Treatment of Breast Cancer in Older Patients – Q&A Summary

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1. What are the main barriers to implementing geriatric assessment (G8) in routine clinical practice?

Answer:
The main barrier is prioritization rather than resistance. Most clinicians agree on the importance of geriatric assessment, but it often does not rank high among daily clinical priorities. Implementation works best when the process is simple and not time-consuming for oncologists. Delegating parts of the process to trained nurses and embedding G8 assessment into MDT routines are key facilitators. Long-term success requires local champions who consistently reinforce its importance.

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2. How can geriatric assessment be implemented efficiently without overwhelming oncology clinics?

Answer:
A stepwise approach is effective. All patients above a certain age undergo initial G8 screening. Patients with abnormal scores complete a digital self-geriatric questionnaire, often together with family members. A dedicated geriatric nurse can coordinate the process, summarize results in the medical record, and escalate selected cases to a geriatric team. This limits the need for full geriatric consultations to a small proportion of patients.

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3. Can geriatric assessment be financially sustainable for hospitals?

Answer:
Yes. In Leuven, the geriatric assessment is implemented as a multidisciplinary report involving oncologists, nurses, and geriatricians, allowing reimbursement from the healthcare system. This reimbursement enabled hospital leadership to fund a dedicated geriatric nurse position, which significantly improved implementation and sustainability.

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4. Is the PORTRET tool prospectively validated and available for clinical use?

Answer:
The PORTRET tool is well validated in multiple cohorts and is freely available online after registration. It integrates traditional prognostic models with geriatric parameters and predicts recurrence, breast cancer-specific survival, and competing mortality. Further national validation studies, including Swedish registry-based projects, are ongoing.

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5. How should pharmacokinetic changes in older patients influence systemic treatment decisions?

Answer:
Aging affects renal and hepatic function, which can alter drug pharmacokinetics, but effects vary between agents. Some drugs can be given at full dose, while others require adjustment. For example, capecitabine requires renal function monitoring. An up-titration strategy may improve tolerability, although prospective trials are limited due to funding challenges. Decisions should be based on available PK and toxicity data rather than rigid dosing rules.

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6. Are older patients able to tolerate standard chemotherapy regimens?

Answer:
Tolerance is regimen-specific. Standard regimens such as docetaxel/cyclophosphamide (TC) can often be given at full dose with appropriate supportive care, including G-CSF. Clinical experience and trial data suggest some older patients tolerate these regimens as well as—or sometimes better than—younger patients, particularly regarding nausea.

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7. Is there a structured way to avoid over- or undertreatment when dosing systemic therapy in older patients?

Answer:
There is no universal structure. Clinicians must rely on pharmacokinetic data, toxicity profiles, geriatric assessment, and clinical judgment. Comparative trials are scarce, limiting the development of firm dosing algorithms. Individualized decision-making remains essential.

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8. How should gene expression profiling be used in older patients when considering adjuvant chemotherapy?

Answer:
Gene expression profiling is routinely used to assess recurrence risk in fit older patients. While no single assay is preferred, such tools help estimate benefit from chemotherapy and can also inform discussions about alternative strategies, such as CDK4/6 inhibitors when chemotherapy is not feasible. However, the evidence for using these assays solely to guide CDK4/6 inhibitor decisions is still limited.

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9. Can gene expression profiling help guide choice of chemotherapy regimen?

Answer:
Some genomic assays, such as MammaPrint, have data suggesting predictive value for selecting anthracycline-based versus taxane-based regimens, although this is not level-1 evidence. These results should be interpreted as supportive information within a broader clinical and geriatric context.