Improving outcomes for older people with cancer

Jagtar Dhanda from Macmillan Cancer Support discusses three keys questions to consider for improving outcomes for older people living with cancer and how Macmillan are responding to such issues.

The transition after active treatment

Dr Amina Singh-Mehta reports on the findings from a study of older cancer survivors’ experiences in South West Wales following the completion of active treatment.
Welcome to issue 16 of Innov-age, focusing on the topic of cancer.

The rise of average life expectancy is excellent news for us all; however, the most significant factor for developing cancer is longevity. The disease disproportionately affects older people with 50% of cancer cases in 2014 diagnosed in people aged over 70 (Office for National Statistics, 2016).

We see a repeating theme across this issue that there is a need to improve quality of life and survival outcomes for older people with cancer. In our lead article, three key questions surrounding outcomes are discussed, as well as the ways in which Macmillan Cancer Support are tackling the issues concerned.

We also hear about specific developments in relation to cancer care. For example, in the field of head and neck cancer, a new development is helping to guide consultations and encourage patients to express any concerns following treatment. The psychological impact of cancer is also discussed, stressing the need to act with compassion and provide support to cancer sufferers.

This issue also highlights the role geriatric assessment, screening tools and early diagnosis have to play to help improve cancer care. Furthermore, how we should avoid using chronological age as indicator of suitability for surgery and optimise strategies to enable optimum fitness for surgery.

Many older people don’t feel they are worthy of receiving the treatment they require, yet it is clear that being elderly is not an excuse for avoiding treatment. Everyone should be given the best chance of survival, appropriate to their individual needs. A patient-centred approach is therefore key to optimum care and where possible tools to facilitate objective assessment are of increasing value.

Jackie Oldham
Honorary Director, Edward Centre for Healthcare Management Research
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Innov-age is the official magazine of the Edward Centre for Healthcare Management Research, part of the Edward Healthcare group of companies.

Published in the UK by Edward Centre for Healthcare Management Research, part of the Edward Healthcare group of companies. Innov-age is produced in association with TRUSTECH, MAHSC and MIT PERFECT.

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Designed and printed by Corner House Design and Print Limited
0161 777 6000  www.cornerhousedesign.co.uk

ISSN 2052-5753 (Print)
Improving outcomes for older people with cancer

Jagtar Dhanda has worked at Macmillan Cancer Support since 2007. Having started as the lead for user involvement, he then set up and headed Macmillan’s Inclusion Department, leading the organisation’s work on patient experience, inequalities, peer to peer support and user involvement. Jagtar was also responsible for developing Macmillan’s Pan London Strategy to further support the organisation’s development and enhance its portfolio of service improvement initiatives across the capital.

Prior to joining Macmillan, Jagtar was the Director of Policy at a leading Human Rights and Equalities organisation. He has also taught social policy as a lecturer at the University of Kent for three years. He is a current member of the National Cancer Equality Initiative, a member of the Dignity Council and is a board member of the Genetics Medicine Centre in South London.

Despite progress, cancer survival in the UK for older people (65+) living with cancer remains lower than in other similar countries (EUROCare, 2000-2007). Older people with cancer are also less likely to get all the information they need and to have access to a clinical nurse specialist when they need them (NCIN, 2015). While there are multiple, interconnecting factors which could contribute to poor survival rates and quality of life amongst older people with cancer in the UK, this article takes a look at three key questions Macmillan feel are crucial to take into account if wanting to improve outcomes.

Is there an undertreatment problem for older people living with cancer?
Although there are many valid reasons behind decisions not to pursue treatment of older patients (Hurria et al., 2015), one key factor that possibly contributes to undertreatment of older adults in the United Kingdom is the use of chronological age as a proxy for fitness for treatment. For instance, an NHS England report (2014) found that older adults with colorectal cancer and older women with breast cancer in England are less likely to receive chemotherapy, despite a good performance status at all ages for the majority of patients. The report noted that, given the marked reduction in provision of chemotherapy that occurs after the age of 65, it is possible that treatment decisions are being overly influenced by chronological age.

This trend can also be seen in access to other treatments, such as surgery. For example, research by Macmillan shows that patients with lung cancer who are aged 75 years or older and in good health, with no metastases (cancer that has spread from the primary site), are six times less likely to receive surgery than younger patients (Shield et al., 2014). This is despite the fact that, of the healthiest patients with lung cancer, 63% who undergo surgery are alive 7 years later, whereas only 2% of those who do not undergo surgery survive as long (Macmillan, 2014). Again, these decisions seem to suggest that a patient’s chronological age influences decision making.

What does chronological age actually tell us?
Chronological age is not an adequate indicator of health or fitness for treatment (Gillespie et al., 2004). Yet there are some things that chronological age can indicate which have an impact on outcomes.

Half of all people aged 75 and over live alone, and one in 10 people have less than monthly contact with friends, family and neighbours. Given that cancer treatment is often intensive and debilitating and the recovery from it can be lengthy, this social context will have a significant impact on cancer services. Type of cancer, socio-economic status, gender and ethnicity, also play a role in shaping people’s needs and outcomes. The needs of active older people in otherwise good health will be very different from those of people living with frailty and other health conditions.

Furthermore, one in five people aged 75 and over state they find it very difficult to get to their local hospital. Caring responsibilities can also get in the way of people accepting treatment; over half a million people aged 65 and over have caring responsibilities that take up at least 20 hours per week (Macmillan, 2012).
What should inform a good outcome?
The number of older cancer survivors aged 65 or over living in the United Kingdom in 2010 is expected to triple by 2040 (Maddams et al., 2012). When considering solutions to the needs of these people – who currently make up around two thirds of the UKs cancer population - it is necessary to consider the wider context, and what patients consider to be important to them as outcomes.

Significantly, people living with cancer and multiple (three or more) other long-term health conditions are more likely to prioritise independence, than those without other longer-term conditions (45% to 34% respectively). More than half (52%) of people aged 65 and over state that they sometimes do not ask for help because they do not want to be a burden to other people. Worryingly, these figures rise for those living with multiple long-term health conditions. Two thirds (67%) of those with three or more long-term conditions, and 65% of those who experience difficulties with three or more tasks, agree that sometimes they do not ask for help because they do not want to feel like a burden on others. This suggests that those more in need of help can be less likely to request it (Macmillan, 2015).

It should also be noted that many cancer treatments temporarily impact upon a person’s ability to be independent, with the intention of restoring and then maintaining independence as recovery progresses. Issues such as change to cognitive function, pain, exhaustion, nutrition and mobility all need to be managed and can require additional temporary or permanent support. However, even temporary changes to an older person’s independence can have longer-term consequences. It is therefore vital that planning for how a person’s independence will be maintained and/or restored is done in advance of treatment decisions being made. Involving geriatricians in care planning can play a vital role in this respect.

