Royal Berkshire
NHS Foundation Trust

Multimorbidity in Cancer Care

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Multimorbidity

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- The presence of two or more long-term health conditions where at least one of these conditions must be a physical health condition. These can include:
  - Defined physical and mental health conditions such as diabetes or schizophrenia
  - On going conditions such as learning disability
  - Symptom complexes such as frailty or chronic pain
  - Sensory impairment such as sight or hearing loss
  - Alcohol and substance misuse

Why does it matter?

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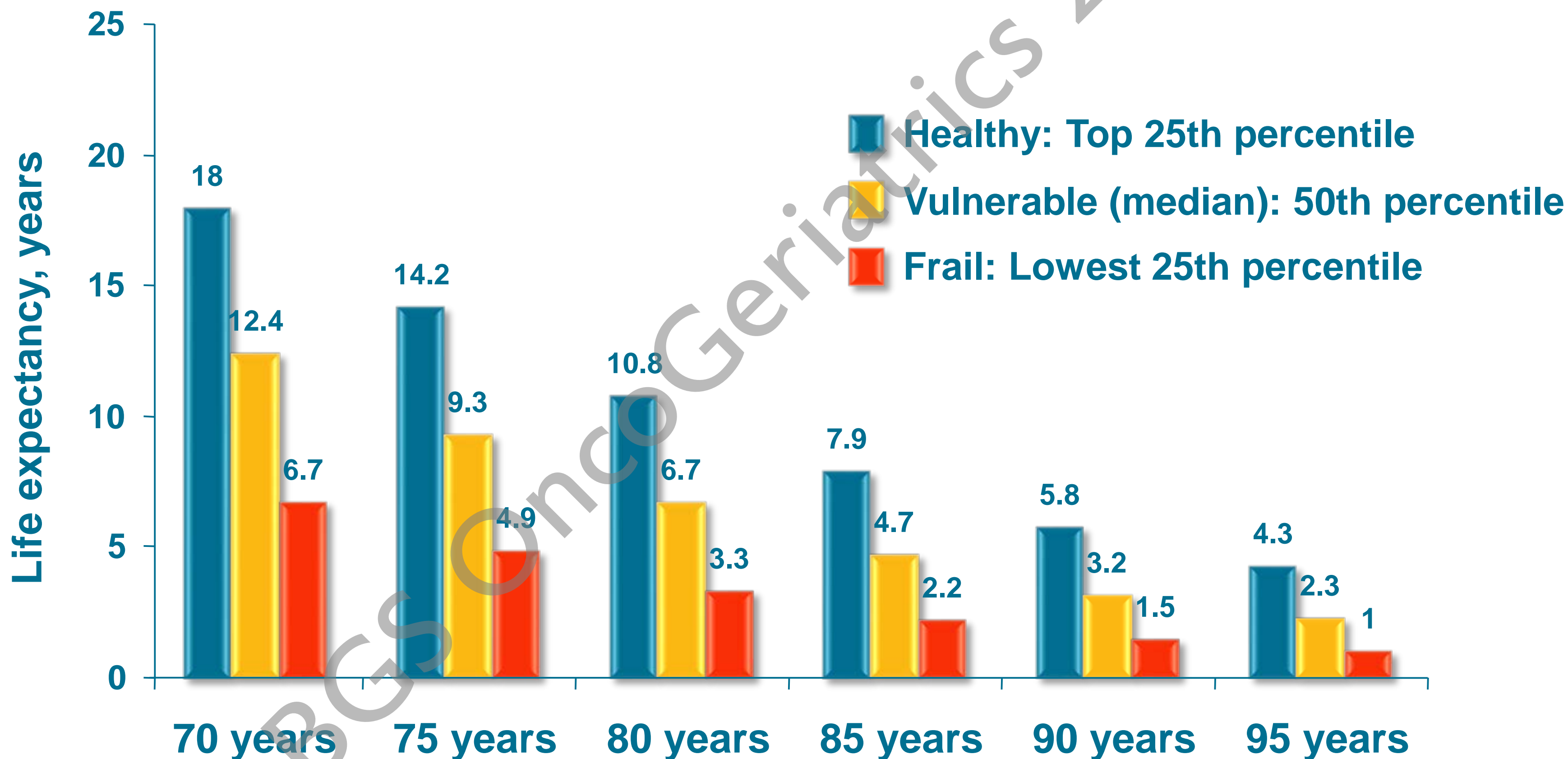
Life Expectancy in Senior Adults: Large Variability Reflects Health Status Variability



