

SDM POSSIBLE Trial Training

*Shared Decision Making for People Over Seventy
with Stage I Breast Cancer to Learn and Engage*

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Objectives

- To review the preference sensitive breast cancer treatment decisions that women ≥ 70 with Stage I, ER+, HER2- breast cancer encounter
- To describe shared decision models and shared decision making challenges
- To learn how to incorporate patient overall life expectancy in breast cancer treatment decision-making with older women
- To review and practice scripts for engaging older women in shared decision making around breast cancer treatment

Breast Cancer in Older Women

- >90,000 US women 70+ are diagnosed with breast cancer annually
- Women ≥ 70 years account for 31% of diagnosed breast cancers
- Majority are diagnosed with stage I, ER+, HER2- tumors
- Increasing recognition that some older women are overtreated:
receive therapies unlikely to improve survival or reduce morbidity

Older women report unmet informational needs

- Older women with breast cancer have low knowledge of survival and recurrence rates
- Feel ill-prepared to communicate their preferences and less comfortable asking their surgeons questions
- Other sources of information are rarely targeted to older women
- Older women heterogeneous in their health and values/preferences

Schonberg et al. Breast Cancer Research and Treatment, 2014;
Freedman et al. Cancer, 2015
Baskin et al. Ann Surg Oncol., 2021

Clinicians may not elicit patient values or preferences

- Physicians underestimate patient desire to participate in treatment decisions, especially for older adults.
- Physicians are often incorrect when they attempt to infer patient treatment preferences.
- Clinicians may not discuss the implications of aging related conditions (e.g., frailty) on the heightened risk of adverse events from treatment

Shared decision making may lead to more person-centered care

- **Shared Decision making:** A collaborative process that encourages patients and their clinicians to make health care decisions together, taking into account the best clinical evidence to weigh the risks and benefits as well as the patients values and preferences.
 - May improve patient risk perception, understanding of treatment options, and satisfaction while reducing decisional regret
 - More people choose options in line with their values
 - May improve patient-clinician communication and outcomes

SHARED DECISION MAKING VS. USUAL CARE

Clinician



Patient



PATERNALISTIC:

Information and recommendations



INFORMED MEDICAL DECISION MAKING:

Information



SHARED DECISION MAKING:

Information and recommendations



Values and preferences

Shared decision-making

- All options mentioned
- Discussion of options
- Recommendation offered only on request
- Nudging avoided
- Option "menu" narrowed down based on doctor assessment of best fit with patient priorities
- Physician recommendation offered, based on experience and what is understood to matter to patient
- Nudging acceptable
- Presentation of a very limited number of options
- Physician strong recommendation volunteered / direct guidance given
- Physician uses known patient/family priorities and applies them to present scenario

Shared decision making most useful when:

- Multiple treatment options
- Uncertainty regarding the evidence supporting a treatment or its outcomes
- Treatment advantages and disadvantages that patients must weigh
 - Trade offs such as length vs. quality of life, prevention of future problems, costs, convenience
- Preference based, no best option
- The decision is high impact



Older women with Stage I, ER+, HER2- breast cancer face many preference sensitive treatment decisions

- Mastectomy vs. Breast conserving surgery (BCS)
 - Reconstruction or oncoplastic surgery
- Sentinel lymph node biopsy
- Radiotherapy after BCS
 - What type of radiotherapy: Whole-breast, hypofractionated regimens; accelerated partial breast irradiation
- Radiotherapy vs. endocrine therapy after BCS
- Cryotherapy vs. surgery
- Primary endocrine therapy (PET) vs. surgery
- Type of endocrine therapy

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Guidelines: Sentinel Lymph Node Biopsy

NCCN 2026/ Society of Surg Onc 2019	SLNB may be omitted after BCS in cN0 women ≥ 70 with early stage HR+, HER2- breast cancer if they will be treated with HT
ASCO 2025	Clinicians should not recommend routine SLNB for patients ≥ 50 years with ultrasound node-negative (T1,N0,G1-2) early-stage invasive breast cancer, that is HR+ and HER2- who undergo BCS.
EUSOMA/ SIOG 2021	SLNB is the standard of care for staging the axilla in patients with clinically/ radiologically negative axilla. Axillary surgery can be omitted in patients with cT1N0 luminal A-like tumors or short life expectancy

NCCN: National Comprehensive Cancer Network; EUSOMA: European Society of Breast Cancer Specialists (EUSOMA); SIOG: International Society of Geriatric Oncology (SIOG); ASCO: American Society of Clinical Oncology

Data on lymph node biopsy in older women

Trial (No. of Patients)	Inclusion Criteria	SLNB/axillary staging	No axillary staging	Summary
SOUND (Sentinel Node vs. Observation After Axillary Ultra-Sound) RCT, 2023 (n=1,405), 5y follow-up	Age >45 (median 60, IQR 52-68), T1, 95% HR+, HER2-	LRR: 1.7% Distant mets: 1.9% DDFS: 97.7% and 98.0% OS: 98.2% Positive LNs: 13.7% Axillary recurrence: 0.4%	LRS: 1.6% Distant mets: 2.3% DDFS: 98.0% OS: 98.4% axillary recurrence: 0.4%	No difference survival, recurrence or adjuvant treatments
Martelli et al. RCT 2011 (n=238), ALND vs none 15y follow up	Age 65-80, <2.5cm, N0, grade 1-3, 85% ER+, RT to the chest, tamoxifen	Ipsilateral recurrence: 4.0% Distant mets: 8.6% BCSS: 92.4% OS: 71.6% Positive LNs: 23% Axillary recurrence: 0%	Ipsilateral recurrence: 8.3% Distant mets: 9.6% BCSS: 90.8% OS: 68.2% Became +: 3.6% Axillary recurrence: 6%	No effect on survival
IBCSG 10-93 RCT, 2006, (n=473) 6.6y median follow-up	Age 60+, cN0, 80% ER+, received ET	DFS: 67% Axillary recurrence: 1.0% OS: 75% Positive LNs: 28%	DDFS: 66% Axillary recurrence: 2.5% OS: 73%	No difference in survival, QoL better post-op w/o axillary staging
CALGB 9343 RCT of RT (n=636), 2013, SLNB optional 12.6y medial follow-up	Age 70+, T1, N0 HR+, Grade 1-2; 38% had ax dissection	Axillary recurrence: 0% Positive LNs: 3.5%	Axillary recurrence: 0% in group treated with RT/Tam 3% in group treated Tam only	No survival difference with or without axillary surgery

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Trial (No. of Patients)	Inclusion Criteria	SLNB/axillary staging	No axillary staging	Summary
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Martelli et al. RCT (n=238), ALND vs. SLNB 15y follow up				No effect on survival
IBCSG 10-93 RCT 2006, (n=473) 6.6y median follow-up	80% ER+, received ET	Axillary recurrence: 1.0% OS: 75% Positive LNs: 28%	Axillary recurrence: 2.5% OS: 73%	No difference in survival, QoL better post-op w/o axillary staging
CALGB 9343 RCT of RT (n=636), 2013, SLNB optional 12.6y median follow-up	Age 70+, T1, N0, HR+, Grade 1-2; 38% had ax dissection	Axillary recurrence: 0% Positive LNs: 3.5%	Axillary recurrence: 0% in group treated with RT/Tam 3% in group treated Tam only	No survival difference with or without axillary surgery

Summary: SLNB after BCS has little to no effect on local recurrence, rarely changes treatment, and does not improve survival for older women

Risks of Sentinel Lymph Node Biopsy (SLNB)

- Lymphedema: 4-7% within 18 months of SLNB
 - Numbness: 9% within 18 months of SLNB
 - Decreased range of motion of the shoulder: 13% within 6 months
 - Pain: 3-50% 1 year after treatment
-
- Older women are at greater risk of harm and the impact may have a greater impact on their function

Guidelines: Radiation Treatment after Breast Conserving Surgery

NCCN 2026	Consider omitting breast irradiation in patients ≥ 70 years old with ER-positive, cN0, pT1 tumors who plan to receive 5 years of endocrine therapy Those eligible for omission of RT may choose to receive RT alone instead of endocrine therapy
EUSOMA/NICE/SIOG 2021	WBRT (whole breast radiation therapy) remains the standard of care for most older patients following breast conserving surgery and omission of radiotherapy in low-risk patients can be safe and reasonable.

