



The SIOG 10 Priorities Initiative



Yunnan, China - © Image by S. Beck

International Society of Geriatric Oncology



Société Internationale d'Oncologie Gériatrique

The SIOG 10 Priorities Initiative

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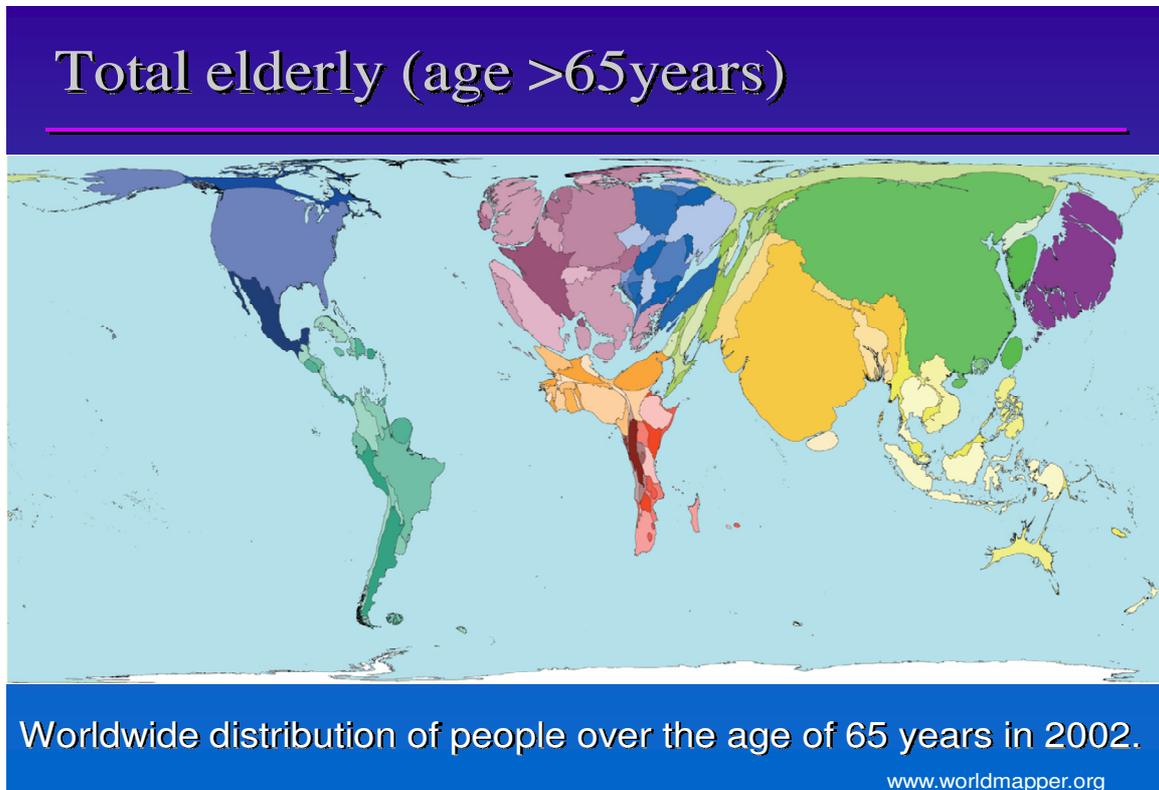
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Note: *all SIOG National Representatives and other participants involved in this initiative are listed at the end of the document.*

Introduction

Thanks to the global improvement in health care and living conditions, the world's population is aging. In developed countries, half of the cancers already occur in patients aged 70 and older, so geriatric oncology is rapidly coming to the foreground of oncology practice. In booming Asian nations, such as South Korea or Japan, the aging trend is particularly striking. In fact, by 2050 the majority of older persons will live in developing countries. As older patients have a very variable health status, the need for proper integration of an oncologic and a geriatric approach has become increasingly important. Incorporating geriatric principles into routine oncology care will serve to optimize the treatment and reduce the functional impairment of older cancer patients and its associated social and personal costs. Given the size of the problem, governmental health agencies, international and local organizations, academic institutions, and the medical community at large will need to identify and primarily target the most pressing issues. Expert input is invaluable in this process, and therefore SIOG decided to build an expert consensus on top priorities within the field of geriatric oncology, based on the input from experts from each world continent. This document can be used for policy making, development of research strategies, and public information, with the final goal of improving care for all older patients with cancer.



