Congrès Interdisciplinaire des Professionnels en GÉRIATRIE

Dépistage du cancer du sein chez la femme âgée

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Dépistage organisé

- **Dépistage organisé** concernant la population des femmes âgées de **50 ans à 74 ans**, sans symptômes ni facteur de risque

- L'Institut national du cancer (INCa) estime que **80 %** des cancers du sein surviennent après l'âge de **50 ans**.
- C'est à partir de cet âge qu'il est proposé aux femmes d'effectuer un dépistage régulier.

- Mammographie et examen clinique tous les 2 ans

Dépistage organisé

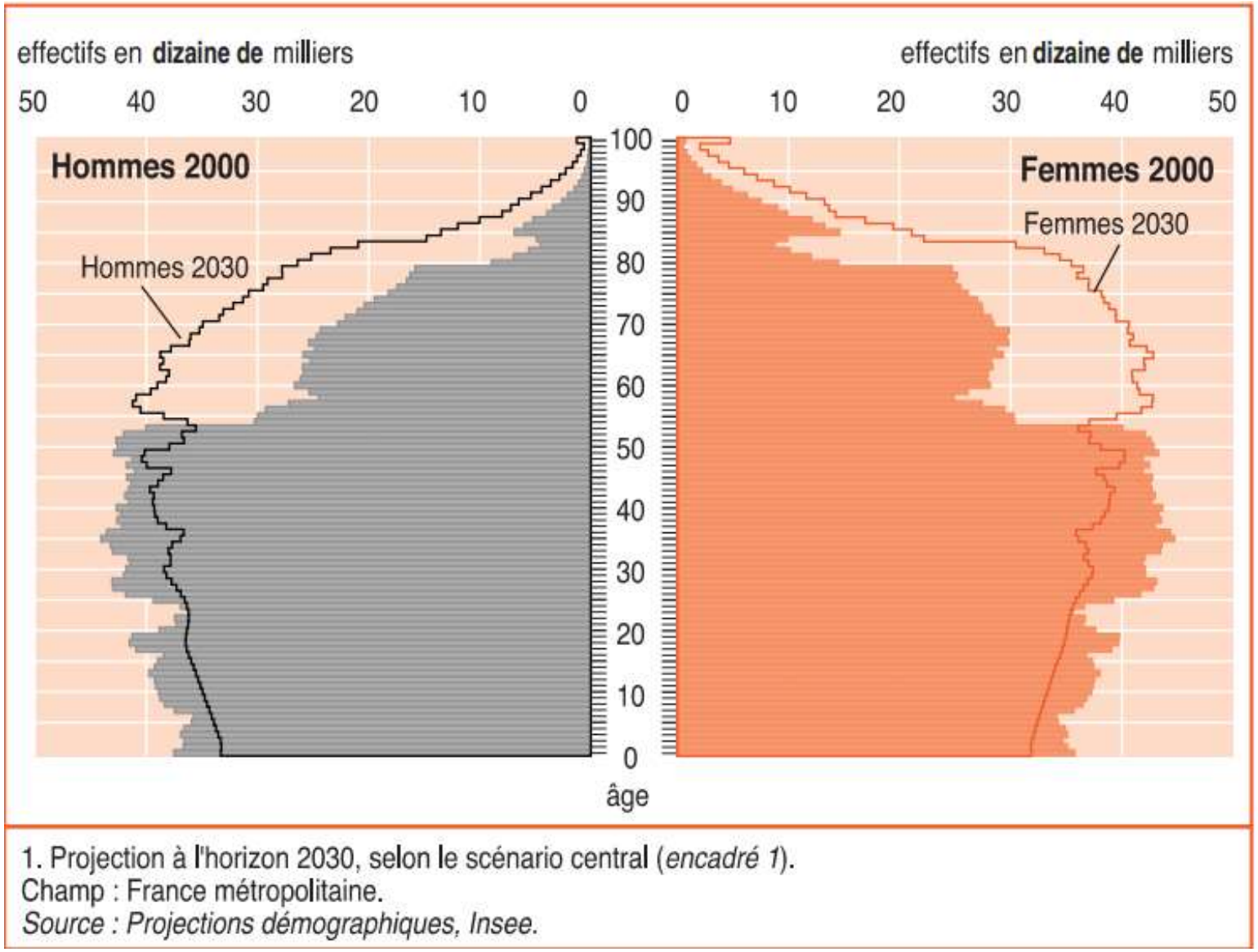
- 50% de la population réalise ce dépistage
- 20 000 cancers / an
- 90% de guérison

Et après 74 ans ?

- Dépistage individuel

- Le taux d'incidence le plus élevé concerne la population de **70-74 ans** (420 / 100 000).
- **30%** des cancers du sein surviennent chez des femmes de **plus de 75 ans**.

