Geriatric Oncology Education for the Oncologist is Overdue

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With the increase in the aging population and longer life expectancy, oncologists are treating more of our “oldest-old” patients (aged >80 years) with cancer therapies. In the recent past, these patients often would have received symptomatic treatment alone. Treatment of these patients differs from that of younger patients in many ways. In addition to the change in clinical behavior of some tumors, the aging process brings physiologic changes leading to decline in the function of organs. For example, kidney function decreases with age, pulmonary compliance lessens, and bone marrow cellularity and reserve decline. Physiologic reserve, or the capability of an organ to perform its activity under stress, is influenced not only by genetic factors but also by environmental factors, dietary habits, multiple chronic diseases, and social conditions. Chronologic age differs from functional age, and this difference must be captured and integrated in the decision-making process of cancer treatment. It is essential to identify patients with longer life expectancy or who are fitter and potentially more resilient, and therefore more likely to benefit from standard treatment, versus those who are more vulnerable to adverse outcomes.

The incidence of comorbidities increases as we age. Frequent coexisting chronic diseases and geriatric syndromes, such as dementia, falls, or functional limitations, may influence management of cancer. Comorbidities may increase the risk of complications, modify cancer behavior, or mask symptoms, causing subsequent delays in cancer diagnosis. Conversely, cancer treatment may worsen comorbidities or increase the frequency of drug interactions. A recent publication by the Institute of Medicine reported a systemic lack of preparation among current oncologists for the care of older patients with cancer, primarily those with multiple health conditions.

Decline in functional status is associated with frailty and worse cancer treatment outcomes, such as decreased survival or greater toxicity. Frail patients often do not complete therapy, and therefore do not derive benefit. Basic and instrumental activities of daily living and other performance measures, such as walking speed and muscle strength tests, have been shown to have a greater predictive value of physical function compared with traditional oncology measures of performance (ie, ECOG or Karnofsky performance status). Therefore, those measures, when deficient, need to be clearly recognized as markers of risk in the elderly.

Patients with cancer who have cognitive dysfunction represent a challenge for oncologists. After age 65 years, the risk of developing Alzheimer’s disease doubles approximately every 5 years. The increased rate of dementia in the elderly converges with the higher likelihood of developing cancer. Patients with cancer/dementia overlap are often diagnosed later in the disease process, screening is less standardized, and adherence with treatment is often difficult. Many oncologists are conflicted as to whether true informed consent for treatment can be obtained from older patients when their cognitive abilities are impaired or unclear. Cancer providers who care for older adults with cancer must be able to assess cognitive function, understand the implications of cognitive impairment when patients need to make decisions, address the potential for treatment-related further cognitive decline, and be able to facilitate shared treatment decision-making.

During active treatment for cancer, oncologists assume responsibility for patients and provide most of their care. Therefore, a patient’s function, cognition, psychosocial issues, caregiver-related issues, and other geriatric syndromes must be addressed by the oncologist. In “Community Oncologists’ Decision-Making for Treatment of Older Patients With Cancer” in this issue (page 301), Mohile et al show that, when available, geriatric-relevant information was very helpful and strongly influenced community oncologists’ treatment decisions. However, <25% of those surveyed felt “very confident” in assessment and interventions...
for function, falls, and dementia. Most of the oncologists surveyed believed that geriatric education was essential and said they would appreciate training in age-related topics.

Despite the need for basic knowledge in geriatrics, most oncologists receive minimal or no education. Therefore, they are not prepared to unmask geriatric syndromes. The Accreditation Council for Graduate Medical Education (https://www.acgme.org/) requires that hematology/oncology fellows demonstrate competence in the care and management of geriatric patients with cancer. Fellows should be expected to obtain the necessary skills to perform some form of geriatric assessment to recognize cognitive impairment or identify gait disturbances before prescribing chemotherapy. However, the quantity of education reported by fellows seems inadequate to prepare them for the care of these patients. Results of a recent national survey sponsored by ASCO and developed by Maggiore et al showed that a minority of fellows had access to geriatric oncology clinical experiences, lectures, or educational resources, and reported a lack of confidence in key geriatric oncology skills. In addition, many of the fellows demonstrated limited geriatric oncology knowledge regarding chemotherapy toxicity in older adults. Exposure to geriatric content during hematology/oncology training was sparse, with <50% of the fellows having had even a single geriatric oncology lecture, and even fewer having had geriatric oncology clinical experience.

Although the specific gaps in knowledge that were identified varied depending on the stakeholders surveyed and method of data collection, several themes have emerged in the literature, including the need for educational content on how to assess older adults and how to identify and manage comorbidities and geriatric syndromes, guidance regarding evidence-based management of older adults with specific cancers, information on the pharmacology of anticancer therapy in older adults and issues of polypharmacy, and understanding of the unique psychosocial challenges affecting older adults.

The integration of geriatric teaching into oncology should include not only oncologists but also all members of the healthcare team. Oncology nurses, pharmacists, and other members of the healthcare team who interact with older patients need to regularly receive geriatric oncology education throughout their training continuum. This need has been identified by the International Society of Geriatric Oncology (SIOG) as one of their top 10 priorities. The Oncology Nursing Society identified specific areas of knowledge for nursing education and developed and published their own resources (https://ebooks.ons.org/book-category/geriatrics). However, the education of oncology nurses focuses primarily on oncology itself, rather than on geriatric information and training. Burhenn et al reported that nurses in their institution had a positive attitude toward caring for older adults, but also showed that knowledge about caring for older adults is definitely needed.

Much progress has been made. Geriatric oncology competencies have been incorporated into curriculum milestones for hematology/oncology fellows, and ASCO University has created a repository for geriatric oncology educational resources. However, few fellows who have access to the geriatric oncology modules sponsored by ASCO University actually use them. These barriers to learning suggest that geriatric oncology concepts should be incorporated into everyday training, and that more effective educational strategies are needed. Development of awareness about the importance of geriatric syndromes and how to identify and integrate them in the decision-making process of cancer treatment is urgently needed. We as healthcare professionals do not ask what we don’t know, and knowledge about these aspects of the patient’s physical, emotional, and environmental health are crucial for effective and compassionate patient-centered cancer care.

References