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Walter LC et al. JAMA 2001, 285, 2750-2756

In cancer it is not the only prognostic factor

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Stage, age, CRC, all patients

	Stage	1976-87 (%)	1988-99 (%)	2000-10 (%)
<75	I,II	48.4	53.4	59.2
	III	22.1	21.6	20.7
	advanced	29.5	23	20.1
>75	I,II	42.6	50.4	55.3
	III	15.2	20.7	20.4
	advanced	41.2	28.9	24.3

Advanced = Stage IV and unresectable

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Evidence of under-management:

Cancer in old age—is it inadequately investigated and treated?

N J Turner, R A Haward, G P Mulley, P J Selby

Proportion (%) of cancers confirmed by histology, cancer patients with no definitive treatment, and cancer patients surviving five years, by age group, Yorkshire 1989-93

	Confirmed by histology			No definitive treatment			Five year survival*		
Site	0-64	65-74	75+	0-64	65-74	75+	0-64	65-74	75+
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Colon	95	89	75	9	16	31	43	39	37
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Prostate	94	91	78	6	8	15	46	46	42
Skin (non-melanoma)	98	98	96	1	1	2	98	99	100
Stomach	90	86	70	32	44	66	16	11	9

*Excludes deaths from other causes.

NJ Turner BMJ 1999

bmj.com

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How do we deal with the whole person?

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What are the aspects of CGA?

Traditional CGA comprises the following elements:

Medical assessment	Problem list Comorbid conditions and disease severity Medication review Nutritional status
Assessment of functioning	Basic activities of daily living Instrumental activities of daily living Activity/exercise status Gait and balance
Psychological assessment	Mental status (cognitive) testing Mood/depression testing
Social assessment	Informal support needs and assets Care resource eligibility/financial assessment

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Who can/should deliver CGA?

Medical assessment	Geriatrician
Assessment of functioning	PT/OT
Psychological assessment	Nurse/Geriatrician/Old Age Psychiatry
Social assessment	Administrator/Nurse
Environmental assessment	OT

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Multimorbidity aka Comorbidity

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Comorbidity Scores

- Geriatric Index of Comorbidity (GIC)
- Adult co-morbidity Evaluation ASA -27
- Cumulative Index Rating Scale for Geriatrics (CIRS-G)
- Charlson Index

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Comorbidity Scores

- **Geriatric Index of Comorbidity**
  - no validation in elderly patients with cancer
- **ASA-27**
  - OK with cancer, but most data due to retrospective extraction

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Comorbidity Scores

- **The Charlson Index**
  - poor correlation with other ageing comorbidity ratings
  - lacks sensitivity - merely yes/no i.e. no severity
- **CIRS-G**
  - measures burden of physical illness
  - mainly validated in residential care
  - poor validation in cancer

