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Issues

Information and ideas for those serving seniors.

on Aging

SENIORS AND THE "BIG C"

Cancer is the second leading cause of death in people 65 and older. In fact, of the 552,000 Americans who died of cancer in 2000, two thirds of them were 65 years of age and older. The American Cancer Society defines cancer as "a group of diseases characterized by uncontrolled growth and spread of abnormal cells." More than 100 diseases are characterized as "cancer" by the general public.

CANCER RATES

It is not commonly known that 63% of cancers are diagnosed in people 65 years and older and that more than one third of cancers are found in people over 75 years of age. But it is true that the incidence of cancer and death rates from cancer increase dramatically with age, and increase more rapidly in men than in women. While progress has been made in earlier cancer detection and treatment in younger people, in the last 50 years the incidence of cancer has increased by 26% in people 65 and older compared with a 10% increase in people under 65. The death rate from cancer has increased 15% in individuals 65 and older, while it has decreased 5% in those under 65 years of age. The probability of developing cancer for women between 60 and 80 is 22.5%, and for men between 60 and 80 it is 36.4%.

CANCER INCIDENCE

Based on Age at Diagnosis

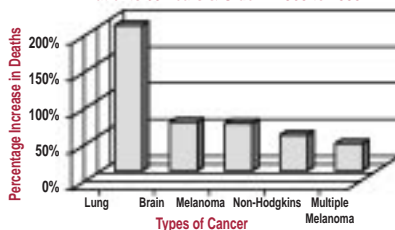


CANCER TYPES

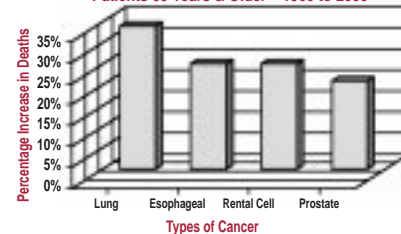
The most common types of cancer which cause death of the elderly are cancers of the lung, colon, prostate and breast. In the last forty years, cancer deaths in both men and women 65 and

older increased dramatically for some types of cancer. During the last forty years for men 65 and older, certain cancer deaths increased significantly as well.

Increased Cancer Deaths In Women
Patients 65 Years & Older – 1960 to 2000



Increased Cancer Deaths In Men
Patients 65 Years & Older – 1960 to 2000



CANCER SCREENING

It is well documented that elderly individuals are not screened for cancer as often as younger persons. Reasons for this include physician perception that these people are already near the end of their lives or that they are not candidates for cancer treatment should cancer be diagnosed. Older adults may

lack access to cancer screening due to transportation difficulties, low income or impaired cognition.

According to the American Cancer Society, screening of symptomless people 65 years and older should include the following:

ACS CANCER SCREENING GUIDELINES

To detect colon and rectal cancer:

- Annual stool test for occult blood
- Sigmoidoscopy* every five years
- Colonoscopy* every ten years
- Double-contrast barium enema* every five to ten years
- *Digital rectal exam with these procedures

To detect prostate cancer:

- Annual PSA blood test
- Digital rectal exam

To detect breast cancer:

- Monthly breast self-examination
- Annual clinical breast exam
- Annual mammogram

To detect cervical or uterine cancer:

- PAP test and pelvic exam every one to three years
- Endometrial biopsy if bleeding occurs after menopause

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CANCER CLINICAL STUDIES

Clinical studies enroll individuals with various types of cancer to determine which treatments are the most effective. Even though 63% of people with cancer are over 65, they make up only 25% of the people enrolled in clinical cancer studies. This was true for all types of cancer, although in breast cancer studies, 49% of the patients are over 65, but only 9% of the clinical study patients were over 65.

Many physicians do not refer their cancer patients to clinical studies because they think they will die of another condition and not their cancer. This is often untrue however; it has been found in a recent study that 58% of women over 75 with breast cancer eventually died of their cancer, even though 80% of them had other potentially life-threatening conditions. Also, physicians may be unaware that many cancer treatments are well tolerated by older adults and that most people 65 and older want effective treatment for their cancers.

Lack of participation by people over 65 in clinical trials results in inadequate data regarding appropriate and effective treatment for older people with cancer. For example, a 35-year-old woman has a 1 in 2,500 chance of developing breast cancer in the next year, but a 75-year-old woman has a 1 in 300 chance of having breast cancer in the next year. The typical breast cancer patient is an older woman living alone or in a nursing home, not a young woman with children at home as is commonly thought. But because clinical studies have been designed to provide data for the best treatment for younger women, it is not clear which treatments will provide older women safe and effective breast cancer treatment to extend their lives by 10 or 11 years, their typical life expectancy after age 65.

