Needs and expectations of elderly breast cancer patients

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A Nurses' perspective

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Board Member, European Oncology Nursing Society

Background

Understand the nursing challenges

- Supporting treatment-decision-making process
- Providing education
- Addressing and managing health and wellbeing

- Survey
  - Elderly = 70 years and over

EUROPEAN ONCOLOGY NURSING SOCIETY

SIOG
INTERNATIONAL SOCIETY OF GERIATRIC ONCOLOGY

CANO ACIO
Canadian Association of Nurses in Oncology
Association canadienne des infirmières en oncologie

1. Challenges in caring for elderly patients with breast cancer

- Challenges related to the aging process
- Challenges related to the system
- Lack of awareness about the needs
- Lack of recognition of nurses' role

1. Challenges in caring for elderly patients with breast cancer

"Treatment decisions are too much focused on technical endpoints, like survival, instead on quality of life or functional loss due to treatment. I believe that when nurses are more involved in the decision-making process, and function more as a spokesperson for patients, cancer treatment will be more 'fitted' to the patient"

2. Ethical concerns

- About over- and under- treatment
- About timing of advanced care planning
- Conflicts between patients and families' treatment wishes

2. Ethical concerns

"*Advanced Care Plans are not on the cancer chart*"

2. Ethical concerns

"The system is designed to treat. Moving away from aggressive treatment is difficult to integrate for many clinicians, but may best align with patients goals"

3. What can nurses do to improve care?

- Being patients' advocate
- Geriatric screening and geriatric assessment
- Promoting Education

3. What can nurses do to improve care?

"I think cancer nurses should be at the forefront of assessing older patients and have a voice in guiding decisions. I think nurses are sometimes in a 'subordinate' role, but we spend the most time with patients and families and can uncover functional and cognitive deficits the oncologist may not"

What to do next?

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Position statement on oncology and cancer nursing care for older adults with cancer and their caregivers of the International Society of Geriatric Oncology Nursing and Allied Health Interest Group, the Canadian Association of Nurses in Oncology Oncology & Aging Special Interest Group, and the European Oncology Nursing Society

Martine Puts [a,*], Fay Strohschein [b], Wendy Oldenmenger [c], Kristen Haase [d], Lorelei Newton [e], Margaret Fitch [a], Schroder Sattar [f], Petra Stolz-Baskett [g], Rana Jin [h], Allison Loucks [h], Ginah Nightingale [i], Cindy Kenis [j,k]

Position statement on cancer nursing care for older adults

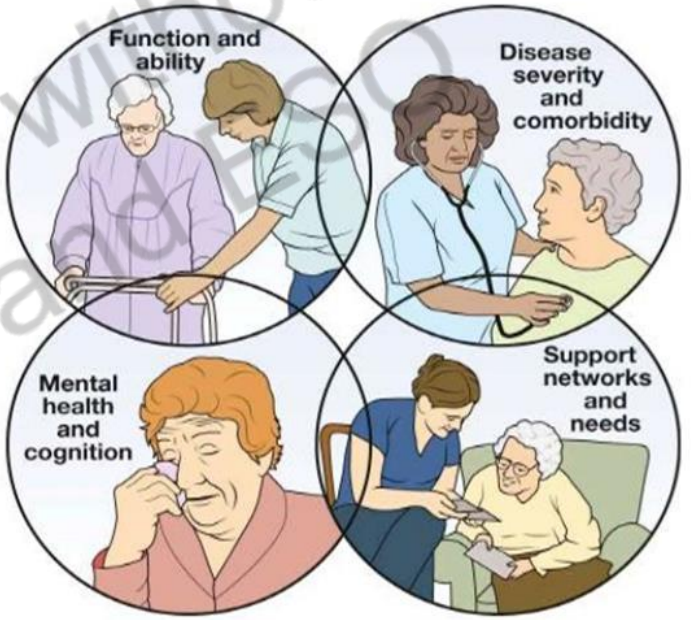
Four roles of cancer nurse to:

- Advocate for specific needs of older adults with cancer
- Identify educational needs related to geriatric oncology
- Recognize age-related issues
- Support older adults during and after cancer treatments

In conclusion

- Advocate for resources to meet the needs of older adults
- Educational resources
- Specific group?

THANK YOU



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BREAST CANCER IN THE ELDERLY

Needs and expectations of elderly BC patients:

A psycho-oncologist's experience – early and advanced cancer

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"It is not how old you are, but how you are old. "

Marie Dressler

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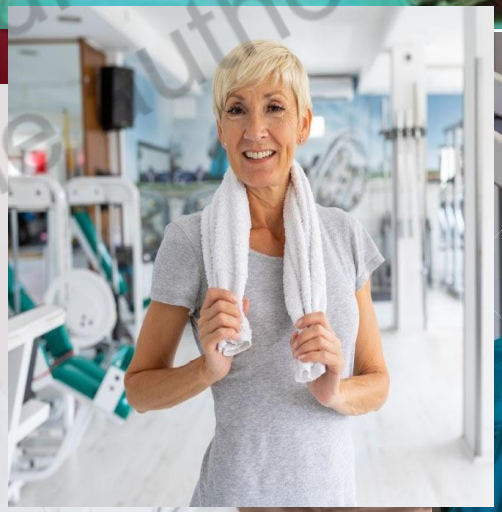

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Older age characteristics

- higher probability of occurrence of health problems
- **Disabilities** (60% > 65% > 76%)
- chronic diseases - neurological, cardiovascular, cancer , diabetes, other
- increasing multi-morbidity and polypharmacy
- organically related mental disorders – dementia, other

➢ **stress factors**: presence of physical illnesses, multiple chronic conditions, limitations of independent life, diminished social participation, diminished quality of life, disabilities in activities of daily living, cognitive impairment, loss of loved ones, **loneliness**, moving to a nursing home

>> Complexity of symptoms and needs

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Mehnert A. et al. Psychological comorbidity in elderly patients with cancer. *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz. 2011 54(1):75-82*

Assessment areas for better treatment planning:

- Physical functional status (autonomy)
- Mental health, including loss (psychological well-being)
- Polypharmacy with multiple chronic conditions
- Stress symptoms
- Social situation (e.g., income, transportation, family support and care)
- Cognitive function status
- Quality of life
- Comorbid diseases, including geriatric symptoms (fatigue, dementia)
- Patient's needs and treatment preferences * (coping)

Given BA, Given CW. The older patient. *Psycho-Oncology*. New York: Oxford University Press, 2010: 491-6.