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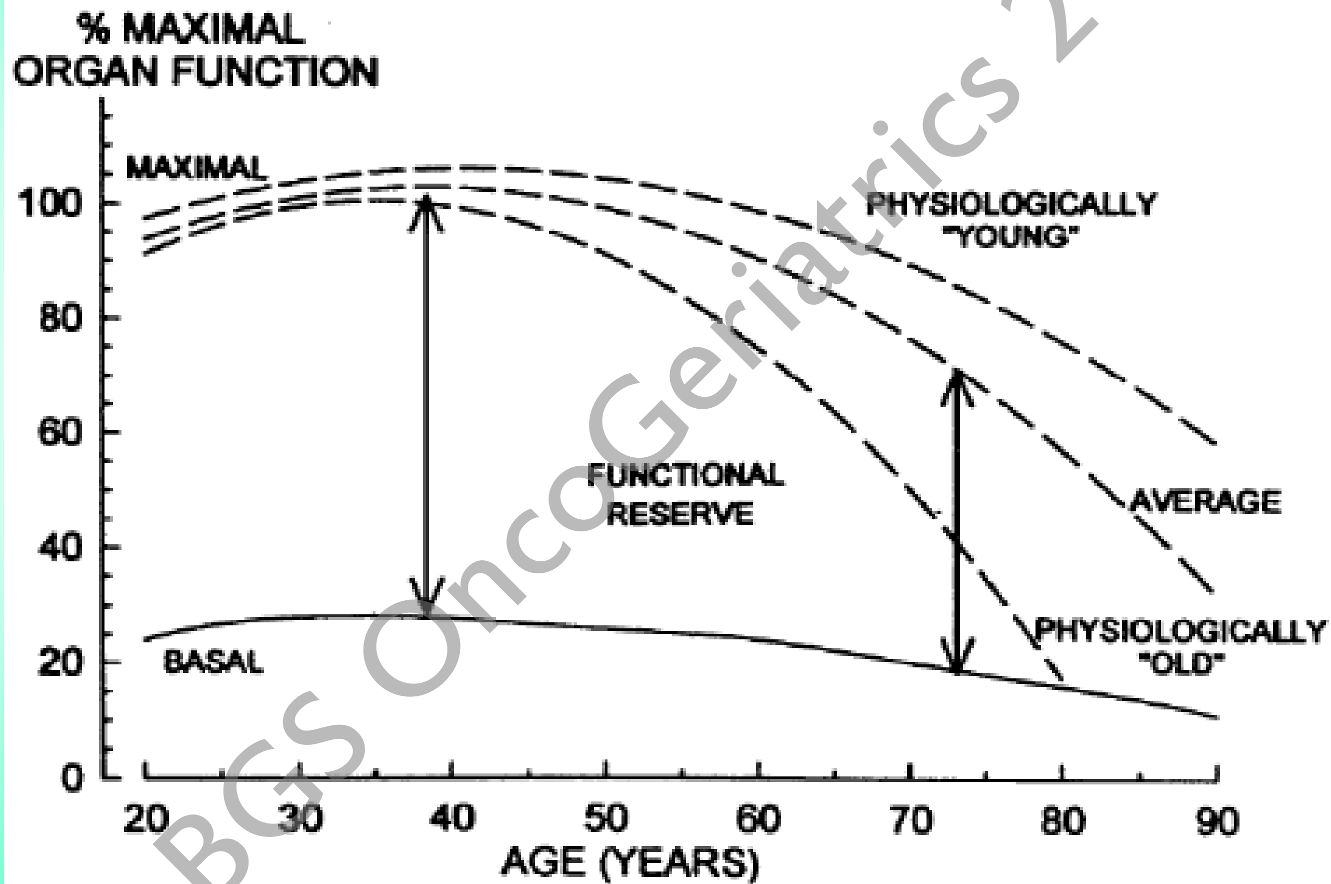
physiological heterogeneity of elderly patients



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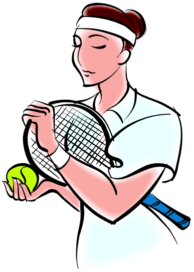
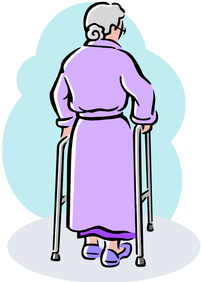
Assess first, then treat

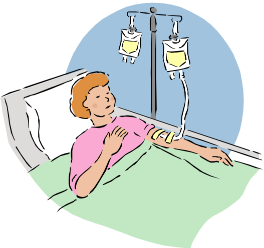


- Good shape: same treatment as younger patients (half of 70 – 75-year-old and 25% of 80 – 85-year-old patients)



- Vulnerable: intervention then standard treatment

- Frail: intervention then adapted treatment or palliation



- "Too sick"

