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## Editorial Comment

# The Elderly: Geriatric oncology finally deserving adequate attention

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This issue of the *European Journal of Cancer* contains two articles which demonstrate, if need be, that indeed geriatric oncology is a field coming of age.<sup>1</sup> The 'field' of geriatric oncology starts by arbitrary definition at age 65, as stated by regulatory authorities in the International Conference on Harmonisation (ICH) document E7 called 'Studies in support of geriatric populations'.<sup>2</sup> This limit is often attributed to a pension age of 65, set following the example started by Chancellor Otto von Bismarck in 1889, when Germany became the first nation in the world to adopt an old-age social insurance program. Actually, the pension age of 65 was set much later. Von Bismarck's initial plan was for age 70, when he himself was already 74.<sup>3</sup>

Medicine regulators in the late 20th century, in documents which clearly need some revision, indicated already in 1989<sup>4</sup> and 1993<sup>2</sup> that it is 'important, however, to seek patients in the older age range, 75 and above, to the extent possible. Protocols should not ordinarily include arbitrary upper age cutoffs. It is also important not to exclude unnecessarily patients with concomitant illnesses; it is only by observing such patients that drug-disease interactions can be detected. The older the population likely to use the drug, the more important it is to include the very old'. These documents do not address oncology, and indeed we still have limited data, if any, for most of the above mentioned situations. Clinical protocols continue to limit participation to

patients who are perfectly fit, ignoring the realities of aging. It is also important to realise that while one has some means to define 'fit elderly patients' who can participate in phase II and III studies,<sup>5</sup> one can also have surprises, in spite of a comprehensive geriatric assessment.<sup>6</sup> Evaluating the elderly and their limitations, related to their aging physiology or to drug interactions<sup>7</sup> is not easy, and while the paper by Hamberg et al.<sup>8</sup> contributes to our understanding of the use of cytotoxic agents in the elderly with breast cancer, it has the same limitations as other recent reviews.<sup>9,10</sup> The sad reality is that we continue to lack adequate studies addressing the limitations for use of surgery,<sup>11</sup> radiation therapy<sup>12</sup> and drugs in the patients with moderate to severe comorbidities, and in those above the age of 75–80. Extrapolation of data from younger to older patients is thus necessary, with all the uncertainties involved in such a process. One can only plead for the development of this needed prospective study database, and the International Society for Geriatric Oncology is one of the groups that helps the discussions in this sense ([www.cancer-world.org/siog](http://www.cancer-world.org/siog)), having suggested criteria for assessment of elderly patients and their frailty or not.<sup>13</sup> It is becoming urgent to address all geriatric oncology questions, as well written by Pasetto et al.,<sup>14</sup> who remind us that the incidence of most types of cancer is age-dependent and progressive population ageing is rapidly increasing the number of elderly

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people who need treatment for cancer. Elderly patients (which they define as older than 70 years) present particular characteristics that make the choice of the correct treatment more difficult. We agree with Pasetto et al. that these patients are often undertreated and largely underrepresented in cancer trials making the experimental evidence on this topic even weaker. The authors discuss in their very well documented paper the lack of appropriate Health-Related Quality of Life (HRQoL) end-points in clinical cancer research in the elderly.

The review by Pasetto et al. underlines the importance of studies on elderly QoL evaluation<sup>15,16</sup> and the need in future trials either to improve QoL assessment in this subcategory of patients undergoing treatment for cancer, or to find specific assessment tools to do it. The EORTC Quality of Life Group and the EORTC Cancer in the Elderly Task Force have joined efforts to undertake the development of an older person-specific module to supplement the EORTC QLQ-C30 in cancer patients aged 70 years and over.<sup>17</sup>

Assessment of HRQOL is now recognised as an essential endpoint of cancer clinical trials, and many standardised generic and disease site-specific instruments are available, yet little work has explored HRQOL in the older person with cancer. Some studies have shown that increasing age is associated with decreasing health and QOL<sup>18</sup> and differing expectations of QOL.<sup>19,20</sup> Improved psychological acceptance has a beneficial effect on QOL in elderly women,<sup>21</sup> and there is evidence that QOL is less affected by physical, mental and social health in older people than in younger people.<sup>22</sup> Collection of reference data on the EORTC QLQ-C30 has highlighted the need to take age into account when interpreting data because responses vary with age.<sup>23</sup> HRQOL in older people is a wide concept. Bowling et al.<sup>19</sup> found in a study of healthy older people, that important features include adequate incomes, family and community resources (to maintain social integration and to prevent loneliness), convenient, affordable, and accessible local facilities and transport (to maintain independence), security and safety. These observations suggest that HRQOL for older people should focus on more than mental and physical health and functioning. Some authors have developed age-specific questionnaires for use in non-cancer subjects, focusing on domains such as autonomy, pleasure, and self-realisation.<sup>20</sup> The Comprehensive Geriatric Assessment (CGA) scale is complex,<sup>13</sup> and the absence of validated instruments has led researchers to adapt other measures for frailty evaluation in recent publications.<sup>24–26</sup>

Management for elderly cancer patients worldwide is far from being optimal. A better organisation of the clinical activity in geriatric oncology should allow a better clinical practice and an optimal clinical research. Future plans should concentrate on the development of divisions, units or departments of geriatric oncology in all major hospitals.<sup>27</sup>

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