Communicating Treatment Options to Older Patients: Challenges and Opportunities

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We've been hearing that the United States population is aging and that the number of older adults is expected to double between 2010 and 2030, as life expectancy increases and “baby boomers” reach age 65. These forecasts seemed like they were far in the future; but now, as healthcare providers, we are seeing the graying of society in our waiting rooms. Today we are encountering first-hand the demographic shift in progress. We clearly see the association between cancer and aging, and this is only the beginning, since cancer incidence is expected to rise by 67% between now and 2030 in people older than 65.¹

Although the numbers are growing, older adults are the minority of individuals enrolled in most clinical oncology trials.² Therefore, outlining treatment choices to older adults, including the risks and benefits, is uncertain territory, because it requires extrapolating recommendations from studies performed in younger patients. Furthermore, these studies often excluded older adults with comorbid conditions or organ dysfunction, who nonetheless form a large part of the older cancer population. So even if the benefits of therapy are comparable across the age spectrum, the risks of therapy are surely magnified by the rise in comorbid conditions and declines in organ function associated with aging. For example, a review of 3 CALGB breast cancer clinical trials showed that only 7% of patients enrolled in clinical trials were older than age 65. That 7%, however, showed an increased risk of treatment-related side effects, early discontinuation of therapy, and treatment-related mortality.³ How would these risks affect older patients who were not even eligible for the study because of comorbidities or poor health? This remains unknown.

One way to remedy the low enrollment of older adults in clinical trials is to pre-specify that the age distribution in the study mirror that of patients with the disease. This is especially important for studies that will be used for FDA approval of new therapeutics. Although oncology therapeutics undergo a stringent approval process under FDA regulations, older adults are inexplicably under-represented in registration trials. As of 1993, federal law has mandated that the NIH include and adequately represent women and minorities in clinical research studies. This leaves us with the question: Why isn’t there a similar mandate for adequate representation of all age categories? If the concern is that toxicity would be too high in older adults, then the investigator should be required to justify the promise of a cancer treatment that is potentially too toxic for most patients who have cancer.

Another challenge of describing treatment options to older adults is whether the information from clinical trials addresses the values that are vital to that individual’s decision-making. Oncology clinical trials often focus on disease-free and overall survival. The potential impact of therapy on short- and long-term physical and cognitive function also plays a critical role in the decision-making process, however, it is usually not addressed in clinical trials. A survey of older adults from Fried et al⁴ showed that the impact of therapy on function and cognition carried greater weight in treatment decision-making than the impact of therapy on overall survival. In fact, in that survey, most respondents said they were willing to forgo life-sustaining therapy that might cause either physical dependence or cognitive decline. These findings are also important on a societal level because most care in this country is performed by family or friends: if therapy impacts function, a caregiver is needed.

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Therefore, when discussing options with older adults, clinicians should not only include the potential benefits of therapy, but also the risks of functional dependence or cognitive decline. Other key questions to include during the treatment planning process: Who will take care of the patient when he/she undergoes intensive treatment? Who does the patient also take care of (spouse, grandchildren), and who will provide that care if the patient cannot do so?

Another particular challenge in discussing treatment decisions with older patients is that any cognitive impairment can be subtle or easily masked. Clinicians must be armed with tools to assess cognitive function and to document a patient’s capacity to make complex treatment decisions. This is especially important now, because the projections that forecast a rapid increase in the number of cancer cases also make similar forecasts for dementia cases both in the United States and worldwide. The number of Americans aged 65 and older with Alzheimer's disease is projected to rise from 5.1 million today to 13.2 million by 2050. These projections have significant implications for cancer care paradigms and ensuring quality of cancer care for older adults with the disease.

An assessment of cognitive function and the individual's capacity to make a decision must be part of the clinical evaluation regardless of therapy. This was illustrated in a study performed in patients aged 65 and over who enrolled in cooperative group trials. Of those who had signed consent for a therapeutic clinical trial, 5% scored above the threshold on a brief cognitive screening tool called the Blessed Orientation-Memory-Concentration Test. Although scoring above the threshold does not mean that the patient does not have the capacity for decision-making, it does suggest that cognitive impairment might not be readily apparent in a brief clinical encounter. Incorporation of this particular screening tool could alert clinicians to probe cognitive function.

The next step would be to assess the capacity for decision-making, which includes 4 essential components: 1) understanding relevant information; 2) appreciating the medical situation in light of one's underlying values; 3) using reason to make a decision; and 4) being able to communicate that choice. If these components are met, the individual has the capacity to make treatment decisions. Ultimately, cancer treatment decisions can only be made in the context of the individual's goals and values, which provide the framework for that decision.

Conclusions
In summary, to be able to discuss evidence-based treatment options with certainty with our older patients, we must bolster the evidence-base by including older adults in clinical trials. Furthermore, the clinical trials would be of far greater value if they included end points and outcomes relevant to older adults, such as the short- and long-term impact of therapy on function and cognition, as well as the need for caregiver support during and after therapy. Routine measures of function, cognition, and social support (captured in a geriatric assessment) in both baseline and follow-up assessments for patients enrolled in clinical trials would start to address this knowledge gap. Guidelines and evidence-based care, while critical in oncology, can only be considered “appropriate care” if proven applicable in the particular situation, and if individuals understand their options and are able to select a treatment decision that fits their overall goals, values, and preferences.

The aging of society is visible now. Those of us under age 65 will not be so forever. We are tomorrow’s older people, tomorrow’s gray-haired patient in a waiting room. It is time to embrace and address the concerns of the aging population, which constitutes most of our patients with cancer.
References