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Editorial Comment

Management of primary breast cancer in the elderly patient

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The results of two European Organisation for Research and Treatment of Cancer (EORTC) trials on the treatment of the elderly (over 70 years), are published in this issue of the *EJC*.

One compared modified radical mastectomy (MRM) with wide local excision plus tamoxifen (WLE + T). Locoregional recurrence (LRR) was higher in the WLE + T group, at a median follow-up of around 10.5 years an actuarial rate of 30% was seen. Unfortunately, the number randomised did not allow for LRR to be further analysed to 'in breast' recurrence and axillary, but this rate does not justify the authors' conclusion that WLE + T is a safe breast-conserving regime. LRR after MRM was 20%, which many would think too high for this operation and this tends to invalidate the interpretation of the authors that LRR after breast conservation is only a little higher than after mastectomy.

The other trial showed (in only 164 patients) that primary medical therapy with tamoxifen (and without surgery until recurrence) again gave a higher rate of LRR than MRM; survival was reported as 'similar'. Do we accept the authors' conclusion, that Tamoxifen alone leads to an 'unacceptably' high rate of LRR?

There have been other trials of tamoxifen versus surgery in the elderly (referred to in the EORTC paper), two in Nottingham and the UK Cancer Research Campaign Trial. These also showed similar or only slightly worse survival in the Tamoxifen group but an expectedly higher rate of LR.

To set against the interpretation of the authors, in the EORTC trial tamoxifen controlled the primary tumour for over 10 years in 25% of the patients. In the second Nottingham trial, in which high Oestrogen Receptor (ER) positivity was an entry requirement, control was maintained in over 86% of the patients at 5 years. We are now seeing some women with complete responses from tamoxifen alone which have lasted more than 17 years. 71 years was the minimum age for these studies: 40% of 70 year olds will have died of natural causes by 10 years and 70% of 80 year olds. Thus, in the Nottingham trials of tamoxifen-treated patients, more than half of those who died did so without recurrence and without having undergone surgery.

As so often occurs with data from clinical trials, the results do not lead to clear clinical guidance, since interpretations differ. In women unfit for surgery, tamoxifen is clearly an option and this applies without a lower age bar. In those with ER-positive tumours and fit for surgery, if LRR were the sole criterion then we would return to Halsted radical plus radical radiotherapy (RT)! The facts above should be put to patients. In my own experience (and confirmed by the two breast care nurses who were present at the time that primary management was discussed with the patients), many elderly women are frightened of surgery, have a realistic view that their life-span is limited, and given the choice around 70% selected tamoxifen.

Primary tamoxifen should not be advanced as unacceptable, but as an option.

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