Démographie et population âgée

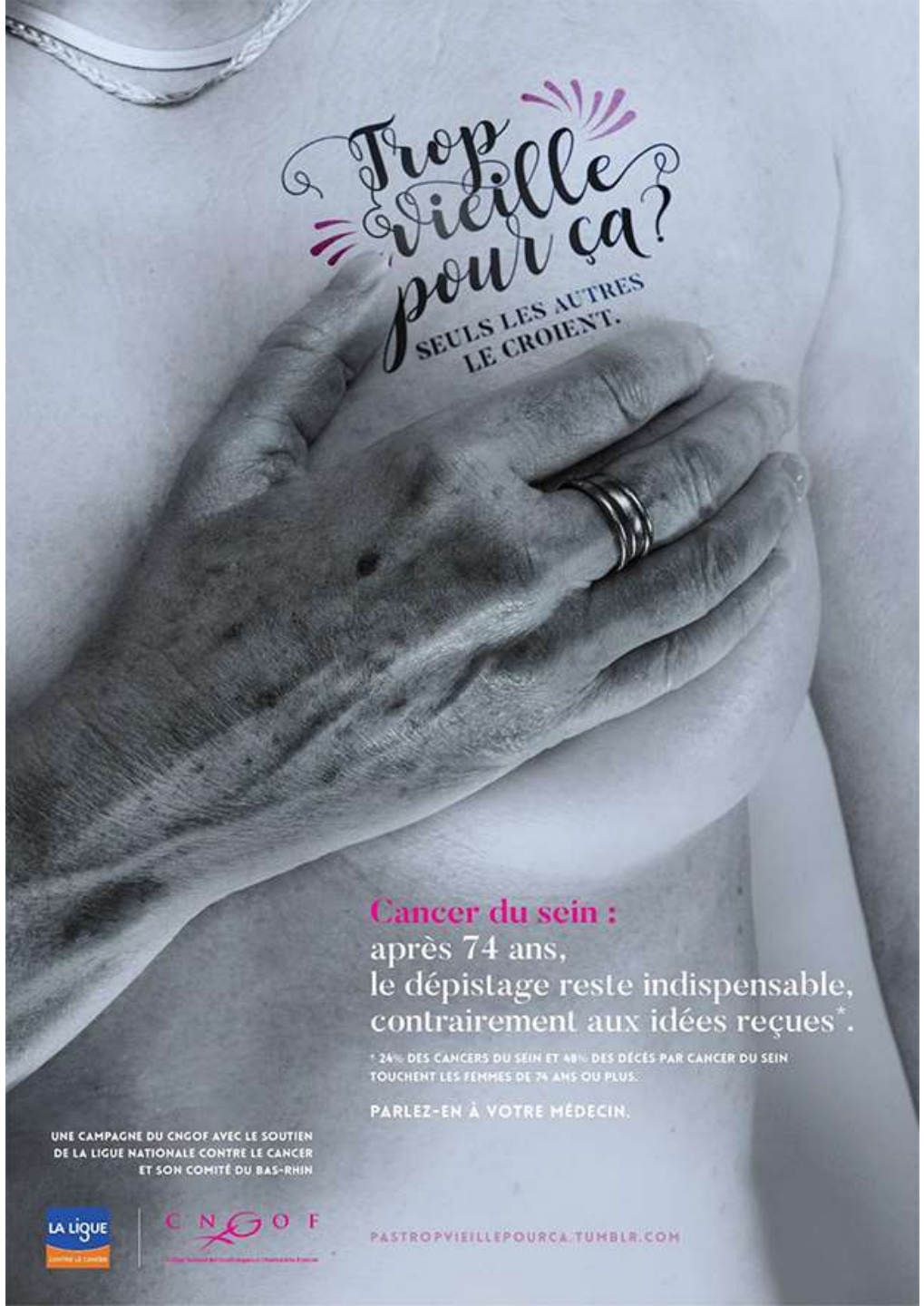


1. Projection à l'horizon 2030, selon le scénario central (*encadré 1*).
Champ : France métropolitaine.
Source : Projections démographiques, Insee.

Cancer du sein – état des lieux

- L’âge est un facteur de risque important dans le cancer du sein.

- Diagnostic des cancers du sein dans la population âgée à des **stades plus avancés**, **plus tardifs**, complexifiant la prise en charge.
- **42%** des cancers diagnostiqués chez les patients de plus de 74 ans, étaient à un **stade avancé**.
- Proportion plus importante que la population de 50-74 ans.


Trop vieille pour ça?
SEULS LES AUTRES LE CROIENT.
Cancer du sein :
après 74 ans,
le dépistage reste indispensable,
contrairement aux idées reçues*.
* 24% DES CANCERS DU SEIN ET 48% DES DÉCÈS PAR CANCER DU SEIN TOUCHENT LES FEMMES DE 74 ANS OU PLUS.
PARLEZ-EN À VOTRE MÉDECIN.
UNE CAMPAGNE DU CNGOF AVEC LE SOUTIEN DE LA LIGUE NATIONALE CONTRE LE CANCER ET SON COMITÉ DU BAS-RHIN
LA LIGUE
CNGOF
PASTROPVIEILLEPOURCA.TUMBLR.COM

Controverses

- **Surdiagnostic** et des **surtraitements** inutiles, sans bénéfice significatif sur la mortalité.
- Ces traitements peuvent avoir des effets secondaires importants, surtout chez les personnes âgées.

Effect of implementation of the mass breast cancer screening programme in older women in the Netherlands: population based study

NA de Glas, 2014

A propos d’un cas

- Patiente de 86 ans
- En EHPAD GIR 2
- Troubles neurocognitifs majeurs d’intensité sévère
- Peu de comorbidités

- Traitement actuel : LEVOTHYROX 75 ug par jour

A propos d’un cas

- Tumeur volumineuse, évidente à l’examen clinique avec souffrance cutanée et peau d’orange.

- Patiente peu compliante aux examens et aux soins.

A propos d’un cas

- Biopsie réalisée avec anxiolyse en amont par Seresta 25 mg
- Anesthésie locale et Oramorph
- Lésion légèrement hémorragique

- Anapath : Carcinome canalaire infiltrant RP + RE + HER2 –
- Ki67 47%

A propos d’un cas

- Proposition d’hormonothérapie seule
- Soins locaux

- Possibilité d’une séance de radiothérapie avec anxiolyse à visée hémostatique selon évolution

A propos d’un cas

- Bonne évolution locale après 1 mois et demi de traitement par hormonothérapie

- Persistance d’une lésion tumorale
- Moins d’effraction cutanée
- Moins de saignement

- Radiothérapie non retenue à ce jour

En conclusion

- Dépistage individualisé
- Examen sénologique
- Echographie mammaire + axillaire / Mammographie

- Qualité de vie

« Nouveautés » thérapeutiques dans le cancer du sein chez la femme âgée

Dr Elisabeth Carola

UCOG PICARDIE

Chef de pôle d'oncologie medicale
GHPSO

sofog

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Liens d’intérêts

Pfizer
Lilly
Eisai
Novartis
Sandoz
Pierre Fabre
Seagen

Daiichi-Sankyo

Jansen
Sanofi
Accord

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L’oncoGériatrie : Un savant équilibre

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Quelques chiffres

40% des cas des cancers du sein sont chez les femmes âgées de 65+ et

30% des cancers du sein >70ans

Espérance de vie à 80 ans d'environ 10 ans

F. *Prioux, M Barbieri, Population-F,67; 2012: 597-656*

Dépistage des fragilités G8 (n=3816pts) – Sensibilité 65% à 92%

L.Decoster and al, Ann oncol, 2014

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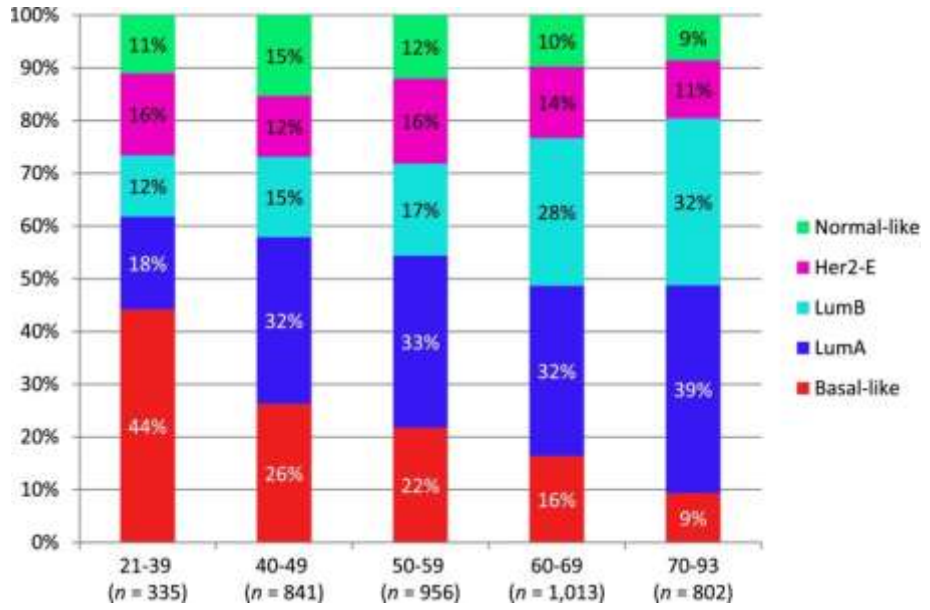
Des sous types plus favorables avec l'âge



Une survie moins bonne

Variable	Model covariates: Age, subtype	Age, subtype, adjuvant treatment	Age, subtype, adjuvant treatment, T size, nodal status, grade
RFS (non-METABRIC)			
Number of patients	1,842	1,464	886
HR (95% CI)	0.98 (0.92–1.06)	1.01 (0.93–1.10)	1.05 (0.92–1.19)
p value	.66	.86	.47
OS (METABRIC)			
Number of patients	1,965	1,965	1,856
HR (95% CI)[a]	**1.22 (1.14–1.32)**	**1.41 (1.30–1.53)**	**1.36 (1.25–1.48)**
p value[a]	**<.0001**	**<.0001**	**<.0001**
DSS (METABRIC)			
Number of patients	1,965	1,965	1,856
HR (95% CI)	0.95 (0.87–1.04)	1.09 (0.99–1.21)	1.07 (0.97–1.18)
p value	.24	.07	.21

The age variable used for multivariable analysis is continuous, and the unit of each hazard ratio is 10 years (i.e., for each 10-year increase in age).
[a]Bold type indicates $p < .05$.
Abbreviations: CI, confidence interval; DSS, disease-specific survival; HR, hazard ratio; METABRIC, Molecular Taxonomy of Breast Cancer International Consortium; OS, overall survival; RFS, recurrence-free survival.

