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Which Surgery in Geriatric Breast Cancer?

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Abstract

Introduction: The improved living and environmental conditions have resulted in an increase in life expectancy with greater observation of breast cancer in elderly. The present study, through a retrospective analysis of our series, compares the results of treatment in two similar groups of patients under 75(65-75) and over 75 (76-85) years of age, evaluating the efficacy and complications of loco-regional and general therapy in relationship to biological age, associated diseases, and also the influence on the results of the cultural level and lifestyle.

Materials &Methods and Results: The criteria that we evaluated retrospective 110patients are: age (65- 85) with mean age 75, of which 69.8% aged between 65-75 while the remaining 30.2% aged between 75-85 years; The TNM, distributed among the patients as: stage I, 5 (4.5%), stage II No 56 (50.9%), stage III No 30 (27.3%) stage IV No. 19 (17.2 %). Associated diseases. Considered in the two groups were BPCO hypertensions, cerebrovascular disease, BMI pathological. Surgical treatment was mastectomy, QUART, lumpectomy and search for the sentinel node. The evaluation excluded patients treated on tumorectomy and mastectomy. Complications, shown in tables, have been modest. Perioperative mortality was absent.

Conclusions: In the treatment of patients with geriatric breast cancer, TNM cancer criteria were adopted without removing other as ASA 'Karnofsky Index. This therapeutic approach, beyond old age, considered almost a marginal factor, obtained satisfactory results with a lengthening of life expectancy

Keywords: Breast surgery; Geriatrics.

Introduction

The improving of socio-economic and environmental conditions has produced an increase in life expectancy, with greater observation of breast cancer in elderly. The actual data confirm this trend by estimating (foncam) 1/400 in the detection of breast cancers in adults (over 70 years). This is related, in this decade of life, with varying thehormonal immune-modulation system, and with a relative decrease in vitamin consumption. The shortcomings are still present in the timing relative therapeutic MISUSE age group (65-85 years) favors a partial staging (3) of the disease to which follows a relatively inadequate treatment, with a reduction of survival. A more aggressive therapeutic approach, oncologically more radical in relation to the extension of life expectancy, even when there are no opinions yet unique [1,2], has led us to develop this study through a retrospective analysis of our experience, considering the 'effectiveness of therapy in two cohorts of patients under 75 years of life and over 75.

Materials and Methods

Patients with breast cancer observed from 2000 to 2010 at the III clinical surgery (2000-04) and in the Department of Surgery Specialist II of the Policlinico Catania were 110. The criteria that we evaluated retrospectively the entire together they were: age (65- 85) with mean age 75, of which 69.8% aged between 65-74 while the remaining 30.2% aged between 75-85 years; The TNM, finding stage I in 5 cases (4.5%), stage II No 56 cases (50.9%), stage III in 30 cases (27.3%), stage IV in 19 (17, 2%). The tumor morphology observed with its variety histological was: infiltrating ductal carcinoma in 88 patients (80%), adenocarcinoma in 11 patients (10%), mucinous adenocarcinoma in 6 patients (5%), disease, Paget in 5 patients(5%). Surgical treatment was assessed both in relation to the TNM that the clinical condition of the patient. All patients forming part of this retrospective analysis were subjected to the processing, as shown in the Tables 1, 2, 3 and 4. To assess elderly patients the impact of treatment on-site regional and general approach, we divided the patients into two cohorts and, in particular, were compared two homogeneous groups of patients where treatment loco regional type was the quart with the study sentinel node (P 16 Group I; 20 p Group II). See Tables 1, 2, 3 and 4.

Table 1: Patients Age Group Criteria

Old patients (65-75)	GroupA 21 cases
	Group B 16 cases
	Group C 9 cases
OldOldPatients (75-85)	Group A 34 cases
	Group B 13 cases
	Group C 10 cases

Table 2: Charlson comorbidity group I and II

Connective tissue diseases	1
Ulcer	1
Mild liver disease	1
Stroke	2
Osteoarthritis	2
Hypertension	5
Peripheral arterial	2
Neoplasms	5
Chronic renal failure	2
Chronic	3
Neurological diseases	2
Diabetes	2
Chronic heart failure	1

Table 3: Site regional surgery

AGE (first group 65-74) AGE (II group 75-85)
Lumpectomy + SLN Group I:20 cases Group II:34 cases figure 1 (50%)
Quart + axillary lymphadenectomy, LFNs + I group 16 cases II group 20 cases (31%)
Mastectomy sec Maddem + lymphadenectomy Group I 11 cases Group II 9 cases (19%)

Complications

Seroma: GroupI 10 casesGroupII, 12 cases (20%)
Phlebitis Group I 3 cases Group II 2 cases (5%)
Lymphedema The group II case 1 group 1 cases (2%)

Radiotherapy complications

The actinic erythema group I 5 cases Group II 7 cases (11%)
Lymphedema (NO) Group I Group II 1 case 1 case (2%)
Hormone therapy or systemic T IA The first group 4 cases (Q2; 2 <Ca) II group 3 cases (7%)
(2<;Q1)
• Note the patients were treated with aspirin or VITD + calcitoninSystemic chemotherapy / complications
Neutropenia the first group 6 cases II group 8 cases (14%)
Infections of 3 cases group I group II 2 cases (5%)

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* Note Patients in both groups were treated with growth factors

Table 4: TNM staging group I and II and tumor morphology

Stage:I-No.5cases (4.5%),
Stage:II-No.56cases(50.9%),
Stage:III-No.30 cases (27.3%),
Stage:IV-No.19cases (17.2%).

