Bringing geriatrics into oncology or also oncology into geriatrics?

We read with interest the article of Sifer-Rivière et al. [1] on the role and status of geriatricians in a Pilot Geriatric Oncology Program that appeared in the October issue of this year. The authors’ considerations derive from the work carried out in one of the Pilot Oncogeriatric Coordination Units, established in France and that are the object of the envy of all non-French medical oncologists specifically taking care of elderly cancer patients and defining themselves as geriatric oncologists [2].

In this article, concerning the situations of the cooperation between medical oncologists and geriatricians, the authors identify two main situations in an oncological environment (cancer center or academic institution): (i) consultation of the geriatrician, (ii) organized participation of the geriatrician in the multidisciplinary consultation meetings for all newly diagnosed cancer patients.

Since as has already reported by one of us [3], the modality of the integrated management may be variable in a different setting, we would like to propose another way to think about the interaction medical oncologists-geriatricians together with having patients proposed to geriatricians in an oncological environment there could be a setting (Geriatric Department, Geriatric or Medicine Unit) where geriatricians can propose for consultation patients to medical oncologists.

We are engaged in such an experiment since in Milan at the predominantly geriatric Institute Palazzolo a Unit of Medical Oncology has been recently established. This institute is a structure of geriatrics and rehabilitation with a 600 beds nursing home, a Department of Rehabilitation including general and specific Rehabilitation Units and a Medicine Unit in prevalence dedicated to older patients. The patient accrual and the medical oncologists work depend mostly from the geriatricians in contrast to that reported by Sifer-Rivière et al. [1]. In these situations, geriatricians are not ‘reduced to make simple assessments, their opinion and proposals being ignored’ with a definite advantage for the management of the old cancer patient. The ‘power struggle between medical oncologist and geriatrician’ here appears to be well balanced. This not probably due to the house policy of this geriatric institution but rather to the fact that most patients are in a condition of frailty, where the decision of an active treatment with chemotherapy should forcibly result from a careful common discussion. Of course, the drawbacks of such a setting consist in treating older patients in an institute where surgery and radiotherapy are not under the same roof of medical oncology.

In conclusion, bringing with a structured model of care, the facility of medical oncology into geriatrics can be another possible example of integrating the practice of the two specialties and possibly offer a better management to frail older cancer patients. But at the same time raises the problem of the need in a geriatric institution of involving in the planning of a possible therapy also medical oncologists, avoiding the risk of elderly cancer patients managed simply by geriatricians or even internists.

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disclosure

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