European Journal of Oncology Nursing 16 (2012) 78–86

Contents lists available at ScienceDirect

European Journal of Oncology Nursing

journal homepage: www.elsevier.com/locate/ejon

Specialist breast care and research nurses' attitudes to adjuvant chemotherapy in older women with breast cancer

Rachel Ballinger [a], Elizabeth Ford [a,*], Emma Pennery [b], Valerie Jenkins [a], Alistair Ring [c], Lesley Fallowfield [a]

[a] Cancer Research UK Psychosocial Oncology Group, Brighton and Sussex Medical School, University of Sussex, Falmer, Brighton BN1 9QG, UK
[b] Breast Cancer Care, 5-13 Great Suffolk Street, London SE1 0NS, UK
[c] Sussex Cancer Centre, Royal Sussex County Hospital, Eastern Road, Brighton BN2 5BE, UK

Keywords:
Breast cancer
Elderly
Adjuvant
Chemotherapy
Nurse
Survey

A B S T R A C T

Purpose: Breast cancer largely affects older women (≥70 y) who have historically been excluded from clinical trials; consequently, treatment is often not evidence-based. Older women may not be offered adjuvant chemotherapy due to assumptions that they would not benefit, cannot tolerate it or do not wish to have it. Specialist breast care nurses (BCN) and research nurses (RN) play an important role influencing decisions. We report the roles, attitudes and involvement of such nurses regarding adjuvant chemotherapy in older women.

Method: A questionnaire examined 259 UK BCN and RN's views about efficacy and desirability of chemotherapy in older women, participation in decision-making in MDTs, and roles when chemotherapy was discussed with patients.

Results: 72% of BCN and 48% of RN agreed that age should not be a factor influencing who is offered chemotherapy. BCNs indicated involvement in decision-making with older breast cancer patients, discussing chemotherapy with patients at different points following diagnosis and during treatment, and proposing chemotherapy in MDT meetings. RNs were involved to a lesser extent. 69% of all nurses had not received specific training in the area and 70% thought training would be beneficial. Nurses disagreed that older patients would not tolerate or did not want chemotherapy but 1/3 agreed or were uncertain that burdens of chemotherapy outweighed benefits. A third felt that older women had less control over treatment decisions than younger women.

Conclusions: This study suggests a need to develop the role of specialist nurses to facilitate treatment decision-making relating to chemotherapy in older women.

Introduction

In the UK, around a third of new breast cancer diagnoses and over half of deaths occur in women aged 70 and over (Cancer Research UK, 2010a,b). Older women as a group are not uniformly defined across the literature, some groups define "older" as 65 years (Aapro, 2008) and others as 70 years or older. We present literature from publications using both definitions and use 70 years as a lower age cut-off in this study. While breast cancer survival is improving in most age groups in the UK, this is not the case in older patients (Moran and Moeller, 2009). There is evidence globally that older women are less likely to receive what would be considered the standard care for their breast cancer (Busch et al., 1996; Crivellari et al., 2007), that is, they are less likely to receive surgery (Husain et al., 2008), chemotherapy (Buist et al., 2009) and radiotherapy (Busch et al., 1996; Wildiers et al., 2007). In addition, those having surgery are less likely to be offered breast conservation or reconstruction (Bouchardy et al., 2007; Girotto et al., 2003; Wildiers et al., 2007). This is an important issue, as less than optimal therapy has a strong negative effect on survival (Bouchardy et al., 2003; Wildiers et al., 2007) and quality of life (Mandelblatt et al., 2003).

Older women are more likely than younger women to have oestrogen-receptor (ER) positive tumours, which respond well to hormonal therapy following surgery and do not necessarily need further treatment (Wildiers et al., 2007). However, tumours in older women tend to be larger and more advanced, with more lymph node involvement at diagnosis (Wildiers et al., 2007). In women with ER negative tumours, large primary tumours, or positive node involvement, adjuvant chemotherapy can achieve a significant

* Corresponding author. Tel.: +44 1273 873035; fax: +44 1273 873022.
E-mail address: e.ford@sussex.ac.uk (E. Ford).

1462-3889/$ – see front matter © 2011 Elsevier Ltd. All rights reserved.
doi:10.1016/j.ejon.2011.03.011

reduction in mortality (Wildiers et al., 2007). It is estimated that about 50% of older women with breast cancer meet these criteria and would benefit from adjuvant chemotherapy (Crivellari et al., 2007). Although the willingness of older cancer patients to have chemotherapy is high (Extermann et al., 2003), some oncologists are reluctant to offer them chemotherapy.

Several reasons have been proposed to explain why fewer older women are offered adjuvant chemotherapy for their breast cancer than their disease characteristics would warrant. The most common reason given by clinicians is that the risk of toxicity is greater in older patients (Hurria et al., 2006; Kemeny et al., 2003; Wildiers et al., 2007). Clinicians also perceive older patients as less likely to tolerate the negative effects of toxicity on their quality of life. However, studies have shown that patients are willing to accept toxicity if they are likely to return to baseline functioning at the end of therapy and if they have a chance of increased survival (Hurria et al., 2006). Older cancer patients have concerns about the long-term effect on their functional status, cognition and quality of life (Hurria et al., 2006), but it has been found that the subjective burdens of treatment are similar for younger and older patients (Ballinger and Fallowfield, 2009; Crivellari et al., 2000; Tallarico et al., 2005). One study has suggested that 71–100% of older cancer patients would be willing to accept moderate to strong chemotherapy and options should therefore be fully discussed with them (Extermann et al., 2003).

