EUROPEAN JOURNAL OF CANCER 43 (2007) 2141–2143

available at www.sciencedirect.com

ScienceDirect

journal homepage: www.ejconline.com

Editorial Comment

About geriatric oncology

*Matti Aapro**

International Society for Geriatric Oncology (SIOG), 1 route du Muids, 1272 Genolier, Switzerland

ARTICLE INFO

Article history:
Received 6 August 2007
Accepted 7 August 2007

What is this relatively new field called geriatric oncology? One should admit that it is the long overdue development of the need for specialised care of those who, as age advances, suffer from both ailments related to senescence and to cancer. It is an area of medicine where the expertise of the geriatrician encounters that of the oncologist (often understood as the medical oncologist), and where much progress needs to be made. This special issue of the European Journal of Cancer summarises many of these recent developments. Geriatric oncology is not the mirror image of paediatric oncology, even if it is obvious that the name of the society that represents this field is inspired by that of SIOP, the Société Internationale d'Oncologie Pédiatrique, where Gériatrique is used to give the acronym SIOG, which translates into International Society for Geriatric Oncology. Geriatric.oncology discussions are complex, as they go beyond the specific 'case-discussion' to look at issues of society, preventative medicine, early detection and treatment (with surgery, radiation and drug therapy, rehabilitation, supportive and palliative care questions often intertwined). The geriatric oncology decision making process also takes into account the variable reality of family or community support, which is so different among the many cultures and their present changes in a world which moves very fast, faster than most elderly (and not so elderly) people can apprehend. This clinical debate should happen in multidisciplinary team discussions, following various clinical models that need to reflect the possibilities given by the framework of the national health service systems that govern the delivery of medical care in each country.

Before we continue this foreword, let us reflect on who is actually called an elderly person. Regulatory authorities have defined this person as anyone above pension age, fixed in many countries at age 65, a few years after the German chancellor Otto von Bismarck suggested to Emperor Wilhelm II of Prussia to create a pension plan, for those aged 70 or more. We all know that this artificial age limit is useful for bureaucracy, but it cannot reflect the reality of aging. Elderly people are diverse, with some aging harmoniously and others suffering from premature loss of function, from more or less severe comorbidities which can affect their expected survival or their ability to cope with a cancer, or the stresses imposed by various treatments for the cancer. This latter question will often lead to treatment plans that will put supportive or palliative measurers to the forefront, sometimes leading to a decision to abandon a curative cancer treatment plan, which might be futile in view of the reduced life expectancy of the patient related to another disease.

The field of cancer treatment only realised the need to address these questions specifically in the 1980s when Rosemary Yancik, epidemiologist at the National Cancer Institute (USA), attracted our attention to the growing number of elderly patients with cancer. One should also realise that while the proportion of elderly patients is high in the 'developed world', the number of these patients is much bigger in areas with restricted resources. In Europe, Silvio Monfardini from Italy, and in North America, Lodovico Balducci, also an Italian, were among the first clinicians to react and to take action, leading a field which has since then started to move forward, albeit much too slowly. We still remember in the early 1990s

* Tel.: +41 22 366 9106; fax: +41 22 366 9131.
E-mail address: maapro@genolier.net.

doi:10.1016/j.ejca.2007.08.010

when distinguished department heads and other eminent professors dismissed the need for such a specialised approach, simply stating that of course they knew how to approach an elderly patient and provide optimal care. Geriatric oncology is a wider and much more complex field compared to paediatric oncology, and will need many more years before reaching maturity. Among others who paved the way for the development of a rational approach towards cancer in the elderly, let us cite Byrl J. Kennedy ('BJ'), who was not only one of the 'founding fathers' of ASCO (American Society for Clinical Oncology), but was also a key figure in geriatric oncology. One should note here that ASCO has attached his name to the prize for geriatric oncology, which was attributed for the first time in 2007. The first recipient was Lodovico Balducci, whose leadership has allowed the worldwide development of this field, and who contributed greatly to the establishment of the International Society for Geriatric Oncology (SIOG).

Oncologists are now learning to take into account the physiologic age of their patient, which is the reflection of a normal and sometimes abnormally accelerated loss of body reserves, certainly related to chronological age but not precisely dictated by it. This understanding is called the comprehensive geriatric assessment, a concept which needs to be adapted to the various cancers and their treatment. Understanding the biology of cancers, which can be quite different in some, but not all, elderly patients, is another challenge for which modern diagnostic tools offer hope. Indeed, in some elderly patients some cancers will be less aggressive (the classic example being the high prevalence of endocrine-responsive breast cancer in the elderly), while others are more aggressive (like brain tumours).

But as oncologists learn the realities related to the treatment of the elderly with cancer, many others have to learn that these treatments can be adapted to the elderly person, and provide considerable benefit, as discussed by the many papers in this issue of EJC. General practitioners and others who should refer an elderly cancer patient to the specialised team need to know that age is not a determinant of 'benign tumour behaviour', and that cancer treatments are not synonymous of undue hardship imposed on their patient who would die anyway from another competing cause of mortality. Unfortunately, many elderly patients will present with advanced disease, as early detection programmes exclude them, and the public is not educated about the signs and symptoms that should alert one to the possibility of a cancer. Then when the elderly person finally comes to a hospital, many reasons will be put forward to modify the treatment or deny it, while if this person comes in with a hip fracture, the surgery is performed immediately. Radiation therapy can have its challenges, and sometimes there is a temptation to use less treatment in the elderly. But has the patient been asked if he or she accepts a higher risk of local relapse? And while adjuvant cancer treatment is yet to be accepted and codified in the elderly, one assists to a remarkable exercise of schizophrenic thinking about chemotherapy, where lymphoma experts feel that anthracyclines are part of curative treatment in the elderly and breast cancer experts debate about the potential for cardiac insufficiency related to these drugs. Treatment proposals should be made on the basis of objective evidence based reasoning, and the subjective and sometimes highly emotional discussions are understandably part of the patient's reactions.

