The review article by Drs. Gillison and Chatta represents a very nice overview of cancer chemotherapy in the older individual across a number of different tumor types. The authors correctly point out that it is very important to distinguish chronologic from physiologic age, and that older individuals have been historically underrepresented in cancer clinical trials. Many of the larger phase III clinical trials in this population are either not designed or not powered to look at individuals over the age of 70. Moreover, trials that do include older individuals often select for the most functional individuals with minimal competing comorbid conditions and often do not include or report secondary analysis that examines outcomes by age, health status, or a combination of both. As a result, health-care providers face challenges when communicating and selecting treatment options with patients and their companions.

On a societal level, policy makers face challenges in determining the most appropriate and cost-effective care for frail older patients. There is a tremendous need for guidelines and markers of high quality care in this population, but it is equally important to individualize care due to the heterogeneity and complexity of overall health in this population. Areas that would benefit from further discussion and consideration in older cancer patients include: (1) the definition of frailty, (2) communication of complex cancer treatment decisions, and (3) comparative effectiveness and cost considerations.

Frailty

Drs. Gillison and Chatta correctly emphasize the need for risk stratification based on functional status and comorbid illnesses. Part of the challenge is defining accurate and reproducible definitions for older cancer patients who are “pre-frail” or “frail” in order to consistently segregate these individuals from healthy older cancer patients. Since Fried and colleagues’ efforts to develop and operationalize a phenotype of frailty,[1] there continues to be a tremendous effort to develop cancer-specific definitions. Examples of recent efforts include the development and application of the Vulnerable Elders Survey (VES-13) and Dr. Balducci’s criteria for identifying vulnerable or frail individuals and predicting quality of care in older cancer patients.[2,3]

As these efforts evolve, it will be important to tie assessment to specific outcome considerations, such as survival, toxicity, quality of life, and functional decline. Moreover, as assessment tools and instruments are refined, it will be critical to ensure their ease of use and practicality in busy community oncology practices, where these tools could have the greatest impact on treatment decision-making.

Decision-Making

Individual treatment decision-making regarding cancer chemotherapy often requires balancing numerous factors including the quality of the scientific evidence, the underlying biology of the disease, competing comorbid conditions, overall health status, and preferences of the older cancer patient. Therefore, it is important to take into consideration a patient’s ability to understand and
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weigh the communicated information when discussing cancer treatment options. The Institute of Medicine (IOM) defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”[4] Many patients over 65 years of age perform at the lower levels of literacy, with some studies suggesting that 80% have poor document literacy, limiting their ability to complete basic health forms employed by many physicians.[5] Health literacy is especially important in older cancer patients who need to balance the risk and benefit of treatment for their cancer against the risk from competing comorbid diseases.

Part of the challenge is that in oncology consultations, much of the information is conveyed orally. Effective patient-physician communication is influenced by both a patient’s health literacy level and the quality of dialogue between patient and physician. Patients with low health literacy may be less likely to ask their oncologist to speak slower and repeat information when their understanding is compromised. Communication could potentially be facilitated by family caregivers and companions, who are often actively involved in oncology treatment consultations and decisions.[6] An estimated 20% to 50% of geriatric patients are accompanied by a family caregiver or companion during routine medical visits.[7]

**Comparative Effectiveness and Cost**

The IOM defines comparative effectiveness research (CER) as “the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition, or to improve the delivery of care.”[8] The review points out that the initial treatment for localized prostate cancer is surgery or radiotherapy, and that for low-risk patients, active surveillance may be reasonable.

One of the high-priority CER topics identified by the IOM is management strategies for localized prostate cancer comparing treatment vs active surveillance, or comparing different surgical or radiation therapy technology.[9] Another high-priority area concerns interventions to reduce health disparities in cancer.[9] Older cancer patients are often undertreated due to an age bias or due to anxiety over the complexity of their medical issues. Community-based interventions or simple health education geared at the primary care provider, oncologists, and patients could improve the degree to which appropriate candidates are offered cancer chemotherapy, and inappropriate candidates are not.

These types of CER studies are critical since the financial costs of cancer are significant and will continue to grow as the population increases over the next several decades. The American Cancer Society estimates that the total 2008 cost of cancer was $228.1 billion (direct and indirect costs).[10] Drs. Gillison and Chatta reviewed the use of standard chemotherapy, but there is an increasing trend toward the use of novel and targeted therapeutics in the elderly. The cost/benefits and toxicities of these new treatment approaches need to be carefully examined in older patient populations. More importantly, the costs of cancer and cancer treatment need to be recognized by providers and communicated, when appropriate, to patients and families in a supportive and constructive way. To this end, the American Society of Clinical Oncology recently released a guide called “Managing the Cost of Cancer Care” for patients and families.[11]

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