NCCN: National Comprehensive Cancer Network; EUSOMA: European Society of Breast Cancer Specialists (EUSOMA); SIOG: International Society of Geriatric Oncology (SIOG); NICE: National Institute for Health and Care Excellence

RCTs on RT after BCS+ET in older women

Trial (No. of Patients)	Inclusion Criteria (all received ET)	Locoregional recurrence no RT	Locoregional Recurrence with RT	p Value	Overall survival
PRIME II RCT (n=1,326), 2023	Age 65+, HR+, T size ≤ 3 cm, N0, (grade III or LNI, not both)	9.5% at 10 yr	0.9% at 10 yr	<0.001	NS
CALGB 9343 RCT (n=636), 2013	Age 70+, T1, N0 HR+/unknown Grade 1-2	10% at 10 yr	2% at 10 yr	<0.001	Not significant (NS)
BASO II RCT, 2013 (n=1,135)	Age 70+, T1, N0 grade 1	8% at 10 yr	2% at 10 yr	CI sig	--
ABCSG RCT (n=869), 2007	Postmenopausal, HR+, T size < 3 cm, N0, grade 1-2	6.1% at 5 yr	2.1% at 5 yr	<0.001	NS
Fyles RCT 2004 (n=769 [325 70+])	Age 70+, T1-2, N0	7.5% at 10 yr	3.0% at 10 yr	<0.001	NS
Observational study					
Palmer cohort study (n=601), 2025	Age 65-90, HR+, T1N0, grade 1/2, Received 6 yrs of ET	5.5% at 10 yr (95% CI [3.8-7.6%])			95 deaths (3 [3.1%] breast cancer)
LUMINA cohort study (n=500), 2023	Age 55+, T1N0, grade 1/2, Luminal A, Ki67 $< 13.25\%$	2.3% at 5 yr (95% CI [1.3-3.8%])			13 deaths (1 [7.7%] breast cancer)
Ongoing trial		no RT (+ET)	RT (no ET)		
EUROPA(n=731) ongoing	Age 70+, T1, N0 (cN0) ER/PR $\geq 10\%$, Ki67 $\leq 20\%$				RT= $\uparrow$ QoL (n=207)

RCTs on RT after BCS+ET in older women

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PRIME II RCT (n=1,326), 2023	Age 65+, HR+, T size ≤ 3 cm,	9.5% at 10 yr	0.9% at 10 yr	<0.001	NS
CALGB 9343 RCT (n=636), 2013					ns (NS)
BASO II RCT, 2013 (n=1,135)					
ABCSG RCT (2007)					
Fyles RCT 2004 (n=769 [325 70+])					
Observational studies					
Palmer cohort study (n=601), 2025					[3.1%] (p=0.001)
LUMINA cohort (n=500), 2023					[7.7%] (p=0.001)
Ongoing trial					
EUROPA (n=731), ongoing	Age 70+, HR+, No (or low) ER/PR $\geq 10\%$, Ki67 $\leq 20\%$				RT vs. No RT (n=207)

Summary: Radiotherapy after breast conserving surgery leads to about 8% reduction (10% to 2%) in locoregional recurrence among women 70+ with Stage I, HR+, HER2-breast cancer who take endocrine therapy but no effect on 10-year survival.

Radiotherapy may better preserve quality of life compared to endocrine therapy

Side effects of RT after BCS

- Fatigue during treatment
- Increases breast pain, breast swelling, fibrosis, and retraction
- Long-term changes in the breast
- Rare but serious side effects such as secondary malignancies and cardiac toxicity, latency period 5 to 20 years

Side Effects with 5 years of Endocrine Therapy

	Tamoxifen	Aromatase Inhibitors (AIs)
Bone fracture	Prevents	Causes bone loss/thinning
Uterine (womb) cancer	↑	-
Stroke	↑	-
Blood clot	↑	-
Cataracts	↑	-
Muscle/joint pain	-	↑
Hot Flashes	↑	↑
Vaginal dryness	↑	↑
Hair loss	↑	↑
Fatigue	↑	↑
Headaches	↑	↑
Decreased memory	Possibly ↑	Possibly ↑
Heart disease	-	Possibly ↑

Guidelines: Primary Endocrine Therapy

EUSOMA/ SIOG 2021	Surgery remains the choice of primary treatment in the majority of older patients with early breast cancer; Primary endocrine therapy can be considered as an alternative in selected patients with a strongly ER-positive tumor and short life expectancy (no more than 5 years); Adverse events of endocrine therapy should be considered in this decision
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EUSOMA: European Society of Breast Cancer Specialists (EUSOMA); SIOG: International Society of Geriatric Oncology (SIOG);

PET vs. Primary Surgery (from RCTs)

Outcome	Primary Surgery +/- ET	PET
Local recurrence/ progression	~5-10% at 5 years	~30-50% at 5 years
Breast cancer-specific survival	Similar	Similar
Overall survival	Similar in RCTs	Similar in RCTs
Quality of life (short-term)	More post-op discomfort	Less initial burden (progression at 18-24 mos)
Quality of life (long-term)	Stable	May worsen (15.5% require salvage surgery, 32.5% change ET)

Many older women with Stage I, ER+, HER2-, breast cancer receive SLNB and RT after BCS

- SLNB in women ≥ 70 with HR+, cN0 (rates range from 25-97%):
 - Age 70-74: 92.1%
 - Age 75-79: 89.1%
 - Age 80-84: 81.7%
 - Age 85-89: 66.2%
 - Age 90-94: 46.2%
 - Age 95+: 29.7%
- RT after BCS (rates range from 40-80%):
 - Age 70-74: 74-80%
 - Age 75-79: 50-65%
 - Age 80-84: 30-50%
 - Age 85+: 10-35%

High quality shared decision making with older women with breast cancer should consider:

Tumor
characteristics/
risk of
recurrence



Lag-time to
benefit of the
treatment



Life
expectancy/
health



Preferences,
values, goals



WHAT WOULD YOU LIKE TO DO?



