Jean-Pierre Droz:

We can do better for our older patients

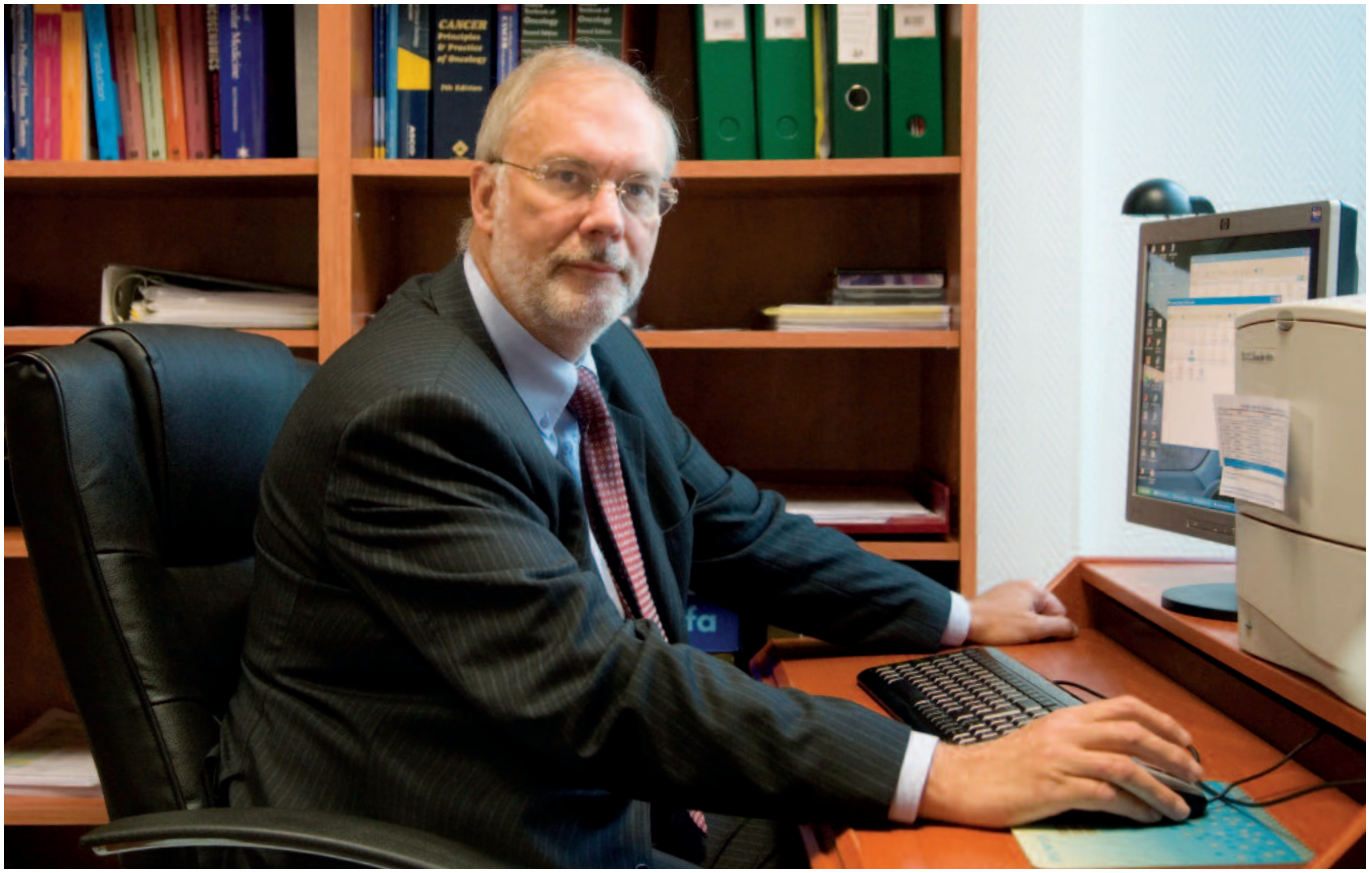
Marc Beishon

Cancer is classically a disease of the elderly, yet all too often the special needs of older patients seem to be ignored. Routine use of screening to distinguish patients healthy enough to receive standard therapy from those who need adaptations, a greater input from geriatricians and geriatric oncologists and better all-round clinical training are needed, argues Jean-Pierre Droz.

