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Q&A

Dr Biganzoli: I would like to thank you, all the presenters very, very much, because of the very interesting way you have discussed your topics, really high-quality, so, thank you very much for your contribution. So, Olivia, we have a lot of questions coming from the audience. What I've realized is that some of them are focusing on the treatment, especially, chemotherapy treatment of older breast cancer patients, so, this is possibly related to the fact that Alex has focused on these aspects, to give to the audience some feeling of how a medical oncologist feel the older patients, but I would suggest to start first with general questions, because tomorrow we will dedicate the morning to the screening, but afterwards, to the treatment of our elderly patients with breast cancer, and we'll discuss more in details chemotherapy or other treatment approaches. So, there was Giuseppe, there was very well performing and addressed already two questions, but I would love him to give a public answer, and so I, put the first question I received from Jose Fernando Prado Moura, I'm sorry for the pronunciation but, so, what protocol can we use to better identify sarcopenia? Tomography, other and so on. So, Giuseppe, rather than giving references as you kindly have done, can you tell us which is the best way to do this?

Dr Colloca: Absolutely. Thank you, Laura. Thank you everyone, and thank you for the question. It's really a good question. The best way to assess sarcopenia, there is no best way. It depends on the definition. We have several definitions of sarcopenia, the more accepted, it's of the group, of the European Group on Sarcopenia, and it's focused on two points: physical performance and muscle mass in terms of quality of the mass. So, what we need is just to assess these two aspects, these two features. About the muscle mass, it's possible to use CT scan, tomography, a DEXA scan, MRI, PET scan, whatever you prefer. The only point is just to assess the muscle mass, the quantity of mass. About the physical performance, all of the definitions that currently we have about sarcopenia focus on physical performance. Also, for physical performance, you can choose whatever you prefer, short physical performance battery, hand-grip strength, walking speed, chart test, whatever you prefer. My advice is just, focus on your resource and to try to decide which is the best way for you. If you have PET, you can use PET scan. If you have a CT scan, you use the parameters for the CT scan about the muscle mass; and about the performance, the easy way for you. If you have the hand-grip strength, it's perfect. Walking speed, it's perfect, whatever you prefer; and in the chat, there is the reference about the paper in which all of these data are explained better.

Dr Biganzoli: Thank you, Giuseppe. There is a comment, it's not a question, from Diana Artene. I would love you to comment on this. So, Diana is writing, "Normal aging nowadays is associated with gradual weight gain, as a sarcopenic obesity due to muscle loss." Boh! "Weight loss is no longer that commonly associated with aging general population, and even more so in breast cancer, patients usually gain weight during treatment."

Dr Colloca: Wonderful, terrific query, Diana. I have to say thank you to Diana. So there is a big difference, and in my talk I tried to explain it, between weight loss, sarcopenia, and then, cachexia, and sarcopenic obesity, and obesity. So, Diana talks about weight loss, and for sure, we have a weight loss with aging process. With aging process, we having a physiological loss of lean mass, we have a physiological loss of muscle mass. This is no sarcopenia, and this is no cachexia. The same is for the obesity, sometime, we have people with high body mass index, or with obesity, but these people are not sarcopenic, and we have also people with high body mass index that are sarcopenic. When we talk about sarcopenia, we're talking about the quality of the muscle mass and not the quantity; so, for Diana, one thing is the loss of weight, one thing is a low intake of nutrients. Another thing is the sarcopenia. Sarcopenia is not physiological. It's not age-related. Sarcopenia is a disease and a condition that may bring you to negative outcome, more toxicity, may bring your patients also to the frailty condition.

Dr Pagani: Can I ask a general question? Because, as I'm not an older patients' expert, so, according to the different presentations, the age limit changed.

Dr Colloca: Yeah.

Dr Pagani: So, Dr Wildiers said that they do the geriatric assessment in all patients over 70. Someone else said over 75. Dr Wright, I liked her very much, do not put any age limits, and there was a question in the chat. "Does it depend also on ethnicity, for example, or where you live?" "In Africa?" This was the question, "the average limit, length of life is much shorter, so, maybe in Africa, the elderly age limits should be put lower." So, I would like, you know, maybe, from the geriatrician, a general comment on what is older, elderly age.

