Geriatric Assessment in Older Patients with Breast Cancer

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Geriatric assessment, breast cancer, comorbidity, cognition, polypharmacy, nutrition, distress, functional status

Abstract
Most cases of breast cancer are diagnosed in older adults. Older women have an increased risk for breast cancer-specific mortality and are at higher risk for treatment-associated morbidity than younger women. However, they are also less likely to be offered preventive care or adjuvant therapy for this disease. Major gaps in evidence exist regarding the optimal evaluation and treatment of older women with breast cancer because of significant underrepresentation in clinical trials. Chronologic age alone is an inadequate predictor of treatment tolerance and benefit in this heterogeneous population. Multiple issues uniquely associated with aging impact cancer care, including functional impairment, comorbidity, social support, cognitive function, psychological state, and financial stress. Applying geriatric principles and assessment to this older adult population would inform decision making by providing estimates of life expectancy and identifying individuals most vulnerable to morbidity. Ongoing research is seeking to identify which assessment tools can best predict outcomes in this population, and thus guide experts in tailoring treatments to maximize benefits in older adults with breast cancer. (UNCCN 2009;7:226–236)

Breast cancer is a disease associated with aging; the median ages of diagnosis and mortality are 61 and 69 years, respectively.1 As the United States population ages, the number of older adults with breast cancer and breast cancer survivors are also rising. Among older adults, factors other than chronologic age can influence treatment decisions and outcomes as independent predictors of morbidity and mortality. These factors (included in what is termed geriatric assessment) include physical function, comorbid medical conditions, cognitive function, psychological state, social support, polypharmacy and geriatric syndromes, and financial considerations. Although a geriatric assessment is routinely performed in daily geriatric practice, it is only beginning to accompany oncology care.

Management of breast cancer can serve as a model to discuss the application of geriatric principles to oncology care. As with other solid tumors, decision making in the adjuvant setting requires accurate estimates of life expectancy to weigh the risks and benefits of therapy. Weighing the impact of comorbid medical conditions on life expectancy and treatment tolerance is a critical part of the decision-making process. For example, clinicians must weigh whether patients are more likely to die of breast cancer or another comorbid illness.

In addition, in both the adjuvant and metastatic setting understanding the association between comorbid medical conditions and vulnerability to side effects is critical to maintaining quality of life. Balancing the short- and long-term side effects of treatment with estimates of potential benefit is particularly pertinent to breast cancer, which can have a variable natural history (based on the tumor’s biologic characteristics) and various treatment options with varying levels of risk. Improved assessment strategies, taking advantage of geriatric assessment tools, can help individualize treatment.
This article outlines the essential components of a geriatric assessment, discusses screening tools for measuring the individual domains, and examines the usefulness of the assessment in a general geriatric population. In addition, this article highlights studies that report on the use of a geriatric assessment among patients with breast cancer, examines gaps in the present evidence-based knowledge, and issues a call for additional research.

The Geriatric Assessment

Physical Function

Assessment of physical function, a key element in geriatric assessment, provides information independent of comorbidity in older oncology patients. In the general geriatric population, impairment in physical function has been consistently associated with increased risk for future disability and mortality. Likewise, physical function may predict susceptibility to toxicity for older adults undergoing cancer treatment.

Oncologists report that treatment recommendations for older women with breast cancer are usually influenced by perceived functional status. No consensus exists regarding which tools to use in evaluating physical function in older patients with cancer or how to modify treatment plans accordingly.

Clinical questions to consider include 1) does physical function predict meaningful outcomes for older women with breast cancer, 2) are oncology performance status scales adequate in assessing physical function for the older cancer patient, and 3) how should treatment plans be altered based on an individual’s physical function?

Traditionally, physical function has been assessed with oncology performance scales, such as the ECOG scale or Karnofsky performance status (KPS). Poor performance on the ECOG scale has been associated with decreased survival in older women being treated with palliative chemotherapy for metastatic breast cancer. Physical function assessment using the ECOG scale alone, however, is inadequate when determining risk for many older adults with cancer. For example, although scores of 3 to 4 correlate with overt disability, scores of 0 to 2 encompass a broad range of functions in older adults (Figure 1). Many older patients present in clinical practice with an ECOG score of less than 3. However, this does not provide oncologists information about subclinical disabilities that might predict tolerability and response to therapy, and therefore more sensitive measures are needed.