E Jenkins Oncologist 2014

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Les Cibles

Les Récepteurs Hormonaux

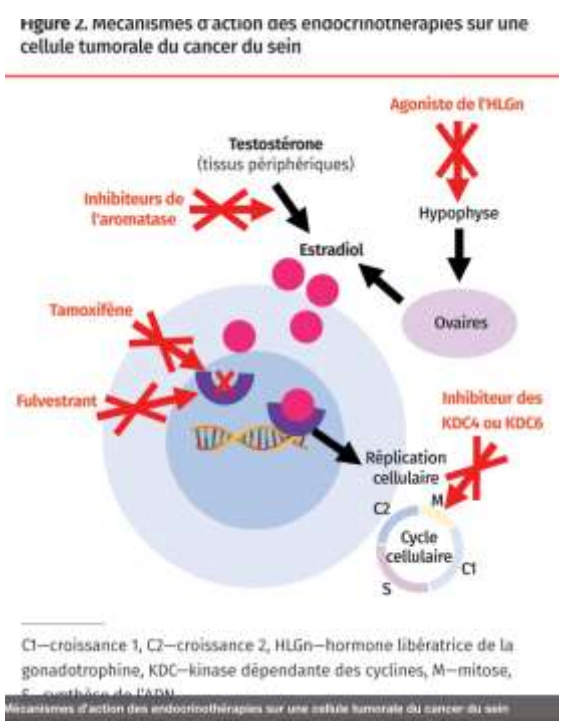
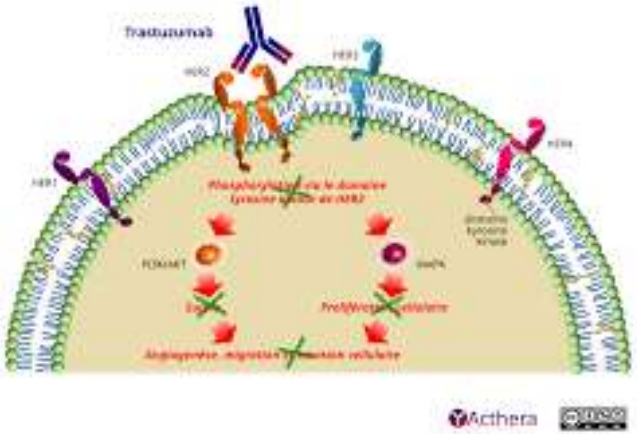
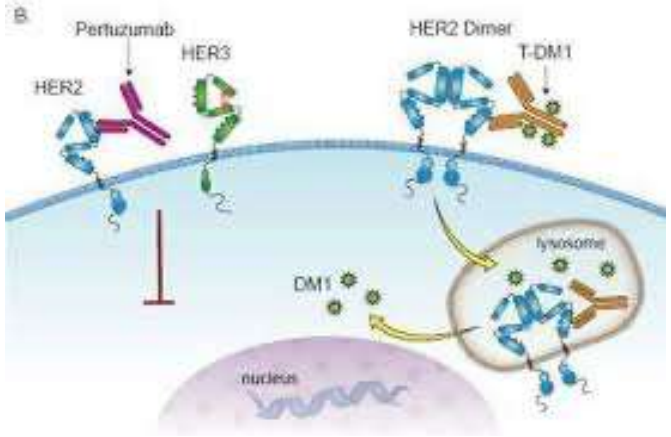


Figure 2. Mécanismes d'action des endocrinothérapies sur une cellule tumorale du cancer du sein

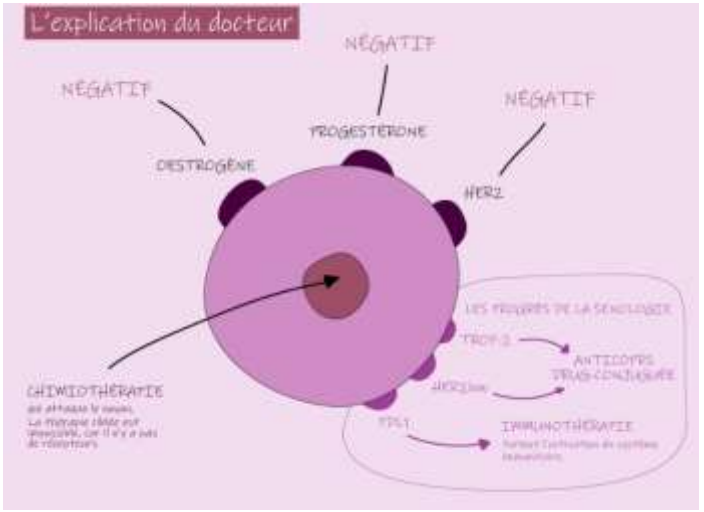
C1—croissance 1, C2—croissance 2, HLGn—hormone libératrice de la gonadotrophine, KDC—kinase dépendante des cyclines, M—mitose, S—synthèse de l'ADN

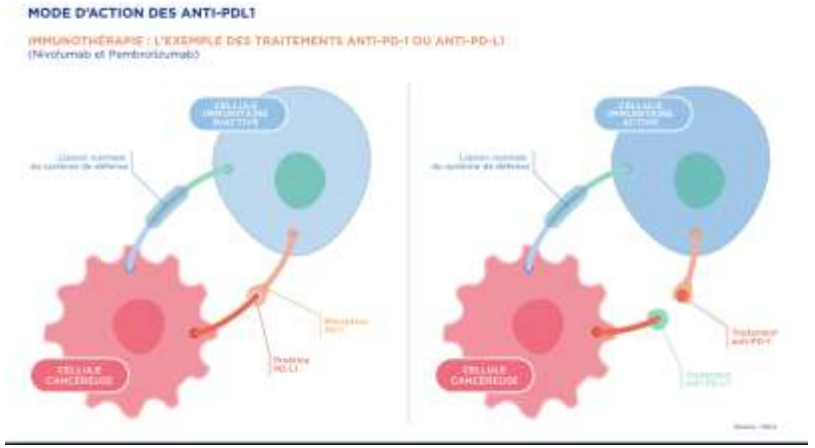
Mécanismes d'action des endocrinothérapies sur une cellule tumorale du cancer du sein