**PROGNOSTIC
CALCULATORS**



**TIME TO
BENEFIT**



**CANCER
SCREENING**

[NEW AND MOST USED PROGNOSTIC CALCULATORS](#)

Estimating life expectancy

Schonberg et al., JGIM 2009, JAGS 2017, Lee SJ et al., JAMA 2006 and Cruz M et al. 2013

Lee Schonberg Index

- Population: Community dwelling adults aged 50 and older
- Outcome: All cause 4, 5, 10 and 14 year mortality
- Scroll to the bottom for more detailed information

English

Español

Français

Português

Risk Calculator

1. How old is your patient?	75-79
2. What is the sex of your patient?	☒ Female ☐ Male
3. What is your patient's BMI?	< 25
4. Which best describes your patient's health in general?	Good
5. Does your patient have chronic lung disease, such as emphysema or chronic bronchitis?	☒ Yes ☐ No
6. Has your patient ever had cancer (excluding minor skin cancers)?	☐ Yes ☒ No
7. Does your patient have congestive heart failure?	☐ Yes ☒ No
8. Does your patient have diabetes or high blood sugar?	☐ Yes ☒ No
9. Which best describes your patient's cigarette use?	Former Smoker
10. Does your patient have difficulty walking 1/4 mile (several city blocks) without help from other people or special equipment?	☐ Yes ☒ No
11. During the past 12 months, how many times was your patient hospitalized overnight?	None
12. Because of a physical, mental or emotional problem, does your patient need the help of others in handling routine needs such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?	☒ Yes ☐ No
13. Because of a health or memory problem, does your patient have difficulty managing money - such as paying bills and keeping track of expenses?	☐ Yes ☒ No
14. Because of a health or memory problem, does your patient have difficulty with bathing or showering?	☐ Yes ☒ No

Mortality Risk for Schonberg Index

Points	Risk of FIVE YEAR mortality	Risk of TEN YEAR mortality	Risk of FOURTEEN YEAR mortality
0 - 1	<3%	5% - 11%	19% - 21%
2 - 3	3% - 6%	9% - 12%	19% - 24%
4 - 5	7% - 8%	15% - 21%	27% - 36%
6 - 7	10% - 12%	26% - 37%	42% - 52%
8 - 9	17% - 27%	37% - 44%	42% - 52%
10 - 11	26% - 29%	53% - 60%	74% - 78%
12 - 13	37% - 41%	60% - 68%	81% - 83%
14 - 15	47% - 52%	74% - 76%	87% - 88%
16 - 17	60% - 61%	86% - 87%	100%
≥17	70%	92%	100%

Patients that have >50% chance of death in a specific time interval have an estimated life expectancy less than that time interval. For example, a patient with a 60% mortality risk at 5 years has a life expectancy <5 years.

Mortality Risk for Lee Index

Points	Risk of FOUR YEAR mortality	Risk of TEN YEAR mortality	Life Expectancy (years)
0 - 1	1% - 2%	2% - 5%	33.1 - 35.4
2 - 3	2% - 4%	7% - 10%	23.7 - 30.1
4 - 5	6% - 8%	15% - 23%	17.7 - 21.1
6 - 7	9% - 15%	34% - 43%	12.6 - 14.3
8 - 9	20%	52% - 58%	8.9 - 10
10 - 11	28% - 45%	70% - 82%	5.0 - 7.2
12 - 13	44% - 59%	83% - 91%	3.8 - 5.1
≥14	63%	93%	2.9

Patients that have >50% chance of death in a specific time interval have an estimated life expectancy less than that time interval. For example, a patient with a 60% mortality risk at 5 years has a life expectancy <5 years.

Vulnerable Elders Survey-13 (VES-13)

Patient Name: _____ Date: _____

Patient ID: _____

In general, compared to other people your age, would you say that your health is:

- ☐ Poor
☐ Fair
☐ Good
☐ Very Good
☐ Excellent

How much difficult, on average, do you have with the following physical activities?

	NO DIFFICULTY	A LITTLE DIFFICULTY	SOME DIFFICULTY	A LOT OF DIFFICULTY	UNABLE TO DO
1. Stooping, crouching or kneeling?	☐	☐	☐	☐	☐
2. Lifting or carrying objects as heavy as 10 pounds?	☐	☐	☐	☐	☐
3. Reaching or extending arms above shoulder level?	☐	☐	☐	☐	☐
4. Writing or handling and grasping small objects?	☐	☐	☐	☐	☐
5. Walking a quarter of a mile?	☐	☐	☐	☐	☐
6. Heavy household such as scrubbing floors or washing windows?	☐	☐	☐	☐	☐

Because of your health or physical condition, do you have any difficulty:

	YES	NO	DON'T DO
7. Shopping for personal items?	☐	☐	☐
8. Managing money (like keeping track of expenses or paying bills)?	☐	☐	☐
9. Walking across the room? USE OF CANE OR WALKER IS OKAY?	☐	☐	☐
10. Do you get help with walking?	☐	☐	☐
11. Doing light housework (like washing dishes, straightening up, or light cleaning)?	☐	☐	☐
12. Bathing or showering?	☐	☐	☐
13. Is your health the reason for not bathing or showering?	☐	☐	☐

mG8 Questionnaire

Table S1. Final modified G8: the ELCAPA-07 cohort study

Items	Score
1 Weight loss during the past 3 months	
>3 kg / patient does not know	10
1-3 kg	2
No weight loss	0
2 Neuropsychological problems	
Mild / severe dementia or depression	3
No neuropsychological problems	0
3 Takes at least six drugs per day	
Yes	2
No	0
4 Compared to other people of the same age, how does the patient rate his or her health status?	
Not as good / patient does not know	3
As good or better	0
5 Performance Status (PS)	
PS 2, 3, or 4: Ambulatory but unable to carry out any work activities / Confined to bed >50% / Disabled	12
PS 1: Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature	4
PS 0: Fully active	0
6 Past history of heart failure or coronary artery disease	
Yes	5
No	0
Total	___ / 35

mG8: scores of 6 or more warrant full geriatric assessment

VES-13: scores of 3 or more warrant full geriatric assessment

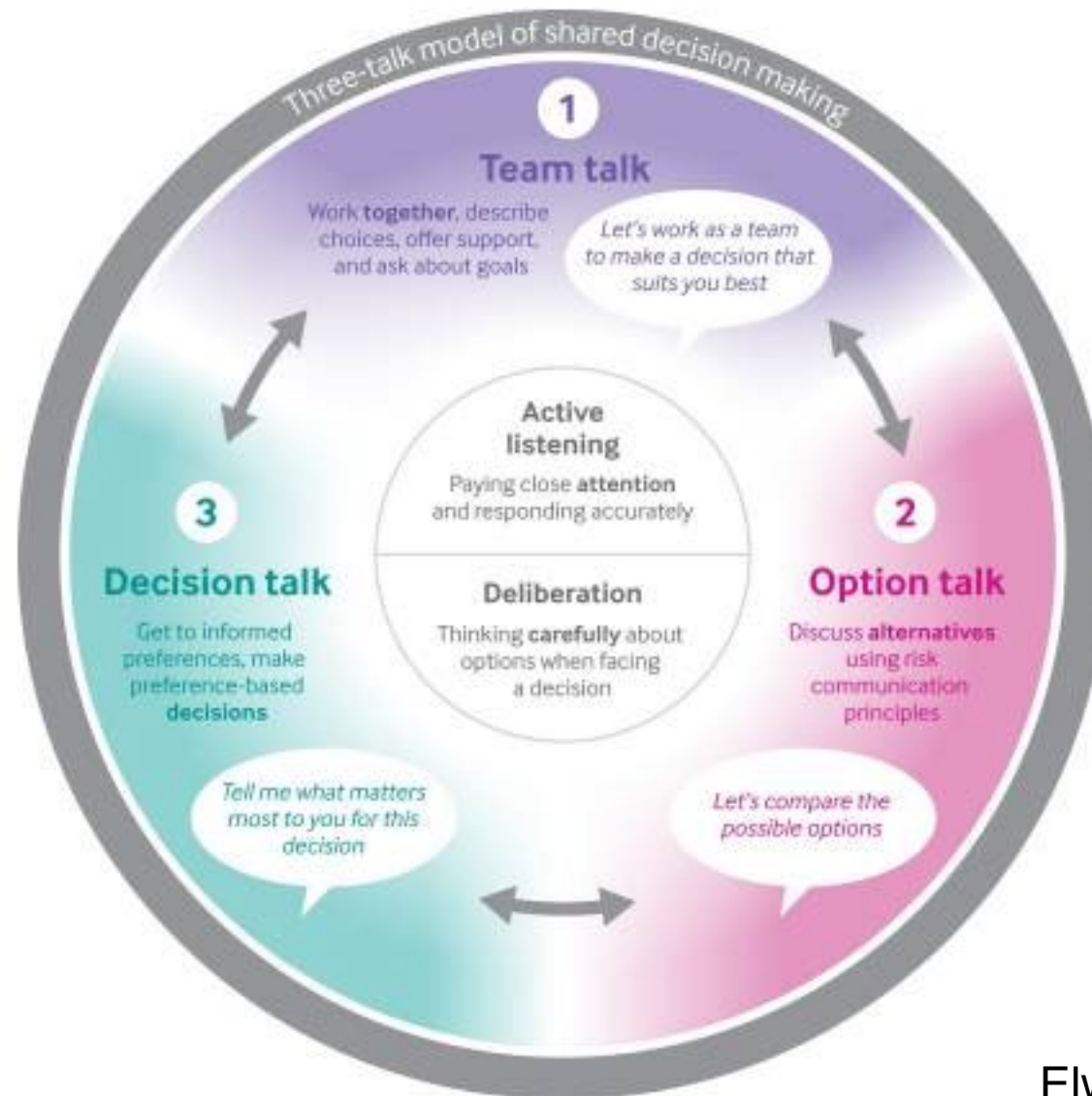
Mohile et al., JCO 2018, Dale et al., JCO 2023