Another reason given by physicians for not offering chemotherapy is that older women have more co-existing medical conditions (Bouchardy et al., 2007; Jennings-Sanders and Anderson, 2003; Kemeny et al., 2003). Sixty-one percent of women aged 70–79 y have two or more comorbid conditions such as arthritis, hypertension, heart disease or diabetes (Tallarico et al., 2005). These may interact with cancer treatment to affect function and survival. Further, some studies have suggested that under-treatment can be explained by patient refusal of chemotherapy, but this is in fact thought to affect a low proportion of patients (Bouchardy et al., 2007). Scenario-based studies, presenting hypothetical cases where only the patient age is changed, have shown that some clinicians base their decision to offer chemotherapy on patient age alone (Kemeny et al., 2003; Protière et al., 2010; Ring, 2010).

A further reason for clinicians not offering chemotherapy is that information about safety and efficacy in older women is lacking, as few older women take part in clinical trials (Kemeny et al., 2003). Older patients (>70 y) have traditionally been excluded from clinical trials, and even when they are eligible, perceptions that they are less likely to benefit, and less able to tolerate intensive treatments, negatively affect enrolment (Biganzoli and Aapro, 2003). Those participating in such trials are usually fitter and healthier than average and therefore not representative of the older population. As a consequence, there is a paucity of evidence-based clinical trial data for older patients with breast cancer (Buist et al., 2009; Wildiers et al., 2007), making treatment decisions difficult for clinicians.

Communication between health-care professionals and their older patients may also influence treatment choices. Older women are more likely to accept the advice of their doctors and put greater trust in them than younger women; they also ask fewer questions and are more passive in their information-seeking behaviour (Husain et al., 2008). One qualitative study suggests that older patients may have problems processing and remembering information and may be reluctant to ask for help and guidance, despite wanting concrete information about their prognosis and treatment (Posma et al., 2009). In addition, studies suggest the quality of physician communication declines with patient age, reducing further the information older patients receive (Maly et al., 2003; Tallarico et al., 2005). Disparities in the treatment of older patients may therefore be partially overcome by more effective clinician communication, and provision of extra support for patients with processing information and making treatment decisions.

Specialist breast care and research nurses have important roles to play throughout older patients' treatment. In the UK, breast care nurses are specialist cancer nurses who "counsel and offer practical advice and emotional and informational support to newly diagnosed patients at the time the diagnosis is given, and discuss treatment plans with them" (EUSOMA, 2000, p. 2290). They see patients at their first out-patient appointments and then offer regular contact throughout investigations and treatment, giving practical information and support in all aspects of breast care. Research nurses are involved in clinical trials within academic units and work closely with medical staff, supporting patients through the stages of their disease and treatments (Raja-Jones, 2002). Their roles may involve recruiting people into studies, collecting data, long-term follow up, handling administration, dealing with grant writing, and the ongoing care and support of patients and their carers within the context of clinical trials and other research. Specialist nurses are perceived as effective and important information providers by cancer patients, especially in relation to provision of explanations and clarifications on information previously provided by physicians (Koutsopoulou et al., 2010). Receiving appropriate and full information may enhance patient adherence to treatment, and give patients a sense of control over their disease. It may also enhance well-being and decrease stress (Koutsopoulou et al., 2010). Nurses are also perceived as helpful in conveying women's needs to doctors in the multidisciplinary team (Liebert and Furber, 2004).

Nurses have been shown to improve treatment options offered to older breast cancer patients (Goodwin et al., 2003), including a trend for older women with advanced cancer to receive more chemotherapy. A review suggested that specialist breast cancer nursing can lead to significant improvements in giving appropriate treatment in accordance with guidelines (Ouwens et al., 2009), increased patient involvement in the decision-making process, and improved physical and psychosocial well-being (Eicher et al., 2006).

Nurses can therefore act as patient advocates, and may have appropriate skills to explain treatment options, help with information processing, and increase comprehension, resulting in better decision-making. However, no study has yet examined specifically the attitudes of breast care and research nurses towards adjuvant chemotherapy in older women with early breast cancer (≥70 y in this study), and the extent of their involvement in clinical and patient decision-making in this area, which this paper reports. Our study is part of a project (AChEW – Adjuvant Chemotherapy in Elderly Women) which is formally examining influences on both clinical and patient decision-making about chemotherapy in this patient group.

Methods

Materials

A study-specific 25-item questionnaire was developed. The questionnaire asked nurses to report on: characteristics of their current post, their consultations about adjuvant chemotherapy with older women with breast cancer (aged ≥70), treatment decision-making in multidisciplinary team (MDT) meetings, nurse involvement in clinical and patient treatment decision-making, patient questions regarding chemotherapy and nurse responses, nurse training in discussing chemotherapy with patients, their beliefs and attitudes regarding chemotherapy and treatment decision-making for older patients, and other perceived influences on patients' decision-making regarding chemotherapy.