ONCOGERIATRIE
HOOGTEPUNTEN SIOG CONGRES 2025, GENT, BELGIË

Prof dr Lore Decoster, UZ Brussel

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INLEIDING

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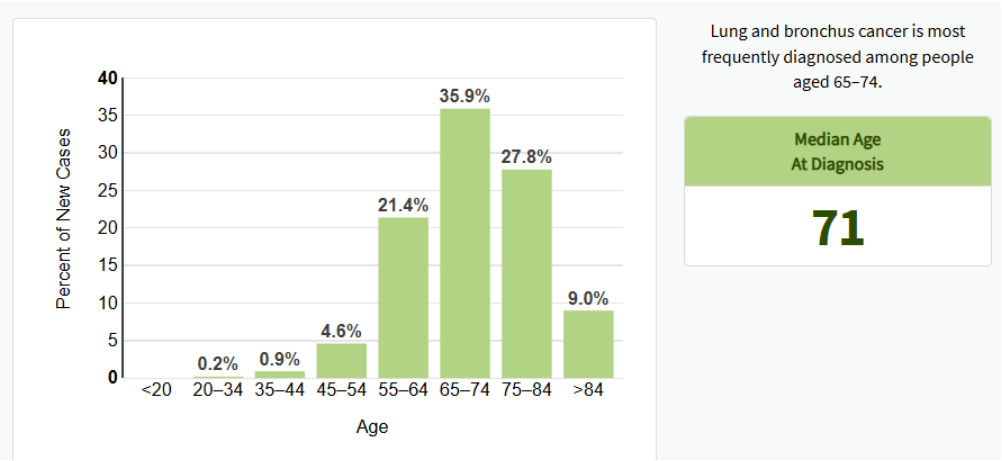
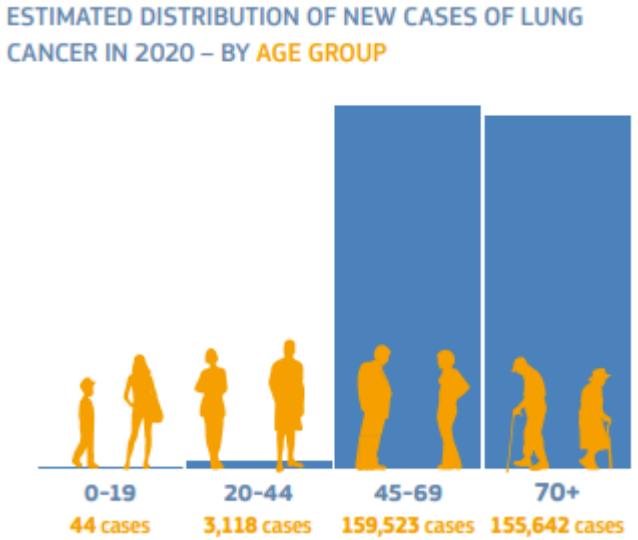
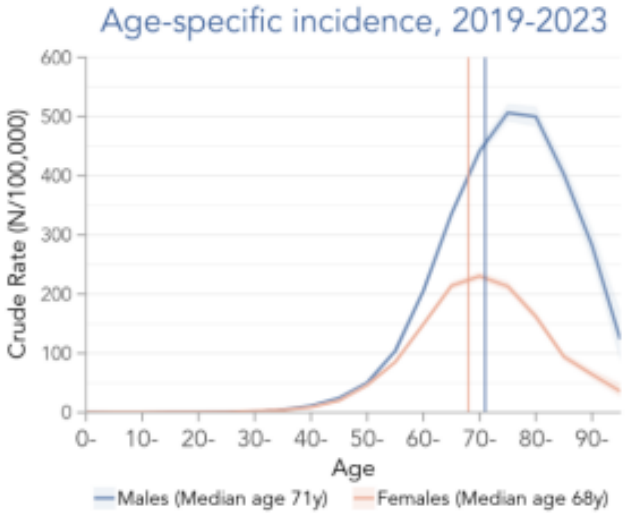
Longkanker +/- 50% ouder dan 70 jaar



USA



Europa



België

Seer.cancer.gov/statfact;jrc.erc.europa; www.kankerregister.org

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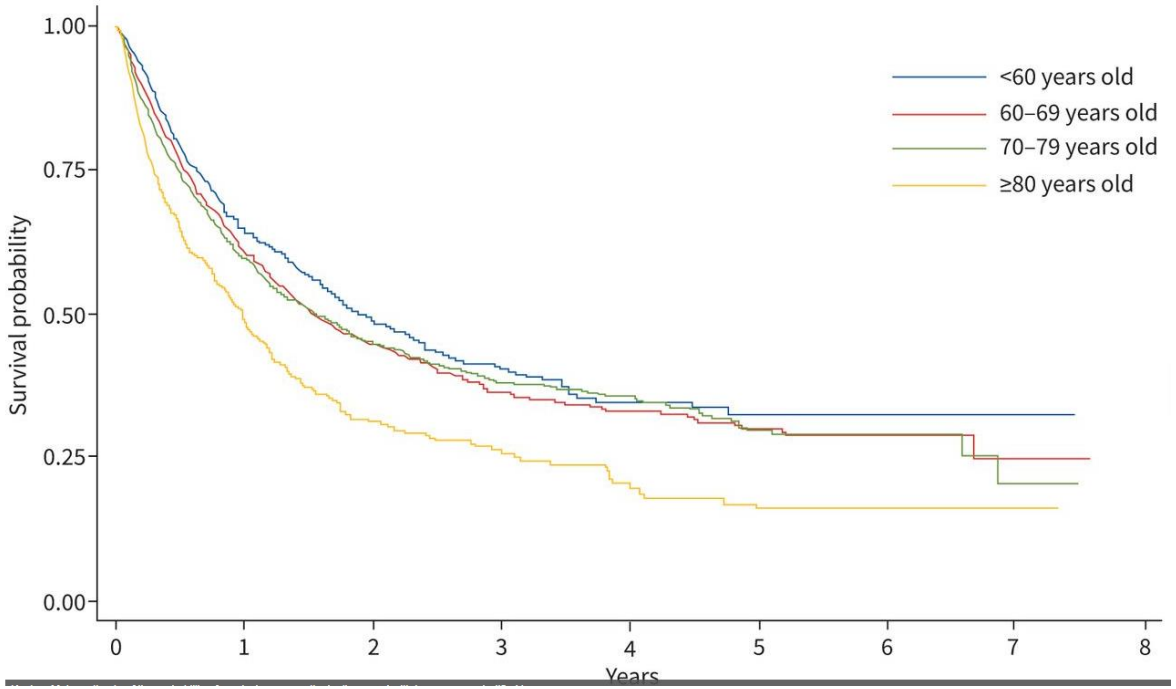
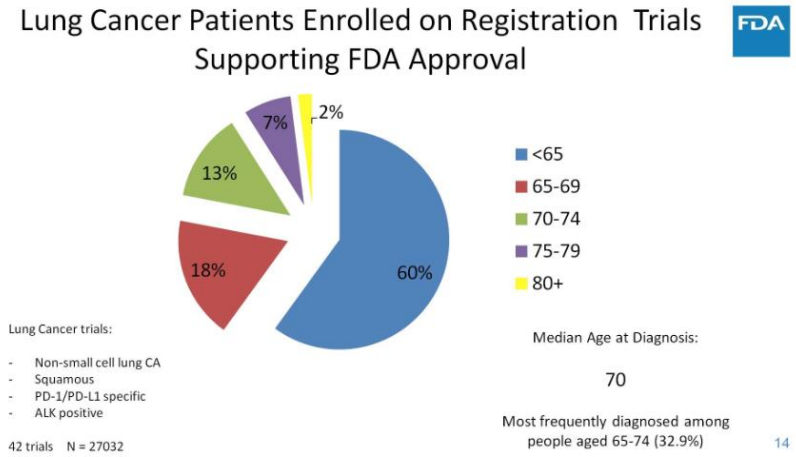
Slechtere overleving in oudere patiënten met longkanker



Pham J et al. ERJ Open Research 2021

INLEIDING

Therapeutische beslissingen vaak complex



- Gebrek aan data uit klinische studies
  - Jonge en fitte patiënten
  - Enkel overleving als eindpunt
- Zeer heterogene populatie
  - Frailty, orgaan functie, co-morbiditeiten, polyfarmacie
  - Levensverwachting zonder kanker
  - Wensen en verwachtingen
- Gevaar voor onderbehandeling (ageism) en overbehandeling (toxiciteit)

Singh H et al ASCO 2017; Soto-de-Perez-de Celis E. Cancer 2024

INLEIDING

Older adults are heterogeneous

Cancer
Comorbidities
Health behaviours
Access to healthcare
Geographical location
Social support

FIT

Life expectancy

Functional status

Organ reserve

Focus on survival

FRAIL

Comorbidities

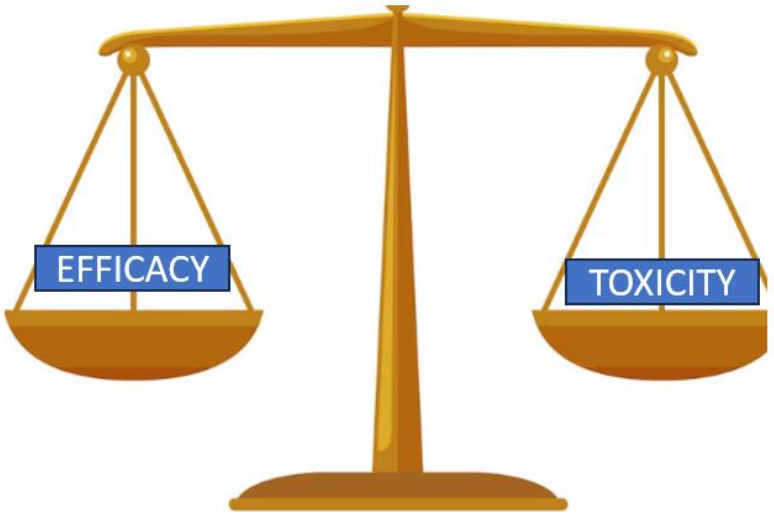
Polypharmacy

Toxicities risk

Focus on quality of life

Courtesy dr N Battisti, UK

INLEIDING



- Is een bepaalde behandeling efficiënt in ouderen?
  - Chemotherapie
  - Immuuntherapie? Gezien immunosenescentie
  - Doelgerichte therapie?
- Wat is de toxiciteit van een behandeling bij ouderen?
  - Risico? Hoger of niet dan bij jongeren? Kan men dit inschatten?
  - Gevolgen van toxiciteit?
- Wat verwachten we van een behandeling bij ouderen?
  - Levensverlenging?
  - Verbetering levenskwaliteit?
  - Behoud van functionaliteit?