How Macmillan is responding to these questions
The treatment rates of, and outcomes for, older adults in the United Kingdom show that in order to make informed, evidence-based decisions about how to treat, care for and support older adults, more is needed than just new evidence on the appropriateness of certain cancer treatments. Clinicians will need an approach that places any evidence in an appropriate context and that is based on an understanding of older patients’ individual health profiles and their practical and social needs, rather than just on their chronological age. It is also important to ensure the entire workforce is equipped with the right skill mix to meet the needs of older patients with solutions that are right for them.

In light of this, Macmillan has convened a Geriatric Oncology Expert Reference Group (ERG) which brings together patients and health and social care professionals, across the whole area of cancer care for older people. The ERG is responding to the cancer care challenges by defining the skills, values and attitudes of all professionals, support workers and volunteers who provide care and support to older people with cancer through all stages of their cancer journey.

Recognising the complexity of factors that have an impact on outcomes (including survival) must also come with the realisation that cancer outcomes are multi-dimensional. Factors including how a person experiences their treatment and care (e.g. whether they are communicated with in a dignified way, if they are involved in decisions about their care, and whether they are enabled to access the right support that is available to them) are all important outcomes in their own right. However, understanding the interrelationship between them, as well as how they can be improved will be key to improving the lives of people with the disease.

Until older people with cancer are treated as more than just numbers, an improved evidence base will not fulfil its true potential, and more and more older people in the United Kingdom will continue to be affected by poorer outcomes.

References:
EUROCARE-5: Survival analysis, 2000-2007. [online]. Available at: https://w3.isa.it/site/EUSResults/
Is it time to expect more from your cancer consultation?

Professor Simon N Rogers, FDS RCS FRCS MD, was appointed as Consultant Maxillofacial Surgeon at the University Hospital Aintree in 1999. He is part of the head and neck cancer centre team and has a particular interest in health related quality of life (HRQOL) following oral cancer. He has several on-going HRQOL studies, has published widely on this topic, and has been invited to present at many national and international scientific meetings. Simon is also involved in the Faculty of Health at Edge Hill University as a founder member of the Evidence-based Practice Research Centre (EPRC).

The National Cancer Survivorship Initiative is a national policy that aims to ensure that those living with and beyond cancer get the care and support they need to lead as healthy and active a life as possible, for as long as possible (NCSI, 2013). At the heart of cancer care are patients’ individual needs and how these are identified and met. This is set in the context of the national debate about how to bring about more person-centred care (The Health Foundation, 2014). Participants in a BMJ discussion (2015) agreed that a change in culture and better use of technology could benefit patients and doctors.

The long-lasting side effects of cancer treatments such as radical surgery or chemoradiotherapy can have profound negative impacts on function, emotional wellbeing and social integration. Patients tend not to raise issues of concern in their clinical interactions, which can lead to healthcare inequalities in the amount of support they receive following treatment. Identifying individual patient concerns and needs in routine practice is a challenge (Rogers et al., 2011). Oncology review clinics are busy and barriers such as time constraints and the traditional medical focus of the consultation can hinder the ‘conversation’ between patient and clinician, meaning their concerns are very easily missed. There are various ways to improve the situation and one is the use of question prompt lists (Yeh et al., 2014; Glynne-Jones et al., 2006). This approach has been shown to facilitate consultations and make them more focused and time efficient (Brown et al., 2001). It is from this background that the concept of a disease-specific prompt list for holistic needs assessment was developed (Miller & Rogers, 2016), known as The Patient Concerns Inventory (PCI) http://www.patient-concerns-inventory.co.uk.

The PCI was initially developed for Head and Neck Cancer (HNC) (Rogers et al., 2009). It consists of a check list of 56 clinical items which patients can select from just before their appointment (figure 1). This helps to guide their outpatient consultation through the symptoms and problems that they would specifically like to mention or discuss following treatment. It can be completed on paper or ideally by touchscreen technology on an iPad as this allows other questionnaires to be used, that aid effective screening. The full package takes between five to ten minutes to complete. The PCI items are grouped together into five domains: physical and functional well-being, treatment related concerns, social care and social well-being, psychological, emotional and...
spiritual well-being, and a free text ‘other’ section. It helps to direct the consultation and can trigger targeted onward referral for clinical areas of need or signingpost for any advice and support they may benefit from, such as speech & language therapy, emotional support therapy, physiotherapy, dietary advice etc.

Since the PCI was first published in 2009, various papers have demonstrated its proof of concept and feasibility (Rogers & Lowe, 2014; Ghazali et al., 2013). Patients who have used the PCI have advised that they would like to continue to use it in future consultations. There is evidence that consultations can be improved through clinicians developing skills in detecting and responding to patient distress, thereby improving their patients’ emotional functioning and reducing psychological distress (Girgis et al., 2009; Tattersall, 2008).

The PCI has been shown to be practicable in the elderly (Rogers et al., 2015). The 75 years or above group reported better anxiety and mood, higher social-emotional subscale scores and better overall quality of life (QoL) as measured by the University of Washington Quality of Life questionnaire (UWQOL). On the PCI, being elderly did not seem to affect the total numbers of items selected, though fewer items were selected from the psychological, emotional and spiritual wellbeing domain, and in particular the item about fear of recurrence.

It has also been shown that the PCI can be used in patients from low socio-economic backgrounds (Allen et al., 2016). This is important, as these patients are less likely to engage in supportive interventions and report a poorer QoL. The most deprived group reported significant problems in regard to mood and recreation, and a non-significant trend in stating their overall QoL as being less than good. It is possible to identify the concerns of patients from lower socioeconomic strata as part of routine follow-up clinics. This allows for targeted multi-professional intervention and supports to improve the outcome in this hard to reach group.

The PCI approach has wide-ranging applicability to the NHS - it is currently in the early stages of being developed as a tool for non-cancer chronic conditions (e.g. rheumatology, acoustic neuroma, elderly care, stroke, burns, speech and language), and for other areas of cancer care (e.g. breast, neuro-oncology, prostate, palliative care).

References:
Addressing the Needs of Older People with Cancer

Dr Shane O’Hanlon is a Consultant in Elderly Care Medicine (Oncogeriatrics and Surgical Liaison) at Royal Berkshire NHS Foundation Trust in Reading.

Dr O’Hanlon works with colleagues in oncology and surgery to provide comprehensive assessment for older people with cancer. He helps to identify active medical issues that need to be managed so that cancer treatment can be as successful as possible. He also provides medical care in the perioperative setting so that any needs can be addressed, and helps to plan safe discharge. He works across the community/hospital divide, assessing people in their own homes or care homes where appropriate. He also helps to initiate advance care planning in conjunction with patients’ expressed wishes.

