



Navigating Cancer Care with Older Adults

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Disclosures

- No financial relationships with commercial interests to disclose



Learning Objectives

- Describe aging demographics
- Consider the impact of cognitive function on patient and provider decision making
- Review expected survival in older adults
- Discuss role of functional assessment
- Describe challenges of older adults navigating health care system

Q1: Which age group is the fastest growing in the US?

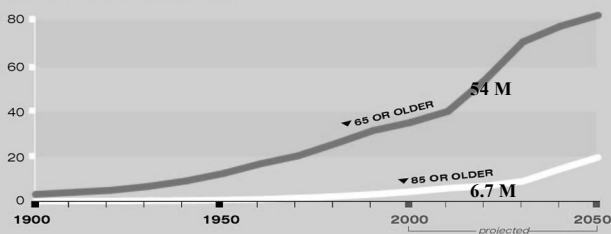
- A. Infants age 0-2
- B. Middle age 40-60
- C. Age 65+
- D. Age 85+

Demographic Imperative

- 2010: 13% of population, 40 million
- 2010-2030 – Baby Boomers start turning 65!
- 2030 -- 72 million, ~ 22% of pop.
- "Old" old (>85 yrs) fastest growing
 - ✓ 2010: 1.9% (~5 mil) → 2050 4% (~ 20 million)

U.S. Older Adult Population

Total number of persons age 65 or older, by age group, 1900 to 2050, in millions



Note: Data for the years 2000 to 2050 are middle-series projections of the population. Reference population: These data refer to the resident population. Source: U.S. Census Bureau, Decennial Census Data and Population Projections.

Decision making in older adults: making sure you get the full picture

Case #1:

- 85 yo F with hx Afib, pulmHTN, PAD, MCI, chronic fatigue presents w/painless jaundice 3/23
- Stented, bx Ampullary adenocarcinoma, referred to UCH Pancreas & Biliary Multidisciplinary Team
- April 2023 visit
 - Dx: Stage IIA (cT3a, cN0, cM0)
 - Tx: whipple if cardiology clears
 - Funx: very sedentary, wt loss 15 lbs pst 3 mo
- Pt preference: "I'll do whatever is advised"

Decision making in older adults: making sure you get the full picture

- Anesthesia and CV pre-op evals
 - ASA4: risk of serious complication 39.6%, any complication 43.6%, cardiac complication 6.8%
- CV noted "concerned about her cognitive ability to handle the large surgery as she asked similar questions repeatedly during the visit and did not get labs drawn as directed" --- rec f/u with PCP
- Dgtr contacted PCP re: whipple scheduled 6/26/23
 - fears pt does not understand surgery & risks
 - reports told "we do whipples all the time" (phone call)
 - wished to review: prognosis w/o surgery and if any viable tx options besides surgery

Decision Making: Getting the full picture
Pt Course:

- Pt errantly held DOAC d/t unsure when to hold for whipple surgery
- Had acute embolic stroke 6/13 w/o major sequelae
- PCP f/u 6/26/23
 - expect 5 yr survival *without* CA 40% (ePrognosis)
 - 40% risk serious complications with surgery not including adverse cognitive effects
 - pt & family prefer no surgery, palliative care
- Next steps: UCH Biliary MDT superb communication but even so: XRT, adjunct tx considerations, stent exchange timing were major challenges to family (and PCP)

Decision Making: Getting the full picture

What can be learned from this case?

- Involve PCP early and often
 - pt presented well but did not fully grasp r/b and tx options
 - cognitive testing 4/23 found new deficits, raised concerns
- Family not in CO major barrier to
 - optimal communication
 - older patient managing all issues w/o in-home support
- Even with support from Cancer Ctr MDT, PCP, and HH providers pt was anxious, confused, flustered, overwhelmed
 - was it possible to get more support from cancer center?
 - UCH Srs clinic has “patient navigators”, PCP did not employ

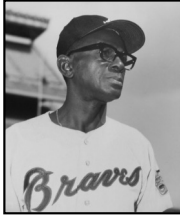
Q2: Which of the following is NOT correct about the life expectancy of an 85 yo women?

