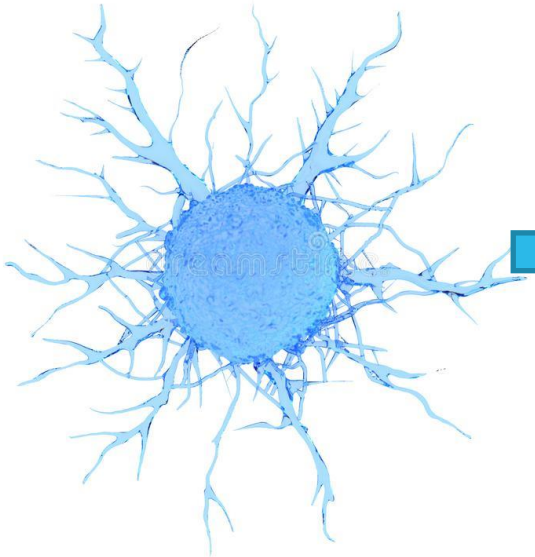
Diakonessenhuis

SIOG
INTERNATIONAL SOCIETY
OF GERIATRIC ONCOLOGY

Do you need a geriatrician to provide optimal geriatric oncology care?

Dr. M.E. Hamaker
geriatrician

Traditional disease and treatment paradigm



Geriatric perspective

Geriatric involvement in geriatric oncology is increasing

Dutch questionnaire 2013: nearly half of geriatricians reported having no geriatric oncology activities at their hospital

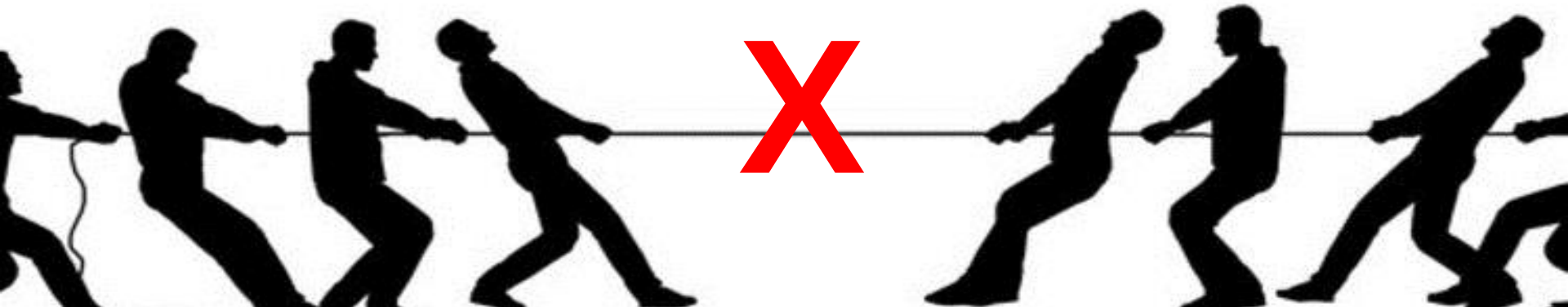
Most of these did not consider this to be an issue

Similar questionnaire 2019: almost all geriatric departments are involved with at least one cancer care pathway at their hospital

Most often in colorectal cancer because of mandatory frailty screening prior to surgery

Geriatrization of medicine

- Interest in collaboration with geriatricians is rising
  - Geriatric oncology
  - Cardiogeriatrics
  - Geriatric trauma units
  - Geriatric nephrology
  - Presurgical geriatric consultation
  - …