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Major mental health problems of older persons

- **cognitive alterations or impairments**:

  delirium; dementia; dimished memory, orientation, and judgement; impaired concentration; short attention span; disorientation

- **emotional problems** :

  associated with poor physical health; crying spells;

- **psychological morbidity :**

  > **depression**: feelings of unworthiness; hopelessness; Loneliness; lonesomeness; apathy; withdrawal; suicidal impulses and/or attempts
  > anxiety disorders; stress incontinence
  > paranoid dellusions

- **behavior alterations**

  agitation; irritability; assaultiveness; demanding behavior; pacing; wandering; alcohol abuse; sleep alterations

adapted from Ferrel & Ferrel, The older Patient. In Holland J. ed. *Psycho-Oncology,* Oxford University Press, 1998: 839-844.

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Distress Prevalence and psychological issues of the elderly patients

- 153 elderly patients with cancer admitted to hospitals
- Distress thermometer and the problem list (NCCN - DT)
- *Results:* **43.8%** (67/153) participants had significant psychological distress.
- top five problems: **worry (73.9%), depression (55.6%), pain (54.2%), economic problems (52.3%), and fear (49.7%).**
- Married participants, those with higher education and higher monthly income had significantly lower psychological distress score compared with single patients, those with lower education, and lower monthly income ($p < 0.05$).

- **Conclusions:** Psychological distress is prevalent among elderly patients with cancer, needs to be addressed by the multidisciplinar HCPs team and integrated in their Tx plan

J.-F. Hong, W. Zhang, Y.-X. Song, L.-F. Xie, W.-L. Wang, Psychological distress in elderly cancer patients, International Journal of Nursing Sciences (2015), doi: 10.1016/j.ijnss.2015.02.006.

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Influence of ANXIETY and DEPRESSION on SURVIVAL in geriatric oncology patients (presented at **ASCO**)

Aim: determine whether moderate to severe anxiety (ANX) and depression (DEP) are independent prognostic variables for patients ≥65 years.

- **Methods:** All patients ≥65 years, referred to BC Cancer from 2011 – 2016 within 6 m of cancer diagnosis were included in the study. Canadian cohort.
- **Results:** **26.323 patients** were included in the analysis. Patients presenting with ANX and DEP were more likely to be female, be aged 65 to 69, have lung cancer and metastatic disease (*p*-values < 0.001). **Patients reporting emotional, informational, physical, and social/family problems or needs were more likely to present with ANX and DEP** (p < 0.001). Median **OS ANX 34 m vs no symptoms 43 m** (p < 0.001) and **DEP 31m vs no symptoms 43m (p < 0.001)**.

Conclusions:

- Geriatric oncology patients who are **female, aged 65-69, have metastatic disease or lung cancer are at risk for distress.**
- **>> ANX and DEP are independent prognostic variables, negatively impacting survival.**
- Geriatric oncology patients should **receive psychological support and follow up to better improve survival.**

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Leung B, Shokoohi A, Bates A, Ho C. Patient-reported psychosocial needs and psychological distress: the influence on survival in geriatric oncology patients. JCO 2018, 36:15_suppl 10033-10033. **Presented at 2018 ASCO Annual Meeting I**

RISK FACTORS for DEPRESSION

- social deprivation
- disability – functional impairments
- physical illness - comorbidities
- structural and biochemical changes associated
- loss of a partner
- sleep disturbance
- previous depressive illness
- female gender
- subjectively-perceived memory impairment
- previous anxiety disorder
- somatoform disorders
- external locus of control
- also: cancer site, stage, symptom severity, and treatment *

Cole MG, Dendukuri N. Am J Psychiatry. 2003. 160:1147-56.
Heun R, Hein S. Eur Psychiatry. 2005. 20:199-204.
*Stommel M et al., Health Psychol. 2004 Nov;23(6):564-73.

Types of Psychological Interventions

1. **Educational interventions & counselling**
2. **Individual psychotherapy**
3. **Cognitive-behavioral therapy (CBT)**
4. **Group interventions:**

    Supportive-Expressive Group Therapy, SEGT (Spiegel & Classen, 2000)

    Meaning-Centered Group Therapy, MCGT (Breitbart et al., 2004)

    Cognitive-Existential Group Therapy, CEGT (Kissane et al., 2007)

CARE Intervention - (Cancer and Aging: Reflections of Elders) specifically aimed toward reducing depression, isolation, and despair; CBT based; RCT suggest CARE is feasible and effective in reducing depression, anxiety, demoralization, and loneliness among older adults with cancer

CCS - **Coping and Communication Support for Older Cancer Patients** is a supportive intervention for older advanced stage patients and their family caregivers. By telephone, e-mail, or clinic visit, according to patient preference. Patients remain in the intervention until death, and their caregivers for one or more years to ensure an easy bereavement.

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EBC - The case of my friend's mother 2017 - Maria

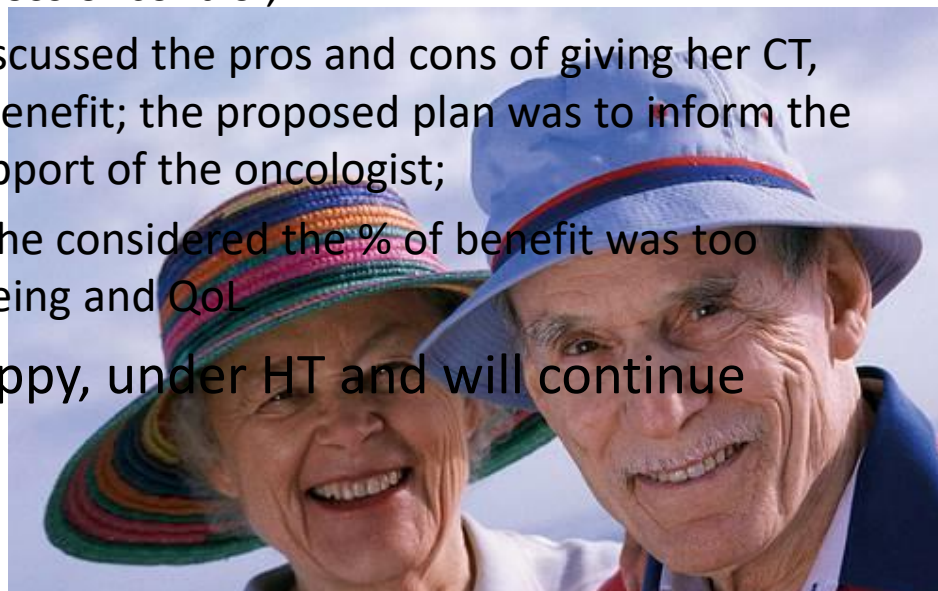
pT1c pN1a (2+) RE 100 % RP 100 % Her2- G2 Ki67 30%

75 yrs old woman beautiful and well cared, married.

