SESSION XIII
Ethical, Cultural and Clinical Aspects of Treatment Decisions for Geriatric Oncology Patients
Chair: M. Rodin

Interactive Cases in Geriatric Oncology
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Learning Objectives
• Incorporate standardized geriatric functional measures into clinical decision-making for cancer treatment
• Identify clinical triggers for multidisciplinary intervention
• Anticipate and proactively intervene in adverse treatment events
• Demonstrate adaptive communication techniques for culturally, cognitively disparate patient scenarios

Procedures: The M.O.
• These are real patients from our practice who have been anonymized for educational presentation
• Patient stem data presented for your evaluation and consensus
• Sequential unfolding of the case
• Opportunities for hindsight

Case #1
• Mrs. T is 82 years old, retired practical nurse attended geriatric clinic alone.
• First visit with this physician, referred from primary care group for
  – Poorly controlled hypertension
  – New urinary incontinence
  – Worsening lower extremity edema
• What is your differential diagnosis?

• Heart failure
• Venous stasis
• Renal failure
• Non-adherence
• IVC thrombosis
Clinic chart indicates she had been previously seen in this clinic over a year ago with the chief complaint of constipation.

Abdominal CT at that time revealed a 5 cm pelvic mass arising from the uterus.

Referral to gynecology for transvaginal biopsy in clinic note but no tissue report in chart or computer.

Medications

- Lisinopril 40 mg po qd
- Metoprolol LA 100 mg po qd
- Amlodipine 10 mg po qd
- Diltiazem 240 XL po qd
- Furosemide 40 mg po qd
- Simvastatin 40 mg po qd
- ASA 81 mg po qd
- Medformin 500 mg po bid
- Glyburide 2.5 mg po qd
- Levothyroxine 0.075 mg po qd
- Enalapril 4 mg po bid
- Flonase nasal spray daily
- Claritin 10 mg po daily
- Simvastatin 40 mg po qd
- Guaifensin/dextromethorphan syrup tsp prn
- Vitamin E
- Albuterol inh prn
- Advair inh prn
- Docusate sodium 100 mg pm
- Sorbitol 70% tbl pm
- MOM tbl pm
- B-complex vitamins
- APAP 500 mg pm
- Ibuprofen 200 mg pm

PMH: Some sort of colon surgery in the 1990's. Mrs. T did not volunteer information about the uterine mass.

When asked, she states the examination was extremely painful and she will not undergo this again.

ROS: As indicated in the CC. Still c/o constipation.

Geriatric assessments:

- VES-13 score = 7
- Geriatric review of syndromes
  - Several falls none within the past 30 days
  - Fatigue but denies aneria
  - Denies memory, appetite, sleep, ADL, IADL difficulty
- GDS refused
- MMSE refused
- SPPB
  - Gait speed <1m/sec
  - 5 Chair stands unable
  - One foot or tandem stand unable
  - Tinetti gait abnormal
- Frailty Index 3

Physical Exam

- Well dressed, well groomed
- BP 210/110 HR 90 NAD afeb not symptomatically orthostatic; obese BMI 32.2 kg/m²
- Dentures
- Chest bibasilar crackles
- Cor IRRR no murmur +S4, palpable distal pulses, 3+ pitting edema B
- Abd Hard, fixed mass to 5cm above the pubic rim; palpable soft inguinal nodes

Clinical Assessment: Problem List

1. Hypertension
2. Incontinence
3. Lower Extremity Edema
4. Constipation
5. Abdominal Mass increasing in size
6. Decisional Capacity
7. Fall Risk
• Refer for CT guided FNA bx to determine tissue dx for best palliation
• Address current complaint to build rapport
• Determine decisional capacity
• Ascertain social support, social resources

Next steps
• Mrs. T I think it is important to find out about this mass in your belly. Can you tell me more about….  
  • “I don’t have cancer.”
  • Blood pressure
  • May I call your daughter.
  • “Yes, but she doesn’t tell me what to do.”
  • Home health referral for BP and safety

After 3 more visits
• BP 160/50 c/o of dizziness
• Brings in bag of medicines
• Edema somewhat better
• C/o constipation and urinary incontinence
• Daughter called before visit to report vaginal bleeding Hg 11.4
• Next steps?