[Why Measure Frailty](#)
[Help Me Choose a Frailty Tool](#)
[Overview of Frailty Tools](#)

CLINICAL FRAILITY SCALE

	1	VERY FIT	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
	2	FIT	People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally , e.g., seasonally.
	3	MANAGING WELL	People whose medical problems are well controlled , even if occasionally symptomatic, but often not regularly active beyond routine walking.
	4	LIVING WITH VERY MILD FRAILITY	Previously "vulnerable," this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities . A common complaint is being "slowed up" and/or being tired during the day.
	5	LIVING WITH MILD FRAILITY	People who often have more evident slowing , and need help with high order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
	6	LIVING WITH MODERATE FRAILITY	People who need help with all outside activities and with keeping house . Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
	7	LIVING WITH SEVERE FRAILITY	Completely dependent for personal care , from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).
	8	LIVING WITH VERY SEVERE FRAILITY	Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
	9	TERMINALLY ILL	Approaching the end of life. This category applies to people with a life expectancy <6 months , who are not otherwise living with severe frailty . Many terminally ill people can still exercise until very close to death.

Three-talk model of shared decision making



Communication pearls

1. Acknowledge the complexity
2. Speak slowly and avoid medical jargon
3. Provide information in small segments
4. Pause to allow patient participation
5. Assess what your patient already knows
6. Periodically check with your patient for understanding
7. Communicate numbers in a way that your patient may understand (frequencies, pictographs)
8. Summarize

Inviting the patient to participate

“My job is to make sure I support you in getting to an understanding of your treatment options so that we can compare them and work out what is best for you.”

“Regardless of what treatment or treatments we choose, most people with your type of breast cancer do very well. For this reason, there is not one right treatment pathway for all people. There are different options with different benefits and risks that we must weigh.”

Eliciting goals and concerns

- Acknowledge the values and preferences that matter to your patient, her goals for treatment
- Agree on what is important to your patient (e.g., recovery time, out-of-pocket costs, being pain free, maintaining independence, maximizing survival).
- “As you think about your options, what’s important to you?”
- “So if I can summarize you think option A is better for you because of X, is that right? I want to be sure I’ve understood your preferences and priorities.”

Facilitate deliberation and decision making

“Tell me what you are thinking about your treatment options, what is your understanding of the benefits and risks.”

“What did you think of the options? Did some aspect of them worry or appeal to you?”

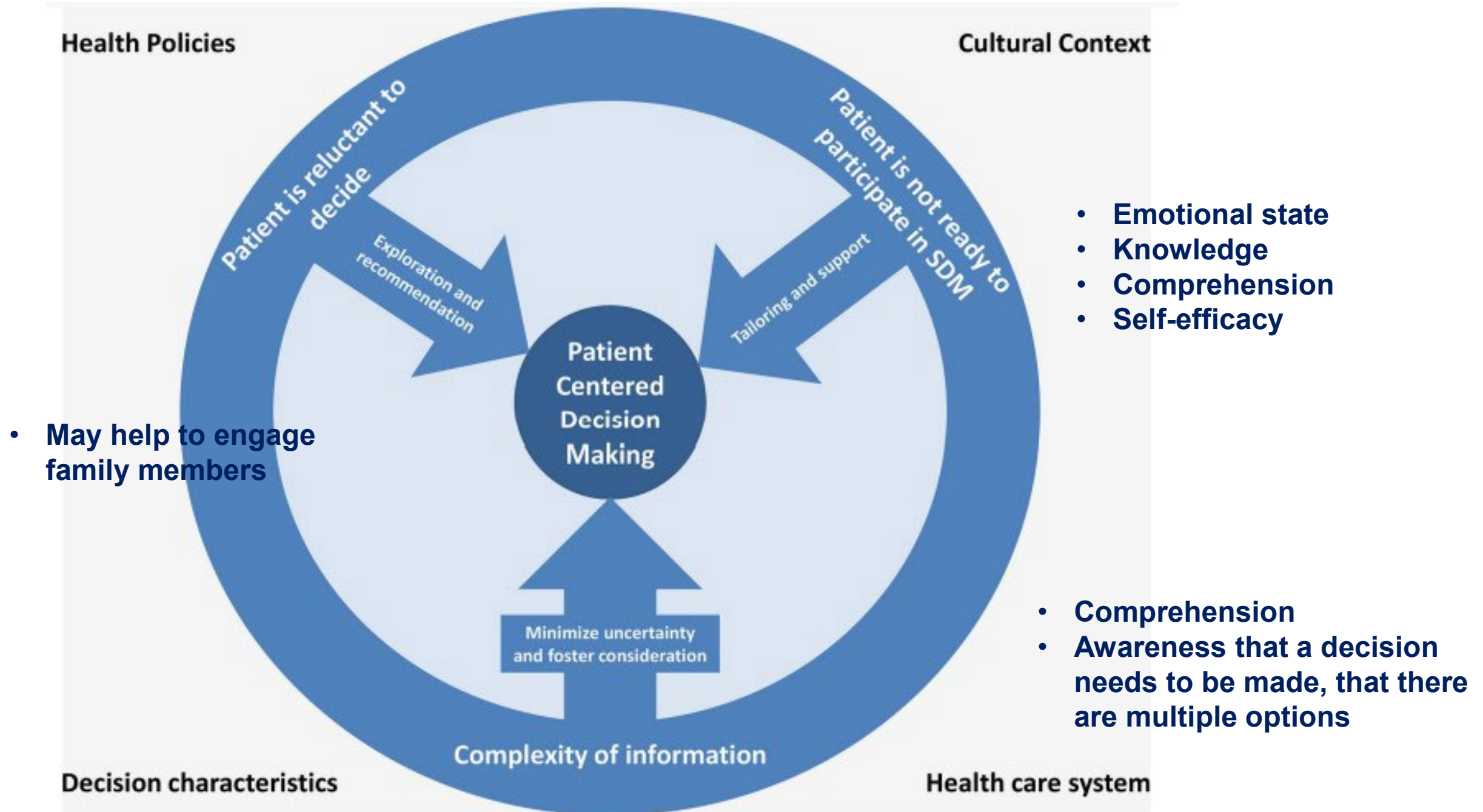
“I want to be sure I have explained things well. Please tell me what you heard.”