Standard treatment

Geriatric intervention

Palliative intervention

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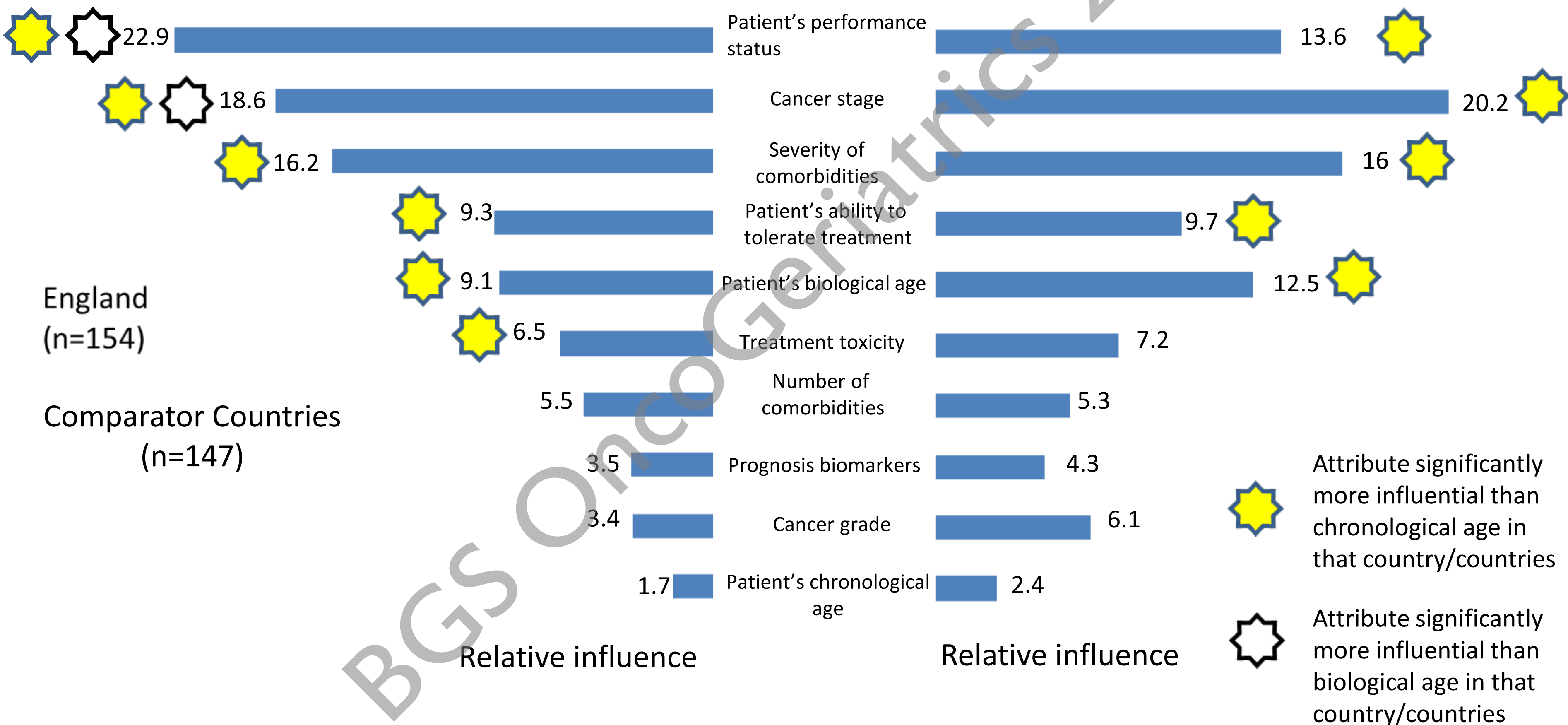
Relative influence of different factors in determining intensity of treatment