Cancer in older people

One of the great successes of the last fifty years has been increased longevity, with many people now living into their eighties or nineties. This is something to celebrate, but it also brings challenges as more people need medical care and the incidence of cancer increases with age. People aged 65 or older are 11 times more likely to develop cancer than people aged 25-44. Unfortunately, mortality rates also increase dramatically with age. Although there has been an overall increase in cancer survival in recent years, the increase has been slower in the older age group (Quaglia et al. 2009).

The chance of having multiple medical conditions also increases as one gets older. For people with cancer, this can make deciding on the right type of care more difficult. Other conditions may have more of an impact on a patient’s quality of life and survival than their cancer. For example, someone with advanced dementia who is diagnosed with bladder cancer may never experience any symptoms from cancer, and so treatment would be unlikely to confer any benefit. These competing comorbidities need to be balanced with each other so that an appropriate management strategy can be formulated. Unfortunately, multiple malignancies are also more common in older people, further increasing the degree of complexity. Finally, many cancers present with atypical symptoms in this group, meaning that diagnosis is often delayed. The overall picture is that cancer in older people is a serious condition that needs to be carefully managed by a multidisciplinary team.

Assessing older people with cancer

Age is an unreliable marker of how fit a patient is. Older people can be described as “fit”, “frail” or “vulnerable” depending on their overall condition. When an older adult is diagnosed with cancer, it is important to perform a full assessment to inform shared decision making. This process is called "Comprehensive Geriatric Assessment” or CGA and involves a multidisciplinary multi-domain assessment.

This holistic 360 degree assessment helps to gain a complete picture of the patient. For example, it may uncover previously undiagnosed cognitive impairment, treatable reasons for impaired mobility, inappropriate prescribing, or care needs that have not been addressed. Even in patients who appear relatively well, CGA can detect multiple health issues. One study found that over 50% of the time, new issues were found and in 25% of patients who had CGA, their cancer treatment decision was influenced (Kenis et al., 2013). Furthermore, impairments found in the CGA are associated with chemotherapy related toxicity, and shorter overall survival (Hamaker et al., 2014).

Non-medical care

A very important component of the CGA is an assessment of a patient’s functional abilities and their social support. In older people, symptoms from their cancer or from its treatment can include fatigue, reduced mobility, impaired cognition, nausea, poor appetite and weight loss. The result of this can be unexpected difficulty in performing activities of daily living. Independence can be adversely affected, and care needs can be significantly increased. This is why an assessment at baseline is useful; so that if things change, then appropriate interventions can be provided. These commonly include equipment such as mobility aids, a raised toilet seat, a commode, grip handles or modifications to the home such as a walk-in shower, downstairs living or a stair-lift. Referral to social services may be needed to trigger a package of care or financial support.

Other practical considerations include organising transport to hospital appointments or ensuring that social isolation is reduced by linking with volunteer support groups.
Treatment

There is widespread recognition that older people with cancer are under-treated compared to younger people. In part, the lower treatment rates may be explained by co-morbidity, shorter life expectancy, or patient choice. However, ageism persists in cancer treatment.

There are often concerns that older people will not tolerate treatment, but in fact many do. Fisher et al., (2012) assessed the uptake and tolerance of chemotherapy in older patients with small cell lung cancer. Of patients who were recommended chemotherapy by their oncologist, 81% began treatment. 52% of those treated completed all planned cycles, with 34% of the treatment group receiving reduced doses. Patients who completed chemotherapy had significantly better survival than those who did not, even when the dose was reduced. In order to facilitate appropriate treatment, chemotherapy risk prediction tools have been developed that have been validated in this group. These can help to clarify the balance of risk and benefit.

Similarly, surgery is under-used in older people and there is a steep decline in the rates of cancer surgery as age increases.

Survivorship

Compared with matched respondents without cancer, longer-term cancer survivors report significant decrements in health status, days out of role, and mental well-being, but not in quality of life. The likelihood of poor health outcomes is much higher among survivors who also reported comorbid chronic conditions. Cancer survivors are more likely to report comorbidity, limited mobility and limitations in activities of daily living. As an increased number of older patients are being treated with cytotoxic chemotherapy, there is increasing evidence of sequelae, e.g., cardiotoxicity, neuropathy, hearing loss, dementia and bone marrow suppression. More work needs to be done to identify how best to support people who have these issues.

Conclusion

Cancer is more common in older people and outcomes are poorer than in younger people. Cancers are detected at a later stage compared to younger people, and are under-treated. Although outcomes are improving, the pace is slower for older people with cancer, resulting in a widening survival gap compared to younger people. Performing a comprehensive geriatric assessment helps to identify those patients who are fit for treatment, and which options are likely to provide the best outcome.

References:


There is a correlation between older patients and substandard cancer treatment. Put explicitly: older people often die of cancer as a result of poor treatment. Surgery offers the highest chance of cure; however, older patients are often not offered this option. Cancer is less frequently tackled the right way when the patient is in the 7th decade of life and beyond (Fig. 1, National Cancer Intelligence Network). The clinical decision to operate or not, is often merely emotional, subjective and biased. Surgeons are very good at making a judgement but this is dependent on intuition, is not truly dependable, not standardised, involves individualised pre-conceptions and lacks both objectivity and consistency.

From the patients’ side, most senior people may believe that they are too old to undergo surgery, not only because they might not withstand the stress of an operation, but also because it is not “worthy” to operate on them.

It is against this background that the need for a more objective approach to these patients has become increasingly apparent.

Figure 1 – National Cancer Intelligence Network
The older cancer population is heterogeneous with respect to overall health status, due to differences in co-morbidities, functional status, geriatric syndromes and socio-economic aspects resulting in decreased physical reserve. Cancer and its treatment may further decrease this physical reserve. Ideally, all older cancer patients should be evaluated by geriatric assessment followed by geriatric interventions and follow-up. However, this approach is resource-consuming and not necessary for all patients. The use of a screening tool has therefore been proposed to identify patients in need of geriatric assessment and a multidisciplinary approach. Screening tools do not replace geriatric assessment but are recommended in a busy practice in order to identify those patients in need. If an abnormal result is observed, screening should be followed by geriatric assessment and guided multidisciplinary interventions (Decoster et al, 2015).

Progress has been made in recent years. Geriatric assessment has been proven to positively influence surgical outcomes, notably length of hospital stay and cost (Audisio et al., 2008). The development of specific tools that were less time-consuming and that seemed ‘surgeon-friendly’ has meant that frail patients can be identified and their surgical outcomes predicted (Huisman et al EJSO, 2015). The ‘Timed Up and Go’ test (TUG) measures the time taken for a seated patient to rise, walk three metres, turn around and return to their seat. This simple test identifies twice as many patients who are at risk of developing post-operative complications when compared to an ASA score (American Society of Anesthesiologists’ physical status classification system for assessing the preoperative health of patients). Malnutrition has also been shown to be associated with functional impairment in several geriatric domains thus underlining the importance of an integrated approach and the potential for preoperative optimisation of nutritional status (Huisman et al., 2013).