“It's fine to take more time to think about the treatment choices. Would you like some more time, or are you ready to decide?”

Triadic decision making: physician/patient/family

- 70% of women 80+ with breast cancer had a family member present during consultation
- Assess patients desired role and role of family in decision making; welcome family in the decision making as appropriate
- Family (friend) may serve as:
 - information gather
 - coach, advisor, negotiator,
 - caregiver (both physical and emotional)
 - legal proxy





Decision Aids

- Educational tools that provide detailed, current information to guide patients through a deliberative process
- Designed to supplement the patient-physician interaction
- May improve patients' knowledge, satisfaction, patient/clinician communication
- Increases patient involvement in decision making and reduces patient decisional conflict and regret

Breast Cancer Treatment Choices For Women Ages 70 and Older



This workbook is for women age 70 or older with:

- ▶ **Stage 1 breast cancer:** Breast cancers that are 2 centimeters or less (which is $\frac{3}{4}$ of an inch or less).
- ▶ **And with the features below:**
 - ▶ **Estrogen or progesterone receptor positive:** also called ER+ or PR+. These cancers have receptors for estrogen or progesterone - hormones that can cause these cancers to grow.
 - ▶ **HER2 negative:** do not test positive for the Human Epidermal growth factor Receptor (HER2-).

*The information in this workbook is from the best studies in the medical literature.
Last updated 6/2025*

Acceptability of the patient DA

- 33 women aged 70+ newly diagnosed with first primary, Stage I, ER+, HER2- breast cancer
 - 72% had completed college, 94% non-Hispanic White, mean age 75 (+/-4 years)
- 97% agreed that the DA was helpful
- Felt it helped prepare them for decision making quite a bit (Mean score on preparation for decision-making scale 4.1 out of 5)
- Increased knowledge (10.6 vs. 9.0 out of 14 True/False questions correct, $p < 0.001$)
- Michigan study: 23 patients found the DA acceptable, appropriate, and facilitated decision-making

Case 1, Ms. S



- 78 yo with COPD (not oxygen dependent but becomes tired walking 3 blocks, former smoker), osteoporosis, perceived health “good”, BMI 26, needs help with household chores
 - Schonberg score:12, 60% chance of 10-year mortality
 - Lee score:8, 52% chance of 10-year mortality
 - Clinical frailty score: 4
- 1.5 cm invasive ductal, grade 2, ER/PR+, HER2-, clinically lymph node negative, L sided breast cancer

Steps to shared decision making

1. Invite the patient to participate
2. Present the options
3. Provide information on the benefits and risks (tailored based on health/life expectancy)
4. Assist patient in evaluating options based on their goals & concerns
5. Facilitate deliberation and decision making
6. Involve trusted others

Invite the patient to participate

“Mrs. S, I'd like to take some time to talk with you about the different treatment options for your breast cancer. There's more than one reasonable path we can take, and each option has pros and cons based on your health, your lifestyle, and what matters most to you.

My role is to help you understand the choices and what to expect with each one, and your role is to share with me what's important to you—like how you feel about certain treatments, your daily routines, and your preferences.

We'll make this decision together and we can include your son or anyone else you want involved. How does that sound to you?"

Scripts for lymph node exploration

“We used to think that taking out lymph nodes under the armpit near the breast to see if breast cancer was there would help us decide how best to treat women. However, more recent studies have found that for women with your type of breast cancer that taking out and testing the lymph nodes for breast cancer rarely changes treatment. In addition studies do not show any survival benefit for testing the lymph nodes for breast cancer in women your type of breast cancer. This is because most women do very well with your type of breast cancer either way.”

“Meanwhile, a lymph node biopsy may cause some women, around 5 out of 100, to have trouble with arm swelling.”

“Some guidelines do not recommend lymph node testing for women age 70 and older with your type of breast cancer who plan to take anti-estrogen pills.”



Lymph Node Biopsies Leads to More Testing



“A lymph node biopsy may also lead people to get tests and treatments that they do NOT need. The likelihood that a lymph node biopsy would find breast cancer is low (<15%) in women your age with your type of breast cancer. But if the biopsy does show breast cancer, people sometimes feel that they must have more tests, procedures, and treatments.”

“But these additional treatments may not actually help them live longer since most people with your type of breast cancer do well either way. Therefore, getting more information from the biopsy could lead to more medical interventions that may not help you live longer or better.”

Shared Decision Making about Radiation: Benefits



“Studies show that for women age 70 and older with your type of breast cancer who choose not to have radiation after a lumpectomy that over 10 years about 10 women out of 100 will have their breast cancer come back in their breast or chest wall compared to 2 women who have radiation treatment (so 8 fewer out of 100). These numbers assume that you will take an anti-estrogen pill for 5 years.”

“If you do not take an anti-estrogen pill your chance of breast cancer coming back in your breast or chest is a bit higher. While having radiation may lower your chance of breast cancer coming back in your breast or chest wall, having radiation does not improve survival. This is because most women do very well with your type of breast cancer either way.”

Shared Decision Making about Radiation: Downsides and Harms



“There are downsides to radiation treatment. While most women do very well some feel very tired during treatment. Radiation treatment may also cause pain or swelling in the breast that can take a while to go away. Some women experience long-term changes to their breast. Having radiation may also slightly increase your long-term risk of heart or lung disease.”

“Also, some women find it difficult or burdensome to travel to a medical facility for radiation treatments.”

RT vs. ET



“Women with your type of breast cancer are increasingly being given a choice of having radiation after a lumpectomy OR to take anti-hormone pills. Both treatments lower the chance of breast cancer coming back in the breast or chest wall. Some women prefer getting treated with radiation for a few weeks rather than taking a pill for 5 years but the decision really comes down to how you weigh the different benefits and downsides of each option.”

“Anti-hormone pills may cause some women to experience fatigue, headaches, hot flashes and sexual problems. The anti-hormone pill most commonly given to women with your type of breast cancer (called aromatase inhibitors), may cause muscle or joint pain and possibly increase bone fractures. The other medication often given, tamoxifen, can slightly increase the chance of blood clots or uterine cancer. But, anti-hormone pills, unlike radiation treatment, can also lower your chance of getting a new breast cancer (e.g., in your other breast)”

“Doctor, what would you do?”

“I’m happy to make a recommendation for you. But, before I do, I would like to just understand a little more about what is important to you. Would that be okay?”

“Before I make a recommendation for you, are there questions about the options I can help to address?”

- may help to confirm patient understanding of the key elements of the decision but respects patient’s preferred decisional role
- Patients may not expect doctors to bring up interventions not in their best interest

Case 2, Ms. B

- 85 yo with diabetes, atrial fibrillation, history of stroke and knee replacement, perceived health “fair”, BMI 28, former smoker, needs help with household chores, housework, and pushing/pulling large objects
 - Schonberg score:17, 92% chance of 10-year mortality, 70% chance of 5-year mortality
 - Lee score:11, 82% chance of 10-year mortality
 - Clinical frailty scale-5
- 1.3 cm invasive ductal and lobular, grade 1, ER/PR+, HER2- by FISH, cN0, palpable R sided breast cancer

Scripts related to Primary Endocrine Therapy

“As we get older, it can take longer to recover or bounce back from some treatments for breast cancer, like surgery. While breast surgery is generally very safe there are side effects that can be burdensome. For women who do not want surgery or who have other significant health issues, taking an anti-hormone pill for 5 years is an option.”