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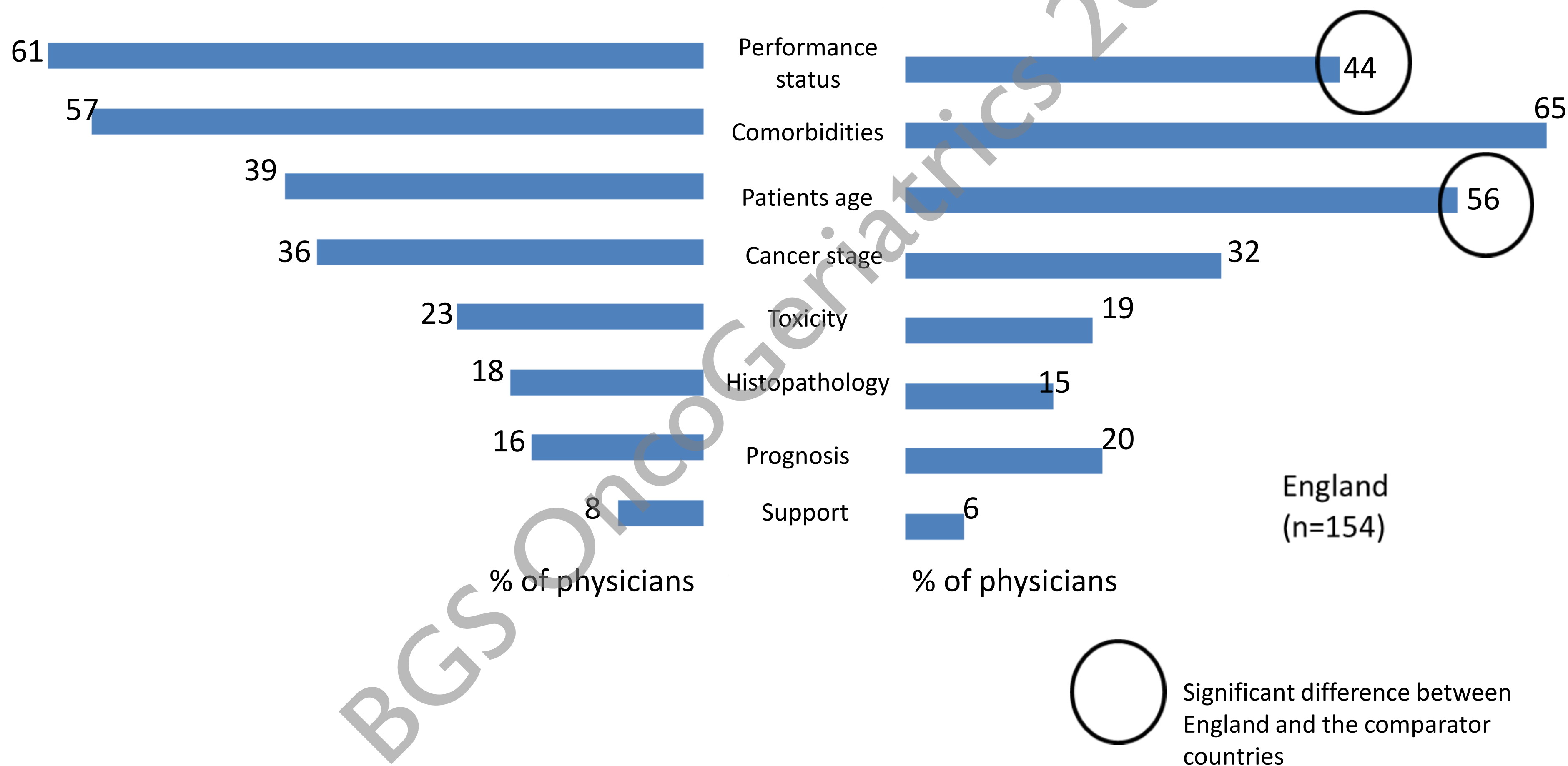
Q: Please rank the following factors in terms of their importance when deciding how intensively you can treat [SPECIFIC CANCER] patients when your goal is to cure them.
Please rank the top 5 factors from 1 to 5 where 1= most important and 5=fifth most important!
Base: 301. All countries, all cancers

Factors that determine treatment intensity when curative outcome is the intention



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Q: What factors dictate how intensively you can treat a patient with [SPECIFIC CANCER] when your goal is to cure them?
Base: 301. All countries, all cancers

Findings

The following issues were identified in the first 70 patients seen by the COCOC team:

- •45% had a history of hypertension
- •43% reported a history of falls
- •41% were taking four or more medications
- •40% lived alone
- •40% had impaired ability to plan and prepare meals
- •38% had three or more comorbidities
- •23% were completely unable to shop
- •19% had a body mass index of less than 20
- •16% showed signs of cognitive impairment on assessment
- •10% required assistance to eat or drink
- •10% had difficulty using the telephone

