

# At Crossroads: The Challenges for Geriatric Oncology in India

Bipinesh Sansar<sup>1</sup> Anuj Gupta<sup>1</sup> Ankita Chitre<sup>2</sup> Bal Krishna Mishra<sup>1</sup> Praveen Lakshmanamurthy<sup>3</sup>  
Pooja Gupta<sup>1</sup> Ajit Sahoo<sup>2</sup> Navneet Kaur<sup>4</sup> Somnath Dey<sup>5</sup> Kunal Ranjan Vinayak<sup>5</sup> Akhil Kapoor<sup>1</sup>

<sup>1</sup>Department of Medical Oncology, Homi Bhabha Cancer Hospital (HBCH) and Mahamana Pandit Madan Mohan Malviya Cancer Centre (MPMMCC), Varanasi, Uttar Pradesh, India

<sup>2</sup>Department of Onco-Physiotherapy, Homi Bhabha Cancer Hospital (HBCH) and Mahamana Pandit Madan Mohan Malviya Cancer Centre (MPMMCC), Varanasi, Uttar Pradesh, India

<sup>3</sup>Department of Internal Medicine, Homi Bhabha Cancer Hospital (HBCH) and Mahamana Pandit Madan Mohan Malviya Cancer Centre (MPMMCC), Varanasi, Uttar Pradesh, India

<sup>4</sup>Department of Clinical Nutrition, Homi Bhabha Cancer Hospital (HBCH) and Mahamana Pandit Madan Mohan Malviya Cancer Centre (MPMMCC), Varanasi, Uttar Pradesh, India

**Address for correspondence** Akhil Kapoor, MD, DM, Department of Medical Oncology, Homi Bhabha Cancer Hospital (HBCH) and Mahamana Pandit Madan Mohan Malviya Cancer Centre (MPMMCC), Varanasi 221005, Uttar Pradesh, India (e-mail: kapoorakhil1987@gmail.com).

<sup>5</sup>Department of Pain and Palliative Medicine, Homi Bhabha Cancer Hospital (HBCH) and Mahamana Pandit Madan Mohan Malviya Cancer Centre (MPMMCC), Varanasi, Uttar Pradesh, India

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### Abstract



Dr Bipinesh Sansar

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- ▶ aging
- ▶ cancer
- ▶ geriatric
- ▶ old
- ▶ oncology

A larger percentage of our population is aging healthily and living on to a ripe old age. 60 years of age is taken as cut-off for identifying geriatric population for the purpose of specialized healthcare. The incidence of cancer is increasing and its expected more so in the geriatric population. At present, there are a limited cancer centres where specialized geriatric clinic is being conducted.

Some of the the key unmet needs are – lack of resources and time for dedicated geriatric screening, lack of validated interventions and lack of awareness about the field of geriatric oncology. Some of the proposed solutions are increasing orientation and exposure of trainees and early career oncologists as well as carrying out country specific research to find useful interventions in this field.

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## Introduction

India's population has crossed 1.428 billion by the end of the month of April 2023.<sup>1</sup> This makes India the world's most populous country surpassing China. Of the many factors responsible for the same, one of the positive factors that stands out significantly is the improved health care leading to reduced mortality and morbidity.<sup>2</sup> This means a larger percentage of our population is aging healthily and living on to a ripe old age. This also puts the onus on the health care teams and systems to provide the special care that this population needs owing to the unique physical and physiological changes they experience. The development of comorbidities adds layers of complexity to the management of various health-related issues for this group.<sup>3</sup>

A standard cutoff to be considered usually as elderly or geriatric for the purpose of specialized health care in our country is more than 60 years of age. This is based on the National Policy for Older Persons, 1999 issued by the Ministry of Social Justice and Empowerment, Government of India, and the operational guidelines of the National Policy for the Healthcare of Elderly (NPHCE), 2011. While the former document establishes the various aspects of the needs of the elderly, the latter is a promulgation of action in the health care segment. We are projected to have a staggering 198 million of our population who will constitute the geriatric population by 2030.<sup>4,5</sup>

