

Geriatric Assessment-Guided Care for Older Adults with Cancer: A Clinical Practice Review

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ABSTRACT

Cancer is a growing global health burden among older adults, with incidence rising most rapidly in low- and middle-income countries. Chronological age alone poorly reflects physiological reserve, comorbidity, frailty, and functional status, which together determine how well an older patient tolerates cancer therapy. This clinical practice review summarizes contemporary geriatric oncology approaches based on international consensus guidelines and current literature. Comprehensive geriatric assessment (CGA), evaluating functional status, comorbidity, falls, cognition, mood, nutrition, polypharmacy, and social support, outperforms performance status alone in predicting chemotherapy toxicity, treatment completion, functional decline, and mortality. Beyond prognostication, randomized trials have shown that geriatric assessment-guided management reduces severe chemotherapy toxicity and improves communication about ageing-related concerns without compromising survival, which is the strongest argument for embedding assessment into routine oncology care. Validated brief screening tools such as the Geriatric-8 (G8) can identify patients who warrant full assessment, and chemotherapy toxicity calculators such as the Cancer and Aging Research Group and Chemotherapy Risk Assessment Scale for High-Age Patients scores improve risk estimation and support shared decision-making. Implementation remains the principal barrier in resource-limited settings, where geriatrician availability, clinic time, and reimbursement constrain routine use; pragmatic adaptations include nurse-led or self-administered assessment and stepwise screening pathways. Geriatric assessment-guided multidisciplinary care, adapted to local resources, should be regarded as the standard of care for older adults with cancer rather than an optional refinement, and deserves explicit incorporation into national cancer control planning.

Keywords: Geriatric assessment, neoplasms, aged, frailty, medical oncology, drug-related side effects and adverse reactions.

INTRODUCTION

Every year, more than five million new cancer cases occur among individuals aged 60 and older in low- and middle-income countries (LMICs), with the highest relative increase expected to occur in low- and lower-middle-income countries.¹ Indonesia, similar to many other countries in the region, is experiencing

this demographic transition along with an epidemiological transition from infectious diseases to non-communicable diseases, which demands management of the increasing number of older patients with care needs that far exceed tumor biology alone.²

Aging is a highly diverse process. Two patients of the same chronological age may have

distinct biological reserves.² Geriatric syndromes (frailty, sarcopenia, cognitive impairment, and mobility limitations), comorbidities, and polypharmacy pose challenges for anticancer treatment and are associated with an increased risk of unpredictable toxicity.² Traditional performance measures in oncology, such as the Eastern Cooperative Oncology Group (ECOG) performance status and Karnofsky Performance Status, were developed in clinical trial populations that are mostly younger and repeatedly shown to correlate poorly with the risk of chemotherapy-related complications in older patients.^{3,4} Nevertheless, older adults, especially those aged 75 and above, remain significantly underrepresented in the key clinical trials that form the basis of current treatment regimens.^{3,4}

GERIATRIC ASSESSMENT: DOMAINS, INSTRUMENTS, AND SCREENING STRATEGIES

Comprehensive geriatric assessment (CGA) is a multimodal and structured evaluation that identifies deficits typically undocumented during standard oncology history-taking and physical examination.^{3,4} The American Society of Clinical Oncology (ASCO) guidelines recommend that at least every patient over 65 years old considered for systemic therapy should be assessed for physical function, comorbidities, fall history, cognition, mental health, nutrition, polypharmacy, and social support.^{3,4} Each domain is mapped to an appropriate instrument: instrumental activities of daily living for functional status assessment, assessment of comorbidities and fall history in the past 6 months, Mini-Cog or MMSE or MoCA-Ina for cognition, Geriatric Depression Scale for depression screening, and nutritional risk assessment.^{3,4}

Because comprehensive multidomain assessment may take 20 minutes or more, quick screening methods are used to identify individuals who need more detailed examination. Geriatric-8 (G8) and Vulnerable Elders Survey-13 (VES-13) are validated screening tools, both independently associated with mortality and functional decline, and can be completed within 5 to 10 minutes.^{3,4} For patients undergoing chemotherapy, specific toxicity prediction tools provide additional

precision: the Cancer and Ageing Research Group (CARG) score, derived from patient-reported and laboratory variables, and the Chemotherapy Risk Assessment Scale for High-Age Patients (CRASH), which separately predicts the risk of hematologic and non-hematologic toxicity. Both are superior to the ECOG performance status in identifying patients at high risk of severe therapy-related complications for older adults.^{3,4}

To minimize the required time to integrate various separate instruments, ASCO, CARG, and the International Society of Geriatric Oncology jointly developed the Practical Geriatric Assessment (PGA), a single composite instrument that combines assessments for each recommended domain along with their evaluation guideline.^{4,5} **Table 1** displays the characteristics of the screening and primary assessment instruments described above.

