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## Follow-up of elderly patients with urogenital cancers: Evaluation of geriatric care needs and related actions☆☆☆

Silvio Monfardini<sup>a,\*</sup>, Sara Morlino<sup>b</sup>, Riccardo Valdagni<sup>c</sup>, Mario Catanzaro<sup>d</sup>, Ardit Tafa<sup>e</sup>, Barbara Bortolato<sup>f</sup>, Giovanni Petralia<sup>g</sup>, Elisa Bonetto<sup>h</sup>, Elisa Villa<sup>i</sup>, Stefano Picozzi<sup>j</sup>, Maria Cristina Locatelli<sup>k</sup>, Giuseppe Galetti<sup>a</sup>, Andrea Millul<sup>l</sup>, Yasmin Albanese<sup>l</sup>, Elisa Bianchi<sup>l</sup>, Claudia Panzarino<sup>a</sup>, Francesca Gerardi<sup>a</sup>, Ettore Beghi<sup>l</sup>

<sup>a</sup> Istituto Palazzolo Fondazione Don Gnocchi, Milano, Italy

<sup>b</sup> Radioterapia, Istituto Nazionale Tumori Milano, Italy

<sup>c</sup> Dipartimento di Oncologia ed Emato-Oncologia, Università degli Studi di Milano, Italy

<sup>d</sup> Chirurgia Urologica Istituto Nazionale Tumori Milano, Italy

<sup>e</sup> Clinica Urologica Università degli Studi Milano, Italy

<sup>f</sup> Radioterapia Ospedale Niguarda, Milano, Italy

<sup>g</sup> Urologia Ospedale Niguarda, Milano, Italy

<sup>h</sup> Radioterapia Ospedale S. Gerardo, Monza, Italy

<sup>i</sup> Radioterapia Istituto Clinico Humanitas, Rozzano, Italy

<sup>j</sup> Urologia Ospedale Policlinico San Donato, San Donato Milanese, Italy

<sup>k</sup> Oncologia Medica, Ospedale San Carlo, Milano, Italy

<sup>l</sup> IRCCS Istituto di Ricerche Farmacologiche Mario Negri, Milano, Italy

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### ABSTRACT

**Objectives:** To investigate a comprehensive geriatric assessment (CGA) with subsequent investigation of healthcare patterns in older patients with urological cancers undergoing initial surgery or radiotherapy, to verify the usefulness of the incorporation of geriatric principles in future care plans.

**Material and Methods:** This is a prospective cohort study. From November 2011 to March 2015, CGA was offered to all patients aged 70+ years treated with radiotherapy or surgery at seven tertiary centers. Patients were classified as fit, vulnerable, or frail according to Balducci's definition. CGA and follow-up data were collected by two trained evaluators at 6 and 12 months. The information collected was not available to the caring physicians during follow-up. **Results:** CGA was performed in 453 patients with prostate cancer (295), bladder cancer (126), or kidney cancer (32). 40% of patients with prostate cancer were fit, 47% vulnerable, and 13% frail. The corresponding values for renal cancer were 25%, 40%, and 34%, and for bladder cancer, 21%, 42%, and 37%. During follow-up, 60% of patients with cardiac diseases, 42% of those with diabetes/other metabolic disorders, 35% of those with hypertension, and 35% of those with respiratory diseases were followed by a specialist (for these severe/extremely severe comorbidities). Of 16 patients with ADL impairment and 63 with IADL impairment, only 4 (25%) and 6 (10%), respectively, were referred to a rehabilitation service. Only one case was referred to a geriatrician.

**Conclusions:** Appropriate clinical care patterns are advisable to improve quality of survivorship in older patients with urological cancers.

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### 1. Introduction

Sixty percent of cancer survivors in the United States in 2008 were adults aged 65 years or older and by the year 2020 two thirds of cancer survivors will be aged >65 years [1]. Based on the number of patients

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\* Corresponding author at: Geriatric Oncology Program, Istituto Palazzolo, Fondazione Don Gnocchi, Via Palazzolo 21, 20149 Milano, Italy.

E-mail address: [smonfardini@dongnocchi.it](mailto:smonfardini@dongnocchi.it) (S. Monfardini).

with co-morbid conditions, approximately 50–75% of elderly patients with cancer are expected to need comprehensive, psychosocial, and physical support [2].

To deal with the complexity of the management of older patients in everyday practice, even in the absence of specific studies, the following options have been proposed: 1. a comprehensive geriatric assessment (CGA); this approach has been applied to evaluate older patients with cancer entering clinical trials [3–5]; and 2. interdisciplinary oncological-geriatric team activities [6,7].

Another way to deal with the complex and interdisciplinary care for older patients with cancer is the development of clinical care patterns

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[8], aimed at improving quality of care in survivors. Recently, an assessment of persistent and coexisting health problems has been suggested [9].

Prostatic cancer is a neoplasm of old age, with more than 60% of cases occurring after 65 years, and a leading cause of death in the western world [10]. Bladder cancer occurs most commonly in the elderly, the median age at diagnosis being 69 years for men and 71 years for women [11]. Also, kidney cancer can be considered primarily a disease of the elderly since the peak incidence occurs between 60 and 70 years [12]. While the rehabilitation of treatment-related effects of prostate and bladder cancer, such as incontinence and impotence, is well known and is managed by surgeons and radiation oncologists, the geriatric side of these patients after the completion of the initial therapy has not been extensively studied. For these reasons, we investigated the clinical and psychosocial follow-up for geriatric patients undergoing a first radical treatment of urogenital neoplasms. Our study was designed with the following aims: 1) to evaluate, using a CGA, comorbidities, functional deficits, depression, cognitive dysfunction, body mass, and socio-economic conditions of these patients; 2) to prospectively assess their care pathways; and 3) to verify the applicability of geriatric principles in current oncological follow-up for future care plans.

