

## You've Lived a Good Life

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Published online ahead of print at [www.jco.org](http://www.jco.org) on October 5, 2015.

Author's disclosures of potential conflicts of interest are found in the article online at [www.jco.org](http://www.jco.org).

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0732-183X/15/3399-1/\$20.00

DOI: 10.1200/JCO.2015.63.3206

Our aging population places a strain on all aspects of the health care system, including oncology services. In an article published in *The ASCO Post*, Holland and Greenstein<sup>1</sup> discussed the need to prepare younger oncologists to care for much older patients. I typically prepare for new patients by reviewing their pathology, radiology, and comorbid conditions. Age is always listed, and although it is something I think about, I need to see the patient to truly get a feeling for his or her performance status, level of social support, and comorbid conditions. We have all seen patients who appear their stated age and patients who do not. Sometimes, we can obtain useful information from performance status or the descriptor of frail included in the medical record; however, the accurate decisions are made in the examination room, whether the patient is 59 or 89 years of age.

Several months ago, I met Ted, an 89-year-old patient who was in fantastic shape. He liked to tinker around the house, tend his garden, and spend time with his girlfriend. He did his own grocery shopping, liked a glass (or two) of wine with his lunch, and had a great social support system. He presented to his primary care physician in January after an abnormal chest x-ray and computed tomography (CT) scan showed a 3-cm mass, noted by radiology to likely be lung cancer. "Wait and see," he was told. Well, he waited, and it grew. Repeat scans in March (CT and positron emission tomography/CT) and July (CT) showed that the mass was growing. Ted continued to live his life, but wondered, "Why is no one going after this?" He saw his pulmonologist and was told that the mass was likely lung cancer, but testing for lung cancer was so hard—biopsy, more scans, chemotherapy. Who wants that? Well, Ted wanted that. He was 89 years old, but he felt much younger.

Older patients are often excluded from clinical trials in oncology, either because of rigid eligibility criteria or because of bias on the part of enrolling oncologists. The problem with the older patient is the other things that come with them, such as frailty, multiple medical comorbidities, and worsening social support systems, all of which may interfere with the patient's ability to withstand anticancer therapy. So what is the oncologist to do?

Back to Ted. He followed up again in October, 9 months after the mass was initially identified. The scan now showed that the primary mass had continued to grow and that there were enlarged lymph nodes and bone lesions suggestive of metastatic disease. There was now little doubt that he had progressive lung cancer and that his window of opportunity for curative therapy had closed. Finally, Ted put his foot down and demanded a biopsy. It was, as expected, primary non-small-cell adenocarcinoma of the lung. Magnetic resonance imaging of the brain was negative, and he was evaluated by radiation oncology, but no therapy was offered, because what had been localized disease was now metastatic. He saw a medical oncologist and was offered single-agent chemotherapy, not a standard platinum-based doublet. Why? He was too old. He was told by his oncologist, "You've lived a good life."

There is always a debate in an oncologist's mind about who should receive chemotherapy and who should not. We have predictive models, guidelines, Eastern Cooperative Oncology Group performance status requirements, and geriatric assessment tools that allow us to estimate an individual's ability to tolerate chemotherapy, but in the end, it is frequently a gut decision. I always tell my patients with advanced disease that my goal is to optimize their quantity and quality of life. If one of these is compromised, we need to re-evaluate our goals of care.

I met Ted 3 days before Christmas for his initial consultation, a full 11 months since the first CT of his chest showed probable lung cancer. He was still sharp as a tack, and I was a little embarrassed to admit that he was dressed much more sharply than I was. All of his records and scans were available for my review. I was interested in his functional status and asked my office staff if he had walked in by himself. Did he come alone? Ted was interactive, gregarious, and entertaining. He brought his A game to see me and was ready to fight. I spoke with his daughter via cell phone, and she confirmed that he was extremely active at home. His girlfriend was with him. He told me he wanted someone to believe in him.

I consulted my former fellowship classmates and my partner in the office next door for advice.

Opinions were divided about what to do. The overwhelming recommendation was to trust my instincts, and I was conflicted. How aggressive should I be?

I shared my dilemma with Ted and presented it in the following way: “I don’t want to kill you, but I want to give you a chance.”

We discussed the benefits and risks of each treatment option: no treatment versus single-agent therapy versus a platinum-based doublet. I discussed with him that platinum based-doublet therapy had long been administered to those younger than 70 years of age; in years past, monotherapy had been considered for those older than age 70 years. However, that had changed with the Intergroupe Francophone de Cancérologie Thoracique 0501 trial, which showed that patients older than age 70 years had a survival advantage when administered platinum-based doublet chemotherapy as opposed to monotherapy. I dove further into that report<sup>2</sup> with Ted and showed him the harsh reality—he was older than the oldest participant (by 3 years), falling into a category about which I had no data to give him, no randomized trial to fall back on to guide our treatment decision. I gave him information, and we would meet again in a few days with a final decision. I presented his case at our local tumor board, where the consensus opinion was that this was a gray area. I recommended starting platinum-based doublet therapy (carboplatin and pemetrexed). And I held my breath.

Ted was ecstatic. Someone believed in him. He had seen multiple physicians who had made decisions for him and not decisions with him. He believed he could handle treatment and was ready to fight. Who was I to say no, based on a number, his age? We talked extensively about all routes of care. We had a roadmap of the pace of the disease, because it had been untreated for almost a year. We discussed not proceeding with any treatment at length; he had already lived a year with this disease. Ted did not want to die without trying to fight this, and I believe I was the first person who truly listened to what he was saying. He was not an unrealistic man; he knew that treatment or no treatment, the lung cancer was likely going to be how he was going to die. We talked about everything before starting. I felt I knew why he wanted to try, even one cycle—he had been told he could not, he should not, and physicians would not give him the treatment. However, Ted had never been told why.

The Institute of Medicine report<sup>3</sup> on delivering high-quality cancer care discusses engaging patients in their medical decisions as part of providing that level of care. It goes on to address patients

with advanced cancer; we as physicians need to address their needs, values, and preferences. Ted had all of those choices planned and knew what he was willing to accept and what he was not; he wanted a seat at the table to decide. He knew that starting one cycle of chemotherapy did not mean he would get a second cycle, but our road ahead was written in pencil, easily changed based on how he responded and his preferences.

He tolerated cycle one with absolutely no problems. I am pretty sure he did not want to give me a reason to stop, and I did not. He received three cycles, followed by a positron emission tomography/CT scan, which showed a great response. He completed his induction regimen, and with two subsequent scans showing continued response, he is now receiving maintenance therapy (pemetrexed based on PARAMOUNT trial<sup>4</sup>). He celebrated his 90th birthday, one that he did not think he would live to see.

They will not all be success stories like this. Ted still is likely to die as a result of his lung cancer, but I feel satisfied with the counsel I provided him, and he certainly seems happy with his decision. Ted smiles and hugs me and thanks me for giving him a chance to continue living his good life.

It was a tough decision, one I know I will struggle with many more times. But for now, Ted’s smiling face tells me that I got this one right.

#### AUTHOR'S DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Disclosures provided by the author are available with this article at [www.jco.org](http://www.jco.org).

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**AUTHOR'S DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST**

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*The following represents disclosure information provided by author of this manuscript. All relationships are considered compensated. Relationships are self-held unless noted. I = Immediate Family Member, Inst = My Institution. Relationships may not relate to the subject matter of this manuscript. For more information about ASCO's conflict of interest policy, please refer to [www.asco.org/rwc](http://www.asco.org/rwc) or [jco.ascopubs.org/site/ifc](http://jco.ascopubs.org/site/ifc).*

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