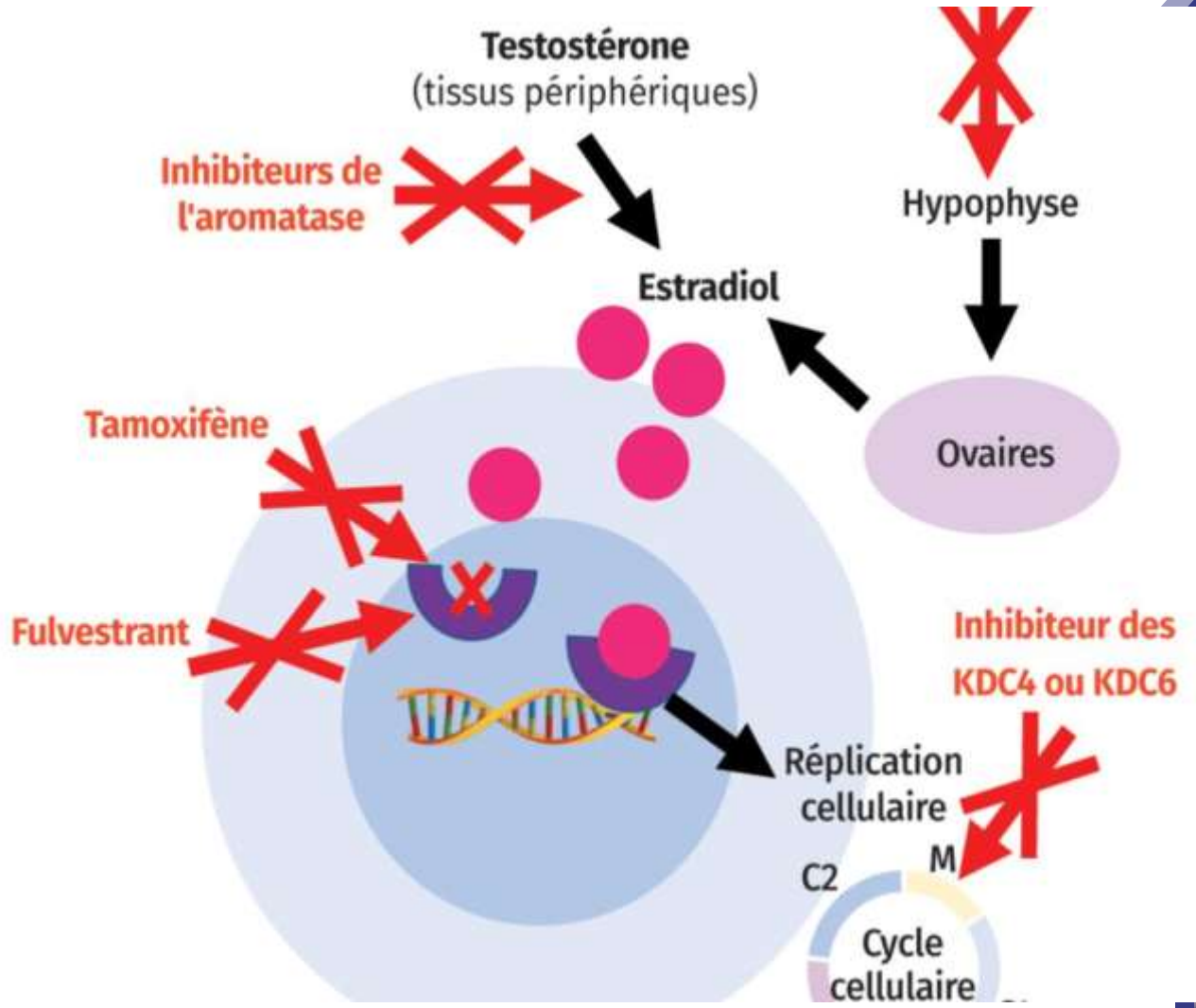
Les CHECK POINT



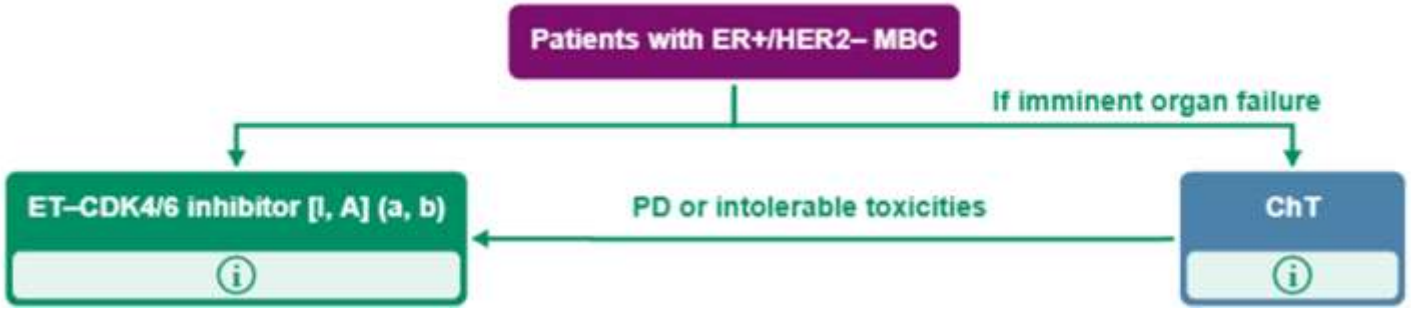


Her2

« Nouveautés » pour les plus fréquentes RH+ Her 2-



Esmo Guidelines 2023



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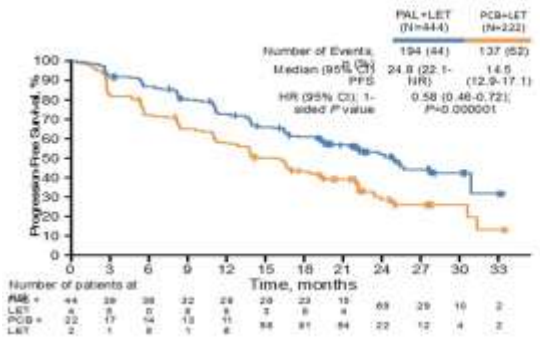
Même PFS
en première ligne métastatique

First line AI combination trials Primary endpoint PFS

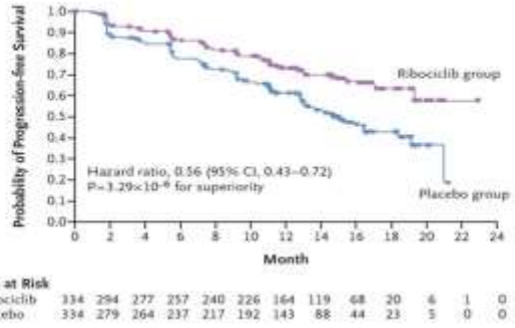
PALOMA2
palbociclib

HR 0.58, p<0.001



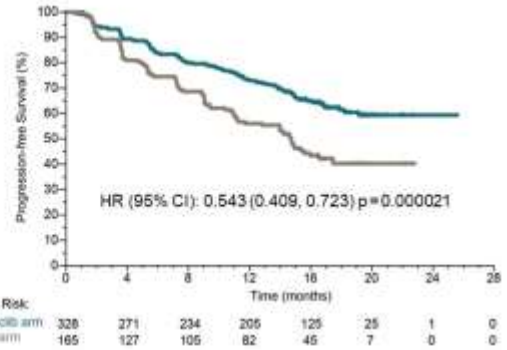
MONALEESA2
ribociclib

HR 0.56, p<0.001



MONARCH3
abemaciclib

HR 0.54, p<0.001



All inhibitors similar efficacy in PFS primary
First line AI plus CDK4/6 inihibitor is the standard of care

Finn *et al* NEJM 2016 | Hortobagyi *et al* NEJM 2016 | Di Leo *et al* JCO 2017

2023 ASCO ANNUAL MEETING #ASCO23 PRESENTED BY: Nicholas Turner

Dalpiciclib HR 0.51
Zhang et al Lancet Oncol 2023

ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY KNOWLEDGE CONQUERS CANCER

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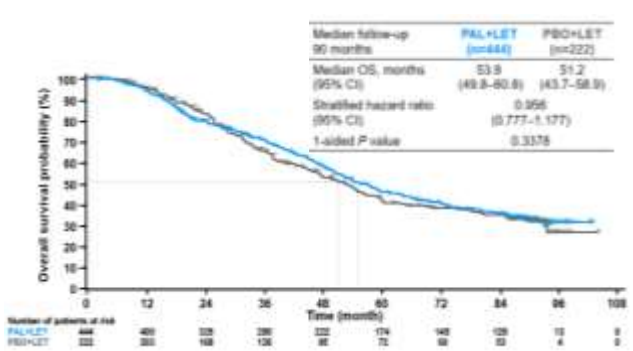
Impact Différent sur la Survie Globale

