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# Aspects of palliative care in older adults with cancer

## How geriatrics can contribute to oncology and palliative care

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# DECLARATION OF INTERESTS

**Gabor Liposits**

**Financial interests:**

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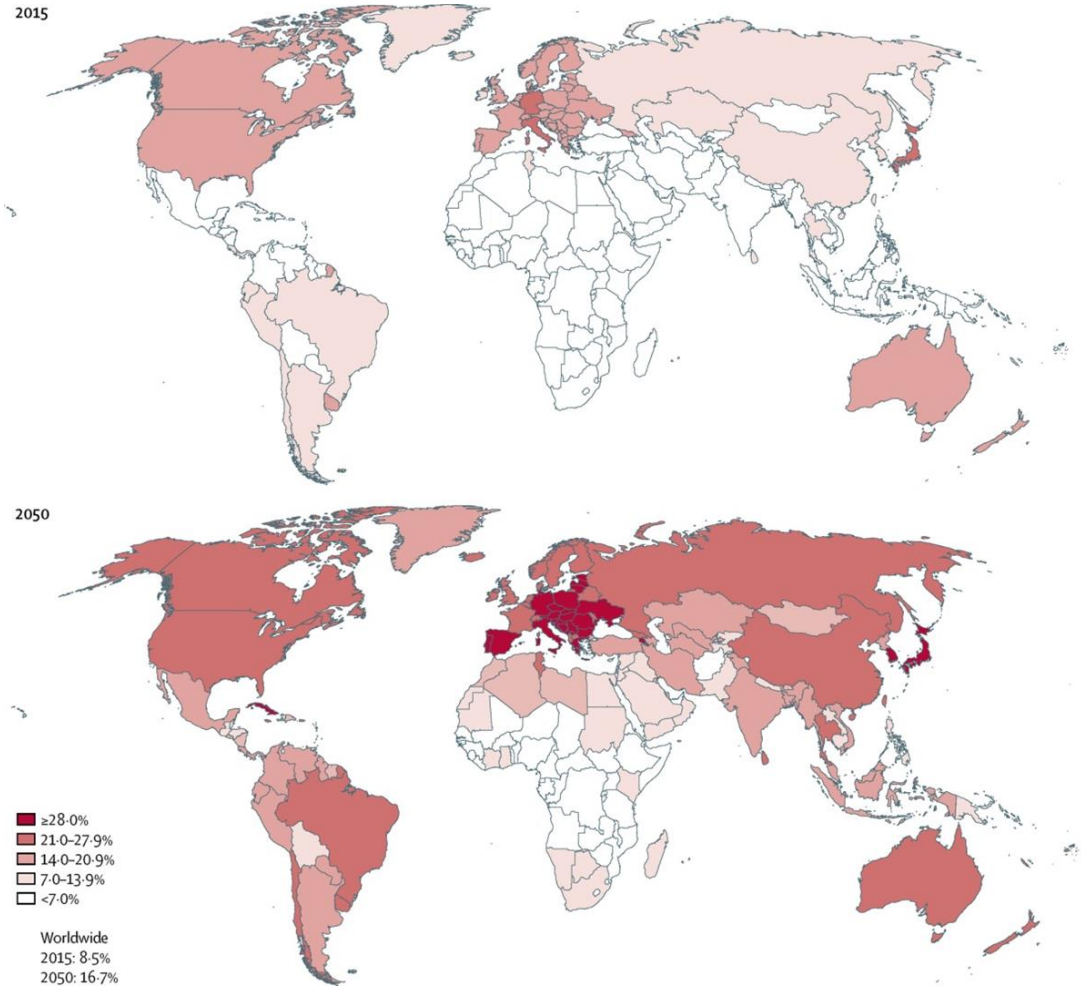
**Non-financial interests:**