Belang van shared decision making

INLEIDING

SIOG 2025 Annual Conference

"Bridging Research and Clinical Practice in Geriatric Oncology"

SELECTIE VAN SIOG SESSIES

1. Geriatrisch assessment in de praktijk
2. Screening en behandeling van longkanker
3. Beweging bij ouderen met kanker
4. Voeding bij ouderen met kanker

INTEGRATIE VAN GERIATRISCH ASSESSMENT IN DE PRAKTIJK

COMPREHENSIVE GERIATRIC ASSESSMENT

*"een multidimensionele evaluatie van de **algemene gezondheidstoestand** maar ook van de **functionele, cognitieve, sociale en psychologische** parameters bij oudere personen"*

COMPREHENSIVE GERIATRIC ASSESSMENT

ASCO richtlijnen

- Alle oudere (65+) patiënten met kanker die in aanmerking komen voor systemische therapie moeten een geriatrisch assessment (GA) krijgen en in geval van geïdentificeerd probleem een geriatrisch gerichte aanpak in hun zorgplan.
  - Resultaten GA moeten de therapeutische beslissing mee sturen en aanleiding geven tot gerichte geriatrische interventies
- GA moet alle domeinen gelinkt met veroudering omhelzen
- Levensverwachting moet ingeschat worden
- De resultaten van het GA moeten leiden tot een gepersonaliseerd en geïntegreerd zorgplan

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Dale W et al. J Clin Oncol 2018 & 2023

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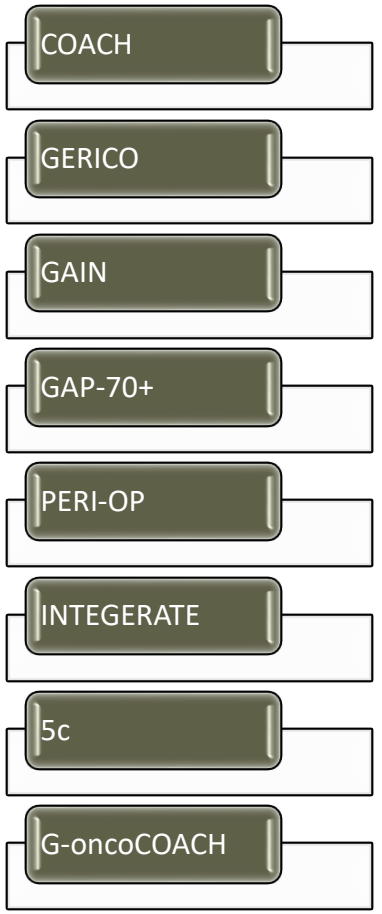
COMPREHENSIVE GERIATRIC ASSESSMENT

1. Detecteert vooraf ongekende geriatrische problemen
2. Beïnvloedt therapiebeslissingen
3. Mogelijkheid tot geriatrische interventies
4. Prognostische waarde voor o.a. overleving
5. Predictieve waarde voor o.a. toxiciteit, complicaties na chirurgie, functionele status…
6. Verbeterde communicatie / gedeelde besluitvorming proces
7. Vermindert chemotherapie-gerelateerde toxiciteit
8. Verbetert uitkomsten gerelateerd aan functionele status
9. Verbetert de kans om de therapie te vervolledigen
10. Verbetert kwaliteit van leven



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Hamaker et al. JGO. 2023

CGA EN CHEMOTHERAPIE GERELATEERDE TOXICITEIT

Totale score casus: 16

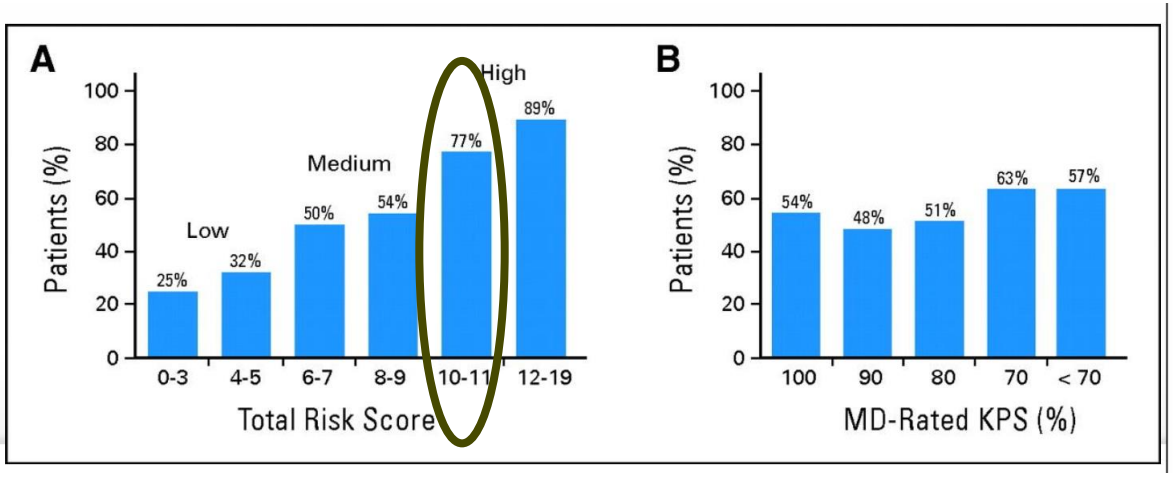

Table 5. Predictive Model

Risk Factor	Prevalence No.	Prevalence %	Grades 3 to 5 Toxicity No.	Grades 3 to 5 Toxicity %	OR	95% CI	Score
Age ≥ 72 years	270	54	163	60	1.85	1.22 to 2.82	2
Cancer type GI or GU	185	37	120	65	2.13	1.39 to 3.24	2
Chemotherapy dosing, standard dose	380	76	204	54	2.13	1.29 to 3.52	2
No. of chemotherapy drugs, polychemotherapy	351	70	192	55	1.69	1.08 to 2.65	2
Hemoglobin < 11 g/dL (male), < 10 g/dL (female)	62	12	46	74	2.31	1.15 to 4.64	3
Creatinine clearance (Jelliffe, ideal weight) < 34 mL/min	44	9	34	77	2.46	1.11 to 5.44	3
Hearing, fair or worse	123	25	76	62	1.67	1.04 to 2.69	2
No. of falls in last 6 months, 1 or more	91	18	61	67	2.47	1.43 to 4.27	3
IADL: Taking medications, with some help/unable	39	8	28	72	1.50	0.66 to 3.38	1
MOS: Walking 1 block, somewhat limited/limited a lot	109	22	69	63	1.71	1.02 to 2.86	2
MOS: Decreased social activity because of physical/emotional health, limited at least sometimes	218	44	126	58	1.36	0.90 to 2.06	1

Abbreviations: GU, genitourinary; IADL, instrumental activities of daily living; MOS, Medical Outcomes Study; OR, odds ratio.

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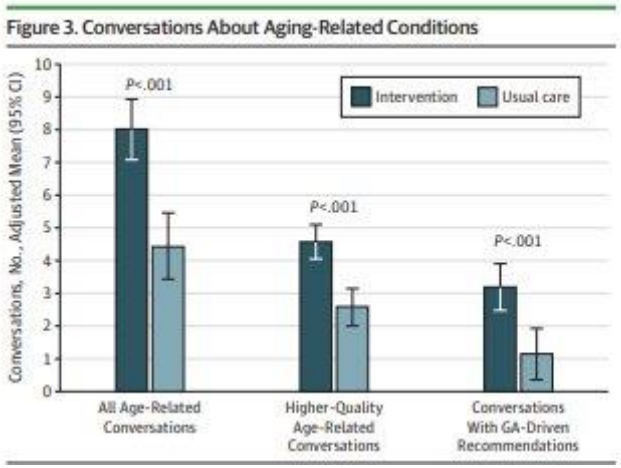
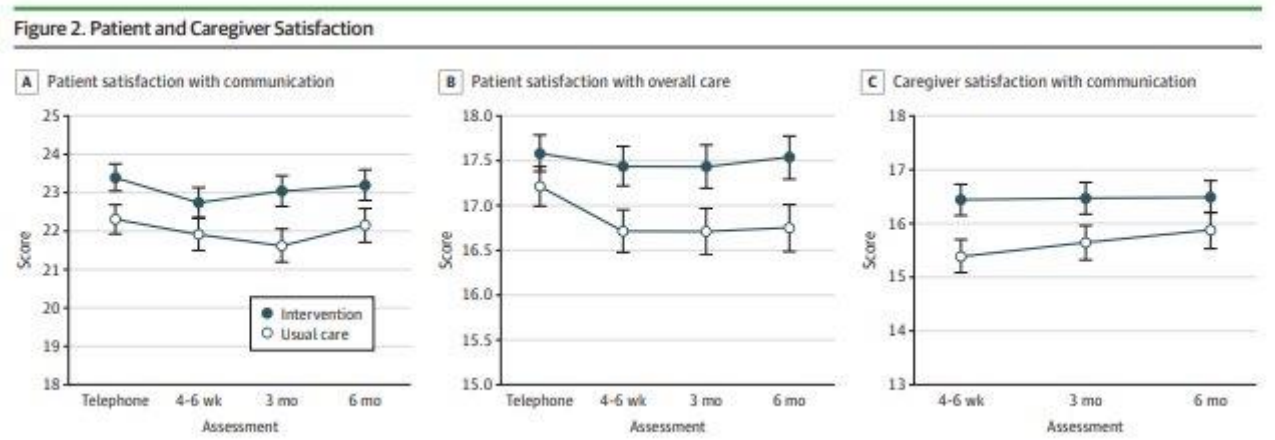
Bron: Hurria et al. J Clin Oncol 2011

RCT: COACH STUDIE

➢ Verbetering van de communicatie

- Patiënten 70+, met gevorderde kanker, gepland voor palliatieve chemotherapie, ten minste 1 abnormaal domein op GA
- Verbeterde communicatie rond ouderdomsgebonden problemen en mogelijke impact op kanker en zijn behandeling





Mohile et al. JAMA Oncol 2020

RCT: GAP70+ EN GAIN STUDIE

- **Verminderen van de toxiciteit**
  - Afname in ernstige chemotherapie gerelateerde toxiciteit
    - GAP70+: 51 vs 71%, p=0.0001, vnl niet hematologisch zoals vermoeidheid, gastrointestinale klachten, infecties
    - GAIN: 50 vs 60%, p=0.02
  - In GAP70+ studie: meer dosisreducties bij start
    - Minder nood aan dosisreducties tijdens de behandeling
    - Zelfde overleving!