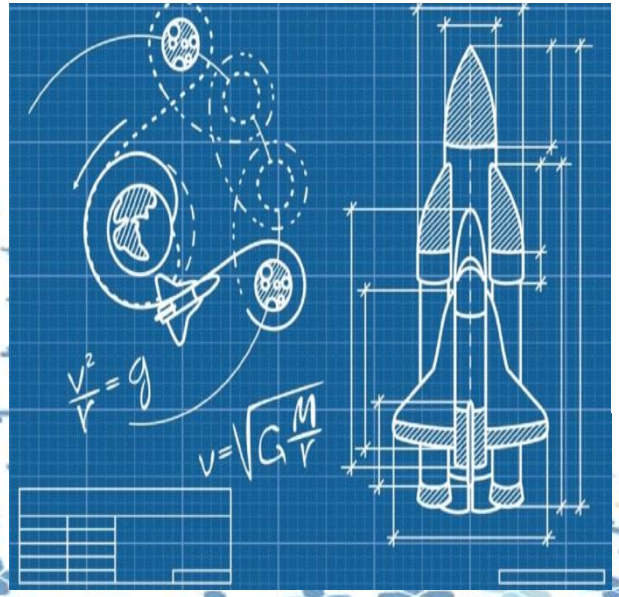


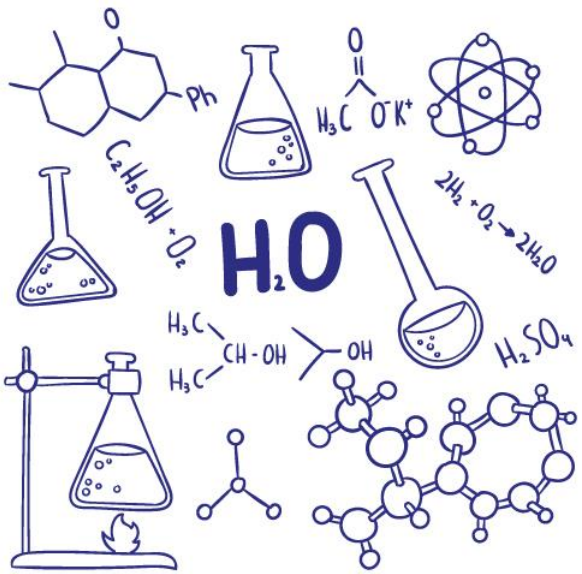
BJC

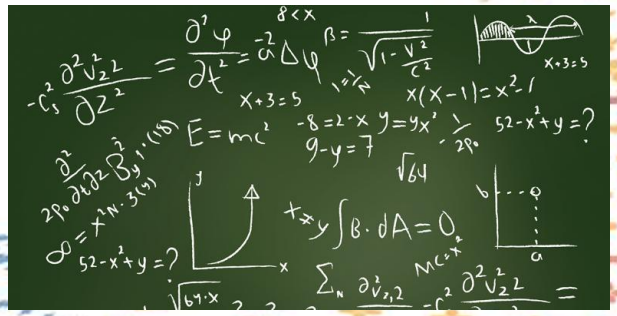
British Journal of Cancer (2017) 117, 470–477 | doi: 10.1038/bjc.2017

Keywords: geriatric assessment; frailty; survival; geriatric oncology

Geriatric assessm… is superior to oncologists' clinic… identifying frailty

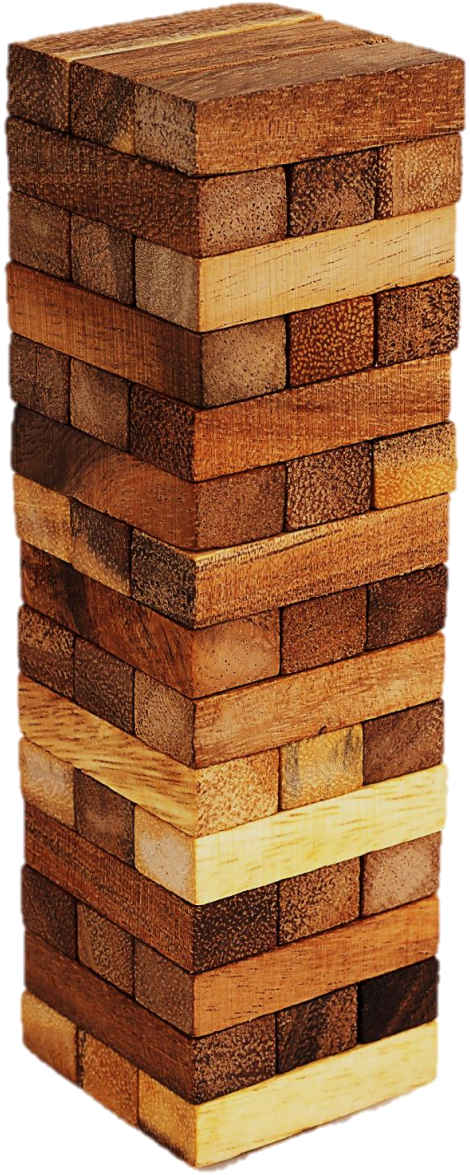






The essence of geriatric oncology

- Focus on the patient
- Assessing patient preferences
- Staging the ageing
- Looking at potential vulnerabilities, deficits and resources



