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# Contribution of the geriatrician to the management of cancer in older patients

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## ABSTRACT

With an increasingly aged population, many patients will present with cancer in their 80s and 90s. Although some may be very fit, frail individuals will require the input of geriatricians to aid in the assessment of co-existing morbidity, in an attempt to assess those most likely to benefit from active treatment of their cancer, and those in whom the 'giants of geriatric medicine' require special consideration before undergoing definitive cancer therapy. The role of the geriatrician in assessment and management of such patients, together with communication and end of life care, may be more important in ensuring a good quality of life, than the cancer therapy itself.

Whilst numbers of geriatricians will not be adequate to care for all elderly patients with cancer, a variety of assessment scales will help target financial and manpower resources to those most at risk.

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## 1. Introduction

The marriage between a geriatrician and an oncologist, or a surgeon, is a relatively new relationship, still within its honeymoon period. Geriatric medicine began in the UK, following the work of Marjory Warren, in identifying the needs of older people in long term care facilities. Oncology has evolved due to new and emerging technologies in the detection and management of cancer. The issue of cancer in older people was identified by Begg and Carbone in 1983 and a variety of individuals and organisations, including the European Society of Surgical Oncology and International Society of Geriatric Oncology, have highlighted the need for the further development of the relationship.<sup>1</sup> Meetings in the early 1990s were poorly attended by geriatricians, but this is no longer the case, indicating the changing clinical and research agenda.<sup>2</sup>

The geriatrician must be involved from the diagnosis of a malignant condition in an older person, through to palliative

and end of life care that many patients will subsequently require. Along the way they must act as an advocate and attempt to avoid collusion, both by healthcare professionals and relatives, act as experts on normal ageing, and facilitate the pre-treatment assessment of older individuals. The geriatrician's expertise in the 'giants of geriatric medicine' and rehabilitation will be vital during and after therapy and if therapy is palliative, or if the cancer reoccurs, the experience of the geriatrician in palliative care for older patients in a variety of settings may be required.

The links between Oncology and Geriatric medicine, although relatively new, have emerged due to the increasing realisation, particularly by the former group, that without both formal and informal input, the speciality of Geriatric Oncology cannot progress and that patients will suffer in the long term. What is still uncertain is whether the research and clinical agenda will progress in parallel or whether one will lead the other. At present the clinical agenda is

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providing questions for researchers, e.g. 'What is the evidence for colorectal screening in older people?', rather than the evidence for randomised controlled trials guiding clinical practice.

## 2. Advocacy

'To publicly support or suggest an idea, development or way of doing something'

Whilst some patients will require a geriatrician as an advocate, this is not a universal finding. The role of medical, nursing or non-professional advocates is controversial, and whilst it may be considered that family or friends can act as advocates, as well as surrogates, many older individuals have equally elderly family and friends, who may not feel that they are suitably trained or adequately experienced, for this role. There is considerable debate as to whether an advocate requires to be knowledgeable about the subject matter, or if a degree of ignorance allows new material to be evaluated. In some areas of cancer care, advocacy has focused particularly within certain groups associated with specific governmental views. This has resulted in biased information and had a negative effect on a patient's desire for such an intervention.<sup>3</sup> Clinicians may also have potentially negative attitudes towards self help groups and advocacy organisations and this has been identified as a potential factor in the under use of self help groups by patients.<sup>4</sup> Some patients may perceive self help groups as useful, although many decide not to attend meetings. Whilst older patients may verbalise a desire for a geriatrician to act as their advocate, a patient's beliefs before a life threatening diagnosis may be different to that expressed when an individual finds themselves with a limited life expectancy due to underlying morbidity. In a study of over 500 fit individuals, 41% stated that an 80 year old who chose not to be investigated with mammography was irresponsible, two-thirds said they wanted to be tested for cancer even if nothing could be done, and 73% would prefer to undergo a total body CT scan, rather than receive US\$1000 in cash.<sup>5</sup> In contrast, however, a study of 125 people  $\geq 60$  years, with limited life expectancy due to congestive heart failure, chronic obstructive pulmonary disease or cancer, the willingness to accept life sustaining treatment (WALT) was significantly associated with age, ethnicity and functional impairments.<sup>6</sup>

Geriatricians must therefore remember that a patient's desire for therapy after a diagnosis of cancer is not always predictable, and may differ from the views expressed prior to this diagnosis.

