Geriatric Oncology: Appropriate Assessment is the Basis for Clinical Trials and Routine Care

In recent years the importance of geriatric oncology has been increasingly recognized due to the demographic changes in many Western nations with a continuous increase in life expectancy and the substantial frequency of malignant diseases in elderly patients [1]. In clinical practice, however, the treatment of elderly cancer patients is still frequently associated with several misunderstandings: physicians may think that elderly cancer patients will not profit at all or at least less than younger patients from the use of standard chemotherapy regimens. Additionally it is believed that chemotherapy in elderly patients is associated with significant toxicity and a decreased life quality. On the other hand medical societies are recognizing the need to improve the care of elderly cancer patients. The American Society of Clinical Oncology (ASCO) has recently issued its curriculum ‘Cancer Care in the Older Population’ which addresses the increasing need to provide high-quality health services to a growing older population. At the same time the EORTC has started a working group on geriatric oncology which in cooperation with the newly formed International Society of Geriatric Oncology (SIOG) has formed a task force to address one of the burning issues in cancer care for elderly patients: How to perform a comprehensive geriatric assessment. Age itself is not a reliable factor to determine which patients can be treated by standard chemotherapy and which patients cannot tolerate this type of treatment and will need alternative approaches. This decision process is rather complex. In order to optimize this approach, the SIOG-EORTC Task Force is trying to develop a standardized geriatric oncological assessment.

The German working party of Geriatric Oncology which was formed jointly by the DGHO (Deutsche Gesellschaft für Hämatologie und Onkologie) and the DGG (Deutsche Geriatri sche Gesellschaft) has also considered an adequate geriatric assessment as an essential element both for improving enrollment and reliability of clinical trial results and for establishing guidelines for routine care. This issue of ONKOLOGIE now holds the essentials of this work describing a comprehensive geriatric assessment in the elderly cancer patient [2]. The tools selected are considered appropriately simple to be used in daily practice. This provides a prescreening for the clinical oncologist to aid him in the complex decision on which type of treatment can be safely applied. In addition to medical aspects such as performance status and organ functions [3], specific instruments dealing with nutritional status, the capability of performing activities of daily living, mobility of the patient, cognitive status, presence of depression and social support as well as comorbidity are considered core elements that will influence specific oncological decisions. Basically the assessment is trying to define three groups of patients [4]:

1. The elderly patient with adequate functional reserves who is able to tolerate standard treatment with adequate supportive care.
2. The patient who has significant deficits but can still tolerate chemotherapy. He needs treatment modifications and intensified supportive measures.
3. The patient with extreme deficits in several areas of geriatric assessment and comorbidities that may by themselves decrease his life expectancy so that no specific anticancer treatment but just supportive measures should be applied.

Although this discrimination may sound simple, its practical application is still not easy. It is our hope that with the instruments and description provided here, a comprehensive geriatric assessment of cancer patients can now be integrated into clinical studies. It is the first aim to prove its validity and usefulness prior to widespread clinical application. On this background it is clearly valuable that a recent study for colorectal cancer treatment in the elderly patient and a study of the German CLL Group will incorporate a geriatric assessment into the study design. Even in the year 2003 the enrolment of older patients in cancer treatment studies is poor leading to
only few meaningful results and not enough data that can help us to develop guidelines for clinical practice [5, 6]. Nevertheless, the demographic problem will not change and there is no decision on whether or not we want to get involved into the field of geriatric oncology – it is just our decision whether we will now start to develop a scientific and clinically sound approach to this field in order to be prepared for the future. In this respect comprehensive geriatric assessment tools in oncology can now be of help even if they may not be perfect at the present time.

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References


