



Contents lists available at ScienceDirect

Journal of Geriatric Oncology



Editorial

A contribution to the future of geriatric oncology training: The SIOG Treviso advanced course

ARTICLE INFO

Article history:

Received 26 October 2016
Received in revised form 1 February 2017
Accepted 9 February 2017
Available online xxxx

Keywords:

Training course
Geriatric oncology

Geriatric Oncology, which began as a niche specialty in Oncology, has become a growing branch of Oncology and Geriatrics. The “Silver Tsunami” [1] of a rapidly expanding older population has increasingly shifted clinical and research attention to these relatively “new” (in terms of clinical focus) patients. Older patients with cancer not only receive care from oncology clinics and wards, but also from geriatric departments and practitioners. To assume, however, that geriatricians possess sufficient expertise to adequately treat patients with cancer does not accurately reflect the reality of geriatric training. While they are accustomed to managing dementia, Parkinson’s disease, polypharmacy, and multiple morbidities, geriatricians may be not be fully prepared to administer appropriate care to older patients with cancer. Geriatricians are also aware that, for the growing sector of the older population who are diagnosed with cancer, coordinating care with clinical oncology specialists is necessary. However their background and/or training may not have prepared them for the process of determining who provides ongoing primary care for patients after initial treatment and how to best address the needs of older patients who present with long-term side effects after anticancer treatments.

What is the best way to resolve this situation? Part of solution may come from the use of multidisciplinary and multidimensional approaches to care, new technologies, and improved communication between clinical oncologists and geriatricians. While this may be true in theory, increasing health care costs, the all too familiar lack of sufficient time for any additional protocols, and the relative scarcity of geriatricians present real obstacles to achieving this goal. At present, improved geriatrician/oncologist interactions have been instituted in various implementations in only a few cancer centers and hospitals in the world [2]. Meanwhile, older patients with cancer are increasingly everywhere – not just in cancer centers and medical oncology units, but also in every kind of medical and surgical department and clinic, as well as in local communities, homes, and residential facilities of all kinds.

Consequently, it is imperative for the welfare of this growing population that we completely rethink the role of geriatric medicine in oncology.

For Geriatric specialists, the Comprehensive Geriatric Assessment (CGA) is generally considered to be a good approach for the management of older patients with cancer [2–5]. The CGA is a very thorough evaluation that can provide many subtle details and recommendations depending on how it is interpreted and implemented. Because of its complexity and length, the CGA is generally judged to be too time consuming by medical oncologists. Thus although the CGA can serve as an excellent template to create the older patient’s profile, it is not a fully satisfactory assessment solution [4,6]. In 2012, the Royal College of Physicians [7] suggested that the geriatric methodology was the only method that could ensure the continued sustainability of health care systems, in full agreement with the 10 priorities advocated by the International Society of Geriatric Oncology [8]. The goal is not to increase the number of geriatricians, but to extend geriatric knowledge to all other medical specializations and reevaluate health care systems using a geriatric perspective. This proposal includes the development of an ongoing dialog between specialties, in which the goal is to ask better questions in order to elicit a comprehensive understanding of the patient’s situation instead of a partial point of view that is constrained by professional tunnel vision. This approach is designed to avoid the rift between the geriatrician and clinical oncologist that older patients with cancer often encounter – each practitioner living in their own world, with two differing points of view, often without exchange of opinions [9]. Such situations support the need to develop a new way of managing older patients with cancer that redefines the relationship between clinical oncologists and the geriatricians rather than creating a new specialty – geriatric oncology. Instead, geriatricians should receive some elementary training in clinical oncology and clinical oncologists should receive elementary training in geriatrics in order to promote reciprocal sharing of information by breaking down differences in methodology and terminology [10].

Another reason to explore alternatives that do not require a large influx of geriatric oncologists is their scarcity. Since 2001, a formal dual training Program in Geriatrics-Oncology has been developed through a joint action of ASCO with the John A. Hartford Foundation in the United States, but this is the only program of its kind in the world (with the exception of France where the successive cancer plans strongly supported the development of master degrees in geriatric oncology). Hence there is a need for some kind of shortcut that would teach the principles of geriatric oncology without the necessity of becoming a specialist. One possibility is to develop short duration (a few days, i.e., the typical time spent at medical conferences) full immersion courses. This kind of class would focus exclusively on topics that would promote interdisciplinary collaboration between geriatrics and oncology.

<http://dx.doi.org/10.1016/j.jgo.2017.02.005>

1879–4068/© 2017 Elsevier Ltd. All rights reserved.

Please cite this article as: Colloca G, Monfardini S, A contribution to the future of geriatric oncology training: The SIOG Treviso advanced course, *J Geriatr Oncol* (2017), <http://dx.doi.org/10.1016/j.jgo.2017.02.005>

Although it would not be possible to address every aspect of an optimal geriatrician/oncologist relationship in such a short period of time, the foundation for a more integrative practice could certainly be established through exposure to the essentials of each specialty and simulations of clinical situations that require an interdisciplinary approach.