USE OF G8 QUESTIONNAIRE FOR INITIAL SCREENING

The G8 assessment, as listed in **Table 2**, does not require laboratory results and can be performed by a nurse or trained non-physician staff in less than ten minutes, rendering it the most practical option to use.³⁻⁵ This instrument has been validated in the Indonesian older adult population with cancer.⁶⁻⁷ Its eight components are scored on a scale from 0 to 17, and a total score of 14 or less indicates significant vulnerability that requires comprehensive geriatric assessment.^{3,4} Several practical points about this instrument enhance its application in daily practice. First, the G8 should be administered before making treatment decisions, not afterward, because its purpose is to inform, not confirm, those decisions. Second, a normal G8 score does not eliminate the need for clinical assessment, as individuals with one significant issue, such as fall history with injury or new cognitive symptoms, may still require targeted follow-up even if the overall score appears reassuring. Third, since the G8 is derived from the Mini Nutritional Assessment, it is highly sensitive to nutritional and functional decline but less sensitive to isolated cognitive or mood disorders. Therefore, clinicians should not use it as a substitute for specific cognitive or depression screening when one is clinically suspected.^{3,4}

CHEMOTHERAPY TOXICITY CALCULATORS: CARG AND CRASH

Once a patient is identified as vulnerable/frail, either through an abnormal screening score or clinical suspicion, chemotherapy-specific

toxicity calculators can provide individualized toxicity risk estimates that can be communicated directly to patients and their families during shared decision-making. CARG and CRASH scores are the two most extensively validated

Table 1. Selected screening and assessment instruments used in geriatric oncology

Instrument	Domain/Item	Estimated Duration	Primary Use
G8	Appetite, weight loss, mobility, neuropsychological status, body mass index, polypharmacy, self-perceived health, age	5–10 minutes	Screening; predicting mortality and identifying the need for CGA
VES-13	Age, self-perceived health, physical function limitations, functional disabilities	5–10 minutes	Screening; predicting mortality, toxicity, and functional decline
CARG toxicity score	11 items: fall history, hearing, mobility, medication management, social activities, demographic and laboratory data	<5 minutes	Estimating the risk of grade 3–5 chemotherapy toxicity
CRASH score	Diastolic blood pressure, IADL, LDH levels, ECOG PS, MMSE, MNA, chemotherapy intensity	20–30 minutes	Independent risk of hematologic and non-hematologic toxicity
PGA	Function, fall history, nutrition, social support, mood, comorbidities, cognition, G8, CARG	15–20 minutes	Comprehensive multidomain assessment with related interventions
Screening of the Older Person with Cancer (SCOPE-C)	Eight customized domains for populations with limited resources and low literacy	~15 minutes	Screening and validated therapy tolerance prediction in India

IADL, Instrumental Activities of Daily Living; LDH, lactate dehydrogenase; ECOG PS, Eastern Cooperative Oncology Group performance status; MMSE, Mini-Mental State Examination; MNA, Mini Nutritional Assessment.

Table 2. G8 questionnaire

No	Item/Question	Score	Description
A	In the last 3 months, has your food intake decreased due to loss of appetite, digestive problems, or difficulty chewing or swallowing?	0	Severe decrease in food intake (only a few spoons)
		1	Moderate decrease in food intake (half of what it was before)
		2	No decrease in food intake
B	Weight loss in the last 3 months	0	Weight loss >3 kg
		1	Does not know
		2	Weight loss 1-3 kg
C	Mobility	3	No weight loss
		0	Bed or chair bound
		1	Able to get out of bed or wheelchair but limited
D	Neuropsychological disturbances or increasingly severe memory impairments	2	Goes out
		0	Severe depression or dementia
		1	Mild depression or dementia
E	Body mass index (BMI) (kg/m²)	2	Normal
		0	BMI < 18,5
		1	18,5 ≤ BMI < 21
F	Consumed medications for more than 3 days	2	21 ≤ BMI < 23
		3	BMI ≥ 23
		0	Yes
G	Compared with other people of the same age, how does the patient perceive his/her health status?	1	No
		0	Not as good
		0.5	Does not know
H	Age	1	As good
		2	Better
		0	>85 years old
		1	80-85 years old
		2	<80 years old
Total score			
If the score is ≤ 14, a geriatric assessment is indicated			