- A. It is more than the expected survival of an 85 yo man
- B. It is roughly 5 yrs less than average if pt is frail
- C. It is roughly 5 yrs more than average if pt in robust health
- D. It is less than 5 years

Life Expectancy at Selected Ages
U.S. Census Bureau, Statistical Abstracts 2019

Age	Men	Women
65	18.2	20.8
70	14.4	16.6
75	11.2	13.0
80	8.3	9.7
85	5.9	7.0
90	4.1	4.9
95	2.8	3.4
100	2.1	2.5

Geriatric Assessment: beyond chronologic age



-Leroy Satchel Paige-

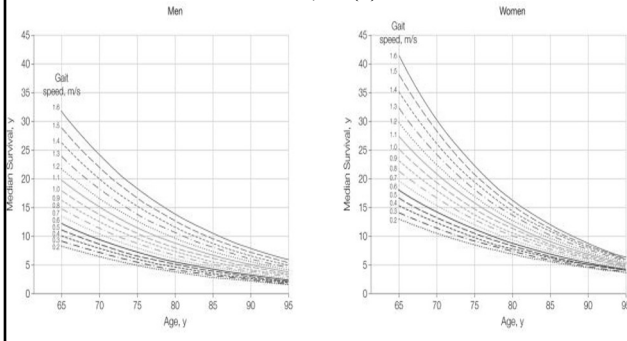
"How old would you be if you didn't know how old you were?"

Geriatric Assessment: beyond chronologic age

- What we ask:
 - Chronological Age
- What we should be asking:
 - Physiological Age
 - BEST MEASURE: gait speed

Gait Speed as mortality predictor

JAMA 2011;305(1):50-58



Practical Assessment of the Geriatric Patient

- What we learned:
 - The pathological etiology

- What we need to know:
 - The functional status

Functional assessment in older cancer patients

Case #2:

- 81 yo male with mild-mod dementia, parkinsonism, falls, new urinary retention & new dx prostate cancer metastatic to lumbar spine discovered when c/o LBP
- Dx on bone biopsy, no gleason score
- Superb Med Oncology eval 9/23 noted
 - “Frail, elderly man in wheelchair”
 - “Some impaired short term memory recall”
 - ECOG Performance Status of 3
- Can performance status guide/improve tx?

Assessing Functional status in older adults

ECOG/WHO score

- 0 Fully active, able to carry on all predisease performance without restriction
- 1 Restricted in physically strenuous activity, but ambulatory and able to carry out work of a light and sedentary nature (e.g. light house work, office work)
- 2 Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.
- 3 Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
- 4 Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.
- 5 Dead

J Geriatr Oncol 2014 Jan;5(1):49-56

Assessing Functional status in older adults

- Are we accurate w/ECOG assessments?
 - n= 100 tx naïve cancer pts wore accelerometer to measure activity and assigned an ECOG PS score
 - 71 pts with ECOG PS 0-1 spent > 50% wake time resting
 - Pts age ≥65 were assigned lower PS scores even when no less sedentary than younger patients
- Is there a better way?
 - Geriatric assessment: helps detect impairment not identified in routine H&P, predicts severe treatment-related toxicity, predicts OS, can influence treatment choice and intensity.
 - Not always accurate nor feasible/available

J Geriatr Oncol 2014;5(1):49-56 J Geriatr Oncol 2021;12:49-56
J Clin Oncol 2014 ;32:2595-2603

Functional assessment in older cancer patients

Case #2: How provider applied funx to this 81 yo male with hx mild-mod dementia, parkinsonism, and falls

- “we discussed the need to mitigate the cognitive and muscle wasting side effects of ADT, while addressing his prostate cancer for palliative purposes”
- “discussed expected low testosterone side effects of ADT”
 - bicalutamide 50 mg daily started
 - “if tolerating, consider relugolix due to potential for rapid T- recovery if has worsening mentation, significant muscle weakness, or increased falls”
- While likely can debate tx options cannot debate excellent comprehensive eval and pt tailored care plans

Challenges of older adults navigating health care system

Case #3: 64 yo w/high grade CA prostate locally advanced

- Complicated decision making for MD let alone lay person
 - Surgery alone
 - Surgery then XRT
 - XRT then ADT
- Treatment information
 - Excellent yet still surprises in XRT
 - Do we emphasize strength training, exercise, diet, sleep enough?
- Stuff happens and it throws even seasoned pts for loop
 - change in specialty pharmacy threat to rx continuity
 - Team availability matters & cannot be overappreciated



**Any
Questions!**