Individualised treatment is associated with improved results and so keeping the patient at the centre of their care is vital (Morgan et al., 2015 and Audisio et al., 2015), yet there is uncertainty about what older patients really want from their treatment. Are surgeons unconditionally certain that, during the consent process, the patient has a broad, all-inclusive understanding? Are discussions about the desired results truly transparent? Is the patient’s decision entirely independent or is it biased by inequality for older individuals, lack of social support, depression and decreased will to live?

It is true that cancer predominantly affects older people, and it is also true that surgeons can successfully deal with it in a rather accurate and precise way and are skilled enough to minimise operative complications and surgical hazard. The TUG has now complemented these skills making significant progress in the way they can assess frailty for each older patient. This protects against under-treating fit patients as well as over-treating the frail ones, who would only receive the stress of the operation and are unlikely to enjoy the benefits of it. There is also plenty of opportunity to pre-habilitate those patients who sit in-between; the “vulnerable” ones who take maximum advantage, for example, of rehydration, correction of anaemia, malnourishment, poly-pharmacy and depression.

Surgeons are now in a very favourable situation where a carefully administered geriatric assessment can point to the right treatment option for each individual older patient suffering from cancer.

References

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Half a million people to be diagnosed with cancer per year by 2035

Predictions from Cancer Research UK, published in the British Journal of Cancer, have suggested that by 2035 cancer rates will soar.

At present, 350,000 people are already diagnosed with cancer each year, but this study suggests that the prevalence of the disease could significantly increase with 150,000 more cases identified per year. The future trends analysis was based on examining cancer data going back to 1979 and predicts that 244,000 women and more than 270,000 men will be diagnosed in 2035.

It highlights the urgent need to plan ahead for the increased demands on cancer services to allow the NHS to cope and ensure that the resources are in place for people to receive a high standard of care.

Prevention will be key. While the rise is said to be due mainly to an ageing population, lifestyle factors such as smoking, alcohol, poor diet and obesity are also playing an important role. Four in 10 cancers in the UK are thought to be preventable and so it’s crucial that people begin to make healthy choices.


Promising study results for detecting those at risk of oesophageal cancer

Oesophageal cancer has a low survival rate, with just 12% of people surviving for at least 10 years. Research into ways to aid earlier diagnoses is therefore highly useful.

Researchers from the University of Cambridge have found that a ‘sponge on a string’ (cytosponge) test can help identify which people with a condition called “Barrett’s oesophagus” have a low risk of developing oesophageal cancer.

The simple test could be performed at local GP surgeries and help avoid patients’ needing to attend hospital for regular endoscopies.

Said to cause minimal discomfort in comparison to an endoscopy, the cytosponge is a small pill with a string attached that the patient swallows.

This then expands into a small sponge when it reaches the stomach and can be slowly pulled back up the throat using the string to collect cells from the oesophagus for analysis.

Initial results have been positive with larger clinical trials to be held in 2017.

Weight gain increases cancer risk

Being overweight increases the risk of 10 types of cancer, including bowel, kidney, breast and pancreatic. It is now the second biggest preventable cause of cancer, after smoking.

A new study, from researchers at the University of Manchester, has looked at this from a new angle, taking into account weight gain over many years and the associated risk of obesity-related cancers. It helps demonstrate that an individual’s risk of obesity-related cancer can accumulate over time and shows the importance of assessing weight gain over their lifetime, rather than just a single BMI calculation at one point in time.

It studied approximately 300,000 people in America and looked at changes in BMI between the ages of 18 and 65. Men who went from a BMI of around 22 to 27 had a 50% increased risk compared to those who remained in the healthy weight bracket. Women who went from a BMI of around 23 to 32 had a 17% increased risk.

Retaining a stable, healthy weight could therefore help to increase defence against developing obesity-related cancers.

Read more here:
http://www.mcrc.manchester.ac.uk/News?newsId=379

Upcoming Events…

World Cancer Day  4th February 2017
People unite around the world to raise awareness of the global impact of cancer and increase understanding of prevention, detection, treatment and care.
http://www.worldcancerday.org/

Early Diagnosis Research Conference  23rd February 2017
Hosted by Cancer Research UK, this two day conference in Central London attracts people from across the early diagnosis community, including researchers, clinicians, policy makers and people affected by cancer.

SICK! Festival  8-25th March 2017
SICK! Festival was launched in 2013 as the first festival of its kind in the UK dedicated to exploring the medical, mental and social challenges of life and death. In 2017, the award winning festival returns with a special focus on issues of identity and belonging in venues across Manchester and Brighton. It includes an international programme of theatre, dance, film and public space installations alongside a series of rich and accessible debates, talks and other events.
www.sickfestival.com

Sharing the Vision for World Class Radiotherapy  20th March 2017
Hosted by Cancer Research UK, this two day conference held in Manchester will provide an opportunity to hear about cutting edge research from some of the world’s leading academics and share innovations in radiotherapy that will translate into patient benefit.
http://crukcentre.manchester.ac.uk/Symposium
The psychological impact of cancer: a need for compassion and support

Dr. Robin Muir is a clinical psychologist who specialises in the psychological aspects of physical illnesses and in particular cancer. He currently practises in Maggie’s Cancer Care Centre in Manchester, which provides emotional, social and practical support to people affected by cancer. Dr. Muir has a particular interest in how people can be supported to build upon their own resources and skills to manage the challenges of physical illness.

Cancer is an umbrella term for a number of conditions in which cells divide in an uncontrollable way (Cancer Research UK, 2016). Incidence of the disease has increased to the point that approximately one in two people will now be diagnosed with cancer at some point in their life.

Whilst cancer is an illness that affects the body, clearly it also has a significant impact on people’s emotions. Cancer presents many psychological challenges to an individual and those people around them. Emotional changes can help the individual to cope with the many practical challenges that cancer brings, such as focussing attention on engaging in treatment and making lifestyle changes (Greer & Watson, 1987). Typically, the time when a person is initially diagnosed is thought of as the most emotional time, but there are many other times that also present psychological challenges, such as during treatment when patients experience side-effects, around the time of scans as treatment effectiveness is monitored, and when active treatment is completed (National Institute for Health & Care Excellence, 2004).

There is a wide variety of ways someone may respond psychologically to cancer. Fear is a common emotion that may centre on a variety of threats, including being unwell, changes to one’s body and appearance, and losing control. People also experience losses throughout their experience of cancer, including loss of identity, physical abilities and roles.

If these losses are important to the individual, they can lead to a depressed mood. Indeed, up to 50% of people experience anxiety or depression at clinically significant levels. The remaining 50% are likely to experience similar emotions, but may be able to find their own ways of coping and adjusting to these challenges (Burgess et al., 2005). An individual’s psychological response to cancer is dependent on many factors, but can be thought of as a process of adjustment to a threat (Greer & Watson, 1987).

