

Optimizing Cancer Care in the Elderly: Progress in Geriatric Oncology

Geriatric oncology is a field in full expansion. Eighty percent of all cancers are diagnosed in people over 55 years of age and by the year 2050 a million centenarians will be alive in the United States!¹ Thus, the aging of the US population in the next two decades will generate a massive increase in cancers occurring in the elderly. This population shift has fueled a burgeoning interest in geriatric oncology in both this country and abroad. Professional organizations have been spawned and governments and voluntary agencies are developing programs and support systems to address the challenges of geriatric cancer care. This journal issue describes and highlights several areas of progress in the field that have occurred since our previous issue (November/December 2000) that was devoted to the topic. It cannot, of course, be fully inclusive, but the research and progress in care achieved since then provide a more solid basis on which to improve evaluation and care and, at least as important, pose further questions that need to be answered by bench, translational, and clinical studies.

As an example, Dr. Lichtman opens this issue with a review of some specific management guidelines that have been developed to better address the needs of our older cancer patients. We now recognize that age can affect the metabolism of some anticancer agents in the elderly, and Dr. Licht-

man also summarizes the current knowledge of this important aspect of cancer care.

Since the health and social status of elderly patients is highly variable, we are challenged to assess them properly in order to optimize individual treatment decisions. A key tool in this decision-making process is a comprehensive geriatric assessment and intervention. Two articles in this issue describe and review this subject. Dr. Wieland and Dr. Hirth superbly synthesize the efforts and progress from decades of geriatric research. They discuss the concepts of geriatric assessment and the data on its use in a way that oncologists will find helpful. Dr. Extermann then reviews the early results of the application of such assessments in the field of oncology. Although results are still preliminary, we are beginning to appreciate how a comprehensive geriatric assessment can not only help define the profile and the prognosis for older individuals with cancer, but also influence the recommended treatment and clinical outcome. Clearly, more work is needed to simplify such assessments to make them more feasible and to determine when they should be repeated during a patient's clinical course.

The next article reviews the complex problems that acute myelogenous leukemia induces in older patients. Unfortunately, the overall prognosis for the disease in this age

group is poor. Dr. Rathnasabapathy and Dr. Lancet evaluate prognostic factors in some detail and emphasize the need for treatment individualization since age alone is not the only negative prognostic factor. They also describe and discuss new biologic markers and targeted therapies that may play important roles in management in the near future.

Many recent articles have emphasized the ability of at least a subgroup of elderly patients to tolerate "standard" treatment for their tumors and, more important, to benefit from it to an extent comparable to younger patients.^{2,3} Although a significant proportion of an average population of older patients will experience a severe toxicity from their treatment as defined by Common Toxicity Criteria, they generally tolerate their treatment well with limited impact on independence, comorbidity, and quality of life levels.⁴ Older cancer patients in both Europe and North America increasingly want the option of chemotherapy presented to them, even if their expectations about treatment outcomes may be overly optimistic.⁵ Key to maintaining good function during chemotherapy is attention to supportive care, a topic that is addressed in the last two articles of this issue. First, Dr. Balducci reviews the increasing evidence that anemia is not a "natural" aging phenomenon without consequences and that we should not assume that anemia in an older can-

cer patient is due to either advanced age or the disease in question. In fact, anemia has a negative impact on survival, function, cardiovascular diseases, and tolerance to chemotherapy, and its causes should be investigated and corrected. In the second article, Dr. Lyman and associates provide an evidence-based systematic review of the use of growth factors for elderly cancer patients. After reviewing efficacy data, they also address the cost-effectiveness issue of early use of these agents.

In developing this issue of *Cancer Control*, we noted an impressive difference compared with our 2000 issue in the competition for the "Ten Best Readings" list. Geriatric oncology papers are now published more frequently in major medical journals, and the choice for "the best" was difficult and necessarily somewhat subjective.

Where, therefore, are we now in this field of geriatric oncology? On the one hand, we have a rapidly increasing population of the elderly with cancer and thus a rapidly and constantly rising case burden. On the other hand, we understand much better than even a few years ago many of the barriers to effective care of our older patients with cancer. We are now more proficient at assessing the comorbidities of elderly individuals, thus allowing us to more accurately predict their prognosis and choose optimal treatment, and we are validating approaches to minimize the deleterious effects our treatments may produce. Bench research is continuing, and more clinical trials that pertain specifical-

ly to the elderly with cancer are being planned and reported, so we will have even more information to allow us to provide optimal care for this, the largest group of patients with cancer.

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