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The International Society of Geriatric Oncology (in French: Société Internationale d'Oncologie Gériatrique, SIOG) is a multidisciplinary society that unites experts in the field of geriatric oncology from throughout the world. As such we launched an initiative to define what, in the experts' opinion, should be the top 10 priorities for the development of geriatric oncology worldwide. This document represents the fruit of our efforts. Our hope is that it will help guide the decision makers at all levels in addressing the global challenge of an aging cancer population. We would welcome any feedback from the various stakeholders as our objective is to foster a continuing process of improvement in the care of these senior patients.

Methods

Over 2009 and 2010, SIOG asked its national representatives (see list in Appendix) to identify the top 10 global priorities in developing the field of geriatric oncology. Their answers were collected by a writing committee and a consensus was built. A second round of questions was then circulated asking the representatives to contribute how these priorities would translate more concretely in their national setting. The writing committee then assembled these answers and redacted a region by region translation of the 10 global priorities. All national representatives had the opportunity to review the final manuscript.

For SIOG:



Martine Extermann
Project Leader
Immediate Past SIOG President



Riccardo Audisio
SIOG President



Matti Aapro
SIOG Executive Director



Dr. Martine Extermann with Dr. Paul Calabresi, first SIOG President

SIOG 10 priorities initiative: General Priorities

Education

1. Increase public awareness of the worldwide cancer in the elderly epidemic and the need for a specific approach to address the problem
 - Political institutions (Health ministries, international organizations)
 - Medical societies
 - Advocacy networks, media, to develop a more positive image of older cancer patients
2. Integrate geriatric oncology in the curricula for medical and nursing education, both during studies and post-graduate education
3. Address the shortage of specialist oncologists/geriatricians & allied health staff in geriatric oncology.
 - Develop/support specific training programs
 - Increase/develop funding to foster academically oriented specialists able to address the populations not targeted by traditional oncology studies

Clinical practice

4. Develop interdisciplinary geriatric oncology clinics, especially in academic institutions and comprehensive cancer centers
5. Integrate geriatric evaluation (including comorbidities) into oncology decision-making and guidelines
6. Address issues of access to care, including the needs of the caregiver

Research

7. Develop, test and disseminate easy screening tools to enable proper referrals to multidisciplinary clinics and encourage integrated approaches between oncologists and geriatricians
8. Create a clear and operational definition of vulnerability/frailty applicable to oncology
9. Increase the relevance of clinical trials for older patients:
 - Require large phase III trials to oversample older cancer patients in order reach a meaningful percentage of their cohorts, and to structure their analysis to provide results specific and pertinent to this population
 - Extend phase II and III trials to patients with high levels of comorbidity or functional impairment with stratified accruals or extension cohorts
 - Design specific trials for older cancer patients
10. Promote multidisciplinary, basic/translational research on the interface of aging and cancer.

Practical suggestions for implementation by regions

EDUCATION

1. **Increase public awareness of the worldwide cancer in the elderly epidemic and the need for a specific approach to the problem**
 - **Political institutions (Health ministries, international organizations)**
 - **Medical societies**
 - **Advocacy networks, media, to develop a more positive image of older cancer patients**

Africa

In Africa older people represent a small percentage of the overall population, however this fraction is rapidly growing. There is little public or professional awareness of the issue. There is need for a change in the culture among the public and health professionals towards the senior patient with cancer. The aim would be to ensure that older patients receive a better chance at treatment and maintenance of independence for whatever duration of life they have left. There is a need to clarify that the costs of appropriate treatment are outweighed by the benefits of avoiding incapacity, and the related care burden for relatives, health care authorities, and society as a whole.

Asia

The proposed ideas followed two main tracks. The first one is to make people aware that cancer can be successfully treated in older patients. For example, by showcasing “success stories” of prominent people who overcame cancer at an advanced age, or making caregivers aware that older relatives deserve the same medical attention as younger people. There is also a need to transform not only the knowledge, but also the attitudes of health professionals towards the elderly. The second issue is to address the political concerns for proper use of resources, as some governments are very cost-conscious. It is important that oncologists continue to emphasize the cost-effectiveness of proper management of older cancer patients.