Fit patient

Vulnerable/potentially frail

Geriatric availability: it’s a spectrum

No geriatricians at all

Full MDT involvement and unlimited consultation


What steps can
the oncology team take
to geriatrify
the cancer care pathway?

First step: Ask ‘geriatric’ questions

- What have you been told/ what do you understand about your disease?
- What does a normal day look like for you?
- Did you walk here from the parking lot or were you dropped off at the door?
- Did you take the stairs or use the elevator?
- Have you had any falls in the past 6 months

- What is important for you, what makes life worth living?

→ Be sure to dig a little deeper than the first answer

‘Geriatric’ signs

- Head turning sign
- Superficial or standard answers → ask details and specifics

- Caregiver in the lead

- Getting up from a chair and gait speed

Next step: Frailty screening tools

Initially developed to identify patients who receive a more elaborate geriatric assessment

Increasing evidence that they have relevant diagnostic and prognostic value in their own right

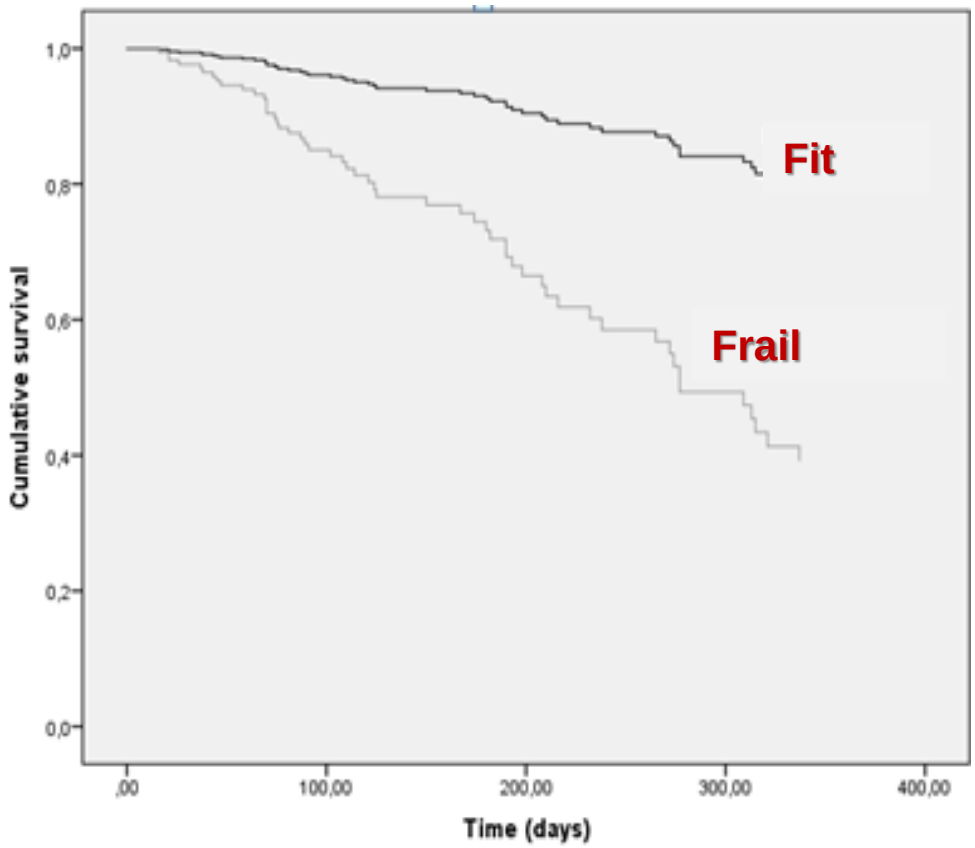
Some discussed in previous presentations: G8, GFI, VES-13

