

Older Women with Breast Cancer (Part 3): Metastatic Breast Cancer by Dr. Hyman Muss, University of North Carolina-Chapel Hill

Dr. Muss:

To end our talk mainly about breast cancer, just a few moments on breast cancer that is spread, what we call metastatic breast cancer. This is a CT scan, if you look at it on the top is a CT scan. It's like the lady in the circus, we've sawed her in half, and we've gone right through her liver. This is her: she's lying on her back, her feet are sticking out in to the room and her head is back in to the screen. She's lying on her back and this is her spinal column, and you can see the liver has all these black spots, which are areas of cancer. This patient went on chemotherapy, and you can see these spots almost all went away.

So why isn't this a cure? The reason it's not a cure is although this chemo or hormonal therapy may last for a year or two using different drugs, we can't kill every cancer cell. So the bad actors are going to grow back and they're going to be resistant to the treatment that the patient is on. On the other hand, a lot of these patients although we can't cure them can have very meaningful long lives. A lot of these patients are working and doing well and have good lives. We have a whole host of drugs to use, including chemotherapy, including different hormonal therapies for certain patients. If they have like spread to a bone and they have pain, we use radiation. We've got a lot of tools. So this is just an example.

Now a lot of people say, "Doc, isn't that liver cancer?" So it's very, very important to understand, doctors name cancers as to where they started and patients tend to name the cancer as to where they end up. So a doctor seeing this in a patient who has had breast cancer – and we've put a needle in here and shown that these cancer cells look just like the ones in the breast – is going to say this is breast cancer that's spread to the liver, and a patient is going to go home and say to their family, "I have liver cancer now." In a way both are right, but what's important to doctors: a breast cancer in the liver is treated differently than a lung cancer in the liver frequently. It really matters as far as how treatment is given in long term prognosis. So the doctor's way allows us to pick the right treatments for the patient, and that's why we name them this way. It's always an area of confusion.

So ending on some good news for the breast cancer portion, here's data from the United States and the United Kingdom, and you notice they have slightly higher mortality rates. But if you look at these curves in both the United States and the UK, they're similar to what I showed you earlier, they are going down since the 1990's and they continue to go down by a few percent a year. So when we are making great headway in improving outcomes for women with breast cancer – we've certainly got a ways to go. But this is very, very good and why it's so important to get the appropriate treatment in the United States and in your community.

Survivorship, about a third of Americans are going to get cancer. Right now there's at least 11 million Americans, there are many more we don't know from this data. The most common survivors are patients with breast, prostate and colon cancer because they can be cured. So there's lots of people in the community with these cancers. Sixty percent of the women and men who are surviving cancer are now 65 years and older, and about 14% of them are 20 years from diagnosis. The importance of this is when you get the cancer that many of you are going to do well, and you can't forget your other health as well.

So getting cancer doesn't mean dealing with high cholesterol or hypertension or diabetes isn't important anymore. Our goal is to get everybody here. But to do that we have to pay attention to your general health as well.

In addition, depending on treatments, there are survivorship issues from the treatment of the cancer, like you may have gotten chemotherapy that causes nerve damage. Some of those types of problems although they're not going to shorten your life can really affect your quality of life. So all these things related to survivorship are further challenges, especially in older patients, but they're very important. I'm showing this because a lot of us are interested in this. Many places and hospitals are building specific survivorship clinics to deal just with the issues of cancer patients who have survived their cancer, but now have other issues in life either unrelated to cancer or related to their treatment of the cancer.

Now I'm going to tell you a few things to end this, how we deal with older people with cancer specifically. The first issue, when you see an older person, they're all in your clinic breast cancer, but is that really the problem in this patient's life?

I give you an example of two people. On the right is Katharine Graham, she was Editor of the Washington Post, Newsweek -- an incredibly gifted woman. She's 80 years old there and she looks like she's ready to go. On the left is her counterpart, an 80-year-old in a facility that needs caring for her around the clock, who's got a little dementia and can't walk. They're both 80. Obviously, if these people were in your office you would think much differently about their potential management. There's no question about that, and we would all do that.