Some researchers have argued it relates to how most people have silent assumptions about their invulnerability and immortality (Janoff-Bulman, 1992). This process of adjustment involves an appraisal of the potential threat, what can be done, i.e. to what extent they or others can affect the disease process, and the likely prognosis. This is a highly individualised process that is dependent on many factors, such as knowledge and beliefs about cancer, past experience and personality. This is one reason for the variability in responses to cancer; a person who has had a number of significant people in their life die because of cancer or been witness to a loved one’s experience of a painful death is likely to experience more fear than someone without such experiences.

This process of appraisal leads to selection of coping strategies. These strategies can be classified as being focussed upon the problem itself, the appraisal of the threat or the resultant emotions (Ogden, 2007).

- Problem-focussed coping involves the confrontation of the threat, such as gaining information and engaging with treatment.
- Appraisal-focussed coping involves attempts to modulate the appraisal, such as breaking the causative
stress down into smaller constituents tasks, trying to redefine the stressor in a more positive and acceptable way, or trying to avoid thoughts about the situation.

- Emotion-focussed coping consists of finding ways to manage the resultant emotions, such as focussing on pleasurable activities and expressing emotions to others to access support and compassion.

Research and clinical guidelines highlight the importance of psychological support for those affected by cancer. This support should be built into their care in line with a needs-based, four level model described in Table 1 (National Institute for Health & Care Excellence, 2004). The key to good quality care is effective communication between professionals, patients and their loved ones, which acknowledges individuals’ psychological responses in a compassionate way and identifies appropriate psychological interventions. For approximately 75% of people, this means empowering individuals to find ways of coping with both the challenges cancer brings and the resultant emotions. This can be done by those working at Levels 1 and 2 of the model, usually cancer nurse specialists. However, sometimes people need more structured support such as that provided at levels 3 and 4. Clinical guidelines highlight that a range of therapeutic approaches have been found to be effective at improving depression, anxiety, coping and self-esteem (National Institute for Health & Care Excellence, 2004). These approaches can be provided through either individual or group models of therapy, and it has been highlighted that these approaches should empower individuals to solve-problems, seek information and find ways of coping with emotions. This support should be accessible throughout people’s experience of cancer from diagnosis to survivorship, recurrence and end-of-life care.

When people find themselves amidst the storm of a cancer diagnosis and everything that comes with it they become vulnerable. It is important that this vulnerability is responded to in a way that recognises emotional distress as an understandable response and attempts to alleviate individuals’ suffering. Unfortunately, often people find that others respond in a way that invalidates their experience; for example, someone expressing fears of recurrence to a loved one may be told that they need to stay positive. Such sentiments, whilst well intentioned, may not be achievable when the possibility of recurrence is real and may inadvertently leave the individual feeling further distress by what they then see as their inability to stay positive. An alternative response would be to express understanding for such fears and, if it is what the individual wants, discussion about things that might help them with this fear. This compassion for psychological distress should be demonstrated by all, including patients’ medical teams, family and friends, and importantly themselves. Self-compassion has been shown to predict depression, stress and quality of life in cancer patients (Pinto-Gouveia et al., 2013). With such compassion people affected by cancer can find their ways of negotiating the many psychological and emotional experiences of cancer.

<table>
<thead>
<tr>
<th>Level</th>
<th>Group</th>
<th>Assessment</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All health and social care professionals</td>
<td>Recognition of psychological need</td>
<td>Effective information giving, compassionate communication and general psychological support</td>
</tr>
<tr>
<td>2</td>
<td>Health and social care professionals with additional expertise</td>
<td>Screening for psychological distress</td>
<td>Psychological techniques, such as problem solving</td>
</tr>
<tr>
<td>3</td>
<td>Trained and accredited professionals, such as counsellors or psychotherapists</td>
<td>Assessed for psychological distress and diagnosis of some psychopathology</td>
<td>Counselling and specific psychological interventions, such as anxiety management</td>
</tr>
<tr>
<td>4</td>
<td>Mental health specialists, such as clinical psychologist and psychiatrists</td>
<td>Formulation and diagnosis of psychopathology</td>
<td>Specialist psychological and psychiatric interventions</td>
</tr>
</tbody>
</table>

Table 1 - Recommended model of professional psychological assessment and support

References:

The Christie Patient Centred Research group (CPCR)

Professor Janelle Yorke leads the Christie Patient Centred Research (CPCR) group at The Christie NHS Foundation Trust and is Deputy-lead of the Supportive Palliative Care (SuPaC) research group at University of Manchester.

Dr Lorna McWilliams completed her PhD within the Division of Psychiatry and Applied Psychology at the University of Nottingham in 2013 and has conducted most of her research within the public health domain.

Dr Carole Farrell is Honorary Lecturer at The University of Manchester and Consultant Editor of Cancer Nursing Practice. Carole has extensive clinical experience as an oncology nurse for almost 30 years and has recently completed a study exploring the experiences and support needs of older people receiving chemotherapy.

Dr Sally Taylor joins the CPCR team in December 2016. She has a PhD in health Psychology and brings a wealth of knowledge to the CPCR team relating to the design and evaluation of health technology, especially in relation to oncology pain.

In February 2016, The Christie NHS Foundation Trust, in partnership with The University of Manchester, launched a new research group – Christie Patient Centred Research (CPCR). CPCR aims to further improve patient experience and patient-centred outcomes through a structured programme of research. Cancer patient-centred research includes the personal, social, environmental and psychological factors related to cancer and experiences of health care. It relates to the organisation and provision of care across cancer pathways, organisational boundaries (i.e. health-social care and hospital-community care) and the use of technology to improve patient outcomes and experience in cancer prevention, early detection, treatment and survivorship.

Three CPCR research themes have been established to take forward this agenda:

1. Prevention and Early Detection – led by Dr Lorna McWilliams
2. Living with and beyond – led by Dr Sally Taylor
3. Cancer and Older People – led by Dr Carole Farrell

Within the Cancer and Older People theme, a number of projects have been developed. Examples of these projects are described below.

Cancer, Dementia and Information needs (CAN-DO)

Little is known about the cancer experience of people with dementia, in particular their cancer-related information needs and cancer-treatment decision-making preferences and priorities. However, there is evidence to suggest that compared to having cancer without a diagnosis of dementia, those with dementia are less likely to receive preventive screening and are more likely to be diagnosed at a later stage of disease and receive less-aggressive cancer treatment.

As part of an award by Manchester Institute for Collaborative Research on Ageing (MICRA), supported by Age UK, CPCR are exploring the information needs and decision-making preferences of cancer patients who have a diagnosis of dementia, their carers and cancer clinicians.