PALOMA-2[1]
Palbociclib

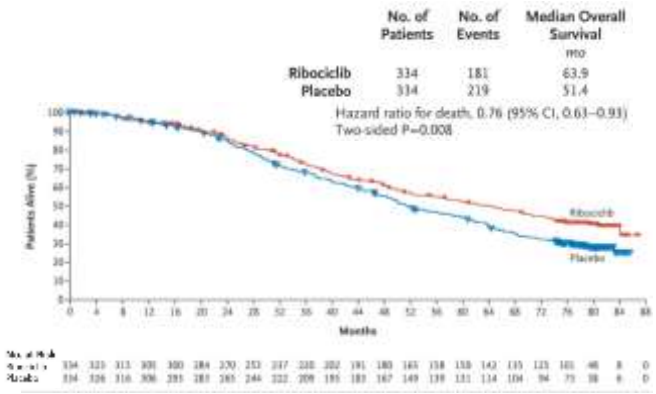
HR 0.96, p=0.3



22% de patients Hormono-résistants

MONALEESA-2[2]
Ribociclib

HR 0.76, p=0.008



≈1,2% de patients Hormono-résistants

MONARCH-3[3]
Abemaciclib

ANALYSE FINALE DES DONNEES DE SURVIE GLOBALE
SABCS 2023

HR 0.0804, p=0.0664 NS

	abemaciclib + NSAI	placebo + NSAI
Median, OS (months)	66.8	53.7

Patients Hormono-résistants non inclus

1. *Rugo, et al. Breast Cancer Research and Treatment (2019) 174:719–729.* ***2.*** *Hortobagyi et al, Annals of Oncology 29: 1541–1547, 2018.* ***3.*** *Goetz GS 0112 SABCS 2023*

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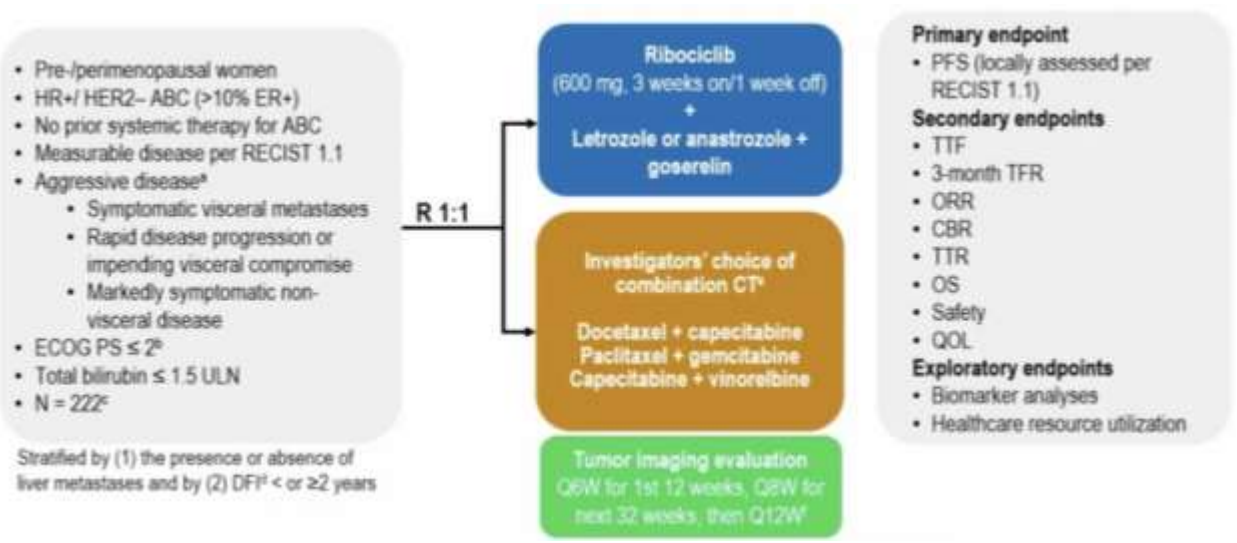
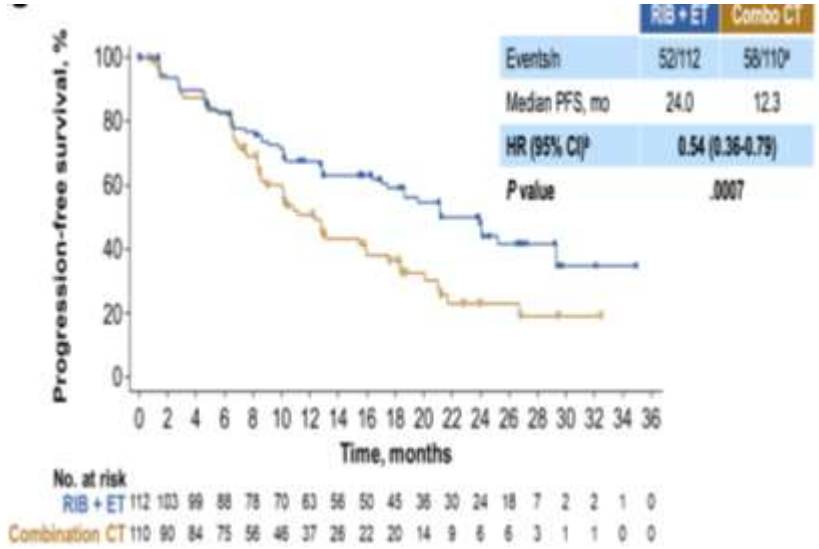
RIGHT Choice pour les Patientes de mauvais pronostic





El Saghir et al. *SABCS* 2022

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Sonia : Désescalade thérapeutique

SSP2

Patients with HR+/HER2 - ABC

- Patiente ménopausées et non ménopausées
- Maladie measurable ou évaluable
- Traitement (néo)adjuvant autorisé
- Pas de traitement préalable en phase M+
- Pas de crise viscérale
- N=1050

R 1:1

- IANS + CDK4/6i → Fulvestrant
- IANS → Fulvestrant + CDK4/6i

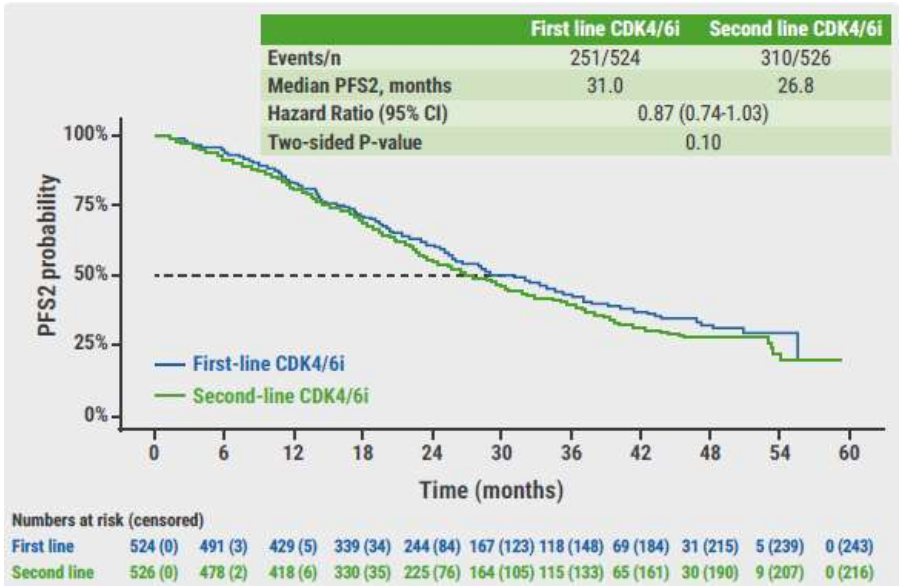
Objectif principal :