Older people – and especially those classed in the 'geriatric' category of over 70 – tend to be shamefully neglected from many standpoints in western nations, where youth commands attention. But it still comes as a surprise to find that, even though cancer is primarily a disease of older people, geriatric oncology is poorly developed, despite this specialty differing in a number of fundamental ways from the practice of cancer medicine in younger groups.

According to Jean-Pierre Droz, a medical oncologist based at the Léon Bérard cancer centre in Lyon, France, whose work with older people has been one of the highlights of the later stages of his career, the critical issue is the marriage of two distinct disciplines – geriatrics and oncology, and he has been one of the pioneers of integrating geriatric assessment in decision-making for managing older people with cancer. "It's a given in countries such as France that we see no end in sight for the increasing proportion of older people in the population, and as half of all cancers occur in those aged over 65–70, this demographic transition is a major challenge for health organisations," he says. "But if you look at studies about how older cancer patients are treated you find they often do not receive the same treatments as younger people. Yet when you ask them, they are often willing to be treated and many can indeed receive the same care as anyone."

The key issue, he continues, is that the needs of 'senior adults' can be better met by oncologists who have been trained in the cancer treatment problems of this growing population, and not by general medical oncologists who may not be making good use of geriatric resources. "As an oncologist in charge of treating an older person you should approach them in exactly the same way as with younger patients, but you should then apply assessment tools that may uncover various health problems that mean you may need certain geriatric interventions. Patient management should ideally be carried out by both an oncologist and a geriatrician, as equal partners in decision-making and applying treatment," he says.



NIGEL DICKINSON

The problems of senior adults can be very complex – they can include social, nutritional and financial issues, for example, as well as their health status, both physical and mental. "While I'm pleased to report that the specialism of geriatric oncology has developed well in the last 10 years, there is still a discrepancy between appearance and reality. Good medical oncology, in my view, is first and foremost good medicine. You can check health status – does this patient have hypertension, heart failure, poor renal function and so on – but there are some medical oncologists who are not looking more deeply, and say, 'If the patient has these problems and he is old I cannot treat him.' That is not sufficient," says Droz. "Some of the conditions are reversible, which means you can treat after applying geriatric interventions," he adds, "and even in those that are not reversible, there are often helpful treatments you can give. And of course older people without impairments can receive the same treatments as younger people."

While there are many questions about how best to treat tumours in older people, the need for a comprehensive assessment of whether to proceed at all is a 'reality check' for the cancer world that those involved with geriatric oncology are putting forward both in their home countries and internationally. But judging by the membership of SIOG, the International Society of Geriatric Oncology, the take-up so far is small and fragmented. As Droz, who has recently come to the end of at two-year spell as president of SIOG, notes, the society was set up only in the year 2000, while the specialism itself only really started about 20 years ago, and exists mainly in a small, but growing, minority of cancer centres. "So far only the US, Germany, Italy and France have developed major geriatric oncology programmes, and there are notable absences from participation in SIOG," he says.

Like other 'minority' areas of cancer, geriatric oncology, he adds, suffers from lack of evidence, especially drug trials that have sufficient representation of older people, or which are targeted at them.

While major conferences such as ASCO (the American Society of Clinical Oncology) feature geriatric oncology streams, Droz says he and his colleagues need constantly to restate the arguments to ensure these do indeed take place. But tools for the all-important geriatric assessment to help oncologists make treatment decisions have been developed and are being piloted in France, for example, and SIOG's major achievement so far, according to Droz, has been to issue a growing set of guidelines for tumours such as colorectal and breast, to help professionals make better informed decisions in the clinic.

Droz is a realist, and says the good news is that it is not necessary actually to have a geriatric oncologist in place. A small team can mirror the work of the programmes like the one developed at Léon Bérard, so long as it also has a geriatrician in attendance, and preferably a specialist nurse; while professionals such as community workers and nutritionists are often in place anyway. While expressing reservations about the narrow focus of some medical oncologists, he feels that appropriate teamworking, together with concerted regional networking and properly evaluated screening and assessment tools, will tip the balance in favour of good treatment for older people. But he stresses the need for all oncologists to develop and practise the full range of clinical skills, which has been his aim until recently.