Eliciting values/preferences

“What major concern or fear do you have about having breast surgery?”

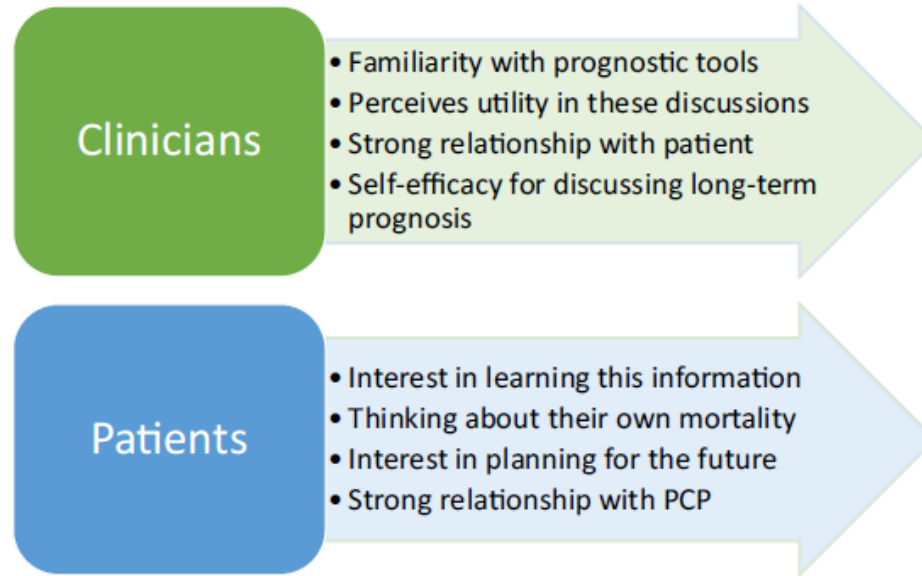
“What major concern or fear do you have about NOT having breast surgery?”

“People have different goals and concerns. As you think about your options, what’s important to you?”

Discuss likelihood of surgery or PET addressing patient’s greatest concerns and the patient’s goals.

Adapted from Naik et al, Journal of the American Geriatrics Society 2025.
Kane et al. CA: A Cancer Journal for Clinicians 2014

Discussing life expectancy



Suggestions for clinicians for these conversations:

1. Ask patient if they would like to discuss long-term prognosis in the context of medical decision making (e.g., deciding on cancer screening) or if patient brings up the topic.
2. Explain how prognostic information may be useful.
3. Inquire what the patient's goals are for their care and quality of life, their expectations of their life expectancy.
4. Use tools such as ePrognosis to obtain estimates of long-term prognosis.
5. Ask patient how they would like to receive this information.
6. Emphasize the uncertainty in estimating long-term prognosis.
7. Consider using the suggested scripts in this manuscript to guide these discussions.

Scripts related to health/life expectancy

“A woman’s overall health may affect her chance of benefitting from breast cancer treatment. Since your type of breast cancer tends to be slow growing, it can take years before it may affect your health or quality of life.”

“Since information on your overall health may be helpful to us in deciding on breast cancer treatment and planning for the future, would it be helpful to talk about how much longer you are likely to live to help us decide together about your breast cancer treatment?”

If patients are interested: Ask patients about their goals of care, expectations of their life expectancy.

Adapted from Jindal...Schonberg MA et al., JAGS 2022

Scripts related to health/life expectancy

- Emphasize the uncertainty in estimating long-term prognosis

- Ask patients how they would like to receive prognostic information (a proportion, a range, a point estimate...)

“Everyone is different and it is impossible to know the future but from information obtained from women your age and in similar health, suggests your life expectancy is probably around 5 years”

“around 50% of women your age and in similar health will live 5 more years, some will live more and some will live less.”

Case 3, Ms. L

- 80 yo with HTN, diabetes, mild dementia, functional decline (began needing help with grocery shopping, house cleaning but able to dress and feed herself), perceived health “good”, trouble walking several blocks, BMI 25, lives alone, daughter visits several times per week and accompanies her at the visit
 - Schonberg score:13, 68% chance of 10-year mortality, 37% chance of 5-year mortality
 - Lee score:11, 82% chance of 10-year mortality
 - Clinical frailty scale-5
- 1.0 cm invasive lobular, grade 2, ER/PR+, HER2-, cN0, palpable L sided breast cancer

Deardorff 1 to 10 year Mortality in Dementia Index

Population: Community-dwelling older adults aged 65 years and older with dementia

Outcomes: All-cause 1, 2, 5, and 10-year mortality

Scroll to the bottom for more detailed information.

Risk Calculator

1. What is your patient's age?

2. What is your patient's body mass index (BMI) category?

3. What is your patient's biological sex?

4. Does your patient have difficulty with walking several blocks?

Deardorff 1 to 10 year Mortality in Dementia Index

Population: Community-dwelling older adults aged 65 years and older with dementia

Outcomes: All-cause 1, 2, 5, and 10-year mortality

Scroll to the bottom for more detailed information.

For a patient with these characteristics, the predicted probability of death equals:	
1 year	9%
2 years	20%
5 years	52%
10 years	87%
Median predicted time to death (25 th to 75 th percentile)	5.1 years (2.6 - 8.2 years)

Inviting family to participate

“I want to make sure we’re making decisions that fit your health, your values, and your preferences. There’s a lot to consider.

I’d also like to invite your daughter to be part of this conversation, if that feels comfortable to you. Sometimes it helps to have someone you trust hear the options with you, ask questions, and think through the pros and cons together.

Would it be okay if we all talk together about the treatment options and what matters most to you?”

Communication pearls for patients with dementia

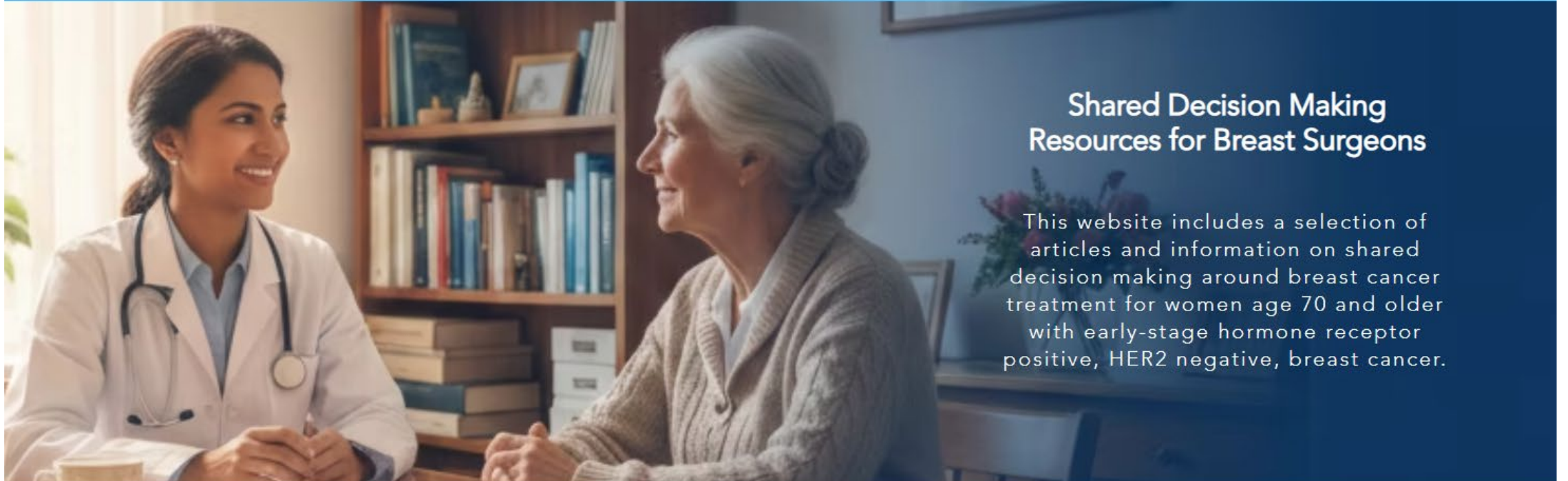
- Older adults with cognitive impairment can often reliably communicate their values and choices
- Simplify the language when possible
- Do not underestimate patient desire to participate in decision making
- Loved ones may also have unmet informational needs
- Shared decision making has been shown to increase patient and family satisfaction when the patient has cognitive impairment