Tumor morphology

Infiltrating ductal carcinoma in 88 patients(80%)
Adenocarcinoma in 11 patients(10%),
Mucinous adenocarcinoma in 6 patients(5%),
Disease, Paget in 5 patients.(5%).

An examination of our patients and especially by the comparison between the two groups fewer than 70 and over is possible to extrapolate some considerations largely in agreement with other AA.

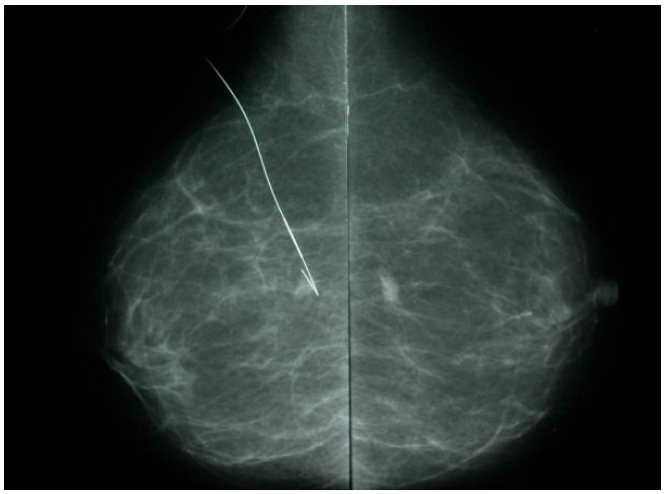

Figure 1: DCIS

Results

-In Patients over 70 years with no positive lymph node> 3 in relation to creatinine clearance were applied schemes of chemo therapy CMF, FEC. Attention was paid to the blocks marrow and resistant infections. Radiotherapy, followed in 13% of cases after quadrantectomy.The QUART, mainly involved patients aged 70-85 years with multicentricity the tumor and resection margins limit (<2 mm). Surgical treatment was palliative in the presence of widespread disease. Radiation therapy has had in these cases the meaning of local control. Risk factors such as comorbid conditions like high blood pressure, diabetes mellitus, the COPD, chronic renal failure, did not affect the postoperative course. In patients with invasive carcinoma (incisional biopsy or breast after administration of radioactive material and mapping without ultrasound or clinical suspicion of lymph node involvement was also performed using the procedure of sentinel lymph node biopsy, regardless of age. The dissection of the cable was complete after positive. In all patients treated, the perioperative mortality was absent. Complications have arisen have been presented in tables, with reference tospecific patients compared (QUART). The mean hospital stay was 5 days (4-6gg). In group of patients over 70 years, complications have extended the average length of stay. At follow-up responded to 80% of patients for a period of 48 months. The survival in stage I covered the 100% of cases. In II stage were found: n 35 patients with stage IIa with no recurrence of the disease en 21 cases in stage IIb with 50% of patients with local recurrence of the disease. In such an extension it was performed surgery with mastectomy sec Madden and no improvement to the 48-month follow-up. N In the remaining 49 cases with advanced disease (stage III and IV), the group of age group between 65-75 a. n were 23 cases, while the remaining 16 were in the age group over 70. In these patients there was a recovery of disseminated tumor in histological variant of adenocarcinoma mucinous and Paget.In patients over 75 with breast cancer ER + operable, the "primary hormone therapy"with tamoxifen or aromatase inhibitors it cannot be considered an alternative to surgery Consideration aforesaid has a pattern of evidence +++. Only in cases of general anesthesia and poor, while bearing in mind that intervention can be conducted in regional anesthesia, in the presence of high comorbidity, frailty senile (frail patients) or deliberate refusal of the surgery, the alternative may be taken in consideration. As can be seen from our experience, surgery can range from lumpectomy, the quart or mastectomy, according to neoplastic conditions encountered. All interventions have pursued the oncological. With regard to the axillary lymph nodes, in patients with invasive carcinoma (incisional biopsy or preoperative breast), after administration of radioactive material and mapping of the region breast axillary, even in the absence of clinical or ultrasound evidence of lymph node dissemination, it should be made the sentinel lymph node biopsy regardless of age. The dissection of the cable should be completed in case of positive lymph node examination impromptu (Research and identification of the sentinel lymph node can be helped by vital dye methylene blue), or after the operation in case of detection of micro metastases at 'Pathologic examination definitive.La breast radiotherapy residual intervention should be considered in all women tumorectomy or quadrantectomy. For patients older data are controversial or insufficient. No doubt the postoperative RT should be undertaken for these patients if life expectancy is high or if there is a high risk of local recurrence (aggressiveness of the tumor resection margin tight, multicentric). For systemic treatments, are significant evidence of the prognostic factors predictive of recurrence, as well as predictors of response to treatment overall (proliferative index of the tumor, ER +, HER2). Hormonal therapy tamoxifen or aromatase inhibitors, goes undertaken in all patients receptor positive (+++ evidence. AIOM, 2014). It must of course also take into account the risk of thrombotic tamoxifen (countered with Aspirinsmall doses) and risks of weakening of the bones to aromatase inhibitors (countered with the intake of calcium, vitamin D and calcitonin).The chemotherapy for patients filling requirements (fit) for the cycles of adjuvant chemotherapy should be undertaken, especially if women are estrogen-negative and/or positive axillary nodes. Attention should be paid to the obviously increased susceptibility of older blocks and spinal cord infections; antibiotic-resistant species of bacteria, blocks marrow can be fought with growth factors (CSF). The lines are the most widely used therapeutic associations CMF and TASSANI, albeit with limitations. As for the use of transtuzumab, the drug can certainly improve the effect of the CHT, but clinical data are lacking: still has to be pointed out the risk of heart failure. In metastatic disease it can be used hormone therapy, chemotherapy, anti HERC2, bevacizumab. The clinical-experimental are still insufficient for a reasoned choice.