## 2. Material and Methods

### 2.1. Enrollment of Patients and Data Collection

This is a multicenter prospective cohort study. From early November 2011 to the end of March 2015, all patients aged 70 years or older admitted to seven institutions of the city of Milano, Italy with histologically confirmed urological cancer after recovery from primary surgery and/or radical radiotherapy were asked to participate in the study. Only patients providing a written informed consent were entered in the study. The responsible urologist or radiation oncologist then contacted the Study Central Office. A request was sent to the Data Collection Unit to arrange an appointment for an evaluation in the outpatient setting of the participating institutions.

### 2.2. Investigators

The Data Collection Unit consisted of two junior investigators who received a special training on the study aims and conduction, collection of data pertinent to CGA, and follow-up. A Geriatric Evaluation Unit made by two of us (SM and a GG) was responsible for the assignment of the cases to the categories of fit, vulnerable and frail on the basis of the CGA items (see below). The other investigators included urologists and radiation oncologists taking care of the patients admitted to the study who collected patients' demographics, tumor histology and stage, and type of treatment. Follow-up data included hospital admissions, assigned treatments, and ambulatory visits.

### 2.3. Tools and Definitions

The CGA included evaluation of patients' functional status, comorbidity, cognition, body mass, psychological state, and social condition. In this study, functional status was determined through the activities of daily living (ADL) [13,14] and the instrumental activities of daily living (IADL) [15,16]. Comorbidity was evaluated through the Cumulative Illness Rating Scale Geriatrics (CIRS-G) [17]. To assess cognition, the Mini Mental State Examination (MMSE) [18] was used. The Geriatric Depression Scale (GDS) [19] was adopted to assess depression. Body mass was assessed with the Body Mass Index (BMI). The Eastern Cooperative Oncology Group (ECOG) Performance Status (PS) was determined. Number and type of medications taken at the time of CGA were also recorded.

On the basis of Balducci's criteria [20,21], each patient entering the study was classified as: 1. *Fit*: functionally independent, only mild or

moderate comorbidities; 2. *Vulnerable*: one or two severe comorbidities and/or one or more IADL functional deficits; 3. *Frail*: three or more severe comorbidities and/or one or more ADL functional deficits and/or age >85 years and/or the presence of the most common geriatric syndromes [21]. This classification was slightly modified in that patients with BMI >30 or <20 were classified as vulnerable.

The information on the CGA was collected separately by the Data Collection Unit but was not delivered to the responsible urologist or radiotherapist until the conclusion of the study.

### 2.4. Follow-up

The term "observed clinical care pattern" referred to the socio-clinical itineraries of the patients after the initial radical treatment for their neoplasm. The following care patterns were searched during a phone follow-up at 6 and 12 months and marked as yes/no: 1) need of caregiver; 2) general practitioner's consultation; 3) need of general geriatric rehabilitation (physical and/or occupational therapy); 4) need of focused rehabilitation (cardiac, respiratory, nutritional, vision, hearing, depression, etc.); 5) integrated home assistance for rehabilitation; 6) integrated home assistance for palliative care; 7) need of nursing home; 8) specialists' consultation (type and number); 9) hospital admissions for cancer-related complications; and 10) hospital admissions for comorbidities.

In patients with comorbidities, follow-up visits with the corresponding specialists at least once during a 12-month period were considered in line with common practice in Italy.

Oncologic follow-up for prostate cancer after radiotherapy and surgery was carried out according to the European Association of Urology (EAU) guidelines with control visits, digital rectal examinations (DRE), and PSA measurements [22]. For bladder muscle invasive carcinoma, oncologic follow-up was performed addressing probability, timing, and possible treatment recurrence according to the EAU guidelines [23], while for non-muscle invasive carcinoma, follow-up was based on periodic cystoscopies, the first to be performed at 3 months [24]. The EAU guidelines were also adopted for kidney carcinoma with a risk-adapted surveillance [25].

The information was collected from the patient or, in his/her absence or inability to collaborate, from the available caregiver.

### 2.5. Data Collection and Statistical Analysis

CGA and phone follow-up were offered to 486 patients. Twenty-seven did not agree, leaving 459 eligible and consenting patients. Two hundred ninety-five patients had prostatic carcinoma, 32 had renal carcinoma, 126 had bladder cancer, five had an ill-defined "pelvis" cancer and one had penile cancer. Patients with "pelvis" and penile cancer were excluded, leaving 453 evaluable patients for subsequent analysis.

All pertinent information was transferred into a web-based database. The quality and completeness of the data were subjected to active centralized monitoring. All the data collected during the interviews were used to assess any differences between the observed care pathways and those suggested by the CGA. Descriptive statistics were performed for relevant demographic and clinical characteristics, including age, sex, presence of a caregiver, cancer type, ECOG PS, BMI, number of grade 3 or 4 comorbidities, ADL deficit (score < 6), IADL deficit (score < 8), depression (GDS ≥ 6), cognitive impairment (MMSE < 24), number of drugs, frailty classification (fit, vulnerable, frail), and type of tumor treatment. These characteristics were described using frequencies and percentages in the whole sample and after stratifying patients according to tumor site. Five different pre-defined care patterns (specialists' consultations, rehabilitation programs, geriatricians' consultation, cancer-related hospitalizations, hospitalizations due to other causes) were described by frequency and percentage of patients. Base-line characteristics from the CGA predicting each specific pattern were assessed using univariable and multivariable logistic regression models.

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