Comprehensive Geriatric Assessment and Adjustment of Cancer Treatment

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Disclosures of potential conflicts of interest may be found at the end of this article.

McCleary and colleagues reported on the feasibility of computer-based cancer-specific geriatric assessment (CSGA). It is very positive and promising that the proportion of elderly patients completing CSGA at baseline and follow-up increased to 97%. The authors stated that although CSGA added information to clinical assessment, it did not currently affect clinical decision making [1].

Does a comprehensive geriatric assessment (CGA), either computer based or with paper and pencil, lead to adjustments in cancer treatment? The clinical question asked is whether oncologists know how to adjust cancer treatment based on the results of a CGA. The answer is, not yet. There is a lack of data on adjustments of cancer treatment based on CGA.

Why are these data lacking despite a decade of research in geriatric oncology? CGA has been introduced in geriatric oncology to predict the outcome of elderly patients and has not yet been evaluated to adjust cancer treatment. Furthermore, outcome of cancer treatment has classically been evaluated using toxicity, progression-free survival, and mortality, not including CGA-related outcome. The impact of cancer treatment on functional and cognitive status has not yet been defined in large cohorts of elderly patients, whereas classical

oncologic outcome parameters are assessed prior to and after cancer treatment. Consequently, we emphasize the importance of incorporating CGA outcome parameters (e.g., functional and cognitive parameters) alongside classical oncologic outcome during follow-up. These CGA outcome parameters should be easily measured (i.e., computer-based) and objective.

CGA predicts classical oncologic outcome [2, 3]; however, evidence of CGA-tailored treatment is still missing. Research should focus on phenotyping elderly cancer patients and follow-up during and after treatment in order to define possible causal relationships. When a causal relationship between a typical geriatric parameter—one that would have been unnoticed without a CGA—and oncologic outcome is established, interventions can be targeted. In future studies, treatment regimens of full-dose systemic therapy and adjusted schedules should be compared. Ultimately, this should lead to an evidence-based change in oncologic treatment and recognition of the potential value of geriatricians on an oncology team.

DISCLOSURES

The authors indicated no financial relationships.

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