A year ago, Droz made a tough decision for such a committed clinician – to retire early from day-to-day oncology and instead devote himself to research, national and international activities, and teaching and mentoring, continuing work on geriatric oncology and also on certain tumour specialisms. "I think that 32 years working as a medical oncologist is enough, and I came to realise that in France, in particular, it is very difficult to do anything other than full-time clinical work. I also do not think you can call yourself a clinician if you pick and choose your patients and spend a lot of time on other activities, such as research and international work."

While being every inch a 'classical' oncologist, who has taken his time with each patient, he does recognise the advantages of systems, particularly in the US, where a hierarchy of assistants and professors allows more time for research and teaching in the big comprehensive cancer centres. He admits immense frustration with the French system, where clinicians are constantly on call for emergency situations and where they also have little impact on changing traditional teaching in medical schools and university hospitals.

For his own part, Droz does have the experience he feels appropriate to medical oncology – though he had no formal recognition in this specialism until 1997. "I always wanted to be a doctor after seeing my father become ill when I was very young, and I went to medical school in Paris, focusing on haematology and intensive care, eventually moving to the Gustave Roussy Institute in Paris, our premier cancer centre, as a fellow. I didn't know what solid tumours were then, but started working on lymphoma, thyroid tumours and myelodysplastic syndromes, before getting very interested in medical oncology and specialising in urological tumours, and especially testicular cancer. I saw the extraordinary progress we were able to make with cisplatin and the first responses to chemotherapy in general, with regimes such as MOPP in Hodgkin's, and of course I've also been involved with all the later progress with targeted therapies.

"But my view is that even bigger gains in outcomes have come in some tumours, such as bladder cancer, with advances in surgery and anaesthesia – the mortality rate for cystectomy was 10–20% in the 1970s, now it's less than 1%, thanks to improved perioperative care."

Droz has treated some 3,000 testicular cancers in his time, but stresses that medical oncologists must cooperate very closely with surgeons, and also radiotherapists. "Whenever one of my patients was operated on the surgeon called me just before and I would attend the theatre so I could also assess the anatomical situation. It is crucial that more medical oncologists become involved with other disciplines."

Clinicians have little impact on changing traditional teaching in medical schools and university hospitals

"There are now many cases where multiple options need to be discussed with patients and joint decisions made"

His interest in the growing importance of multidisciplinary working led to involvement with the then new field of supportive care in oncology. "I participated in the first randomised trial of supportive care treatment – of odansetron, for cisplatin-induced vomiting – published in the *New England Journal of Medicine* in the late 1980s, and French researchers have also contributed to the equally important development of pain treatment. Supportive care is about the perceptions, wellbeing and effects of treatment from the point of view of your patients, and it has paralleled the development of mandatory multidisciplinary discussions among doctors, as well as helping to open up true dialogue between patients and doctors, and also helping to establish patients' rights."

As Droz adds, there are now many cases where multiple options need to be discussed with patients and joint decisions made, especially in tumours such as prostate cancer, where he has also developed expertise. "It's a completely different view of your clinical work and it all takes time, and is one of the reasons why it is very difficult to be involved in other activities outside the clinic."

Droz left Gustave Roussy in 1993, mainly because he was tempted by the visionary ideas of Thierry Philip, the director of Léon Bérard, a private, not-for-profit cancer centre, typical of the French system. "He is a leader in medical oncology through work on child and adult lymphomas, and on renal cancer immunotherapy and neuroblastoma treatment, but I also shared his ideas of building a comprehensive cancer centre on the lines of those I'd seen in the US. However, when I arrived, there were not yet any research labs – it was just a good private clinic. And because of what's possible in France, it has taken us 15 years to do what could have been done in less than five."

He adds that, even at this time, it was unusual in France for doctors to move between centres at this level. "I was a stranger here in Lyon for several years," he says. "And people tended to be promoted within a sort of oligarchy in French medicine. I had to spend a lot of time proving myself and convincing people to work together."

As the head of medical oncology, Droz says he initially found that his doctors were mostly working to their own agendas, and he considers as one of his key achievements helping to

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establish common protocols for treatments for each tumour type. He also streamlined research alongside the clinics, including translational work programmes.

Now, adds Droz, in his main fields of interest, Léon Bérard is second after Gustave Roussy for work on germ cell tumours, and is noted also for programmes on prostate, renal and endocrine tumours, particularly for trial work and targeted therapies. He has also been president of the genito-urinary group of the French federation of cancer centres.