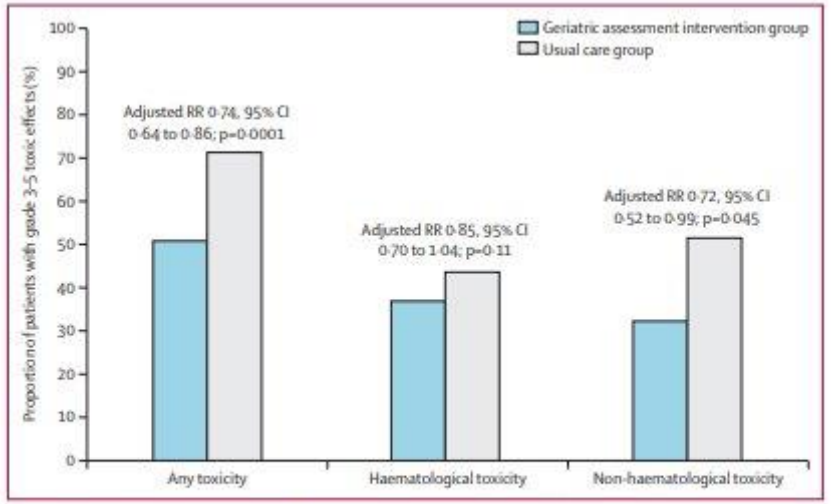


Figure 2: **Prevalence of any grade 3–5 Common Terminology Criteria for Adverse Events toxic effects over 3 months**
RR=risk ratio.

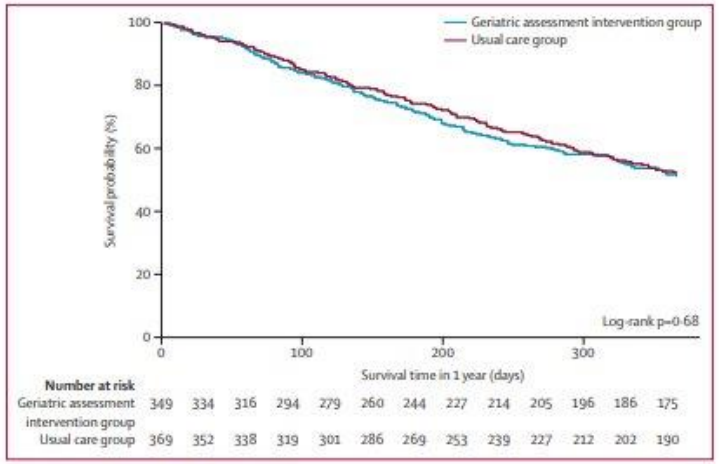


Figure 4: **Survival over 1 year by study group**

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Mohile S, et al. Lancet 2021

Li D et al. JAMA Oncol 2021

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RCT: INTEGERATE

➢ Verbetering van de levenskwaliteit

- ➢ HRQOL neemt af tijdens de behandeling maar minder in de groep patiënten met CGA
- ➢ Grootste voordeel in patiënten die baseline een intermediaire score hadden
- ➢ Ook minder spoedpresentaties en minder ongeplande hospitalisaties
- ➢ Zelfde overleving

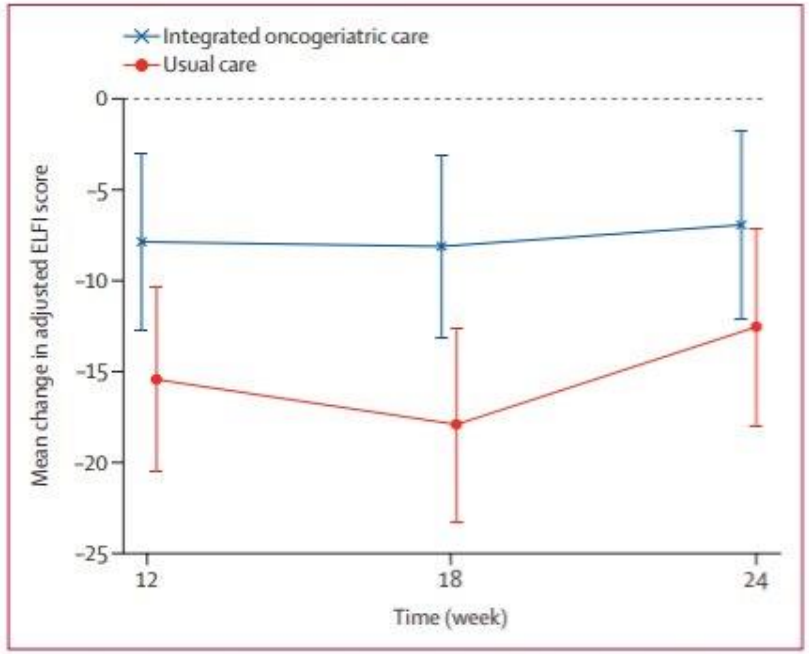

Figure 2: **Mean change in adjusted ELFI scores from baseline to 12, 18, and 24 weeks by study group in the intention-to-treat population**
Negative change indicates worsening function. ELFI=Elderly Functional Index.

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Soo WK et al. Lancet Healthy Longev 2022

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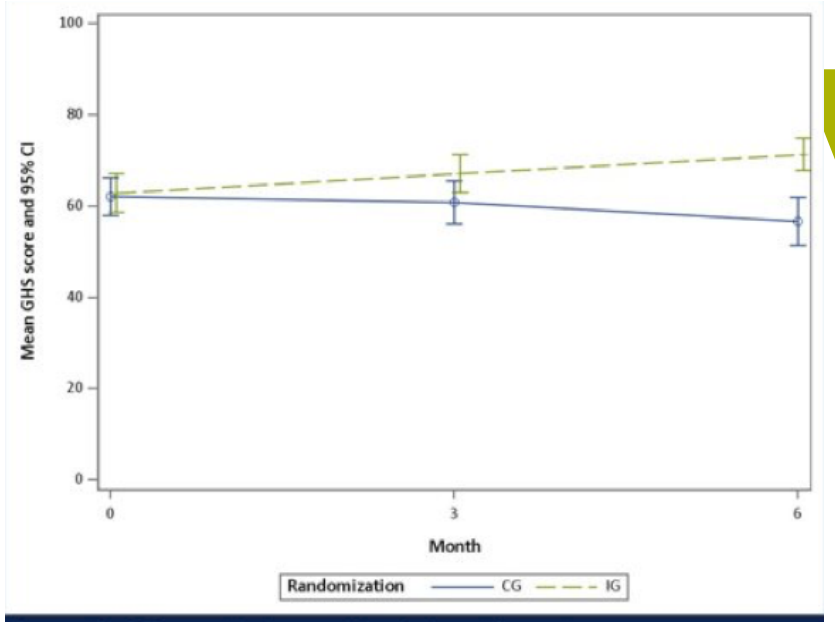
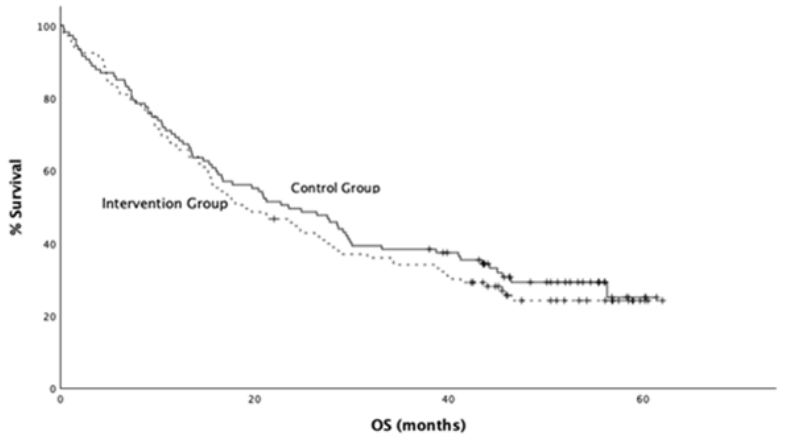
RCT: G-ONCOCOACH

➢ Verbetering van de levenskwaliteit

- ➢ Betere levenskwaliteit na 6 maand in de CGA groep met een gemiddeld verschil van 10.9 punten, p=0.003
- ➢ Geen verschil in overleving: mediaan 23.5 versus 18.8 maand p=0.473
- ➢ Geen verschil in graad 3/4 toxiciteit voor de totale populatie 45 vs 40%; p=0.474
  - ➢ Maar wel significant minder toxiciteit voor patiënten met risicoprofiel volgens screening met G8 die chemotherapie kregen 56 vs 36%; p=0.033
- ➢ Geen verschil in ongeplande hospitalisaties 53 vs 46%; p=0.271





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Kenis C, et al. Lancet Healthy Longev 2025 & Poster presentatie SIOG 2025

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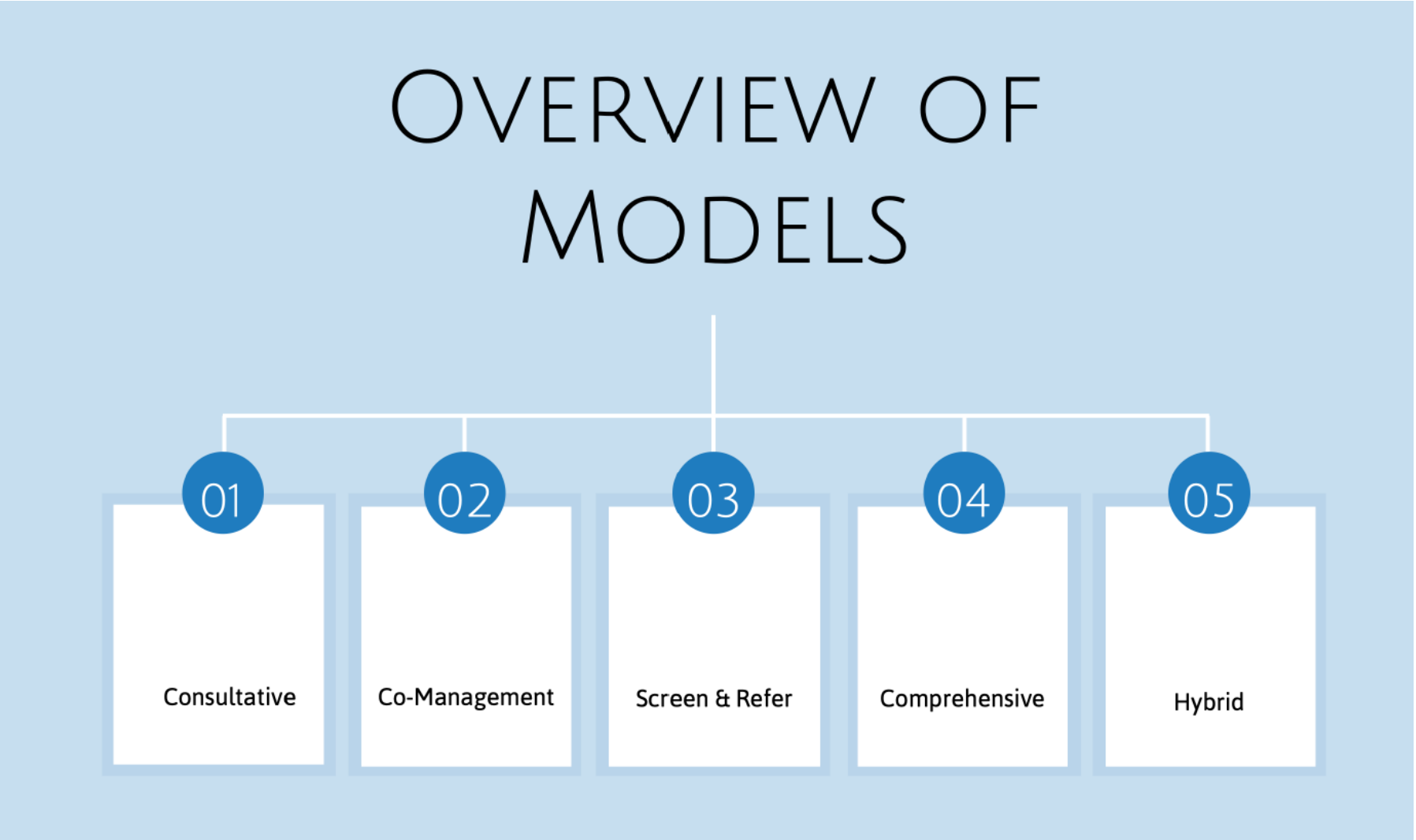
CGA IN DE PRAKTIJK



Colm Mac Eochagain, St James Cancer insitute Dublin, SIOG 2025

CGA IN DE PRAKTIJK

What Is a Consultative Model?

