Older Survivors and Cancer Care

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The current sizeable population of cancer survivors has brought to the forefront key issues related to treatment decisions, management of adverse consequences of cancer and its treatment, and complex health needs related to cancer and other chronic comorbid conditions (1).

Although improvements in cancer diagnosis, early detection, and treatment have led to dramatically increasing numbers of cancer survivors, cancer continues to be the second most common cause of death in the United States, and an estimated 1,444,920 new patients are expected to be diagnosed with cancer during this year alone (2). Cancer survivorship research focuses on the health and life of individuals living with the late or long-term effects of cancer or its treatment(s). By definition, patients living with advanced disease are cancer survivors.

Individuals older than age 65 account for 60% of the estimated 10.8 million cancer survivors in the United States today (1). With the aging of the population, a rising trend in numbers of older cancer survivors is expected. Given the median age at diagnosis (67 years; all sites combined) and increasing survival estimates, comorbid conditions, especially among older survivors, are and will be an important factor in treatment decisions, posttreatment follow-up care, and palliative care (3,4). Studies have demonstrated that the presence of comorbid health conditions and perceived health vulnerability of the elderly by physicians can lead to under- or less aggressive treatment of the elderly, with resulting poor prognoses. Comorbidity in older patients may limit the ability to obtain (or for patients to undergo procedures that furnish) prognostic information (eg, axillary lymph node dissection), minimize treatment options (eg, breast-conserving therapy), and increase the risk of death from causes other than cancer (5).

We propose that “cancer-related care” can be envisioned at four levels: 1) acute treatment of the cancer; 2) surveillance and follow-up care for disease recurrence, management of adverse treatment-related consequences and noncancer comorbidities; 3) palliative care for advanced cancer; and 4) end-of-life care. Supportive and palliative care have been recognized as important components of quality care for all cancer patients, particularly for those with advanced or incurable disease (6,7). Although it is increasingly accepted that quality palliative care should be provided through an interdisciplinary team approach with a focus on comfort and quality of life (8), the lack of a strong evidence-based foundation for this important area of research may result in missed treatment opportunities, the provision of nonbeneficial and burdensome interventions, and over- or undertreatment (9,10).

Within palliative surgery and other invasive specialty areas, specific concerns include the risks of major morbidity and mortality associated with many cancer-specific treatment approaches and the impact of decreased or severely restricted decision-making capacity among patients, especially those who are frail and elderly. The diversity of ethnic, cultural, and religious backgrounds of patients experiencing life-threatening illness at older ages adds further complexity to the provision of acceptable and optimal cancer-related care.

The fact that the Medicaid-insured nursing home patients studied by Bradley et al. (11), as reported in this issue of the Journal, had a preponderance of late and unstaged disease, high mortality within a few months of diagnosis, low hospice utilization, and little cancer-directed treatment is of concern, and future studies should further examine these issues. Timely cancer treatment and the alleviation of symptoms have the potential to extend life and enhance the quality of survival. Especially noteworthy are the findings that 1) relative to patients aged 86 years and older (the fastest-growing segment of the US population), patients aged 76–80 years and 81–85 years were less likely to be diagnosed with late or unstaged cancer at diagnosis; and 2) compared with patients with breast cancer, patients with colorectal, lung, prostate, and other cancers were more likely to be diagnosed with late or unstaged cancer. These results in particular underscore the fact that within the overarching category of “older survivors”, complexities related to early detection and management of the disease increase with age. In addition, some cancers other than breast cancer tended to have been diagnosed relatively late in this study, highlighting the need for vigilance toward possible cancer-related symptoms for some common cancers. These findings also might reflect the impact of established guidelines and practices relating to mammograms, as opposed to inconsistencies regarding prostate-specific antigen testing, colonoscopy, and screening for lung cancer.

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Bradley et al. (11) found that demographic characteristics and comorbid conditions were not highly predictive of cancer detection, treatment, survival, or hospice utilization among Medicaid nursing home residents. These results contrast with previous studies, possibly because previous studies were not confined to nursing home patients. In addition, these results could reflect the homogeneity of the group and lack of variability in the distribution of these factors.

In terms of patterns of diagnosis, mortality, and treatment, elderly nursing home Medicaid patients are a unique population, especially when compared with non-nursing home residents or private-pay nursing home patients. In frail individuals, the impact of unnecessary biopsies and emotional stress is an important factor to consider in decision-making related to care. It is also important to consider the attitudes, beliefs, and preferences of the patients and their families. The social environment (social support or network, availability of caregivers, etc) of these patients may be a key factor in treatment choices. Future studies need to examine the possible impact of patient or family preference, cultural mores, and the provision of complex cancer-related care in the presence of other comorbid conditions (12).

The larger scientific community has called for care approaches that will lead to both increased length and quality of life for all cancer survivors (13,14). Older survivors of cancer are a particularly vulnerable population due to the impact of cancer and its treatment on long-term or late effects of the disease or its treatment, the potential impact of the cancer on the risk for or severity of comorbid conditions, and the effect of comorbidities on cancer and its care. By assessing the patient and the family, effectively using existing resources, and aligning services to specific patient and family needs, it is possible to expand access to palliative services and improve quality of care in ways that are financially feasible and acceptable to patients, families, clinicians, administrators, and payers (15). It is time that we enhance efforts to achieve clarity regarding the experiences of cancer-related care in our elderly cancer survivors. Standards, guidelines, or best practices for care that prevents, detects early, or ameliorates the adverse consequences of cancer or its treatment among all patients who have or are at risk of cancer, especially those who are older, are needed. Findings from methodologically rigorous studies (eg, prospective cohort studies or case-control studies) will improve our understanding of the nature and extent of the burden of illness carried by older (by age strata) cancer survivors and yield key information regarding quality cancer-related care, especially when notable health disparities might exist.

Optimal palliative care will often require multidisciplinary approaches and treatment plans made in accordance with the wishes of, and in partnership with, the patient and family, with a goal of decreasing morbidity and a focus on quality of life. Accurate communication, consideration of psychological problems, timely use of quality-of-life measurements for morbidities associated with treatments, effective palliative care, understanding of the patient’s spiritual and cultural background, and sufficient forewarning of impending death are important factors affecting the provision of quality palliative care (16). With continued research in this field, we may be able to achieve much-improved evidence-based cancer-related care for all survivors, irrespective of age or prognosis.

References