Based on these concepts, we reconceptualized the pedagogy of geriatric oncology to accommodate the restrictions of a short course intended for specialists in geriatrics and clinical oncology (medical oncologists, as well as surgical oncologists and radiotherapists).

The end result is the Treviso Advanced SIOG course in Geriatric Oncology, developed with an international faculty of both medical oncologists and geriatricians (14 recognized international experts). In separate sessions, geriatric faculty provided firsthand instruction in the basic elements of geriatric medicine for clinical oncologists, and clinical oncology faculty provided parallel instruction for geriatricians. Afterwards, members of the faculty chaired joint discussion sessions with both groups of trainees that presented actual clinical cases with the aim of comparing the two different ways of determining patient care. These courses gave participants the necessary knowledge and communication skills to establish or redefine geriatric oncology practice as an integrated and interdisciplinary process in their native countries. The hope is that these young geriatricians and clinical oncologists will be advocates and practitioners of the integrative approach.

These annual courses began in July 2014 through the joint action of the Geriatric Department of the Catholic University in Rome and SIOG, along with the sponsorship of ASCO and the support of the ESO. The third edition of this course was held in 2016 in Treviso which is near Venice inside, appropriately enough, a Venetian villa. Thirty-one young specialists in geriatrics and oncology from eighteen different countries spent four days with leading experts in geriatric oncology in order to learn more about collaboratively managing the primary types of tumors that occur in older patients. Each student then chose a mentor from the faculty who will be available to help them start new programs in their native country as well as to support them in future endeavors.

Please find below a few comments from Course participants that may help convey the spirit of this initiative:

"The goal of this fellowship and the reason why I would like to apply to this Geriatric Oncology Advanced Course in Treviso is to gain more knowledge in the field of the geriatric oncology to be able to build on oncogeriatric consultation within our clinic to improve the care of our older patient." **Verene**

"As a geriatrician I am interested in participating in the course because I would like to broaden my knowledge in oncology." **Kathleen**

"Help improve health policy in my medical area, my hospital and my country so also will generate research and knowledge to optimize resources in this age group for better assessment and treatment." **Jonathan**

We believe that this kind of feedback from course participants will help guide new teaching approaches in geriatric oncology in the near future.

Disclosures and conflict of interest statements

The authors have no conflicts of interest to disclose.

References

- [1] "The silver tsunami." Econ. 2010.
- [2] Wildiers H, Heeren P, Puts M, et al. International society of geriatric oncology consensus on geriatric assessment in older patients with cancer. *J Clin Oncol* July 2014.
- [3] Colloca G, Corsonello A, Marzetti E, et al. Treating cancer in older and oldest old patients. *Curr Pharm Des* 2015;21(13):1699–705 <http://www.ncbi.nlm.nih.gov/pubmed/25633116>.
- [4] Decoster L, Van Puyvelde K, Mohile S, et al. Screening tools for multidimensional health problems warranting a geriatric assessment in older cancer patients: an update on SIOG recommendations. *Ann Oncol* June 2014. <http://dx.doi.org/10.1093/annonc/mdu210>.
- [5] Balducci L, Colloca G, Cesari M, Gambassi G. Assessment and treatment of elderly patients with cancer. *Surg Oncol* 2010;19(3):117–23. <http://dx.doi.org/10.1016/j.suronc.2009.11.008>.
- [6] Luciani A, Biganzoli L, Colloca G, et al. Estimating the risk of chemotherapy toxicity in older patients with cancer: the role of the vulnerable elders survey-13 (VES-13). *J Geriatr Oncol* 2015;6(4):272–9. <http://dx.doi.org/10.1016/j.jgo.2015.02.005>.
- [7] Hospitals on the edge? The time for action | RCP London. <https://www.rcplondon.ac.uk/guidelines-policy/hospitals-edge-time-action>.
- [8] www.siog.org.
- [9] Holmes HM, Albrand G. Organizing the geriatrician/oncologist partnership: one size fits all? Practical solutions. *Interdiscip Top Gerontol* 2013;38:132–8. <http://dx.doi.org/10.1159/000343615>.
- [10] Monfardini S, Giordano G, Sandri R, Gnocchi PL, Galetti G. Bringing geriatrics into oncology or also oncology into geriatrics? *Ann Oncol* 2012;23(3):801–801. <http://dx.doi.org/10.1093/annonc/mdr597>.

Giuseppe Colloca
Geriatric Department Fondazione Policlinico Universitario A. Gemelli,
Università Cattolica Sacro Cuore, Rome, Italy
Corresponding author.
E-mail addresses: giuseppe.colloca@rm.unicatt.it, gius.colloca@gmail.com.

Silvio Monfardini
Geriatric Oncology Program, Istituto Palazzolo, Don C Gnocchi, Milan, Italy

26 October 2016
Available online xxxx