The intensive care unit (ICU) provides a model for decision making, when a patient lacks both decision making capacity and the presence of a surrogate decision-maker. In a study of 303 ICU admissions, 49 (16%) lacked both decision making capacity and a surrogate during their entire ICU stay. When compared with other ICU patients, they were more likely to be male, white and  $\geq 65$  years (29% versus 13%  $p = 0.007$ ).<sup>7</sup> A geriatrician may need to act as an advocate during certain treatment decisions, and will invariably have to act in some difficult end of life decisions if and when older patients lack surrogates.

## 3. Ageist attitudes and collusion

As a specialty, Geriatric medicine has never been as popular for nurses and doctors as Paediatrics. Despite this and the public's clear choice to support charities involved with children or animals above those involved with older people, geriatric medicine has survived and indeed is thriving as a specialty. In the past, paediatricians have worked hard to develop paediatrics as an area of medicine that focused on one specific age group and then diversified into various sub-groups, neonatology, development and community services. Geriatric medicine has fought using the same evidence that specialisation based on age as well as identified need results in better outcome for that particular patient group. This has been seen particularly in oncology for children. Early progress in this area was hampered by the lack of clinical trials, slow acceptance that this group of patients was biologically different, and a poor evidence base. This form of ageism must not occur in older people with cancer.

Ajaj et al. recruited elderly patients from day hospitals and outpatient clinics and asked their opinion on the quantity and type of information that they would wish to receive in the event of a diagnosis of cancer being made. In the group of 270 patients (mean age 79.9 years) 88% wanted to be informed of the diagnosis. Those aged over 75 were more likely to not want to be informed and when considering those who wished to be informed 62% wanted to know as much as possible about their cancer.<sup>8</sup> Although researchers have reported that relatives of older people with cancer do not wish them to be informed, in this study, 72% of elderly respondents did want their relatives to be informed if a diagnosis of cancer was made in the respondent. Living alone or with a partner had no effect on attitude towards the receipt of the cancer diagnosis. It must be remembered that some patients do not wish their family to know their underlying diagnosis. These UK findings are similar to those in other areas of Europe. In a study of 630 younger individuals attending health care centres in Turkey, 84% of participants wanted to be informed if they were diagnosed with cancer and this proportion increased in those with a higher educational level. However, only 63% of participants wished their diagnosis to be shared with their relatives.<sup>9</sup> Any clinician dealing with the diagnosis of cancer in an older individual must be realistic, provide the patient with the opportunity to ask questions and acknowledge them as an individual when discussing prognosis. Doctor's behaviours that were rated the most 'hope giving' included offering the most up to date treatment (90%), appearing to know all there is to know about the patient's cancer (87%) and saying that pain would be controlled (87%).<sup>10</sup>

Unfortunately when older patients are diagnosed with cancer, there is an attitude prevalent among some families that 'non-disclosure' should occur. A study of relatives of 150 patients who had recently been diagnosed with cancer found that 66% of the relatives did not want the diagnosis to be disclosed. Relatives were more likely to have a 'do not tell' attitude if the patient was male, had a diagnosis of a non-breast malignancy, the presence of stage IV disease, when the patient did not request disclosure or when the relative either had insufficient knowledge about cancer, or had a