Summary

- Women aged 70 and older with Stage I, ER+, HER2- breast cancer face many preference sensitive treatment decisions
- Shared decision making is associated with more person centered-care
- Ideally, patients are informed that many breast cancer treatment decisions are preference sensitive, they are informed of the options, invited to share in the deliberation, and that the decision is aligned with the patient's values and preferences
- Decision aids may help support shared decision making

sdmpossible.com

SDM POSSIBLE - Shared Decision Making For People Over Seventy With Stage I Breast Cancer To Learn And Engage Trial

[Home](#)[Breast Cancer Treatment](#)[Shared Decision Making \(SDM\)](#)[Geriatric Care Models](#)[Health & Life Expectancy](#)[More](#)

Shared Decision Making Resources for Breast Surgeons

This website includes a selection of articles and information on shared decision making around breast cancer treatment for women age 70 and older with early-stage hormone receptor positive, HER2 negative, breast cancer.

[Home](#)

[Breast Cancer Treatment](#)

[Shared Decision Making \(SDM\)](#)

[Geriatric Care Models](#)

[Health & Life Expectancy](#)

[More](#)

Breast Cancer Treatment Articles

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Guidelines & expert reviews

Guidelines and expert reviews that include information on treating women aged 70 and older with Stage I, ER+, HER2- breast cancer.

American Society of Clinical Oncology (ASCO)

Articles -

[1. Park KU, Somerfield MR, Anne N, Brackstone M, Conlin AK, Couto HL, Dengel LT, Eisen A, Harvey BE, Hawley J, Kim JN, Lasebikan N, McDonald ES, Pradhan D, Shams S, Vega RM, Thompson AM, Torres MA. Sentinel Lymph Node Biopsy in Early-Stage Breast Cancer: ASCO Guideline Update. J Clin Oncol. 2025 May 10;43\(14\):1720-1741. doi: 10.1200/JCO-25-00099. Epub 2025 Apr 10. PMID: 40209128.](#)

National Comprehensive Cancer Network (NCCN)

Articles -

[1.National Comprehensive Cancer Network, NCCN Clinical Practice Guidelines in Oncology \(NCCN Guidelines\), Breast Cancer, Version 1.2026 -- January 16, 2026, NCCN.org.](#)

[2. National Comprehensive Cancer Network, NCCN Clinical Practice Guidelines in Oncology \(NCCN Guidelines\), Older Adult Oncology, Version 2.2025 -- May 13, 2025, NCCN.org.org.](#)

International Society of Geriatric Oncology (SIOG)

Articles -

Sentinel Lymph Node Biopsy in Early-Stage Breast Cancer: ASCO Guideline Update

Ko Un Park, MD¹ ; Mark R. Somerfield, PhD² ; Nirupama Anne, MD³; Muriel Brackstone, MD, PhD⁴ ; Alison K. Conlin, MD⁵; Henrique Lima Couto, MD, PhD⁶ ; Lynn T. Dengel, MD, MSc⁷; Andrea Eisen, MD⁸; Brittany E. Harvey, BS² ; Jeffrey Hawley, MD⁹ ; Janice N. Kim, MD, MS¹⁰ ; Nwamaka Lasebikan, MBBS¹¹ ; Elizabeth S. McDonald, MD, PhD¹² ; Deepti Pradhan, PhD¹³ ; Samantha Shams, MD¹⁴; Raymond Mailhot Vega, MD, MPH¹⁵ ; Alastair M. Thompson, MD, MBChB¹⁶; and Mylin A. Torres, MD¹⁷ 

DOI <https://doi.org/10.1200/JCO-25-00099>

ABSTRACT

ASCO Guidelines provide recommendations with comprehensive review and analyses of the relevant literature for each recommendation, following the guideline development process as outlined in the [ASCO Guidelines Methodology Manual](#). ASCO Guidelines follow the [ASCO Conflict of Interest Policy for Clinical Practice Guidelines](#).

Clinical Practice Guidelines and other guidance (“Guidance”) provided by ASCO is not a comprehensive or definitive guide to treatment options. It is intended for voluntary use by clinicians and should be used in conjunction with independent professional judgment. Guidance may not be applicable to all patients, interventions, diseases or stages of diseases. Guidance is based on review and analysis of relevant literature, and is not intended as a statement of the standard of care. ASCO does not endorse third-party drugs, devices, services, or therapies and assumes no responsibility for any harm arising from or related to the use of this information. See complete disclaimer in [Appendix 1](#) and [2](#) (online only) for more.

PURPOSE To update the ASCO evidence-based recommendations on the use of sentinel lymph node biopsy (SLNB) in patients with early-stage breast cancer treated with initial surgery.

METHODS ASCO convened an Expert Panel to develop updated recommendations based on a systematic literature review (January 2016–May 2024).

RESULTS Eleven randomized clinical trials (14 publications), eight meta-analyses and/or systematic reviews, and one prospective cohort study met the inclusion criteria for this systematic review. Expert Panel members used available evidence and informal consensus to develop practice recommendations.

RECOMMENDATIONS Clinicians should not recommend routine SLNB in select patients who are postmenopausal and ≥50 years of age and with negative findings on pre-

ACCOMPANYING CONTENT

 Listen to the podcast by Brittany Harvey, Dr Park, and Dr Torres at <https://ascopubs.org/doi/sentinel-lymph-node-biopsy-early-stage-breast-cancer-guideline-update>

 Appendix

 Data Supplement

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Evidence Based Medicine

Committee approval: January 8, 2025

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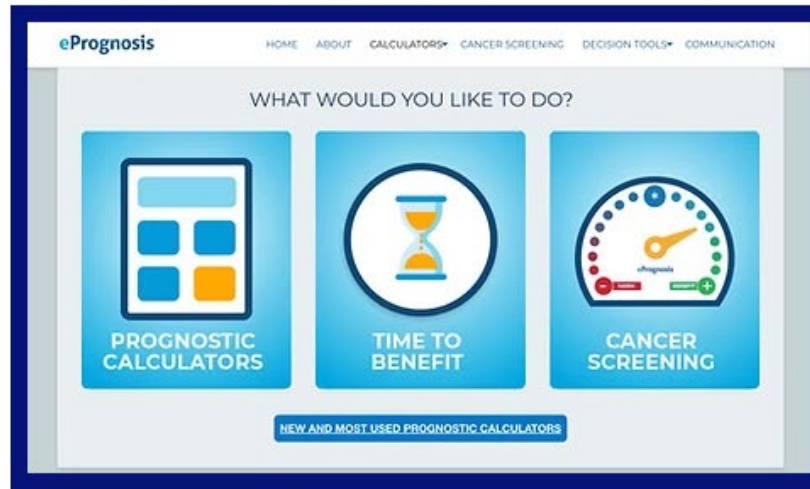
Health & Life Expectancy Articles