instruments for this purpose. Both aim to predict the risk of severe chemotherapy-related toxicity; however, they differ substantially in design. Therefore, selection of the appropriate tool should be guided by the specific clinical question and the resources available at the point of care.^{3,4} The practical differences between the two instruments are summarized in **Table 3**.

Both instruments are complementary in practice. They are regarded as decision-support tools and should not be used independently from clinical judgment or the patient's individual treatment goals.^{3,4} Other prediction research incorporating geriatric assessment in Indonesian older adults with cancer shows that polypharmacy, poly-chemotherapy, frailty and GI cancer increase the risk of severe chemotoxicity.⁸

In addition to overall assessment, pre-chemotherapy organ function evaluation is an essential step due to the narrow therapeutic index of most cytotoxic agents. Consequently, impaired organ function may result in drug accumulation and increased toxicity. Baseline evaluation should include hematologic parameters (hemoglobin, leukocyte count, platelet count), hepatic function (aspartate aminotransferase/AST, alanine aminotransferase/ALT, bilirubin levels), renal function (serum creatinine and estimated glomerular filtration rate/eGFR), and

cardiac function (echocardiography), especially when cardiotoxic agents are being considered.

Myelosuppression is a major dose-limiting toxicity associated with numerous chemotherapy agents, including alkylating agents, antimetabolites, and platinum-based therapies, and is associated with dose reductions and adverse clinical outcomes. Hepatic function is important for the metabolism of several chemotherapeutic agents, including taxanes, anthracyclines, and irinotecan, in which hepatic impairment may increase the risk of systemic toxicity. Additionally, renal function has a pivotal role in the elimination of agents such as cisplatin, carboplatin, methotrexate (MTX), and ifosfamide. Reduced renal function may increase the risk of nephrotoxicity and necessitate dose adjustment or close monitoring, including therapeutic drug monitoring for certain agents.

Some chemotherapeutic agents may also cause organ-specific toxicities, including neurotoxicity associated with vincristine and paclitaxel, and pulmonary toxicity related to bleomycin. Thus, comprehensive assessment of organ function before chemotherapy is important to determine treatment eligibility, optimize dosing, and minimize potentially life-threatening complications.

Table 3. Practical comparison of the CARG and CRASH chemotherapy toxicity calculators

Characteristic	CARG score	CRASH score
Validated population	Adults aged ≥65 years with solid tumors or lymphoma who are scheduled to initiate any line of chemotherapy	Adults aged ≥70 years with histologically confirmed cancer who are scheduled to initiate a new chemotherapy regimen
Estimated duration for assessment	Less than 5 minutes; primarily consists of patient-reported items supplemented by routine laboratory values	20-30 minutes; requires completion of several embedded geriatric assessment instruments, including the IADL, MMSE, and MNA
Outcome	A single overall estimate of the risk of grade 3-5 toxicity, expressed as a percentage.	Two separate estimates: grade 3 hematologic toxicity and grade 3-4 non-hematologic toxicity, adjusted for chemotherapy intensity
Primary advantages	Rapid, freely accessible online, and feasible for point-of-care use with minimal staff burden	This instrument serves as a comprehensive assessment rather than merely a screening tool.
Limitations	Provides a composite estimate of toxicity risk without distinguishing specific types of toxicity, which may limit its utility for regimen-specific dose planning	The time and training required make it less feasible for high-volume or resource-limited clinical settings
Best clinical use	A rapid, general estimate of overall toxicity risk is needed to support time-limited clinical consultations.	A comprehensive geriatric assessment is already planned or available, or when separate stratification of hematologic versus nonhematologic toxicity risk would influence regimen selection.