In geriatrics, functional status is commonly assessed using Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) scales. ADLs cover basic self-care skills (i.e., bathing, dressing), whereas IADLs address skills needed to maintain independence in the community (i.e., transportation, taking medications). The NCCN Clinical Practice Guidelines in Oncology propose these task-specific scales for use in geriatric assessment of older patients with cancer because they add vital information to the ECOG performance scale. Among 363 older cancer patients in a geriatric oncology clinic with an ECOG performance score less than 2, Repetto et al. found 9% had ADL disability and 38% IADL disability.

In studies of geriatric assessment in older women with breast cancer, a substantial number presented with ADL or IADL disabilities. For example, Girre et al. evaluated 105 patients aged 70 years and older, and reported that 42% required assistance with ADLs and 54% required assistance with IADLs, despite the fact that only 7% of patients received an ECOG score of greater than 2. In a study of older adults enrolled in a phase II trial for metastatic breast cancer, Del Mastro et al. reported that 26% of the trial population required assistance with ADLs and 73% required assistance with IADLs.

Further research is needed to understand the significance of ADL and IADL scores when weighing the risks and benefits of treating older women with breast cancer. Limited data suggest that ADL disability may...
be associated with inferior treatment response. In non–breast cancer studies (i.e., non–small cell lung cancer, acute leukemia), IADL disability has been associated with decreased survival. Additional short survey measures, such as the Vulnerable Elders Survey 13 (VES-13), which includes self-reported items on health, ADL, and mobility, are being investigated in older adults with cancer and included for consideration in the NCCN Clinical Practice Guidelines in Oncology: Senior Adult Oncology (to view the most recent version of these guidelines, visit the NCCN Web site at www.nccn.org).

In addition to self-reported functional status, objective measures of physical performance can provide an assessment of physical function that is free of patient or physician bias. Physical performance measures provide a quantitative and reproducible assessment of specific functional tasks, such as walking speed, lower extremity strength, or grip strength. These tests complement self-report functional assessment through detecting subclinical changes that may also predict morbidity and mortality.

Objective physical performance measures have been shown to predict hospitalizations, disability, and mortality in the ambulatory geriatric population. These measures include the Short Physical Performance Battery (SPPB), walking speed, standing balance, chair stands, the Timed Get Up and Go test, and isometric grip strength.

The Timed Get Up and Go test has been previously evaluated as part of a geriatric assessment feasibility study in older cancer patients. This test measures how many seconds it takes an individual to stand from a seated position, walk a distance of 10 feet, turn, walk back to the chair, and sit down again. The simplicity of this test makes it a practical choice for the clinical setting. Future research, including an ongoing multisite geriatric assessment study, will help determine the efficacy of this and other measures in predicting who is at increased risk for cancer treatment toxicity, thus facilitating its use in the clinical setting.

Currently no consensus exists about which physical function measures better predict outcomes and life expectancy for older women with breast cancer. Consensus guidelines, including those from NCCN, recommend ADL and IADL assessments in addition to oncology performance scales in making decisions about treatment. Ongoing and future prospective studies will help validate these measures and provide clinical cutoff scores to guide treatment decisions in older adults with cancer.

**Comorbidity**

Most older adults with breast cancer have comorbid medical illnesses that can affect breast cancer treatment. When making treatment decisions and weighing the impact of comorbid medical conditions, 2 main questions should be considered: 1) is the patient more likely to die of cancer or another comorbid condition, and 2) will the comorbid medical condition influence the patient’s ability to tolerate treatment and, if so, should treatment be modified?

**Is the Patient More Likely to Die of Cancer or Another Comorbid Condition?** To answer this question, an estimate of life expectancy must be weighed against the risk for cancer relapse during this projected life expectancy. Average life expectancy according to age and gender is summarized in Table 1. Comorbid medical conditions can further influence life expectancy within each age cohort. Several tools project the risk for mortality within a specific timeframe based on comorbid medical conditions. For example, Lee et al. developed a prognostic index of mortality risk over 4 years based on the variables of age, sex, comorbid medical conditions, and functional status.

Another tool commonly used is the Charlson Comorbidity Index, which ranks and compares comorbid medical conditions that increase the 1-year risk for mortality. A Charlson Comorbidity Index is also available that accounts for the impact of age in addition to comorbid conditions.

After getting an estimate of life expectancy, the next step is to weigh the risk for breast cancer mortality against mortality from other causes. Satariano and Ragland evaluated the risk of breast cancer–specific mortality versus mortality from another cause among

![Table 1 Life Expectancy by Age and Gender](image-url)
a cohort of patients with breast cancer. They found that breast cancer patients with 3 or more of 7 designated comorbid conditions had a 20 times higher mortality rate from causes other than breast cancer. Similar findings have been seen in other studies of older adults with early-stage hormone receptor–positive breast cancer, in whom most deaths occur from causes other than breast cancer.  

