

Giorgio Maria Paul Graziano<sup>1</sup> and Prof Antonino Graziano<sup>2\*</sup>

<sup>1</sup>University of Catania Medical School, Italy

<sup>2</sup>Aggregate professor University of Catania, Azienda Policlinico, Dpt Sciences Medical Surgery and advanced technologies, G Ingrassia, Italy

**Dates:** Received: 01 March, 2016; Accepted: 14 March, 2016; Published: 16 March, 2016

**\*Corresponding author:** Prof, Antonino Graziano, Department of Sciences, Medical Surgery and Advanced Technologies, G Ingrassia via S Sofia, 86 - Cap 95125, Catania, Italy, E-mail graziano@policlinico.unict.it

[www.peertechz.com](http://www.peertechz.com)

ISSN: 2455-2968

**Keywords:** Breast surgery; Geriatrics

## Research Article

# Which Surgery in Geriatric Breast Cancer

### Summary

**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 and Methods:** The criteria that we evaluated retrospective 110 patients 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 hypertension, cerebrovascular disease, BMI pathological.

**Results:** 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 1, have been modest. Perioperative mortality was absent.

**Discussion:** In geriatric patients with breast cancer it is significantly detected as our series. This finding raises the question of what therapeutic strategy should be implemented to overcome the line of thought that suggests a limited therapeutic treatment, and therefore presumably inadequate. The TNM staging effective to determine the true extent of the disease is essential to avoid a therapeutic treatment is not appropriate, without unnecessary unless a truly effective treatment for elderly patients

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

## Introduction

The improving of socio-economic and environmental conditions have 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 the hormonal immune-modulation system, and with a relative decrease in vitamin consumption. The short comings are still present in the therapeutic age group (65-85 years) with favors a partial staging [1,2], of the disease to which follows a relatively inadequate treatment, with a reduction of survival. A more aggressive therapeutic approach, oncological more radical in relation to the extension of life expectancy, even when there are no opinions unique [3,4], has led us to develop this study through a retrospective analysis of our experience, considering the 'effectiveness of therapy in two group 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 1a,b,c,d. To assess elderly patients the impact of treatment on-site regional and general approach, we divided the patients into two groups and, in particular, were compared two homogeneous groups of patients where treatment side-regional type was the quart with the study sentinel node (Figures 1-3).

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

## 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 e/o QUART, mainly patients aged 70-85 years with multicentricity. The tumor and resection margins limit (<2 mm).

Table 1a: Surgical treatment.			
Lumpectomy + sentinel node	Group I - 2 cases	Group II - 3 cases	(-5%)
Quart + axillary lymphadenectomy	Group I - 16 cases	Group II - 20 cases	(-33%)
*Mastectomy sec Madden + lymphadenectomy	Group I - 11 cases	Group II - 9 cases	(-18%)
Table 1b: Surgery Complications.			
Seroma	Group I - 10 cases	Group II - 12 cases	(-20%)
Phlebitis	Group I - 3 cases	Group II - 2 cases	(-5%)
Lymphedema	Group I - 1 case	Group II - 1 cases	(-2%)
Table 1c: Radiotherapy complications.			
The actinic erythema	Group I - 5 cases	Group II - 7 cases	(-11%)
Lymphedema	Group I - 0 case	Group II - 1 case	(-2%)
Neutropenia	Group I - 6 cases	Group II - 8 cases	(-14%)
Infections	Group I - 3 cases	Group II - 2 cases	(-5%)
Table 1d: Hormone therapy.			
Or systemic	group I 4 cases	group II - 3 cases	(-7%)
*Note the patients were treated with aspirin or VIT-D + calcitonin for Systemic chemotherapy, because osteoporosis.			
* Note Patients in both groups were treated with growth factors.			

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 BPCO, chronic renal failure, did not affect the postoperative course. In patients with invasive carcinoma the incisional biopsy, 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 lymph in all patients treated, the perioperative mortality was absent. Complications have arisen have been presented in Tables 3 with reference to specific 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, 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 Aspirin small doses) and risks of weakening of the bones to aromatase inhibitors (countered with the intake of calcium, vitamin D and calcitonin). The

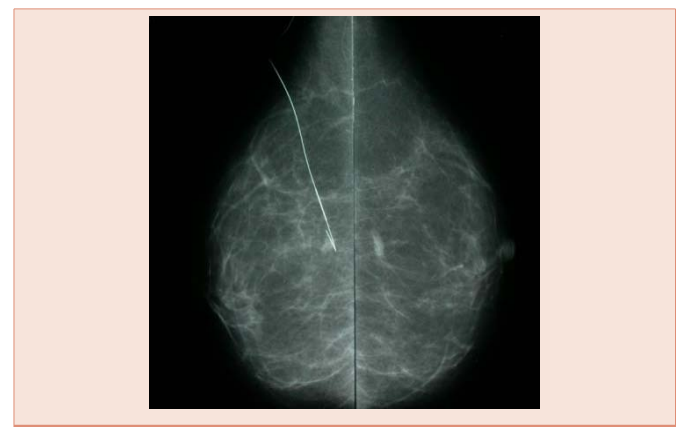


Figure 1: : Breast cancer T1c.

