ACKNOWLEDGMENTS

The authors wish to thank Maarit Wuorela, MD, Evangelos Margaritis, MD, Heli Ylä-Outinen, MD, laboratory assistant Heidi Jokinen, biostatistician Tero Vahlberg, and colleagues from the Geriatrics Department, Turku City Hospital.

Financial support came from Uulo Arhio Foundation, Turku; special government transfers for Turku City Hospital, Turku; Jalmari and Rauha Ahokas Foundation, Helsinki; Finnish Anti-Tuberculosis Association, Helsinki; Academy of Finland, Helsinki; Research Funds of University of Helsinki, Helsinki; Sigrid Juselius Foundation, Helsinki; all in Finland.

Conflict of Interest: The authors have no conflict of interest in connection with this paper.

Author Contributions: Aronen, Jartti, and Viikari take responsibility for the content. Aronen, Viikari, Jartti, Vuorinen: study concept and design. Aronen, Viikari, Langen, Sadeghi, Hämeenaho: acquisition of data. Aronen, Jartti, Vuorinen, Söderlund-Venermo: analysis and interpretation of data. Aronen, Jartti: drafting of manuscript. Aronen, Jartti, Viikari, Vuorinen, Viitanen, Söderlund-Venermo: critical revision of manuscript for important intellectual content. Jartti, Viikari: administrative, technical, or material support; study supervision.

Sponsor's Role: The sponsors and employers had no role in the design, methods, subject recruitment, data collections, analysis, or preparation of paper.

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WHAT DO OLDER ADULTS KNOW ABOUT THEIR CANCER DIAGNOSIS AND TREATMENT? THE ELCAPA-08 COHORT STUDY

To the Editor: Disclosure of cancer diagnosis and treatment options is critical for people with cancer and physicians. An information strategy customized to patient preferences may improve treatment adherence, coping strategies, and quality of life at the terminal stage.[1] Older adults seem to wish to know their diagnosis[2] and perceive this information to be important, whereas physicians and families view full disclosure with some reluctance.[3,4] The objective of the current study was to assess what older adults with cancer know about their diagnosis and treatment and to identify factors associated with the completeness of this information.

This was a cross-sectional analysis of the prospective Elderly CAncer Patient (ELCAPA) cohort[5] survey of individuals aged 70 and older with as-yet untreated malignancy between 2007 and 2012. Individuals were referred to geriatric oncology clinics in teaching hospitals near Paris, France. Each participant had received information during a dedicated visit with the oncologist. The endpoint was the completeness of self-reported information about cancer diagnosis and treatment, assessed by a geriatrician. Complete information was defined as correct information about diagnosis and planned treatment, partial information as correct information about either of these points, and no information as no or incorrect information about both points. Demographic, tumor-related, and geriatric characteristics were recorded prospectively at baseline. Planned cancer treatments were categorized as curative, palliative, or exclusive supportive care.

There were 615 patients with a median age of 80; 52% were men, 38% were inpatients, 52% had metastases, and 42% had a Performance Status (PS) of 2 or greater. The four most common cancer types were colorectal (24%), breast (17%), urinary tract (14%), and prostate (11%). Median activity daily living (ADL) score was 4 (interquartile range (IQR) 5–6) and median Cumulative Illness Rating Scale for Geriatrics (CIRS-G) score was 11 (IQR 8–15). Twenty-eight percent of patients had two or more major comorbidities, and 19% had a Mini-Mental State Examination (MMSE) score of less than or equal to 23. Treatment intent was curative in 51%, palliative in 28%, and exclusive supportive care in 21%.

Overall, 548 (89.1%, 95% confidence interval (CI) = 86.4–91.5%) reported complete information, 31 (5.0%, 95% CI = 3.5–7.1%) partial information, and 36 (5.9%, 95% CI = 4.1–8.0%) no information. Proportions of patients reporting complete information were similar for all tumor sites (86–95%, $P = .50$) except for carcinoma of unknown primary (CUP) (50%, $P < .001$) and lung cancer (63.5%, $P < .001$). Table 1 shows the factors associated with partial and no or incorrect information in univariate ordinal logistic regression. Because strong correlations linked PS, metastatic status, and treatment intent (Cramer V >0.40), only treatment intent was introduced into the multivariate model. The partial and no information categories had small numbers of patients, with no marked differences according to univariate analysis, and were collapsed into a single group. There was a significant interaction between age and treatment intent ($P = .03$). According to multivariate analysis, factors independently associated with not reporting complete information were CUP or lung cancer (adjusted odds ratio (aOR) = 7.70, 95% CI = 2.73–21.72), two or more major comorbidities (CIRS-G Grade 3 or 4) (aOR = 2.72, 95% CI = 1.26–5.87), MMSE score less

Table 1. Univariate Analysis of Factors Associated with Completeness of Self-Reported Information: The ELCAPA-08 Cohort Study

