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## RT nelle pazienti anziane

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Fondazione del Piemonte per l'Oncologia

# Management of elderly patients with breast cancer: updated recommendations of the International Society of Geriatric Oncology (SIOG) and European Society of Breast Cancer Specialists (EUSOMA)

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As the mean age of the global population increases, breast cancer in older individuals will be increasingly encountered in clinical practice. Management decisions should not be based on age alone. Establishing recommendations for management of older individuals with breast cancer is challenging because of very limited level 1 evidence in this heterogeneous population. In 2007, the International Society of Geriatric Oncology (SIOG) created a task force to provide evidence-based recommendations for the management of breast cancer in elderly individuals. In 2010, a multidisciplinary SIOG and European Society of Breast Cancer Specialists (EUSOMA) task force gathered to expand and update the 2007 recommendations. The recommendations were expanded to include geriatric assessment, competing causes of mortality, ductal carcinoma in situ, drug safety and compliance, patient preferences, barriers to treatment, and male breast cancer. Recommendations were updated for screening, primary endocrine therapy, surgery, radiotherapy, neoadjuvant and adjuvant systemic therapy, and metastatic breast cancer.

| | 2007 recommendations (SIOG) | Current recommendations (SIOG/EUSOMA) |
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| General recommendations for all aspects of management | .. | All management decisions for an older individual with breast cancer should consider:<br>Physiological age<br>Life expectancy<br>Potential risks vs absolute benefits<br>Treatment tolerance<br>Patient preference<br>Potential barriers to treatment |
| Competing causes of mortality | .. | Relative breast-cancer survival is the preferred way to describe the outcome of older patients with breast cancer<br>Assessment of comorbidity and function can predict likelihood of dying from non-breast cancer causes |
| Geriatric assessment | .. | Collaborative geriatric and oncology management can optimise care<br>General health and functional status can be captured in a multidomain geriatric assessment; however, it is unclear which elderly patients are most likely to benefit and which method is best<br>A screening assessment is a reasonable first step in identifying patients that may benefit from an extended CGA<br>Active intervention for CGA-identified reversible geriatric domains can reduce morbidity and mortality, and improve quality of life<br>Serial geriatric assessment can identify incident deterioration, for which intervention might improve outcomes |
| Screening mammography | There are no strong data for screening mammography in women older than 70 years<br>Screening in women aged 70–75 years could be appropriate with the individual decision based on risks and benefits, patient preference, physiological age, and life expectancy | There are no strong data for screening mammography in women older than 70 years<br>Screening in women aged 70–75 years could be appropriate with the individual decision based on risks and benefits, patient preference, physiological age, and life expectancy |
| Ductal carcinoma in situ (DCIS) | .. | There are no strong data available for treatment of older women with DCIS<br>Healthy older women with localised DCIS should be considered for BCS and postoperative radiotherapy |

Impossibile visualizzare l'immagine. La memoria del computer potrebbe essere insufficiente per aprire l'immagine oppure l'immagine potrebbe essere danneggiata. Riavviare il computer e aprire di nuovo il file. Se viene visualizzata di nuovo la x rossa, potrebbe essere necessario eliminare l'immagine e inserirla di nuovo.