Another, less successful, part of his work has been involvement with teaching at the Laennec medical school at Lyon University, where as professor of medical oncology he was able to participate initially on ideas in France to reform traditional organ-based teaching to a more problem-based, holistic model of approaching patients. "But the problem is that we are up against the traditional way of thinking of the French teaching system and we have made little headway," he says.

He also says that France is turning out medical oncologists who lack a solid background in internal medicine. "Here, when you choose medical oncology, you train for five years, instead of say doing three years of internal medicine followed by two years medical oncology and then another two years as a specialist fellow or registrar. I think the French system emphasises purely the treatment side of my specialty and not the features of the all-round clinician who knows how to conduct the full range of medicine."

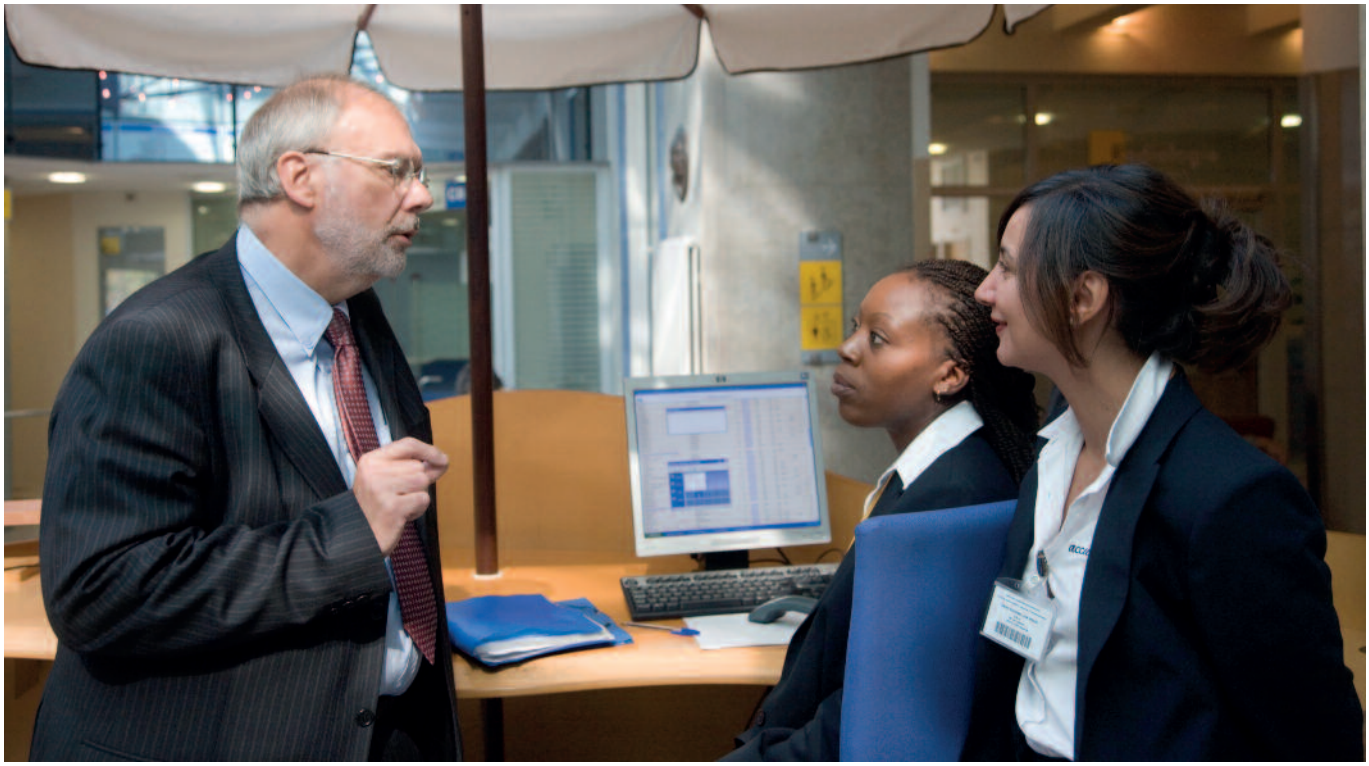
Such views about the place of medical oncology are no better crystallised than in the growing field of geriatric oncology. Apart from being asked to establish medical oncology at Léon Bérard, one of the visionary tasks that Philip set for Droz was to look at the needs of older people, as both were rightly convinced that with the ageing population geriatric oncology would be a vital service to offer at any cancer centre. "As a private clinic there is also a business case of course to look at the market for the patients of the future, but it was clear that this was a group that was not well managed," says Droz.

