**Introduction (1)**

- **Definition**
  
  "Comprehensive Geriatric Assessment (CGA) = a multidimensional, interdisciplinary patient evaluation that leads to the identification of patient’s problems"

**Introduction (2)**

- **4 good reasons** to perform a CGA:
  1. CGA has important prognostic information
  2. CGA can predict treatment toxicity or decrease in quality of life
  3. CGA can reveal previously unknown geriatric problems
  4. CGA allows targeted interventions


**Introduction (3)**

- **Methodology: two-step approach**

  1. **Screening**
  2. **Comprehensive Geriatric Assessment (CGA)**

*Recommended in the guidelines of NCCN, SIOG, and EORTC.

**Screening tool**

- **to be simple and fast**
- **to have a great potential to identify older persons with a geriatric profile who can benefit from a full CGA**
  - High sensitivity
  - High negative predictive value (NPV)
  - (High specificity)

**Screening tool: overview**

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>INSTRUMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening tool</td>
<td>G8</td>
</tr>
<tr>
<td></td>
<td>Flemish Triage Risk Screening Tool (TRST)</td>
</tr>
<tr>
<td></td>
<td>Groningen Frailty Indicator (GFI)</td>
</tr>
<tr>
<td></td>
<td>Vulnerable Elders Survey - 13 (VES-13)</td>
</tr>
<tr>
<td></td>
<td>abbreviated Comprehensive Geriatric Assessment (aCGA)</td>
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<tr>
<td></td>
<td>Senior Adult Oncology Program 2 (SAOP2)</td>
</tr>
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<td></td>
<td>...</td>
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</tbody>
</table>
14 studies included (period 2007-2011)
- 7 conference abstracts
- 7 full papers

Screening method = an approach designed to assess frailty, irrespective of the population of purpose for which the method was intended

CGA = an assessment using validated methods to investigate at least three of the following domains:
- cognitive function
- mood and depression
- nutrition
- ADL
- IADL
- comorbidity
- polypharmacy
- mobility and falls
- social support
### Annals of Oncology, Jan 2012

**Screening older cancer patients: first evaluation of the G8 geriatric screening tool**

Bellera et al.

- Sensitivity: 85%
- Specificity: 65%

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### Bellera et al.: Results

![Graph showing screening results](image)

**VES-13**
- Sensitivity: 68%
- Specificity: 78%
- NPV: 66%

**G8**
- Sensitivity: 87%
- Specificity: 61%
- NPV: 52%

**Flemish TRST (c)**
- Sensitivity: 92%
- Specificity: 47%
- NPV: 64%

**GRI**
- Sensitivity: 57%
- Specificity: 86%
- NPV: 40%

**Fried**
- Sensitivity: 31%
- Specificity: 91%
- NPV: 42%

**Barber**
- Sensitivity: 59%
- Specificity: 79%
- NPV: 63%

**aCGA**
- Sensitivity: 51%
- Specificity: 97%
- NPV: 48%

**SAOP-2**
- Sensitivity: 91%
- Specificity: 44%
- NPV: 67%

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### SIOG 2012: abstracts

- Molina-Gatido et al.

<table>
<thead>
<tr>
<th>Sens.</th>
<th>Spec.</th>
<th>NPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barber</td>
<td>74</td>
<td>39</td>
</tr>
</tbody>
</table>

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### SIOG 2012: abstracts

- Barber

- Sensitivity: 74%
- Specificity: 39%
- NPV: 56%
Conclusion

- Current clinical practice:
  - Lack of a common ‘golden standard (= CGA)’ to examine the diagnostic characteristics of screening tools
  - High sensitivity often at cost of the specificity leading to high number of false positives

Recommendations

- Further validation studies of short screening tools in older cancer patients are required and ongoing.
- Consensus on the ‘golden standard (= CGA)’ to use, has to have high priority.
- By lack of a screening tool with high sensitivity, NPV and specificity, we suggest to give priority on a screening tool with high sensitivity.

Take home message

“It is better to do some kind of imperfect geriatric screening / assessment than doing no screening / assessment at all…”

Thanks for your attention!

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