• Readdress issue of finding out about the mass

Referral
• Agrees to referral to a different gynecologist “to discuss”
• Actual appointment, same physician as previous visit is attending, patient leaves
• EUA brief GAS scheduled with another physician. Transvaginal Bx obtained without incident
• What is it?

Carcinosarcoma
Grade 2
FIGO Clinical stage IIIc (TNM T3aN1Mx)
Goals of care

- Elderly pt suffers with non-pain cancer-related symptoms that may improve with palliative intervention
- Based on age, comorbidity and pre-treatment functional status:
  - Pre cancer RLE estimated 2 years

Gynecology oncologist recommends

- Neoadjuvant chemotherapy to improve likelihood of successful palliative debulking.
- Cycle 1 of 3 q 3wk planned carboplatin and paclitaxel with GC-SF prophylaxis
- What are your concerns about this plan?
- What might you do in anticipation?

- Obesity masks low muscle mass
- Incomplete/inaccurate self-report ADL/IADL function
- Caregiver issues: no follow through with home health
- Patient decisional capacity issues
- Poor prognosis tumor

Then:

- Day 10 post chemo patient is found on the floor by her daughter.
- Has been there perhaps 2 days.
- Admitted through the ED
- Hg 7.6 mg/dl, markedly azotemic
- What happened?

Redux

- Patient offered and continued to refuse home hospice
- Fall at home with subsequent hip fracture
- Transfer to NH for orthopedic “rehab”
- Mass up to umbilicus, increasing pain from mass effect, evident cachexia
- Daughter consented to hospice, NHT
- Patient expired approx 2 mos p NHP; 3 years after initial CT diagnosis.

Case #2

Mrs. J is 73 years old and is followed in geriatric clinic for mild hypertension and mild-moderate dementia.
VES-13 = 3 based on her reliance on her daughter for IADL.

MMSE = 19/30; 5th grade education

SPPB = 12 (perfect)

- Her PCP receives a phone call from the medical resident.
- Admitted through the ED for LGIB requiring transfusion.
- New onset atrial fibrillation
- What is the differential diagnosis?
- What is her surgical risk? CHADS score?

- CRC
- Hemorrhoids
- Diverticulosis
- UGIB
- VTE: Mesenteric ischemia
- AMI
- PE

- Emergency colonoscopy: incompletely circumferential friable bleeding mass at the hepatic flexure
- Abdominal CT: 2 small areas of low attenuation in the liver; transaminases normal
- Afib resolves with metoprolol IV/po
- Pharmacological stress test negative for ischemia
• Laparoscopic partial colectomy without complication.
• Surgical path: Dukes D2 serosal invasion
• Stage IV based on liver mets
• What further evaluations do you recommend?
  – PET scan for distant disease lights up only in 2 liver sites already known
  – CEA pre-op 15ng/ml; 6 weeks post-op 10ng/ml
  – Detailed ROS and geriatric assessment, KPS/ECOG

• Median survival for this extent of disease
• What is standard therapy in this clinical situation?
• How would this therapy modify this patient's prognosis?

Available options: including, but not limited to...
- FOLFOX (SFU/LV/Oxaliplatin)
- FOLFOX plus bevacizumab
- FOLFIRI (SFU/LV/Flutamide)
- FOLFIRI plus bevacizumab
- Bolus IFL (SFU/LV/Flutamide)
- Irinotecan plus Cetuximab
- Bevacizumab plus cetuximab
- Irinotecan plus cetuximab plus bevacizumab (CBI)
- SFU/LV
- SFU/LV with bevacizumab
- Camptothecin

Trends in the Median Survival for Patients with Advanced Colon Cancer

Explain the options to the patient
• Does she have decisional capacity?
  Patient expresses a choice
  Gives a reason for their choice
  Understands the information given
  Appreciates the consequences of their choice
  go to 15

Legal standard
• Patient expresses a choice
  – Intelligible
  – Rational even if against medical advice see #2
  – Consistent in expressing this choice over time and with different examiners
  – Consistent with their previous decisions in similar circumstances
• Gives a reason for their choice
• Understands the information given
• Appreciates the consequences of their choice
### Legal standard
- Patient expresses a choice
- Gives a reason for their choice
  - May not be a “good” reason, but it is conventionally understandable
- Understands the information given
- Appreciates the consequences of their choice

### Legal standard
- Patient expresses a choice
- Gives a reason for their choice
- Understands the information given
- Appreciates the consequences of their choice

### Patient’s input
- Ask my daughter, what do you think?
- Well, it might help, it could control the cancer.
- I know you can’t cure it.
- Whatever you think is best.