On the other hand, among patients with high-risk breast cancer, the danger of death from breast cancer is likely to outweigh that from the other comorbid condition. This is best illustrated by a recent randomized trial of poly- versus single-agent adjuvant chemotherapy for older adults with breast cancer. Most participants had node-positive breast cancer or a tumor size greater than 2 cm. With a short follow-up of 2.4 years, polychemotherapy was associated with a decreased risk for relapse and mortality from breast cancer, highlighting the importance of considering adjuvant treatment among patients with high-risk disease in whom breast cancer might limit life expectancy. In this situation, risk for breast cancer outweighed risk of dying from another comorbid disease.

Tools such as Adjuvant! Online have been developed, which incorporate breast cancer characteristics, age, and a general estimate of comorbidity (e.g., major medical problems, medical problems average for age, minor medical problems, perfect health). Together these data provide an estimate of the risk for dying from cancer versus another medical problem. However, this program has limitations. Because older adults have been underrepresented in breast cancer clinical trials, fewer data are available on the benefits of chemotherapy in adults aged 70 and older. In addition, because the impact or severity of specific medical problems are not considered in Adjuvant! Online, using a comorbidity index in addition may be useful in daily practice.

Will the Comorbid Medical Condition Influence the Patient’s Ability to Tolerate Treatment?: Among older adults with breast cancer, comorbidity is a better predictor of the toxicity risk from adjuvant chemotherapy than age alone. Hypertension was the most prevalent comorbid medical condition in a study of 1800 postmenopausal woman aged 55 or older and is a risk factor for anthracycline-induced cardiomyopathy. In addition, prior or concurrent use of antihypertensive medications is a risk factor for congestive heart failure among patients undergoing anthracycline- and trastuzumab-based adjuvant therapy.

Diabetes is another example of a common comorbid medical condition that can have a serious impact on breast cancer treatment. Patients with preexisting diabetes or glucose intolerance will be at increased risk for hyperglycemia secondary to steroids, which are commonly used as antiemetics or to prevent or treat chemotherapy allergic reactions. Patients with diabetes are also at risk for neuropathy, which may be exacerbated by neurotoxic chemotherapy drugs such as taxanes or vinca alkaloids.

Age-related changes in physiology can also affect the tolerance to cancer treatment. For example, age-related declines in renal function or insufficiency secondary to diabetes or another comorbid medical condition must be considered when dosing chemotherapy that is renally metabolized.

In summary, comorbid medical conditions and age-related changes in physiology can influence risk for toxicity, and the dosing and side effect profile of treatment.

Cognition
Impaired cognitive function is a common complaint among older women presenting for medical treatment, and the differential diagnosis of type and extent of cognitive impairment is an important consideration in treatment planning and prognosis. The main question is: does this patient have cognitive impairment, and if so, to what degree will this impairment affect decision-making capacity, compliance, and tolerance to treatment?

Cognitive disorders in older patients are undiagnosed without screening. One fifth of geriatric cancer patients have screened positively for cognitive disorders in an academic setting. An estimated 6% to 10% of people aged 65 years or older experience dementia. The prevalence increases to 25% to 48% in samples of community-living populations older than 80 years. The prevalence of early or mild cognitive impairment is estimated to be even higher.

Cognitive impairment is associated with an increased risk for progression to dementia, with progression rates of 10% to 15% per year compared with 1% to 2.5% in persons who are cognitively intact.

Cognitive disorders such as dementia limit life expectancy and have a major impact on cancer treatment. Cognitive disorders interfere with compliance to medications and consent to treatment and increase caregiver burden; it has been shown that
cognitively impaired persons receive less definitive cancer care than other patients.55,47,48

Over the past several years, investigators have prospectively studied the impact of breast cancer treatment on cognitive functioning, following up on complaints of memory changes and impaired concentration. Unfortunately, the data are still limited regarding the impact of adjuvant chemotherapy on an older person's cognition. In one longitudinal prospective study of older patients with breast cancer, 51% of 45 evaluable patients perceived a decline in cognitive function from prechemotherapy to 6 months postcompletion of chemotherapy.49 Other studies showed no significant change in Mini-Mental Status Examination (MMSE) scores after chemotherapy or hormonal therapy over a short period.52,50

