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Editorial

The caregiver effect on treatment decisions for the elderly

The proper management of the axilla in all patients with breast cancer has been an area of active investigation. Although involvement of the axillary nodes remains an important prognostic factor, the approach to gathering this information has changed dramatically. Axillary lymph node dissection (ALND), long a standard component of the management of early stage breast cancer, remains the standard approach only for patients with clinically palpable axillary nodes or many positive axillary nodes confirmed by sampling techniques. For women with early stage breast cancer with a clinically negative axilla, ALND is no longer a routine part of the surgical treatment of breast cancer, having been replaced with the less invasive sentinel lymph node biopsy (SLNB).[1,2] In patients with clinically node negative breast cancer, SLNB identifies patients without axillary node involvement, sparing them the morbidity of ALND.[3] Several studies have shown that SLNB is associated with lower rates of arm morbidity, including lymphedema, sensory loss, and range of motion deficits when compared to a standard ALND.[4–7]

Older women with breast cancer should stand to particularly benefit from this therapeutic shift. Breast cancer is the most common cancer among older women, and nearly one half of new cases of female breast cancer in the United States are diagnosed in women age 65 or older.[8] Some data suggest that older women may suffer from greater arm morbidity following ALND than younger women, particularly if they have pre-existing arthritis, a common age-related condition.[9] Older women tolerate SLNB well, and it is associated with lower rates of arm morbidity than ALND.[10,11] SLNB may be particularly appropriate for older women as it may be performed without the use of general anesthesia.[12] In addition, because axillary node sampling is a staging procedure, some authors suggest that selected older women do not require any axillary lymph node assessment as the knowledge will not change treatment or outcome. This is particularly true for those individuals whose comorbidities preclude consideration of chemotherapy or radiotherapy. Moreover, several studies have also shown no difference in outcome in older patients (≥70 years of age) with small (<2 cm) ER-positive tumors and a clinically uninvolved axilla treated with endocrine therapy and without axillary sampling.[13–16] Based on these data, ALND should not be the initial approach to the axilla in older women with early stage breast cancer, having been replaced by SLNB or simple observation.

In this issue of the Journal of Geriatric Oncology, Dr. Cluze and colleagues examine the use of sentinel lymph node biopsy in a French cohort of older patients with early stage breast cancer between October 2006 and December 2008. All of these women have universal health insurance and receive their breast cancer care free of charge. These patients met French guidelines for SLNB eligibility at the time, with unifocal T1 tumors, a clinically negative axilla, and no history of neoadjuvant chemotherapy or a prior breast surgery. The investigators examined factors associated with NOT undergoing a sentinel lymph node biopsy, taking into account patient health status and clustering by hospital. In addition, the impact of the lymph node surgery type on women's quality of life was evaluated.

Their results are striking. An ALND was performed without previous SLNB in 20% of the cases eligible for this procedure, and the rates of SLNB did not significantly change over time. Eighty-four percent of patients treated with immediate ALND had no lymph node involvement. In univariate and multivariate analysis, immediate ALND was performed more often in women 75 or older and among those who did not have an immediate family member providing support for the patient and her treatment. Axillary surgery type was not associated with other socio-demographic factors, BC characteristics or the geriatric assessment. It was not physician or hospital dependent and was not explained by increased comorbidities. Not surprisingly, the older women treated with immediate ALND reported significantly higher rates of adverse effects and depressive symptoms than those treated with SLNB alone and also experienced lower levels of physical and psychological quality of life.

Why would a group of women over the age of 75 with low risk tumors – many of whom could have been rationally treated with no axillary surgery at all – be more likely to have an immediate axillary node dissection? It has been previously noted that SLNB is less likely to be used in certain populations. Following a similar pattern with other treatments for early stage breast cancer, SLNB has been underused in certain vulnerable populations such as the elderly, ethnic minorities, and individuals with low socioeconomic status. Two prior studies of early stage breast cancer patients in the National Cancer database reported a lower rate of SLNB among patients 72 or older, African Americans, and those with no insurance or Medicaid.[17,18] Another recent study

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also reported that even among those older women who receive axillary staging, very elderly women were less likely to receive SLNB.[19] Some of the disparities in SLNB rate have been attributed to inequalities of access for such individuals in the US health system. Yet in a group of French women with universal health coverage and access, Cluze et al. report similar results. This finding is particularly concerning given that the principal benefit of SLNB is the reduced morbidity associated with the procedure, and the elderly clearly stand to benefit from procedures that reduce morbidity.

Part of the answer to the puzzle may lie in the finding that an immediate ALND was performed more frequently in older women who were not accompanied by an immediate family member. How the immediate family member influenced the medical encounter and decision-making is not clear in this study. However, social support has been well-recognized as an important factor in cancer diagnosis and treatment. The extent and quality of social support has been linked to illness outcomes in the elderly and the ability to cope with illness.[20] Undertreatment in the elderly with poor social support may be partially explained by difficulty the patient may have with coping with the difficulties posed by cancer treatment in everyday life, i.e. obtaining transportation to multiple surgical appointments and adequate support during recovery time.[21] Family relationships and presence also appear to be important for optimal decision-making for the older cancer patient. Older women may have difficulty processing information after diagnosis and may rely on family members for this function.[22] Several investigators have reported that the presence of a companion can alter the dynamic of a medical consultation because the companion may bridge barriers to treatment, ask clarifying questions, and facilitate communication.[23–25]

Physician factors may also account for some instances of inappropriate treatment of elderly women with breast cancer. Caring for older women with few social resources is challenging for all physicians, and it is easy to understand given the pressures of medical practice how the most expedient, rather than the best, treatment might be adopted in such a circumstance. The assessment of social environment, family support, and organization of care is time consuming, and physicians may spend less time with older patients.[26] However, it is also clear that pretreatment discussions, a good physician–patient interaction, and optimal organization of care can reduce the risk of patient refusal of treatment, decrease adverse events, and increase compliance.[21,27]

The results reported here by Cluze et al. echo a previously published study by Mandelblatt et al. examining adjuvant chemotherapy decision-making by older women. In this study, one unanticipated finding was that women who had a companion present during consultations with a medical or surgical oncologist were more likely to receive appropriate chemotherapy. The actual relationship of this companion to the patient was not studied. In this study, it was unclear if the effect was related to a direct influence of the companion on the patient's decision making, general social support, help in recording and understanding complex medical information, or the influence of a third person on the interaction between patient and physician.[28]

There are a number of potential explanations for the observed "caregiver effect" described in this paper and others. This remains an important area for additional research. Whether or not the caregiver or companion effect is limited to the presence of an immediate family member, or could perhaps be replicated by a trained support person assigned to elders with poor social support remains to be studied. In a previous study reported by Goodwin et al, nurse case management resulted in more appropriate surgical management of women with breast cancer, and women with poor social support were particularly likely to benefit from the intervention.[29] Until the important interaction between a caregiver's presence during medical consultations and the appropriate administration of breast cancer care is better understood, physicians treating elderly women should be aware of the potential for undertreatment that poor social support poses, and work to minimize this risk through appropriate assessments, referrals, and efforts to facilitate improved communication with the patient and her family.

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