strong religious belief.<sup>11</sup> Collusion not only harms patients but also the involvement of health care professionals, results in impaired nurse/patient relationship and deterioration in clinical practice.<sup>12</sup> Predictably the disclosure of the diagnosis of cancer does affect the quality of life when measured by the EORTC QLQ-C30 questionnaire. Following the disclosure of a diagnosis of lung cancer deterioration in arm pain, physical functioning, role functioning and both emotional and social functioning occurred, whereas the patient's own assessment of global quality of life did not show a deterioration.<sup>13</sup> This provides further evidence of the importance of psychological support at the time of diagnosis. Older patients with cancer who present in a variety of ways to elderly care units will often have the diagnosis and prognosis explained initially by the geriatrician, especially in advanced stage disease, when management is palliative. Clinicians must be reassured that despite their concerns about the psychological impact of discussing a poor prognosis with older patients, the majority of patients with advanced cancer have a good understanding of their diagnosis although many may not fully understand their prognosis. Although patients with deteriorating general health are more likely to be psychologically distressed it is not awareness of the prognosis per se that causes the depression.<sup>14</sup>

The geriatrician must attempt to stamp out ageist attitudes. The Royal College of Physicians' (RCP) audit of lung cancer management in the UK was carried out in 51 hospitals. The mean age of those investigated for suspected lung cancer was 69 years, however only 29% of men and 27% of women investigated were aged 75 years or above.<sup>15</sup> This suggested that many older individuals were not actively managed. The geriatrician must act in the older person's best interest and not intentionally or by neglect, fail to refer an elderly individual with a suspected tumour for definitive investigations.<sup>16</sup> The audit found that 12% of patients had not been told their diagnosis and in many cases, this was due to the family requesting that this did not happen.<sup>15</sup>

#### 4. Normal ageing

Geriatricians on the whole do not ask the age of the patient. Biological and chronological age seldom coincides and age per se should not be used as an excuse for therapeutic nihilism. Although gerontology and geriatric medicine are practised by different individuals, a knowledge of normal ageing, including pharmacokinetics and pharmacodynamics ensures drug safety, as well as the correct identification of pathology that may previously have been attributed to ageing. Whilst polypharmacy may be the result of good practice, there is little doubt that many patients are on too many drugs.<sup>17</sup> The geriatrician as part of a comprehensive review often reduces or stops drugs that interact or cause side effects.<sup>18</sup> Unfortunately some older patients are prescribed drugs with little evidence or evidence only derived in younger people. It must also be remembered that some older people have a limited life expectancy that makes legitimate the removal of drugs whose efficiency is only expected after five years on therapy.<sup>19</sup> Altered physiology may result in increased effects of radiotherapy, particularly to the mediastinum and

pulmonary tissue, impaired tissue healing and the coexistence of polypharmacy, which further increases the risk of adverse effects in this patient population.

#### 5. Assessment

One of the main roles of a geriatrician is the comprehensive assessment of acute and chronic diseases, in a range of settings.<sup>20</sup> This includes the diagnosis and treatment of acute illness presenting in the presence of comorbidity, and particularly the diagnosis of geriatric syndromes. Assessment is critical, as there is no such thing as a 'typical' 80 year old. The effect of premorbid state on the diagnosis and management of cancer is well described, and physical, social and psychological impairments, as well as the effect of gender, age, marital status, country and wealth, all impact on survival.

Since the majority of hospital admissions are individuals aged over 65 years, the geriatrician must focus on the most frail.<sup>21</sup> Geriatric Medicine service design around the world ranges from needs related, integrated, to age related admission criteria. Whilst each service has its advantages and disadvantages, most geriatricians would concur that the group that benefit most from their intervention is the very frail.<sup>22</sup> Across Europe the number of geriatricians serving a given population varies, but recommendations suggest three geriatricians per 125,000 population.