In one longitudinal study, 28 older women with breast cancer who underwent adjuvant chemotherapy, underwent neuropsychological testing and a comprehensive geriatric assessment (CGA) before therapy and 6 months after completion of chemotherapy.51 At 6 months, 39% of patients had an increase in the number of scores 2 standard deviations below normative data compared with their baseline neuropsychological test scores,51 but exploratory analyses of longitudinal CGA results showed no changes in functional status, comorbidity, or depression scores.52 At the same time, one population-based study suggests that women with breast cancer who undergo chemotherapy have a higher likelihood of developing dementia after long-term follow-up.46 More prospective, long-term, larger studies are necessary to definitively assess the impact of breast cancer treatment on the cognitive function of older patients.

Clinical suspicion of dementia is not as sensitive as available screening tools.53 A CGA cognitive assessment tool for older patients with breast cancer should be used to screen for baseline impairment and to follow effects of therapy on cognitive functioning. Cognitive screening tools include the Blessed Dementia Rating Scale,44 MMSE,51 Mini-Cog,56 and Short Portable Mental Status Questionnaire.57 The purpose of screening is to assess cognitive capacity and stratify risk; abnormal scores should trigger a comprehensive workup with cognitive specialists. Unfortunately, these tools have not yet shown the ability to detect changes in cognition due to treatment, and a more detailed neuropsychological evaluation is needed to accomplish this goal.49

Polypharmacy
Age-related changes in physiology can influence the pharmacodynamics and pharmacokinetics of cancer-related drugs, thus affecting efficacy and toxicity.55,59 Predicting drug efficacy and tolerance is even more complicated because of the high prevalence of polypharmacy in this population.60,61 Key clinical conditions to consider include 1) is the patient on any medications that have a high risk for adverse events in older adults, 2) can this medication be substituted for a safer alternative or discontinued, and 3) will any medications the patient is currently taking interact with those prescribed for cancer.

Studies of older adults with cancer report that the average number of medications ranges from 4 to 9, depending on the population sampled.60–63 One study of 105 patients aged 70 years or older, including a large proportion of breast cancer patients, reported 74% taking 3 or more medications.64 This number likely increases in patients undergoing chemotherapy.61

Polypharmacy is associated with adverse drug reactions, increased risk for drug–drug interactions, and decreased compliance with medications.60 These risks are particularly important considerations in older adults who are challenged with chemotherapy treatments. No evidence-based guidelines are available for evaluating and managing polypharmacy in older adults undergoing cancer therapy. Practical recommendations include a careful review of the medication list before initiation of cancer treatment. Unnecessary or potentially inappropriate medications should be discontinued if possible. Consensus guidelines for medications that carry a high risk for toxicity in older adults, such as the Beers list, may be helpful in identifying and discontinuing potentially harmful medications.66 Finally, potential or existing drug–drug interactions should be reviewed. These simple measures may improve compliance, tolerance, and efficacy of treatments.

Nutritional Assessment
Nutritional status plays a major role in the overall prognosis for older adults; in the general geriatric population, late-life weight loss has been associated with increased mortality.68 Undernutrition in older adults at cancer diagnosis influences tolerance to therapy and response to treatment. The key clinical questions to be addressed in an oncology consultation include 1) does the patient have evidence of impaired nutritional status, and 2) can a nutritional consult help find the cause (e.g., lack of access to food, poorly
fitting dentures, cancer/chemotherapy-related symptoms) and implement interventions to prevent or reverse nutritional decline?

Weight loss before diagnosis or treatment has been associated with poor outcomes in multiple tumor types. An analysis of 3047 patients enrolled in ECOG chemotherapy trials showed a negative association between weight loss before chemotherapy and survival. In the breast cancer subset, an association between weight loss and decreased chemotherapy response was also noted.

Data on the prognostic significance of nutritional status in older patients with breast cancer are limited. However, small geriatric assessment studies have shown that assessment of nutritional status can detect impairments in some older adults. In one study of older cancer patients, 60% with breast cancer, weight loss greater than 10% occurring 3 months before diagnosis was reported in 7% of patients. Approximately 14% had a body mass index (BMI) less than 18.5 kg/m², suggesting undernutrition.