She had done surgery + RT + HT and was prescribed CT

- she didn't want to take CT: the most precious thing for her was to keep her physical and emotional stability so as to continue to enjoy her good QoL with her husband;
- she was afraid that CT, while making her lose her hair, would also make her loose her joy and drawn her into a cascade of loss of control;
- she asked for a 2nd opinion: the MDT discussed the pros and cons of giving her CT, there was no agreement as to the cost-benefit; the proposed plan was to inform the patient and have her decide with the support of the oncologist;
- the patient decided not to take it since she considered the % of benefit was too small compared to the risk to her well-being and QoL

** She is now 80 yrs old well and happy, under HT and will continue



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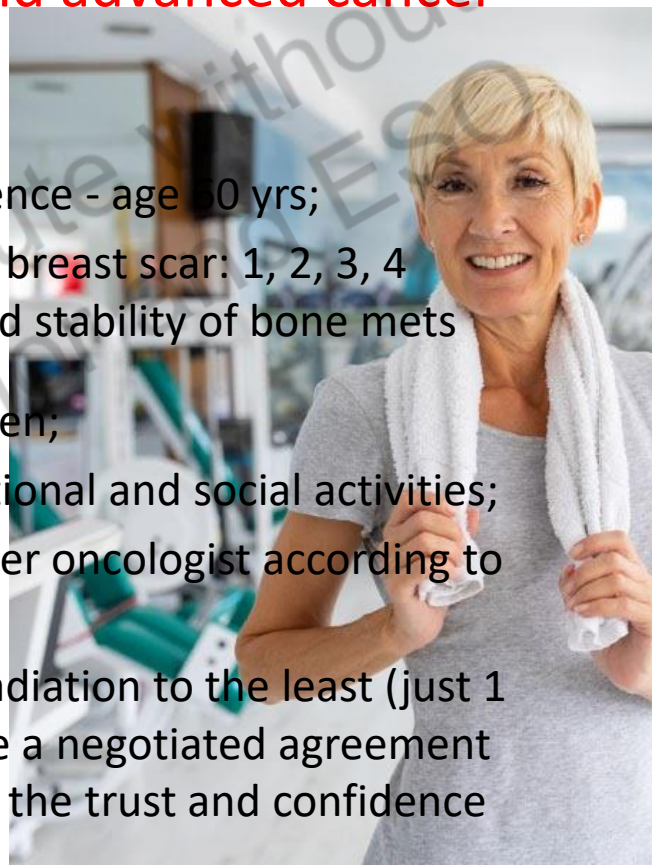

MBC - The case of Patricia

1995 EBC lobular invasive – age 49 yrs; 2006 local N recurrence - age 60 yrs;

2014 MBC recurrence – age 68 yrs – mets in the bones and breast scar: 1, 2, 3, 4 lines+RT; PD + liver 5th line with regression of liver mets and stability of bone mets

- Independent woman living alone, not married no children;
- she values her retirement and to enjoy physical, recreational and social activities;
- her QoL is everything to her so she negotiates Tx with her oncologist according to the side effects/limitations they may produce;
- she also is very keen on reducing imaging exams with radiation to the least (just 1 PET/yr), which challenges her oncologist, but both have a negotiated agreement that works well for the patient, and consistently affirms the trust and confidence she has on her oncologist;

> Now she is 75 yrs she is living with many bone metastasis, reduced a bit her energetic activities, but well and still independent and enjoying life

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which treatments??

Pre-morbid conditions

Pros

Life-extension

Not a priority!!

Cons

Treatment side-effects (fatigue, dependencies, nausea, insomnia, etc)

Quality of life !! YES

Patients' values, beliefs, culture, **preferences**, constraints, pre-morbid conditions

Good communication: information, expectations, goals, **informed decision-making**

Assessment & **Management of complexity** (biopsychosocial)

Multidisciplinary **multiprofessional** team for good communication, treatment, symptoms management, psychosocial care; palliative care

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Treatment decisions influenced by many factors:

- presence of comorbid diseases (eg cardiovascular diseases) and psychological disorders (eg depression)
- fatigue and physical weakness (frailty)
- fear of worsening functional ability and of loss of autonomy
- family pressures (availability of caregiver)
- aspects of care
- prognostic factors

➢ medical treatment needs to **balance between** the loss of current functioning, quality of life and possible life extension

➢ **Good communication skills** to elicit **patients concerns** and **goals** and make appropriate recommendations for Tx

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Lessons from the 2 cases

- In both cases patients need information to make informed decisions upon their lives
- Quality of life is more valued than quantity
- Trust in the oncologist is crucial
- **Good communication skills are essential**
- Patient centered care – patients preferences and needs – each pt is different requiring adjustment and flexibility on the Tx solutions
- Negotiating Tx choices, sharing decision making through good doctor-patient communication and based on balancing cost-benefit (%)

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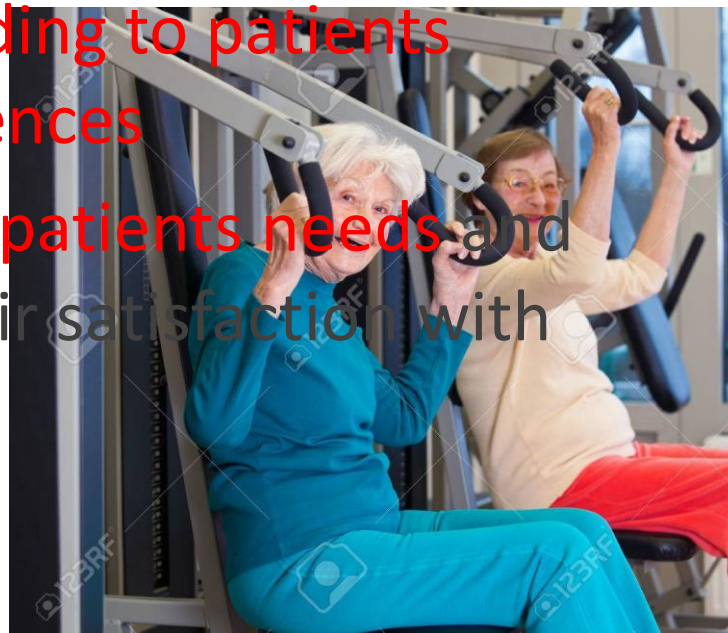
in summary:

- Geriatric patients are complex
- Geriatric oncology requires the integration of clinical and psychosocial factors into comprehensive treatment planning
- Good communication skills are essential to individual tailoring of treatment plan according to patients vulnerabilities, needs and preferences
- HCPs have to adjust their care to patients needs and not the opposite, to optimize their satisfaction with care and their outcomes



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brighton and sussex medical school

A Geriatrician's Experience

Professor Juliet Wright
University Hospitals Sussex
Brighton and Sussex Medical School

brighton and sussex medical school

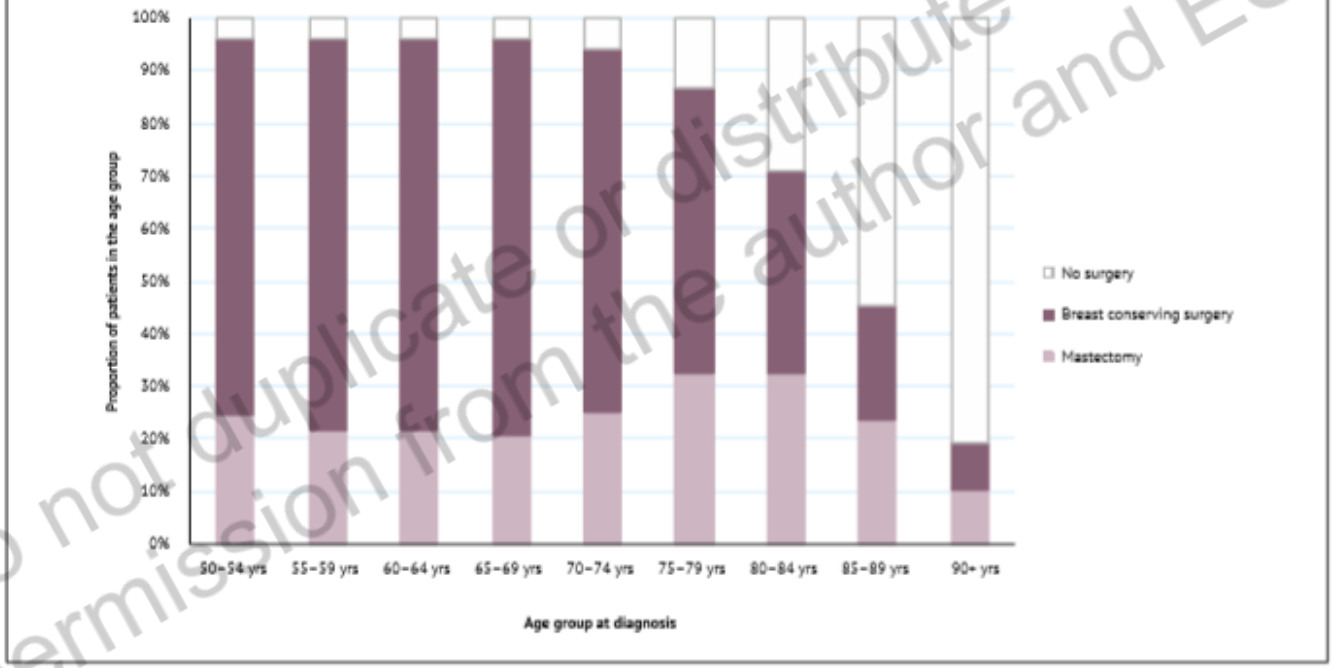
A joint geriatric oncology clinic for the management of elderly women diagnosed with breast cancer

NICE Guidance 2009

“Treat patients with early invasive breast cancer, irrespective of age, with surgery and appropriate systemic therapy, rather than endocrine therapy alone, unless significant comorbidity precludes surgery.”

Surgical omission related to Age

Figure 7.1 Type of primary treatment for early invasive breast cancer, by age at diagnosis



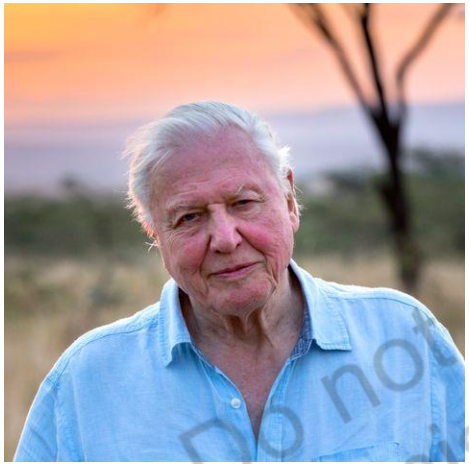
NABCOP Annual Report 2018

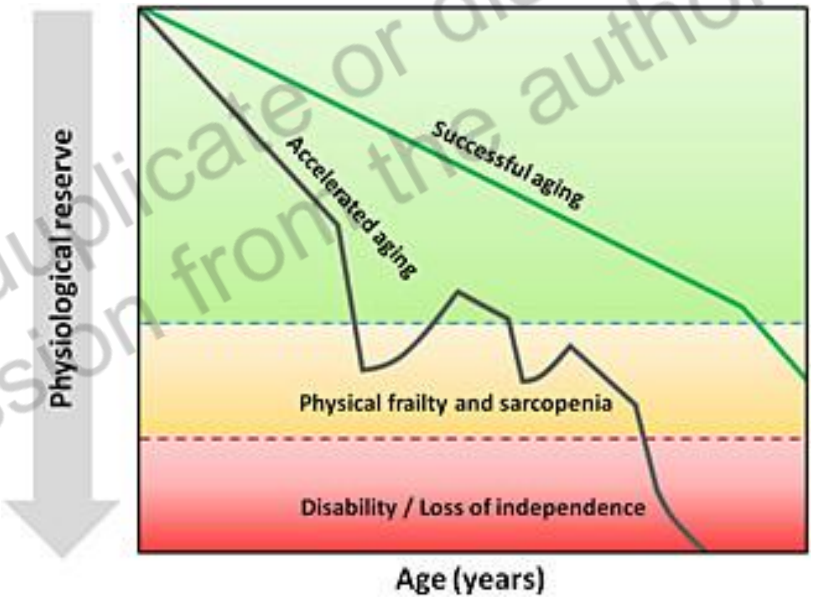
Ageing

Successful ageing

Frailty

Well-being, QoL,
Health, functional ability





Performance Status (WHO / ECOG)