In contrast to other specialties, individuals requiring inpatient geriatric care are usually in their last two years of life and consuming the majority of their total life time health funding.<sup>23</sup>

There is no such thing as an ideal assessment score and those that are more familiar to geriatricians are either not used by oncologists, and/or not fit for purpose when considering the older person with cancer, or are too cumbersome for everyday clinical practice, particularly in the busy outpatient setting. Assessment scales need to provide clinicians with an indication of the patient's fitness to receive therapy, to help anticipate likely side effects of treatment and predict survival. Unfortunately, no one score has been found to serve this purpose.

Functional assessment scores particularly pertinent to the geriatrician include the Barthel Index (BI) and a variety of 'activities of daily living' dependency scores. The BI, first described in 1965, is an observational score, particularly useful in the assessment of patients following a stroke.<sup>24</sup> The initially derived score was 100, the more widely used form is of ten sections, scoring a total of 0–20. A score of four indicates total dependency with 20 being normal. Unfortunately, cognitive impairment, communication problems and delirium affect an individual's Barthel Index and therefore a premorbid score, dating from before the diagnosis of cancer, may be more important than that obtained at diagnosis. In addition, the BI has not been validated in cancer and is poorly sensitive to healthcare interventions.<sup>25–29</sup>

Activities of daily living dependency scales, including the Katz index, have been shown in individuals over 70 years of age to be a good discriminator of one year mortality, following hospital admission.<sup>30</sup> Whilst surgical assessment scales, such as Acute Physiology and Chronic Health Evaluation (APACHE

II) and Physiological and Operative Severity Score for the enUmeration of Mortality and Morbidity (POSSUM), are good predictors of intensive care unit morbidity and mortality, in a variety of patients undergoing surgery for malignant diseases, they do not predict which individual elderly patient will benefit most from which particular surgery. Comorbidity scores, including Geriatric Index of Comorbidity (GIC), Adult Comorbidity Evaluation (ASA-27), Cumulative Index Rating Scale for Geriatrics (CIRS-G) and the Charlson Index, all have their particular advantages and disadvantages (see Table 1).

The comprehensive geriatric assessment (CGA) is a collection of scoring systems that have been found to improve both mental health and functional status of patients, although its role in preventing mortality is unproven. As with any form of geriatric assessment, the CGA is of no value unless additional and specific therapy is targeted at potential or actual problems highlighted by the CGA. Comprehensive geriatric assessment in whatever form is the role of all geriatricians and therefore many would advocate its use before, during and after the diagnosis and management of a newly diagnosed patient with malignancy.<sup>31–33</sup> The CGA combines a variety of well validated assessments, covering physical, psychological and social needs. Therefore, unfortunately, due to its comprehensive nature, it is cumbersome and time consuming, and often abandoned due to fatigue in both patient

and clinician. Maas has critically described the role of geriatric assessment and its effect in oncology practice elsewhere in this edition.<sup>34</sup> As there is always going to be a mismatch in the number of geriatricians versus the number of elderly patients with cancer, a stepwise procedure that first identifies individuals with frailty is an appropriate method for targeting resources. Those identified as fit should be treated as individuals 20 years younger within the evidence base, and the frail elderly patient should undergo a more thorough multidisciplinary assessment. The latter group should have treatment adapted according to the presence of the geriatrics giants or syndromes.

## 6. The giants of geriatric medicine

Bernard Isaacs in 1976 described the giants of geriatric medicine (see Table 2).<sup>35</sup> He included incontinence, both faecal and urinary; impaired cognition, both delirium and dementia; impaired balance and falls, and impaired hearing and vision.