Discussion

In geriatric patients the breast cancer is significantly detected as our series. That finding raises the issue of which therapeutic strategy should be implemented to overcome the line of thought that suggests a therapeutic treatment limited, and therefore presumably inadequate [1, 4, 5]. The TNM staging effective to determine the true extent of the disease is essential to avoid a therapeutic treatment is not appropriate, without undue prejudice to a truly effective treatment for elderly patients. In our study, the percentage of complications were predictable and almost identical (and still with no statistically significant difference) in both mature women [10] than in older patients and did not represent a contraindication to treatment site prior to regional and general, while the combination of risk factors such as hypertension, BPCO, renal failure and cardiovascular disease, common events in elderly, did not result in any increase in mortality.

In support of a surgical treatment based on the parameters you have cancer studies conducted by the authors [5, 6] that show delays in the diagnostic for geriatric patients (over 70) than women under that age. Surgical treatment provided in our experience also axillary lymphadenectomy to level II when the sentinel node is positive. Functional complications were not found in the treated cases, which corroborates the fact that the surgery should be correlated with the staging rather than with age and with a careful evaluation of the SAA *, and index values Karnofsky. Then in the presence of metastatic disease (17.2% of the total) surgical treatment carried out even though in the absence of oncological radicality represented the first line of treatment can offer a quality survival for the risk of ulceration, as experienced by other authors [4,8]. The radiation therapy was performed after QUART, [11] even in the elderly or as II-line treatment in patients with metastasis and surgical resection not oncologically radical. The use of tamoxifen has been based on detection of amount of estrogen receptors> 10 fmol [7] for the purpose of increase in percentage the number of responses and to obtain a prolongation of disease-free. Special attention was paid to the prevention of thrombotic risk (tamoxifen/aspirin) and osteoporosis (with intake of calcium, and calcitonin vitamin D / aromatase inhibitors). Chemotherapy has seen its application always based on the detection of positive lymph nodes (> 3) receptors and negative, in both groups of women. The lines have been represented by the CMF and Taxanes administration transtuzumab in some cases has improved the effectiveness of responses to chemotherapy even if the survey is insufficient in older women. In stages III and IV, in the presence of ASA * high was carried out a removal (lumpectomy) in regional anesthesia with sedation, as proposed by several authors [8,9,14], and in day surgery. [12, 15, 17]

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* (High anesthetic risk)

Conclusions

In the evaluation of patients with breast cancer geriatric, they were adopted criteria cancer TNM without ignoring the parameters and the ASA 'Karnofsky Index. This therapeutic approach has achieved satisfactory results with a lengthening of life expectancy combined with a percentage of perioperative complications comparable to those of patients less. The TNM staging also found the proportion of stages of illness similar to the two cohorts of patients. In treatment planning for the success we should be given consideration biological age of the patient and not to their chronological age with particular attention to the correction of the parameters of preoperative comorbidities. Particular attention may be given to drugs that affect the immune system. Even the understanding of the psycho-social aspects due to reduced cognitive ability often accompanied by depression should find space therapy support. Surgical treatment and general treatment can therefore be generally customized and sometimes customized, based on the principles of oncological, on the recovery of functional capacities and on careful evaluation of social factors.

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