## The Need for Geriatric Oncology

The incidence of cancer is increasing at an alarming rate in our country. As we know, for multiple reasons, cancers relatively occur more frequently in the elderly age group. The cancer incidence in our country as per the last GLOBOCAN report stood a humongous 1,324,413 in the year 2020.<sup>6</sup> By 2026, it is predicted that nearly 8.20 lakhs of these new cancer incidence will be in the geriatric population.<sup>7</sup>

With this background, it is not difficult to predict that the population needing specialized geriatric care will increase in number substantially. Also, the increasing incidence of cancer in this population and the increased prevalence due to patients living longer with more effective therapies will lead to the burgeoning of geriatric oncology burden. And, with the development of newer modalities like immunotherapy, targeted therapy, and other experimental therapies, it is expected that new spectra of adverse effects may be seen. In the elderly, the challenge will be to predict fitness for these regimens. While many adverse effects may be managed reasonably well in the younger population, doing the same in the elderly requires a more nuanced and pragmatic effort.<sup>8</sup>

Thus, a need for a separate subspecialty of geriatric medicine was recognized long back and the erstwhile Medical Council of India granted permission to start a separate Doctor of Medicine course in the year 1998 at Madras Medical College. This was followed suit by other top colleges of the country and as of now we have 69 geriatric medicine specialists graduating every year.

Along with these, the integration of geriatric care has been envisioned at the primary and secondary levels and is being performed through the National Health Mission in accordance with the NPHCE, 2011. The tertiary component is rolled through Regional Geriatric Centres (located at 19 medical colleges in 18 states of India and 2 National Centres of Aging).<sup>5</sup>

Coming back to our focus of interest, geriatric oncology, the needs of which are being addressed, but a huge lacuna exists with respect to the number of elderly who need to be catered versus the resources we have at our disposal to do that. As we can observe, even the NPHCE lacks a special focus on geriatric oncology. At present, we have around 1,000 oncology centers in our country serving cancer patients of which around 60 are academic centers. But, only a handful of these centers have a dedicated geriatric oncology clinic.

The most established program for the same is being run at Tata Memorial Hospital, Mumbai, Maharashtra, India. This program, under the leadership of Dr. Vanita Noronha, has recently completed 5 years of service.<sup>9</sup> But there are only a handful of other centers with dedicated geriatric oncology subspecialty. While it is difficult to estimate the exact number of such centers, a Google search for "geriatric oncology clinic in India" returned approximately less than 20 such centers. A dedicated geriatric oncology clinic has been running at the authors' home institution which has completed 1 year of service.

## Key Unmet needs

But the problem even with these specialized clinics is that less than 5% of geriatric oncology patients are being able to be assessed in these clinics due to lack of resources and time for dedicated screening. Some of the measures to address this issue include a quick geriatric screening for all patients using validated tools followed by detailed evaluation based on this screening. This will enable more time to be provided to those elderly who are likely to benefit more from a specialized assessment and intervention.<sup>10</sup>

The second problem is the lack of validated interventions for geriatric patients specifically directed at our patients. It is well known that there are a lot of cultural differences in the lifestyle of the western population and the Indian population. And these differences are even more so for the people who currently qualify as elderly and who will qualify for the same in the next 10 to 15 years. Thus, we need to find appropriate tools and interventions based on the lifestyle of our population which will help us determine their resilience, frailty, and overall fitness for a specific treatment.

Third is the lack of awareness about the field of geriatric oncology. At a large number of centers the awareness regarding the same remains quite low and elderly patients are frequently assumed to be not fit for moderate to high-intensity treatments despite having good functional status. This problem happens at both the level of community oncologists and at tertiary care centers. We ourselves have

been more often surprised than not at the mismatch between the assumed fitness of elderly patients for treatment pre- and post detailed geriatric evaluation.

Fourth, and one of the biggest hindrances to improving outcomes, is the lack of willingness and fear among caregivers of the elderly population regarding the offered treatment regimens. This happens more so for metastatic diseases. Many of times, the caregivers are only willing for oral therapies as they perceive them to be less potent than intravenous treatment options. Thus, it becomes very important to counsel them about the risk-benefit ratio of all the available treatments and choosing the same rationally based on a detailed or a screening geriatric assessment to strike a balance between the purported benefit which may be achieved versus the risk of detriments the treatment might lead to.