## 7. Cognition

Delirium is a transient, mental condition, which is characterised by global disorders of cognition and attention.<sup>36,37</sup> It is a common problem, particularly in those over 70 years of age,

**Table 1 – Assessment Scales used in older people with cancer**

	Description	Advantages	Disadvantages	Role in older cancer patients
Barthel Index	Observational, validated in stroke patients 0–20	Quick and easy. Patient or carer can complete	Limited in patients with cognitive/communication problems	Not validated in cancer patients
Karnofsky Performance Status	Validated in cancer patients 0–100	Patient or surrogate can complete	Not sensitive to change in patient status	Good in cancer especially young patients
Geriatric Index of Comorbidity (GIC)	Indication of presence of 15 common disorders	Good predictor of mortality	Determines the presence/absence of a condition but not its severity	Not validated in elderly cancer patients
Adult Co-morbidity Evaluation-27 (ACE-27)	Derived from Kaplan–Feinstein Index (KFI)	Good assessment of co-morbidity and its severity	Often cited when data has been retrospectively extracted—not prospectively obtained	Used in specific cancer types
Charlson Index (CI)	Presence or absence of co-morbidity	Predicts operative risk for both elective and emergency surgery. Good inter-rater reliability	Lacks the sensitivity of ACE-27	Good correlation of CI and CIRS-G
Cumulative Illness Rating Scale – Geriatric (CIRS-G)	Measures burden of physical illness. Quick and easy to perform	Validated in elderly people in residential care.	Lacks sensitivity	Has been used as a prognostic indicator in older lung cancer patients
Multi-dimensional Assessment for Cancer in the Elderly (MACE)	Assesses physical performance, co-morbidity and cognition. Includes Katz, Lawton and WHO activities scores	Comprehensive, covers areas pertinent to older people	Cumbersome, repetitive. Does not measure mood	Not specifically validated in this group of patients but likely to be useful as it is comprehensive
Comprehensive Geriatric Assessment (CGA)	Designed to identify co-morbidity which requires intervention	Comprehensive and long, but does have an abbreviated form	Time consuming	The most comprehensive and validated scoring system available



**Table 2 – The giants of geriatric medicine (geriatric syndromes) as described by Bernard Isaacs**

- Incontinence – faecal and urinary
- Instability and falls
- Impaired hearing and vision
- Intellectual decline – including both dementia and delirium

See Ref. [35].

and increases with acute illness and hospitalisation. The role of the geriatrician in the diagnosis and management of delirium, which occurs in 14–56% of hospitalised older adults, is well documented.<sup>38,39</sup> There are standard criteria for diagnosing and measuring delirium (DMS-IV), and this classification clearly distinguishes between delirium due to substance intoxication or withdrawal and that due to a general medical condition.<sup>40</sup>

It has been suggested that neurotransmitters are important in the pathophysiology of delirium. Acetylcholine deficiencies are seen in chronic cognitive decline, which pre-disposes to delirium, therefore supporting the cholinergic hypothesis.<sup>41,42</sup> Whilst prevention of delirium is important, even with a multifaceted strategy, it is commonplace. The role of the geriatrician in dealing with precipitating factors, such as biochemical abnormalities, hypoxia as a result of respiratory or cardiovascular disease, and neurological illness, is vital. The geriatrician has expertise in reducing polypharmacy, as well as managing delirium.<sup>43,44</sup> Local development of medication strategies to deal with delirium is essential; however it must be remembered that certain drugs such as haloperidol, which are suitable for younger individuals, result in extra-pyramidal side effects in older people, especially in high doses or following prolonged administration. Newer atypical anti-psychotic drugs are frequently used by geriatricians and include risperidone and quetiapine, which have fewer drug interactions and less extra-pyramidal effects. Risperidone is contraindicated in patients who have recently had a cerebrovascular event and the evidence for newer anti-psychotic medication in delirium is still essentially anecdotal.<sup>45–47</sup>

The early recognition and treatment of delirium reduce both morbidity and mortality. The role of Mental State Examination as part of the preoperative assessment of patients is described elsewhere and easy to use, well validated scoring systems, as described by Folstein, (see Table 3), should be in widespread use.<sup>48</sup>

