Diagnosis and treatment on primary breast cancer in older women

The global population is ageing and older age is a major risk factor for breast cancer. When our group describes our research programme aiming to personalise the management of primary breast cancer in older women, we highlight the importance of looking at tumour biology, which appears to differ due to age (1). In order to optimise the care of this population, it is paramount that we continue with our efforts in improving the diagnosis and treatment. It is with this vision in mind that we publish a series covering a number of less thought about areas under this theme.

Lemij and colleagues in the Netherlands describe the problem as a global challenge from an epidemiological perspective (2). Breast cancer is the most commonly diagnosed malignancy among women, with more than 30% of all patients being over 70 years at the time of diagnosis. The number of older women with breast cancer is expected to increase in the upcoming decades due to the ageing of the population worldwide. Unfortunately, this heterogeneous older population is under-represented in clinical trials. Most older women with breast cancer present symptomatically and mammographic screening remains debatable. Evans discusses its pros and cons, stressing that there is currently no conclusive evidence of a reduction in breast cancer mortality with screening (3). Definitive evidence may come from the AgeX trial in the UK which is due to report in 2026. Another area of interest seldom talked about in this population is genetic testing. Chang describes a 1% detection rate of BRCA1/2 mutations in women older than 65 years of age and highlights the lack of current guidelines on genetic testing and intervention, such as prophylactic mastectomy, in this population (4).

On the treatment front, there are three articles (5-7). One looks at the lack of literature in the subject of oncoplastic surgery, which has been increasingly performed in younger women undergoing breast conserving surgery. This is in keeping with a recent publication from our group identifying a lower uptake of oncoplastic surgery in the older population (8). We also have two important articles describing the role of the geriatrician and the perspective of the patient. Traditionally the treatment of cancer is looked after by the oncologist (surgical, radiation and medical) but in this specific population where frailty assessment, decision making, treatment goals (preservation of function and quality of life as opposed to prolongation of survival) all matter, and the help of geriatric assessment will become extremely useful (6). Turner's article is extraordinary and thought-provoking (7). It is the only one in this series written by a patient, who also describes the experience of her mother-in-law when she was undergoing treatment for a triple negative breast cancer.

Finally, I would like to draw readers' attention to the latest recommendations on the management of breast cancer in older women, published jointly by the European Society of Breast Cancer Specialists (EUSOMA) and the International Society of Geriatric Oncology (SIOG), another example of 'co-management' of an older cancer patient, by oncology and geriatrics (9). While we strive our efforts on research, we must continue to appraise available evidence and recommend what clinicians (and patients!) could do every day.

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