- Referral-based, episodic geriatric/GA consultation
- Oncology team retains primary responsibility for treatment
- GA informs decisions; oncogeriatric team not always involved long-term
- Multidisciplinary, typically half-day visits
- Written recommendations to the oncology team
- Follow-up often limited or optional

Colm Mac Eochagain, St James Cancer insitute Dublin, SIOG 2025

CGA IN DE PRAKTIJK

What Is a Co-management Model?

- Geriatric and oncology teams share ongoing responsibility
- Involvement spans pre-treatment, inpatient/operative, and early follow-up
- GA findings incorporated into tumour boards and care plans
- Common contexts: surgical oncology wards or dedicated units

Colm Mac Eochagain, St James Cancer insitute Dublin, SIOG 2025

CGA IN DE PRAKTIJK

WHAT IS A SCREENING & REFERRAL MODEL?

- Systematic screening of older adults (age cut-offs vary)
- Positive screen → referral for CGA and/or geriatric input
- Often tumour-group-specific pathways
- Enables targeting of limited geriatric capacity
- Popular in resource limited and high volume settings

Colm Mac Eochagain, St James Cancer insitute Dublin, SIOG 2025

CGA IN DE PRAKTIJK

Comprehensive Geriatric Oncology Models

- Geriatric oncology embedded across the care continuum
- Multiple settings: inpatient, outpatient, home, assisted living
- Full CGA and multidomain interventions standardised
- Often linked to research and training infrastructure

Colm Mac Eochagain, St James Cancer insitute Dublin, SIOG 2025

CGA IN DE PRAKTIJK

WHAT DO WE MEAN BY 'HYBRID'?

- Combine elements of consultative and screening models
- GA performed by trained oncology APP or nurse
- Embedded geriatric workflows within oncology clinics
- Use telehealth and digital tools for reach

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Colm Mac Eochagain, St James Cancer insitute Dublin, SIOG 2025

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CGA IN DE PRAKTIJK

GEEN UNIFORM MODEL
Aangepast aan de setting binnen het ziekenhuis

WHAT THESE MODELS TELL US

- No single "right" model – structures are adapted to context and resources
- CGA/GA, MDT decision-making and some screening are non-negotiable core elements
- Co-management and comprehensive models deepen impact but require more resources
- Hybrid models and digital tools are common strategies for scalability

CGA IN DE PRAKTIJK

Choosing and Adapting a Model Locally

- Start by clarifying goals: decision support only, or full co-management?
- Map local workforce and IT capacity (geriatricians, nurses, EMR)
- Consider phased approaches:

  Consultative clinic → add screening → move toward hybrid/co-management
  Build in data collection from the outset

SCREENING EN BEHANDELING VAN NSCLC

SCREENING

SIOG Expert Consensus Recommendations – Steimer D et al . – Submitted JTO

Guideline #1: Screening with LDCT detects earlier stage lung cancer and reduces cancer related mortality in high-risk patients.

- NSLT studie (50-74j; 5% 70-74), NELSON studie (55-74j; 8,8% 70-74), MILD studie (49-75j; <4% 70-75)

Guideline #2: Older patients benefit from lung cancer screening and chronologic age should not be an exclusion criteria from LCS programs.

- Hogere long kanker incidentie in >65 jaar (NSLT studie)
- Verbeterde behandeling voor vroegtijdige stadia

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Steimer D et al. SIOG Expert consensus recommendations. Submitted to JTO

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SCREENING

SIOG Expert Consensus Recommendations – Steimer D et al . – Submitted JTO

Guideline #3: Patient preferences and goals of care should be prioritized when discussing lung cancer screening.

- Voor en nadelen van screening bespreken
- Fitheid voor oppuntstelling alsook voor eventuele behandeling
- Wensen en verwachtingen, gezondheidsdoelstellingen

Guideline #4: Geriatric assessment tools can help guide decision making for initial and continued LCS screening in older patients.

- Fitte patiënten zouden in aanmerking moeten komen voor screening indien dit overeenkomt met hun wensen en gezondheidsdoelstellingen
- Screening zolang er geen significante verandering is in hun gezondheid

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Steimer D et al. SIOG guidelines. Submitted to JTO

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SCREENING

SIOG Expert Consensus Recommendations – Steimer D et al . – Submitted JTO

Guideline #5: Older patients with suspicious nodules on LDCT should undergo additional workup and optimal management discussed in a MDTB

Steimer D et al. SIOG guidelines. Submitted to JTO

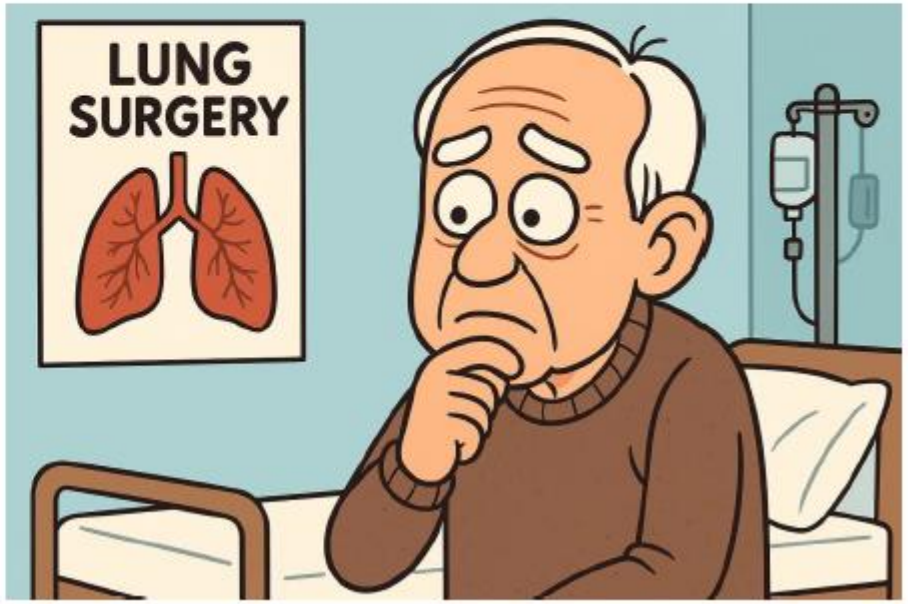
HEELKUNDE VOOR RESECEERBAAR NSCLC

- Evidence in elderly patients (>70 or ≥80) is encouraging but less definitive

- Many cohort studies show that sublobar resections in older/frail patients.
  - comparable survival
  - better functional outcomes

BELANG VAN : PATIENT SELECTIE

VOORKEUR VOOR MINIMAAL INVASIEF: VATS en Robotic

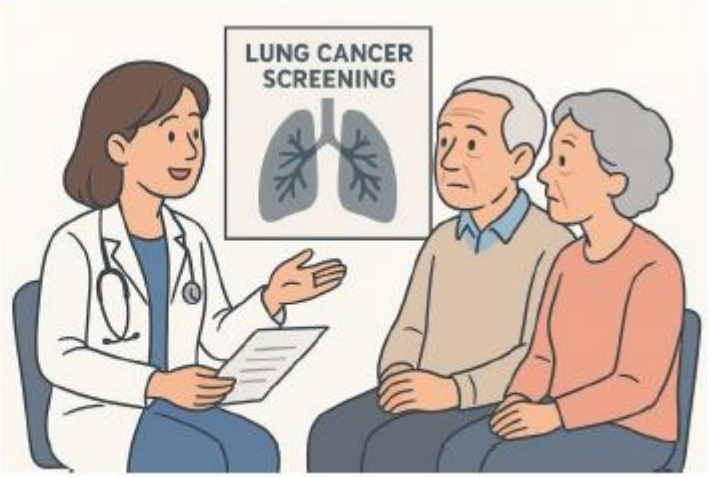


Pommerening et al. SIOG 2025

HEELKUNDE VS RADIOTHERAPIE VOOR RESECEERBAAR NSCLC

- SBRT may achieve survival comparable to surgery
  - Carefully selected, small tumors
    - fewer short-term side effects
  - Comorbidity / frailty tilt risk–benefit away from surgery

- Shared decision-making is essential
  - Trial underpowering
  - Persistent selection biases



Pommerening et al. SIOG 2025

DOELGERICHTE THERAPIE IN METASTATISCH NSCLC

- SIOG review in ≥ 70 jaar
  - Efficiëntie gelijkaardig in (fitte) ouderen vs jongeren
  - Toxiciteit gelijkaardig maar hoger impact (valrisico, orgaandysfunctie, …)
  - Belangrijke gaten in kennis: levenskwaliteit, functioneren, geriatrische eindpunten

- Aanbevelingen
  - Leeftijd is geen exclusie voor doelgerichte therapie
    - Beslissingen afhankelijk van CGA (fitheid, orgaan reserve, …) en wensen
    - Toxiciteitsmonitoring bvb QTc bij osimertinib
    - Altijd kijken naar drug-drug interacties

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Decoster L, et al. Lung Cancer 2025

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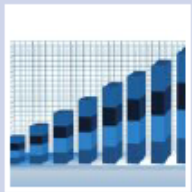
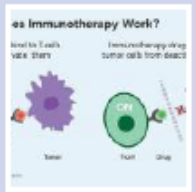
IMMUNOTHERAPIE IN METASTATISCH NSCLC



META-ANALYSES SHOW ICIS IMPROVE OS VERSUS CHEMOTHERAPY WITH SIMILAR RELATIVE BENEFIT IN OLDER ADULTS.

