Commentary (Extermann): Geriatric Syndromes and Assessment in Older Cancer Patients

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Older individuals are at risk for adverse events in all settings where cancer is treated. Common geriatric syndromes can complicate cancer therapy, and thus, increase patient morbidity and the costs of care. Furthermore,

Providing the oncologist with many practical approaches and tools for the treatment of elderly patients, this is a beautiful article from one of the leading geriatric centers in the country. I will highlight a few of the review’s more salient points.

As the authors mention, syndromes such as delirium are either dramatically underrecognized or mistaken for dementia in oncology practice, leading to the possibility that the potential reversibility of this syndrome is overlooked. How many attending physicians have also had to teach residents that "alert and oriented times three" means more than "the patient talks to me and makes sense with the help of his caregiver"? Even simple screenings such as the three-item recall or formal-date recall can detect many cognitive impairments.

Visual and hearing impairments may seriously affect a patient’s understanding of and compliance with treatment. These syndromes are another highly underscreened problem in oncology clinics.

Depression

Depression is difficult to recognize in older cancer patients because they often do not manifest typical symptoms such as crying. Patients may hide behind common consensual statements, such as "I am old anyway," and often disguise their deep mood. In many series, general oncologists or primary care physicians only recognize depression in half of their depressed patients, with the subsequent consequences of lack of treatment.[1] Such a pattern seems to persist even among patients receiving hospice care (Michael Weitzner, personal communication). At the extreme, in some areas of the world, such a lack of recognition may have fatal consequences. Depression, however, is amenable to screening with simple tools, the use of which can greatly improve a patient’s quality of life.

Abuse and Neglect

Elderly abuse and neglect is another syndrome that has a significant prevalence (1.3% to 7.4%, but probably underreported) and goes largely unrecognized, due both to patient underreporting, and the reluctance of physicians to engage in questioning that could lead to time-consuming and disagreeable consequences.[2] However, most of the time, both patient and caregivers go to great lengths to ensure the patient’s relative independence in a personal home environment. A correct assessment of the patient’s social situation, including the caregiver’s major health problems or limitations, will help to identify risky situations and prevent potentially dramatic complications of treatment.

Functional Assessment

Assessment of function is an interesting topic in older cancer patients. The Eastern Cooperative Oncology Group performance status (ECOG PS) or Karnofsky index are widely used by oncologists. However, there is a "natural" adaptation of this score with age. We do not expect the patient who is 80 years old to meet the same criteria for an ECOG score of 1 as the patient who is 20 years old. Trying to mitigate this problem, geriatricians have developed task-based tools such as the various versions of the Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) scales. Although the basic ADL is relatively gender-indifferent, IADL scales may present significant gender biases. Such is the case for Lawton’s 8-item IADL scale; Lawton himself designed a 9-item version of his scale to address this problem.
It is also important to ask whether the patient can do a task, rather than whether he or she actually does it.[3] Geriatric scales have an interesting potential in oncology. Whereas only 20% of elderly patients achieve an ECOG score of 2 or more, more than half display some dependence in their IADL.[4] This suggests that, in well-functioning patients such as those receiving chemotherapy, the IADL may be more sensitive to change than the ECOG PS.

The Karnofsky score and ECOG PS are closely correlated (Spearman $r = 0.87$).[5] However, despite being more detailed, the Karnofsky index does not appear to have a higher predictive power.[5]

**Correlation of Geriatric and Oncologic Scales**

More targeted measurements such as geriatric scales may fare better. Two studies have assessed the correlation between oncologic and geriatric scales. One is mentioned by Naeim and Reuben, and evaluates the Karnofsky index; the other, a study of the ECOG performance status, was conducted by our group.[4,6] Table 1 illustrates the correlation between these scales. Our original publication used the more conservative nonparametric Spearman correlation, given the skewed nature of score distribution in oncologic patients. We recalculated a Pearson correlation to allow direct comparison with Crooks’ results. The correlation of geriatric scales with oncologic scales, although good, does not allow simple substitution, however. Both scales seem to be applicable to both populations, thus favoring a future dialog between oncologic and geriatric research on that aspect.

Finally, Naeim and Reuben suggest a screening tool for use in the primary care setting. The tool they highlight, developed by Moore and Siu,[7] or a similar tool developed by Lachs et al,[8] would be a convenient aid to the busy oncologist. Patients screening positively on these tools could benefit from further assessment, ideally by a multidisciplinary geriatric or oncogeriatric team. It is pleasing to note that as a fruitful dialog continues between geriatrics and oncology, user-friendly tools are being developed, and both specialties will benefit from a common understanding of their patients—who, after all, are the ultimate beneficiaries of the process.

**References:**


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