Geriatric Oncology: a multidisciplinary approach in a global environment

REPORT FROM THE 2016 ANNUAL CONFERENCE OF THE INTERNATIONAL SOCIETY OF GERIATRIC ONCOLOGY (SIOG)

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SUMMARY

The 2016 annual conference of the International Society of Geriatric Oncology took place in Milan, Italy from November 17-19th. More than 450 delegates from 42 countries with a special interest in the care for older patients with cancer attended this conference. The meeting provided an overview of current advances in geriatric oncology.

(BELG J MED ONCOL 2017;11(2):78-80)

INTRODUCTION

The 2016 annual conference of the International Society of Geriatric Oncology (SIOG) focused on a multidisciplinary approach for older patients with cancer in a global environment and explored global differences of care. While many countries are in their starting blocks, Belgium had one of the most advanced care programs for older patients with cancer supported by Cancer Plan Action 24. However, since the end of this specific action of the Cancer Plan in 2015, there is no structural funding for geriatric oncology in Belgium and incorporation of geriatric assessment (GA) in existing geriatric structures remains difficult in many centres. Nevertheless, we need to continue the effort because with the aging of the population, all oncologists will become geriatric oncologists.

SURGICAL APPROACH TO OLDER PATIENTS WITH CANCER

At SIOG 2016 the Surgical Task Force reported on a survey exploring surgical oncologists' approach toward older patients with cancer.[1] Quality of life (QoL) and functional recovery were considered the main endpoints in onco-geriatric surgery and age was not perceived as a limitation. However, screening for frailty, performance of GA and collaboration with geriatricians were rather uncommon.

IMMUNOTHERAPY IN OLDER PATIENTS WITH CANCER

With the introduction of checkpoint inhibitors in clinical practice, older cancer patients are increasingly treated with these drugs. It is therefore reassuring that safety in older patients is similar to younger patients.[2] However the possible role of the aging process and immunosenescence on the efficacy of such agents is unknown since only a small percentage of patients included in clinical trials are older than 65.

In the second line non-small-cell lung cancer (NSCLC) studies with check point inhibitors, subgroup analysis showed a similar benefit for patients older than 65

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Conflict of interest: The authors have nothing to disclose and indicate no potential conflict of interest.

Keywords: geriatric oncology, 2016 SIOG congress.

KEY MESSAGES FOR CLINICAL PRACTICE

1. **All oncologists will become geriatric oncologists.**
2. **Geriatric assessment is time well spent.**
3. **In Belgium, funding is needed to continue to provide high quality multidisciplinary care for older patients with cancer.**
4. **Continuous education of health care professionals involved in the treatment of older patients with cancer is warranted. This is one of the main aims of SIOG (www.siog.org).**

years but the number of patients older than 75 was very small.[3-6]

An important study is KEYNOTE 052 in which patients with locally advanced or metastatic bladder cancer who were unfit for cisplatin (either because of renal function or performance status (PS)) were treated with pembrolizumab.[7] In the preliminary results, presented at the European Society of Medical Oncology (ESMO) congress 2016, the trial included mainly older patients (median age 75 years old and 13% of patients older than 85) and resulted in a response rate of 24% and a response duration of six months or more in 83%.

GERIATRIC ASSESSMENT IN OLDER PATIENTS WITH CANCER

Treatment decisions in older patients with cancer remain very challenging with an important focus on maintenance of QoL and functional independency. GA remains the gold standard to assess these patients but incorporating GA in daily oncology practice faces important challenges.[8] The first one is to translate the outcome into GA-guided interventions in order to investigate if the improvement or elimination of a geriatric impairment may impact prognosis or treatment-related toxicity. Another challenge is to translate the outcome into disease-specific treatment allocation. In NSCLC, GA-based treatment allocation failed to improve progression free and overall survival when compared to standard treatment allocation, but patients in the GA arm experienced less all grades toxicity, reported higher QoL scores and demonstrated less treatment failures because of toxicity.[9]

CONCLUSION

SIOG 2016 has demonstrated once again that elderly specific trials, certainly with new treatment modalities, are necessary and that GA is time well spent as M. Hamaker stated. If we can pay thousands for mutation analysis or sophisticated imaging and tens of thousands for targeted therapy or immunotherapy, we can surely spend time with patients to establish whether a treatment is likely to help or harm them. The continuous education of all health care professionals involved in the treatment of older patients with cancer is therefore warranted. SIOG will again hold an advanced course in geriatric oncology in Treviso, Italy from June 28th till July 1st, 2017. This four-day course is designed to provide specific skills in assessment care pathways and therapeutic choices for older patients with cancer. It includes geriatrics for clinical oncologists and clinical oncology for geriatricians. In addition interested physicians, nurses and other health care professionals are welcome at the SIOG 2017 annual conference which will be held from November 9-11th, 2017 in Warsaw, Poland. Further information as well as application for the Treviso course and the SIOG annual conference can be found at *www.siog.org*.

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