Rehabilitation Needs of the Elderly Patient with Cancer

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KEYWORDS

• Cancer • Rehabilitation • Geriatric • Function

KEY POINTS

- The challenge for a physiatrist is to anticipate and coordinate treatments for elders suffering from cancer or the effects of its treatments.
- The physician should anticipate changes in clinical status and must adjust rehabilitation goals accordingly.
- Treatment options and rehabilitation goals should be tailored to help maximize quality of life in these patients.

BACKGROUND

As the average age in the United States population grows older, the prevalence of cancer in the elderly is more apparent. It is estimated that, by 2030, 70% of all cancers will be within people older than 65,[1] with prostate, breast, lung, and colorectal cancers being the most common.[2] This estimated increase in cancer prevalence highlights the connection of carcinogenesis with aging.

Elderly patients with cancer are consistently undertreated or alternatively treated when compared with younger patients. For example, patients with breast or stage II colorectal cancers are less likely to receive chemotherapy and radiation as age advances. Radical prostatectomy is considered the gold standard of curative treatment in prostate cancer, yet, as patient age, the rates of prostatectomy decrease accompanied by an increase in rates of radiation and more conservative management.[3] Studies across many types of cancer consistently reach the same conclusion: we often treat

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geriatric patients differently than our younger populations. The reason for this disparity is multifactorial, but is largely a fear of intolerance to more aggressive therapies in the elderly. Geriatric patients are physiologically more susceptible to complications owing to decreased cardiac reserve, decreased intestinal motility, decreased lung vital capacity with impaired gas exchange, diminished glomerular filtration rate leading to increased drug half-life, changes in arterial pressure and cerebral blood flow, and disequilibrium resulting in confusion, syncope, and falls. The challenge for a physiatrist is to anticipate and coordinate treatments for elders suffering from cancer or the effects of its treatments. In the majority of these cases, the physician observes an amplification of symptoms and abrupt change in functional status with slower return to baseline.

PHYSIATRIC ASSESSMENT OF THE ELDERLY PATIENTS WITH CANCER

Pretreatment performance level assessment should include level of independence, need for mobility aids and adaptive equipment, and history of falls. The physiatrist should investigate, in great detail, the types of cancer treatment undergone: surgery, radiation, chemotherapy, and immunotherapy, as well as maintenance therapy. Enquiring about social support, recreational activities, emotional needs, and cognition is highly important because these factors will affect the rehabilitation program directly. In addition to history and comprehensive physical examination, it is useful to include standardized functional status measurements. Examples include the Timed Get-Up and-Go and the unipedal stance test, which help to identify patients at risk for falls.[4,5] Addressing fall risk is an important task for the rehabilitation team. Elderly patients with cancer may have a higher risk for falls compared with elderly patients without cancer.[6] Reducing or preventing falls will improve morbidity and mortality in this patient group.

The Comprehensive Geriatric Assessment (CGA) is an assessment tool that gives physicians and other caregivers a comprehensive analysis of the overall global health of a geriatric patient. This assessment includes all aspects of health, including functionality, comorbid medical conditions, nutrition, cognition, psychological status, polypharmacy, social support, financial status, and geriatric conditions. This assessment divides patients into 3 broad categories: Fit, Vulnerable, and Frail.

Fit patients include:

- Patients in good to excellent health,
- Patients who are functionally independent,
- Patients with no medical comorbidities, and
- Patients with no geriatric conditions.

Vulnerable patients include:

- Patients in fair to good health,
- Patients who are independent in their activities of daily living (ADLs), but may need assistance in some instrumental ADLs,
- Patients with fewer than 3 mild comorbidities, and
- Patients with mild geriatric conditions including mild depression, mild cognitive deficits, or risk for malnutrition.

Frail patients include:

- Patients with overall poor health,
- Patients who require assistance in some or all ADLs,
- Patients with 3 or more medical comorbidities or 1 life-threatening comorbidity, and
- Patients with geriatric conditions.