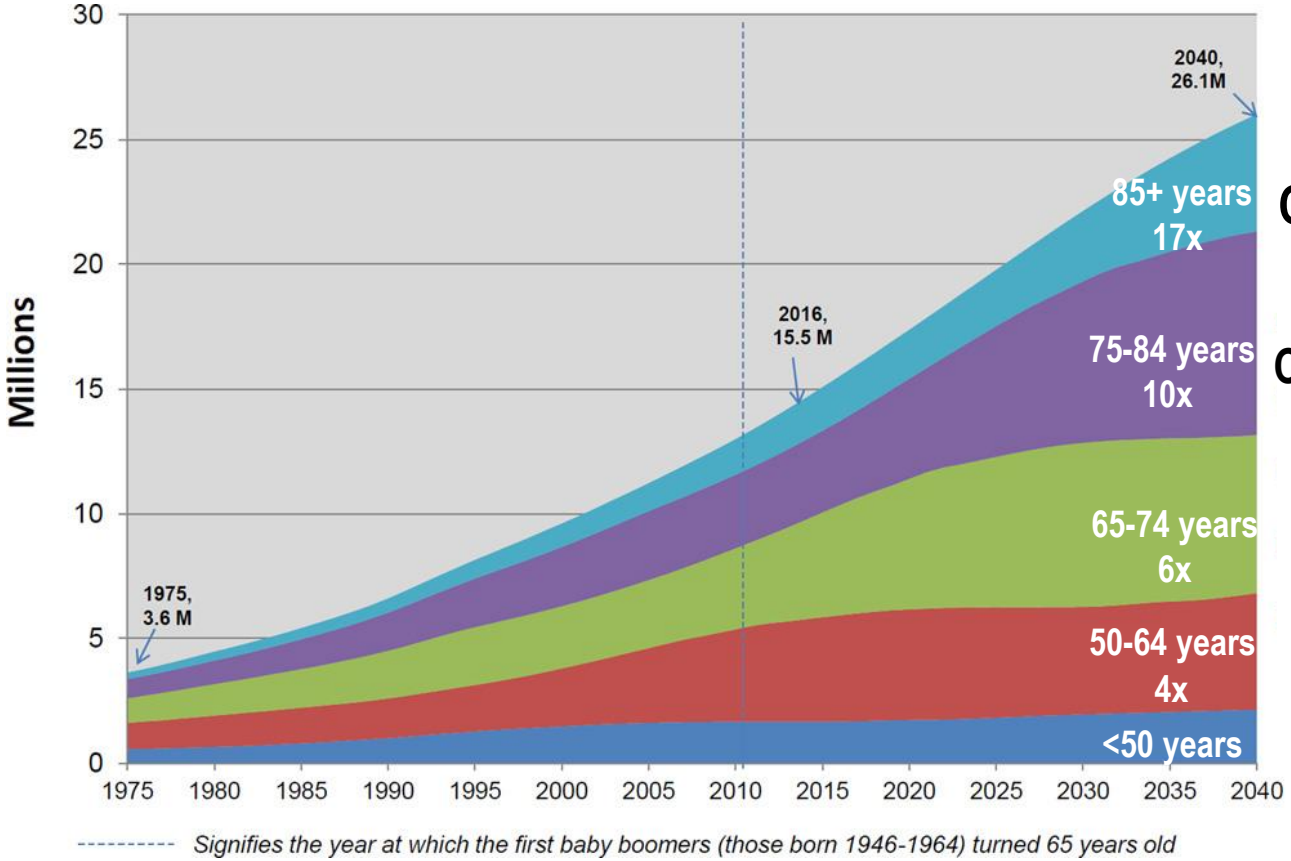
ESMO POWG member
ESMO DCWG member
SIOG social media ad hoc committee member
SIOG public policy committee member
EORTC member




Soto-Perez-de-Celis, The Lancet Oncology, 2018

# Aging population becomes (is already) a global phenomenon

# Combined incidence of all cancer types, SEER database 1975-2011




**Cancer is a disease of aging**

**Cancer incidence increases in all age groups**

**Most pronounced in adults ≥ 65 years**

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Bluethmann SM, Cancer Epidemiol Biomarkers Prev. 2016

# All adult oncologists are geriatric oncologists...

## All Oncologists Are Geriatric Oncologists...They Just Don't Know It Yet

By Stuart Lichtman, MD, FACP, FASCO
August 25, 2019

Get Permission

**You don't have** to be a geriatrician to properly evaluate and manage older patients with cancer. The wave of older patients with cancer predicted over 30 years ago is now fully upon us. The oncology community finds itself ill-prepared to manage the increased number of older patients. It is not just the age of the patient but the comorbidities, social issues, and cognitive decline that will confront oncologists with complex problems to solve in a short period of time.