TOXICITY PROFILE IS GENERALLY MORE FAVOURABLE THAN CHEMOTHERAPY, ESPECIALLY FOR HAEMATOLOGIC TOXICITY.

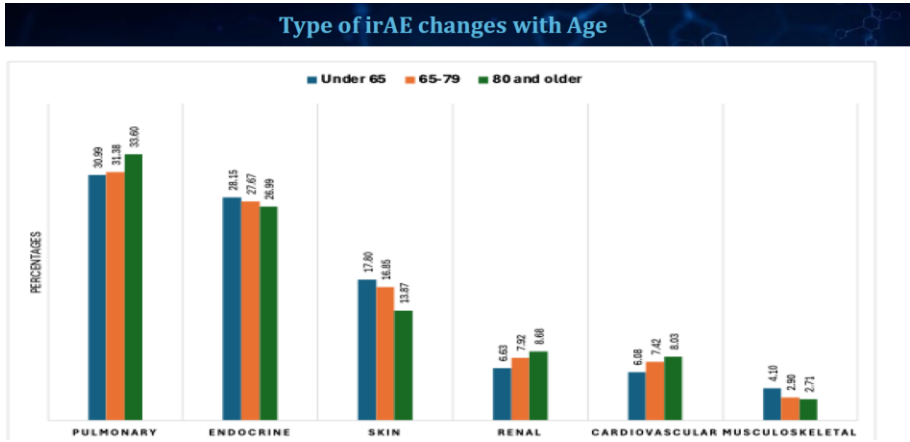


SINGLE-AGENT PD-1/PD-L1 IS ATTRACTIVE FOR PD-L1–HIGH, COMORBID OR FRAIL PATIENTS.

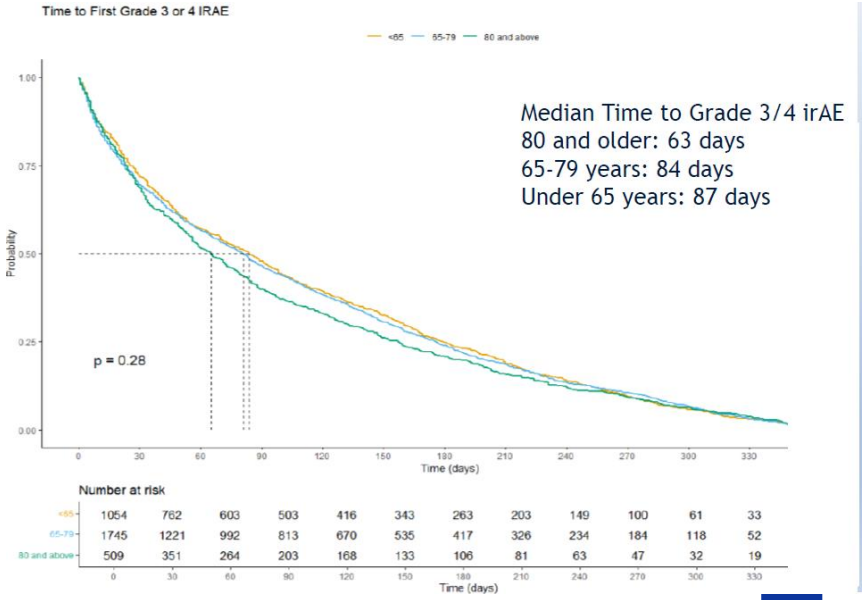
BE VIGILANT FOR IMMUNE-RELATED AES IN THE VERY OLD AND THOSE WITH UNDERLYING AUTOIMMUNITY OR ORGAN DYSFUNCTION.

9. Nishijima TF et al. JAMA Oncol. 2016;2:1167–73. 10. Elias R et al. J Thorac Oncol. 2021;16:196–206.

AGE SPECIFIC RISKS OF irAES



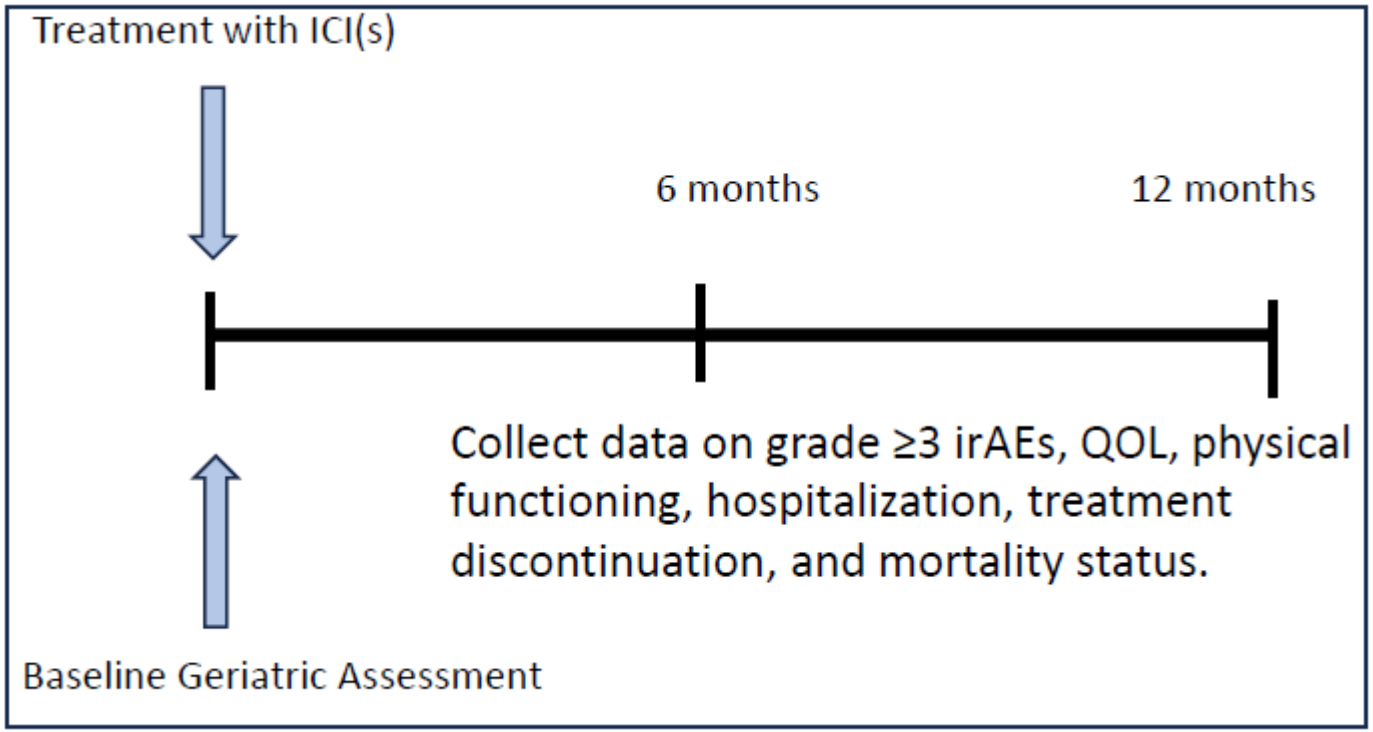
- Retrospectieve analyse van grote US databank
  - N= 96,067 ptn waarvan 51,111 tussen 65-79j en 12,095 ≥80j
- Meerderheid immuuntherapie monotherapie, +/- 4% ipi/nivo
- +/- 52.1% irAEs
  - 50.9% bij <65j; 52.6% bij 65-79j en 52.9% bij 80+
  - Risico lijkt toch wat toe te nemen met de leeftijd
- Type irAEs lijkt wat anders ifv de leeftijd
  - Meer pulmonaal, cardiaal en renaal
  - Minder huid tox
- irAEs treden vroeger op bij ouderen
  - Nauwe monitoring in de eerste 3 maand



Nikita Nikita et al. Oral abstract presentation SIOG 2025

IMPACT VAN irAES OP QOL EN FYSIEK FUNCTIONEREN

- Data uit 2 prospectieve studies in Nederland: TENT en IMAGINE
  - ≥65j met soliede tumor en gepland voor behandeling met ICIs



Ozkan A et al. Orale abstract presentation SIOG 2025

IMPACT VAN irAES OP QOL EN FYSIEK FUNCTIONEREN

- N= 169 pts; mediane leeftijd 73j; 58% frail

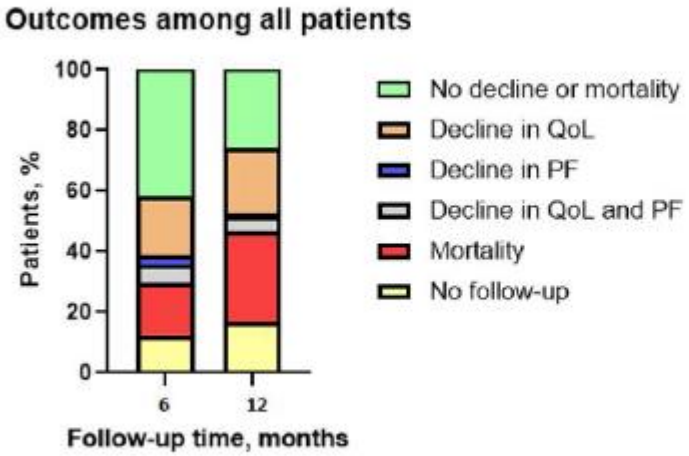


Fig. 1. Comparison of the composite endpoint at 6 and 12 months among all patients.