FURTHER READING

1. Aapro M, Bennett J, Broxmeyer H, et al. Promises and challenges of oncology and hematology, including geriatric oncology. *Crit Rev Oncol Hematol* 2004;**50**:1–2.
2. Aapro MS, Kohne CH, Cohen HJ, Extermann M. Never too old? Age should not be a barrier to enrollment in cancer clinical trials. *Oncologist* 2005;**10**:198–204.
3. Audisio RA, Bozzetti F, Gennari R, et al. The surgical management of elderly cancer patients; recommendations of the SIOG surgical task force. *Eur J Cancer* 2004;**40**:926–38.
4. Audisio RA, Zbar AP, Jaklitsch MT. Surgical management of oncogeriatric patients. *J Clin Oncol* 2007;**25**:1924–9.
5. Balducci L, Extermann M. Management of cancer in the older person: a practical approach. *Oncologist* 2000;**5**:224–37.
6. Balducci L, Extermann M. Management of the frail person with advanced cancer. *Crit Rev Oncol Hematol* 2000;**33**:143–8.
7. Balducci L, Aapro M. Epidemiology of cancer and aging. *Cancer Treat Res* 2005;**124**:1–15.
8. Blower P, de Wit R, Goodin S, Aapro M. Drug-drug interactions in oncology: why are they important and can they be minimized? *Crit Rev Oncol Hematol* 2005;**55**:117–42.
9. Castiglione M, Gelber RD, Goldhirsch A. Adjuvant systemic therapy for breast cancer in the elderly: competing causes of mortality. International Breast Cancer Study Group. *J Clin Oncol* 1990;**8**(3):519–26.
10. Extermann M, Aapro M, Bernabei R, et al. Use of comprehensive geriatric assessment in older cancer patients: recommendations from the task force on CGA of the International Society of Geriatric Oncology (SIOG). *Crit Rev Oncol Hematol* 2005;**55**(3):241–52.
11. Fentiman IS, Tirelli U, Monfardini S, et al. Cancer in the elderly: why so badly treated? *Lancet* 1990;**335**:1020–2.
12. Horiot J-C. Radiation therapy and the geriatric oncology patient. *J Clin Oncol* 2007;**25**:1930–5.
13. Kennedy BJ. Aging and cancer. *J Clin Oncol* 1988;**6**:1903–11.
14. Launay-Vacher V, Chatelut E, Lichtman S, Wildiers H, Steer C, Aapro M. Renal insufficiency in elderly cancer patients: International Society of Geriatric Oncology clinical practice recommendations, Annals of Oncology 2007, in press, doi:10.1093/annonc/mdm011.
15. Lichtman SM, Wildiers H, Launay-Vacher V, Steer C, Chatelut M, Aapro M. International Society of Geriatric Oncology (SIOG) recommendations for the adjustment of dosing in elderly cancer patients with renal insufficiency. *Eur J Cancer* 2007;**43**:14–34.
16. Lichtman SM, Wildiers H, Chatelut E, et al. International Society of Geriatric Oncology Chemotherapy Taskforce: evaluation of chemotherapy in older patients—an analysis of the medical literature. *J Clin Oncol* 2007;**25**:1832–43.
17. Lichtman SM, Balducci L, Aapro M. Geriatric oncology: a field coming of age. *J Clin Oncol* 2007;**25**:1821–3.
18. Monfardini S, Chabner B. Joint NCI-EORTC consensus meeting on neoplasia in the elderly. *Eur J Cancer* 1991;**27**:653–4.
19. Monfardini S, Aapro M, Ferrucci L, Zagonel V, Scalliet P, Fentiman I. Commission of the European Communities Europe Against Cancer Programme. European school of oncology advisory report. Cancer treatment in the elderly. *Eur J Cancer* 1993;**29A**(16):2325–30.
20. Monfardini S, Aapro MS, Bennett JM, et al. Organization of the clinical activity of geriatric oncology: report of a SIOG (International Society of Geriatric Oncology) task force. *Crit Rev Oncol Hematol* 2007;**62**:62–73.

21. Repetto L, Biganzoli L, Koehne CH, et al. EORTC Cancer in the Elderly Task Force guidelines for the use of colony stimulating factors in elderly patients with cancer. *Eur J Cancer* 2003;**39**:2264–72.
22. Surbone A, Kagawa-Singer M, Terret C, Baider L. The illness trajectory of elderly cancer patients across cultures: SIOG position paper. *Ann Oncol* 2007;**18**:633–8.
23. Tirelli U, Aapro M, Obrist R, et al. Cancer treatment and old people. *Lancet* 1991;**338**:114.
24. The International Society of Geriatric Oncology: Cancer World. www.cancerworld.org/siog.
25. Yancik R, Carbone PP, et al. *Perspectives on prevention and treatment of cancer in the elderly*. New York: Raven Press; 1983.