- SSP après 2 lignes (SSP2)

Objectifs secondaires :

- Qualité de vie
- Survie globale
- Coût

Stratifié par CDK4/6i, maladie viscérale, HT adjuvante



G.S. Sonke et al. ASCO® 2023, Abs. #LBA1000

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Des Toxicités différentes

	Palbociclib	Ribociclib	Abémaciclib
Neutropénie	✓✓✓	✓✓✓	✓✓
Anémie	✓✓	✓✓	✓✓
Thrombocytopénie	✓		
Fatigue	✓	✓	✓
Diarrhée	✓	✓	✓✓
Nausée			✓
Prolongation QTc		✓	

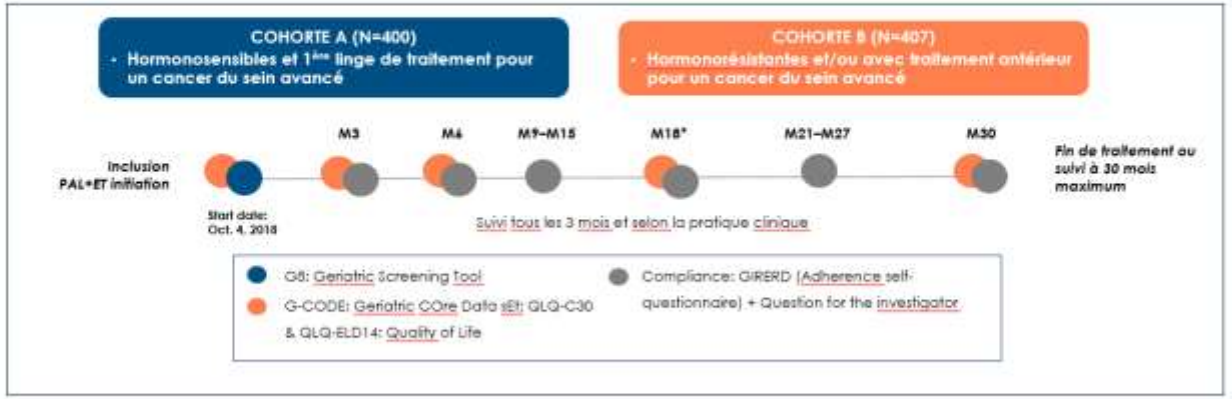
- DeMichele A. et al, ASCO 2018

Palomage : Des données spécifiques patientes âgées

2018 : PalomAGE

Design et objectif de l'étude

- Objectif : Décrire les caractéristiques patientes à la baseline de PalomAGE, étude française de vraie vie, prospective, non interventionelle, de patientes ≥ 70 ans atteintes de cancer du sein avancé RH+ HER2- (N=807)



- Objectif primaire : proportion de patients qui arrêtent leur traitement de façon permanente à 6 mois (Cohorte B) et à 18 mois (Cohorte A) pour toute raison (toxicité, choix de la patiente, progression ou décès).

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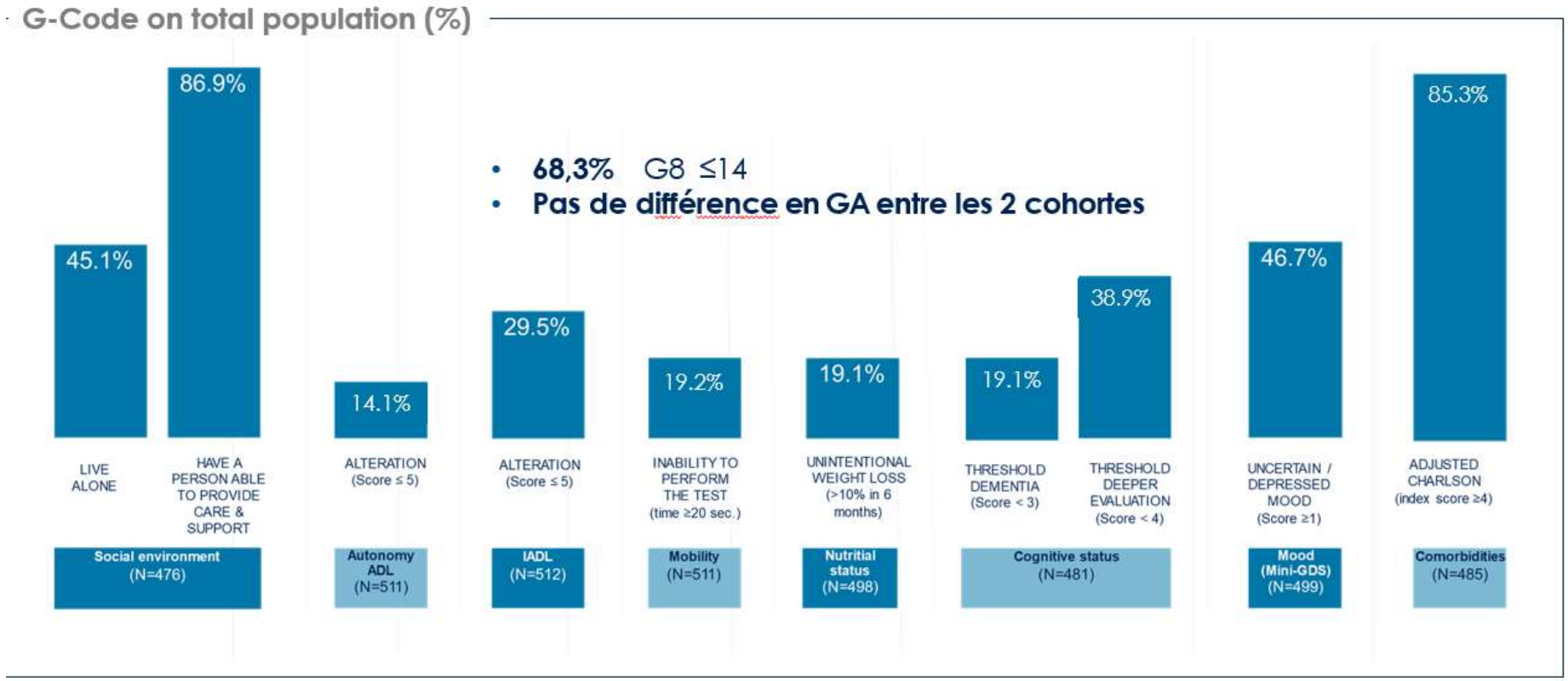
Caractéristiques à la baseline

Age moyen : 78 ans

PS>ou=2 : 20% des patientes

G8 <ou= 14 : 68,3% des patientes



Brain E, et al. Poster P1-18-04. SABCS 2021, Caillet P, et al.- ASCO 2021.