Dr Colloca: What means age and the age in which you start to begin older? I love to talk about life expectancy. In all of my talks, I never say, you have to consider aged people from 75, or 70, or 65, but you have to think about the life expectancy. In my talk, I showed also a paper of Lancet in which was one thing, in a wonderful way, explained how currently it's possible to find futures of people of 75 in the west world, in person that are 80 years old and to find in the low-income countries, persons with the features, persons, non-patients, persons with the features of 65-years-old man in people with 50-years-old, 55 or 45, for example, in Afghanistan, Papua New Guinea, et cetera, et cetera. When I put data about, for example, 75, it's related to Italy. In Italy as a geriatrician, we decide to say that you don't have to consider older person, if a person is less than 75-years-old, but this is just a limit to say, keep in mind that the people, the persons, and the age-limit per person are personal fit, you don't have to consider just the anagraphic, the chronological data. So, my advice, if you want to start in some way the assessment and to put an age to start an assessment, is, in the west world, to consider 70, but for sure, as from geriatric point of view, you have to look at the life expectancy of the patients, at the future of the patients, at the fitness of the patients and not absolutely at the anagraphic data of the patients, chronological age of the patients, or the person.

Dr Pagani: Any comment back from Juliet and Hans?

Prof Wright: Thank you, it's very nice to be invited to speak. So, I mean, I'm very much of, as you've hopefully seen from my presentation, of not using age at all, and I really try in my clinics for age to be the very last thing that I ask, and that I look at reserve, comorbidities, and however you wish to define it, frailty, and there is no WHO definition of aging. I think if you look at some of the data, different countries, different ethnicities, you know, what do people consider as old, and what people consider as young is quite interesting, and certainly, definitions around contributions to communities and much more functional descriptions of what old age means, I think is what you find if you look wider, so, I don't find numbers of birthdays very helpful in making

treatment decisions at all, and interestingly, I do a very similar clinic for older people with HIV, and again, you know, a lot of those patients are in their early 50s, but their comorbidities, their physiology, their frailty make them function much like somebody without those risk factors, so, yeah, I really try not to look at age and just to finish, you know, certainly the data in breast cancer has obviously been very 70s focused, you know, with the previous data, particularly, around operative interventions, but yeah, that's certainly how we do it in our clinic.

Dr Pagani: Hans, your position?

Dr Wildiers: The evaluation in our center, in my clinic, starts with a G8, so, it's also not the age itself, and that's the start. It's just the start, but you have to decide in which patients you measure the G8, and we cannot measure G8 in a 40-year-old person, makes no sense, so, it's a very arbitrary choice to put it at 70, because below 70, the percentage with low G8 is low, but still, we can individually decide if we visually have the impression that there is a frailty problem, we can still do it.

Dr Pagani: Alex, you wanted to comment.

Dr Eniu: Yes. I just wanted to say that actually, the goal of my presentation was to present what, you know, a general oncologist thinks, and actually, to present some of our fixed ideas, and, as you see, also in the chat, people would like to have shortcuts. People would like to have, you know, thresholds to say, "Okay, I'm doing chemo," "I'm not doing chemo," and the bad news, and I think it's that we do not have this kind of algorithm, and there's no shortcut for doing a complete assessment to try to take into consideration all that was considered today; so, I was a little bit provocative with the things that I was putting in the presentation.

Dr Pagani: So, maybe Laura, the magic word is comorbidity and life expectancy.

Dr Biganzoli: Yes.

Dr Pagani: Irrespective of age.

Dr Biganzoli: Oh, yes, that's for sure, and, you know, comorbidities and life expectancy are two key-issues that we will discuss tomorrow, that we have to consider, especially, when we have to decide for adjuvant systemic treatment, because we have not to forget that an elderly breast cancer patient can die for reasons that are not related to breast cancer, so, we have really to change our view in respect to younger patients that have the diagnosis by various cancers, so, comorbidities, life expectancy and the ladder of other information we get from geriatric assessments, like, for example, functionality that is also related to life expectancy, are important information that we have to consider to decide how to proceed with our older patients. If you are satisfied with this discussion on this specific topic, there is a question that, you know, I'm familiar with because, you know, in Italy, the family tries to protect the older patients, and this is, I guess, typical also of the Mediterranean countries, and the question is, should we communicate the diagnosis of cancer to an older patient? Or we have to protect her, in this case, a breast cancer patient, giving treatment but without telling the right diagnosis, because this could have a negative impact on the psychological performance of the patient. Luzia, I believe that you are the right person to start answering this question.