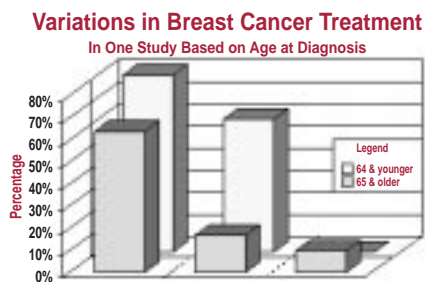
This problem extends to nearly all other types of cancer as well. While clinical studies focus on long-term curative treatment for young and middle-aged patients, there is little to no data on treatment that will extend life by 10 years and be mild enough to be tolerated by older patients. As a result, there is significant evidence that older

people often do not receive standard, well-tolerated treatment of their cancers with the result that many die unnecessarily of cancer.

CANCER TREATMENT

For a number of reasons previously discussed, cancer treatment may be less effective in people 65 and older than in younger people. Due to inadequate cancer screening, cancer is often diagnosed in later stages in older people than in people under age 65. With little or no data from clinical studies on effective treatment for seniors, treatment protocols are less well defined, leading to discrepancies in cancer treatment. And treatment of cancer pain has been found to be very inadequate in people 65 years of age and older.

Research into cancer diagnosis and treatment shows that cancer patients aged 65 and older have few diagnostic and staging procedures, in which the spread of cancer is determined to help decide on the most effective treatment. Less treatment is provided to older persons, and survival rates decline with age. In fact, the older the patient, the less often definitive treatment is provided.



Again using breast cancer as an example, a record review of 68 women age 75 and older in Hawaii found evidence that elderly women are less likely to receive radiation and chemotherapy for breast cancer. During the 10-year investigational timeframe, 30 of the 68 women had lumpectomies but only 64% of these women had radiation treatment. This well-tolerated treatment is generally provided 80% of the time to women who have lumpectomies. Of the 68 women studied, 34 had mastectomies but only 17% of those who had cancer in their lymph nodes received chemotherapy. Younger women with positive lymph

nodes receive chemotherapy 60% of the time. And six women in the study received only a biopsy of the tumor, clearly an inadequate approach to a breast tumor. Few of these women studied had refused treatment; many times further treatment was not offered by their physicians.

The failure of medical professionals to provide sufficient pain medication for cancer patients was the subject of an article in the June 17, 1998 issue of the Journal of the American Medical Association. This five-state (Kansas, Maine, Mississippi, New York, South Dakota) study of cancer patients aged 65 and older showed that 4003 patients who reported daily pain received the following treatment:

- 16% received acetaminophen (Tylenol) or aspirin
- 32% received codeine or similar drugs
- 26% received morphine
- 26% received no pain medication at all

For patients 85 years and older, even less pain medication was prescribed. For example, only 13% received codeine or similar drugs compared with 38% of those aged 65 to 74 years. In addition, elderly minority patients received less pain medication than Caucasians, with African-Americans 50% less likely than Caucasians to receive pain medicine. Hispanics and Asians also received less pain medication than Caucasians but more than African-Americans.

HELPING SENIORS WITH CANCER SCREENING AND TREATMENT

The statistics on cancer rates, cancer screening, clinical trials and cancer treatment make a strong case for advocacy for seniors with cancer or at risk of cancer. The goal of health care advocacy is to ensure that clients receive appropriate health screening, thorough medical evaluation of symptoms and the opportunity to consider all effective treatments for their health problems, including cancer.

Geriatric Care Consultants are in a unique position to ensure their elderly clients receive recommended cancer screening services by requesting screening when communicating with their clients' physicians. In addition, Care Consultants can educate clients

about lifestyle choices which can limit their risk factors for cancer, such as avoiding smoking or smoky environments and in choosing a diet rich in fruits and vegetables. They can also advise and remind clients to report any changes in their skin, bodily functions or other symptoms.

When screening or symptoms arouse a suspicion of cancer, the Care Consultant can help the client and/or significant others discuss with the client's physician the full range of testing options available. Oftentimes, the client will need help in arranging for and participating in the necessary testing. When test results are complete, again the Care Consultant can ensure that the physician will fully communicate the diagnosis and all treatment options to the client and/or responsible parties. When the choice of treatment is questionable due to the client's poor physical health or significant cognitive

impairment, the Care Consultant can help the client and/or responsible parties discuss the ethical issues as well as the medical concerns of treatment, often in a care conference with the medical professionals, clergy and other important to the client. When the client and/or responsible parties choose a treatment plan, the Care Consultant can facilitate implementation of the plan. And when palliative, or supportive treatment, is chosen, the Care Consultant can assist in making arrangements for hospice care and other comfort measure to ensure comfortable, dignified care until the client's death.

It is important to note that the Care Consultant does not make decisions for clients, but ensures that all clients receive optimal screening, thorough diagnostic evaluation and the opportunity to consider treatment options for their conditions.

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