

ONCOLOGY NURSING SOCIETY POSITION



Oncology Nursing Society and Geriatric Oncology Consortium Joint Position on Cancer Care for Older Adults

Most cancers are diagnosed in patients older than the age of 65, yet older adults with cancer are a medically underserved segment of the U.S. population (Yancik & Ries, 2000). Compared with younger adults, those 65 years or older are less likely to be screened for cancer and when a diagnosis of cancer is made, are less likely to be offered curative therapy or participation in clinical trials (Kearney, Miller, Paul, & Smith, 2000). Older adults may receive less aggressive therapy than younger adults (Truong, Bernstein, Lesperance, Speers, & Olivotto, 2006). Clinicians may hold ageist beliefs that older adults will not tolerate current therapeutic modalities as well as younger patients despite evidence to the contrary (Bernardi et al., 2006). Treatment of older adults often is complicated by concurrent management of comorbid conditions. This intricate clinical challenge is poorly investigated and has little evidence to guide practice (Koroukian, Murray, & Madigan, 2006). Older adults who survive cancer have wide-ranging concerns and unmet health, functional, and psychosocial needs (Deimling, Bowman, Sterns, Wagner, & Kahana, 2006; Sweeney et al., 2006). Finally, older adults often are not provided appropriate palliative and end-of-life care (Ragan, Wittenberg, & Hall, 2003; Rao, Hsieh, Feussner, & Cohen, 2005). As a consequence, older patients with cancer often experience diminished quality of life (Esbensen, Osterlind, & Hallberg, 2006).

Essential elements of evidence-based supportive care for older adults with cancer include pharmacologic and non-pharmacologic interventions. Current supportive care to limit complications of therapy, provide palliation across the disease trajectory, and anchor end-of-life care relies on evolving science and emerging systems of care. Hematopoietic growth factors to address myelosuppression, antiemetics that limit nausea and vomiting, selective serotonin reuptake inhibitors and other agents to treat depression, and opioids and other analgesics that relieve pain continue to be underused in caring for older adults (Alexopoulos, 2005; Gridelli, 2004; Sutton, Demark-Wahnefried, & Clipp, 2003). Reasons for underuse are explicated incompletely in current literature. Physical therapies and other rehabilitative strategies to reduce functional morbidity; behavioral interventions to mitigate depression, anxiety, and other psychological conditions; and social interventions, such as case management to make best use of available health and social resources, are relatively unexplored. Limited evidence therefore hinders best practice.

People older than 65 continue to be underrepresented in cancer clinical trials and other clinical research. Barriers to participation remain despite efforts to remedy poor enrollment, resulting in a paucity of data relevant to older adults (Lewis et al., 2003). Common comorbidities, age-related organ functional changes, and psychosocial and socioeconomic factors do not factor into current study design and may further limit participation and advancement of the science. Similarly, behavioral and social research has focused largely on younger adults, leading to a void in understanding the complex and often unique needs of older adults with cancer and their family caregivers (Giacalone, Blandino, Spazzapan, & Tirelli, 2005). Exploration of identity, function, and the chronic illness experience in psychological, emotional, and spiritual well-being is critical to progressing current templates for clinical decision making and treatment planning. Generational and cohort effects on social roles and economic stability likely contribute to older adults' understanding of cancer and its treatment. Thus, study of these factors must parallel treatment advances. Finally, interconnections among social support, cumulative loss, and care needs require study that documents and improves consequences of social need on cancer care for older adults.

Projected aging of the population and expected epidemiology of cancer, along with common comorbid conditions, are poorly matched by current and future funding and public policy for research and care. Available analyses, although few, suggest looming inadequacies in the provision of and payment for cancer care for older adults (Bhattacharya, Shang, Su, & Goldman, 2005).

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It Is the Position of ONS and the Geriatric Oncology Consortium That

- Ageism in cancer care, and research, education, and public policy that support it, must be eliminated.
- Age is measured in ways that move beyond chronology to include biologic, functional, and personal dimensions of advanced age, ageing, and late life.
- Outcomes of cancer care for older adults extend beyond disease-free survival and include impact of comorbidity, global and specific function, and quality of life.
- Older adults have full and equal access to cancer care from screening and diagnosis through treatment, rehabilitation, and palliation to survivorship, wellness, and end-of-life care.
- Interdisciplinary teams and geriatric assessment strategies are used to optimize treatment planning, access to care, and outcomes across the cancer care trajectory.
- Research, education, outreach, and incentives are necessary to understand and remedy barriers to clinical trials, participation, and other research involvement for older adults.
- Shifts in advocacy and legislation leverage policy reform to recognize and manage implications of aging and cancer in our aging society.
- Policy reform mandates that research is necessary to the development of appropriate health and social services for older adults with cancer.
- Increased funding for basic, clinical, and translational research in aging and cancer is vital to address this agenda.

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Approved by the ONS Board of Directors and the Geriatric Oncology Consortium Board of Directors, 2/04; revised 1/07.

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