Stuart Lichtman, MD, FACP, FASCO

At the same time, we have seen a surge in new modalities of treatment, including immunotherapy and drugs targeting various cell processes and actionable mutations, new radiation therapies, and surgical techniques. However, chemotherapy for most of the common diseases will still be with us for the foreseeable future. It is absolutely incumbent on all oncology practitioners to be able to evaluate older patients for their specific specialty.

Most of the focus of assessing older patients has been on chemotherapy toxicity, with guidance on drug selection and dosing as well as overall cancer outcomes. Studies have

https://ascopost.com/issues/august-25-2019/all-oncologists-are-geriatric-oncologists/

# Precision medicine

## In-depth characterization

TUMOR

PATIENT

# Older adults are heterogeneous

Long life expectancy

High level of functioning

No significant comorbidities

Normal organ function

No/few geriatric syndromes

Low level of syst. inflammation

**Fit – standard of care**
**Focus on survival**

**Vulnerable - interventions**
**Balancing survival and QoL**

Short(er) life expectancy

Low level of functioning

Significant comorbidities

Impaired organ function

Geriatric syndromes

Systemic inflammation

**Frail – BSC**
**Focus on quality of life**


# The iceberg principle of geriatric oncology

## A patient-centered approach

## Systematic evaluation (CGA, GAM)

## Correct stratification

## Shared decision-making

# Decision-making in older adults with cancer

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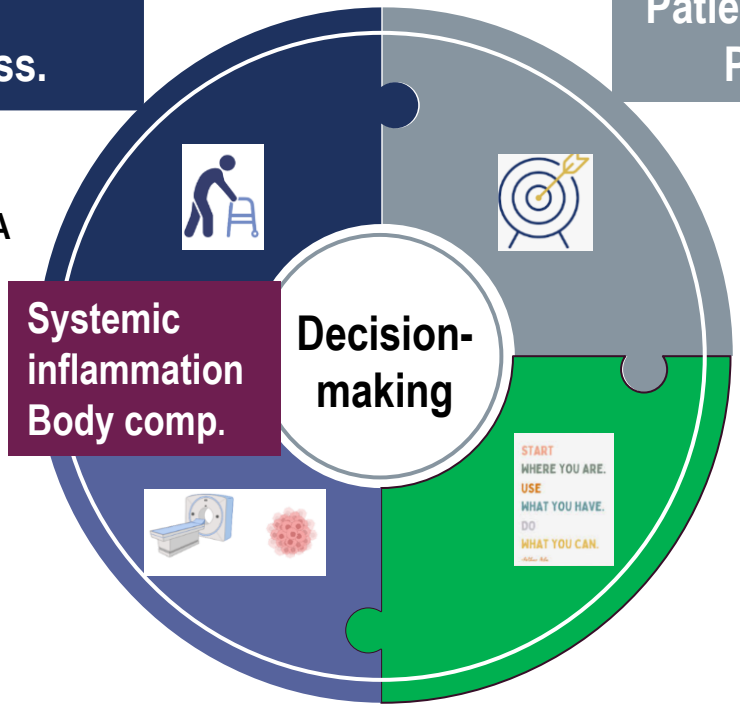
## Patient-related factors
## Geriatric screening/assess.

Life expectancy
Functioning, cognition, comorbidities, nutrition, geriatric-syndromes – GS/GA
Socioeconomic factors
Caregiver availability

## Tumor-related factors
## Diagnostic work-up

Molecular characteristics
Tumor burden
Symptomatic vs asymptomatic




## Patient values, goals & preferences
## Patient-centered endpoints

Quality of Life
Preservation of functioning
Symptom control
Early supportive and palliative care

## Practical issues
## Local environment

Access to geriatric and PC services
Availability of therapeutics/reimburs.
Access to clinical trials
Financial and time toxicity
Mindset
Ageism

