

# Preface

As the population is aging to unprecedented levels, more and more older patients are referred to our clinics. It might be assumed that we do not need any specialized knowledge as we are all used to dealing with older patients in our daily practice. On the other hand, it has become very clear that older patients with cancer represent an entirely unique subset, presenting with special needs and requiring tailored care.

Genitourinary cancers represent a unique model in our practice, as the three major urological malignancies have different impacts on the risk of dying of cancer. Therefore, the conflict between the risk of dying of cancer and dying of other causes poses uncertainties in the design of a treatment plan. Conflicting risks of death are present in older patients, the most important being comorbidities, but dependence, malnutrition, fall, and even cognitive impairment may also play important roles. Tools are now available to assess the patients' health status, and they come under the name of Comprehensive Geriatric Assessment (CGA). These tools help to predict the individual likelihood of survival. This prediction is, however, only a probability and not a certainty.

Patients with low-risk prostate cancers are unlikely to die of their malignancy, while high-risk, life-threatening prostate cancers can develop. This is also the case with kidney cancer: small volume renal lesions and slow-growing masses are unlikely to be cancerous, and even when proved to be malignant, they generally do not develop into life-threatening conditions. Conversely, infiltrating bladder cancer presents with a completely different scenario, and this poor-risk condition requires surgical treatment.

The basic question is: what are the chances of living in relation to a health status evaluation? What is the chance of living with cancer rather than surviving the cancer treatment? This fine balance is more accurately estimated by weighing frailty (CGA) against cancer prognosis. Estimating these factors allows us to develop a patient-centered decision-making process for each individual patient.

It is important to appreciate how principles for the implementation of these decision-making processes are still needed. These aspects, cancer prognosis and the

possibility to undergo treatment, as well as health status and need for a geriatric intervention, must be carefully considered.

No universal rule is available; hence our personal experience is essential in adapting the acquired knowledge into our clinical practice. The implementation of sophisticated geriatric tools into our oncology/urology practice is a big challenge. Different instruments have been developed to assist screening patients' health status and stratifying them into risk groups: i.e., fit, vulnerable, frail, and "too sick" patients. These tools have limited efficiency in decision making, but are extremely useful in clinical practice.

This book has been specifically designed and developed with the purpose to assist clinicians in optimizing their clinical proactivity when dealing with senior urological patients. Our aim was to review all different aspects of a geriatric oncology approach to urological cancers. Some sections might overlap, but they reflect the numerous and different schools of thought. It is indeed the reader's challenge to develop a critical interpretation of these different approaches. Eventually the reader will be inspired to build their own decision-making process on the basis of personal experience.

Genitourinary cancers are generally cancers of older patients, especially prostate and bladder cancers. The available literature is rich in experiences of treating older patients with prostate and bladder tumors as these cancers are highly prevalent among the elderly. Non-Hodgkin lymphomas are also relatively frequent in elderly patients, thus a chapter on this topic has been included.

Conversely, there are only minor differences evident in the prevalence of most other genitourinary cancers in older patients when compared with their prevalence in the general population. One exception is testicular cancer: germ cell tumors occur in patients younger than 50 years, and for this reason this tumor type is not included in this book. Other tumors show no age-related specificity, i.e., penile cancer, adrenal tumors, retroperitoneal sarcoma, or upper urinary cancers. It was nevertheless interesting to review the published data relevant to older patients, even though there was no specific decision-making processes to be developed.

We would like to congratulate all the authors and thank them for their enthusiasm in summarizing their experience. A special note of gratitude goes to Dr. Helen Boyle for her generous support on numerous areas across this editorial project.

It is our hope that this book might become a useful tool to assist the dissemination and implementation of geriatric oncology into urological practice.

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<http://www.springer.com/978-0-85729-986-4>

Management of Urological Cancers in Older People

Droz, J.-P.; Audisio, R.A. (Eds.)

2013, XIV, 374 p., Hardcover

ISBN: 978-0-85729-986-4