

Not old, just older: considering age in cancer care

In 2019, the number of people older than 65 years worldwide surpassed that of children younger than 5 years for the first time. With this growing demographic, the burden of cancer is also likely to rise. Yet, older patients are undeniably under-represented and even discriminated against in cancer care.

Comorbidities in patients aged 65 years or older can preclude their inclusion in cancer clinical trials. One analysis quantified this fact: people in this age group accounted for just 29% of patients included in colon cancer trials and 15% of those in breast cancer trials. Aside from clinical factors, non-clinical factors might contribute to this discrepancy. Another study showed larger age disparities between study participants and the incident disease population in trials with industry sponsorship than in those not sponsored by industry—a bias that one could argue cynically encourages more positive results.

When patient selection is so stringent, it calls into question whether the study population is representative. Trials are typically affected by the healthy volunteer effect—people enrolled in trials are often healthier and have fewer comorbidities than the general population, despite having cancer. Such patients might also be better educated and have higher socioeconomic status. Add to that a rigid age cutoff, and the study population becomes distinct from the real-world population. Can results from such trials be truly representative of the average patient with cancer? As an example, although the incidence of colorectal cancer is increasing in younger people, with an average age of onset of 68 years in men and 72 years in women, a standard upper limit of 65 years can lead to the exclusion of many diagnosed cases, leaving an atypical population with an earlier onset—and perhaps more aggressive—form of the disease. Treatments developed in such a population might be inappropriate for older patients. Therefore, age inclusion criteria in trials that are dependent and relevant to the cancer type should be used.

Although a move away from paternalism in cancer care is essential, this shift has gone too far in some areas. For example, evidence suggests that older people are increasingly undergoing more complex and high-risk surgery. The number of major upper-abdominal resections done in octogenarians with cancer (aged 80–89 years) was found to have risen in 2001–11, despite an increased morbidity risk. Frailty in older patients who need surgery

predicts postoperative mortality, complications, and length of hospital stay. Patient choice might be a factor in the rising incidence of complex surgeries, so it is vital that the risks and benefits of all clinical options are clearly communicated to patients, especially those at greater risk of complications, so that the best choice is made for each individual irrespective of chronological age.

With under-representation in trials on one end of the scale and potential overuse of surgery on the other, the ideal scenario for older patients lies somewhere in between. The unique requirements of this older population of patients with cancer needs to be recognised. Increasingly, clinicians are realising that use of chronological age, created arbitrarily by sociolegal norms, can be poorly representative of an individual's health status, and instead are opting to use geriatric assessments tools to evaluate older patients' health to inform cancer care. Clinical guidelines from organisations such as the International Society of Geriatric Oncology provide advice for those involved in the care of older patients with cancer. The American College of Surgeons' Coalition for Quality in Geriatric Surgery have also developed a new geriatric surgery verification programme, which sets out standards that hospitals should meet to improve surgical outcomes for older patients. These innovations are a welcome sign of much needed focus on, and recognition of, the needs of older patients. But with a report from the Community Oncology Alliance showing that some 423 US community cancer clinics had closed between 2008 and 2018, and that 45 practices reported sending Medicare patients to other clinics for cancer care, neglect of older patients is clearly an ongoing concern. Thus, better collaboration and coordination between all health-care providers is needed to develop personalised evidence-based treatment plans delivered in the right place at the right time.

It can be easy to perceive those over a certain age as weak or frail. But remove two letters from the word elderly and you will arrive at an entirely different word, elder—with its connotations of knowledge and wisdom. Older patients should not be viewed as fragile or side-lined, but should be recognised as a population from whom much can be learned. It has been said that age considers, while youth ventures. In keeping with this philosophy, the needs of older patients must be considered in every aspect of cancer care. ■ *The Lancet Oncology*



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For the *Lancet Oncology Series on Geriatric Oncology* see <https://www.thelancet.com/series/geriatric-oncology>

For the study on **geriatric patients in cancer clinical trials** see *Proc Am Soc Clin Oncol* 2019; 37 (suppl): e23032 (abstr)

For the study on **age disparities in trial participants by industry sponsorship** see *JAMA Oncol* 2019; published online June 3. DOI:10.1001/jamaoncol.2019.2055

For the study on the **incidence of colorectal cancer** see *Articles Lancet Gastroenterol Hepatol* 2019; 4: 511–18

For more on **trends in major upper abdominal surgery in octogenarians** see *Cancer* 2018; 124: 125–35

For more on **frailty and post-operative outcomes in older patients** see *BMC Geriatr* 2016; 16: 157

For more on **geriatric assessments to guide decision making in older patients with cancer** see *Series Lancet Oncol* 2018; 19: e305–16

For **International Society of Geriatric Oncology guidelines** see <http://www.sio.org/content/siog-guidelines-0>

For more on the **geriatric surgery verification programme** see <https://www.facs.org/quality-programs/geriatric-surgery/goals>

For the **Community Oncology Alliance report** see <https://www.communityoncology.org/2018-community-oncology-practice-impact-report/>