Dr Travado: Well, this is a typical issue that many times the families address but it depends on the cognitive reality of the patient. Of course, if you are dealing with a dementiated patient, family has to make a decision, but if you are dealing with a patient that is still in her own right, it is important to break the news in a language that is not very aggressive, because, usually, elderly people, which some of you have mentioned, have lived mostly their life in the 20th century, for them just mentioning the word cancer is a disaster, is death sentence, and they will lose hope and they will get into despair, so, this is a very sensible issue, and that's why communication skills are so important, so, you really need to understand what are the concerns of the family? So, sometimes, the family will tell you, "This patient is suicidal," and you need to know that, or "She's very depressed" or "She's lonely," and so, you need to understand what are the family's concerns. And then, as a

medical doctor, you cannot perform a treatment without your patient's consent, so, you have to tell them something, but be very careful with the language that you use, and the protocol is to tell them that they have something that will require treatment, and try to understand if they want to know more, so, going chunk by chunk, step by step with the patient and not pressing the full diagnosis on the patient. That is the protocol, so letting the patient make questions, if they want to know more. Of course, you have to tell them that, because of that circumstance, that tumor or that disease that you found, you will have to do some treatment, and if they agree that, you treat them, and so, this creates an opportunity of dialogue that will let you know if the patient wants to know a little bit more. One of the parts of the protocols, particularly, the SPIKES protocol, which is a protocol on how to break bad news in a sensible way, is to understand if the patient perceives what's going on with her, if she has any kind of idea of what is going on with her, because if she already perceived that something might be wrong, then you can add a little bit to that, and if she doesn't, if she's very far away, then, you will have to let her know that, you know, we have done these exams, because there is a suspicion that something was not so okay, and then, to see what the patient demands from you in terms of this dialogue, so, that would be somewhat the dialogue, telling, allowing the patient to ask you questions, see their concerns and, of course, you will have to ask permission to the patient to do some kind of treatment, and if you mention chemotherapy as an option, then, of course for them, many of them will know what this means, and if they don't, because some people from the rural areas might not understand what that means, maybe, you will have to explain them and then, they well may have questions or not, or you may ask them if they prefer, if they don't speak too much, that you will address someone in their family to discuss these more complicated issues, but you have to have the permission of the patient to do this, either to have someone in the family to dialogue with. Sometimes, they say, "Well, my daughter's, she knows a little bit more, so, I would prefer that you discuss this issue with her." Then, you have the permission, but before that, you need to entail some trust and confidence by giving the priority of choice to the patient.

Dr Biganzoli: I'm really interested in knowing your opinion also of the patients' advocates on this side. You have to unmute, Susan.

Ms Knox: Okay, can you hear me now?

Dr Biganzoli: Yeah.

Ms Knox: Yeah, okay. No, I'm very happy to respond also, not just as a person who's been treated in Italy twice, but as a patient advocate, that, of course, I agree with Luzia, but unless there are really significant cognitive issues that make it impossible to communicate, I believe in this day and age, all patients have an absolute right, and doctors have a duty to give up-to-date important and factual information to patients. It really is their right, and having also undergone some of this personally, I can tell you that not telling people creates more confusion and concern than telling people the truth about their diagnosis and about the treatment that they ought to have, and certainly, we in the patient advocacy community across Europe believe very strongly that patients have a right to receive up-to-date, factual information about their treatment and about the diagnosis, and it really helps, again, in the communication process, and being older, again, has nothing to do with whether or not people should receive accurate up-to-date information, as long as they can understand what's being communicated.

Dr Travado: Just let me add to that, Susan. Of course, there is a diverse... I agree with what you said, but we have to consider the cultural diversity and the geographical areas. Of course, people from the city are very different from people from rural areas, and a study about how people wanted to know their diagnosis or not in Portugal, we were surprised that 85% of people said they wanted to know, but still, there were 15% of patients that did not want to know the diagnosis, so, the doctor needs to know who are these people in any case in front of them, and smashing the diagnosis on the patient's face is also not the most adequate thing, so, still, respecting the patient's preferences and needs, and allowing the patient to ask questions before

having all the information upfront. I think it's a very, a very sensible issue. I don't know if you agree, but I think...