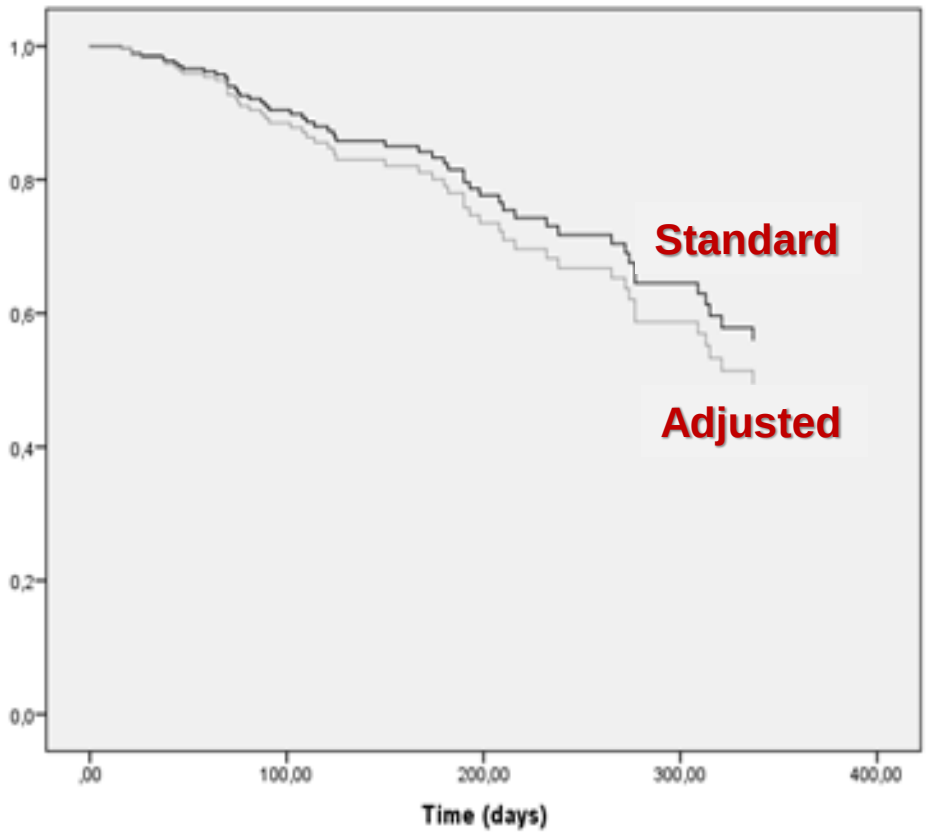

Geriatric assessment
Frailty screening
Geriatric questions

Basic components geriatric assessment

Functioning: basic and instrumental activities of daily living
Mobility and falls
Nutrional status
Cognition
Mood
Social support
Patient priorities and preferences

Importance of frailty for prognosis





Schulkes et al. Clin Lung Cancer. 2017

Geriatric assessment tools

For each domain, multiple instruments are available
Can be completed by any (trained) health care professional