Outpatient clinic at DRO, Sarawak, East Malaysia

Europe

Several European governments have taken initiatives to develop geriatric oncology: grants for research (e.g. Belgium, France), creation of a network of expert onco-geriatric units (e.g. France). Geriatric oncology needs to be integrated further in national cancer plans, as this is a major way cancer outcomes can be improved at a national level. In the Netherlands The National Care for the Elderly Programme (“Nationaal Programma Ouderenzorg”) was designed to improve care for elderly people with complex care needs. Practitioners, patients and supporters can create or collaborate with advocacy societies (e.g. Austria: “Senioren-Krebshilfe” (Senior Cancer Aid), Germany: No Ca Society, France: GEPOG), which could provide funding and political pressure. Question sessions addressing politicians directly could also be useful. Lecturing in the professional and in the public settings would make people aware of the importance of the problem. Geriatric oncology professionals and advocates should work at improving the image of geriatric medicine as a discipline among students, general practitioners, and head of departments, e.g. by inviting “star speakers”. Geriatric Oncology working groups and task forces are also active within some medical societies and can serve as leverage to emphasize the field (e.g. GeriOnNe in the Netherlands). More need to be developed.

North America

Key political educational targets are legislative representatives and key persons in the national health systems (e.g. Medicare). There is a need to show that proper care can save lives and money. Medical societies have several working groups in geriatric oncology: ASCO is very active, other societies have variable activity levels. A key education need is to show that evaluation tools are available and can change outcomes. So far, local and national media have been underutilized for advocacy. We should emphasize that improving the care for older patients will mean better quality of life and treatments appropriately tailored to individual patients.

Oceania

In Australia, one strategy may be to commission a credible report using local data to document the expected increase in cases and the shortfall in medical resources. The role of geriatric oncology as part of the solution could be highlighted. This data can then be used as a lobbying tool. Meetings with high-level politicians will be required to facilitate change. Continued engagement with the oncologic, hematologic, and geriatric communities through medical societies is needed in a multidisciplinary fashion (e.g. meeting presentations, surveys of society members about practices and attitudes). Consumer groups and mainstream media should be engaged by presenting good stories of successful treatment in older people or highlighting cases of discrimination.

2. Integrate geriatric oncology in the curricula for medical and nursing education, both during studies and post-graduate education

Africa

The principles of geriatric assessment should be integrated in the undergraduate medical and nursing curricula, and geriatric oncology in the post-graduate curricula.

Asia

The needs of each country appear variable. In some, like India, oncologists need to interact with the geriatrics department/sections in the department of internal medicine to examine the current incidence of cancer in their older population and demonstrate the benefits of working together. In other countries, such as Singapore, geriatric medicine itself would need first to be reinforced. Finally, in some countries, the work is at the very beginning and initial educational opportunities are probably best available at the postgraduate level.

Europe

In many countries specific post-graduate courses are available for primary physicians and specialists alike, as well as for nurses and allied health professionals. They range in scope from 2-3 day courses to full tertiary programs with diplomas. In some countries though, setting up such courses will represent a real challenge because the practice of oncology is fragmented between organ specialists. Better integration of oncology practice there might facilitate training. Some countries are starting to formally introduce geriatric oncology in their medical studies curriculum (e.g. Slovakia, France, Norway). There is an opportunity for societies such as SIOG to give guidance on graduate and specialty training core curricula items. Visiting professorships in geriatric oncology might be initiated at medical universities.



Giorgione: *Ritratto di Vecchia* (Venezia, Galleria dell'Accademia)

North America

Presently, geriatric oncology is minimally or not represented in the general ASCO/ESMO or in the Canadian fellowship curricula. Evidence-based items should be added. Dual geriatric oncology fellowships are accepted by the American Board of Internal Medicine in the US, but a limited number are active. For continuous education, ASCO just updated its geriatric oncology online curriculum. Geriatric oncology should also be introduced in medical studies (e.g. in a multidisciplinary oncology clerkship month), and in nursing training and certification. It should be integrated also in the post-graduate training of other specialties, such as surgery or gynecology. Conversely, the amount of oncology should be increased in geriatrics training.

Oceania

In Australia there is a need to advocate for changes in the curricula at all levels. This can be done by direct approaches from oncology and aged care organizations and academic leadership from dual trained clinicians.

South America

Discussing the integration of geriatrics and oncology curricula is the first step that needs to be taken.

Global

A process to support and promote geriatric oncology CME activities and conferences all over the world should be developed.