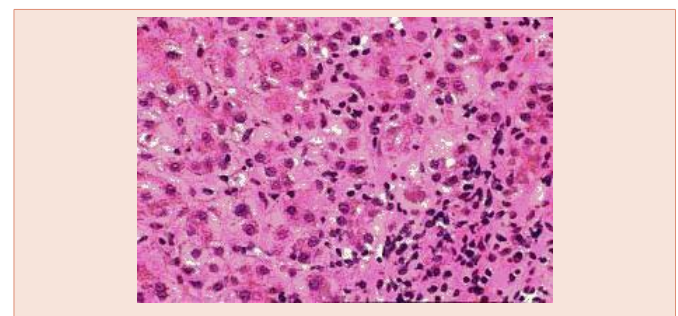


Figure 2: Histology breast cancer.



**Figure 3:** QUART.

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 trastuzumab, 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 with breast cancer it is significantly detected as our series. This finding raises the question of what therapeutic strategy should be implemented to overcome the line of thought that suggests a limited therapeutic treatment, and therefore presumably inadequate [3-5]. The TNM staging effective to determine the true extent of the disease is essential to avoid a therapeutic treatment is not appropriate, without unnecessary unless a truly effective treatment for elderly patients. In our study, the percentage of complications were predicTable and almost identical (and yet with no statistically significant difference) in both mature women [6], than older patients and is not a contraindication to the treatment site prior to regional and general, while the combination of risk factors such as hypertension, BPCO, renal failure and cardiovascular diseases, common events in the elderly, did not involve any increase in mortality. In support of a surgical treatment based on the parameters you have cancer studies conducted by the authors [7,8], that show delays in diagnostic geriatric patients (more than 70) compared to women under the age [9]. The surgical treatment provided in our experience even level II axillary lymph node dissection when the sentinel node is positive. Functional complications were not found in the cases treated, which confirms the fact that the intervention must be correlated with the staging rather than with age and with a careful evaluation of the ASA \*, and Karnosky index values. So, in the presence of metastatic disease (17.2% of total) surgical treatment carried out even in the absence of oncological represented the first line of treatment can offer a quality survival, as experienced by other authors [10,11]. Radiotherapy was performed after QUART [12], even in the elderly or as II-line treatment patients with metastasis and surgical resection is not radical oncological. The

use of tamoxifen is based on the detection of the amount of estrogen receptors > 10 fmol [13], in order to increase the percentage of 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 calcium , and calcitonin vit.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 administration taxanes transtuzumab in some cases improved the effectiveness of responses to chemotherapy, although the investigation is insufficient in older women. In stages III and IV, in the presence of ASA \*( is a high removal was performed (lumpectomy) under regional anesthesia with sedation, as proposed by several authors [14] and in day surgery [15,16].

## Conclusions

In the evaluation of patients with breast can geriatric, evaluation criteria were adopted TNM without ignoring the parameters and the ASA 'Karnosky Index. This more aggressive treatment approach has achieved satisfactory results with an increase in life expectancy in combination with a percentage of perioperative complications comparable to those of younger patients. TNM rating has allowed the treatment planning. For the successful treatment must be considered the 'biological age of the patient and not the' chronological age with particular attention to the correction of preoperative comorbidity parameters. Special attention can be given to drugs that affect the immune system. Useful in prolonging survival Even the understanding of the psycho-social aspects due to reduced cognitive ability often accompanied by depression has found support in specific therapy. Surgical treatment can then be customized, based on the principles of oncology, on the recovery of functional capacity and a careful evaluation of social factors.