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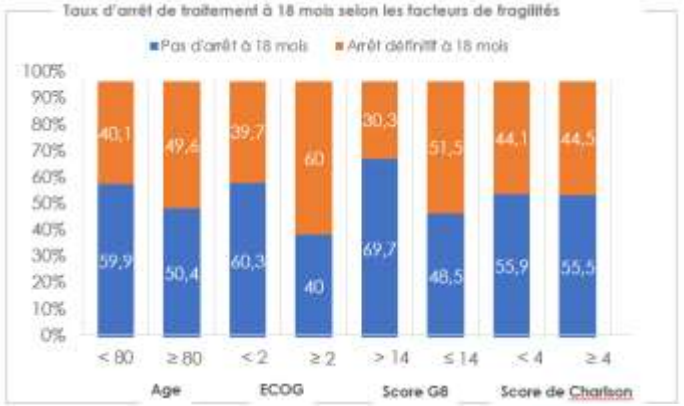
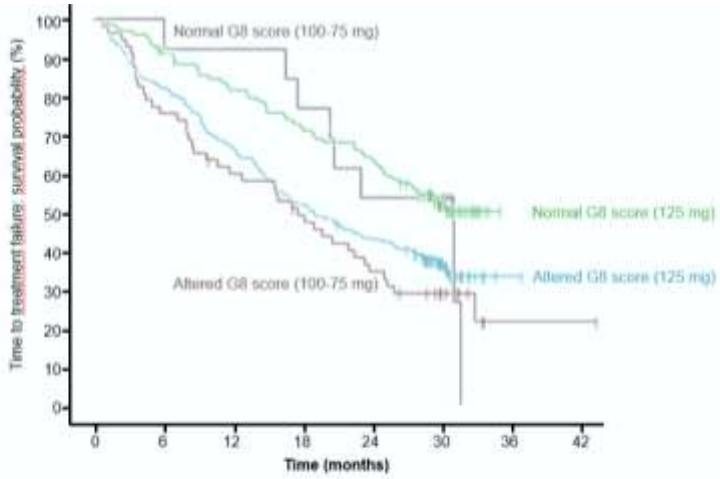
Cohorte Hormonosensible

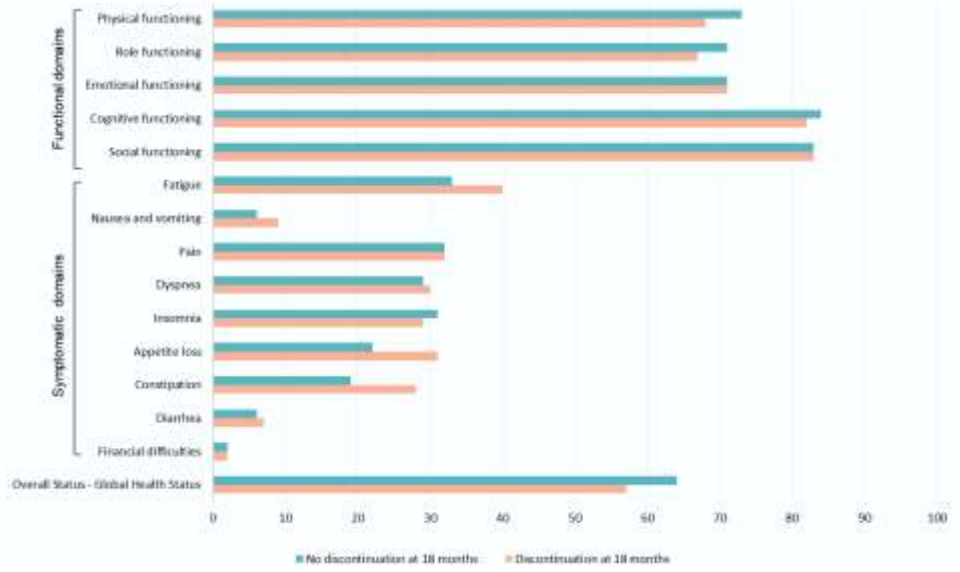
- **Le taux d'arrêt définitif du palbociclib à 18 mois était de 41,9 % (IC à 95 % : 36,6 %-47,2 %) pour les raisons suivantes :**
  - Progression de la maladie (20,8 %),
  - Toxicité (7,7 %),
  - Choix du patient (6,7 %),
  - Décès (4,6 %)
  - Autre raison (2,1 %).



- **Un ECOG PS ≥2 et un G8 ≤14 à baseline étaient associés à un plus grand taux d'arrêt définitif du palbociclib (*p*<0.01*)**



Normal G8 score (125 mg)	103 (0)	96 (9)	85 (19)	75 (29)	67 (38)	34 (49)	0 (50)	0 (50)
Altered G8 score (125 mg)	198 (0)	163 (35)	133 (65)	103 (95)	85 (112)	47 (124)	1 (127)	0 (127)
Normal G8 score (100 mg or 75 mg)	13 (0)	13 (1)	12 (1)	10 (3)	7 (6)	5 (6)	0 (8)	0 (8)
Altered G8 score (100 mg or 75 mg)	58 (0)	44 (14)	34 (23)	27 (29)	19 (37)	12 (40)	1 (41)	1 (41)



SSP = 28,1 mois

Carola E, et al. ASCO 2023. Abs.#1018,
Carola E et al SABCS 2024, Abs

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ABC7
Bridging the Gap

ABC7

ER POSITIVE / HER-2 NEGATIVE ABC

NEW

In view of the substantial survival benefit seen with ET + CDK4/6 inhibitors in 1st line, this combination is considered the standard of care for 1st line therapy for the majority of patients with ER+/HER2 negative ABC, independently of the patient's age. (LoE/GoR: II/A)

Real world-data suggest that ET+CDK4/6 inhibitors can be beneficial also in unfit older patients.
(LoE/GoR: III/B)

Total # of votes:		(43)	
1.	YES:	93.0%	(40)
2.	NO:	2.3%	(01)
3.	ABSTAIN:	4.6%	(02)

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Real-world effectiveness comparison of first-line palbociclib, ribociclib or abemaciclib plus endocrine therapy in advanced HR+/HER2- BC patients: results from the multicenter PALMARES-2 study

L. Provenzano, M.V. Dieci, G. Curigliano, M. Giuliano, A. Botticelli, M. Lambertini, G. Rizzo, R. Pedersini, M. Sirico, N. La Verde, A. Gennari, A. Zambelli, A. Toss, M. Piras, M. Giordano, B. Tagliaferri, D. Generali, D. Sartori, D. Miliziano, A. Menichetti, F. Ligorio, C. Zurlo, G. Griguolo, P.P. Berton Giachetti, V. Faso, C. Corti, E. Chiappe, S. Scagnoli, S. Pisegna, C. Capasso, C. De Angelis, G. Arpino, C. Criscitiello, V. Guarneri, G. Pruneri, L. Mariani, C. Vernieri G. Bianchini, E. Munzone, A. Marra, L. Boldrini, A. Carnevale Schianca, J. Katrini, M.S. Cona, V. Cantile, A. Grieco, M. Pirolo, M. Zappulo, M.A.R. De Giglio, M. Laganà, D. Cosentini, U. De Giorgi, A. Vingiani, A. Belfiore, G. Fotia, G. Mazzoli, C. Sposetti, A. Abate, V. Bianchessi, G. Capri, G.V. Bianchi, F. de Braud, P. Baili, G. Scaperrotta, C. Depretto, A. Lasagna, F. Jacobs, O. Ponzoni, S. Maccarone, C. Strina, S. Coccato, R. Coviello L. Provenzano, M.V. Dieci, G. Curigliano, M. Giuliano, A. Botticelli, M. Lambertini, G. Rizzo, R. Pedersini, M. Sirico, N. La Verde, A. Gennari, A. Zambelli, A. Toss, M. Piras, M. Giordano, B. Tagliaferri, D. Generali, D. Sartori, D. Miliziano, A. Menichetti, F. Ligorio, C. Zurlo, G. Griguolo, P.P. Berton Giachetti, V. Faso, C. Corti, E. Chiappe, S. Scagnoli, S. Pisegna, C. Capasso, C. De Angelis, G. Arpino, C. Criscitiello, V. Guarneri, G. Pruneri, L. Mariani, C. Vernieri G. Bianchini, E. Munzone, A. Marra, L. Boldrini, A. Carnevale Schianca, J. Katrini, M.S. Cona, V. Cantile, A. Grieco, M. Pirolo, M. Zappulo, M.A.R. De Giglio, M. Laganà, D. Cosentini, U. De Giorgi, A. Vingiani, A. Belfiore, G. Fotia, G. Mazzoli, C. Sposetti, A. Abate, V. Bianchessi, G. Capri, G.V. Bianchi, F. de Braud, P. Baili, G. Scaperrotta, C. Depretto, A. Lasagna, F. Jacobs, O. Ponzoni, S. Maccarone, C. Strina, S. Coccato, R. Coviello