3. Address the shortage of specialist oncologists/geriatricians & allied health staff in geriatric oncology

- **Develop/support specific training programs**
- **Increase/develop funding to foster academically oriented specialists able to address the populations not targeted by traditional oncology studies**

Asia

The needs are again variable. Some countries, such as India, could propagate the US geriatric oncology fellowships model and discuss how it can be modified to suit local needs. In other countries, such as Malaysia, the general medical shortage, including that of geriatric and oncology specialists needs to be addressed first. In some countries, such as Singapore, cross-training might be feasible, but financial compensation is needed to support the longer duration of training.

Europe

Several countries are adopting a cross-training approach as part of continuous education (e.g. French CE courses, Belgian common society meetings...). In other countries, a combined certification derived from the combined US fellowship model appears more desirable (e.g. Germany, Slovakia). Some countries, such as the Netherlands, have a formal fellowship in geriatric oncology. The development of academic positions should include research possibilities to target this underserved and not traditionally targeted population, whether academic or pharma-funded, depending on the funding structure of clinical research in each country. A concern is that in several countries, oncologic care is fragmented among organ specialists, for whom it is only part of their practice. In that setting, having geriatric oncologists find their place and have patients referred can be challenging. Multidisciplinary consultations might be a possible solution. In certain countries, such as Switzerland, there are already a handful of specialists with dual certification in oncology and geriatrics, and a new generation is slowly emerging.

North America

In the US, initiatives like the combined geriatric oncology fellowships, the P20 grants to develop geriatric oncology programs in cancer centers, or the Cancer and Aging Research Group need follow-up and development. Academic oriented specialists are presently not a priority politically in Canada, but pushing for the training of more geriatricians may lead to a higher potential for multidisciplinary care.

Oceania

In Australia, dual training in geriatric oncology is currently unattractive in part due to the length of time required to complete training in both disciplines. There is currently no flexibility to enable a combined program. We need to work with the Royal College of Physicians (RACP) to create a subspecialty and streamline the existing training program.

Research and infrastructure funding comes from government, philanthropy and pharma. Multipronged approaches to gain funding are required dovetailing with the advocacy mentioned above to increase awareness and the need for change; recognizing this will cost money.

CLINICAL PRACTICE

4. Develop interdisciplinary geriatric oncology clinics, especially in academic institutions and comprehensive cancer centers

Africa

In a country like Egypt, the general trend of practice is in separate disciplines with referral or consultation between practitioners on a case by case basis. A good approach would be to integrate a specific clinic or shift in a general oncology clinic attended by motivated oncologists/geriatricians. Building upon the existing work culture would facilitate a progressive change towards an interdisciplinary model. This model whilst being less familiar for clinicians will enable enhanced care of older patients with cancer.

Asia

Two approaches are suggested as feasible. One is to develop and integrate these multidisciplinary clinics as a part of a comprehensive cancer center. Another approach is to develop combined weekly rounds.

Europe

This process is at various levels of development depending on the country. In some countries, a cultural change needs to happen by developing dialog between geriatricians and oncologists who have had little interaction so far (e.g. Netherlands, Norway, Slovakia). Some countries see the development along the line of regular pluridisciplinary consultative meetings rather than separate clinics (e.g. Belgium, Switzerland). France is further along in the process and is developing a regional geriatric oncology unit in each of its 15 regions. Programs in development might use the opportunity to visit established programs abroad for training. The integration of geriatric oncology units should become part of Comprehensive Cancer Center accreditation.

North America

Two models are possible: Dually trained oncologists leading geriatric oncology programs or collaborative models with geriatric teams supporting oncology teams. Several comprehensive cancer centers are now hiring geriatricians.

Oceania

Australia: Set up examples in large centers and encourage others to model clinics on existing infrastructure. The best model of care will vary according to the infrastructure available. There is a successful geriatric oncology clinic in Adelaide whose experience can serve to develop similar programs.

South America

In Brazil, the first need is to integrate geriatric and oncology education before the development of geriatric oncology programs can follow. Because overall life expectancy is still low, such programs would certainly be limited in the beginning to large referral centers.

5. Integrate geriatric evaluation (comorbidity included) into oncology decision-making and guidelines

Asia

There is a general consensus that a comprehensive geriatric assessment (CGA) should become part of routine practice and that this is a crucial point to prevent suboptimal care in older patients. Local physicians with an interest in geriatric oncology should meet to design guidelines adapted to each country. The practical implementation of multidisciplinary clinics is challenged by the competing interests of the few geriatricians available.