Impaired balance and falls are common in older individuals and the coexistence of cognitive impairment increases not only the frequency of falls, but also diminishes the evidence base in the prevention of such events.<sup>49</sup> A multi-disciplinary assessment, including the identification of reversible risk factors and an evidence based intervention, reduces falls and fractures. It is however difficult to delineate which of the multi-disciplinary and multifaceted interventions is of greatest benefit. One in three patients over the age of 70 years falls each year and 10% of falls result in injuries. The co-administration of many of the drugs for the management of patients with malignant disease increases the risk of postural hypotension and peripheral neuropathy, which in turn increase fall rates. Hypercoagulable states are common in cancer and

**Table 3 – Mini mental state examination**

Mental assessment	Yes		
Knows age to within one year			
Knows the time of day to within one hour			
42 West Street-Check immediately registered, then at the end of test			
Knows month of year			
Can recall current year			
Name of place-Ask the type of place or the area of town			
Knows the date of birth			
Knows the year of first or second World War (1914–1918, 1939–1945)			
Knows the name of present monarch			
Can count backwards from 21 to 1	Score 8–10		No problems
Can remember address	Score 7		Problems likely
<b>Score = number of ticks out of 10</b>	<b>/10</b>	<b>Score 6 or less</b>	<b>Significant problems requires specialist assessment</b>

See Ref. [48].

result in thrombotic events, and as a result of this, many patients require formal anti-coagulation. This coupled with an increase in falls may result in subdural haematomas.

Tumours that metastasise to bones, such as lung, prostate and breast, are particularly common in older individuals. The presence of skeletal metastases in patients with coexisting falls increases the risk of pathological fractures.

The four main causes of blindness and visual disability in old age include cataract, macular degeneration, chronic simple (open angle) glaucoma and diabetic eye disease. Cataracts are the commonest reversible cause of visual loss, but until a patient has been reviewed for other co-existing diseases, the true severity of visual impairment may not be detected. Steroids often prescribed in cancer management are aetiologically linked to cataracts. Visual impairment due to cataracts should result in ophthalmological referral and surgery. Since surgery is generally performed under topical anaesthetic, it should be considered regardless of age or general health. Impaired vision results in poor understanding of written instructions and may impact on the older patient's ability to provide informed consent. Visual impairment prevents patients reading instructions, checking their temperature and reduces drug compliance. Impaired vision, in the presence of impaired manual dexterity due to a previous stroke or arthritis, increases the potential problems of managing urinary or faecal stomas. Impaired vision and physical disability affects transport to and from hospital, access to the building itself and the patient's ability to negotiate around clinical areas.

Whilst Thomas Edison, the inventor, found that his hearing difficulties helped him to concentrate without distraction, hearing impairment in many older people is not so well received. The everyday problems of having difficulty following conversation, particularly in a noisy or crowded environment, as well as poor relationships with family, friends and healthcare professionals are well documented. Social isolation, as well as anxiety and depression, often occurs. Approximately 16% of the adult population of the UK has hearing loss and when considering people aged 75–79 years, the prevalence rises to 80%. Presbycusis is the commonest cause of a bilateral sensorineural loss in old age. Wax is the commonest cause of conductive hearing loss and although the former is difficult to treat, the latter is certainly not.<sup>50–52</sup> Impaired hearing impacts on the older individual's ability to hear clinicians explaining therapy, offering therapeutic options and explaining risks of treatment. De Vries et al. describe 10 recommendations to improve the recall of information in the older cancer patients. These recommendations offer sensible advice, and include a variety of strategies to correct for sensory deficits, and could be equally appropriate for any geriatric medical clinic in both the hospital and community setting.<sup>53</sup>

The detection and management of both visual and hearing impairment in older people is 'everyday' clinical practice to a geriatrician.