BENEFITS OF GERIATRIC ASSESSMENT-BASED RISK STRATIFICATION

The clinical value of CGA depends on the extent to which its findings are translatable into actionable interventions, known as geriatric assessment-guided management (GAM). It is defined as the use of assessment findings to modify treatment intensity and trigger targeted non-oncologic interventions, such as physiotherapy referral, nutritional counselling, or medication review.^{3,4}

This approach has been directly evaluated in several large randomized trials since 2020. In the GAP70+ trial conducted in community oncology practices, providing oncologists with a geriatric assessment summary and management recommendations reduced the incidence of grade 3-5 chemotherapy toxicity from 71% to 51% and reduced falls over 3 months, while also increasing medication discontinuation.⁴ The GAIN trial, conducted at an academic cancer center, demonstrated a similar reduction in toxicity and a significant improvement in completion of advance directives, with no evidence of adverse effects on overall survival.⁴ Among patients with colorectal cancer, the GERICO study revealed higher chemotherapy completion rates without dose reduction when geriatric assessment-guided care was implemented, accompanied by improved quality of life.⁴ The COACH trial showed that providing oncologists with a geriatric assessment summary improved patient and caregiver satisfaction with communication regarding aging-related concerns.⁴

Other clinical trials have yielded more mixed results. The 5C and INTEGRATE studies demonstrated improvements in quality of life. In INTEGRATE, geriatric assessment-guided management was also associated with fewer potentially avoidable hospitalizations, although neither study exhibited a survival benefit.^{4,5} In the EGeSOR trial enrolling patients with head and neck cancer, as well as in subsequent tailored trials involving patients with gastrointestinal and thoracic cancers, no significant differences were observed in the respective primary composite outcomes. Overall, the evidence suggests

that geriatric assessment-guided management consistently reduces treatment-related toxicity and improves patient-centered outcomes, including communication, satisfaction, and completion of advance care planning.⁴

FRAILITY ASSESSMENT-BASED ALGORITHM FOR CHEMOTHERAPY DECISION-MAKING

After the treating oncologist has selected the chemotherapy regimen according to the evidence from screening, assessment, and toxicity prediction discussed in this review,^{3,4,9} a pragmatic four-step approach can be applied consistently across tumor types. The algorithm stratifies patients as fit, vulnerable, or frail and links each category to a specific, actionable treatment strategy. **Table 4** provides details of the four steps.

GERIATRIC SYNDROMES ASSESSMENT IN OLDER ADULTS WITH CANCER

Frailty, defined as a state of diminished physiological reserve across multiple organ systems, has emerged as a key concept in geriatric oncology because it captures vulnerability that may not be fully reflected by any single GA domain.⁹ A recent scoping review demonstrated substantial heterogeneity in the operational definitions of frailty across cancer studies, limiting direct comparisons of reported prevalence and outcome estimates and underscoring the need for standardized, validated instruments in future clinical trials.⁸ Recent composite instruments developed specifically for patients with cancer, such as the Multidimensional Oncological Frailty Scale, seek to provide a rapid, cancer-specific alternative to time-intensive comprehensive assessments while maintaining predictive accuracy for mortality.¹¹ Frailty status has also been shown to influence the clinician-patient relationship: frail older adults with advanced cancer are less likely to discuss aging-related concerns during oncology visits, highlighting the additional communication-related consequences of unrecognized frailty.⁷ Frailty and its associated symptom burden are independently associated with poorer health-related quality of life among older cancer survivors after completion of treatment, beyond the effects of treatment

Table 4. Practical four-step algorithm for frailty-based chemotherapy decision-making in older adults with cancer

