EDITORIAL

Focusing on care of older adults with cancer

In several of my editorials I have pointed out trends that oncology nurses ought to know about. This column follows along the same theme. I want to alert you to several recent publications that could be helpful to you in thinking about the care of older adults with cancer.

Cancer is predominantly a disease of older adults as the majority of cancers are diagnosed in individuals over the age of 65 years. Given the increasing cohort of older adults in Canada, oncology nurses need to be aware of the needs and special requirements of older adults facing a cancer diagnosis.

Older adults are not a homogenous population; their health status ranges from fit to frail and is not necessarily related to chronological age. However, older adults are not well represented in research studies designed to find new treatments or identify the supportive care needs. There are gaps in our understanding about the best treatment approaches for this population and how to support individuals during and after treatment.

Three recent studies have added helpful perspectives to the discussion about improving care for older adults with cancer. The first is an evidence synthesis completed under the auspices of the Canadian Partnership Against Cancer (CPAC, 2016). This review affirmed the following:

• Older adults are under-represented in clinical trials and significant gaps exist in our knowledge about how cancer and cancer treatment affects them.
• The heterogeneous nature of the population means that it is important for clinicians to carefully assess each individual. (Studies support the use of a standardized Comprehensive Geriatric Assessment Tool to help assess issues that might affect treatment and classify the patients as fit, vulnerable or frail.)
• Assessments can be used to plan interventions to mitigate effects of treatment and plan for appropriate supports; they need to include the domains of functional status, cognition, social support, objective physical performance, psychological status (anxiety and depression), nutrition, co-morbidity, and polypharmacy (Sattar et al., 2014)
• Attention must also be paid to caregiver burden and evidence of actual support available. Recommendations for referrals include social work, transportation assistance, caregiver management, home safety evaluation, support groups, spiritual care, and psychology/psychiatry.

The second study by Puts et al. (2017) explored the perspectives of older adults regarding their participation in research. During focus group sessions, participants clearly stated that older adults ought to be involved in research if we are to truly understand their unique care requirements. Somewhat contrary to expectations, they expressed interest in becoming team members and being involved in the research process itself. They identified several factors that would facilitate their involvement on research teams: flexibility in meeting times and locations, accessibility to computer technology, transportation support, materials translation (to ensure understanding), short training sessions, and opportunities for peer support. Their preference was for in-person meetings.

Finally, the third study of interest was conducted to understand more about the influences on older adults when they were making decisions about chemotherapy (Puts et al., 2016). Semi-structured interviews were held with 29 adults aged 70 and older with advanced prostate, breast, colorectal, or lung cancer and 24 of their family members. The sample was stratified by age (70–79, 80+) and all interviews were analyzed using thematic analysis. There was no difference in the treatment decision-making influences based on age. Most older adults in this study thought they ought to have the final say in the treatment decision, but strongly valued the view of their oncologist. ‘Trust in my oncologist’ and ‘chemotherapy as the last resort to prolong life’ were the most important reasons to accept treatment. Co-morbidity and potential side effects did not play a major role in the decision-making.

We have a great deal to learn about providing person-centred care to older adults with cancer. But beginning steps can be taken by careful listening and understanding the perspectives of those in our care. Suggestions for improving care offered by older adults who have been cancer patients include:

• More discussion about what is to happen next (i.e., appointments, transportation, financial costs) and allow time for them to arrange to bring someone with them.
• More time during appointments to allow for questions to be asked.
• Clarification about medication terms.
• Nurses taking more time to talk and be able to provide support.
• Assign a consistent person to help navigate the complex and confusing system, especially for those who do not speak English.
• More continuity in staff support (i.e., same person on various office/clinic visits).
• Clearly identified numbers to call for help when necessary; someone on the telephone line to answer questions or respond to concern.

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REFERENCES