Interpretation is needed

- score vs diagnosis
- context
- ‘intrinsic’ frailty vs. cancer-related

Translating the outcome of the assessment to a treatment decision

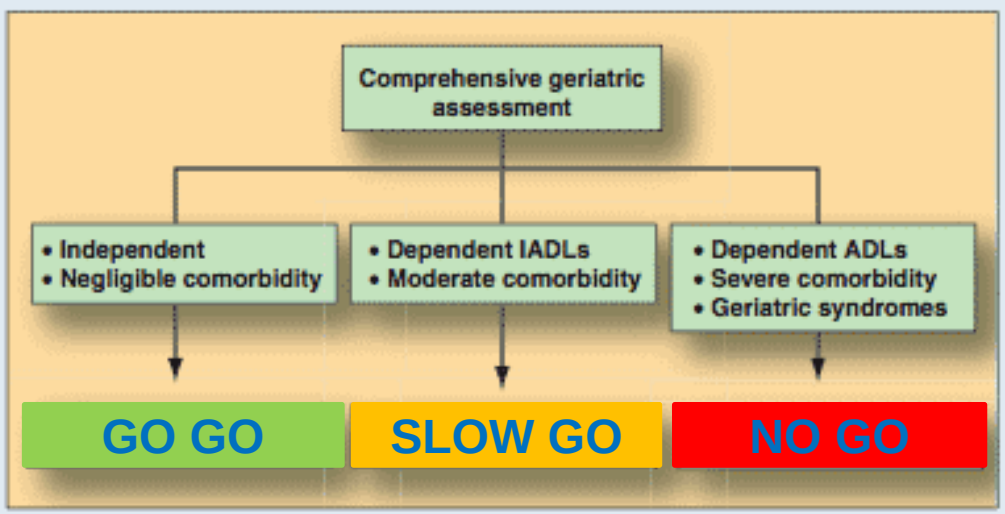


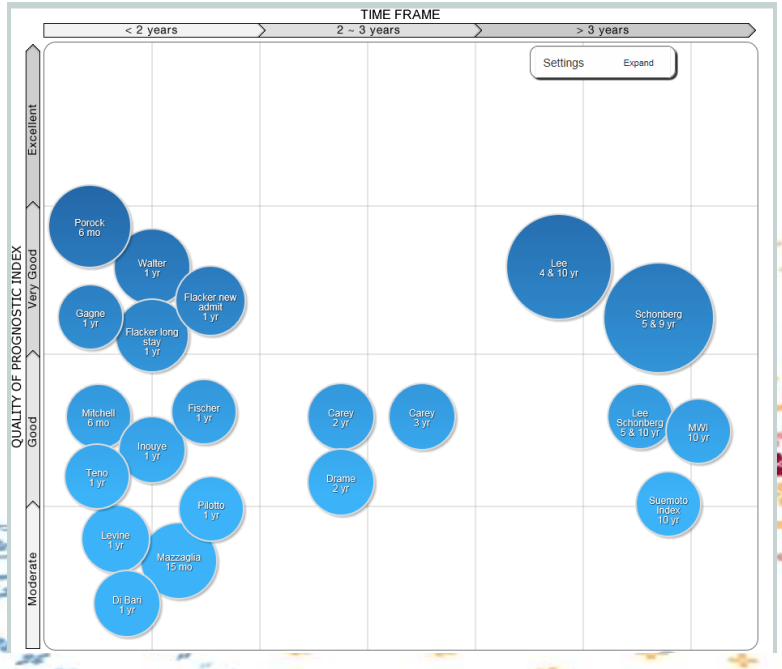
Figure 2: Treatment of Older Cancer Patients—Algorithm directing the administration of chemotherapy in older individuals. ADLs = activities of daily living; IADLs = instrumental activities of daily living.

Predictive value

Predicting toxicity:

http://www.mycarg.org/Chemo_Toxicity_Calculator

Estimating remainging life expectancy: eprognosis.ucsf.edu



Treatment adjustment?

- What matters most to the patient?
- What are the patients complaints?
- What is the natural course?
- What exactly are you trying to prevent? What is the benefit?

- What is your chance of success?
- When will this benefit be seen?
- What are the risks of treatment?

- Are there alternatives?
- What are the risks and benefits of these alternatives?

Balancing capacity and resilience with treatment burden

Geriatric interventions

Initial focus in geriatric oncology primarily on highlighting deficits

Much more important: resilience and resources

Frailty is not always reversible but that does not mean that there is nothing you can do

Examples

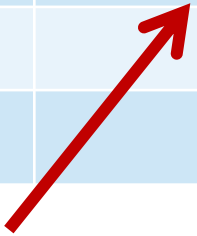
Cognitive impairment → involve caregiver, professional care for support/medication reminders/assessing side-effects, further diagnosis

Impaired mobility → mobility aids, physiotherapy, practical assistence for coming to clinic

Nutritional status → dietary evaluation, supplements, recommendations, additional follow-up

Effect of GA with interventions

Outcome	Number of studies	% with positive effect
Treatment completion	4	75%
Complications of treatment	10	60%
PROMS	3	33%
Survival	7	29%
Health care utilisation	10	20%



NB: Also no negative effect

Hamaker et al. Journal of Geriatric Oncology 2018

‘Great! So I don’t need a geriatrician at all?’

