

65+

Excellence in
cancer care for
the older adult



Memorial Sloan-Kettering
Cancer Center

About the 65+ Program

A diagnosis of cancer is difficult at any age, but older patients face unique challenges. Memorial Sloan-Kettering Cancer Center is committed to providing cancer patients aged 65 and older with the treatment and support they need.

With the generous support of the Joachim Silbermann Family Program for Aging and Cancer, Memorial Sloan-Kettering offers the services of a multidisciplinary geriatric team. This team includes physicians, clinical nurse specialists, social workers, nutritionists, pharmacists, and psychiatrists, as well as members of the Pain and Palliative Care Service and the Integrative Medicine Service. The programs and care the team provides focus on the unique needs of cancer patients aged 65 years and older.

If you would like more information about the 65+ Program or a referral to one of our team members, please call 646-888-4741.

65+ TEAM MEMBER SPOTLIGHT: William Tew, MD

I am a medical oncologist specializing in gynecologic cancer who has developed a unique research niche in applying the principles of geriatrics to patients with cancer. My research has focused on developing better assessment tools to predict toxicity of cancer treatments (surgery, radiation, and chemotherapy) and ultimately to improve our older patients' outcomes and quality of life.

Cancer is a disease of the aging. When compared to those younger than 65 years of age, older adults have an 11-fold increased cancer incidence and a 16-fold increased cancer mortality. This population of older adults is growing rapidly, accounting for 20% of the population by 2030. Unfortunately, we are ill-prepared for this demographic shift, as older adults have been under-represented in cancer clinical trials.



I first developed an interest in caring for older patients when I was a medical student at the University of Rochester. Dr. T. Franklin Williams, one of the founders of the field of geriatric medicine, was my clinical mentor and had a large influence on my career. Through his encouragement, I enrolled in the Hartford Foundation's fellowship pro-

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RECENT NATIONAL/INTERNATIONAL NEWS

With Alzheimer's Patients Growing in Number, Congress Endorses a National Plan

Summarized from the New York Times, December 15, 2010

Congress has voted unanimously to create, for the first time, a national plan to combat Alzheimer's disease with the same intensity as the attacks on AIDS and cancer.

The bill, expected to be signed by President Obama, would establish a National Alzheimer's Project within the Department of Health and Human Services, to coordinate the country's approach to research, treatment, and caregiving.

Its goal, the legislation says, is to "accelerate the development of treatments that would prevent, halt or reverse the course of Alzheimer's" and "improve the early diagnosis of Alzheimer's disease and coordination of the care and treatment of citizens

with Alzheimer's."

The project would include an advisory council of representatives from agencies like the Centers for Disease Control and Prevention, the National Institutes of Health, the Department of Veterans Affairs, the Food and Drug Administration, the Indian Health Service, and the Centers for Medicare and Medicaid Services. Scientific experts, healthcare providers, and people caring for relatives with Alzheimer's would also be included.

The legislation was driven by the rapidly rising number of people with Alzheimer's, which is currently about 5.3 million and is expected to triple by 2050. The cost

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RESEARCH FOCUS

Predicting Chemotherapy Toxicity in Older Adults with Cancer

A prospective 500 patient multi-center study

Hurria A, Togawa K, Mohile SG, Owusu C, Klepin HD, Gross C, Lichtman SM, Katheria VM, Klapper S, Tew WP, on behalf of the Cancer and Aging Research Group. *J Clin Oncol* 28:15s, 2010 (suppl; abstr 9001).

Five hundred cancer patients aged 65 and older being treated at one of seven institutions, including Memorial Sloan-Kettering Cancer Center (PI: William Tew), completed a pre-chemotherapy assessment capturing: 1) sociodemographics, 2) tumor/treatment variables, 3) labs, and 4) geriatric assessment variables (function, comorbidity, cognition, psychological state, social activity/support, and nutritional status). Patients

were followed through the chemotherapy course to capture toxicity. Grade 3-5 toxicity occurred in 53% (50% grade 3, 12% grade 4, 2% grade 5). A predictive model for toxicity was developed: a scoring system and risk stratification schema identified older adults at low, intermediate, or high risk of chemotherapy toxicity ($P < 0.0001$). KPS-rated by treating physician was a poor indicator for toxicity. ■

65+ Program Upcoming Events

The 2011 65+ Educational Lecture Series will offer presentations beginning in March.