To date, 28 participants have taken part (10 patients, 9 carers, 9 clinicians) in semi-structured interviews. Type of cancer includes skin,
urological, head and neck, gynaecological and colorectal. Emerging findings reveal that:

- carers provide significant support in treatment decision-making processes
- understanding the potential impact of cancer treatment on dementia is an important factor
- clinicians would welcome additional dementia-specific training and additional support from clinicians with expertise in dementia early in the patient’s cancer pathway.

These early results suggest that patients with dementia and their families require specific support in making cancer-treatment decisions. The findings from the study will inform the development of an information and decision-making guide, which will be tested in future research within the CPCR group.

**Delivering dignity of care for older people during chemotherapy**

Chemotherapy can be challenging for older people since side-effects may be increased and even small toxicities can result in functional deterioration affecting independence and mobility. However, little is known about the impact of chemotherapy from the perspective of older people and their partners/informal caregivers.

A three-year study completed in September 2016 and funded by The Burdett Trust for Nursing aimed to explore the experiences of patients aged 65+ and their informal caregivers during chemotherapy, including dignity of care.

**Stage 1** recruited 20 patients and 10 caregivers post chemotherapy, conducting semi-structured interviews to explore the concept of dignity alongside their experiences during treatment. Patients reported “feeling lucky” to receive treatment and were stoical and reluctant to report problems to health professionals, often minimising the impact chemotherapy had on their lives.

**Stage 2** explored experiences during chemotherapy with 146 patients and their carers (85 in total), and a range of questionnaires relating to needs assessment and caregiver burden were completed. Semi-structured interviews were also conducted with the first 50 patients. Results showed that many patients felt overwhelmed by the amount of written information and struggled to assimilate complex information, including statistics / prognostic information. Maintaining independence was important for most patients, however, this was adversely affected during chemotherapy. Nutrition was a significant problem, with many patients at risk of malnutrition. A clear need for enhanced-patient-centred care was identified for older people receiving chemotherapy.

**Stage 3** involved a telephone intervention delivered to 50 patients by specialist oncology/chemotherapy nurses post chemotherapy cycles 1 and 3. Nurses used a semi-structured interview guide to gather holistic information, including functional and psychosocial needs, symptom management and any unmet needs.

The results from this study will form the foundation of further research involving a large interventional study and collaboration with a wider multidisciplinary team.

The CPCR team welcome any enquiries about the above studies and potential collaboration.
The transition after active treatment - A qualitative exploration of older cancer survivors’ experiences in South West Wales

Dr Amina Singh-Mehta is a Qualitative Researcher at the University of Oxford. Amina has a social work background in cancer care for older people. Prior to doing her PhD at Swansea University, she worked as a social work practitioner on an oncology ward in Swansea. Her main focus of research is ageing, chronic health conditions, and application of interventions in older people.

Professor Deborah Fitzsimmons is Professor of Health Outcomes Research at Swansea Centre for Health Economics, Swansea University. With a background in cancer nursing, Deborah has over 20 years of experience in health research with particular focus on patient reported outcomes.

There are now 2.5 million people living with or beyond cancer in the UK, estimated to increase by 3.2% each year (Macmillan Cancer Support, 2015; Maddams et al., 2009; Maddams et al., 2012). Older people have distinctive needs and concerns such as social support and co-morbidities which are important in assessing older people’s quality of life (Wheelwright et al., 2013). This is important as over 130,000 people aged 65+ have survived for at least 10 years after being diagnosed with cancer in the UK (Macmillan Cancer Support and National Cancer Intelligence Network, 2013c). It is well recognised that the time after treatment completion can mean a period of uncertainty and vulnerability for patients, in terms of feeling powerless and having conflicting emotions about their lives when treatment is completed (The Institute of Medicine, 2006). Cancer treatment can have many consequences for cancer survivors, impacting their physical health and psychosocial life (Avis and Deimling, 2008). Older cancer survivors can face a magnitude of challenges such as being prone to comorbidities and chronic health conditions. (Rowland and Bellizzi, 2014). Research shows that physical functioning has been reported to decline for older people with cancer after treatment completion (Beck et al., 2009; Sehl et al., 2013, Westrup et al., 2006).

The interplay between cancer treatment–related health effects and normative age-related health issues presents significant challenges for survivorship care for older people. However, these are not well understood from the older person’s perspective (Rowland and Bellizzi, 2014). Whilst evidence is emerging on understanding the transition for people from active treatment to follow-up care, there has been little in-depth prospective investigation from older cancer survivors’ perspectives. To address this, a qualitative study was undertaken at Swansea University as part of a PhD studentship funded by Tenovus Cancer Care. This article reports the current understanding on the transition experiences for older cancer survivors and the key findings.

What are transitions for older cancer survivors?
Transitions can be defined as processes occurring over time with a sense of development, flow or movement from one state to another (Schumacher et al., 1999). Processes of change in life’s developmental stages, or changes in health and social circumstances and the response to such changes are central to this conceptualization (Kralik et al., 2006). Transitions can be cyclical, recurring, or repetitive and therefore are complex (Kralik and van Loon, 2010). According to Bellizzi et al. (2008), cancer for older people entails different demands and stressors than in other age groups. For older people, this could mean experiencing new demands, as well as opportunities to adapt to the changes occurring due to cancer and their ageing processes.

Previous qualitative studies have explored older people’s cancer experiences (Esbensen et al., 2008, Esbensen et al., 2012, Hughes et al., 2009, Hughes, 2011, Hughes, 2014, Loerzel and Aroian, 2012, Loerzel and Aroian, 2013; Thome et al., 2003, Towsley et al., 2007), but have not focused explicitly on this important phase of the cancer journey (after active treatment). The research evidence shows that older cancer survivors appear to experience both negative and positive experiences, with each potentially dominating at different times during their cancer trajectory (Hughes et al., 2009). To the authors’ knowledge, only four studies (Pentz, 2002, Pieters et al., 2011, Pieters, 2016, Towsley et al., 2007) have attempted to explore older cancer survivors’ experiences.
The aim of this study was to explore older people’s transitions after treatment completion. A prospective longitudinal qualitative study design was applied. Participants were recruited from two local health boards in South-West Wales. Twenty-nine older people aged 70 years and above were interviewed at baseline, 6-months and 12-months follow-up. A thematic analysis was performed according to Braun and Clarke’s (2006) framework.