Geriatric contributions to decision making and cancer care

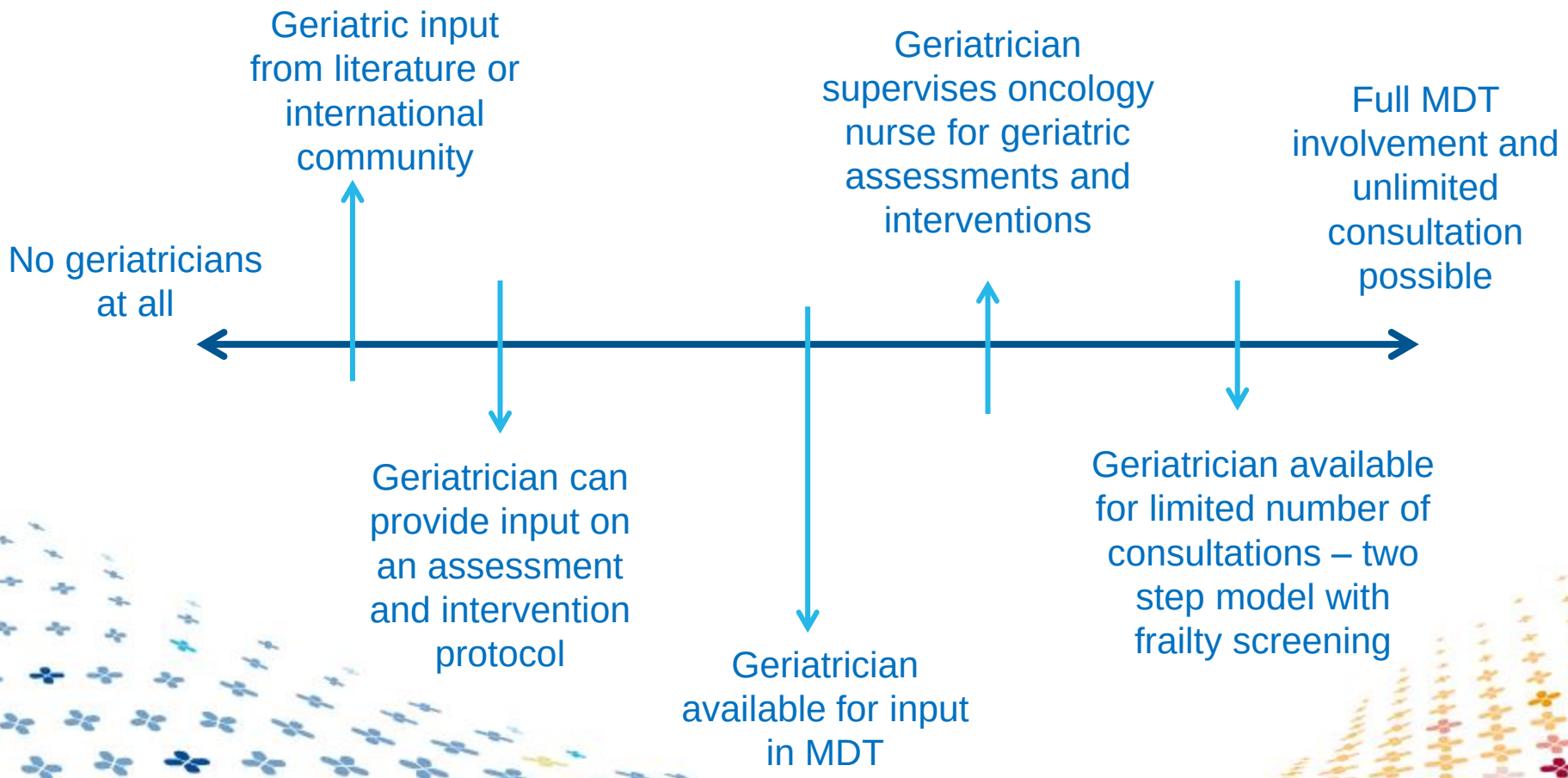
- Knowledge/experience with aging, multimorbidity and geriatric syndromes

- Diagnosing and treating geriatric impairments
- Managing and optimizing comorbidities
- Evaluating a patient's reserve capacity and ability to tolerate treatment

- Elucidating patient preferences and priorities
- 'Second opinion' for the oncology team
- Independent sparring partner for the patient

- Time!