Various measures can be used to screen for impaired nutritional status, including self-reported weight loss before treatment and calculation of BMI. The Mini-Nutritional Assessment (MNA) has been validated in elderly populations and piloted in older adults with breast cancer. This tool includes anthropometric measurements; questions related to lifestyle, mobility, and medications; a brief dietary questionnaire; and self-perception of health and nutrition. It takes approximately 10 minutes to perform and has detected nutritional risk in 8 of 15 older patients with breast cancer. Larger studies will be needed to determine if tools such as the MNA add prognostic information to practical markers of frailty, such as self-reported weight loss and low BMI.

**Psychological State**
Distress related to cancer is defined as a “multifactorial, unpleasant emotional experience of a psychological (cognitive, emotional), social, or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment.” Older adults with cancer reportedly experience similar or less distress than younger adults. However, socially isolated patients are most vulnerable to the impact of distress, which frequently goes unrecognized. The key clinical questions include: 1) are there screening tools that help identify older adults with cancer who are distressed; 2) what is the cause of the distress, and will it interfere with the patient’s ability to successfully complete treatment; and 3) how can we help the older adult with cancer to better handle distress?

Several screening tools can be used to evaluate distress. The NCCN guidelines endorse a simple distress thermometer, which consists of a single question asking the patient to characterize their level of distress on a scale of 0 to 10. A score of 4 or greater on the distress thermometer correlates with scores on other standardized depression scales and warrants further evaluation.

Distress is a term that encompasses various psychological states, including depression, and is associated with several adverse clinical outcomes, including functional decline, a need for informal caregiving, and increased use of healthcare resources. Screening tools include the Geriatric Depression Scale and Hospital Anxiety and Depression Scale. However, these scales have not been specifically developed for older adults with cancer, in whom the typical symptoms of depression may be confounded by tumor- and treatment-related symptoms. In a busy oncology practice where time is limited, the single question “do you often feel sad and depressed?” may be an adequate screen. Others have reported, however, that this simplified method may miss a significant proportion of patients who are depressed.

**Financial Considerations and Social Support**
Evaluation of social support should address both economic and social barriers to treatment. The questions to consider include 1) what are the financial and social barriers that could compromise cancer care in this older patient, and 2) can these barriers be overcome or mediated before the initiation of treatment?

Cancer care is expensive. Older patients with Medicare face significant out-of-pocket treatment costs. Medicare coverage has significant gaps in payment for health care, including private nursing, physical therapy or rehabilitation, transportation, dental care, eyeglasses, and hearing aids. These services are often necessary for adequate cancer care, but can be prohibitively expensive for some older patients. Even with the creation of Medicare Part D, many older persons pay for medications out-of-pocket because prescription drug coverage, including for drugs for supportive care such as pain management and nausea

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Table 2  Geriatric Assessment Domains and Measures

<table>
<thead>
<tr>
<th>Domain</th>
<th>Possible Measures</th>
<th>Predictive Value</th>
<th>Numbers of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical function</td>
<td>Activities of Daily Living (ADL)</td>
<td>Predicts institutionalization and mortality in geriatric populations</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Instrumental Activities of Daily Living (IADL)</td>
<td>Predicts survival in selected small studies of older cancer patients</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Vulnerable Elders Survey</td>
<td>Predicts mortality and functional decline in geriatric populations</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Get Up and Go Test</td>
<td>Correlates with ability to transfer independently</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Short Physical Performance Battery</td>
<td>Predicts future disability and mortality in geriatric populations</td>
<td>5</td>
</tr>
<tr>
<td>Comorbidity</td>
<td>Charlson Comorbidity Scale</td>
<td>Analyzes 1-year risk for mortality; age-adjusted index is available</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Lee Prognostic Index</td>
<td>Analyzes 4-year risk for mortality (includes age, sex, comorbid medical conditions, and functional status)</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Adult Comorbidity Evaluation-27 (ACE-27)</td>
<td>Analyzes the impact of comorbidity in patients with cancer</td>
<td>27</td>
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<tr>
<td>Cognition</td>
<td>Mini-Mental State Examination</td>
<td>All are screening tools for cognitive impairment and have been associated with dementia and increased morbidity and mortality in community-dwelling samples</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Blessed Orientation-Memory-Concentration (OMC) Test</td>
<td>Associated with impaired survival in cancer patients</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Short Portable Mental Status Questionnaire (SPMC)</td>
<td>Associated with mortality in community-dwelling older populations</td>
<td>10</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Self-reported weight loss</td>
<td>Associated with impaired survival in cancer patients</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Body Mass Index (BMI)</td>
<td>&lt; 18.5 kg/m² cutoff per WHO</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Mini-Nutritional Assessment (MNA)</td>
<td>Predictive of mortality in hospitalized elders</td>
<td>18</td>
</tr>
<tr>
<td>Psychological state</td>
<td>Distress Thermometer</td>
<td>High concordance between scores on the Distress Thermometer and the Hospital Anxiety and Depression Scale Cutoff score of 4 had the greatest sensitivity and specificity when compared with the Center for Epidemiological Studies Depression scale Patients with cancer who scored ≥ 4 on the Distress Thermometer were more likely to also report physical, emotional, practical, and family problems</td>
<td>1</td>
</tr>
<tr>
<td>Social support</td>
<td>MOS Social Support Survey: Tangible Subscales</td>
<td>Tangible subscale measures access to material aid or behavioral assistance and emotional/information subscales measure the expression of positive affect and empathetic understanding; the offering of advice, information, guidance, or feedback</td>
<td>20</td>
</tr>
<tr>
<td>Geriatric syndromes</td>
<td>Incontinence</td>
<td>No comprehensive tool exists, but questions to ask include frequency and severity of syndromes that are not assessed within other measures of the comprehensive geriatric assessment</td>
<td></td>
</tr>
</tbody>
</table>
control, are not always fully covered. In addition, older adults with limited fixed incomes may forego medications, such as antinausea or pain medications, if faced with an either/or decision between an anticancer drug and supportive medications. \(^6\)