## 8. Rehabilitation

It is the geriatrician's view that rehabilitation and geriatric medicine are inextricably intertwined. The comprehensive geriatric assessment is a core process, characterised by multi-disciplinary assessment and treatment. There is little doubt that the CGA delivered by the hospital based elderly care departments provides the best results.<sup>54</sup> Rehabilitation is a problem solving and educational process aimed at reducing the disability and handicap experienced by someone as a result of disease, always within the limitations imposed, both by the available resources and by the underlying disease.<sup>51</sup> All rehabilitation should be highly individualised and treat the whole person, rather than a part. In addition, the emphasis must be on functional abilities, including self care, mobility and leisure and have a wider vision than just hospital care. The role of the geriatrician is paramount since rehabilitation always requires a creative, problem solving approach, in which the patient works at the extremes of their physical and functional abilities. Geriatricians lead multi-disciplinary teams that identifies the patient's potential, is involved in rehabilitation goal setting and, together with therapists, ensure that reablement occurs and rehabilitation is structured, with regular reviews and subsequent readjustment of therapy and expected outcomes. The geriatrician provides the clinical assessment which identifies an impairment. This impairment is subsequently measured on a validated scale, prior to establishing rehabilitation goals. The geriatrician's mantra of 'rehabilitation starts on day one', ensures that as many older patients as possible have a sound assessment and analysis of problems, timely and efficacious interventions to remedy or modify impairments, disabilities and handicap and

subsequently there is an evaluation of progress and tailoring of the interventions as required.<sup>55,56</sup>

## 9. Palliative care

Many older patients die in hospital, either as a result of their cancer or from coexisting medical problem. There is evidence however that older people lack access to quality palliative care, and this is particularly those with non-malignant disease.<sup>57,58</sup> This may occur for a variety of reasons, some of which are avoidable. Whilst palliative care is usually practised as a terminal event, in many older individuals it becomes a very long drawn out process, particularly if the older individual has a chronic or slowly progressive illness.<sup>59</sup> In many older people it is difficult to predict the course of the illness and the prognosis of a variety of diseases and therefore the timing of delivery of palliative care needs may be difficult.<sup>60,61</sup>

The Liverpool Care of the Dying Pathway (LCP) was designed to transfer the hospice model of care into other care settings. Whilst there was initial scepticism that the LCP could be used outside the hospice setting, qualitative research has shown that this is not the case.<sup>62</sup> The LCP has also been well validated in older individuals, both in general elderly care wards and in stroke units. Personal experience has highlighted the need for the LCP, particularly in order to formalise the point in the clinical course of older people with cancer, when a decision is made that 'this patient is dying' and all therapy focuses on palliation. It ensures that pointless monitoring, such as the routine measurement of blood pressure, temperature and pulse, are discontinued; useless drugs are discontinued (e.g. antithrombotic prophylaxis, antihypertensives and intravenous fluids) and communication with patients and relatives is optimum. It also highlights the need for spiritual support, which for many older patients is important, even if their previous religious activities have been limited or non-existent.

Whilst a geriatrician will never replace the surgeon or oncologist in the management of cancer in the older patient, the role of the geriatrician remains crucial. Indeed, in the recently developed SIOG guidelines on the 'Treatment of the Elderly Colorectal Cancer Patient', the need for the input of the geriatrician in the assessment of patients with certain comorbidities is well described. Whilst many geriatricians may be frightened away from the management of the older patient with cancer, they can provide an excellent knowledge base around the management of co-morbidity in older patients, which will aid the oncologist, not only at the time of cancer diagnosis, but also during subsequent treatment, follow-up and even palliative care.<sup>63,64</sup> It is unfortunately clear that across Europe there are insufficient geriatricians to provide input to all patients with cancer. In the UK, approximately 1700 consultants in elderly care exist in a population of 61 million, of whom 16% are over the age of 65 years and of whom 50% will have a diagnosis of cancer. Clearly resources will be stretched with the geriatrician only able to support a small number of individuals. It must be remembered that the majority of older individuals are fit and healthy until the diagnosis of cancer, and therefore those with underlying comorbidity must be prioritised when resources are limited.

## Conflict of interest statement

None declared.

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