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Proffered paper oral

Increased Breast Cancer Recurrence in Elderly Patients is Explained by a Higher Risk of Distant Recurrence – a TEAM Study Analysis

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Background: Recently, we reported a higher breast cancer recurrence and mortality with increasing age in hormone sensitive postmenopausal patients, which may be explained by age specific undertreatment. Locoregional recurrence may be the result of insufficient local and/or systemic treatment, while distant recurrence is more likely to reflect insufficient systemic treatment. To explore this hypothesis, we evaluated first site of breast cancer recurrence by age at diagnosis.

Materials and Methods: Patients enrolled in the Tamoxifen Exemestane Adjuvant Multinational (TEAM) trial were included. Primary endpoint was site of first breast cancer recurrence, i.e. locoregional recurrence, contralateral breast cancer, or distant recurrence. Analyses were stratified by age at diagnosis (<65, 65–74, ≥75 years).

Results: Overall, 9766 patients were included, 5349 were <65 years, 3060 were 65–74 years, and 1357 were ≥75 years. Administration of radiotherapy after breast conserving surgery (94%; 92%; 88% respectively) and adjuvant chemotherapy (51%; 23%; 5% respectively) decreased with increasing age ($p < 0.001$). Overall breast cancer recurrence increased with increasing age (≥75 years multivariable HR 1.34 (95% CI 1.09–1.64), $p = 0.02$). Risks of locoregional recurrence and contralateral breast cancer were similar among age groups. Risk of distant recurrence increased with age (≥75 years multivariable HR 1.41 (1.11–1.79), $p = 0.017$). Stratified by T stage, similar results were observed.

Conclusions: Increased breast cancer recurrence with age was explained by a higher risk of distant recurrence. These results are suggestive of undertreatment of systemic therapy, which may be a concern in otherwise fit elderly breast cancer patients in particular.

	5 years relapse	Univariate		Multivariable*	
		HR (95% CI)	p value	HR (95% CI)	p value
Distant recurrence			0.014		0.017
<65 years	8%	1 (reference)		1 (reference)	
65–74 years	8%	1.04 (0.89–1.22)		1.18 (0.99–1.41)	
≥75 years	10%	1.34 (1.10–1.63)		1.41 (1.11–1.79)	
Locoregional recurrence			0.097		0.125
<65 years	2%	1 (reference)		1 (reference)	
65–74 years	1%	0.81 (0.57–1.15)		0.69 (0.47–1.02)	
≥75 years	2%	1.34 (0.90–2.00)		1.02 (0.64–1.63)	
Contralateral breast cancer			0.591		0.358
<65 years	1%	1 (reference)		1 (reference)	
65–74 years	1%	1.02 (0.63–1.65)		1.21 (0.71–2.07)	
≥75 years	1%	1.36 (0.75–2.47)		1.65 (0.83–3.29)	

*Hazard ratios adjusted for country, histological grade, T stage, nodal stage, estrogen receptor, progesterone receptor, surgery, radiotherapy, chemotherapy and endocrine therapy.

Wednesday, 21 March 2012

15:45–17:15

EUROPA DONNA SESSION

Survivorship

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Invited

Cancer Survivorship: NCI research and insights into this new and growing area

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Background: The number of breast cancer survivors (BCS) is growing globally. This is the result of broader dissemination of advances in early detection, treatment efficacy and supportive care. As their numbers increase, however, we face the new challenge of optimizing the function and health-related quality of life (HRQOL) of women and their families living long-term with a history of breast cancer. Identifying and addressing the needs of these survivors represents an active area of scientific inquiry.

Material and Methods: We reviewed the pattern of survivorship research supported by the NCI since the creation of the Office of Cancer Survivorship in 1996. The focus of funded grants was examined and gap areas of research were identified. General findings and lessons learned from past research, and survivors themselves, were also summarized.

Results: The number of grants being funded in this area is growing rapidly. Across these studies, women treated for breast cancer are the most widely researched group of survivors. While studies of the psychosocial and behavioral outcomes of cancer still predominate, more recent research is examining the long-term and late physical consequences of survival. Much of this work, however, has been conducted among white, middle aged samples; relatively few studies are being conducted among BCS at the ends of the age spectrum, those who are younger (aged ≤ 39) or older (≥ 65), or among those of diverse racial or ethnic backgrounds. While most BCS are resilient, they have taught us that being declared cancer free does not mean they are free of the disease experience. Many suffer chronic physical (fatigue, pain, sexual dysfunction, memory problems, lymphedema), emotional (fear of recurrence, depression), social (work and relationship difficulties, isolation or stigma) and/or existential (concern about purpose in life, spirituality) effects of their disease and its treatment. They are also at increased risk for late occurring problems: second malignancies, heart disease, osteoporosis, diabetes, poor function. A number of interventions to promote psychosocial and physical well-being are useful in improving health and HRQOL among BCS, but these are not broadly disseminated. Identifying best practices for the rehabilitation and follow-up care of BCS after treatment is an emerging area of research interest in this now adolescent field of cancer control science.

Conclusions: Cancer survivorship, the period after acute treatment, presents unique challenges to breast cancer survivors and their healthcare providers. To reduce the global burden of breast cancer, more research is needed to understand the enduring effects of this illness, identify women at risk for poor outcomes, and to deliver effective interventions and post-treatment care to prevent unnecessary morbidity and mortality.

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Invited

A Young Survivor's Perspective

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We all know that unfortunately breast cancer can strike at any age and can and does affect younger women as well. Fewer than 7 percent of all breast cancer cases occur in women under 40 years old. One of the difficulties is diagnosing breast cancer of younger women, because youth don't think about any disease at all, mammograms are not recommended and there are not enough preventive activities and no any special programs for youth at all.

It is very important that we have to have in our mind that breast cancer, found in early stage, is very well-cured and about 90 % of these women will survive. That is why awareness and knowledge about this disease is much needed!

In August 2005, with ages of 33, I was diagnosed with breast cancer. As a breast cancer survivor I will express my personal experience and personal view and feelings during and after treatments, which led me to the present situation, that I am now a breast cancer advocate.

We have a lot of work to inform and educate about this disease especially young people, particularly on the field of self examination and knowing our body; to be aware of the breasts, to be persistent and trustful with the doctor and to communicate with other young women with breast cancer in Europe and all over the world. Some national fora Europa Donna have 'Section of younger woman' with goal to offer a particular support and help in specific problems for younger patients.

Study from Cancer Nursing "Life After Cancer, Living with risk" [1] showed, that cancer survivors have a broad range of interpretations of second cancer risk. Cancer survivors' perceptions of their second cancer risk do not always translate into behaviors to prevent, detect, and manage that risk. Understanding how cancer survivors conceptualize and assess risk in relation to having a history of cancer must remain a priority if we are to deliver follow-up based on real rather than perceived or presumed need.

In practice each country solve problems on a national level. But people, who are diagnosed with breast cancer, we feel the same everywhere in the world, but we are not the same. We must be aware that we are not machines, we are not identical and therefore disease can have different impacts on us.

Many of us our breast cancer experience completely changed us, our personality and also our life. We went threw medical treatment and also psychological rehabilitation. I believe that the latter one is as important for us and our good perspective as medical one.

References

- [1] Krista L. Wilkins, PhD, RN and Roberta L. Woodgate, PhD, RN; Cancer Nursing, Life After Cancer, Living with risk; Posted: 11/11/2011