvant trastuzumab trials in HER2-positive breast cancer, for example, only 16% of patients enrolled were over the age of sixty.

While chronological aging is uniform and relentless, biological ageing is not. As was once said by Stanley Muravchick, of the University of Pennsylvania, people are never more alike than they are at birth, nor more different by the time they enter old age.

Assessing where individual elderly patients lie on the continuum from fitness to frailty sounds time consuming but does not have to be. The G8 screening tool, which considers – among other things – social support, functional status, cognition, depression, fatigue and polypharmacy (Kafka again!) can identify patients with complex problems who need comprehensive geriatric assessment (CGA).

There is another important saying in the field: “adequate assessment yields appropriate care”. This applies...
both to treatment directed at the cancer itself, which may be curative, life-prolonging or palliative in intent, and supportive care. In many community settings, it is difficult to find a dietician, psychiatrist, physiotherapist or pharmacist to join a multidisciplinary team. In many hospitals also, this is a problem. Any assessment should have consequences in action. But this means someone must take responsibility for following up the findings.

As part of its efforts to encourage individualised care of the elderly cancer patients, SIOG has organised a series of Task Forces to address specific issues. A Task Force on single agent oral chemotherapy has just reported in the European Journal of Cancer (Biganzoli et al, 2015), concluding that oral agents – compared with intravenous administration – are convenient, require fewer healthcare resources, and may be preferred by older people. Oral capecitabine and vinorelbine are active in advanced breast and colorectal cancer. The combination of acceptable activity and tolerability means that metronomic chemotherapy is worth considering in the elderly. Another Task Force report – on optimising use of taxanes in elderly breast cancer patients – is in press with Cancer Treatment Reviews.

Caring for the carers

Health professionals are responsible for a great deal of cancer care. But most care in the community is provided by family and friends. Because such carers are themselves likely to be relatively old, and will themselves experience health problems, they too need support. Their experiences were described by Jane Phillips, a professor at the Centre for Cardiovascular and Chronic Care of the University of Technology, Sydney, Australia. Carers incur profound costs, social and financial. They experience emotional difficulties, for example in managing their fears for the person in their care, and they may neglect their own health. Perhaps not surprisingly, many who have experienced the life of a caregiver say that they would not do it again. Caregivers too need information and access to services but find it difficult to ask for help. In retrospect, carers think they should have sought help more often than they did.

Rob Stepney, medical writer
Charlbury, UK
e-mail: robstepney@outlook.com