| | 2007 recommendations (SIOG) | Current recommendations (SIOG/EUSOMA) |
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| Primary endocrine therapy | In healthy older women, primary endocrine therapy with tamoxifen is inferior to surgery (with or without hormonal therapy) for local control and PFS, without significant difference in overall survival<br>Data for primary therapy with aromatase inhibitors are missing | Primary endocrine therapy should only be offered to elderly individuals with ER-positive tumours who have a short estimated life expectancy (<2–3 years), who are considered unfit for surgery after optimisation of medical conditions or who refuse surgery<br>The involvement of a geriatrician is strongly recommended to estimate life expectancy and guide management of reversible comorbidities<br>It is reasonable to choose tamoxifen or an aromatase inhibitor based on potential side-effects |
| Adjuvant hormone therapy | There is no age-dependent efficacy of tamoxifen or aromatase inhibitors<br>Efficacy is slightly greater with aromatase inhibitors in terms of DFS; however, elderly patients are more vulnerable to toxicity and safety is important in choice of agent<br>Initial treatment should be tamoxifen or an aromatase inhibitor<br>Patients given tamoxifen up front should be considered for a switch to an aromatase inhibitor after 2–3 years | There is no age-dependent efficacy of tamoxifen or aromatase inhibitors<br>Efficacy is slightly greater with aromatase inhibitors; however, elderly patients are more vulnerable to toxicity and safety is important in choice of agent<br>Initial treatment should be tamoxifen or an aromatase inhibitor. Patients given tamoxifen should be considered for a switch to an aromatase inhibitor after 2–3 years. Extension of adjuvant treatment with an aromatase inhibitor after 5 years of tamoxifen could be considered for healthy elderly patients<br>Omission of endocrine therapy is an option for patients with a very low-risk tumour (pT1aN0) or life-threatening comorbidities |
| Adjuvant chemotherapy | The decision to treat with adjuvant chemotherapy should not be age-based<br>Older patients with node-positive, hormone-receptor negative disease potentially derive the largest benefit<br>Four cycles of an anthracycline-containing regimen are usually preferred over CMF<br>In healthy patients with high-risk disease, taxanes should be considered in addition to anthracyclines<br>TC or CMF can replace anthracyclines in patients with cardiac risk<br>Patients with HER2-positive breast cancer, without cardiac disease, should be offered trastuzumab in combination with chemotherapy | The decision to treat with adjuvant chemotherapy should not be age-based<br>Older patients with node-positive, hormone-negative disease potentially derive the largest benefit<br>Four cycles of an anthracycline-containing regimen are usually preferred over CMF<br>Standard AC and CMF chemotherapy are better than single-agent capecitabine<br>Taxanes are associated with increased toxicity compared with younger women, but can be added to anthracyclines in high-risk healthy elderly patients, or replace anthracyclines to reduce the cardiac risk<br>Patients with HER2-positive breast cancer, without cardiac disease, should be offered trastuzumab in combination with chemotherapy (see text) |
| Metastatic breast cancer | Hormone treatment is the treatment of choice for older women with ER-positive metastatic breast cancer<br>Chemotherapy is indicated for ER-negative, hormone-refractory, or rapidly progressing disease<br>Single-agent chemotherapy is preferred to combination regimens; however, evidence for specific monotherapy in elderly patients is limited<br>Dose reductions and schedule modifications are controversial, but should be considered based on pharmacology and toxicity<br>Patients with HER2-positive disease should receive trastuzumab and chemotherapy<br>Data for bevacizumab efficacy and toxicity is limited | Hormone treatment is the treatment of choice for older women with ER-positive metastatic breast cancer<br>Chemotherapy is indicated for ER-negative, hormone-refractory, or rapidly progressing disease<br>Single-agent chemotherapy and combination oral chemotherapy are feasible options in elderly patients<br>Dose reductions and schedule modifications are controversial, but should be considered based on pharmacology and toxicity<br>Patients with HER2-positive disease should receive HER2-targeted therapy and chemotherapy<br>In patients with HER2-positive ER-positive disease with a contraindication to chemotherapy, or without life threatening disease, anti-HER2 therapy plus endocrine therapy is an option<br>In patients with HER2-positive ER-negative disease, trastuzumab monotherapy could be reasonable<br>Bevacizumab is active in elderly patients in terms of increased PFS; however, toxicity and cost efficacy are important issues that need to be further elaborated |

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| Drug safety and compliance | - | Careful drug prescription is warranted because of physiological age-related pharmacokinetic alteration, comorbidities, and polypharmacy<br>Renal function evaluation is mandatory for treatment with renally excreted or nephrotoxic drugs<br>A thorough medication review is advised, ideally involving a clinical pharmacist<br>Drug compliance should be actively promoted<br>Close adverse event monitoring to allow prompt intervention is recommended, since elderly patients have lower physiological reserve, side-effects can present in an atypical way, and unaddressed toxicity can compromise compliance |
| Patient expectations | - | Physicians should provide clear information to elderly patients with breast cancer on prognosis, treatment options, expectations of treatment, and potential toxicity<br>Physicians should be attentive to the expectations and preferences of individuals, with particular attention to quality of life |
| Barriers to treatment | - | Barriers to therapy should be identified and addressed<br>Special attention should be paid to comorbidity (particularly cognitive status, anxiety, and depression) and social setting (particularly transport) that can affect patient decisions<br>Physician bias should not influence management<br>Family and caregivers cannot reliably predict patient preferences, and caregiver bias should not unduly influence management |
| Male breast cancer | - | In older men with breast cancer, there is only indirect evidence on which to base treatment guidelines<br>It is reasonable to follow guidelines for post-menopausal women for surgery, radiotherapy, chemotherapy, and anti-HER2 therapy<br>Tamoxifen is indicated for ER-positive disease, whereas there is insufficient data on aromatase inhibitors in elderly men with breast cancer to allow recommendations |

SIOG=International Society of Geriatric Oncology. EUSOMA=European Society of Breast Cancer Specialists. CGA=comprehensive geriatric assessment. BCS=breast-conserving surgery. WBRT=whole-breast radiotherapy. ALND=axillary lymph-node dissection. SLNB=sentinel lymph-node biopsy. PBI=partial-breast irradiation. PFS=progression-free survival. ER=oestrogen receptor. DFS=disease-free survival. CMF=cyclophosphamide, methotrexate, and fluorouracil. TC=docetaxel and cyclophosphamide. AC=cyclophosphamide plus doxorubicin.

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## Conclusions

No aspect of management of older individuals with breast cancer should be driven by chronological age alone. A multidisciplinary oncological and geriatric approach can optimise management. Patient preference, comorbidities, and potential toxicity should guide management decisions. Patients should be closely monitored, with prompt intervention for toxicity. Several breast-cancer trials in older individuals have closed prematurely because of poor accrual. In some settings, prospective subgroup analyses and observational studies could be practical alternative sources of information to guide management.