### The treatment
- Planned 4-cycles 5-FU, oxaliplatin, leucovorin, avastin
- What happened?
  - Tolerated all tx
  - No grade 3-4 toxicity
  - No mucositis, vomiting or diarrhea
  - Anorexia, 22 lb. weight loss
  - Fatigue during ctx
  - CR NED post tx scans

### Follow-up at 1-year
- Regained most of her weight
- Living alone as before
- “Routine” CT reveals multiple areas of low density in the liver.
- Pt has no symptoms
- What is the next step?
  - Infusional therapy
  - Oral Xeloda
- Pt and daughter agree to single agent oral therapy
Follow-up 2-year
• Initial partial response, then no further radiographic regression of disease
• Daughter reports anorexia, fatigue, weight loss
• In geriatric clinic pt less well-groomed and says very little. MMSE 13/30
• CT reveals stable disease

What is the next step?
• Is this progression of dementia
• Is it non-radiological progression of cancer
• Is it treatment toxicity
• Oncologist elects to continue Xeloda

Redis
• Pt relinquishes decisions to her daughter
• Xeloda is stopped
• Daughter elects home hospice and arranges to sleep over nights
• Pt expires peacefully at home about 4 months later

Case #3
Mr. A is 78 years old. He was admitted to the hospital for productive cough and shortness of breath.

In addition to CAP a spiculated nodule is observed medially in his LUL.

History in ED obtained from his son since Mr. A speaks very little English/French.

PMH: One prior hospitalization for presumed MI in his native country “several years ago.” He has been a lifetime smoker of unfiltered cigarettes
• Reports no exercise limitation. Son says he is sedentary.

Successful businessman in his country
• Recently brought to this country by his children who are professional people
• Blames the cold, wet weather for his illness.
• In bed wears wool wrap around his neck, Muslim prayer beads in his gown pocket
• Muslim unknown sect or observance but will not eat hospital food; “Halal”
NCCN Practice Guidelines v.2.2008

- Clinical Assessment
- Staging Evaluation
- Resectability
- Treatment

• PFT's
  - N2,N3 LN-
  - NSCL-7

• Stage IIIA
  - Bronchoscopy
  - N2 LN+
  - NSCL-7

• (T1-3, N2)
  - EBUS,EUS FNA

• Stage IIIB
  - Mediastinal LN
  - N3 LN+
  - NSCL-9

• (T4, N0-1)
  - PET scan
  - Metastatic
  - NSCL-11

  - MRI brain

Staging Work up

• Chest MRI: 3.0 cm mass 2.5 cm from the carina with no evidence of local invasion.
• EGFR negative
• TBB: moderately differentiated adenocarcinoma.
• MRI brain no disease, some chronic ischemic changes
• PET: uptake in ipsilateral peribronchial and subcarinal LN ≤ 1cm, EBUS no additional info
• PET negative for contralateral or distant metastasis.
• PFTs: moderate obstructive disease somewhat responsive to bronchodilators
• Split lung functions: would tolerate L lobectomy with some limitation of functional reserve; WNT total pneumonectomy.

Clinical decision-making

• What do you recommend Mr. A to do?
• Risk, benefit, prognosis.

• On rounds, Mr. A is alert, calm, cooperative. Can exchange social pleasantries but LEP
• What to do now?

• Preconference with family.
• Sons do most of the talking. Daughters-in-law, wife when present say little.