Geriatric availability: it's a spectrum




JUST
BEGIN

GerOnTe

- Streamlined **Geriatric** and **Oncological** evaluation based on information and communication **Technology** for holistic patient-oriented healthcare management for older multimorbid patients with cancer

Current health care pathways

Developed around a single disease

Not adequate for older patients / those with comorbidity or geriatric impairments

Delay in diagnostic and treatment trajectory

Misattribution of symptoms

Concurrent issues not sufficiently weighed and treated

Undertreatment and overtreatment

Patients with multimorbidity and cancer

Multimorbidity leads to significant illness burden

Increased risk of death, impact on quality of life

Fragmentation of health care

Need for holistic approach with focus on the patient

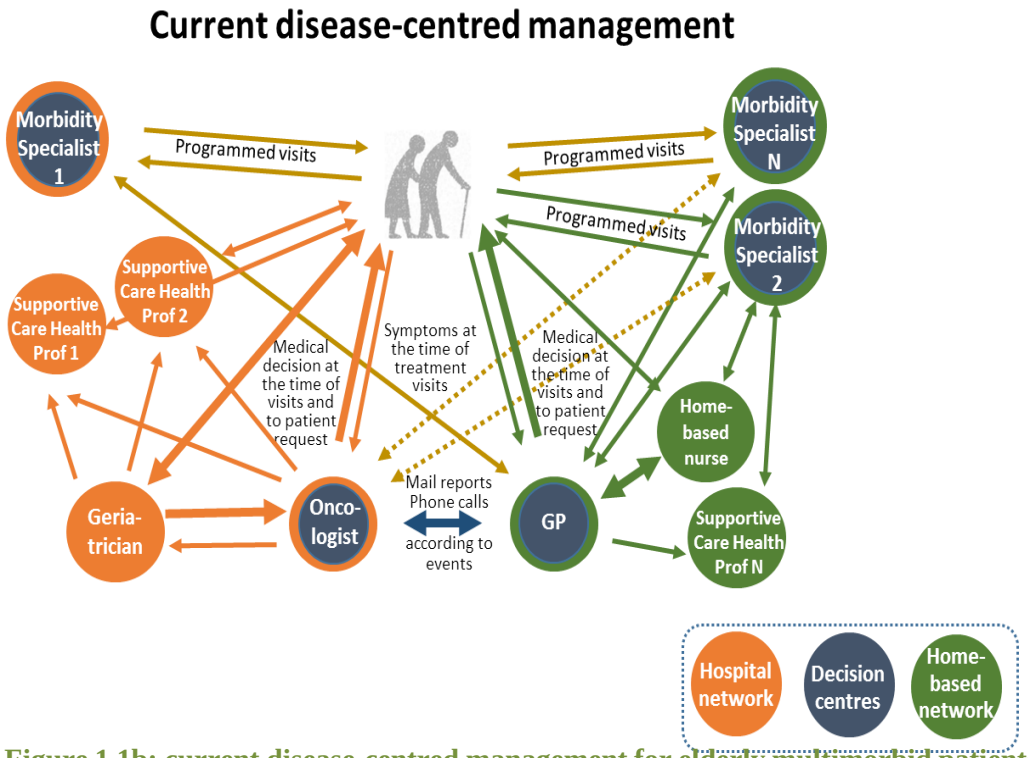


Figure 1.1b: current disease-centred management for elderly multimorbid patients, compared to GerOnTe

Aim of Geronte: Transforming care pathway

Which data do you need for diagnosis and treatment decision

- About the cancer
- About multimorbidity
- About geriatric domains
- About patients preferences and priorities

Which health care professionals should be involved?

- In decision making
- In the care trajectory

How can we provide better care to patients during treatment?