Factor	Complete Correct Information, n = 548	Partial Correct Information, n = 31	No or Incorrect Information, n = 36	*P*-Value[a]
Age, median (IQR)	79 (76–83)	83 (79–86)	83 (79–85)	<.001
Inpatient, n (%)	196 (36)	17 (55)	23 (64)	<.001
Intent of cancer treatment, n (%)				
Curative	277 (54)	5 (19)	7 (25)	<.001
Palliative	139 (27)	10 (38)	10 (36)	
Supportive care only	93 (18)	11 (42)	11 (39)	
Activity of daily living score, median (IQR)	6 (5.5–6)	5 (4–6)	4.5 (3–6)	<.001
High fall risk, n (%)	308 (57)	26 (84)	31 (86)	<.001
Timed Get Up and Go score ≥20″, n (%)	192 (35)	19 (61)	20 (56)	.001
Mini-Nutritional Assessment, median (IQR)	23 (19–26)	20 (17–24)	20 (17–23)	.003
Serum albumin, g/dL, median (IQR)	3.6 (3.0–4.0)	3.3 (2.7–3.6)	3.0 (2.4–3.5)	<.001
Number of daily medications, median (IQR)	6 (4–8)	6 (5–8)	7 (5–9)	.007
CIRS-G score, median (IQR)	11 (8–15)	14.5 (10.5–19.5)	17 (11–20)	<.001
≥2 CIRS-G Grade 3 or 4 comorbidities, n (%)	125 (24)	19 (61)	21 (60)	<.001
Renal failure, n (%)	35 (7)	5 (17)	6 (20)	.001
Geriatric Depression Scale Short Form-4 score ≥1, n (%)	158 (31)	17 (57)	17 (50)	.003
Mini-Mental State Examination score ≤23, n (%)	91 (17)	11 (35)	17 (47)	<.001

[a]From global Wald test of ordinal logistic regression.

IQR = interquartile range; CIRS-G = Cumulative Illness Rating Scale for Geriatrics.

than 23 (aOR = 1.95, 95% CI = 1.0–6.44), and palliative treatment in participants aged 80 and older (aOR = 6.5, 95% CI = 1.87–22.67).

A large majority of older adults reported complete information on cancer diagnosis and treatment for all tumor sites. The lack of information that the oldest participants reported was consistent with earlier data.[3] Among possible explanations is a desire of physicians to protect older adults by withholding bad news independently from cognitive status and PS.[3] Older adults may prefer to receive less information than younger individuals,[6] and they may be less likely to seek information on their own, particularly from the Internet. An 18-study review indicated that older adults with cancer were usually satisfied with the content, quality, and timeliness of medical information.[7]

Age modified the association between treatment intent and completeness of self-reported information: in participants aged 70 to 80, palliative intent had no significant association with information, whereas those aged 80 and older for whom palliative treatment was proposed were less likely to report complete information than those of same age in curative setting. Full disclosure may be more stressful for physicians,[8] particularly for individuals with incurable diseases.[3] Older adults and those with more-advanced cancer more often use denial as a coping mechanism.[9] Satisfaction with the delivery of bad news may be related to the physician's empathy, time spent on the discussion, and care taken in making the environment comfortable.[10]

The findings of the current study may improve information disclosure by raising awareness of physicians about the challenges that individuals aged 80 and older receiving noncurative treatment and those with cognitive impairment or severe comorbidities present.

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ACKNOWLEDGMENTS

We thank A. Wolfe, MD, for editing the manuscript and M. Di Palma, MD, for reviewing the manuscript.

Conflict of Interest: The authors have no conflicts of interest to disclose. The ELCAPA Study Group consisted of five geriatricians (P. Caillet, M. Laurent, E. Liuu, E. Paillaud, H. Vincent), two oncologists (S. Culine, Ch. Tournigand), one radiation oncologist (J.-L. Lagrange), three epidemiologists (F. Canouï-Poitrine, S. Bastuji-Garin, E. Audureau), one pharmacist (P.A. Natella), two biostatisticians (E. Guery, A. Le Thuaut), one clinical-research medical doctor (N. Reinald), and two clinical-research assistants (C. Poumba, E. Jan).

Author Contributions: Kempf: analyzed and interpreted data, drafting the article, approval of final version. Canouï-Poitrine: study design, data collection, revision of article, approval of final version. Rousseau, Tournigand: analyzed and interpreted data, revision of article, approval of final version. Le Thuaut: analyzed data, revision of article, approval of final version. Bastuji-Garin, Lagrange, Paillaud: study design, revision of article, approval of final version. Liuu: data collection, revision of article, approval of final version. Caillet: study design, drafting the article, approval of final version.

Sponsor's Role: The study was funded by the nonprofit organization French National Cancer Institute, which had no role in designing the study, collecting or analyzing the data, or writing the article.

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LARGE NONMELANOMA SKIN TUMORS IN OLDER ADULTS WITH MULTIPLE COMORBIDITIES: A CASE–CONTROL STUDY

To the Editor: The incidence of basal and squamous cell carcinoma, often referred to as nonmelanoma skin cancer (NMSC), is increasing worldwide and predominantly affects older adults as a result of cumulative lifetime sun exposure.[1,2] An estimated 5.4 million individuals were diagnosed with NMSC in the United States in 2012.[3] Tumors larger than 10 mm in diameter are often referred for tissue-sparing Mohs micrographic surgery to reduce surgical margins and preserve cosmesis.[4] Very large tumors may also require radiation treatment or systemic chemotherapy, which are each associated with significant toxicities.[5,6] The current study evaluated whether comorbidities affect NMSC tumor size at the time of diagnosis.

METHODS

This was a case–control study in which cases and controls were individuals with NMSC biopsied in a dermatology clinic at the Atlanta Veterans Affairs (VA) Medical Center (VAMC) from July 1, 2012, through December 31, 2014. The Atlanta VAMC teledermatology service initially