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Editorial Comment

Enough rehabilitation for our elderly cancer patients?

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One of the authors has recently published an article in the *European Journal of Cancer* on the management of unfit older cancer patients, yet there was still no mention made concerning the problem of rehabilitation of the elderly.[1] For these patients, rehabilitation includes taking care of their nutritional status, their mobility, and improvement of their quality of life. While for clinical oncologists the rehabilitation of the elderly with cancer has not yet been considered an important priority, it is quite evident to geriatricians that rehabilitation in older patients requires a special approach. In fact, very little has so far been published on this issue for older cancer patients in Europe and USA.

It may be worth mentioning that, to geriatricians, rehabilitation is an intervention whose purpose is to restore functional ability and enhance residual functional capability, thereby improving quality of life in elderly people with disabling impairment, which in this instance is from the cancer itself or from the cancer treatment.[2,3] Of course, to establish a rehabilitative programme (patient-focused goals for rehabilitation), it is necessary to know the functional status prior to the diagnosis.

It is also very important to consider the many aspects that influence the collaboration and the delivery of treatment, such as visual and hearing impairment, cognitive status (cognitive impairment, dementia), education, psychological condition (anxiety, depression), and motivation.

Other geriatric syndromes must also be ascertained such as delirium, incontinence, falls, and comorbidities or intercurrent illnesses that require close medical supervision and for which concomitant treatment must be identified.[4]

It is also important to point out trouble managing medications and polypharmacology that can contribute to drug interaction and adverse drug events. The Comprehensive Geriatric Assessment provides information on the aforementioned aspects and can therefore guide interventions.[5] Also, detailed assessment of symptoms (related to previous conditions, cancer or cancer treatment), such as anaemia, fatigue, poor appetite, malnutrition, dehydration and pain, is important for correct management with supportive care. Evaluation of social conditions (presence of social isolation, care giver support) is also important for the compliance of rehabilitation and for adequate discharge planning.

Medical oncologists should make an effort to understand that rehabilitation for older cancer patients involves a highly individualised approach. All elderly patients should be screened for rehabilitation in an appropriate setting and with a multidisciplinary approach since even small gains in several areas may result in improved functional status and quality of life.

Concerning the question as to who should follow the older patient with neoplasia needing rehabilitation, we have no doubt that geriatricians are probably the best resource (depending upon availability in Europe, as they are completely absent in some regions and too scarce in others).

Last, data regarding the cost-effectiveness of a geriatric approach in cancer rehabilitation are limited. Standard tools to aid assessment and measure outcomes should be defined.

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More data are necessary to clarify the extent of rehabilitation needs, interventions and outcome measures.

This comment also calls for specific research for improving the quality of life of our older patients.

Conflict of interest statement

None declared.

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