The series will open with three consecutive months (March, April, and May) of experiential and didactic sessions presented by the rehabilitation department. Physical Therapist Jennifer Aquino and other staff will provide education to enhance knowledge and increase physical functioning.

In June, dermatologist Mario Lacouture, MD, will discuss the effects of treatment and aging on the skin of the older patient.

In July we welcome Dorian Block, from the New York Academy of Medicine, who will be discussing the "Age Friendly NYC" initiative. New York City is currently engaged in a groundbreaking project to adopt a new planning paradigm whereby all facets of city life are viewed through the lens of aging. Building on the work the World Health Organization's Global Age-friendly Cities project, the New York Academy of Medicine, a private nonprofit organization, has been working in partnership with the City Council and the Mayor's Office on a comprehensive assessment of what older New Yorkers want and need as well as an assessment of how city agencies from multiple sectors could become

more age friendly. These assessments resulted in 59 new city initiatives and the seating of a public-private commission of leaders from a range of professions charged with engaging the private sector and developing public-private partnerships to make the city a better place in which to age. This year, the commission has begun by focusing on three areas — age-friendly businesses, age-friendly schools, colleges, and universities, and aging improvement districts. This project models how to create public-private partnerships to address the challenge of population aging and how to involve multiple sectors (both public and private) in efforts to maximize older residents' participation in city life, including its transportation systems, parks and outdoor spaces, cultural institutions, health and social services, communication and information, and housing.

September's event will be a panel discussion on Aging and Cognition with members from Psychiatry, Neuropsychiatry, Occupational Therapy, Pharmacy, and Pain and Palliative Care.

In October, our annual 65+ Health Fair will focus on Sexuality and the Older Patient. ■

Did You Know?

More than

60%

of all cases of cancer in the US are diagnosed in individuals over the age of 65, with **67%** of cancer deaths occurring in this age group.

(National Center for Health Statistics, 2007)

IN THE COMMUNITY

GMHA's Fifth Annual Conference: Overcoming Obstacles and Seizing Opportunities

FRIDAY, MAY 13
New York Marriott at the Brooklyn Bridge

Keynote Speaker:

Frederic Blow, PhD

Professor, Department of Psychiatry, University of Michigan

This daylong conference will feature a keynote address and a variety of workshops that will explore the behavioral health needs of older adults.

Go to the Mental Health Association of New York City website (www.mha-nyc.org) for more details as they become available.

65+ TEAM MEMBER SPOTLIGHT:

William Tew, MD *continued from page 1*

gram at Harvard University, where I first learned to appreciate the unique challenges older adults face — declining function, accumulating comorbidities, and often unsolvable economic and psychosocial barriers.

During my oncology fellowship at Memorial Sloan-Kettering, I recognized these challenges are most consequential when an older adult is diagnosed with cancer — a diagnosis that too often requires aggressive therapies for cure. Unfortunately, there is no standard mechanism for an oncologist to assess an older patient's ability to tolerate cancer treatment except by assigning a Karnofsky performance status (KPS) or an Eastern Cooperative Oncology Group (ECOG) performance status score. KPS/ECOG scores may be misleading in the frail elderly, as scores do not fully account for social support, comorbidities, or assistance with daily activities.

In 2006, along with Dr. Arti Hurria from City of Hope, I became part of the founding group of oncologists to form the Cancer and Aging Research Group (CARG). Our goal is to connect geriatric oncology researchers in a collaborative effort to design and implement clinical trials in older adults with cancer. CARG has received funding from MSKCC and other cancer centers, the Association of Specialty Professors, the Hartford Founda-

tion, and the American Society of Clinical Oncology. Our mission statement was published in the *Journal of Clinical Oncology* in 2007, and we recently secured an NIH U13 grant (“Geriatric Oncology Research to Improve Clinical Care”) to expand our educational and collaborative activities.