• Ask physicians not to use the word cancer "It would cause father to lose hope."
• Friends would not visit if they thought he had cancer...ashamed.
• Another son says this is nonsense since his father is a very intelligent and modern man.
Medical Interpreters

- Are certified through formal training programs, often members of the community they are asked to interpret for...
- Using “interpreters of convenience...” colleagues, housekeepers, house staff
- Family members as interpreters
- NEVER use a young child (age) to interpret for a parent

- Preconference with the interpreter
- Understands the content to disclose.
- Determine any disclosures the interpreter will not or cannot translate and HOW they intend to explain it: the exact words.
- Any pre-existing inter-ethnic problems:
  - e.g. Great Russians interpreting for Russian-speaking Muslim Central Asians
- Introduce interpreter to patient, family explain their role.
- In U.S. hospitals required to provide professional interpretation services at no charge.

- Family and interpreter agree that specific discussions of prognosis and estimated survival should be avoided.
- Agree on a euphemism in Arabic for cancer that is understood as just that, a euphemism.
- Oldest son favors aggressive treatment.
- Wife indicates it is in Allah’s hands and she agrees with anything her husband decides.

- Interpreter verifies patient’s wish to have his family present during discussion.
- Interpreter verifies patient understands the purpose of the discussion
  - Provide him with information about his illness
  - Explain what kinds of treatments can be given
  - Answer his questions, family questions
  - His treatment decision will not be necessary today, he should think about it

Disclosure

- Patient shows no surprise or strong emotional reaction to the disclosure
- Asks what treatment he can get
- Says he wants to live as long as Allah determines
- Thanks the doctors for their kindness and wisdom
- States the doctors should make the decision

Proffered Papers

G. Zulian
Content of advance directives (ADs) completed by elderly cancer patients

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Introduction

• Geneva legislative frame makes a large place to patients’ rights since 1996: … « advance directives, written by the patient prior to become incapable of judgment, must be respected by health professionals if their intervention takes place within a therapeutical situation previously envisaged by the patient. »

• Since 2004, patients receive an information flyer about ADs at admission. Those completing ADs are given written support and oral help.

➢ Aim of the study was to identify preferences and values mentioned in ADs.

Methods

• Retrospective chart review of all consecutive hospitalized elderly pts with advanced cancer who completed ADs from 2004 to 2007.

• Demographic data and main motivations to complete ADs were collected.

• Item’s content of ADs was analyzed.

• Practical utility of ADs was measured for those patients who died under our care.

Results (1)

• Admissions: ≈1600
• Completed ADs at admission: 5 (0.3%)
• Interested patients: 149 (9%)

• Signed ADs (n=50 (3%)):
  - mean appointments = 3
  - age = 71.9±9.6 years
  - MMSE = 28±1.8
  - GI + respiratory tracts

Results (2)

Main items | Wanted | Don’t wanted | Not cited
---|---|---|---
To be resuscitated | 1 | 49 | 0
Transferred to another hospital in case of complication (hip fracture) | 5 | 5 | 40
High doses analgesics in case of intractable pain even with lower consciousness | 31 | 7 | 12
Artificial nutrition | 3 | 30 | 17
Artificial hydration | 31 | 4 | 5
Tracheostomy or colostomy | 0 | 2 | 48
Antibiotics | 29 | 7 | 14

Results (3)

Main items | Wanted | Don’t wanted | Not cited
---|---|---|---
Blood transfusion | 12 | 13 | 25
Additional tests | 0 | 3 | 47
Palliative sedation in case of refractory symptom | 27 | 0 | 23
Hospital place wish if new hospitalisation | 15 | 0 | 35
Personal wishes for dying process | 5 | 0 | 45
Religious support | 4 | 1 | 45
Autopsy permission | 9 | 22 | 19
Funeral wishes | 17 | 0 | 33
Results (4)

No resuscitation measures
No antibiotics in 2 febrile pts
Palliative sedation in 2 pts
Severe pain + intact cognition in 2 pts
No permission for autopsy in 1 pt

39 died in hospital
No need for ADs n=6
ADs respected n=32
ADs not respected n=1

Number of days with altered consciousness
4.2±2.4

Conclusions

• A minority of elderly cancer pts are prepared to put their personal wishes in writing.
• Completion of ADs takes time and energy.
• Elderly cancer patients should be informed about ADs and encouraged to complete them early in the course of their disease.
• ADs should not be another questionnaire, but a process to improve honest communication between pts, proxies and health professionals.