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Short communication

Deciding on adjuvant chemotherapy for elderly patients with stage III colon cancer: A qualitative insight into the perspectives of surgeons and medical oncologists

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ABSTRACT

Objective: The aim of this study is to identify doctor-related factors determining the decision-making for adjuvant chemotherapy for patients with stage III colon cancer aged ≥75 years.
Materials and Methods: 21 surgeons and 15 medical oncologists from 10 community hospitals were asked to complete a short questionnaire including tick-box questions regarding motives for non-referral/non-treatment, consultation of geriatricians, chemotherapy schemes prescribed and an open question regarding tolerability of chemotherapy.
Results: 29 medical specialists returned a completed questionnaire (response 81%). The motives for non-referral/non-treatment reported most often were comorbidity/bad general health condition of the patient; surgical complications; and treatment offered but refused by patient/family. 39% of the surgeons and 55% of the medical oncologists reported consultation of a geriatrician in 2–30% of their decisions. CAPOX and capecitabine were reported by medical oncologists as the most frequently prescribed regimens. Factors that influenced the decision for monotherapy or combination therapy were comorbidity; general health condition of the patient; and toxicity profile of the chemotherapeutics. In general, medical oncologists defined grade ≤2 toxicities as tolerable, with the exception of neuropathy, for which grade ≤1 toxicity was accepted.
Conclusions: In case medical oncologists prescribe adjuvant chemotherapy to elderly patients with stage III colon cancer, the chemotherapy schemes used are in line with

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clinical guidelines and they agree on acceptable levels of toxicity. However, the variation among surgeons and medical oncologists in motives for non-referral, non-treatment and consultation of geriatricians when deciding on adjuvant chemotherapy for elderly patients with stage III colon cancer, shows the complexity and need for specific knowledge.

1. Introduction

In previous studies, we showed that only a small proportion of elderly patients with stage III colon cancer receives adjuvant chemotherapy[1] and that there is a large variation between hospitals in the southern part of the Netherlands with regard to adjuvant chemotherapy administration among these patients, which could not be explained by casemix. Additionally, type of prescribed chemotherapy varied, broadly distinguishing between oxaliplatin-containing chemotherapy and non-oxaliplatin-containing chemotherapy.[2]

The objective of the current study was to identify subjective, doctor-related factors in the decision-making on adjuvant chemotherapy in elderly patients with stage III colon cancer. More specifically, the aim of the study was fourfold. The first goal was to identify which motives surgeons and medical oncologists have for non-referral for, or non-treatment with, adjuvant chemotherapy of patients with stage III colon cancer aged 75 years or older. Secondly, we evaluated whether surgeons and medical oncologists consult geriatricians in the decision-making process. Thirdly, we investigated which chemotherapy schemes medical oncologists prescribe to patients and what motives they have for prescribing monotherapy or combination therapy. Finally, we assessed the (grade of) toxicity caused by the adjuvant chemotherapy deemed acceptable by medical oncologists.

2. Materials and Methods

36 medical specialists with colorectal cancer as their area of interest and who are directly involved in the treatment of patients with colon cancer (21 surgeons and 15 medical oncologists) were asked to complete a short questionnaire between December 2013 and January 2014.

The medical specialists represent all 10 community hospitals in the southern part of the Netherlands. Eight of these hospitals are also teaching hospitals (seven for surgery, eight for internal medicine and four for clinical geriatrics). In 2013, between 75 and 200 patients with colon cancer were diagnosed in each hospital, of whom 2–15% was 75 years or older and diagnosed with stage III disease. Furthermore, all hospitals have multidisciplinary tumor boards. More than 90% of the patients are discussed in these multidisciplinary tumor boards.[3] Geriatricians are present in each hospital, but it is unknown whether they are available for oncological consultation.

Self-administered questionnaires were developed and discussed with a medical oncologist involved in the study for content and relevance. Two slightly different versions (one for surgeons and one for medical oncologists) of the questionnaire with room for remarks were created. The questionnaire addressed to surgeons included tick-box questions regarding motives for non-referral of patients with stage III colon cancer aged 75 years or older for adjuvant chemotherapy and consultation of a geriatrician in the decision for (non-)referral (Appendix A). The questionnaire addressed to medical oncologists included tick-box questions regarding motives for omitting adjuvant chemotherapy in patients with stage III colon cancer aged 75 years or older, consultation of a geriatrician in their treatment decision, type of chemotherapy schemes the medical oncologists prescribed to these patients, and an open question regarding the (grade of) toxicities deemed (un)acceptable (Appendix B). Demographic characteristics of the respondent (gender, age) were also included in both questionnaires. To increase the number of respondents, the final versions of the questionnaires were intentionally kept to a three page maximum, which could be completed within 10 min.

The medical specialists were requested to return the questionnaire to the Netherlands Comprehensive Cancer Organisation (IKNL) in a provided envelope. Returned questionnaires contained a study number only. If the questionnaire was not returned within 4 weeks, a reminder letter and questionnaire were sent. A second digital reminder and online questionnaire were sent 2 weeks after the first reminder.

3. Results

29 medical specialists from 10 hospitals returned a completed questionnaire (response 81%). More specifically, 18 surgeons (response 86%) and 11 medical oncologists (response 73%) participated. All hospitals were represented by at least one surgeon (range 1–3) and one medical oncologist (range 1–2). A large majority of the respondents was male (25/29, 86%) and were in the age groups 40–49 years (10/29, 34%) or 50–59 years (10/29, 34%). In contrast, among the non-respondents (3 surgeons, 4 medical oncologists), the majority was female (4/7, 57%). Age of the non-respondents was unknown.

3.1. *Motives for Non-Referral and Non-Treatment*

Fig. 1 presents the proportions of surgeons and medical oncologists reporting each listed reason as motive that they have for non-referral or non-treatment with adjuvant chemotherapy of patients with stage III colon cancer aged 75 years or older. The motives that most surgeons had were comorbidity or bad general health condition of the patient (100% of the surgeons); presence of surgical complications (89%); and refusal of adjuvant therapy by the patient and/or family (61%). These motives were also reported by most of the medical oncologists (91%, 63% and 91% of the medical oncologists, respectively). Medical oncologists also frequently reported that they had the motive that expected side effects were too severe (63%). Age per se was only an issue for a