Step	Description	Classification	Recommended Action
1. Screening	Perform G8 (or VES-13) screening in all patients aged ≥60 years (prioritizing those aged ≥70 years when resources are limited) at the treatment-planning visit.	G8 >14: negative screening G8 ≤14: positive screening	Negative screening → proceed to Step 3 (fit pathway) Positive screening → proceed to Step 2
2. Assessment	Complete a full multidomain geriatric assessment and administer a chemotherapy toxicity calculator (CARG as the first-line tool; CRASH when more detailed assessment of hematologic toxicity risk is required)	Fit: no or one mild geriatric assessment impairment, low risk of toxicity Vulnerable: impairment in 1-2 domains, moderate risk of toxicity Frail: ≥3 impaired domains, ADL dependence, severe comorbidity, or high risk of toxicity	Assign the frailty category and proceed to Step 3
3. Decision	Apply the treatment strategy corresponding to the assigned frailty category.	Fit → standard-dose regimen with standard scheduling Vulnerable → modified regimen Frail → geriatric optimization before treatment initiation	Fit: standard chemotherapy according to guideline recommendations, with routine monitoring Vulnerable: single-agent therapy rather than combination (doublet) therapy; consider an initial dose reduction (e.g., ~20%) with escalation according to tolerance; increase the frequency of toxicity monitoring; and provide parallel referrals for geriatric assessment-guided interventions, including physiotherapy, nutritional support, and medication review Frail: address reversible conditions (e.g., malnutrition, depression, and polypharmacy) before deciding on cytotoxic therapy; involve a geriatrician or primary care physician; discuss best supportive care, less-intensive or non-curative treatment approaches, or a short therapeutic trial with close monitoring; and conduct explicit goals-of-care discussions involving the patient and caregiver.
4. Re-evaluation	Repeat brief screening or targeted geriatric assessment at each new treatment cycle, upon disease progression, following hospitalization, or after grade ≥3 toxicity.	Patients may transition between categories over time	Adjust treatment dose, schedule, or supportive interventions as clinically indicated; the initial classification should not be regarded as fixed throughout the course of treatment

toxicity and survival, further supporting the need for serial rather than one-time assessment.¹⁰⁻¹²

Sarcopenia, characterized by progressive loss of skeletal muscle mass and strength, commonly co-occurs with frailty and malnutrition and independently predicts postoperative morbidity, prolonged hospital length of stay, and poorer oncologic outcomes following cancer surgery.¹⁴ This recognition has driven increasing interest in prehabilitation, defined as structured

optimization of physical function, nutritional status, and psychological well-being delivered over several weeks before a planned oncologic intervention. Multimodal prehabilitation programs incorporating aerobic and resistance exercise alongside nutritional supplementation have been associated with improved preoperative functional capacity, reduced loss of lean body mass, and, in some studies, fewer postoperative complications following abdominal, esophagogastric, and other

major cancer surgeries. Nevertheless, the quality of clinical trials and duration of interventions remain heterogeneous, highlighting the need for adequately powered studies.¹⁴⁻¹⁷ Feasibility studies such as the PROADAPT program suggest that structured prehabilitation pathways can be integrated into routine oncology care for older adults undergoing planned surgery.¹⁶ Similar supportive-care approaches are being developed for older adults with hematologic malignancies, including lymphoma, who may be disproportionately vulnerable to complications from standard-intensity regimens, to minimize toxicity while preserving functional status and quality of life.¹⁸

Cognitive screening is an essential and non-negotiable component of geriatric assessment, as unrecognized cognitive impairment can affect nearly every subsequent step in patient care. A positive screening result on a brief instrument, such as the Mini-Cog, does not in itself establish incapacity, but should prompt careful evaluation of the patient's ability to understand, retain, and weigh the information necessary to provide informed consent for the proposed treatment plan.^{3,4} Structured counselling of patients and families regarding the risk of delirium, together with medication review to minimize exposure to agents with high anticholinergic or sedative burden, is recommended whenever cognitive screening yields an abnormal result,^{3,4} because chemotherapy, surgery, and hospitalization independently increase the risk of delirium in cognitively vulnerable older adults. Referral to a geriatrician for more comprehensive cognitive assessment is indicated when the diagnosis or severity of impairment is unclear or when it is likely to substantially influence treatment recommendations.^{4,5}

Polypharmacy and the use of potentially inappropriate medications are common among older adults with cancer and have been associated with greater treatment-related toxicity, hospitalization, and, among patients with hematologic malignancies, an increased likelihood of frailty.²⁰ These findings have positioned deprescribing, the planned and supervised reduction or discontinuation of medications for which the potential harms now

outweigh the expected benefits, as an explicit goal of CGA-based interventions, particularly for patients with limited life expectancy, for whom preventive medications may no longer provide meaningful benefit within their remaining lifespan.¹⁹ Pharmacist-led medication reviews integrated into oncology practice have been shown to identify a substantial proportion of medications that may be appropriate for discontinuation.²¹

The rapid adoption of immune checkpoint inhibitors and targeted therapy into standard clinical practice has transformed treatment options for many tumor types. However, older adults, particularly those aged ≥ 80 years, remain underrepresented in the clinical trials underpinning these regimens, and population-specific questions, such as the interplay among frailty, immune senescence, and treatment tolerability, remain areas of active investigation.⁴ Current guidelines extrapolate the same CGA principles applied to chemotherapy to patients being considered for immunotherapy or targeted therapy, based on the premise that baseline vulnerabilities identified by CGA, including fall history, cognitive impairment, comorbidities, and functional dependence, remain relevant to treatment toxicity and management regardless of the therapeutic modality used.⁴

