

ONCOLOGY NURSING SOCIETY POSITION



Oncology Nursing Society and Geriatric Oncology Consortium Joint Position on Cancer Care in the Older Adult

Cancer is primarily a disease of older adults. Approximately 60% of all cancers occur in those older than age 65 (Ries et al., 2000). Therefore, as the population of the United States continues to see rapid demographic shifts in the old (i.e., those older than age 65) and the old-old (i.e., those older than age 85), the number of older adults receiving cancer care will be unprecedented (Yancik & Ries, 2000). The older adult population is physiologically, psychologically, and socially heterogeneous. Society and healthcare providers continue to view this population in ageist ways, acting on assumptions of uniform frailty, treatment intolerance, and cognitive impairment. Such assumptions have and continue to limit the adequacy of research, appropriateness of care, and currency of education within cancer care. The Oncology Nursing Society (ONS) and the Geriatric Oncology Consortium (GOC) acknowledge the unique needs of older adults and the nature of cancer in older adults and their implications for an aging society.

It Is the Position of ONS and GOC That Care of Older Adults With Cancer Requires

- Elimination of ageism in research, education, care, and public policy as it stands against core American values of autonomy and choice.
- Education of students and practicing clinicians across health disciplines in both oncology and elder care on the unique physiologic, developmental, psychological, emotional, social, and spiritual needs of older adults with cancer and their families.
- Incorporation of measurement of age beyond chronology to include biologic, functional, and personal dimensions.
- Acknowledgement of and assessment for risks related to declining functional reserve as part of normal aging.
- Redefinition of optimal outcomes to extend beyond disease-free survival and to include comorbidity, function, and quality of life.
- Full and equal access to cancer care across the trajectory (e.g., screening, diagnosis, treatment, rehabilitation, palliative care, survivorship, wellness care).
- Interdisciplinary teams and comprehensive geriatric assessment to optimize treatment planning, access, and resulting outcomes.
- Integration of geriatric oncology care within and across care settings and delivery systems, including

primary care, acute and critical care, and long-term institutional and home care and hospice.

- Increased funding for basic, clinical, and translational research in aging and cancer.
- Improved education, outreach, and incentives for older adults to participate in clinical research.
- Advocacy, policy, and legislation that recognizes the demographic implications of aging and cancer and mandates necessary research and development of appropriate health and social services.

Background

Older adults with cancer are underserved. Compared with younger adults, those 65 years or older are less likely to be screened for cancer and, when a diagnosis of cancer is made, are less likely to be offered curative therapy or participation in a clinical trial. In addition, older adults, especially those for whom curative therapy is not appropriate, often are not provided appropriate palliation. As a consequence of these practices, older patients with cancer often experience a diminished quality of life and an increased burden. The management of cancer has evolved dramatically in recent years as more aggressive, targeted therapies involving combinations of surgery, radiation therapy, chemotherapy, and immune modulators now are available. However, older adults may receive

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less aggressive therapy than younger adults, often based on the belief that older adults do not tolerate such therapies as well (Du & Goodwin, 2001). Existing studies generally contradict that erroneous assumption (Begg & Carbone, 1983; Chen et al., 2003; Christman, Muss, Case, & Stanley, 1992; Giovanazzi-Bannon, Rademaker, Lai, & Benson, 1994; Sargent et al., 2001; Yancik, Ries, & Yates, 1989). Along with other factors, these conflicting findings may be attributable to variability in older adults' physiologic reserve (Evers, Townsend, & Thompson, 1994). Many options to palliate symptoms of disease and treatment side effects are available to interdisciplinary teams providing care to older adults with cancer, including behavioral strategies to maintain function and treat depression and other psychological conditions; physical therapies to reduce functional morbidity of surgical and other treatments; case management to make full use of available health and social resources as well pharmacotherapies such as hematopoietic growth factors for anemia, neutropenia, and thrombocytopenia; antiemetics for nausea and vomiting; selective serotonin reuptake inhibitors and other agents for depression; and opioids and other analgesics for pain. Further research is required to refine their use in groups of older adults with various malignancies.

Empirical evidence that illuminates the unique needs of older adults with cancer is strikingly limited in proportion to the demographics of cancer in our aging society. For example, patients older than 65 historically were excluded from clinical trials, resulting in a paucity of data relevant to this age group. Similarly, behavioral and social research has focused largely on younger adults, leading to a void in understanding the complex psychosocial needs of older adults with cancer. Recognition of distinctions among chronologic age and biologic and functional age along with unique features of aging in our society such as experience of comorbid illness, achievement of age-appropriate social roles, and thinning social support can foster a new paradigm for research and practice. Clinicians, researchers, educators, legislators, and policymakers must address themselves to this societal challenge and seek a new perspective on aging and cancer, improved resources for research and education, more sophisticated investigation, targeted professional

and public education, and redesigned systems of care (Kagan, 2004):

Approved by the ONS Board of Directors and the Geriatric Oncology Consortium Board of Directors, February 2004.

The ONS Board acknowledges the contributions and expertise of Lodovico Balducci, MD, Ralph Boccia, MD, Stewart Bond, RN, MSN, AOCN®, Deborah Boyle, RN, MSN, AOCN®, FAAN, Kimberly Christopher, PhD, RN, OCN®, Kathleen Effingham, RN, OCN®, William Ershler, MD, Laura Fennimore, RN, MSN, Robert Hauser, PharmD, PhD, Sarah Kagan, PhD, RN, Stuart Lichtman, MD, Molly Loney, RN, Gary Lyman, MD, Julie Meyer, MPH, ARNP, OCN®, Howard Ozer, MD, Rowena Schwartz, PharmD, BCOP, Jody Simon, MS, RPh, and Jennifer Tam, PharmD, PhD, who assisted in the development of this position.

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