Ms Knox: Well, I agree if the patient communicates that they don't want to know, but I don't agree in allowing necessarily other family members to make that decision on behalf of patients.

Dr Travado: Of course, of course.

Ms Knox: Unless, they have real cognitive difficulty in understanding the diagnosis and therefore, a decision has to be made for them. Otherwise, I think in general people need to know, obviously, the communication can be more or less, needs to be sensitive, and obviously, some people want less information, so, a lot doesn't have to be defined or laid out or explained to patients if they'd rather not hear all the details but I think it is up to the patient to make that decision.

Dr Travado: I completely agree, and that's the patient's right.

Dr Pagani: Elizabeth, just you know, to have your Nordic view and then, I have a question for you, because I was really impressed, I never thought of that, about the age-gap between the doctor and the patient, so, I think this is the other way round, and getting older and treating young women, so, this is also the other way round, but I think that... you mentioned that, which is important, that if you are older, maybe, or you are more embarrassed to discuss something with a 35-years-old doctor, so, I think you touched this and I think it's important, maybe, if you can tell us more, and your Nordic opinion, and also, Wendy's, the nurse from Netherlands, you Nordic opinion about telling the truth, using the word cancer, for example.

Ms Nordström: Yeah, I agree, but also, we have to also realize here, we have people attending this meeting that come from different parts of the world, and we do have cultural differences even, I mean, in different countries, different parts of the world as well, so, I think the doctor has to... just told that, the issue has to be addressed according to where you are in the world, and also, where the patient is in relation to the patient's capacity and capacity to understand and so on, but to get addressing the question, when you said that there are cultural, where, I said rather, there are cultural differences between, or comparatively, cultural differences in the age gap between doctor and patient, this can be difficult, and I also mentioned older patients, at least in the Nordic countries, they rarely speak of their shortcomings, and then, as I also said, it doesn't change that if they have a cancer diagnosis, so, then, it is, I understand it must be difficult for a doctor to try to sort of pass through this barrier, or border to get to talk to the patient about those issues that may be difficult to address, and this is where I think also, when from a psychological standpoint, it's very interesting with this course, because you have all the specialists, specialist functions, talking about the same topic with their backgrounds, and I think everyone can really learn a lot from each other. I think it is a lot of, it demands a lot of psychology really, to also address difficult issues with the patient and especially, with a cancer diagnosis, because also, as has been said, a cancer diagnosis was, and is still in some parts of the world, equal to a death sentence. I don't know whether I've responded enough, but I agree with Susan, who said that the patient should really be involved, because this is also what I talked about, being included in an informed decision, and an informed decision means that you have to include the patient, but again, some patients have not the possibility to really participate and understand the issue.

Dr Biganzoli: Okay, so we are short on time. We have five minutes to conclude our discussion. I would like to have on this issue the opinion also of the nurse, because the nurses are very often closer to our patients that we are, so, they are really following also the trajectory of the treatment of our patients, so, it would be of extreme value to have also the opinion of our nurse.

Mrs Oldenmenger: I can tell you, I totally agree with the previous speakers here, that of course, we should tell the truth to our patients, but also in a more careful and cultural sensitive way, so, communication is the key-issue here, I think, and especially, looking from a Dutch perspective, yes, we try to be as open as possible,

not only the physicians, but also, the nurses that together with patients and families, and especially even patients, and many of our patients are treated at a cancer ward and over in a Cancer Institute, so, also, then the family doesn't allow them. I've seen that in daily practice, that they actually fool each other. They're both of them that don't want to know it from each other, yet the patient is also not crazy, he's been treated in a Cancer Institute, so, yeah, so, the best way is to be as honest as possible, but also, be careful in the communications that you don't hurt them, I think, yeah.

Dr Pagani: Okay, I think we need to close, unfortunately, so, I think for the medical questions tomorrow, we will have time to go into more details. We need to reconvene at 10:00 a.m. for the debate on mammographic screening over the age of 70 and then, all the medical treatment issues. I think I learned a lot and I think it was really very nice, and I thank all the speakers and of course, Laura and also the participants who were very active, and thank you very much all, and see you tomorrow morning.

Dr Biganzoli: Have a nice evening, or afternoon.

Dr Travado: Thank you, thank you.

Ms Knox: Bye.

Dr Travado: Bye, bye.