While initial ideas were put forward in the early 1980s about geriatric oncology, it was only about 20 years ago that programmes were developed by Lodovico Balducci of the H Lee Moffitt Cancer Center in Tampa, Florida, and also by Silvio Monfardini, based at Padua in Italy (the latter co-authored a paper in the *Lancet* in 1990, entitled Cancer in the elderly: Why so badly treated?, and is profiled on page 30 of this issue of *Cancer World*).

Progress was initially slow, but Droz says things have picked up in the last 10 years, such that, in 2004, Monfardini was moved to suggest, in the *Journal of Clinical Oncology*, that it could be widely recognised as a discipline (Geriatric oncology: a new subspecialty?).

"There is a proportion of oncologists – we don't know how many – who know that the treatment of senior adults should be considered a speciality. In France it is clear there is consciousness of geriatric oncology, as it is now a priority of our National Institute of Cancer [INCa], and in the US there is a growing academic network because the NCI [National Cancer Institute] has developed a centre of excellence, but it is not widespread in general oncology practice there. In Germany there are important developments, and Italy has a very good network. But in the UK, Spain and Canada there is still little interest outside of some researchers. We started from a position some 12 years ago at the first conference on geriatric oncology where people were saying things like, 'I know how to treat breast cancer and I don't need you to tell me how to manage my older patients.'"

But organ-based approaches, which tend to work well with younger people (and which are increasing thanks to rapid specialisation in tumour types), simply will not work with senior adults because of the multiple factors that can affect them. As Droz says, this is the domain of geriatrics, and of the comprehensive geriatric assessment – and there is a long list of factors and procedures that can be addressed, including a medical exam, co-morbidities, nutritional status, walking ability, social



NIGEL DICKINSON

dependence, cognitive impairment, depression and poly-drug use. "This can be a lengthy process, taking from four to six hours and spread over two to three days, but it provides a complete geriatric view of each patient and is the gold standard. But what most oncologists need is a screening tool that will tell them whether a full assessment is worth doing."

The problem is that there are many screening approaches that can be used, including those that may be applicable to certain groups or tumours, such as men with prostate cancer. And there is clearly a big difference between what can be carried out at a comprehensive cancer centre and at an outlying clinic. Droz's group at Lyon, and the other key teams at Tampa and Padua, have developed specific geriatric assessments for medical and surgical oncology, which identify problems in the main areas, such as physical and mental status, social and economic situation, and functional status. As he says, such programmes often also identify multiple and previously unknown problems in patients, such as malnourishment.

But the Lyon programme has been developed with colleagues in a specialist geriatric hospital, and so this onco-geriatric assessment benefits from a multidisciplinary research team that would be hard to replicate outside of major centres. That is why Droz and colleagues are currently piloting more simple tools that would help other clinics carry out a rapid screening that would help to classify patients into the key categories – those who are in good health and can receive standard treatments, those who are 'vulnerable' but can receive the standard treatment after an appropriate geriatric intervention, those who are 'frail' and can have adapted treatment after an intervention, and those who are really too sick to receive anything more than palliation.

Organ-based approaches, which often work well with younger people, simply won't work with senior adults

"Screening is to raise suspicion, the comprehensive geriatric assessment is like a biopsy and diagnosis"

Two tools are being tested and compared with a full assessment of some 1,600 patients to see how well they measure up. "It's important to stress that screening is just to raise suspicion, like a cervical smear test – the comprehensive geriatric assessment is like a biopsy and diagnosis," he says. The tools are the well-known Karnofsky index and the Vulnerable Elderly Survey-13 (VES-13), and the latter has shown more promise in earlier work. Attention to detail when seeing older patients is also important – as an example he mentions that consulting rooms should have a toilet and an easily visible clock.

Droz says such work is now greatly helped by the French Cancer Plan, which has not only created a geriatric oncology branch within INCa, but has also set up a network known as UPCOG (pilot units of onco-geriatric coordination). As a result, according to Balducci, France now has "arguably the most effective research network in geriatric oncology in the world," for which Droz should take most credit.