LIFE EXPECTANCY ESTIMATION AND SHARED DECISION-MAKING

Because many cancer therapies offer delayed benefits relative to their immediate harms, estimation of non-cancer life expectancy is a necessary complement to CGA when the goal of treatment is long-term recurrence prevention instead of immediate symptom control.^{3,4} Validated prognostic indexes, such as the Schonberg and Lee index, which were primarily derived from North American cohorts, are available through the freely accessible ePrognosis platform and estimate mortality over approximately four- to fourteen-year time horizons using variables that substantially overlap with geriatric assessment domains, including age, comorbidities, functional status, and self-perceived health.^{3,4} Despite these indexes being developed primarily in high-

income, English-speaking populations, their applicability in other settings remains limited. The Suemoto index, which was validated using cohorts that included populations from Mexico and Brazil, is therefore recommended for use outside North America. When no sufficiently representative prognostic index is available, locally derived actuarial life-expectancy tables stratified by health status may provide a pragmatic alternative.⁵

POTENTIAL FOR IMPLEMENTATION IN INDONESIA

The evidence base in geriatric oncology has been developed predominantly in high-income, resource-rich settings, although the greatest growth in the number of older adults with cancer is occurring in low- and middle-income countries (LMICs), where geriatric expertise, multidisciplinary teams, and dedicated screening approaches often remain scarce.¹ The 2025 ASCO global guideline acknowledges this disparity and adapts its recommendations into a tiered framework comprising basic, limited, and advanced resource settings. Within this framework, clinicians are encouraged to use at least a validated brief screening instrument, such as the G8, with locally adapted cutoff values where available, and to escalate to more comprehensive assessment and management according to resource availability, even when a full multidisciplinary geriatric assessment cannot be performed.⁵ Similarly, the 2025 AGOS guideline provides a practical roadmap for implementing geriatric oncology services within Asian healthcare systems, emphasizing stakeholder engagement and the phased implementation of services.^{2,25}

Telehealth and internet-based platforms provide additional avenues for expanding the reach of geriatric oncology services. A remote geriatric assessment and multidisciplinary intervention program implemented across diverse regions of Brazil, including rural and low-income areas, demonstrated measurable improvements in physical function and health-related quality of life. These findings suggest that the geographic and workforce barriers characteristic of many LMICs, including much of Indonesia outside

major urban centers, may be at least partially addressed through structured telemedicine models without requiring the physical presence of a geriatrician at every location.²⁴ In the Indonesian context, these findings suggest a potentially feasible implementation strategy: integrating brief screening instruments such as the G8 into routine oncology consultations, training oncology nurses or other appropriately trained non-physician healthcare personnel to administer more detailed, locally adapted assessment instruments, and establishing telemedicine links with specialized geriatric centers, such as those affiliated with academic hospitals, to support the care of patients identified as frail.

Despite continued endorsement in multiple guidelines, the implementation of geriatric assessment in routine oncology practice remains limited, even in high-resource settings. Surveys consistently identify time constraints, uncertainty regarding which assessment instruments to use, and inadequate staff training as major barriers.⁴ These challenges are further compounded in LMICs by the relative scarcity of specialist expertise and multidisciplinary infrastructure.^{1,2} Standardization of frailty measurement is also needed. Currently, there remains limited consistency in the operational definitions of frailty across studies, which restricts the ability to compare prognostic and interventional outcomes.⁸

CONCLUSION

Older adults with cancer represent a rapidly growing and highly physiologically heterogeneous population. For these patients, chronological age and conventional oncology performance status measures provide an insufficient basis for treatment decision-making. Comprehensive, multidomain geriatric assessment, initiated through validated brief screening methods and explicitly linked to specific therapeutic decisions, identifies vulnerabilities that can meaningfully influence treatment tolerability and patient-centered outcomes. For countries such as Indonesia, locally validated, tiered assessment approaches and telehealth-supported multidisciplinary models offer practical, evidence-based strategies for integrating the benefits of geriatric assessment into routine clinical practice.

CONFLICT OF INTERESTS

The authors declare no conflicts of interest.

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