So the questions we've got to ask are -- one of goals of treatment -- is this a potentially curative patient or is it a stage IV patient where it's going to be more controlling symptoms? How long is the patient going to live? If the patient comes in with breast cancer and they're on dialysis and they've had three heart attacks and other problems, a tiny breast cancer -- certainly we're going to make some recommendations, but it's not really going to be what's affecting a patient's life. Then if we recommend treatment, what are the side effects? Although I won't dwell on it, what are the costs, not just the financial costs but the time costs? How are you going to get to the clinic if you're older, does someone have to drive you? All these issues that relate to you and your family and your social support system.

So one thing we're becoming very good at in oncology is to quickly but rather thoroughly go through your functional status called the geriatric assessment. Now we'd love to be able to send you to a great geriatrician if you're not feeling well, but they're getting very short in the United States. So we're learning how to do this ourselves. Here's an example of what we can do and what we do in our geriatric oncology clinic at UNC; Dr. Weiss who's hosting it has a study, he's doing this with many of his patients. We look at your functional status, basic stuff; can you dress and wash yourself, activities of daily living. They're key: you can't take care of yourself or live without help if you can't wash and bathe, etc.

Instrumental activities of daily living are needed to essentially live alone. These are paying your phone bill, doing your washing, picking up groceries. If you can't do this you could be living by yourself in an apartment, but someone has to do it for you. Comorbidity is just, how many other illnesses you have in addition to your breast cancer that are consequential. Nutrition is important. In older people weight-loss is scary because it may indicate malnutrition or side effects due to the cancer, which are very important. Cognition, very important to directly assess memory in older people, you can be fooled -- and we tend to this with some very quick tests.

Then what's key is what kind of support do older people have in the clinic. Do they have family that can bring them in, or are they by themselves in the community with very little support and it's a monumental task to get them to the doctor. Then last, polypharmacy: we find in the United States we give people too many medicines. Frequently they see several doctors and no doctor has a complete grasp of what they're taking, and we know that that really can interfere with people's lives, really to immense costs and be dangerous. So, we measure the types of meds, make sure they're all appropriate and frequently we can slim them down.

So this is what we do, and I'm going to just give you an example of why this is important.

So here's a little study that we did in 500 people to predict what we call grade 3 toxicity from chemotherapy. So grade 3 are side effects like mouth sores, nausea, vomiting, nerve damage, low blood counts that really impact people's lives. So we wanted to see if we could in older patients predict these side effects so we can offer better judgment on whether to treat them or whether to modify their doses, just do a better job in general.

What we did was we asked patients numerous questions and we came up with key issues, both clinically like what type of cancer they had, what was their hemoglobin, their red blood cell count. But look at some of these questions here: one or more falls in six months, not being able to hear, can't walk a block, requiring help with medication, decreased social activity. These are questions frequently maybe your doctor has never asked you. But we've learned they're very important. We obtained these in the geriatric assessment I just showed you. We had our statisticians give us a point system for all these things. So if you couldn't walk a block, you got two points off your scale for that.

So, how is this helpful? We've learned that we could take these points – and if you look here, this is the incidence, the number of grade 3 or more toxicity, serious toxicities, and these are the bar graphs. So, if your points were between zero and five points, pretty functional person. You had only about a one and four chance of getting any serious side effects. So a person like that you could tell that patient, "Well, it's very likely you're not going to have any really great problems with the chemotherapy." On the other hand, if your points were higher, about half the patients are going to get side effects. If you had a lot of point like many things – look at this, almost everybody was going to get side effects.

So if you came in and saw me and we were thinking about chemo, and I got this little assessment which we're trying to do in as many patients as possible – it doesn't take very long, but unfortunately today we're all pressed for the time – then I might be able to look you in the eye and say, "This chemotherapy may have too many side effects." Or at least if we think it's a good idea to try it, we're going to start at a lower dose and work our way up just so we don't have a terrible problem from the initial treatment. So this is what we're trying to do with this information, is use it to best select treatments, in this case chemotherapy. But you can see how similar things could be used to select surgery or radiation or many other treatments related to patient care of cancer.

It's been a whirlwind tour and I hope you've enjoyed this. Thank you for your attention.