# Palliative care – an unmet need (also) in older adults

WHO: 56.8 million people need palliative care each year

Almost half of those (25.7 million) during the last year of their life

34% have cancer

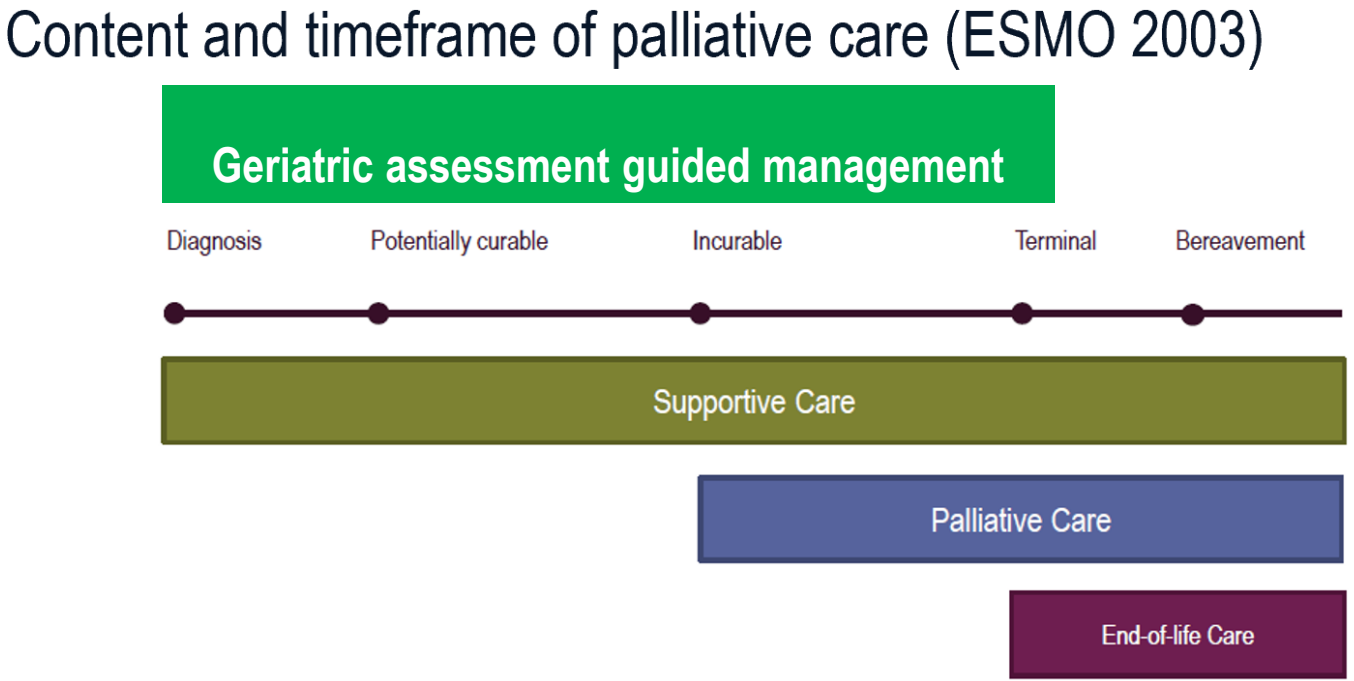
40% are ≥70 years

Currently only about 14% of those who need palliative care receive it

Cancer cases in older adults will rise from 9.95 mil/year in 2020 to 18.6 in 2040

https://www.who.int/news-room/facts-in-pictures/detail/palliative-care

# Early integrated supportive and palliative care




Cherny NI, *et al.*, Ann Oncol 2003;14(9):1335-1337

# Differences

## Geriatrics

**Older adults ≥ 65 years (80+)**

**Primary care specialty**

**Multiple chronic conditions**

**Focus on functional recovery**

**Specific concerns e.g.,**

functional impairments

multimorbidity

polypharmacy

**Common ground**

## Palliative Care

**All age groups**

**Chiefly consultative**

**Complex symptom management**

**Pure comfort-oriented goals**

**Specific concerns e.g.,**

symptom burden

prognostic understanding

coping

spiritual and religious needs

# Common ground

Holistic, patient-centered approach - health complexity and complexity of the symptoms

Team-based, interprofessional, and goal-oriented care models based on individual preferences

Value-added service to particularly vulnerable and frail older adults and their caregivers

Proactive multidimensional assessment and identification of unmet needs

Pay attention to psychosocial factors, caregivers' needs and include them in care planning

Improve survival, quality of life and reduce health care cost

# Common ground

Should be an integrated part of cancer care

(Most) oncologists are not properly trained in geriatrics and palliative care

Scarce resources and poor recognition compared to other specialties

Dearth of students choose geriatrics and palliative care

Misconceptions

# Challenges in palliative care dedicated to older adults

Palliative care needs of older adults are substantially different from those of younger patients

Impaired functioning profoundly influence decision-making

The multitude of specialists and the lack of care continuity result in a fragmented care (polypharmacy, conflicting recommendations)

