Geriatric Core Dataset (G-CODE) for cancer clinical trial:

Reference: Paillaud E et al. Multidisciplinary Development of a Geriatric COre DatasEt (G-CODE) for clinical research in older patients with cancer: a French initiative with international survey European Journal of Cancer sous press Article reference: EJC10776

1. Social environment: 2 questions

- "Do you live alone?" Y/N

For people living in nursing homes, the answer is « no ».

- "Do you have any person able to provide you care and support?" Y/N

Answering "yes" to this question means that the patient has a primary caregiver, support at home, or a strong circle of family / friends / neighbor capable of meeting the patient's needs at the time of the evaluation.

2. Functional status: ADL and 4-IADL

Activities of Daily Living – ADL Score: ..../6

ADL scored according to the following table from *Katz S, Ford AB, Moskowitz RW, et al: Studies of illness in the aged: The index of ADL—A standardized measure of biological and psychosocial function. JAMA 1963; 185:914-9), and score for each item as:1: independence (left column) – ½: need some help (center column) – 0: dependence (right column):*

Recommendations for scoring are summarized in the following table:

ADL	Scoring: 1: independence – ½: need some help – 0: dependence			
Bathing	0	½	1	Bathes self completely or needs help in bathing only a single part of body such as the back.
Dressing	0	½	1	Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.
Toileting	0	½	1	Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.
Transferring	0	½	1	Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable.
Continence	0	½	1	Exercises complete self-control over urination and defecation.
Feeding	0	½	1	Gets food from plate into mouth without help. Preparation of food may be done by another person.

Instrumental Activities of Daily Living – 4-IADL Score: ..../4

IADL scored according to the following table from *Lawton MP, Brody EM. Assessment of older people: Self-maintaining and instrumental activities of daily living. The Gerontologist 1969; 9(3): 179-86. And Barberger-Gateau P, Dartigues JF, Letenneur L. Four Instrumental Activities of Daily Living Score as a predictor of one-year incident dementia. Age Ageing. 1993 Nov;22(6):457-63.*

4-IADLScoring: For each category, circle the item description that most closely resembles the patient's highest functional level (either 0 or 1)	**Score**
Ability to Use Telephone: **1** Operates telephone on own initiative-looks up and dials numbers etc. **1** Dials a few well-known numbers **1** Answers telephone but does not dial **0** Does not use telephones at all	0 or 1
Mode of transportation **1** Travels independently on public transportation or drives own car **1** Arranges own travel via taxi, but does not otherwise use public transportation **1** Travels on public transportation when accompanied by another **0** Travel limited to taxi or automobile with assistance of another **0** Does not travel at all	0 or 1
Responsibility for own medications: **1** Is responsible for taking medication in correct dosages at correct time **0** Takes responsibility if medication is prepared in advance in separate dosage. **0** Is not capable of dispensing own medication	0 or 1

Ability to handle finances: **1** Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income **1** Manages day-to-day purchases, but needs help with banking, major purchases, etc. **0** Incapable of handling money	0 or 1

3. Mobility: Time Get Up and Go test (TUG)

TUG scored according to the following table *from Podsiadlo D, Richardson S. The Timed "Up & Go": A test of basic functional mobility for frail elderly persons. Journal of the American Geriatric Society 1991, 39 (2), 142-148.*

Instructions to the patient: When I say "Go," I want you to:

-Stand up from the chair; you may use the arms of the chair to stand up
-Walk to the line on the floor (3 meters) at your normal pace (I want you to move as quickly as you feel safe)
-Turn
-Walk back to the chair at your normal pace
-Sit down again; you may use the arms of the chair to sit down.

On the word "Go" begin timing. Stop timing after patient has sat back down and record. The patients may use any gait aid that they normally use during ambulation, but may not be assisted by another person.

4. Nutritional Status: Weight loss during the last 6 months and BMI. If one of the test is abnormal, the nutritional status is considered impaired.

Weight loss during the last 6 months.

BMI = weight (kg) / height^2 (m).

5. Cognitive status: Mini-Cog^{TM}

Mini-Cog scored according to the following *table from Borson S, Scanlan JM, Chen PJ et al. The Mini-Cog as a screen for dementia: Validation in a population-based sample. J Am Geriatr Soc 2003;51:1451–1454. And Borson S, Scanlan J, Brush M, Vitaliano P, Dokmak A. The mini-cog: a cognitive 'vital signs' measure for dementia screening in multi-lingual elderly. Int J Geriatr Psychiatry. 2000;15(11):1021-7.*

Instructions to the patient:

1. Three-word registration: "Please listen carefully. I'm going to say three words that I want you to repeat back to me now and try to remember."

Examples:

- Banana – sunrise – chair
- Leader – season – table

2. Clock drawing: "I want you to draw a clock for me using this preprinted circle. First put in all of the numbers where they go. Then, when it's completed, set the hands to 10 past 11". Scoring clock draw = 0 or 2 points
   Normal clock= 2 points ; inability or refusal to draw a clock=0 points
3. Three-word recall: "What were the three words I asked you to remember?"
   Scoring word recall = 0 to 3 points. 1 point for each word spontaneously recalled without cueing.

If necessary, use the following link:
https://www.alz.org/documents_custom/minicog.pdf

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6. Depressive mood: Mini-GDS

Mini-GDS scored according to the following table from *Cheng, S.-T., & Chan, A.C.M. (2005). Comparative performance of long and short forms of the geriatric depression scale in mildly demented Chinese. International Journal of Geriatric Psychiatry, 20, 1131–1137. And Clément JP, Nassif RF, Léger JM, Marchan F. Development and contribution of a brief French version of the Yesavage Geriatric Depression Scale [in French]. Encephale. 1997;23:91-99*

Mini-GDS		
Are you basically satisfied with your life?	YES = 0	**NO = 1**
Do you feel that your life is empty?	**YES = 1**	NO = 0
Do you feel happy most of the time?	YES = 0	**NO = 1**
Are you afraid that something bad is going to happen to you?	**YES = 1**	NO = 0
0 = not depressed 1 = uncertain 2 to 4 = depressed **Score**	___ **/ 4**	

7. Comorbidities: Updated Charlson Comorbidity Index (updated CCI) (maximum=24).

Updated CCI scored according to the following table from *Quan H, Li B, Couris CM, et al. Updating and validating the Charlson comorbidity index and score for risk adjustment in hospital discharge abstracts using data from 6 countries. Am J Epidemiol. 2011;173(6):676-82*

Circle the item when the patient presents the comorbid condition, and add each point to obtain the total score. Cancer or hematological malignancy has to be scored as well.

- Metastatic solid tumor: 6 pts
- AIDS/HIV: 4 pts
- Moderate / severe liver disease: 4 pts
- Any malignancy, including leukemia and lymphoma: 2 pts
- Mild liver disease: 2 pts
- Hemiplegia or paraplegia: 2 pts
- Congestive heart failure: 2 pts
- Dementia: 2 pts
- Chronic pulmonary disease: 1 pt
- Rheumatologic disease: 1 pt
- Renal disease: 1 pt
- Diabetes with chronic complications: 1 pt

Score …./24