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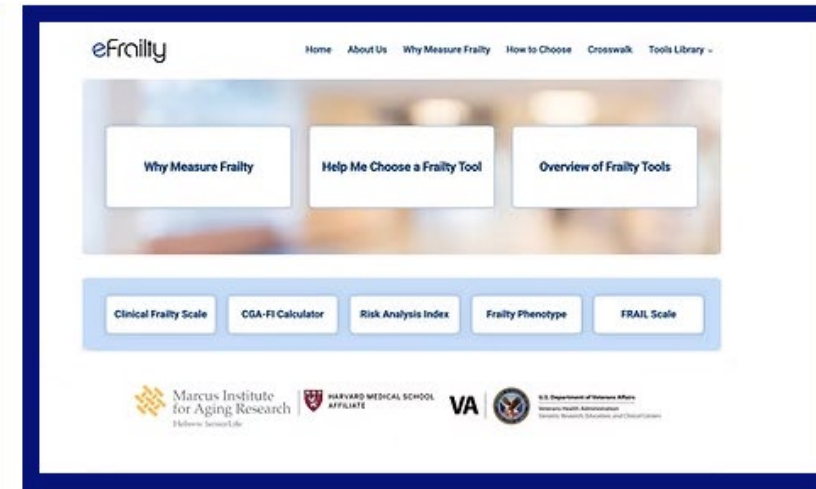
- [General mortality indices](#)
- [General frailty indices](#)
- [Discussing overall health / prognosis with older adults](#)

Useful websites:

(access these websites by clicking the blue boxes below)



ePrognosis



eFrailty

General frailty indices

Articles -

1. Kim DH, Cheslock M, Sison SM, Orkaby AR, Schwartz AW. eFrailty: Making frailty assessment accessible to clinicians and researchers. J Am Geriatr Soc. 2025 Jan;73(1):318-322. doi: 10.1111/jgs.19138. Epub 2024 Aug 12. PMID: 39134464; PMCID: PMC11735311.
2. Martinez-Tapia C, Canoui-Poitaine F, Bastuji-Garin S, Soubeyran P, Mathoulin-Pelissier S, Tournigand C, Paillaud E, Laurent M, Audureau E; ELCAPA Study Group. Optimizing the G8 Screening Tool for Older Patients With Cancer: Diagnostic Performance and Validation of a Six-Item Version. Oncologist. 2016 Feb;21(2):188-95. doi: 10.1634/theoncologist.2015-0326. Epub 2016 Jan 13. PMID: 26764250; PMCID: PMC4746991.
3. Saliba D, Elliott M, Rubenstein LZ, Solomon DH, Young RT, Kamberg CJ, Roth C, MacLean CH, Shekelle PG, Sloss EM, Wenger NS. The Vulnerable Elders Survey: a tool for identifying vulnerable older people in the community. J Am Geriatr Soc. 2001 Dec;49(12):1691-9. doi: 10.1046/j.1532-5415.2001.49281.x. PMID: 11844005.



Supplemental Table for:
Optimizing the G8 Screening Tool for Older Patients with Cancer: Diagnostic Performance and Validation of a 6-item Version
Etienne Audureau et al.

Table S1. Final modified G8: the ELCAPA-07 cohort study

Items	Score
1 Weight loss during the past 3 months	
>3 kg / patient does not know	10
1-3 kg	2
No weight loss	0
2 Neuropsychological problems	
Mild / severe dementia or depression	3
No neuropsychological problems	0
3 Takes at least six drugs per day	
Yes	2
No	0
4 Compared to other people of the same age, how does the patient rate his or her health status?	
Not as good / patient does not know	3
As good or better	0
5 Performance Status (PS)	
PS 2, 3, or 4: Ambulatory but unable to carry out any work activities / Confined to bed >50% / Disabled	12
PS 1: Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature	4
PS 0: Fully active	0
6 Past history of heart failure or coronary artery disease	
Yes	5
No	0
Total	___ / 35

The total score is the sum of the scores on each of the 6 items.
A total score ≥ 6 is considered abnormal and warrants a full geriatric assessment in the two-step approach.

Surgeon talking points

Surgeon talking points

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On this page

- [How to engage women age 70 and older with small \(<2cm\), ER+, HER2-, breast cancers in shared decision-making around breast cancer treatment](#)
- [How to discuss 10-year life expectancy with women ages 75 and older who are interested in this information](#)

How to engage women age 70 and older with small (<2cm), ER+, HER2-, breast cancers in shared decision-making around breast cancer treatment

Make clear:

- There's a decision to make
- There are no "right" or "wrong" answers
- Women's values and preferences matter in the decision
- That you have the patient's best interest at heart
- That the patient has time to think about her treatment options and does not have to decide right now.

Communication pearls (from Fagerlin et al. JNCI 2011)

Thank you! Questions?

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GERIATRIC 5Ms* DESCRIPTION

Mind	• Mentation • Dementia • Delirium • Depression
Mobility	• Impaired gait and balance • Fall injury prevention
Medications	• Polypharmacy, deprescribing • Optimal prescribing • Adverse medication effects and medication burden
Multicomplexity	• Multimorbidity • Complex biopsychosocial situations
Matters most	• Each individual's own meaningful health outcome goals and care preferences

Table 1. Geriatric assessment domains and tools

Geriatric assessment domain	Tools ^a	Interventions for positive finding
Functional status	• Self-reported: ◦ Activities of daily living ◦ Instrumental activities of daily living ◦ Falls • Objective tests: ◦ Timed up and go test ◦ Gait speed ◦ Short physical performance battery	1. Mobility and health aids 2. Home safety equipment 3. Promote physical activity 4. Physical therapy and rehabilitation
Comorbidity	• Charlson Comorbidity Index • Cumulative Index Rating Scale-Geriatric • Adult Comorbidity Evaluation-27	1. Comorbidity management 2. Referral to a geriatrician or other specialists 3. Clarify goals of care
Social functioning and support	• Medical Outcomes Study survey • RAND-36 Healthcare Survey	1. Consult social work 2. Consult financial services
Cognition	• Blessed Orientation Memory Concentration test • Mini Cog • Mini Mental State Examination • Montreal Cognitive Assessment	1. Counseling 2. Assess inappropriate medications 3. Evaluate decisional capacity 4. Referral to geriatric neuropsychologist
Psychological status	• Distress Thermometer • Geriatric Depression Scale (several versions available) • Mental Health Inventory • Patient Health Questionnaire (several versions available)	1. Cognitive behavioral therapy 2. Non-pharmacological approaches (meditation) 3. Anti-depressants 4. Referral to a geriatric psychiatrist 5. Communicate with primary care team
Nutrition	• Weight loss • Body mass index • Mini Nutritional Assessment • Malnutrition Universal Screening Tool	1. Address factors contributing to malnutrition 2. Address chemotherapy-induced adverse effects like nausea/vomiting 3. Oral care 4. Supplemental nutrition 5. Refer to dietitian
Polypharmacy	• Beers Criteria • Medication Appropriateness Index • STOPP/START criteria	1. Medication reconciliation 2. Evaluate adherence 3. Evaluate drug interactions 4. Deprescribing 5. Home health for medication management

START, Screening Tool to Alert to Right Treatment; STOPP, Screening Tool of Older Persons' Prescriptions.

^aAt a minimum, consider one tool from the domains of functional status (instrumental activities of daily living), cognition (Mini Cog or Blessed Orientation Memory Concentration), and psychological status (PHQ-2); assess weight loss, comorbidity, and medications from the medical records; and inquire about source of social support from the patient.