

Age in Head and Neck Cancer: It Matters When It Happens. Implications for the Speech Pathologist.

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INSTRUCTIONAL LEVEL: Intermediate

LEARNER OUTCOMES: After completing this activity, participants will be able to:

1. Describe demographic changes in the head and neck cancer (HNC) population and how they are expected to change in the future.
2. Explain the differences and similarities between younger and older cohorts in terms of their coping styles, preferences for informational counseling, and support needs.
3. Generate ideas for how this information can be utilized in new practice models to optimally serve the needs of HNC patients of all ages.

ABSTRACT:

Dramatic changes in the head and neck cancer (HNC) population are occurring. Human papillomavirus-associated HNC is dramatically increasing in younger adults while, simultaneously, the older population continues to grow. These groups have divergent needs in informational counseling, decision-making, coping styles, and support requirements, impacting care as will be discussed

SUMMARY:

The face of head and neck cancer has changed dramatically in the last 30 years. The number of tobacco and alcohol related squamous cell carcinomas have steadily declined, but there has been an increasing incidence of human papillomavirus (HPV) related cancers (Young et al., 2015). Estimates suggest that 70–90% of new oropharyngeal cancers may be related to HPV. These individuals differ from those who experienced HNC in the past in that they are more likely to be non-smoking adults in their 40's and 50's (Deschler et al., 2014). Survival rates for these patients are higher, likely due to HPV positive cancers being more responsive to treatment. At the same time that there has been a growth in the number of young adults with HNC, the number of elderly people with and surviving after HNC is also rising due to the increase in average lifespan in Western society in general (Syrigos et al., 2009). As with younger patients, elderly patients require a multidisciplinary approach in order to optimize treatment results but the prognosis for cure may be poorer (Koch et al., 1995).

There is relatively little information about the differences in management needs between younger and older adults with HNC. Drawing from other literature on disability, however, it is known that the sudden occurrence of a new disability (such as after surgery) is much more disruptive than those that are gradually occurring (such as the effects of chemoradiation). In a study of couples in which one partner had been diagnosed with multiple sclerosis (MS; Starks et al., 2010), for example, the authors identified two patterns of adaptation. Couples that were "in sync" were characterized by a relapsing-remitting type of MS that progresses more slowly,

allowing both partners to maintain their social roles and identities, and that this allowed for the development of a more collaborative problem-solving style. Couples that were “out of sync” had a more rapid progression of MS, which was associated with the loss of employment before retirement age, and struggles with preadolescent children. This type of disruption is also consistent with research about other adult-onset disabilities, such as visual impairment, in which it has been shown that middle-aged adults experience more disruption than older adults (Boerner & Wang, 2010). The higher number of problems reported by middle-aged adults may be due to greater complexity of their responsibilities, including work, marital, and child-rearing responsibilities, and also to the earlier onset of a disability being considered an “off-time event.” For younger adults, having undergone HNC treatment at an earlier age places them at greater risk for the occurrence of late side-effects of treatment which is one of the motivations for so-called de-escalation protocols to reduce the long-term burden of treatment (Masterson et al., 2014). For older adults, reduced functional reserve and the presence of comorbidities may make completing the full course of treatment more difficult (VanderWalde, et al., 2013) which may increase the need for support. Additionally, these comorbidities may increase the potential for complications from standard treatment toxicities leading to medical issues such as aspiration pneumonia. In some cases, older adults may face “age-ism” due to the fact that some providers may be less likely to recommend adequate treatment due to concerns about an individual’s age, resulting in reduced chances of cure (Sanabria, et al., 2007). In others, the benefit of more aggressive treatment is outweighed by the burden of side-effects (O’Neill, et al., 2015) and so it is clear that the optimal oncologic treatment protocols remain to be defined (Maggiore, 2014).

For the speech pathologist treating the HNC patient, an awareness of these demographic differences and how they may impact treatment is essential in providing knowledgeable and effective multi-disciplinary care. Evidence shows that the informational needs of HNC patients and their family members are often poorly addressed (Fang & Heckman, 2016). For younger adults with HPV-associated HNC, particular concerns may include signs and symptoms of recurrence, chances of being cured, rehabilitation after treatment, treatment and recovery timeframes, and financial assistance (Zimka, 2015). For older adults, central concerns may relate to treatment decision-making including uncertainty regarding appropriate clinical treatment and the potential for disfigurement and loss of independence resulting in diminished quality of life (Wallace, 2012). It also appears that the spouse or caregiver is often overlooked and disruption in their life as a result of the treatment burden can place them at risk for psychologic distress (Verdonck-de Leeuw et al., 2007). An area that remains to be explored is the impact on children whose parent undergoes HNC treatment. Evidence from other types of cancer treatment suggest that positive parental psychological function, marital satisfaction, and family communication are associated with lower levels of psychological distress in children (Visser et al., 2004).

In addition, the two groups may use very different coping styles during their course of treatment. Younger adults tend to use active coping strategies significantly more often and they perceived more internal control over the cause of their disease, while older patients used religious coping and religious control more frequently (Derks et al., 2005). The use of either type of coping strategy appears to be equally effective. However avoidance coping in both groups is associated with more depressive symptoms and worse quality of life. Longitudinally, there have been found to be no significant differences in the risk of depression and poor quality of life between younger and older adults (de Graeff et al., 2000) but older adults who are HNC survivors and experience depression are at increased risk of hospitalization (Laurence et al.,

2016). The fact that functional health and “physiologic age” are so important for management has spurred a growing interest in pre-screening older adults prior to treatment, in order to better provide individualized care and support during treatment using a team-based “gero-centric” approach (Maggiore, 2016). Practice guidelines less clear for younger adults but optimal models will likely draw from other programs targeting younger cancer patients and considering their specific needs and providing access to informational, educational, financial, and other types of support. It is likely that the speech pathologist will face increasing numbers of both younger and older patients with HNC in the future. Understanding the differences between these age cohorts in terms of their needs, preferences, expectations, and concerns will be central to the provision of knowledgeable rehabilitation and care. To quote from a recent *New York Times* article by Louise Aronson (2017):

The sad fact is that we frequently don’t know how to best care for the old. Treatments rarely target older adults’ particular physiology, and the old are typically excluded from clinical studies. Sometimes they are kept out based on age alone, but more often it’s because they have one of the diseases that typically accompany old age. And yet we still end up basing older people’s treatment on this research, because too often it is all we have. Equally troublesome is the failure of studies to measure outcomes that reflect older people’s priorities. Most would rather live comfortably and independently for a shorter time than live for a slightly longer time confined to a bed or nursing home... Life is a three-act play. It’s time our medical system reflected that truth.

Understanding the differences between these “three-acts” will enable clinicians to provide better informed, more meaningful, and more effective care.

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