Fragmented care is a major cause of treatment-related harms, wasted resources, and reduced quality ( burdensome interventions, hospitalizations in the last months of life)

Scarce evidence base  underrepresentation of multimorbid frail patients in clinical trials

Tension between the two specialties due to the conceptual shift in PC

# Solutions and future directions

Research should be enhanced by dedicated funding programs

Timely integration of ACP can significantly improve decision-making

Improved transition and coordination of care between sectors result in continuity

More effective data collection and sharing (telemedicine, PROMs)

Clarification of responsibilities within and between teams is crucial

Mutual recognition, better communication and interdisciplinary collaboration

# When to refer to a geriatrician?

## The 5 M's

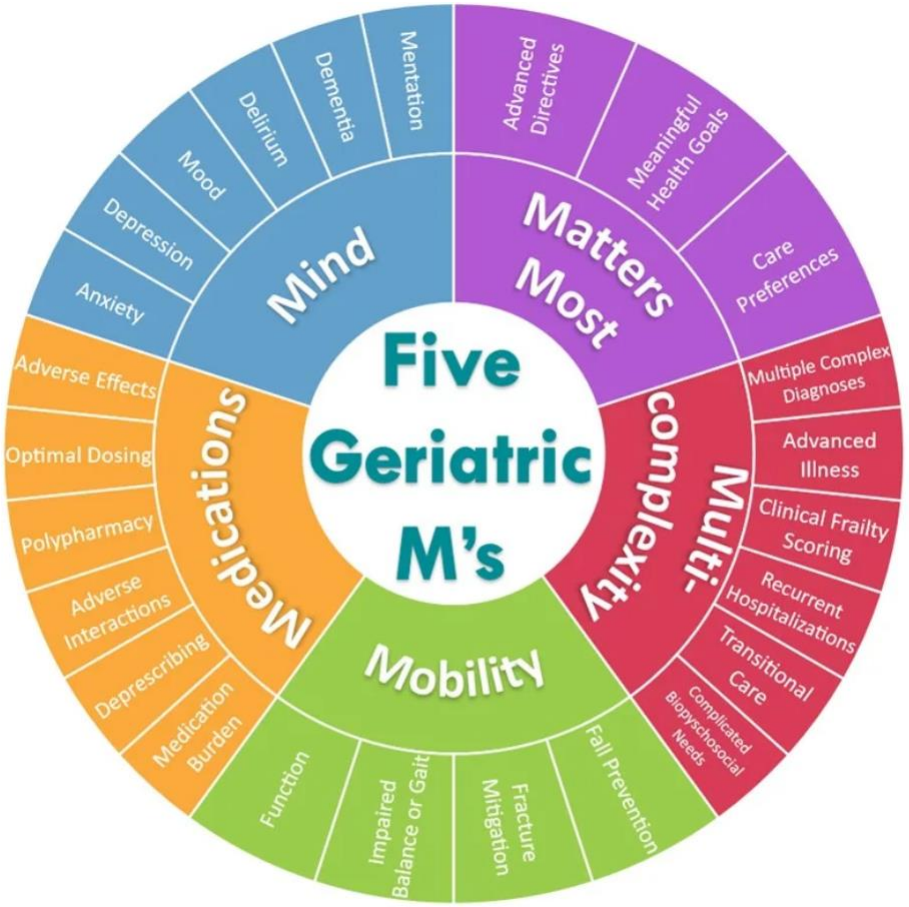
**Multi-complexity**

**Mobility**

**Medications**

**Mind**

**Matters most**




https://www.geriacademy.com/post/when-to-see-a-geriatrician

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# Thank you for your attention!

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# References


**Soto-Perez-de-Celis E**, Li D, Yuan Y, Lau YM, Hurria A. Functional versus chronological age: geriatric assessments to guide decision making in older patients with cancer. Lancet Oncol. 2018 Jun;19(6):e305-e316. doi: 10.1016/S1470-2045(18)30348-6. Epub 2018 Jun 1. PMID: 29893262.

**Bray F**, Laversanne M, Sung H, Ferlay J, Siegel RL, Soerjomataram I, Jemal A. Global cancer statistics 2022: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. CA Cancer J Clin. 2024 May-Jun;74(3):229-263. doi: 10.3322/caac.21834. Epub 2024 Apr 4. PMID: 38572751.