0 – Asymptomatic (Fully active, able to carry on all predisease activities without restriction)

1 – Symptomatic but completely ambulatory (Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature. For example, light housework, office work)

2 – Symptomatic, <50% in bed or chair during the day (Ambulatory and capable of all self care but unable to carry out any work activities. Up and about more than 50% of waking hours)

3 – Symptomatic, >50% in bed or chair, but not bedbound (Capable of only limited self-care, confined to bed or chair 50% or more of waking hours)

4 – Bedbound (Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair)

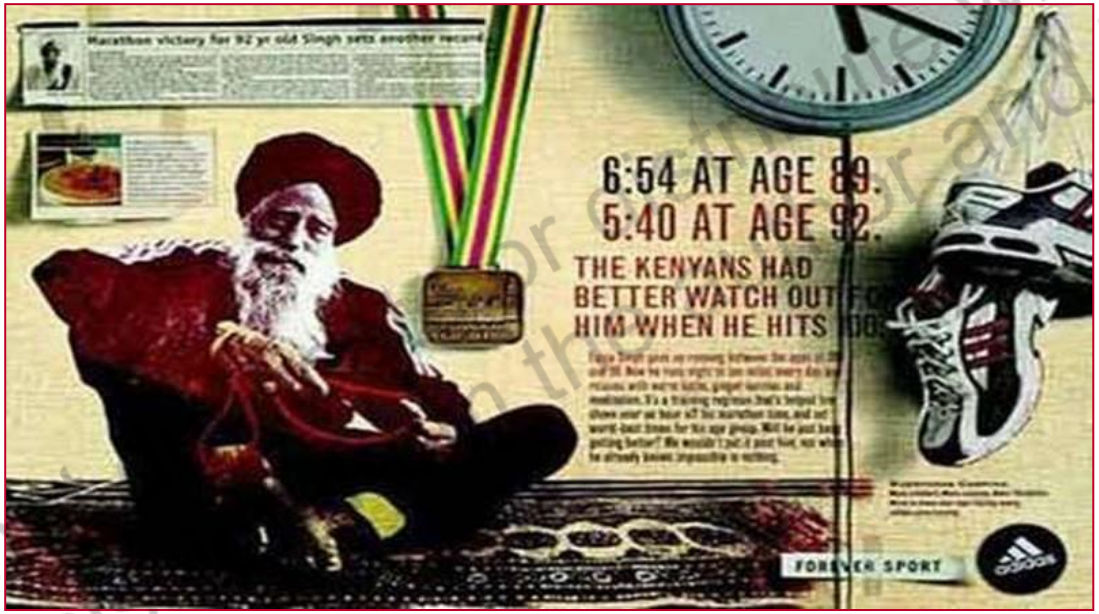
Normal ageing

Ageing is characterised by many combined changes[1–3]

- Gradual reduction in height
- Weight loss due to loss of muscle and bone mass
- A lower metabolic rate
- Longer reaction times
- Declines in certain memory functions
- Declines in sexual activity
- A functional decline in hearing, olfaction, and vision
- Declines in kidney, pulmonary, and immune functions
- Declines in exercise performance
- Changes in endocrine axis

1. Craik FIM an. Salthouse TA. (eds). 1992. Handbook of Aging and Cognition, Erlbaum, Hillsdale, NJ; 2. Spence AP. 1995. Biology of Human Aging; 3. Hayflick LJ. Gerontol A Biol Sci Med Sci 2004;59(6):B573–8.

Fauja Singh



- Age tells us useful information about groups not individuals
- Conscious and Unconscious bias

Frailty

- F(railty) word
- What we want to know is the risk/reserve/robustness…..R word

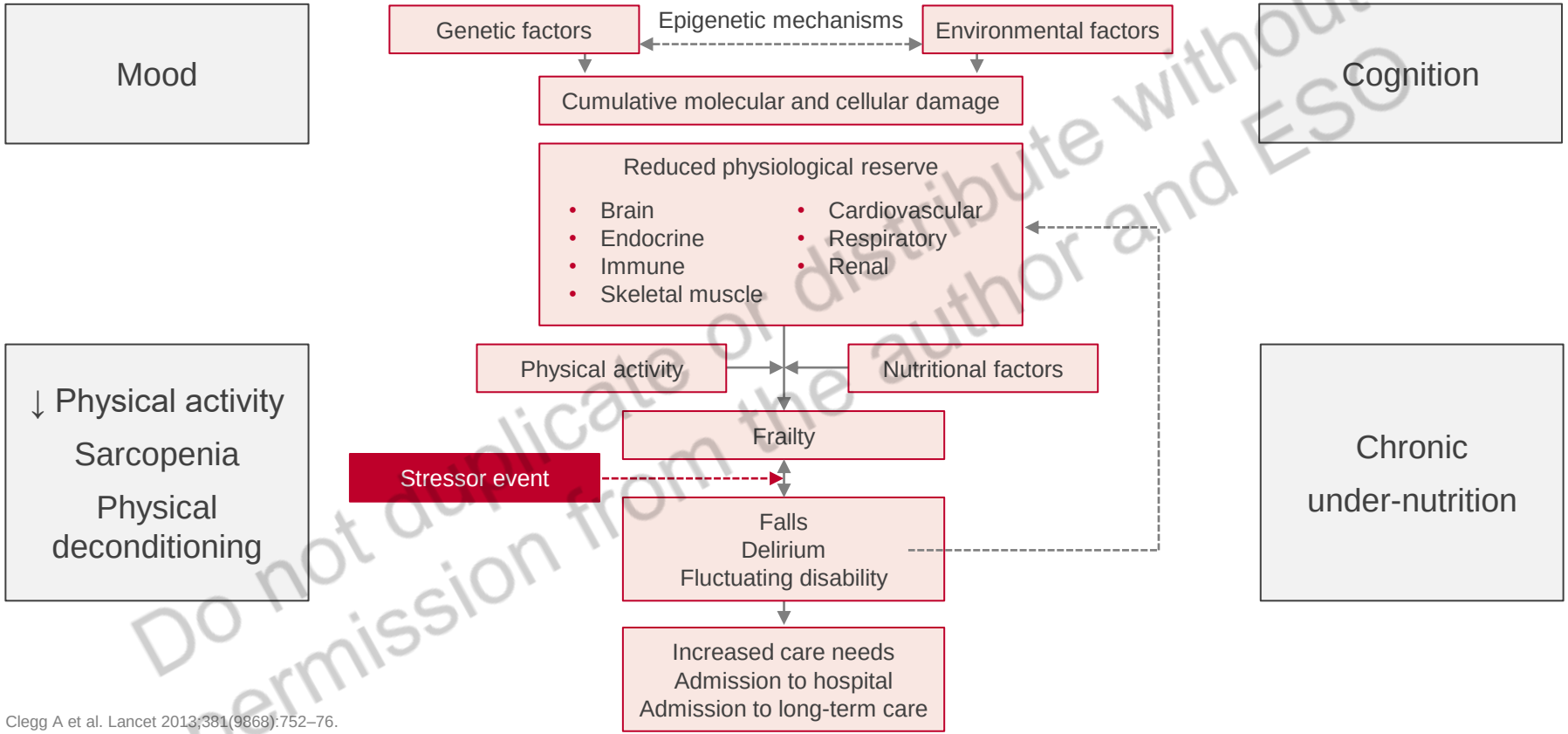
What is frailty?