Unfavorable outcome

- 6 months: 45.6%
- 12 months: 56.2%

- Frailty en niet de aanwezigheid van irAEs was geassocieerd met achteruitgang in QoL, fysiek functioneren en mortaliteit
- Patiënten met frailty werden ook frequenter gehospitaliseerd, maar niet omwille van irAEs

Ozkan A et al. Orale abstract presentation SIOG 2025

RICHTLIJNEN VOOR irAES AANPAK BIJ OUDEREN

Management of immune checkpoint inhibitor-associated toxicities in older adults with cancer: recommendations from the International Society of Geriatric Oncology (SIOG)

Colm Mac Eochagain, Nina Rosa Neuendorff, Karolina Gente, Jan Leipe, Marthe Verhaert, Christine Sam, Nienke de Glas, Sindhuja Kadambi, Beverly Canin, Fabio Gomes, Lore Decoster, Beatriz Korc-Grodzicki, Siri Rostoft, Nicolò Matteo Luca Battisti, Hans Wildiers**

- Impact van irAEs hoger: functioneren, meer hospitalisaties
- Behandeling irAEs gelijkaardig aan jongeren
  - Enkele kleinere nuances bvb tragere opstart LT4, belang van hydratatie bij diarree
- Risico's corticosteroiden: infecties, sarcopenie, delirium, hyperglycemie

Mac Eochagain C. et al. Lancet 2025

CHEMOTHERAPIE +/- IMMUNOTHERAPIE IN METASTATISCH NSCLC

- Toxiciteit chemotherapie neemt toe met de leeftijd
  - Hoger risico op neutropenie, vermoeidheid, neuropathie
  - Meer nood aan dosisreducties
  - Strategie gebaseerd op CGA en CARG risico analyse alsook wensen patiënt
    - Fit: standaard doublet chemotherapie +/- ICI
      - Best geen cisplatinum: belangrijke toxiciteit
      - Eventueel met dosis reductie vanaf cyclus 1 (GAP70+)
    - Kwetsbaar/hoog risico: Dosisreductie of single agent
      - Eventueel voor Sq NSCLC carbo/paclitaxel wekelijks 3w/4
      - IPSOS studie: enkel ICI (atezo) niet meer terugbetaald
    - Frail: BSC

Quoix et al. Lancet 2011; Corre et al. Lancet 2016

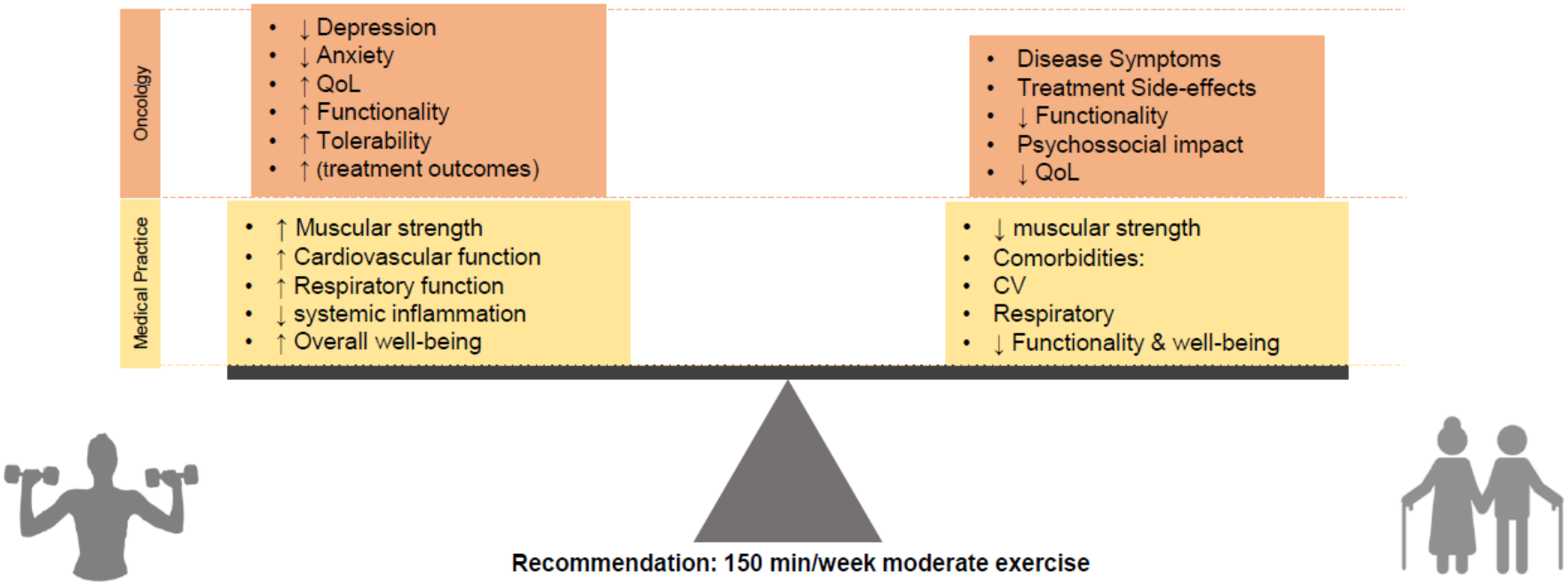
BEWEGING IN OUDEREN MET KANKER

ROL VAN BEWEGING IN PATIËNTEN MET KANKER

SIOG INTERNATIONAL SOCIETY OF GERIATRIC ONCOLOGY 25 YRS 2025 GHENT BELGIUM 20–22 NOV

Exercise during and after treatment

The role of Exercice in Patients with Cancer during and after treatment



Bigaran, A., et al. (2025). JAMA Network Open, 8(2) Campbell KL, et al. Med Sci Sports Exerc 2019;51: 2375–90 Mikkelsen, et al. The Oncologist, 2022, 27, 67–78

Universitair Ziekenhuis Brussel

Bergerot P. SIOG 2025

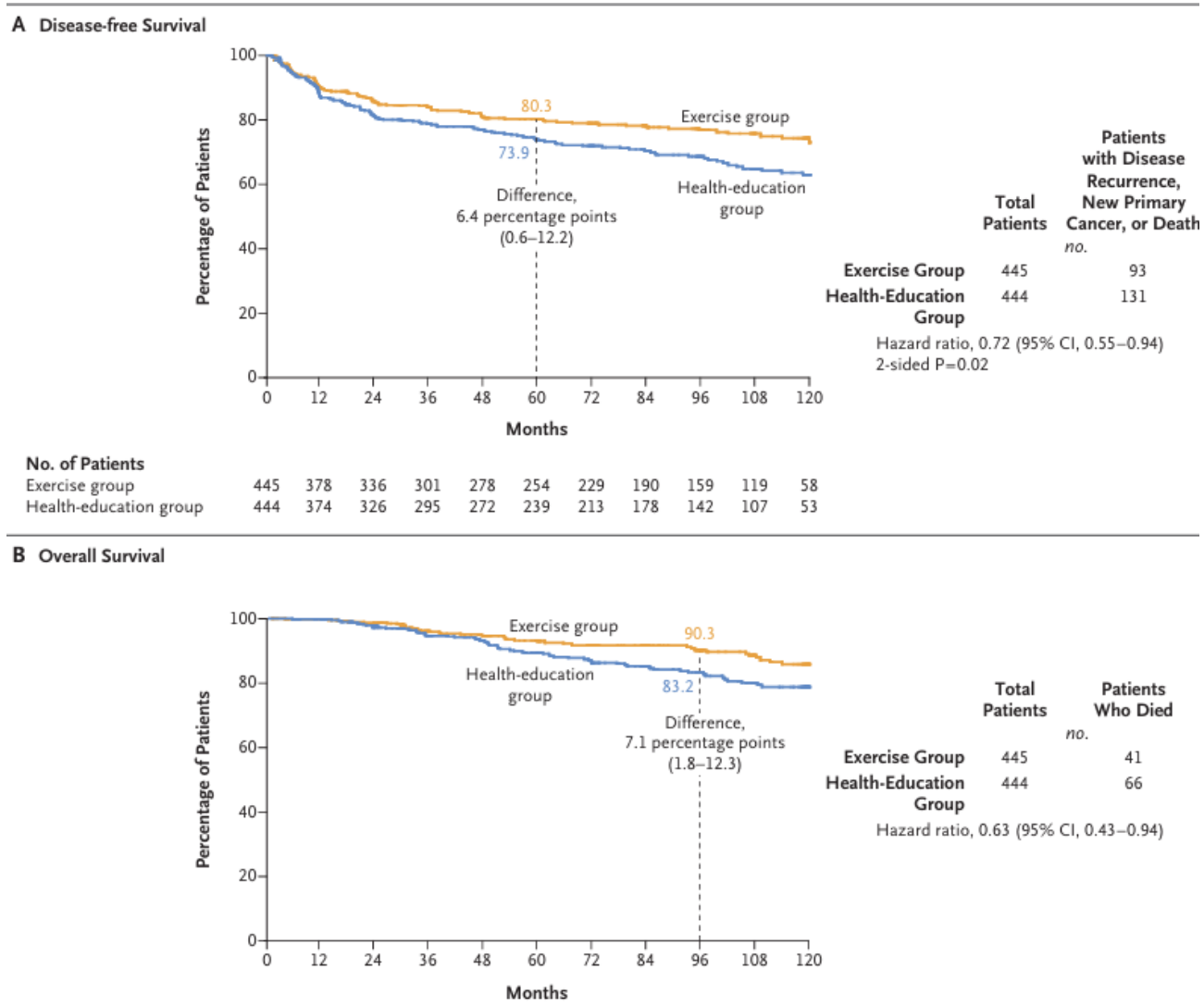
VUB

RCT BEWEGING IN CRC

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JULY 3, 2025 VOL. 393 NO. 1

Structured Exercise after Adjuvant Chemotherapy for Colon Cancer



Courneya et al. N Engl J Med 2025

BEWEGING BIJ OUDEREN MET KANKER

Journal of Geriatric Oncology 16 (2025) 102244

Contents lists available at ScienceDirect

Journal of Geriatric Oncology

journal homepage: www.elsevier.com/locate/jgo

Research Paper

Enhancing quality of life in older adults with cancer: Outcomes of a 12-week supervised remote exercise intervention

Paulo Gustavo Bergerot [a,*], Cristiane Decat Bergerot [a], Jonas Ribeiro Gomes Silva [a], Marcos V.S. Franca [a], Jasmin Hundal [b], William Hiromi Fuzita [a], Paulo Sergio Lages [a], Gabriel dos Anjos [a], Andressa Cardoso de Azeredo [a], Carolina Bezerra Patriota [a], Marco Murilo Buso [a], Errol J. Philip [c], Kathryn H. Schmitz [d], Narjust Florez [e], Enrique Soto-Perez-de-Celis [f]

Study design

- Pilot, single arm study
- 12-week remote exercise program for older patients (65+ years) undergoing systemic treatment for cancer.

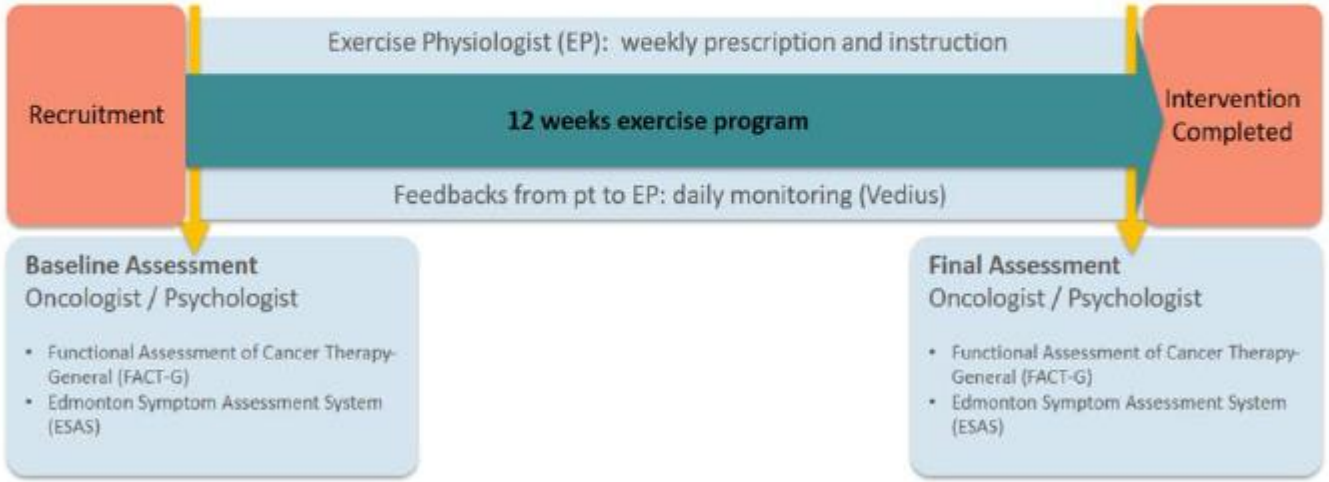
- **Primary endpoints**: impact of a 12-week supervised remote exercise program on healthrelated quality of life (HRQOL)
- **Secondary outcomes**: Feasibility and acceptability

Bergerot PG, et al. (2025). J Geriatr Oncol. 2025 Jun;16(5):102244.