Lastly, a hindrance often felt while planning treatment for the elderly is the lack of suitable national and international guidelines dealing with the geriatric population. This is most commonly a result of the exclusion of the elderly population in most of the trials pertaining to a specific treatment. Also, many a times patients with any comorbidities are excluded from trials and the elderly having a very high probability of having some comorbidity tend to miss out more frequently. While it is true and even more important in the elderly that the final treatment decision should be based on clinical judgment, the guidelines are important in laying out a pattern from which individual variations in treatment can be drawn out and measured. So, it is very important that large meta-analyses and analysis of real-world data of treatment outcomes in the elderly population in various scenarios are done and published to throw light on this difficulty.

## Proposed solutions

The solution to the above problems lies in increasing the orientation of trainees as well as experienced oncologists to geriatric oncology. This can be done by incorporating geriatric oncology workshops and sessions in major national conferences. This will send the right message about prioritizing this field as well as pique interest in the minds of current and future oncology trainees. Apart from this, in-person and virtual workshops especially focused on geriatric oncology for those already having an interest in the field should be undertaken. This will help create a “field effect” whereby the oncologists attending these events will orient their colleagues back at their workplace to the nitty-gritty of caring for elderly cancer patients.

Another important aspect of the solution lies in devoting more resources to carrying out country-specific research in this field. As of now, there are a few publications from our country on this topic which are listed in [Table 1](#). The tertiary care centers should collaborate to bring about meaningful and impactful research for the benefit of the geriatric oncology patients of our country. A few steps in this regard has been the publication by Ostwal et al where they have validated the Cancer Aging Research Group scoring for Indian patients. Another Indian study is the development of SCOPE-C score by Banerjee et al where a multi-item scoring system specific to the needs of our population was found helpful to guide the intensity of therapy.<sup>9-20</sup>

Further, young oncologists from our country should be encouraged in every possible manner to participate in international geriatric oncology conferences to discuss and imbibe different models of care for the elderly practiced throughout the world. In this aspect, the authors have not been able to

**Table 1** Some research publications in geriatric oncology from India

Serial No.	Authors	Title	Journal	Year
1	Vijaykumar et al	Geriatric oncology: The need for a separate subspecialty	IJMPO	2012
2	Vora et al	Geriatric oncology in India: A data on patient profile from one of the cancer centers in North India	JGO	2012
3	Sarkar and Shahi	Assessment of cancer care in Indian elderly cancer patients: A single center study	SAJC	2013
4	Patil et al	Patterns of care in geriatric cancer patients – An audit from a rural based hospital cancer registry in Kerala	IJC	2015
5	Parikh et al	Geriatric oncology landscape in India – Current scenario and future projections	CRST	2020
6	Ostwal et al	Cancer Aging Research Group (CARG) score in older adults undergoing curative intent chemotherapy: a prospective cohort study	Geriatric Medicine	2021
7	Banerjee et al	Implementing and validating a care protocol for older adults with cancer in resource limited settings with a newly developed screening tool	JGO	2021
8	Noronha et al	Impact of the geriatric assessment on cancer-directed systemic therapy in older Indian persons with cancer: An observational study	CRST	2022
9	Noronha et al	The current status of geriatric oncology in India	Eancer	2023
10	Sankarapillai et al	Epidemiology of cancers among older adults in India: findings from the National Cancer Registry Program	Public Health	2023

attend any such event and they have not heard of many instances of colleagues planning to attend the same. Participation in these kinds of gatherings can at times bring about a completely life-changing perspective for the attendee.

## Conclusion

To conclude, we hope that we will see a rapid emergent growth of the field of geriatric oncology in our country led by young oncologists under the apt guidance of senior oncologists. This will provide much-needed succor and bridge the chasms in the care of the increasing number of elderly cancer patients.

### Conflict of Interest

None declared.

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