

When Reporting on Older Patients with Cancer, Frailty Information is Needed

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Any effort to bring new light on the management of older patients with cancer should be welcomed and considered with interest. A large amount of evidence has now been gathered, proving significant delays in cancer detection, under-staging, and substandard treatment of this age subgroup, resulting in inferior survival. We have no standard of care and no evidence-based guidelines available for this age group because it has regularly been excluded from clinical trials: our knowledge on cancer management simply has never been validated in the older subsetting.

One note of concern rests on the fact that world-renowned centers of excellence omit data on frailty, hence failing to identify which patients have been involved in their studies.^{1–3} Several editorial notes also lack the same information. Reports from these researchers only include age and ASA, with no reference to comorbidities, frailty, or performance status.^{4–6} Consequently, these series most frequently present highly biased findings retrieved from super-selected cohorts: it is only the superfit onco-geriatric patient that reaches surgical theater. This implies that all considerations and conclusions cannot be applied to the overall geriatric population.

It would be totally unacceptable to present series without clearly stating patients' stage. The TNM staging system is fundamental in drafting treatment plans, comparing series, testing new drugs, drafting guideline, consenting patients, etc.

In a very similar way, we are no longer justified to present series of older patients without frailty data. Anagraphic age

is not sufficient to characterize these patients; after a decade of discussion with geriatricians, it is now clear that Comprehensive Geriatric Assessment is the most accurate instrument. Unfortunately, this is not adequate for our busy clinical practice because it requires several hours per patient. For this reason, quicker tools have been tested and validated.^{7–9} These tools are capable of identifying those frail individuals who should be referred to special geriatric care before surgical management.

A modern approach should take advantage of the few available days/weeks before elective cancer surgery is planned to correct anemia, dehydration, malnourishment, and depression; optimizing the patient's conditions, as highlighted by frailty assessment tools, will eventually reduce the occurrence of operative complications. The use of neoadjuvant chemoradiation for several malignancies offers an excellent window of opportunity to this purpose.

Interestingly, present research is moving one step forward and the already available tools are being tested against quicker ones, only taking 3–5 min to administer, hence being informative and appropriate to use in our busy routine.¹⁰

We entirely agree with the authors statement that the "involvement of physicians and affiliated caregivers equipped to evaluate and apply multidisciplinary treatment programs tailored to preexisting comorbidities rather than age per se may hold the best promise for improved prognosis in this challenging clinical circumstance."⁶ We need to bring this into clinical practice as well as scientific reporting. The lack of frailty data makes the conclusions meaningless.

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