For medical oncology, Droz says the most important aspect of health status tends to be renal function. "Renal function in older people can often be half that of younger patients and of course a lot of drugs are excreted through the kidneys." He also highlights cognitive impairment as a key issue. "If you take your time, it is possible to obtain an understanding of the situation and possibly an agreement with the patient," he says. "And one of the most difficult decisions is not to treat, but you must have a true diagnosis and evaluation and keep the patient fully informed." As he warns, making decisions to treat or not to treat based on a less-than-good assessment can mean people undergoing unnecessary side-effects and loss of quality of life, or loss of what could be a good spell of quality life. Good medicine, he adds, will balance the cost equation, as the wrong decisions can also be expensive.

There are also, not surprisingly, major gaps in knowledge about the effects of chemotherapy drugs and long-term complications in older people, not least because this is hardly a high priority for drug companies. "Some trials have no senior adults at all, and others that do may only have a small proportion who are otherwise in good health and so are not representative," comments Droz. "We already know they can be treated as usual." Other trials that have included patients with impairments have mixed different health problems and also included younger patients with the same issues, which is not very useful in homing in on specific groups, he adds, noting that studies estimate that 80% of the population over 65 has at least one chronic condition.

"But there are some trials now that are aimed at older people and are trying to divide them into the healthy, vulnerable and frail categories, especially in lymphomas, while there are others for senior adults in poor condition who also have colorectal and lung cancer." He mentions colleague Martine Extermann of Tampa, who has now taken over as president of SIOG, as leading work on appropriate trials in the US and Europe. (Extermann also collaborated with him and others on an international study comparing attitudes of older patients toward chemotherapy, in this case between France and the US.)

Droz describes his work with prostate cancer as a 'wonderful' model for geriatric oncology, as it encapsulates a spectrum of complex issues with older men with either advanced or limited disease, the latter making up an increasing proportion of patients. The Lyon geriatric assessment programme has been crucial to navigating the balances that need to be struck between several treatment choices, toxicities, health issues such as vitamin D deficiency, quality of life and of course survival in a population that is living longer, and Droz and colleagues are working on new guidelines for SIOG. As he notes, there have not, for example, been any comprehensive recommendations so far for managing senior adults with metastatic prostate cancer.

Along with networking at national and international levels, Droz also started an onco-geriatric diploma for the south of France in 2002, which now has 40 students attending 12 sessions of two days each over two years, staged at various university hospitals in the region, and a similar initiative has started in Paris. Problem-based role-play is part of the teaching and one may assume that students are left in no doubt of his conception of medical oncology.

Droz has been fortunate to work alongside many of the great names in French oncology, such as Georges Mathé, who he says invented modern oncology in the country, Jean-Louis Amiel for mentoring on medical thinking, Maurice Tubiana as a forerunner in translational research and of course Thierry Philip at Lyon. "But I think I have made no major impact on medical oncology – I see myself as a good artisan who has treated a lot of patients. I've also not involved myself in the politics of healthcare too much." However, he did write a paper on the rules governing reimbursement of care for older cancer patients in France – clearly there are major issues beyond treatment, such as rehabilitation, accommodation and support in all western countries, and there can be considerable public resistance to spending more on very old people.

Droz is a year into his 'retirement' now, and calls himself a medical consultant, but maintains an office at Léon Bérard and has an emeritus professorship at the Laennec medical school. His recent output on co-authored papers in geriatric oncology and prostate cancer is prodigious, and he's written many book chapters. His interest in the basic biology of germ cell tumours continues, while he is also helping to develop younger colleagues in various specialties (notably Catherine Terret, who is co-leading now on geriatric oncology at Lyon, with Gilles Albrand). "It is very difficult to establish yourself in France – you're still considered young at 60," he says.

He has two grown-up children and neither they nor his wife have worked in medicine. His main personal interests are languages and classical music and he intends to spend time looking at musical theories, but admits he's still not off the work 'treadmill' even now.

Unlike some in oncology, he is not expecting any major breakthroughs in therapies for the foreseeable future, but in France he sees good scope for increased research capacity under the Cancer Plan. But he is resigned to seeing French medical education continuing on its present path. "When I see third year students – some 100 of them in the room – I ask them, 'What is your aim and the role of medicine?' and they all say, 'To cure and treat disease.' I say, 'No, your role is to increase health.'"

And as Droz has just turned 62 and is approaching senior age himself, he will be even better placed to hammer home the message that chronological age by itself should never be a deciding factor in someone's chance for better health.

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