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NICE Versus NASTY

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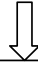
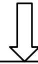
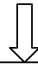
Adult who may benefit from an approach to care that takes account of multimorbidity



Principles and steps to follow



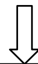
Discuss the purpose of the approach to care



Establish disease and treatment burden

Identify patient preferences and priorities

Review medicines and other treatments



Agree an individualised management plan

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Individualised management plan

- Find out what the patient wants (agree how realistic it is and then prepare for the negotiations)
- Look at comorbidity
- Look at medication and be realistic
- Sort out healthcare appointments (probably cancel most)
- Try to imagine how things are going to change particularly after surgery or oncological input
- Think about who is going to co-ordinate the care and this list of people who need to be cc'd
- Think about follow up and who needs copies of the management plan

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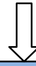

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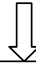

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Principles and steps

- How will treatments interact with pre-existing health conditions (what affects on quality of life)
- Patient's preferences and how treatment will impact on life style and goals e.g. peripheral neuropathy etc.
- Which guidance on single health conditions are now important (life expectancy trumps some evidence based medicine)
- Can we reduce treatment burden adverse events and unplanned care by altering treatment without necessarily impacting on survival?
- Improving co-ordination of care

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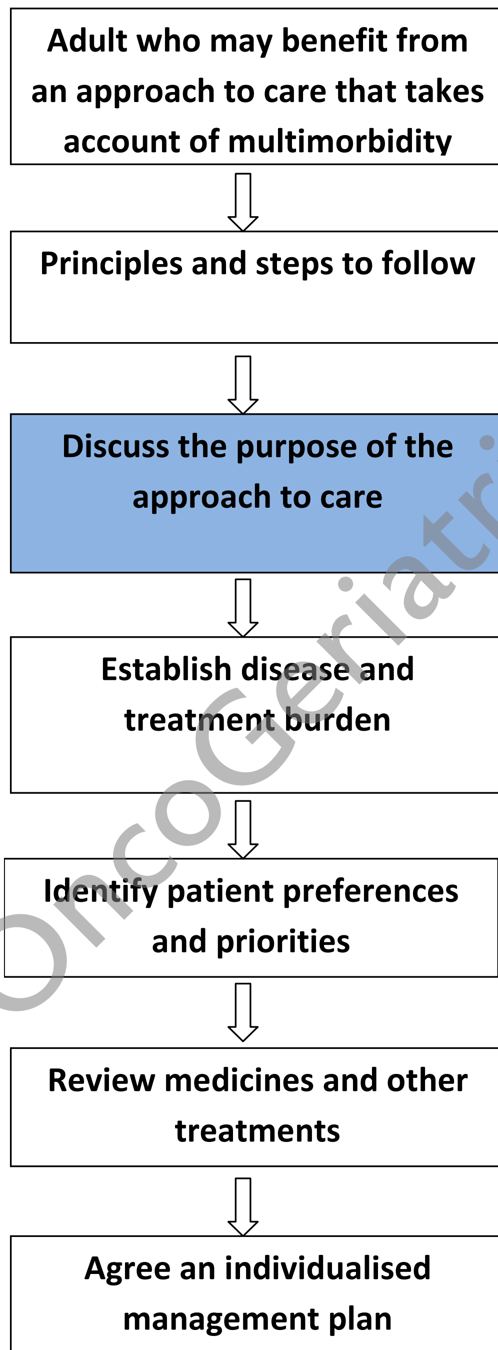

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Discuss the purpose of the approach to care

- How do we maximise the benefit from existing treatments (pragmatism vs. evidence based medicine)
- What can we stop because of limited benefit (statins my favourite)
- Can we reduce treatment and follow up burden (SOS rather than routine follow up)
- Identify the Geriatrician's favourite medicines e.g. high risk of adverse events (remember; falls, GI bleed and AKI!)
- Non pharmacological treatments instead of pills
- How do you reduce the number of appointments?

