Supporting Older People with Cancer – Merging Geriatric and Oncological Knowledge

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Abstract

Cancer in old age means a complex situation that may differ depending on where in the aging process the person is. For the older patient it is a reminder of that life is going to its end. Cancer treatment is to be provided in addition to handling other health problems and the overall frailty that goes with old age. Comprehensive geriatric assessment and case management may be a way to handle the frailty and merging oncology and geriatric knowledge.

Keywords

Comprehensive geriatric assessment, case management model, aging process, cancer in old age

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It is well known that there is a demographic transition all over the world. The most important explanation to this is the change from previously large groups of children in a family to now commonly only one or two children in most countries. This decrease in birth giving together with improved longevity means that most countries have some very large cohorts of people born during or right after the Second World War now reaching the age of retirement and the period thereafter. That means that large groups of people have already, or will soon reach the age where chronic diseases including cancer, and later in the aging process, functional decline develops. Integrating the knowledge from geriatrics and oncology is needed in order to provide high quality care and treatment in these last phases of life.

The transition towards an older population is often regarded as a threat and a challenge for societies whilst in fact it is a story of success. The mortality among newborns has decreased substantially and the longevity and the survival rate improved for most severe diseases. Most people can foresee to still live a long period after retirement. However, the older they get the more vulnerable they will be. This long period, is marked by phases in which the life condition differs significantly. Thus getting cancer may take on a different meaning depending on when in the aging process it develops. The phases are marked by a period after retirement when most of the older people are healthy, mobile and live an active life with a high quality of life.[1] Their expectations may be to now take the opportunity and do all those things people have not had the time or opportunity to do earlier on. The expectation would be to remain healthy as long as possible. During the next phase diseases slowly occur, mainly chronic diseases, of which cancer is one. Also health complaints of various kinds develop: chronic pain, communication difficulties, mobility restrictions and so on. Quality of life can still be very good but the fact that life is not endless is coming closer. In longitudinal studies a paradox can be seen in that during this process from retirement to death the number of diseases increases significantly and so does medical treatment. However, mobility, working ability and quality of life was found to improve.[2] Thus the picture is mixed, seemingly life is better but costs in terms of health care and medical treatment are higher. The phase meaning a true blow to quality of life is when the person becomes increasingly dependent on others due to limitations in functional ability and health complaints and this is the time when it becomes obvious that life is moving towards its end.[3] When at this stage, the person in most cases is suffering from several diseases, complex treatments and the reserve capacity to handle mental and physiological challenges is restricted.

In essence this means that the aging process means a continuous transition and getting cancer may take on a very different meaning depending on when in this process it develops. Thus providing cancer treatment means entering into different and very complex health situations. It has been reported that those around 75–80 years old had a significantly poorer quality of life compared to other age groups with cancer indicating that the existential blow may be harder in a stage were people still hope for a healthy and active life.[4] Also developing cancer after the age of 65 meant a sudden awareness of the finiteness of life, painful insights into losses but also awareness of possibilities.[5] Similar findings reported cancer in old age as a turning point marking old age, losing control, disturbed family balance and life and death suddenly becoming apparent, and at the same time hope and enjoyment of life becomes vital.[6] Haug et al. reported the need for

maintaining the activities of a normal daily life. It was also reported to be important to name and handle decline and loss as well as finding a space for existential meaning making.[7] In addition the older the person is the more fragile and thus more sensitive to challenging cancer treatment. In summary this means that care and treatment should take into account that the person diagnosed with cancer is a physically fragile person in an existential crisis. The cancer experience will take on a different meaning depending on other complaints related to health per se, other diseases and treatment related to the cancer and the aging process.

Handling cancer in old age is a health care situation in which geriatrics and oncology should go together and merge each other's expertise in clinical practice and it should be adapted to where in the aging process the person is. In particular, there are two developments in geriatrics that may be useful in oncology for older people throughout the process of diagnosis, treatment and aftercare. These two developments are applying a comprehensive geriatric assessment (CGA) that in turn informs the care and treatment plan,[8] and the organizing of care in a case management (CM) model modified to suit the person depending on where s/he is in the process of disease and treatment.

CGA is a multidimensional and interdisciplinary process to determine a frail older person´s medical (nutrition, comorbidities and severity, medication) and mental health (cognition, mood anxiety, fears), their functional capacity (ADL, gait, balance, activity, exercise) and social circumstances (informal support social network, formal care eligible) as well as environmental conditions. This assessment is the basis for a coordinated and integrated plan for treatment, rehabilitation, support and long term follow up. There are plenty of valid measures available to carry out a CGA. Some additional criteria may need to be included due to the specific cancer and cancer treatment.

CM is a way to structure the care and the responsibility in relation to a patient. The model needs to vary in relation to patient groups, the competence in the team behind and where in the organisation the case manager is placed. The model was developed to prevent fragmentation and duplication of programmes and contacts in particular when the patient has complex health needs and is at risk of "falling between the chairs". It is defined as a collaborative process of assessment, planning, facilitating, care coordination, evaluation and advocacy for options and services to meet a patient's and family's comprehensive health needs, through communication and available resources, to promote quality cost-effective outcome.[9] It is often nurses, preferably specialised, with a team behind that act as CM. The models can be applied with different levels of responsibility and interventions included.[10] The minimal model is mainly about case findings, assessing the patient's needs and planning to determine which organisation should take the responsibility of providing for the patient's care. This model is suitable for insurance companies and perhaps not so relevant for treatment and care for patients with complex health situations. The coordination model in addition to tasks included in the minimal model includes being the patient's advocate, working with the client and the client's support system and it also includes continuous assessment and re-planning. In addition, the case manager may be involved in the care process and provide interventions of various kinds. This model is suitable for cancer patients with a complex health situation and perhaps during the treatment process until discharge. The close relationship between CM and the patient and family allows for listening and understanding what the patient wants for the remaining period of life. The comprehensive model in addition to the tasks included in the coordination model also includes resource developing, monitoring quality, public intervention and crisis intervention. This model is perhaps most suitable for very vulnerable patients with a complex health and treatment situation for instance palliative care or end of life care. The professional competence needed varies in relation to the tasks included, and sometimes the team behind the model should be mainly geriatric and in other cases mainly oncological experts. So far research has been inconclusive, mainly due to the presence of multiple models. Patient and families however, favor the model although more research is needed in the same context and including the same target group to establish its effectiveness in providing high quality care to a vulnerable group of cancer patients. ■

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