- Age-related decline in multiple physiological systems
- Threshold of homeostatic reserve reached, resulting in:
  - An ‘at risk’ state
  - Vulnerability to minor stressor events
- **Disproportionate changes** in health status:
  - From mobile to immobile
  - From lucid to confused
  - From independent (‘managing’) to requiring help
- An increased risk of adverse events

Underpins the ‘non-specific nature’ of some medical presentations in older adults

Clegg A et al. Lancet. 2013;381(9868):752–76.

Schematic representation of the pathophysiology of frailty



Clegg A et al. Lancet 2013;381(9868):752–76.

Common presentations of frailty

- Fatigue, unintentional weight loss, frequent infections[1]
- Falls (a non-faller may fall due to a minor stress event)[1]
- Over time failure of postural and gait systems (vision, balance, muscle strength)[2]
- Unable to guarantee safe navigation of undemanding environments – spontaneous, recurrent falls may occur[2]
- Delirium: Present in 15–30% elderly patients on admission to hospital[3]
- Fluctuating disability (‘good’ and ‘bad’ days)[1]

1. Chen X, Mao G and Leng SX. Clin Interv Aging 2014;9:433–41; 2. Eeles E and Low Choy N. Frailty and Mobility, in Theou O, Rockwood K (eds). Frailty in Aging. Biological, Clinical and Social Implications. Interdiscipl Top Gerontol Geriatr. Basel, Karger, 2015, vol 41, pp 107–20; 3. Inouye SK. Clin Geriatr Med 1998;14(4):745–64.

How do we define it?

- This is difficult
- No consensus definition exists
- Two major schools of thought:
  - The Frailty Phenotype – a frailty syndrome[1]
  - The Frailty Index – a frailty state[2]

Images found in the public domain, no copyright

1. Fried LP et al. J Gerontol A Biol Sci Med Sci 2001;56(3):M146–56; 2. Rockwood K and Mitnitski A, Clin Geriatr Med 2011;27(1):17–26.

The Frailty Phenotype

Shrinkage	*Weight loss, unintentional, >=10 pounds in one year, or at follow up of >=5% body weight in the prior year*
Weakness	*Grip strength in lowest 20% at baseline, adjusted for gender and BMI*
Poor endurance and energy	*Self report of exhaustion, identified from two questions on the CES-D*
Slowness	*Slowest 20% of population based on time to walk 15 feet, adjusted for gender and standing height*
Low physical activity	*A weighted score of kilocalories expended per week, with low activity if in lowest quintile for gender*

Fried LP et al. J Gerontol A Biol Sci Med Sci 2001;56:M146–56.

Scored as:

- 0 items = Robust
- 1–2 items = Pre-fail
- 3 or more = Frail

Criticism:

- Very physically focused
- Does not take in to account individual comorbidities
- Does not include cognition or mood
- Not easy to use clinically

Frailty Index

An alternative frailty model, which utilises a multi-dimensional approach where deficits accumulate across a range of functional, physical and cognitive domains (Rockwood and Mitnitski, 2011) as part of the Canadian Study of Health and Aging. Basedon Comprehensive Geriatric Assessment (CGA)

- Deficit accumulation
  - Deficits = symptoms, signs, disease states, specific functional deficits
  - Markers of the decline in physiological reserve
  - The more you have the more likely you are to be frail
  - So if 10/40 deficits present, their FI = 0.25
  - Adverse outcomes proportional to deficits - more you have, worse you do
  - Cut off between fitness and frailty around 0.25
  - Upper FI threshold around 0.67, where any more leads to death

FI, frailty index

Rockwood K and Mitnitski A, Clin Geriatr Med 2011;27(1):17–26.

CLINICAL FRAILTY SCALE

1 VERY FIT — People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.

2 FIT — People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g., seasonally.

3 MANAGING WELL — People whose **medical problems are well controlled**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.

4 LIVING WITH VERY MILD FRAILTY — Previously "vulnerable," this category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up" and/or being tired during the day.

5 LIVING WITH MILD FRAILTY — People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.

6 LIVING WITH MODERATE FRAILTY — People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 LIVING WITH SEVERE FRAILTY — **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).

8 LIVING WITH VERY SEVERE FRAILTY — Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.

9 TERMINALLY ILL — Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

In **very severe dementia** they are often bedfast. Many are virtually mute.

DALHOUSIE UNIVERSITY

Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

Other frailty rating scales

There are many!

- Edmonton Frail Scale[1]
- FRAIL score[2]
- SHARE frailty index[3]
- Groningen Frailty Indicator[4]
- Tilburg Frailty Indicator[5]
- Study of Osteoporotic fractures[6]
- CGA based FI[7]
- Prisma 7[8]
- Clegg et al – electronic frailty index[9]

But:

- What should they include?
- Different for different specialities/interventions?
- Should social factors be included?
- What about cognition and mood?
- Should we use physical, self reported, objective, laboratory results, biomarkers (IL6, CRP)?
- Is the scale clinically applicable?