The first CARG study, Cancer-Specific Geriatric Assessment (Study#06170), investigated the ability of a brief questionnaire to predict grade 3-4 toxicity in a heterogeneous group of 500 patients older than 65 receiving any type of chemotherapy. We enrolled over 250 patients at MSKCC. This assessment measured functional status, comorbid medical conditions, cognition, psychological status, social functioning and support, medication review, and nutritional status.

The tool was easy to administer — it had a mean time to completion of 27 minutes and was largely self-administered. Risk factors for grade 3-5 chemotherapy toxicity included: 1) age \geq 73, 2) cancer type (GI or GU), 3) standard chemotherapy dosing, 4) poly-chemotherapy regimens, 5) falls within the past six months, 6) assistance with instrumental daily activities, and 7) decreased social activity. Surprisingly, KPS-rated by physician was a poor predictor for toxicity. See the research summary from our ASCO 2010 abstract on

page 2 of this newsletter for more details.

Our next step is to validate this assessment tool in patients with specific cancer types and chemotherapy regimens. At MSKCC, in collaboration with Dr. Beatriz Korc from our Geriatrics Service, I plan to study 50 patients with newly diagnosed ovarian cancer and perform assessments along the continuum of primary surgical debulking and chemotherapy. Since more than half of women with ovarian cancer are older than 65, this is an ideal disease in which to test our assessment tool. Treatment toxicity and outcomes ideally will be predicted with the assessment. In addition, half of the patients will receive a weekly telephone contact by a geriatric nurse who will reinforce medication compliance, offer psychosocial support, and facilitate appropriate referrals. Quality of life, use of care, and satisfaction parameters will be compared to those of patients receiving standard oncology care alone.

Geriatric oncology is a relatively new field, introducing oncologists and patients to the language and benefits of geriatrics principles. I am encouraged by the success of my recent collaborative efforts, both at MSKCC and nationally, to improve outcomes for our older patients. ■

Did You Know?

Americans age 65 and older account for

40%

of all prescriptions but comprise only 15% of the US population.

(World Health Network, 2006)

RECENT NATIONAL/INTERNATIONAL NEWS

With Alzheimer's Patients Growing in Number, Congress Endorses a National Plan *continued from page 1*

of Alzheimer's patient care to Medicare and Medicaid was about \$170 billion last year. By 2050, the *Times* reported, it will grow to \$800 billion a year, more than the military budget.

Alzheimer's experts said the effort could make a significant difference. “What really makes this so powerful is that it takes us from a lot of small efforts going on locally to doing something in a coordinated way,” Dr. Kenneth Kosik, a neuroscientist

at the University of California, Santa Barbara, told the *Times*. “If there's one thing we know in science it is that to draw conclusions we need numbers, large-size populations to study.”

The national plan will reinforce efforts to detect brain changes that occur years before people develop symptoms of dementia, and to develop drugs to prevent or substantially delay symptoms. ■

CLINICAL CASE

Beatriz Korc, MD, Chair, Geriatrics Service

Ms. H is an 82-year-old woman with uterine cancer. She had surgery two months ago with removal of her ovaries and uterus. The plan is to start treatment with chemotherapy once she recovers from the surgery. However, recovery has been very slow. Since the surgery she has felt weak, fatigued, and dizzy. She has no appetite and lost six pounds. She fell once at home while going to the bathroom and self-care has been difficult. She was referred by her oncologist to the Geriatrics Service for evaluation and recommendations.

Ms. H has other chronic medical problems. She has a history of high blood pressure, adult onset diabetes, esophageal reflux, and osteoporosis for which she takes the following: Metoprolol 50 mg twice daily, HCTZ 25 mg once a day, Amlodipine 5 mg once a day, Metformin 500 mg twice a day, Fosamax once a week, and TUMS as needed. Her physical exam showed her blood pressure at 105/58, heart rate at 58, and weight at 54 Kg. She had no fever. She was alert, fully oriented, and very pleasant but became tearful when talking about her lack of family support. The rest of the exam was normal and her surgical scar was healing well. The laboratory results were unremarkable with the exception of the albumin level that was low at 3.4. The glucose was 85.