This study found that older cancer survivors’ transition experiences were characterised by a process of realignment and reconciliation. The process of realignment was an outward experience in which older cancer survivors renegotiated their changed physical capabilities and applied certain strategies. Sharing experiences and comparing oneself with other people diagnosed with cancer shaped an important element of integrating cancer into their lives. Furthermore, older cancer survivors rationalised their experiences in context of their ageing processes. Many participants experienced after effects of their treatment such as tiredness and limitations in physical activities. Whilst they assumed that this was caused by their cancer treatment, they also associated these changes with their ageing processes which were perceived as normal. Often participants expressed that there was little clarity about the reasons for experiencing these symptoms. In addition, some older cancer survivors discussed physical symptoms with their specialist nurses in order to integrate these into their day to day lives. The ability to share these experiences with other older cancer survivors helped them to feel better about their situation and be able to remain positive in life. Nonetheless, participants also reported that other life transitions (e.g. family issues, caregiving responsibilities) took over. Some even felt they didn’t have the time to deal with their cancer experiences.

The process of reconciliation was an inward process. During this process, older cancer survivors gradually accepted cancer as part of their life and assimilated to living with cancer over the study period. Many participants reported finding it difficult in the beginning but explained that things normalised over time. Participants also experienced struggles to remain positive, dependent upon how cancer was experienced at the time. A few participants experienced recurrence of cancer which led them to move backwards in their transition. Recurrence of cancer also had implications on how physical changes were experienced. Therefore, it was concluded that the process of realignment and the process of reconciliation were interrelated. The way transitions were experienced was dependent upon their cancer experience, ageing processes and other life transitions.

This study has important implications for health and social care professionals in terms of how to support older cancer survivors through transitions. Understanding these processes of renegotiation of physical capabilities and the challenges older cancer survivors face is important. This can be incorporated into care planning across the survivorship period.

Professionals can implement clear goals during care planning with the patient to tackle issues such as resuming hobbies or exercise at home. An individualised approach is required to treat every older person uniquely. Future work needs to be undertaken in order to understand how older cancer survivors can be supported to renegotiate their capabilities through targeted interventions and how resilience can be enhanced during the survivorship period.

Acknowledgments
We would like to thank Tenovus Cancer Care for supporting and funding this PhD studentship.

References
CANCER RESEARCH UK. (2012). 1 in 2 people get cancer in their lifetime, UK. 
The importance of early stage diagnosis in older cancer patients

Dr Rebecca Birch is a Cancer Research UK Population Health Postdoctoral Research Fellow based at the University of Leeds. Her research focuses on the variation in cancer diagnosis, treatment and outcomes in relation to age. She specialises in the use of routinely collected population based healthcare data, such as cancer registration and hospital episodes data to assess areas of inequity and inequality.

Studies have shown that survival from cancer in the UK lags behind other European countries for many disease types and that the variation observed may be, in part, due to differences in stage at diagnosis and access to treatment (De Angelis et al., 2014). Other international comparisons have supported this finding and suggest that the poorer outcomes of older patients in the UK may account for a significant amount of the difference seen (Allemani, 2014, Coleman, 2011). It is widely acknowledged that older cancer patients have poorer outcomes, particularly survival, and lower active treatment rates than their younger counterparts. The reasons behind this are complex and not fully understood but late stage disease is thought to play a key part in the observed variation.

Ensuring equality in treatment and the best possible outcomes for older patients is now a key focus of several major reports (Macmillan Cancer Support, 2012a, 2012b; NHS England, 2013; NHS England, 2014) and is a priority for the NHS.

Older patients have been shown to be more frequently diagnosed with later stage disease than their younger counterparts (Lyratzopoulos et al., 2012). Stage is known to impact on both the treatments available to a patient and their outcomes from the disease, with later stages making curative treatment less likely. Older age is also associated with an increase in emergency presentation, which in turn is associated with more advanced disease. The reasons for this are not fully understood but delay in diagnosis, whether due to patient or service factors, is thought to play a significant part. Interventions to target this population in order to achieve an earlier diagnosis have become a focus in recent years.

The relationship between age, stage and outcomes is not limited to diagnosis alone. Surgery is the main, potentially curative, treatment used for solid tumours. It is known that rates of major surgical resection decrease with age and this has been demonstrated across multiple cancer sites (Figure 1).

Similar patterns have been demonstrated in the use of chemotherapy and radiotherapy (National Cancer Intelligence Network, 2014; NHS England, 2013).

In older patients, the uptake of different treatments is impacted by a combination of factors, such as comorbidity, frailty, patient choice and late stage. Unlike comorbidity and frailty, the incidence of late stage disease can be reduced.

Figure 1
Percentage of major surgical resections by cancer site and age-group (2006-2010, England)

Source: NCIN (National Cancer Intelligence Network)
Major resections by cancer site, in England; 2006 to 2010

Footnote: Only the four most commonly diagnosed cancer types in older patients (colorectal, lung, breast and prostate) are included in this graph, however, the pattern is not unique to these sites alone.
and several interventions over recent years, alongside the introduction of screening programs, have focused on this across the whole population.

Treatment for early stage disease is generally less intensive than that for more advanced disease, meaning that it may be suitable for use in a greater number of cases, including those with comorbidity. This increases the potential for use in older patients. A stage shift towards earlier stage disease across all cancer sites would be an important step towards increasing the number of patients in this group able to receive treatment.

Over half of all cancer deaths in the UK occur in people aged 75 and over and rates of death soon after diagnosis of cancer are higher among older people in the UK than in other comparable European countries (Allemani, 2014; De Angelis et al., 2014), a finding often associated with delayed diagnosis. The National Cancer Intelligence Network demonstrated not only significant differences in survival between early and late stage disease (Figure 2) but also demonstrated that older patients fare worse than their younger counterparts, even after adjustment for the higher rates of death due to other causes in this group (National Cancer Intelligence Network, 2014).

Optimal outcomes for solid tumours are achieved when cancer is diagnosed at an early stage. It is likely that the increase in later stage tumours in older adults accounts for the reduction in major surgery and poorer survival in this group. It is not currently known how much of the difference is accounted for by this but it remains an important area when looking to improve outcomes from cancer in older patients in the UK.

References


National Cancer Intelligence Network.(2014). Older people and cancer.


HIT to get fit for cancer surgery

Miss Catherine Boereboom, Surgical Research Registrar and Dr Bethan Phillips, Assistant Professor, are both currently based at the MRC Arthritis Research UK Centre of Excellence for Musculoskeletal Ageing Research at the University of Nottingham, Royal Derby Hospital site.

Catherine graduated from University of Sheffield Medical School in 2005 and started surgical training in the East Midlands North rotation in 2007. She has currently taken time out of her surgical training to complete a PhD at the University of Nottingham, exploring preoperative exercise in colorectal cancer patients.

Dr Bethan Phillips is an Assistant Professor in the School of Medicine at the University of Nottingham. In addition to teaching postgraduate medical students, her research activities centre around exercise and nutritional interventions to improve human health across the lifecourse.