1. Rolfson DB. Age Ageing 2006;35(5):p526–9; 2. Morley JE et al. J Nutr Health Aging 2012;16(7):601–8; 3. Romero-Ortuno R and Soraghan C. BMJ Open 2014;4:e006645; 4. Steverink N et al. Gerontologist 2001;41:e236–7; 5. Gobbens RJ et al. Gerontologist 2012;52(5):619–31; 6. Li G et al. BMC Musculoskelet Disord 2017;18(1):46; 7. Rockwood K and Mitnitski A. Clin Geriatr Med 2011;27(1):17–26; 8. Raîche M, Hébert R, and Dubois MF. Arch Gerontol Geriatr 2008;47(1):9–18; 9. Clegg A et al. Age Ageing 2016;45(3):353–60.

Is frailty permanent?...

- Not necessarily!
- Frailty does appear to be a dynamic process[1]
- But… trajectory is mainly toward more frail states[1]
- Based on FFP (Fried Frailty Phenotype)[2]:
  - If pre-frail:
    - Those scoring 1 – more likely to become non-frail
    - Those scoring 2 – more likely to progress to frail
  - If frail:
    - Those scoring 3 – best chance of becoming pre-frail
    - Those scoring 4 or 5 – more likely to progress to death
- Very rare to revert from frail to non-frail (0–0.9% chance)[1]
- In most people, frailty is progressive

1. Gill TM et al. Archives of Internal Medicine 2006;166(4):418–23; 2. Fried LP et al. J Gerontol A Biol Sci Med Sci 2001;56:M146–56.

Risk factors: Potential targets for intervention

- Alcohol misuse
- Cognitive impairment
- Falls
- Functional impairment
- Hearing problems
- Mood disorder
- Poor nutritional status
- Physical inactivity
- Obesity avoidance
- Polypharmacy
- Smoking
- Social isolation
- Loneliness
- Poor vision
- Incontinence

Stuck AE et al. Soc Sci Med 1999;48:445–69.

- BGS best practice guidance for frailty
- Aimed at outpatient and community settings
- Acknowledges that frailty:
  - Varies in severity
  - Is a dynamic process that may be made better or get worse
  - Is not an inevitable part of ageing

BGS, British Geriatrics Society

British Geriatrics Society. Fit for Frailty. Available at: www.bgs.org.uk/campaigns/fff/fff_full.pdf .

How to assess

- Prisma-7 screening Q
  - Can be self completed
  - Can use based on premorbid status is unwell
- Walking speed
  - Less than 0.8m/sec
  - >5 secs to walk 4m
- TGUG
  - Over 10 seconds

- Prisma-7 (≥3 = frail)
  1. Age >85
  2. Male sex
  3. Any health problems that require you to limit activities?
  4. Do you need help on a regular basis?
  5. Any health problems that require you to stay at home?
  6. In case of need can you count on someone close to you?
  7. Do you regularly use a mobility aid to get about?

TGUG, timed up and go test; BGS, British Geriatrics Society

Raîche M, Hébert R, and Dubois MF. Arch Gerontol Geriatr 2008;47(1):9–18.

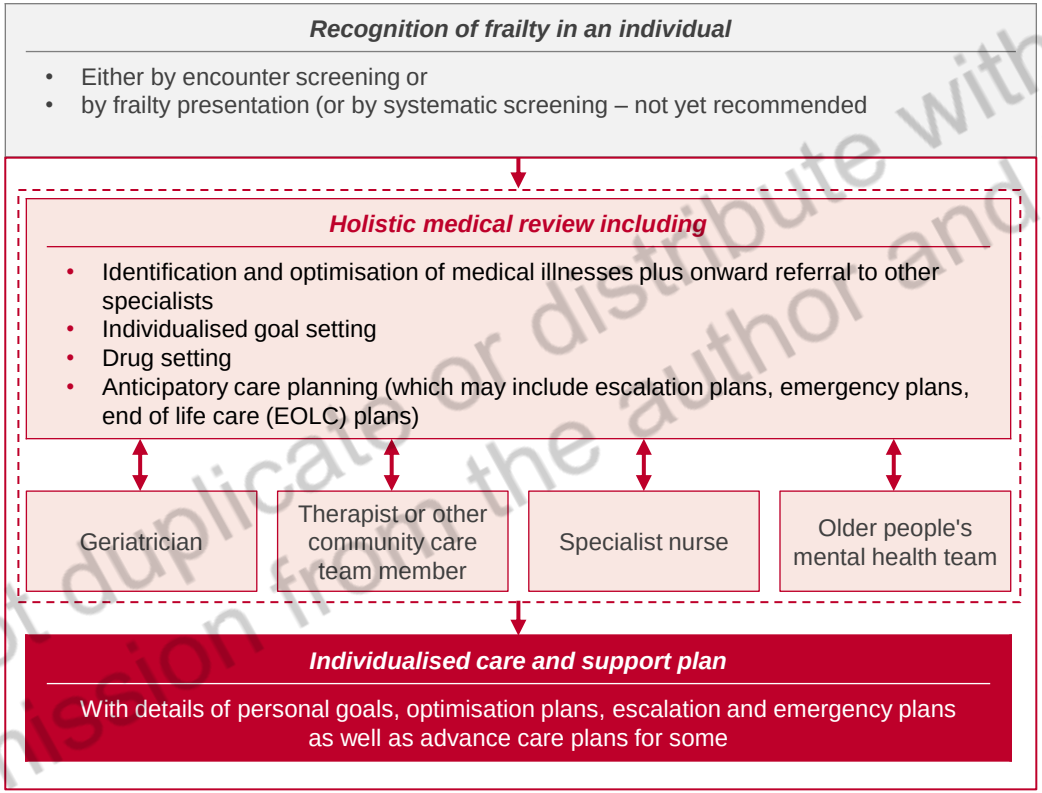
Comprehensive Geriatric Assessment (CGA)

Full CGA likely to take 1.5–2.5 hours

Common problems:

Falls
Cognition
Continence
Mood
Mobility
Weight loss/nutrition
Polypharmacy
Physical inactivity
Alcohol excess
Smoking
Visual loss
Social isolation and loneliness

Physical exam – eyes, ears, neuro – VITAL



Holistic review likely to take 45–60 minutes

Capacity should be assessed

Care and support plan:

Named individuals
Health and social care summary
Optimisation and maintenance plan
Escalation plan
Urgent care plan
Advanced care plan

British Geriatrics Society. Fit for Frailty. Available at: www.bgs.org.uk/campaigns/fff/fff_full.pdf

CGA

Joint Clinic

Bespoke service

- Local clinical need
- Local interest and expertise
- Success of BSUH ‘Silver Clinic’ older patients with HIV

