

BREAST CANCER IN THE ELDERLY

Is breast cancer in an elderly person a different entity than in a younger person? Many clinicians view breast carcinoma in the elderly as a less aggressive process, but is this true? Furthermore, many biases and misconceptions exist. Decisions about breast cancer screening, diagnosis, and treatment are affected by clinical concerns, including limited life expectancy, comorbid disease, and inability to tolerate systemic/radiation treatment.

The majority of articles written about breast cancer focus on women in the 35-65 year old age group. However, 20% of the women diagnosed with breast cancer, and >30% of the women dying from breast cancer, are more than 75 years of age. This number will only increase in the future with the increasing percentage of elderly persons in the US population.

Synthesizing information from the Commission on Cancer of the American College of Surgeons (ACoS), this newsletter discusses the clinical, pathologic, and treatment differences for elderly versus younger patients.

Clinical

Clinicians may approach their workup of elderly patients differently than for younger patients. It was discovered in the ACoS study that physicians rarely perform routine clinical-breast examinations on elderly patients as compared to the younger patients. Elderly patients are also less likely to perform self-breast examinations.

Screening mammograms are perhaps underutilized in the older population due to lack of public awareness of the increased risk of breast cancer as one ages. In addition, the older population themselves may not know the benefits and the value of mammograms. In fact, older women have less dense breast tissue allowing better contrast between adipose tissue and breast tissue. Therefore, the elderly may benefit greatly from

mammography since it has a higher sensitivity in this age group to detect breast-tissue abnormalities.

Tumor Characteristics

The location of primary breast cancers is similar for both elderly and younger patients with the upper, outer quadrant being the most frequent location. Tumor size is similar as well. However, there is a lower overall incidence of *in situ* lesions in the elderly, probably because their breast cancers tend to be diagnosed at a later stage.

Some differences are seen in hormone receptor status. The elderly are more likely to have ER-positive and PR-positive tumors. There is an increased incidence of mucinous (colloid) carcinomas in the elderly; these tumors are usually considered low-grade lesions that are well differentiated and less aggressive. Papillary and lobular carcinomas also have a higher incidence.

Treatment

There is a dichotomy in the surgical approach to suspicious breast lesions in the elderly versus younger patients. For one faction, concern of morbidity and mortality from major surgery prompts a minimalist surgical approach. On the other hand, in some regions of the country, there is automatic performance of a mastectomy in the face of potential malignancy, with little chance of breast conservation or reconstructive options. In the end, operative morbidity for breast surgery in the elderly is reasonably low, with negative outcomes related to wound infections and other complications.

Another controversial surgical issue is whether lymph node staging is necessary in the elderly. Davis et al. found that, in greater than 40% of patients older than 80 years old, axillary dissections were not done. He cites that if dissection was performed, the extent was usually less than in younger patients, based on the mean number

of lymph nodes removed. The risk of axillary disease must be weighed against the possible increase in the operative risk with more advanced age.

Radiation was yet another controversial issue. One study found in elderly patients undergoing breast-conserving therapy, 90% of women younger than 65 received follow-up radiation therapy (RT); 86% of women aged 65-75 received follow-up RT; and only 41% of women older than 75 years old had adjuvant radiation.

The use of chemotherapy in the elderly is meager. Older women were less likely to be referred for chemotherapy, and even less likely to be treated with it, with the major concern being toxicity and relative benefit. Some research recommends giving Tamoxifen (a partial E2R agonist) or other adjunct therapy as a substitute for radiation. At present, the data concerning this topic is still being collected.

Summary

The U.S. population continues to age. The life expectancy of a 75-year-old woman is 11.1 years and that of an 85-year-old woman is 6.2 years.

It is apparent that, for the elderly compared to younger patients, there are differences regarding breast cancer screening, diagnosis, and treatment. There are no right or wrong approaches. However, concerns about limited life expectancy, co-morbid disease, and inability to tolerate surgery or systemic/radiation treatment may not always be justified.

FNA in the Elderly

Fine needle aspiration biopsy is well tolerated by elderly patients. The biopsy technique can usually be modified to accommodate patients with limited mobility, cardiac problems, or respiratory problems that would make lying down difficult. FNA can be safely performed on patients taking anticoagulants. Because no anesthesia is needed, there are no possible anesthetic side effects. Patients can return to their normal routine immediately after the biopsy.

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COMPANY PROFILE

OUTPATIENT CYTOPATHOLOGY CENTER (OCC) is an independent pathology practice that specializes in performing and interpreting fine needle aspiration biopsy specimens. OCC is accredited by the College of American Pathologists. The practice was established in 1991 in Johnson City, Tennessee. Patients may be referred for aspiration biopsy of most palpable masses as well as for aspiration of non-palpable breast and thyroid masses that can be visualized by ultrasound. OCC is a participating provider with most insurance plans. Our referral area includes patients from Tennessee, Virginia, West Virginia, North Carolina, South Carolina, Kentucky and Georgia.

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