Cancer treatment in the elderly: the need for a better organization

“Cancer in the elderly: why so badly treated?”. This was the title of an article published by us over 15 years ago in a widely available medical journal [1]. The foreseen increasing incidence of cancer in the elderly at the beginning of the new millennium has been confirmed [2]. At present, around 60% of new cancer cases in European Countries and in North America occur in people older than 65 years, and around 40% in persons older than 70, but the dimension of the problem is also increasing in less developed countries [3]. More than two-thirds of tumor deaths occur in people older than 65 years [4]. Since we first drew attention to the problem, considerable knowledge has been accumulated in the last decade through retrospective and prospective clinical trials in the various solid tumors and in haematological neoplasias for older patients requiring medical treatment. Further progress has also been made by the establishment of an International Society of Geriatric Oncology (SIOG) with an official journal, working groups and task forces on surgery in the elderly, on chemotherapy dose adaptation, on the use of haematopoietic growth factors to treat anaemia and leukopenia, and on Multidimensional Geriatric Evaluation (MGA). We know now that some antitumor drugs are ‘elderly friendly’ and some regimes should be modified to avoid excessive toxicity. We have also learnt how to use the best supportive therapy, including prevention and treatment of chemotherapy-related complications in older patients. The specific methodology of the MGA has also been applied to evaluate older cancer patients entering clinical trials [5]. This basically implies that the medical oncologist takes into consideration the information provided by the MGA, paying special attention to comorbidity, functional status, depression and mental impairment before deciding on the therapeutic approach. By scoring these MGA items, a distinction can be made between older, fit patients who can be treated as adult patients; frail patients handled mostly with palliation only; and patients in an intermediate state, or the vulnerable, treated with reduced or adjusted chemotherapy regimens [6]. This body of practical notions to manage older patients with cancer has led to the development of clinical and research activity defined as ‘Geriatric Oncology’ [7]. In the last few years, training programs in geriatric oncology have been activated by the ASCO Fundation in the USA to produce academicians who will be teachers of geriatric issues in medical oncology and lead research efforts in geriatric oncology. As a further step, in the year 2005, grants for a total of 25 million dollars of the National Institute of Cancer and of the National Institute of Aging have been provided to designated cancer centers to study age-integrated aspects. In Europe, the French ‘Institute National du Cancer’ has established a Special Research Program on Geriatric Oncology and nine Programs of Geriatric Oncology have been funded with a global grant of 1 273 000 Euros [8]. Also in France a diploma has been established in geriatric oncology. The SIOG also, through a specific task force, has dedicated special attention to the aspects of the
organization of the clinical activity of geriatric oncology [9]. At present, specific activities for cancer in the elderly worldwide (mainly in USA and Europe) are carried out in some medical oncology departments of general hospitals but also in some cancer institutes, as well as, but to a minor extent, in geriatric departments. This activity, with minor differences, is taking place through a Geriatric Oncology Program. Such a clinical activity can be defined as a coordinated effort of medical oncologists, geriatricians, physiotherapists, nurses and social workers to generate treatment plans for older cancer patients [10]. Such programs can avoid frequent hospital admissions, reduce nursing home placements and increase older patients’ and family satisfaction. However, more time is required, especially for the MGA (30–45 min). Geriatric Oncology Programs have been able to combine the best oncological with the most appropriate geriatric approach in the same patients, but this takes place only in a minority of institutions in USA and Europe. This new organization needs instead to be generalized. It is astonishing to note that this contribution, which allows the specific therapeutic needs generated by the increasing burden of cancer in old people to be met, has not yet been applied on a large scale. Nobody is surprised today if, when dealing with children affected by cancer, there is a merging of the paediatric with the oncological expertise, while for older patients a structured working relationship between clinical oncologists and geriatricians is still lacking in most hospitals. The activation of a Geriatric Oncology Program could be the first organizational attempt to cope with the medical problem of cancer in the elderly, therefore offering the proper approach in many instances, at practically no cost.

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