Model

- Breast Surgeon
- Geriatrician
- Specialist breast care nurse

(*Parallel oncology clinic)*

Brighton Breast Clinic

Referral criteria:

- Older women (no age cut-off)
- Newly diagnosed with breast cancer, considered unfit for or declining surgery
- Patients on primary endocrine treatment who develop disease progression

Joint Assessment ‘Same Time’ Assessment

‘CGA’ geriatrician led

- Functional status
- Cognitive status
- Polypharmacy
- Management of comorbidities

Breast cancer assessment - surgeon led

- Joint formulation of management plan
- breast cancer treatment options
- pre-operation optimisation
- optimisation of medical issues
- referral to other specialities and MDT

THE TOOL | PUBLICATIONS | FAQS | CONTACT

Age Gap Decision Tool

A tool designed to allow for the comparison of breast cancer treatments for older women. The treatments considered within this tool are surgery, primary endocrine therapy and chemotherapy. This tool is designed **for use by clinicians** with appropriate knowledge of breast cancer and the two types of treatment that are addressed here. Choose a comparison below to get started...

→ Compare Surgery and Primary Endocrine Therapy (PET)

→ Compare Surgery With & Without Chemotherapy

First Time Here?

Download our instructions for use to get started.

Decision Support Booklets

- Surgery and Primary Endocrine Therapy
- Surgery with and without Chemotherapy

Age Gap Decision Tool feedback survey

We would appreciate it if you could take 2 minutes to provide feedback by completing either the Clinician or Patient survey.

Your feedback will be anonymous. Thank you.

Clinician survey

Patient survey

CE

The Age Gap Decision Tool is a software medical device that provides reference information to help a Healthcare Professional to use their knowledge to make a clinical decision.

The University Of Sheffield. | Cardiff University / Prifysgol Caerdydd | Sheffield Hallam University | FUNDED BY NIHR | National Institute for Health Research

Version 1.0 ©2021 The University of Sheffield Built by epiGenesys

Please Note: The Age Gap on line tool uses a mathematic model based on information from many thousands of women over the age of 70 years diagnosed with early breast cancer between 2002 and 2012. Data was obtained using the UK cancer registration service. Outcomes are predicted based on the actual outcomes of these women. The model was developed on one set of data from the West Midlands and Northern and Yorkshire regions which has been subjected to peer review and published and has been validated on a second dataset to enhance accuracy and reliability. Despite this, as with any mathematical model, it may be inaccurate for an individual woman and can only provide an estimate of likely outcomes. The tool is designed to be used in consultation with an expert clinician and take into account a wide range of parameters and in collaboration with the patient and her preferences and opinions.

Age (70 - 99)

Tumour grade ○ 1 ◉ 2 ○ 3

Tumour size 15 mm

Disease nodes positive ◉ No ○ Yes

Comorbidities - Tick all that apply

- ☐ AIDS
- ☐ COPD
- ☐ Cerebrovascular Disease
- ☐ Congestive Heart Failure
- ☐ Connective Tissue Disease
- ☐ Dementia
- ☐ Diabetes Mellitus (no complications)
- ☐ Diabetes Mellitus (with organ damage)
- ☐ Hemiplegia
- ☐ Liver Disease (mild)
- ☐ Liver Disease (moderate/severe)
- ☐ Moderate/Severe Renal Disease
- ☐ Myocardial Infarction
- ☐ Other cancer (metastatic)
- ☐ Peptic Ulcer Disease
- ☐ Peripheral Vascular Disease
- ☐ Previous/concurrent cancer (non-metastatic)

Frailty - Activity of Daily Living (ADL)

Please enter a score for each dimension below (0 = No difficulty, 1 = Some difficulty, 2 = A lot of difficulty, 3 = Unable) and the ADL Stage will be calculated automatically.

Difficulty eating ◉ 0 ○ 1 ○ 2 ○ 3

Difficulty getting to and using the toilet ◉ 0 ○ 1 ○ 2 ○ 3

Difficulty dressing ◉ 0 ○ 1 ○ 2 ○ 3

Difficulty transferring (to and from chair/bed) ◉ 0 ○ 1 ○ 2 ○ 3

Difficulty bathing ◉ 0 ○ 1 ○ 2 ○ 3

Difficulty walking ◉ 0 ○ 1 ○ 2 ○ 3

Enter the patient's details above and click the button: GENERATE OUTCOMES

If you need to collect the information in stages you can download a paper form and fill in the online form at a later date.

CE

The Age Gap Decision Tool is a software medical device that provides reference information to help a Healthcare Professional to use their knowledge to make a clinical decision.

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Joint Clinic

- April 2015-March 2020 182 patients were seen

  including three men
- 82 years (range 69-99 years).
- 57% of patients were followed up between 1-6 times.
- 13% of patients were referred for surgical treatment after initial PET.
- 10% of patients underwent a change in endocrine therapy.
- Medical management was changed in 35% of patients, typically for treatment optimisation, further investigations or referral to other specialists.

It’s not about age - it’s about individualised care

Needs and expectations of elderly breast cancer patients

A Patient Advocate's Experience

Elizabeth Bergsten Nordstrom

Obstacles in Being ”elderly”?

- Older people do not complain
- Major role in family life
- Health deficiencies other than BC
- Age difference with respect to treating Doctor
- Life expectancy and QoL matter in treatment decisions

Communication

- Dialogue is key
- First meeting - build trust
- This applies regardless of age

➢ So, what is different with an older patient?

Older patients as a group

- Heterogenous
- Lack of data – no data from clinical trials
- Without data and information it is difficult to advise
- Life-expectancy
- Co-morbidity

Treatments

- Standard treatment according to tumor status and biology
- De-escalation – right treatment for the right patient
- Based on the patients individual risk – if standard treatment is considered negative

Treatments and options

- Reason for optimal treatment
- Patient always involved in the decision
- Older patients may think they do not get the optimal treatment due to age

Include Patients in Decisions

- Correct/right information for informed decision
- Trustworthy communication – win-win solution
- Risk assesment in relation to QoL and side-effects
- Difficult questions/topics: life-span/expectancy, life situation, etc.
- Include patient – through dialogue

Last but not least

Words to remember:

- Age matters
- QoL
- Life expectancy and life span
- Communication/Dialogue

Thank you for including patient voices in education for medical professionals

Elizabeth Bergsten Nordstrom

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