BEWEGING BIJ OUDEREN MET KANKER

Study Design

- 1st appointment via Telehealth: Assessing patient conditions
- Personalized prescription plans
- Gradual intensity enhancement



Exercise Prescription

Physical Activity Prescribed	
Resistance exercise	Warmup Lower limb Upper limb CORE
Aerobic exercise	Walking (running)
Mobility exercise	Activity mobility exercise control articular rotation (CARs)
Note.	Weeks 1-2 Monday, Wednesday, and Friday: Mobility Tuesday, Thursday, and Saturday: Aerobic Weeks 3-12 Monday, Wednesday, and Friday: Strength Tuesday, Thursday, and Saturday: Aerobic/Mobility

Bergerot PG, et al. (2025). J Geriatr Oncol. 2025 Jun;16(5):102244.

SIOG 25 YRS
INTERNATIONAL SOCIETY OF GERIATRIC ONCOLOGY

2025 GHENT BELGIUM 20-22 NOV



ExlOnc - GeriOnc

Research Paper
Journal of Geriatric Oncology 16 (2025) 102244

Enhancing quality of life in older adults with cancer: Outcomes of a 12-week supervised remote exercise intervention

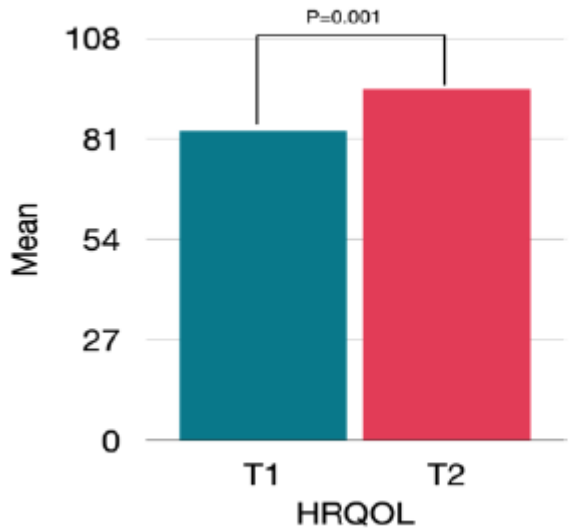
Characteristics	N (%) / M (SD)
Age [M(SD)]	70 (7.4)
Sex [N (%)]	
Male	18 (43.9)
Female	23 (56.1)
Marital Status [N (%)]	
Single	2 (4.9)
Married	24 (58.5)
Divorced	5 (12.2)
Widowed	10 (24.4)
Education [N (%)]	
Elementary School	4 (7.3)
High School	15 (36.6)
College Degree	17 (41.4)
Post Graduation	5 (12.2)
Type of Cancer [N (%)]	
Breast	11 (26.8)
Genitourinary	9 (22.0)
Lung	7 (17.1)
Gastrointestinal	5 (12.2)
Others	9 (22.0)
Disease Stage [N (%)]	
III	2 (4.9)
IV	38 (97.6)

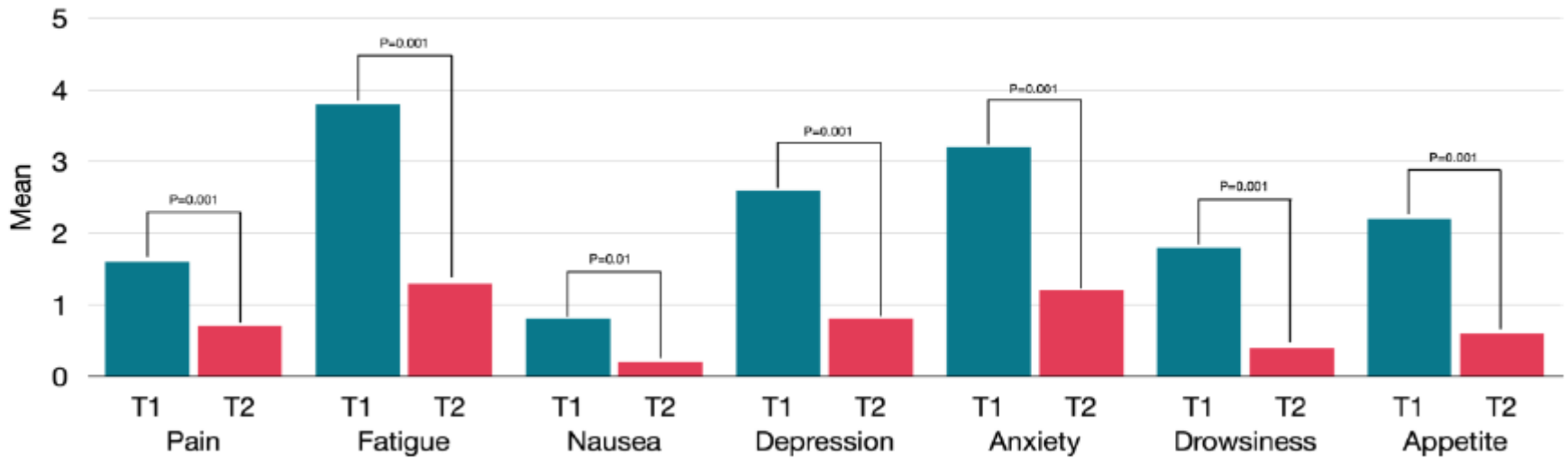
Results

- 48 patients approached, 41 patients were enrolled
- High Adherence Rate: 87.8% with 72.2% retention.
- Program Satisfaction: 87.8% praised its convenience, flexibility, and supportive guidance.

Adherence to 12-Week Program

26 patients for 12 weeks
10 patients for 8 weeks
5 patients < 8 weeks





Bergerot PG, et al. (2025). J Geriatr Oncol. 2025 Jun;16(5):102244.



ExlOnc - GeriOnc

Research Paper
Journal of Geriatric Oncology 16 (2025) 102244

Enhancing quality of life in older adults with cancer: Outcomes of a 12-week supervised remote exercise intervention

Discussion ExlOnc Geri study

- Real-time monitoring
- Personalized exercise adaptation
- Continuous support
- Enhancing engagement among older adults with cancer

- Advantageous for patients facing mobility limitations

Telehealth and remotely delivered interventions are **feasible** and **beneficial** for older adults with cancer.

These programs can help overcome barriers such as travel difficulties and limited access to healthcare providers, by providing accessible, home- based exercise options

Bergerot PG, et al. (2025). J Geriatr Oncol. 2025 Jun;16(5):102244.

BEWEGING BIJ OUDEREN MET (LONG)KANKER

Challenges in Translating Exercise Interventions in Developing Countries: From Pilot Studies to Clinical Practice

Patient-Related Barriers (The "Human" Challenge)

- **Physiologic frailty and comorbidities**
- Overlapping symptoms:
  - disease symptoms
  - treatment side effects
  - normal aging
- **Poor motivation**
- Psychological barriers (fear, depression, fatalism)

Socioeconomic & Cultural Barriers

- Persistent **belief that "rest is best" during cancer treatment**
- Limited family/caregiver support (or active discouragement)
- **Transportation barriers**, long distances, work/family obligations
- **Poor long-term adherence** even when initial participation achieved
- Perceived benefits often outweighed by daily survival priorities

Systemic & Economic Barriers

- **Costs** of supervised programs (staff, equipment, space)
- **Scarce infrastructure** and trained exercise professionals
- Limited funding for geriatric oncology & exercise research
- No reimbursement → programs remain research-only, non-sustainable
- Key question: **Who delivers? Who pays? Who ensures safety?**

AANBEVELING IVM BEWEGING BIJ OUDEREN MET KANKER

CONSENSUS STATEMENT

Exercise recommendations for older adults living with and beyond cancer: A consensus statement by the Advancing Capacity to Integrate Exercise Into the Care of Older Cancer Survivors expert panel

- Panel: oudere patiënten met kanker en mantelzorgers, experten
- 11 aanbevelingen

TABLE 1 Consensus-based exercise recommendations for older cancer survivors.

	Exercise Domain	Consensus Statement
1	Medical evaluation	For an older cancer survivor, additional medical evaluation beyond what is recommended in the current ACSM EGCS and NCCN guidelines is not required to begin an appropriately prescribed exercise program.
2	Exercise testing	In addition to ACSM-recommended health-related fitness assessments to determine an exercise prescription, the following functional assessments are recommended for older cancer survivors: Timed Up and Go, Short Physical Performance Battery, and tests of static and dynamic balance.
3	Exercise prescription	The exercise prescription for older cancer survivors should include balance training; an appropriate balance prescription is one or two sets of four to 10 different balance exercises at least 3 days per week.
4		The exercise prescription for older cancer survivors should include flexibility training; an appropriate flexibility prescription is for stretches that target each of the major muscle–tendon units held to the point of mild discomfort and/or tightness for 30–60 s per stretch at least 2 and up to 7 days per week.
5	Exercise tolerance and safety	The exercise professional should routinely monitor older cancer survivors for symptoms/conditions, including but not limited to the following: joint pain, fatigue, vertigo/dizziness/lightheadedness, nausea, palpitations, chest pain or heaviness, muscle pain or weakness, shortness of breath, and/or incontinence with movement.
6		An exercise professional should consider the following environmental factors and instructional techniques to deliver safe and effective exercise for older cancer survivors: assess the environment for fall hazards, limit auditory and visual distractions, use appropriate cueing and feedback, demonstrate exercises and repeat instructions as needed, and educate participants about appropriate clothing, footwear, nutrition, and hydration.
7	Implementing prescriptions in practice	A person who prescribes and delivers exercise to older cancer survivors should have empathy and patience and be able to appropriately modify and tailor exercises. It is strongly encouraged for people who prescribe and deliver exercise to older cancer survivors to gain experience, education, and/or advanced certification specific to exercise in older adults and/or cancer survivors.
8		An exercise professional should consider the following when encouraging an older cancer survivor to engage in structured exercise training: behavioral techniques (i.e., goal setting and incentives), education about expected responses to exercise (i.e., delayed-onset muscle soreness), initial starting volume and progression (e.g., start low and go slow), individual circumstances, social support, cancer team support, caregiver support, and/or potential barriers to ongoing exercise.
9		In an older cancer survivor who has significant deficits in strength, mobility, and/or balance, exercise programming should first focus on improving muscle strength, flexibility, and balance before moving on to improving aerobic capacity. In addition, exercise programming should include exercises that emphasize functional movement patterns (e.g., chair stands, stepping routines, walks with turns, etc.) as much as possible.
10		In a supervised setting, the exercise professional should consider personal characteristics (e.g., age, comorbidities, polypharmacy, and physical and/or cognitive limitations) when determining the recommended degree of supervision (e.g., group size and instructor: participant ratio) during exercise.
11		If unsupervised exercise is deemed unsafe, it is important to modify exercises and/or engage a caregiver, family member, or friend to assist the individual and/or provide supervised exercise.