- Central care coordinator
- Streamline (para)medical care
- Health care professional consortium
- Home monitoring
- Self-management

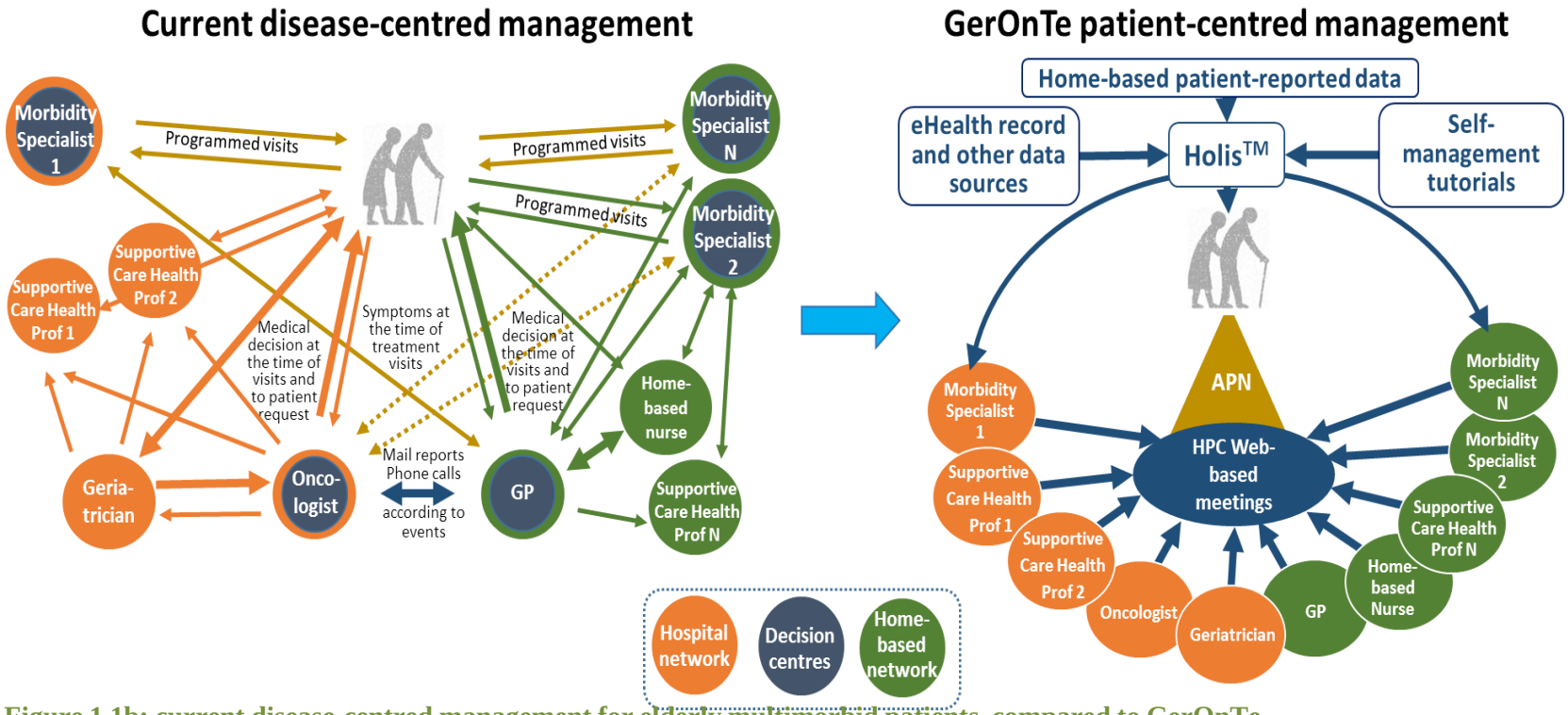


Figure 1.1b: current disease-centred management for elderly multimorbid patients, compared to GerOnTe

Technology support: Holis application

Combining information from various sources, providing holistic overview

- Electronic health files
- Organ specialists, paramedical professionals
- Geriatric assessments
- Primary care physician etc.

Home monitoring app aimed at early signaling of complications, decompensated comorbidities, functional decline

Selfmanagement

Ultimate aim

Tailoring of cancer treatment and care

Improving oncologic outcomes

Improving quality of life and satisfaction, maintaining independence, patient empowerment

Decreasing unplanned health care utilisation

Cost effective

Three phases

Year 1: designing care pathway and apps

Year 2,3: clinical trail of care pathway in France, Belgium, Netherlands

Year 4,5: data analysis and European implementation roadmap

Thank you!