Innov-age magazine issue sixteen winter 2016

Increases in treatment effectiveness, improved diagnostic testing, screening programmes and an ageing population mean that cancer has become more prevalent. For many types of cancer, surgery is the best chance of complete cure. Surgery, especially involving the abdomen and thorax, is a big stress on the body, challenging many body systems. It seems intuitive that the fitter people are before they undergo cancer surgery, the better and more quickly they recover. One of the issues with improving fitness prior to surgery is the short amount of time available before the start of cancer treatment. The NHS is bound by guidelines to begin cancer treatment within 31 days of a decision to treat, or 62 days from referral by the general practitioner (National Cancer Action Team, September 2016). This does not leave much time to get fit, especially in the older population, who often suffer with other health concerns.

One of the most informative ways of testing fitness is a cardiopulmonary exercise test (CPET). Recent colorectal cancer studies have shown that patients with higher peak oxygen consumption and anaerobic thresholds (both measured by CPET) were less likely to suffer complications after surgery, including in-hospital death (West, et al., 2014a; West, West et al., 2014b). So the question is, how can cancer patients’ fitness be improved in a short time period?

Based on guidelines from the World Health Organisation (WHO, 2010), the Department of Health recommends that all adults perform 150 minutes of moderate intensity exercise or 75 minutes of vigorous activity every week. Activities to improve strength and balance are also encouraged, with advice that sedentary time should be minimized. This time commitment is not achievable for everyone and if the targets seem unattainable, it may risk alienating people into doing no exercise at all.

Resistance training programs, such as weight lifting, have been used with good effect to improve many facets of health; most notably muscle strength and body composition. Independent of age, resistance training increases strength and improves quality of life (Benton and Schlairet, 2012). Especially in the elderly, resistance training increases muscle mass, strength and function whilst decreasing fat mass (Tr fourth and Ryan, 1994; Geirdottir et al., 2012). However, this kind of exercise is not designed to improve cardiorespiratory fitness; the type of fitness known to be beneficial for surgical outcome.

Endurance exercise training, such as swimming, running and cycling, aims to improve the cardiac and respiratory response to exercise typically with moderate effort over prolonged periods (i.e., 30-60 min). A group of 80 year olds who undertook endurance training saw a 15% increase in oxygen consumption. However, this was achieved over a period of 12 months (Evans et al., 2005). Therefore, although endurance training does improve cardiorespiratory fitness, it traditionally takes much longer than the time available before an operation.

An alternative type of training is interval training. High-intensity interval training (HIT) is characterised by short bursts of high-effort cardiovascular exercise interspersed with periods of rest or low effort. Evidence has shown that despite the much reduced time-commitment of HIT, the changes in cardiorespiratory fitness can be greater than with endurance training (Milanovic, Sporil and Weston, 2015).

HIT programmes have many different protocols with different activity and rest periods. The University of Nottingham uses HIT comprising 60 seconds maximal effort cycling alternated with 90 seconds of cycling with no resistance. This is repeated 5 times. Each HIT session lasts approximately 15 minutes, so can be squeezed into even the busiest of schedules. Current studies at Nottingham are looking at HIT training in pre-treatment colorectal and urological cancer patients. Recent studies in healthy, age-matched participants have shown that HIT causes a significant improvement in fitness in the same time-frame that would be available for cancer patients (Boereboom et al., 2016).

References

Dr Richard Berman
Consultant in Supportive Care
at the Christie NHS Foundation Trust.

What is your current position and what was your career path that took you there?
I’m a consultant physician in supportive care at the Christie NHS Foundation Trust and I’m the national lead for the “Enhanced Supportive Care” initiative for NHS England. I trained initially as a GP and then in 2002 enrolled on training in palliative medicine and became a consultant in 2007.

What challenges do you face in your current position and which has been the greatest one?
The main challenge has been finding a way to modernise palliative care so that it fits better within the changing landscape of cancer. This is really important, because more and more people are now surviving cancer or living with cancer. The research shows if you deliver early supportive and palliative care to patients, then they have better quality of life and live longer. In our cancer centre we have rebranded palliative care to supportive care, providing a much more positive approach. End of life care is still hugely important, but we have changed our focus a little towards helping people get through their cancer treatment in a positive way, rather than just planning end of life care.

In your opinion, what are the top three issues affecting the care of older people?
1. It’s important that people who are going through cancer treatment, at whatever age, are given hope.
2. Managing their symptoms - My focus as a supportive care physician is to work hard to treat pain and symptoms caused by cancer and cancer treatments to help people get through their chemotherapy.
3. Ensuring good communication between the cancer centre and the local GP and Macmillan community services so that there is seamless care and patients continue to get the right treatment closer to home.

What changes in elderly care do you anticipate in the next few years?
This concept of rebranding palliative care to supportive care and being involved at a much earlier stage is being rolled out as part of a national scheme called Enhanced Supportive Care. 22 top cancer centres across England are adopting the scheme – there should therefore be better access to this kind of specialist support for elderly people going through cancer.

If you hadn’t become a consultant in supportive care, what might you have done?
I would have liked to have been an actor. I went to drama school and thought about doing that as a career but had an equal passion for medicine and so this was the pathway I decided to take in the end.

What experience has influenced your career the most?
I’ve met some great people and travelled to some amazing places as part of my job. Meeting influential and pioneering people from around the world inspires me to do better and bring great practice in supportive and palliative care to Manchester.

What advice would you give to someone contemplating following in your footsteps?
Go for it! It’s a brilliant specialty, fast changing with huge opportunities. The role for supportive care is growing alongside the improvements that are happening in cancer treatment.

Where do you go for advice and information?
I have a lot of support from my colleagues here at the Christie and also work with senior colleagues across the country.

I also attend international conferences where I sometimes present work that we’ve done here at the Christie around supportive care.

Who would you most like to work with?
Richard Branson - I think there’s room for commercial expertise and leadership in the NHS and we can learn a lot from entrepreneurs and successful people in industry to help us deliver better services in healthcare.

What do you enjoy doing when you are not working?
I am drummer in a band called Inhale; we rehearse weekly in my garage and perform at private parties across the year.

What do you do in a typical working day?
I start at 8am, go through my emails and then at 9am do a ward round of patients with supportive care problems at the Christie. Then in the afternoon I will have a joint clinic with one of the cancer teams, dealing with any pain or symptom control problems and preventing them from escalating. Whenever I can fit them in, I will also attend strategy meetings and try and get on with research and audit projects.

If you were stranded on a desert island what would be your one luxury?
A convertible Porsche 911 to drive up and down the beach in – black with cream leather.
In our next quarterly issue of Innov-age we will be looking at Older People and Nutrition.

Latest estimates suggest that 1.3 million people over the age of 65 suffer from malnutrition, and the vast majority (93%) live in the community. Overall, almost one third of elderly people admitted to hospital are at risk of malnutrition. The outlook is even worse for those being admitted from care homes – with 50% found to be at risk. [Age UK, 2016]. Join us for the next issue of Innov-age where our contributors share their knowledge and experiences of nutrition and other important eldercare issues...