**Morgan E**, Arnold M, Gini A, Lorenzoni V, Cabasag CJ, Laversanne M, Vignat J, Ferlay J, Murphy N, Bray F. Global burden of colorectal cancer in 2020 and 2040: incidence and mortality estimates from GLOBOCAN. Gut. 2023 Feb;72(2):338-344. doi: 10.1136/gutjnl-2022-327736. Epub 2022 Sep 8. PMID: 36604116.

**Bluethmann SM**, Mariotto AB, Rowland JH. Anticipating the "Silver Tsunami": Prevalence Trajectories and Comorbidity Burden among Older Cancer Survivors in the United States. Cancer Epidemiol Biomarkers Prev. 2016 Jul;25(7):1029-36. doi: 10.1158/1055-9965.EPI-16-0133. PMID: 27371756; PMCID: PMC4933329.

**https://ascopost.com/issues/august-25-2019/all-oncologists-are-geriatric-oncologists/**

**Unroe KT**, Meier DE. Research priorities in geriatric palliative care: policy initiatives. J Palliat Med. 2013 Dec;16(12):1503-8. doi: 10.1089/jpm.2013.9464. Epub 2013 Oct 22. PMID: 24147877; PMCID: PMC3919476.

**Pacala JT**. Is palliative care the "new" geriatrics? Wrong question--we're better together. J Am Geriatr Soc. 2014 Oct;62(10):1968-70. doi: 10.1111/jgs.13020. PMID: 25333530.

**Meier DE**. Focusing together on the needs of the sickest 5%, who drive half of all healthcare spending. J Am Geriatr Soc. 2014 Oct;62(10):1970-2. doi: 10.1111/jgs.13020_1. PMID: 25333531.

**Voumard R**, Rubli Truchard E, Benaroyo L, Borasio GD, Büla C, Jox RJ. Geriatric palliative care: a view of its concept, challenges and strategies. BMC Geriatr. 2018 Sep 20;18(1):220. doi: 10.1186/s12877-018-0914-0. PMID: 30236063; PMCID: PMC6148954.

**Castelo-Loureiro A**, Perez-de-Acha A, Torres-Perez AC, Cunha V, García-Valdés P, Cárdenas-Reyes P, Soto-Perez-de-Celis E. Delivering Palliative and Supportive Care for Older Adults with Cancer: Interactions between Palliative Medicine and Geriatrics. Cancers (Basel). 2023 Jul 29;15(15):3858. doi: 10.3390/cancers15153858. PMID: 37568674; PMCID: PMC10417379.

**Hamaker ME**, van Huis-Tanja LH, Rostoft S. Optimizing the geriatrician's contribution to cancer care for older patients. J Geriatr Oncol. 2020 Apr;11(3):389-394. doi: 10.1016/j.jgo.2019.06.018. Epub 2019 Jul 5. PMID: 31285173.

**Nipp RD**, Subbiah IM, Loscalzo M. Convergence of Geriatrics and Palliative Care to Deliver Personalized Supportive Care for Older Adults With Cancer. J Clin Oncol. 2021 Jul 1;39(19):2185-2194. doi: 10.1200/JCO.21.00158. PMID: 34043435.

**Cherny NI**, Catane R, Kosmidis P; ESMOTaskforce on Supportive and Palliative Care. ESMO takes a stand on supportive and palliative care. Ann Oncol. 2003 Sep;14(9):1335-7. doi: 10.1093/annonc/mdg379. PMID: 12954570.

**Lorenz KA**, Lynn J, Dy SM, Shugarman LR, Wilkinson A, Mularski RA, Morton SC, Hughes RG, Hilton LK, Maglione M, Rhodes SL, Rolon C, Sun VC, Shekelle PG. Evidence for improving palliative care at the end of life: a systematic review. Ann Intern Med. 2008 Jan 15;148(2):147-59. doi: 10.7326/0003-4819-148-2-200801150-00010. Erratum in: Ann Intern Med. 2009 Nov 3;151(9):674. PMID: 18195339.

**Tieman J**, Sladek R, Currow D. Changes in the quantity and level of evidence of palliative and hospice care literature: the last century. J Clin Oncol. 2008 Dec 10;26(35):5679-83. doi: 10.1200/JCO.2008.17.6230. Epub 2008 Nov 10. PMID: 19001326.

**https://www.geriacademy.com/post/when-to-see-a-geriatrician**

**https://www.who.int/news-room/facts-in-pictures/detail/palliative-care**