Caregivers of older persons with cancer are also an important consideration, \(^6\) because the presence or absence of social support can influence the care an older person with breast cancer receives. \(^9\) For example, unmarried women with breast cancer are less likely to receive definitive treatment. \(^9\) Older persons who do not have an appropriate and easily accessed social support system may have more difficulty psychologically and emotionally with their cancer diagnosis. \(^9\) Several studies in older breast cancer patients have noted that poor social support correlates with adverse health outcomes. Low social support is also independently associated with decreased satisfaction and poor psychosocial outcomes after breast cancer treatment. \(^9\) In the Nurses’ Health Study, socially isolated women had a 66% increased risk for all-cause mortality and a twofold increased risk for breast cancer-specific mortality when adjusting for significant covariates, including stage of disease. \(^8\) Poor social support is also linked to medical adherence. \(^8\) Aspects of social function include social network (social relationships and contacts), social support (provision of assistance by network), subjective well-being, and social resources (income, assets, housing). These all independently affect complex cancer decisions and influence cancer care. \(^6\)

A geriatric assessment should include a comprehensive assessment of the patient’s financial needs to recognize and address barriers to effective and safe treatment. Evaluation of social support and financial barriers is essential in devising strategies for appropriate care, recognizing potential problems/needs early, and initiating preventative intervention. \(^5\) A social worker with a background in aging can be an invaluable resource in identifying community and financial resources to help meet the patient’s needs.

Geriatric Assessment of Breast Cancer

Geriatric Syndromes: Problems Common to Older Adults

Many of the most common conditions that geriatricians treat, including delirium, falls, frailty, dizziness, and urinary incontinence, are classified as geriatric syndromes. The term geriatric syndrome is used to capture clinical conditions that do not fit into discrete disease categories. \(^7\) However, the concept of geriatric syndromes remains poorly defined. These syndromes, prevalent among older and frailer individuals, have multifactorial causes and an adverse impact on health outcomes. Risk factors for the development of geriatric syndromes include older age, baseline cognitive impairment, baseline functional impairment, and impaired mobility. \(^7\)

Koroukian et al. \(^6\) evaluated 952 older patients with breast cancer and found that 35% had at least 1 geriatric syndrome at diagnosis. Geriatric syndromes were also found to be prevalent in hospitalized older patients with cancer. \(^9\) In older populations, the presence of geriatric syndromes predicts further functional decline, hospitalizations, and mortality. \(^9\) More research is needed to understand the impact of geriatric syndromes individually or together on the outcomes of older women with breast cancer. \(^10\)

Conclusions

Most breast cancers occur in older adults. Factors other than chronologic age, which are addressed in a geriatric assessment, independently predict morbidity and mortality and can alter the spectrum of cancer care from diagnosis to treatment to outcome.

This article discusses the standard components of a geriatric assessment and highlight screening tools that can be used in daily practice to measure each domain (Table 2). Further research is needed to identify which domains most effectively predict morbidity and mortality among older adults with breast cancer, answer specific questions within each domain, and develop interventions that will help vulnerable older adults with breast cancer receive quality care. Further study that integrates geriatric and oncology care principles should provide the necessary guidelines.

References


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