



Cancer Care in Senior Patients

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Cancer care in senior patients is another of my areas of expertise. And also, one of the areas I'm really passionate about is how to improve the care, or how to improve the care, of senior patients. Next slide please.

What is important, what is really important, to talk about cancer in senior populations? A great proportion of patients with cancer are over the age of 70, and this is well defined. In any cancer centre, roughly about 30 to 35 up to 40% are roughly over the age of 70, newly diagnosed cancer patients. And this is important to realise because this is a very specific population. So why? Senior patients present with other medical conditions or medical problems. Usually, these patients have recessive medical problems, such as hypertension diabetes and so forth. They also have other medical conditions that make them very vulnerable in terms never getting diagnosed with cancer for cancer care purposes. Senior patients may also present with some functional issues, meaning that they may not be as functional as they used to be. And, of course, that all presents a challenge when we treat these patients. In cancer cases, we definitely need to look into what we call functional scores, and this is one main issue sometimes when we face these patients, where we need to define what we mean by a good functional or a bad functional score, and a majority of these patients have some functional problems, limitations, disabilities, and so forth. And of course, some of the treatments that we deliver may be too toxic for our senior patients, so we need to strategise as to deliver a more personalised therapy for these patients. Next slide, please.

So what are some of the strategies we can use? First, we need to understand what do we mean by ageing? And I think this is important because sometimes one of the factors that we sometimes overlook is that we sometimes tend to see patients as really functional, but there is something called chronological age and also biological age, and they are two different concepts, so we go more with the biological age of the individual as opposed to the chronological age of the individual, so you can have two different settings if you will. You may have a patient who is 55 or 60 but look like an 80-year-old, and vice versa. You may have an 80-year-old who looks like a 50 year old. And, of course, that makes a huge difference as to which patient gets what kind of treatment. So, we also need to understand how to improve therapy options. Chemotherapy is being delivered with less, and less, and less, and less frequency these days. We're trying to use a more personalised approach, more of a targeted therapy approach. This is something that, perhaps in the future, is gonna help to improve the quality of life of this population because quality of life is very important. We do have some patients who are 80/85 years old who basically get a recent diagnosis of hematologic malignancies, for instance, and then these patients, of course, would like to spend as much time as possible at home as opposed to in a cancer centre. There are many new strategies being devised at this point to improve that sort of specific time that patients may get with families as opposed to spend here at the cancer centre. Also, we need very adequate geriatric assessment tools. By that we mean that we can get certain tools by which we can control or we can predict some of the outcomes these patients will have. It is not only based on function (functionality), but also on other aspects of the ageing process. And that is very helpful to predict how



patients will respond to therapy, and about certain outcomes we should be looking for. And also, something important that is important as part of these strategies is that many of the clinical trials that we do in oncology, meaning that in the sign of specific clinical trials in preparation to develop new treatment regimens, unfortunately, many senior patients have not been included, and this is definitely something that we would need to change if we want to improve outcomes of this population. Next slide, please.

So, in conclusion, we need to improve the expertise in Geriatrics Oncology. Definitely, we tend to see more and more of these patients in any regular cancer centre. And here, at Miami Cancer Institute, we have a program called Geriatric Oncology Program, in which we not only see patients from the cancer-care standpoint but also from the geriatrics' standpoint. And we try to develop on where we do as geriatricians so we can improve the outcomes of the population. We know for a fact that senior populations used to be put in clinical trials for many years, for many years they had not been included, especially for patients of ages 70 or 75. That is changing, which is a good approach. But, definitely, we need to keep improving that inclusion of patients in the clinical trials. And of course, as we saw in the case of HIV oncology, also for geriatrics oncology we need a multidisciplinary approach. Because remember, we need geriatricians, we need case managers, navigators, and social workers, other specialities are gonna help us in the care of senile patients with cancer.