



OCTOGENARIANS: LOOKING CLOSER TO A NEW GROUP OF CANCER PATIENTS

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The number of older cancer patients has increased in recent years (1). Treatment of elderly cancer patients poses a significant therapeutic challenge to oncologists owing to numerous pre-existing comorbidities, often poor performance status and the increasing risk of treatment-related toxicities (2). This condition may have particular clinical importance in elderly cancer patients over 80 years, the so-called octogenarians. Short-term quality of life and the ability to continue managing their activities of daily living may be more important than a survival advantage for this special age group (3). Therefore, octogenarian patients with malignant disease must be allowed to balance the potential risks and benefits of treatment when deciding whether or not to have anti-tumor therapy, especially the cytotoxic agents.

In this study, we documented the clinical characteristics of octogenarian patients with breast cancer who were treated in our Breast Cancer Unit between 1999 and 2010. We observed that the number of octogenarian patients doubled in the last five years (8 versus 16). The median age of these 24 patients at the time of diagnosis was 83 years. Detailed clinical data were available in 21 patients. The median time period between the onset of symptoms and the diagnosis was six months. Only one patient's tumor was detected on screening mammography. Twelve (57%) patients had invasive ductal carcinoma, 3 had invasive lobular carcinoma, 2 had mucinous carcinoma, 2 had mixed ductal/lobular carcinoma, and 2 had anaplastic carcinoma. Fifteen (71%) patients had estrogen receptor (ER) positive and/or progesterone receptor (PR) positive tumors, whereas six (28.5%) patients were triple-negative (ER/PR/HER2-negative). Immunohistochemically, all tumors were negative for HER2 protein overexpression. Two patients had metastatic disease at the time of diagnosis. Six patients presented with early-stage breast cancer, and five patients presented with skin involvement by carcinoma (T4 disease). Axillary lymph node metastasis was detected in 10 (47.6%) patients. These patients were treated with various combinations of surgery (n=11), radiotherapy (n=3), chemotherapy (n=4), and hormone therapy (n=15) for breast cancer.

Sixteen of 21 patients (76%) had one or more comorbid conditions. Hypertension was the most common comorbidity in our cohort, and observed in 14 (66.6%) patients. Other important comorbidities included diabetes mellitus, congestive heart failure, cerebrovascular diseases and chronic obstructive pulmonary disease. Interestingly, none of the patients underwent a comprehensive geriatric assessment before, during and after their cancer treatments.

Breast cancer in octogenarian patients is increasing (4) and there is currently little evidence-based data to support treatment decisions. Therefore, information regarding the natural course of the disease and the outcome of therapy in this population is of uppermost importance. We believe that clinicians should report their medical experiences with these patients. The treatment of octogenarians with breast cancer should be individualized. Potential curative therapies should not be withheld from these patients because of their age alone. A comprehensive geriatric assessment can assist in determining the treatment or care plan that is most appropriate in light of the patient's functional status, social circumstances, and life expectancy. However, our study revealed that this approach may sometimes be overlooked by clinicians.

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