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Adult who may benefit from an approach to care that takes account of multimorbidity

Principles and steps to follow

Discuss the purpose of the approach to care

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Establish disease and treatment burden

- Need to talk about mental health especially depression and anxiety
- How disease burden is affecting well being pre and post cancer diagnosis
- How are the health problems interacting and how this affects quality of life

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Lists to remember

1. Number of appointments
2. Number of medicines
3. Diet, exercise and psychological treatments

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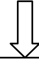

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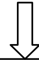

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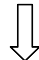

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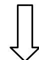

Review medicines and other treatments

Agree an individualised management plan

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Identify patient preferences and priorities

- Communication with family members and carers
  - Has anyone sat down and talked to everyone together?
- Personal goals, values and priorities
- Can the patient maintain their independence after cancer treatment?
- Can the patient continue working and taking part in social activities including family life after cancer treatment?
- How is it important preventing specific adverse outcomes e.g. post operative cognitive dysfunction, reducing harm from medication, reducing treatment burden, lengthening life remembering quality vs. quantity.

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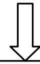

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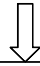

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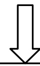

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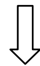

Review medicines and other treatments

Agree an individualised management plan

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Review medicines and other treatments

- Always ask yourself
  1. Effectiveness of a treatment
  2. Duration of treatment trials
  3. Populations included in treatment trial
- Look particularly at treatments that are relieving symptoms e.g. PPI
- Preventative treatment e.g. Bisphosphonates after three years treatment!

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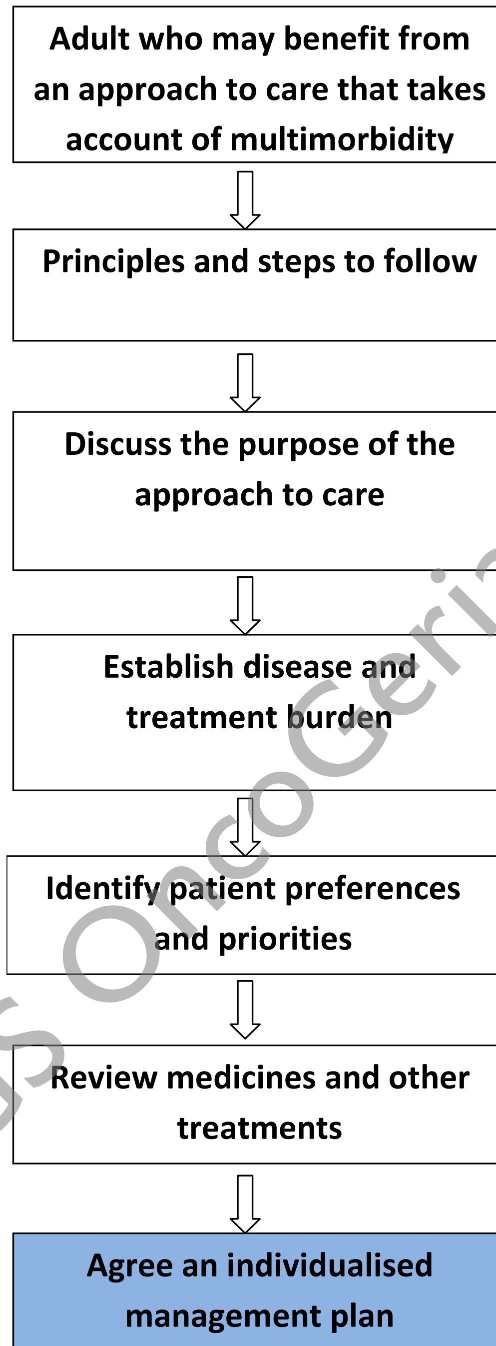

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- Adults with individualised management plan and multimorbidity feel that decisions about their treatment have taken into account their values, priorities and goals

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Who benefits from management plans for multimorbidity?

- Service providers (GP Practices, District Nurse services, Community Pharmacies, Hospital’s)
- Healthcare professionals (GP’s, Practice Nurses, District Nurses, Community Pharmacists)
- Commissioners
- Patient’s and family members

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Multimorbidity

- The rules are the same but more important.
- Cancer treatment can complicate decision making
- Use it as an opportunity to “Spring Clean”
- Don’t forget the Geriatrician as the voice of reason

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