

CANCER SCREENING AND EARLY DETECTION IN OLDER PEOPLE: CONSIDERATIONS FOR NURSING PRACTICE

SARAH H. KAGAN AND KRISTEN W. MALONEY

OBJECTIVE: *To synthesize relevant issues in cancer screening for older people for nursing practice.*

DATA SOURCES: *Published scientific literature, clinical literature, and published cancer screening guidelines from the United States and Canada.*

CONCLUSION: *Nurses are caring for increasing numbers of older patients and, with this demographic shift, face increasing demands to address cancer screening and detection in both primary and specialty practice.*

IMPLICATIONS FOR NURSING PRACTICE: *Ageism, self-stereotyping, cancer fear and fatalism, and cancer survivorship experiences influence cancer screening and generate the need for improved awareness of these issues to advance nursing practice.*

KEY WORDS: *older adult, cancer screening, ageism, cancer fear, gero-oncology, health promotion, preventive health care.*

Sarah H. Kagan, PhD, RN, AOCN: *Lucy Walker Honorary Term Professor of Gerontological Nursing, School of Nursing.* Kristen W. Maloney, MSN, RN: *AOCNS, Nurse Manager, Hospital of the University of Pennsylvania, University of Pennsylvania, Philadelphia, PA.*

Address correspondence to Sarah H. Kagan, PhD, RN, AOCN, Hospital of the University of Pennsylvania, University of Pennsylvania, Philadelphia, PA 19104. e-mail: skagan@nursing.upenn.edu

© 2017 Elsevier Inc. All rights reserved.

0749-2081

<http://dx.doi.org/10.1016/j.soncn.2017.02.006>

Cancer screening, long a mainstay of preventive primary care for mid-life adults, becomes more complex when guidelines are applied to older people. The science and practice of cancer screening is changing as populations age across the United States (US). Advancing age is proverbially referred to as the “single greatest risk factor for developing cancer.” However, more discrete understandings of carcinogenesis, specific genetic and epigenetic risk profiles, and the risk-benefit balance in screening join to create a rapidly evolving landscape in cancer screening. Biological knowledge supporting cancer

screening is complicated by a variety of psychological and social factors that are connected to aging and later life. Ageism commonly results in both under- and over-screening by health care providers, as well as preferences for screening among older people. Similarly, older people are typically subject to socially constructed age-related self-stereotyping that then affects their participation in cancer screening activities. More generally, people of older generations today may be unduly influenced by cancer fear and fatalism, recalling times in their youth when cancer meant an almost certain death sentence. Frail, multimorbid elders present challenges of applying screening guidelines, gaining concordance with recommendations, and finally completing screening in light of functional impairments. As a result, the practice of cancer screening requires considerable scrutiny to derive implications for nursing practice.

Nurses encounter older patients across all settings of care who pose questions or express concerns about cancer detection and who may be in need of guidance regarding cancer screening practices. This article synthesizes relevant science and clinical literature and reviews applicable guidelines to define issues specific to nursing practice for cancer screening and detection in older people. Aging demographics and cancer epidemiology are briefly summarized before ageism, self-stereotyping, cancer fear and fatalism, survivorship, multimorbidity, and frailty are explored in relation to cancer screening and detection to derive considerations for nursing practice across the spectrum of health care settings in which older people receive care. Current screening guidelines are reviewed to highlight issues pertinent to screening older people, especially those over the age of 75. Implications for education, science, and policy advocacy to improve nursing practice in cancer screening for older people are addressed, as relevant, throughout the article.

AGING DEMOGRAPHICS AND CANCER EPIDEMIOLOGY

The US is often spoken of as an aging society without precise analysis of direct implications of these forces for nursing science and practice. Most broadly, an aging society is determined by a declining birthrate that then shifts ratio of children under age 18, working age adults between 18 and 64 years of age, and older people over age 65.^{1,2} The

primary consequence thought to emerge in an aging society is a growing elder dependency ratio, wherein fewer working age adults are caring for more and more older people.² However, with changes in life expectancy and the health and function of current generations of older people, concerns about population elder dependency hold little precise implication for nursing care demands beyond workforce development overall.³

Two factors implicit in aging demographics present direct repercussions for nursing. First, life expectancy at age 65 alters life expectancy to help determine appropriate screening. Typically, in the absence of specific age guidelines, cancer screening that is beneficial before age 65 should be continued after that age if 10 or more years of life are expected. Presently, life expectancy at age 65 is about two decades, regardless of ethnicity or sex.⁴ As a result, many older people in their late 60s are likely to be faced with decisions regarding screening, as in the case of detecting colorectal cancer where evidence is quite definitive and in prostate cancer where guidance is considerably more equivocal.⁵ Importantly, nurses, mindful of life expectancy for ages 65 and older, are able to explore knowledge of and decisions around cancer screening with people in mid-life and beyond.⁶

Knowledge and behavior, as human factors affected by cohort effects, are inherent to cancer screening. Cohort effects are experiences, beliefs, and attitudes shared by groups of people born during a period in history and exposed to forces as they grow and age.⁷ Social generations are the best known representation of cohort effects. Cancer screening entails cohort-specific attitudes and beliefs, as well as scientific knowledge to derive behaviors for self-care and screening participation. Cohort-associated attitudes and beliefs are generally seen as relevant to the person being screened. However, cohort-specific as well as general beliefs about aging and cancer on the part of the clinician or team providing knowledge, guidance for self-care, and access to screening tests and imaging almost certainly influence cancer screening as they do cancer care more broadly.^{8,9} Presently, older people seen by nurses in practice with questions or concerns about cancer screening are possibly members of the Greatest or Mature Generation and are more likely to be those of the Silent Generation, as well as the oldest baby Boomers (see [Table 1: Current Generations](#)).¹⁰⁻¹²

Chronological age, as determined by the dates of birth for a generation, is only a proxy variable

Download English Version:

<https://daneshyari.com/en/article/5571551>

Download Persian Version:

<https://daneshyari.com/article/5571551>

[Daneshyari.com](https://daneshyari.com)