Europe

The present challenge is to convince oncology colleagues to use a geriatric evaluation in their daily practice. Several solutions are suggested: Generalize the screening tools in the practice, continue to publish convincing data, ask as reviewers or in letters to editors about lack of control for geriatric factors in published papers, integrate the geriatric decision process into guidelines. Attention also should be paid to national journals, to reach colleagues who are not fluent in English. Local geriatric oncology societies have a clear advocacy role to foster. Reimbursement issues need to be addressed, as in some countries, such as Belgium, geriatric consultations are only reimbursed for hospitalized patients and not for ambulatory patients who are the majority of cancer patients.

North America

A strategy is to promote the inclusion of a geriatric evaluation in references such as ASCO's geriatric curriculum, or the NCCN guidelines with displays for older patient subgroups. We should continue to accumulate data to show that an integrated approach leads to interventions that can optimize disease specific and overall care. Practical validated tools need to be diffused.

Oceania

The priority in Australia would be to create a useful, feasible, accessible tool for oncologists to use and to ensure that the infrastructure is available to handle the results. Using new technologies and creative database integration would help increase its attractiveness to clinicians and enable

data collection and pooling. Once a tool has been designed and established for use in the Australian context, lobbying government to ensure clinicians are paid to use it would be vital to its ongoing utility. There is a call to push a single, SIOG-branded assessment tool.

6. Address issues of access to care, including the needs of the caregiver

Asia

The situation varies by country. For example, in Sarawak (Malaysia), where various ethnic groups are present, access to care mostly depends on the younger generation, especially for those who live in rural areas. Hence the education of the public plays a vital role in whether the elderly have access to care or not. In Singapore, the approach needs to be integrated into the CGA.

Europe

As most European countries have universal healthcare coverage (private or public), finance-related barriers are minimal. **Age limits should be discouraged in guidelines.** Although support for caregivers of patients with Alzheimer's disease or caregivers of younger patients has been developed with help from advocacy societies, there is still a need for the development of similar support for the caregivers of older cancer patients. Studies in this field are required to provide crucial objective data on these caregivers role, needs, and access to care. The formation of caregivers should be developed.



Very young...100 year-old lady - Image from Dr JP Droz, former SIOG President

North America

Access to care is not considered a problem in the Canadian system. In the USA, there are issues with the cost of oral therapies and their coverage by Medicare. Concerning physical/social barriers and caregiver support, pilot studies are needed, with later expansion to accrual in cooperative groups.

Oceania

In Australia, there is no significant financial problem with access to care because of universal coverage. Other aspects of access restriction are more subtle. There is a need to campaign

against ageism from all levels of health providers, at the same time being mindful of health economics. Being proactive in the study of health economics may be required.

RESEARCH

7. Develop, test and disseminate easy screening tools to enable proper referral patterns to multidisciplinary clinics or integrated approaches between oncologists and geriatricians

Asia

Some form of easy adaptable tool may be developed for busy clinics that may facilitate access to oncology care, given the shortage of geriatric oncology specialists.

Europe

At the present time, the major issue is to sort among the available screening tools . There is a call by several national representatives for a joint effort from SIOG to identify and support 1-2 consensual screening tools with the best performance for diffusion.

North America

At this time, the need is to present and compare the geriatric assessment evaluations, and encourage participation in various studies testing and using them. In Canada, there is a need for someone or a group to champion and develop their use.

Oceania

As in Europe, there is a call to develop a SIOG sanctioned and branded tool, and have facts to back up its effectiveness, its ease of use, and its ability to pick up geriatric syndromes.

Global

Comment from the SIOG leadership team: At the present time, SIOG deems best to let data accumulate and let tools be sorted spontaneously based on the evidence that emerges.

8. Create a clear and operational definition of vulnerability/frailty applicable in oncology

Asia

Simple tools are needed, as well as moving towards more objective biological markers and correlating with clinical outcomes for validation.

Europe

A SIOG working group might develop this definition as pertains to cancer patients. Trials could also establish a network prospectively collecting data. An avenue would be to convince politicians to integrate geriatric oncology networks as a topic in the EU research framework. The geriatric literature should be tapped to integrate their findings into geriatric oncology research, and

reciprocally, oncology literature should be integrated in aging research. A new initiative to define frailty was recently started within academic geriatrics, led by Simon Conroy in the UK. The global effort should be linked to academic geriatricians who could be targeted in the European Academy for Medicine of Ageing (EAMA) and in the European Union of Geriatric Medicine Specialty (EUGMS). At the present time, geriatric oncology is briefly touched, whereas frailty is extensively covered in their courses.