The number of adults aged 65 years and older in the United States increased from 25 million in 1980 to 35 million in 2000, and it is further expected to increase to 72 million by 2030. Cancer occurs more commonly in older adults. The age-associated increase in incidence of malignant tumors, together with expected rise in the number of elderly people due to demographic changes, will result in a higher absolute number of elderly patients with cancer. It is projected that by 2030 approximately 60% of patients diagnosed with cancer and 70% of cancer-related mortality will occur in individuals older than 65.

Older adults with cancer trigger some unique concerns. Frailty and decreased physiologic reserve increase risk of further functional decline and determine higher susceptibility to adverse outcomes such as institutionalization and mortality. Increase in the number of other chronic medical conditions may affect survival as well as treatment tolerance. Cancer patients aged 70 years and greater have on average three comorbidities that can affect detection, evolution, and treatment of cancer. Older adults' medication lists are longer, and they are more prone

to adverse drug reactions or interactions. In addition, there is a larger incidence of cognitive dysfunction than in younger cancer patients and a diagnosis of dementia is associated with shortened survival. A geriatric assessment captures all the factors that may influence life expectancy and treatment tolerance such as functional status, comorbid medical conditions, psychological state, social support, and cognitive function.

Ms. H has several conditions that may interfere with recovery and delay cancer treatment:

1. Ms. H has a history of elevated blood pressure, and she takes several medications that have remained unchanged "for years." Today, her blood pressure is quite low, and it is probably lower at home when she is not in the doctor's office or when she gets up from bed. This is a very frequent problem for frail patients after surgery with poor appetite and weight loss. In Ms. H's case low blood pressure is probably a reason for persistent dizziness and one factor in her fatigue. An adjustment in BP medications with close monitoring was recommended.

2. She has a history of diabetes and she takes Metformin twice a day. Today, even though her glucose level was normal, it may be lower than her usual baseline prior to surgery. It was recommended that she restart monitoring her blood sugar at home (she has not been doing so for months) and call if it becomes less than 80 or over 200. Hypoglycemia or hyperglycemia may be another factor influencing her weakness, fatigue, and "sick" feeling.

3. Ms. H has poor social support. She lives alone and it has been a struggle for her to care for herself. The Geriatric Depression Scale, a tool used to screen for depression, was positive and she agreed that she felt discouraged and lonely. In addition, lack of social support can be especially problematic for older patients such as Ms. H who are undergoing treatments that require frequent visits. She was referred to the geriatric social worker for evaluation and recommendations.

4. Ms. H has a history of osteoporosis. She had already had one fall luckily without

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CLINICAL CASE

Beatriz Korc, MD, Chair, Geriatrics Service

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consequences, but a fall with a fracture could have serious consequences. She was referred for home physical therapy, evaluation of the home for fall risks (i.e., loose rugs, poor light, lack of grab bars, etc.), and exercises to improve balance.

5. Finally, since her appetite had been poor and her weight had dropped, Ms. H was referred to the nutritionist to help maximize her intake of nutrients necessary for her upcoming treatment.

All recommendations were discussed with the primary oncologist and shared with all the doctors involved in her care, including the community primary care physician. The Geriatrics Service will follow Ms. H during the course of cancer treatment, striving to predict and/or prevent sometimes avoidable complications related to her age, frailty, other chronic medical conditions, and social factors that could interact and/or interfere with cancer treatment. ■

New 65+ Team Member

Christopher Anrig, LCSW-R, has joined the 65+ team this year. Chris comes to us after working for the past ten years on the inpatient Genitourinary and Urology Services. Chris received his BA degree from Kenyon College and his master's degree from Columbia University in clinical social work. Chris has postgraduate degree training in end-of-life care from New York University. He also completed training in human sexuality at the New York-Presbyterian Hospital/Weill Cornell Medical College and is a member of the Cornell faculty. ■