Winters-Stone K et al. Cancer 2026

AANBEVELINGEN IVM BEWEGING BIJ OUDEREN MET KANKER

EXERCISE PRESCRIPTION

Statement 3. The exercise prescription for older cancer survivors should include **balance training**; an appropriate balance prescription is 1-2 sets of 4-10 different balance exercises at least 3 days per week.

Statement 4. The exercise prescription for older cancer survivors should include **flexibility training**; An appropriate flexibility prescription is for stretches that target each of the major muscle-tendon units held to the point of mild discomfort and/or tightness for 30-60s per stretch, at least 2 and up to 7 days per week.

- Recommendations to avoid inactivity and engage in aerobic and resistance training should also be met
- Attention to patient burden; consider multi-component exercise

Winters-Stone K et al. Cancer 2026

AANBEVELINGEN IVM BEWEGING BIJ OUDEREN

Special Considerations for Safe and Effective Delivery of Exercise for Older Cancer Survivors

Reduce Fall Risk

Minimize fall risk with attention to proper lighting, changes in color/texture of flooring, removal of slip/trip hazards, spacing of equipment for safe ambulation

Limit Distractions

Minimize noise and competing stimuli such as loud or off-tempo music. Minimize visual and environmental distractions (i.e., pets or clutter)

Instructional Technique

Slower the pace of instruction. Use simple language / terms when teaching/cueing. Demonstrate movements first; repeat as needed

Nutrition & Hydration

Consider a nutritional assessment; encourage 1g /kg PRO/day; encourage 48-60 oz water and increase intake in hot/dry climates

Proper Exercise Gear

Encourage proper footwear (athletic / sturdy shoes; no sandals, slippers, loafers, etc). Educate about proper clothing and sun protection

Temperature Control

Ensure proper climate control and ventilation in a class environment. Encourage layered clothing / proper outerwear and encourage proper hydration

AANBEVELINGEN IVM BEWEGING BIJ OUDEREN MET KANKER

Statement 5. The exercise professional should **routinely monitor** older cancer survivors for **symptoms/conditions** including, but not limited to the following: joint pain, fatigue, vertigo/dizziness/lightheadedness, palpitations, muscle pain or weakness, shortness of breath, and/or incontinence with movement.

- Signs of poor tolerance can be used to modify exercise programming

Statement 9. In an older cancer survivor who has significant deficits in strength, mobility and/or balance, exercise programming should **first focus on improving muscle strength, flexibility and balance** before moving on to improving aerobic capacity. In addition, exercise programming should include exercises that emphasize **functional movement patterns** (e.g., chair stands, stepping routines, walks with turns, etc.) as much as possible.

Winters-Stone K et al. Cancer 2026

VOEDING BIJ OUDEREN MET KANKER

VOEDING BIJ OUDEREN MET KANKER

Contents lists available at ScienceDirect

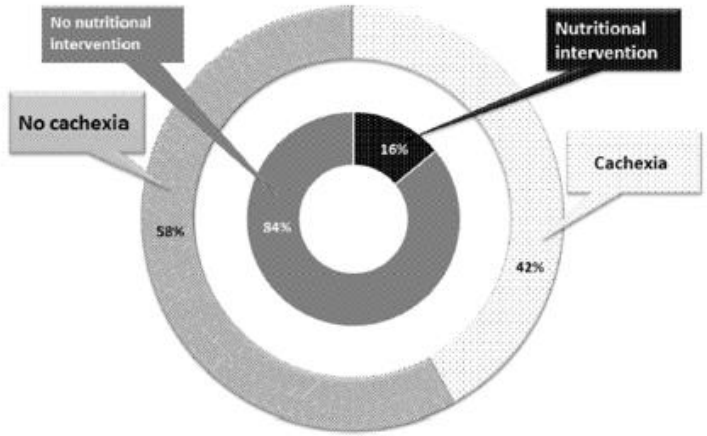
Nutrition

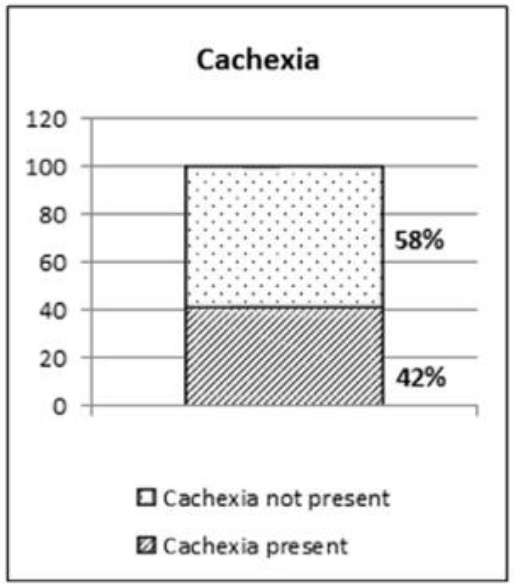
journal homepage: www.nutritionjrnl.com

Applied nutritional investigation

Unidentified cachexia patients in the oncologic setting: Cachexia UFOs do exist

Elisabeth De Waele M.D., Ph.D. [a,b,*,1], Joy Demol BSND [a,b,1], Riccardo Caccialanza M.D., Ph.D. [c], Paolo Cotogni M.D., Ph.D. [d], Herbert Spapen M.D., Ph.D. [a], Manu LNG Malbrain M.D., Ph.D. [a], Jacques De Grève M.D., Ph.D. [e], Joeri J. Pen M.D., Ph.D. [b,f]





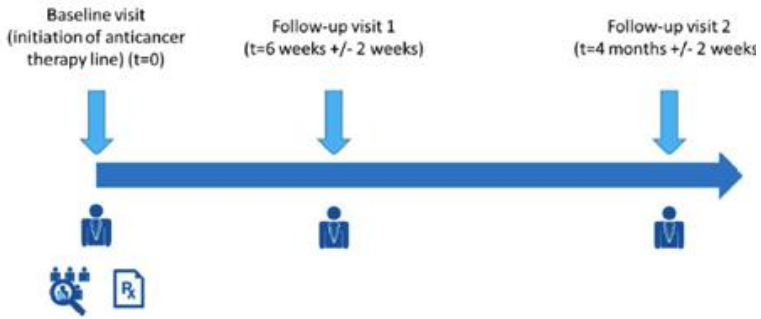
- 9694 patient files
- 118 new diagnosis
- 42 % cachexia
- Nutritional intervention by oncologist: 16%

VOEDING BIJ OUDEREN MET KANKER

RESEARCH

Malnutrition prevalence in cancer patients in Belgium: The ONCOCARE study

Marika Rasschaert[1] · Pieter Vandecandelaere[2] · Stéphanie Marechal[3] · Randal D'hondt[4] · Christof Vulsteke[5,1] · Marie Mailleux[6] · Wendy De Roock[7] · Joanna Van Erps[8] · Ulrike Himpe[2] · Marc De Man[9] · Geertrui Mertens[10] · Dirk Ysebaert[11]



- Real life cohort study Belgium
- Malnutrition : underdiagnosed
- 50% at risk (NRS-2002)
- 25% malnourished (GLIM)
- Largely underestimated by oncologist

Supportive Care in Cancer (2024) 32:135

VOEDING BIJ OUDEREN MET KANKER

Risicofactoren op ondervoeding bij ouderen

Physiologic	Pathologic	Sociologic	Psychologic
Decreased taste	Dentition	Ability to shop for food	Depression
Decreased smell	Dysphagia, swallowing problems	Ability to prepare food	Anxiety
Dysregulation of satiation	Diseases (cancer, CHF, COPD, diabetes, ESRD, thyroid)	Financial status low socioeconomic	Loneliness
Delayed gastric emptying	Medications (diuretic, antihypertensive, dopamine agonist, antidepressant, antibiotic, antihistamine)	Impaired activities of daily living skills	Emotionally stressful life events
Decreased gastric acid	Alcoholism	Lack of interactions with others at mealtime	Grief
Decreased lean body mass	Dementia		Dysphoria

CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease; ESRD = end-stage renal disease.

Evans C et al. Perm J 2005

VOEDING BIJ OUDEREN MET KANKER

- **Bijkomende risicofactoren**

  - Rol van kanker: compressie slokdarm
  - Rol van vermoeidheid
  - Rol van antikanker behandeling: oesofagitis, stomatitis, nausea, constipatie, …

VOEDING BIJ OUDEREN MET KANKER

- Nutritie is ook bij oudere patiënten met kanker een belangrijk probleem
  - Belgische studies:
    - 58% risico voor malnutritie en 15% malnutritie
    - 37% van de artsen waren niet op de hoogte van nutritionele problemen
    - 70% van de aanbevelingen waren voor nutritionele problemen en 43% vd interventies was doorverwijzing naar diëtiste
  - USA studie:
    - 49% had >3 kg gewichtsverlies laatste 6 maand
    - 42% malnutritie

Kenis et al. Ann Oncol 2013 ; Kenis C, Decoster L, et al Ann Oncol 2019;
Zhang et al J Geriatr Oncol 2019

VOEDING BIJ OUDEREN MET KANKER

- 'Frailty' en depressie predictief voor malnutritie
  - Nauwere opvolging nodig

- In een meta-analyse is de aanwezigheid van malnutritie bij oudere patiënten met kanker geassocieerd met een slechtere overleving

- Malnutritie heeft ook een invloed op de behandeling
  - Verminderde tolerantie, verhoogd infectie risico, verhoogd risico op operatieve complicaties

Zhang et al. J Geriatr Oncol 2019

TAKE HOME MESSAGES

TAKE HOME MESSAGES

- Behandeling van kwetsbare ouderen met kanker is complex
- Maak gebruik van een Geriatrische Evaluatie
- Keuze van behandeling op basis van biologische leeftijd
- Impact van bijwerkingen mogelijks veel groter: be prepared!
- Aandacht voor beweging en voeding