## References

- Herbsman H, Feldman J, Seldera J, Gardner B, Alfonso AE (1981) Survival following breast cancer surgery in the elderly. *Cancer* 14: 2358-2363.
- Hunt KE, Fry DE, Bland KI (1980) Breast carcinoma in the elderly patient an assessment of operative risk morbidity and mortality. *Am J Surg* 140: 339-342.
- (2014) Linee guida AIOM XVI Congresso Nazionale a Roma dal 24 al.
- Gentile A, Greco L, Chiumarulo C (2003) carcinoma mammario in età avanzata. *Ann Ital Chir* LXXIV, 3: 275-278.
- Isik A, Peker K, Firat D, Yilmaz B, Sayar I, et al. (2014) Importance of metastatic lymph node ratio in non-metastatic, lymph node-invaded colon cancer: a clinical trial. *Med Sci Monit* 20: 1369-1375.
- Metcalfe K, Gershman S, Ghadirian P, Lynch HT, Snyder C (2014) Contralateral mastectomy and survival after breast cancer in carriers of BRCA1 and BRCA2 mutations: retrospective analysis. *BMJ* 11: 348: 226.
- Bordeleau L, Panchal S, Goodwin P (2010) Prognosis of BRCA-associated breast cancer: a summary of evidence. *Breast Cancer Res Treat* 119: 13-24.
- Kirova YM Savignoni A, Sigal-Zafrani B, de La Rochefordiere A, Salmon RJ, et al. (2010) Is the breast-conserving treatment with radiotherapy appropriate in BRCA1/2 mutation carriers? Long-term results and review of the literature. *Breast Cancer Res Treat* 120: 119-126.
- Pierce LJ, Strawderman M, Narod SA, Oliviotto I, Eisen A, et al. (2000) Effect of radiotherapy after breast-conserving treatment in women with breast



- cancer and germline BRCA1/2 mutations. *J Clin Oncol* 18: 3360-3369.
10. Host H, Lund E (1986) Ages as a prognostic factor in the breast cancer cancer 57: 2217-2221.
  11. Møller P, Borg A, Evans DG, Haites N, Reis MM, et al. (2002) Survival in prospectively ascertained familial breast cancer: analysis of a series stratified by tumour characteristics, BRCA mutations and oophorectomy. *Int J Cancer* 101: 555-559.
  12. Svastics E, sulyokz, beszzyak I (1989) Treatment of breast cancer in women older than 70 years. *J Surg Oncol* 41: 19-21.
  13. Ingle JN, Twito DI, Schaid DJ, Cullinan SA, Krook JE, et al. (1991) Combination hormonal therapy with tamoxifen plus fluoxymesterone vs tamoxifen alone in postmenopausal women with metastatic breast cancer. An updated analysis. *Cancer* 67: 886-891.
  14. Heemskerck-Gerritsen BA, Brekelmans CT, Menke-Pluymers MB, van Geel AN, Tilanus-Linthorst MM, et al. (2007) Prophylactic mastectomy in BRCA1/2 mutation carriers and women at risk of hereditary breast cancer: long-term experiences at the Rotterdam Family Cancer Clinic. *Ann Surg Oncol* 14: 3335-3344.
  15. Kessler HJ, Seton JZ (1978) The treatment of operable breast cancer in the elderly female. *Am J Surg* 135: 664-666.
  16. Graziano A (1992) ruolo della linfectomia di I livello nel ca mammario Atti SIC Roma I: 483-487.
  17. Trainer AH, Lewis CR, Tucker K, Meiser B, Friedlander M, et al. (2010) The role of BRCA mutation testing in determining breast cancer therapy. *Nat Rev Clin Oncol* 7: 708-717.
  18. Graziano A (2012) Examination axillary sentinel for Ultrasound in breast cancer 13 - 15 September, 2012 - Palma de Mallorca, Spain USP NESA Innovation Days.
  19. Atchley DP, Albarracin CT, Lopez A, Valero V, Amos CI, et al. (2008) Clinical and pathologic characteristics of patients with BRCA-positive and BRCA-negative breast cancer. *J Clin Oncol* 26: 4282-4288.
  20. Turner NC, Filho JS (2006) Basal-like breast cancer and the BRCA1 phenotype. *Oncogene* 25: 5846-5853.
  21. Boughey JC, Khakpour N, Meric-Bernstam F, Ross MI, Kuerer HM, et al. (2006) Selective use of sentinel lymph node surgery during prophylactic mastectomy. *Cancer* 107: 1440-1447.
  22. Greenfield S, Bianco DM, Elashoff RM, Ganz PA (1987) Patterns of care related to age of breast patients. *Jama* 257: 2766-2770.

**Copyright:** © 2016 Graziano GMP, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

**Citation:** Graziano GMP, Graziano PA (2016) Which Surgery in Geriatric Breast Cancer. *J Surg Surgical Res* 2(1): 014-017. DOI: 10.17352/2455-2968.000023