One of the points you make in the editorial is that older adults have been historically understudied in clinical trials for breast cancer. Can you elaborate on what factors have led to these patients being excluded?

PONDÉ: “Changing demographics are key here. Most of human societies today are aging, a process called demographic transition. Life expectancy is increasing. This is true in both developed and developing countries and has many causes.

“Older persons being a larger proportion of the population and, additionally, having a higher risk of having cancer means for oncologists a larger number of older patients seen at the clinic every day—which alone justifies the need for more research efforts in the area of geriatric oncology.

“As to why this population has been historically underrepresented in clinical trials, a number of explanations are available and ultimately I think all of them are correct. First, due to safety concerns, many trials exclude older patients. In the past, age-based exclusion criteria were a reality. But though these are not common today, other exclusion criteria can keep older patients out—for example, those that focus on serious comorbidities or altered laboratory test results—which will of course be more frequent in older patients. Another problem is that physicians themselves overlook older patients for trial participation due to safety concerns.”

Your editorial mentions results from the RESPECT trial. What was noteworthy about that research?

AZAMBUJA: “Older patients are a highly heterogeneous population. As we can see in daily life, a 75-year-old woman can be completely independent, live on her own, work, and be a caregiver for other family members. On the other hand, she can be the one in need of care due to a stroke, for instance. It means some older women don’t tolerate chemotherapy well—risking loss of functionality, neutropenia, possibly the need to be admitted to the hospital for a chemotherapy-related complication.

“The results of RESPECT suggest that for small, node-negative, HER2-positive breast cancer, the loss in efficacy due to suppressing chemotherapy is very minimal—and therefore we can give to some women trastuzumab alone safely—protecting them both from disease recurrence and chemotherapy toxicity.”

So, how do we shift the paradigm and improve treatment and care for these older patients?

PONDÉ: “Better care for older patients is a huge challenge for our health care systems. In oncology, two key changes to improve care for this population are [first] to create/expand geriatric oncology services so that eventually all older patients can benefit from being cared for within such a setting. Second, more trials focused on older patients are critical, and some research groups like the European Organization for Research and Treatment of Cancer (EORTC) are to be commended for focusing on this and producing highly valuable data.

“It is also important to add that the way toxicity is evaluated currently in clinical trials is suboptimal—even more so for older patients. Ideally, older patients in clinical trials would be followed by trained geriatricians to evaluate the long-term impact of adverse events, particularly those who lead to hospitalization or to increase mortality due to complications.”

AZAMBUJA: “Most patients with early HER2-positive disease have exceptionally good outcomes today, largely due to anti-HER2 antibodies. Trials such as RESPECT point the way in which our field needs to advance for many patients—de-escalation of chemotherapy. This is true for all patients, particularly older ones.”

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