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Cancer Research and the Aging Population

B.J. Kennedy

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Cancer Research and the Aging Population

by B.J. Kennedy, M.D., M.A.C.P.

Cancer is a disease of aging and a major cause of morbidity and death in the United States. Nationally, more than 50 percent of all cancers occur in people aged 65 and older. This same group accounts for 70 percent of cancer deaths. As the number of elderly Americans continues to climb, the prevalence of cancer will also increase. In men and women older than age 75, lung cancer is the leading cause of cancer-related deaths. In women older than 75, colorectal cancer is the second leading cause of cancer deaths. Thirty-five percent of all colon cancers in women occur in those older than age 80. In men older than age 75, prostate cancer is the second most common cause of cancer death. By age 90, prostate cancer occurs in 90 percent of men, although it may not cause their death.

The need for more research on cancer in the older population is apparent. There are few clinical trials for this age group. Few patients are referred to existing trials. Among the reasons for low participation in existing clinical trials are concerns about toxicity of treatments, lack of benefit from treatment, as well as economic, logistic, and social factors that do not support participation.

Of the limited research on older patients that exists, some results emphasize potential opportunities. Twenty-five years ago, investigators

B.J. Kennedy, M.D., M.A.C.P., is Regents' Professor of Medicine, Emeritus Masonic Professor of Oncology, Emeritus at the University of Minnesota Medical School, in Minneapolis, Minn.

in my Medical Oncology Division at the University of Minnesota Hospital in Minneapolis reported that older patients with acute leukemia should be treated similarly to younger persons. While tolerating the treatments put older persons at greater risk, the subsequent benefits were comparable to those experienced by younger patients. More recently, the National Cancer Cooperative Groups have directed research on patients older than age 60. The results emphasize the benefits of treating acute leukemia in older patients.

The National Cancer Data Base has demonstrated that stage-for-stage older patients with Hodgkin's disease do not survive as well as younger patients. However, studies have shown that older breast cancer patients do better. Such research emphasizes that there are biological differences of the same cancer with respect to age.

The need for clinical trials is particularly important for older persons with non-Hodgkin's lymphoma. The incidence of this cancer in those older than age 65 is rising rapidly—up by 75 percent between 1973 and 1994, according to the National Cancer Institute's (NCI) Surveillance Program.

The standard chemotherapy for intermediate and high-grade lymphomas is CHOP. Because this treatment is more toxic in older patients, the outcomes are often poorer for the elderly. Often, older patients respond to therapy initially but do not maintain remissions as long as younger patients. Consequently, clinical trials are underway in search of less toxic chemotherapy combination regimens, or the use of other agents such as monoclonal antibodies.

The National Institute of Aging, the National Cancer Institute, and

the National Institute of Environmental Health Sciences have established a program to stimulate research in prostate cancer. This research should help in diagnosis, management, and understanding the etiology of this cancer.

While progress in overall cancer management was demonstrated recently—cancer deaths declined during the period 1991 to 1995—the decline in deaths did not apply to patients older than 80.

A NEW ERA OF GERIATRIC ONCOLOGY

With the anticipated growth of the aging population and an accompanying rise in cancer rates, there is a great need to train oncologists in the care of older cancer patients. Twenty-five years ago we envisioned the need for a new specialist, the medical oncologist. This has been accomplished. Oncologists have had a major impact, providing modern cancer management in the community and internationally. Now the care of the growing number of older patients with cancer is an additional skill that medical oncologists as well as other specialty oncologists must develop.

Currently older patients with cancer are screened less, staged less, and treated less aggressively, inadequately, or not at all. Physicians are often unaware of the potentials of the life span of older persons and the impact of therapies on older patients. Due, in part, to the lack of clinical research on patients over the age of 75, use of potentially effective therapies is poorly understood. While some progress is being made in identifying the problems of managing cancer in older patients, much remains to be done.

An opportunity exists for oncologists to develop skills in

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geriatric care by working with geriatricians, especially during the training phase in oncology. Integrating geriatrics into oncology training could help establish guidelines for teaching geriatric assessment and care as part of oncology training and postgraduate education. At the same time, promotion of research efforts could lead to better cancer management for older persons. In addition, primary care physicians must teach cancer prevention, be qualified to diagnose neoplastic disease early, and coordinate cancer management with oncologists.

MORE ASPECTS TO CONSIDER

The cost of cancer care, and medical care in general, will have a major impact on our aging society. Under the current system, Medicare will not be able to pay the bill. Medicare must pay for peer-review clinical trials and cover appropriate screening procedures for early detection of cancer. In the long run, this would be a cost saving.

We can learn a great deal by studying the aging population in other countries as well. Japan, for example, is the nation with the oldest population. In 2010, its demographics will resemble those that we will face in 2030. We have an opportunity to learn how others are handling this issue.

Cure by eradication of cancer is not the only effective goal for older patients with cancer. Control and palliation, as well as quality of life and psychosocial support at the end of life, are important to the older cancer patient. Older Americans should be able to look forward to improved health just as do younger Americans. ☐

A Model Protocol Management System

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allow a nurse to "see" only a select group of events (i.e., by patient, physician, description, disease site, completed or due date). Filters can be saved and/or edited for future use. There are three "pages" or views to the Events Screen: the Events Summary, Events Detail, and Events Status. Both the Summary and Detail pages display the events in table format with columns for case number, patient name, physician, event description, due date, and a check box denoting whether the event has been completed or not. The main difference between the Summary and Detail page is that the Detail page displays specific patient personal and clinical information. The Events Status Screen provides event filtering information along with other database information. The Event Screens are the repository for the entire PMS program and can be populated by well over 100,000 events.

The Calendar of Events module presents the events due in a calendar format allowing the user to filter the events for a certain day, week, month or year.

Patients

The Patients Screen contains all the patients that have been added to the PMS program, which to date is well over 1,500. Like the Events Screen, the Patients Screen has a powerful filtering option. More than 10 different patient criteria in various combinations can be used for filtering. As in the Events Screen, three "pages" or views exist in the Patients Screen: Patient Detail, Patient Summary, and Patient Status pages. Various reports are available in the Patients Screen.

Protocols

Protocols are the foundation for all of the events added and tracked for all patients. Therefore, the Protocol File Maintenance (PFM) is a unique and important module in the PMS. Accessed with supervisory rights only, the protocols must be defined and entered accurately. Any revisions and amendments to the protocol must be changed manually for each patient affected. The PFM module can contain hundreds of protocols. A protocol definition can contain an unlimited number of events. Events can be defined as periodic (i.e., CBC/DIFF every three weeks) or non-periodic (i.e., submitting a consent form).

Utilities

Supervisor Utilities allows for administrative management of the PMS program. The Utilities module includes such activities as Adding or Deleting Affiliate Groups, User File Maintenance, Reconstructing Index Files, PMS File Backup and other functions relevant to maintaining an accurate and efficient data system.

IN CONCLUSION

The PMS program has been a powerful tool for managing the research program. It has helped ensure compliance with protocol, research base and NCI requirements. We have been fortunate to have our computer systems consultant, Carlos Emmons, since the inception of the program. He has been responsive to our needs to adapt the PMS program to the ever-changing technology and data requirements. ☐