North America

Geriatric researchers should be involved. Exploit what has been done by other experts in the field, review and adapt it. Beyond the definitions, the tools should be used and associated with specific interventions that will change treatment and outcomes.

9. Increase the relevance of clinical trials for older patients:

- **Require large phase III trials to oversample older patients in order reach a meaningful percentage of their cohorts, and to structure their analysis to provide results specific and pertinent to this population.**
- **Extend phase II and III trials to patients with high levels of comorbidity or functional impairment with stratified accruals or extension cohorts**
- **Design specific trials for older cancer patients**

Africa

Multicenter, multinational studies with inclusion criteria that allow senior cancer patients to participate should be encouraged. Even more appropriate would be studies specific to older patients.

Asia

Research is mostly conducted by taking part in international trials rather than developing local ones. Participating in international geriatric oncology consortiums might be a way to address this priority.

Europe

The priority is to find ways to generate incentives towards investigators and sponsors for developing relevant trials. The majority of clinical trials are supported by the pharmaceutical industry, financially but often also in terms of design. One way to convince sponsors could be to have EMEA require that this population be addressed in clinical trials. Another suggestion is that academic funding might be restricted if elderly patients are inadequately covered. This would require establishing national/international criteria to demonstrate adequate recruitment of elderly patients. Financial support of trial extensions to older patients should be increased. Specialist cooperative groups such as the French GERICO could collaborate with larger cooperative groups such as EORTC to design targeted trials. A Summer school run by SIOG could be established for junior researchers. Alternatively, a geriatric oncology day could be integrated

and elderly specific protocols encouraged in the “Methods in Clinical Cancer Research” workshops.

North America

A key objective is to develop this aspect in cooperative groups and other consortia: CALGB has some activity. We should raise the issue of the adequacy of the Common Terminology Criteria for Adverse Events in their present form for measuring toxicity in older patients. Toxicity should be stratified by age. In Canada, geriatric oncology is still too small to initiate phase III trials but will participate in multinational trials.

Oceania

Australia: Upper age limit practices should be eliminated in clinical trial inclusion/exclusion criteria. Geriatric oncology researchers need to approach all clinical trial organizations and become part of the scientific advisory committees. Clinical trial organizations need to think about clinical trials in the frail and poor performance status patients. We need to advise in this regard. To enable this, governments and trial bodies need to be persuaded that cancer in the elderly is a funding priority and thus enable good research with appropriate funding.

South America

In Brazil, funding is lacking to promote local clinical and translational research. Taking part in multicentric trials is the reality available in the immediate future.

10. Promote multidisciplinary basic/translational research on the interface of aging and cancer

Asia

In some countries, such as Malaysia, geriatric oncology is very new to most health professionals, and there is an urgent need to educate them. One way would be to begin with basic science research. With an increase in aging population globally, the underlying principles of care of the elderly cannot be more emphasized. In other countries, such as Singapore, an active research agenda is in progress.

Europe

Two common priorities are: First, to better integrate this topic in SIOG and other meetings and to create a translational task force within SIOG to which to invite basic scientists. Second: to develop the funding support. Specialized cooperative groups, such as GERICO, could integrate translational aspects in their trials. Research Ministries should be prompted to set up national research programs in the field. European Union representatives should also integrate this topic in EU research frameworks programs. Pharmaceutical industry research should be encouraged to develop specific susceptible to improve the outcomes and quality of life of the elderly presenting with many diseases, disorders, and disabilities, along with their cancer, as there is mounting evidence that aging and comorbidity influence the tumor biology, behavior, and response to treatment.

North America

In the US, there is a need for more specific expertise in the NIH study sections and better targeting of this area in program announcements and requests for applications. AACR and similar translational organizations should play an important role in promoting this type of research. In Canada, this is not yet perceived as a priority.

Oceania

In Australia, the focus should be on continued interaction with the aged care and gerontology community. Collaborations need to be promoted.



Image Simon Howden – freedigitalphoto.net

APPENDIX - The following SIOG members contributed to this monograph:

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