Annals of Oncology

DOI: 10.1016/j.annonc.2025.03.023

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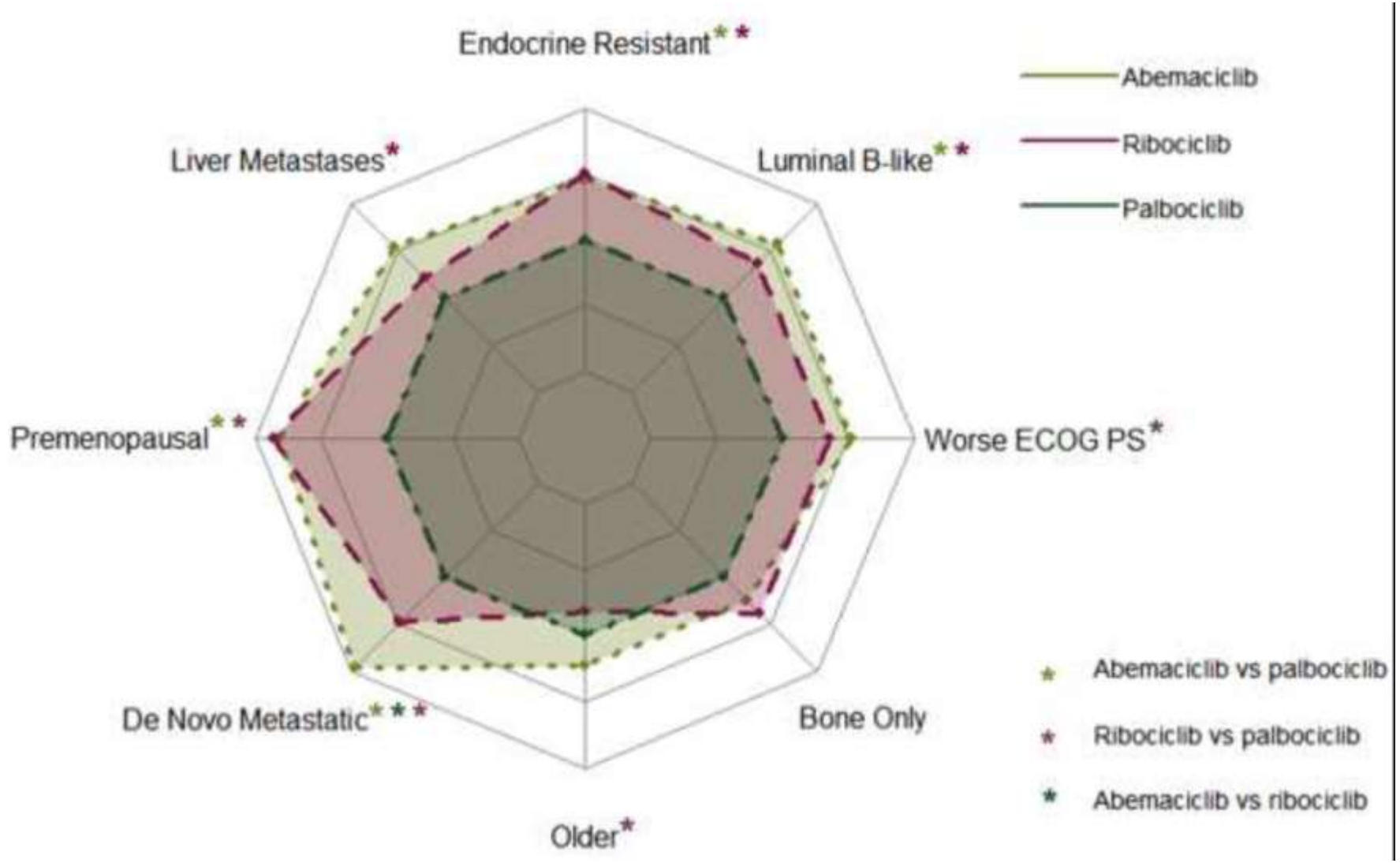

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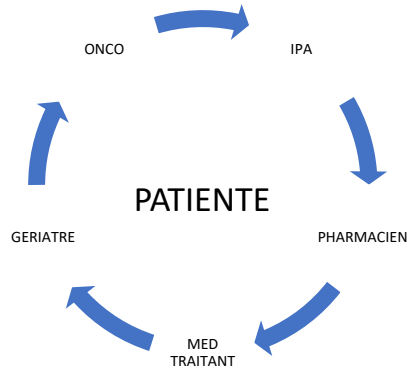
Les Stratégies possibles en Première Ligne M+

- Patiente âgée fragile : Palomage
- Patiente âgée fit avec bonne espérance de vie et maladie agressive : Right Choice
- Patiente âgée très fragile : Sonia
- Patiente âgée fit : Palomage, Monaleesa 2 et Monarch 3 en fonction des tox , localisations métastatiques (PALMARES 2025)

- Dans tous les cas :



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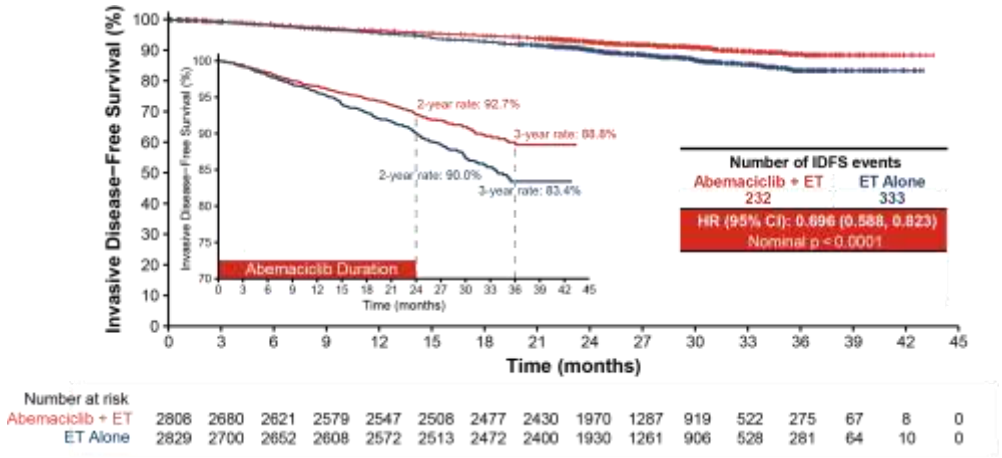
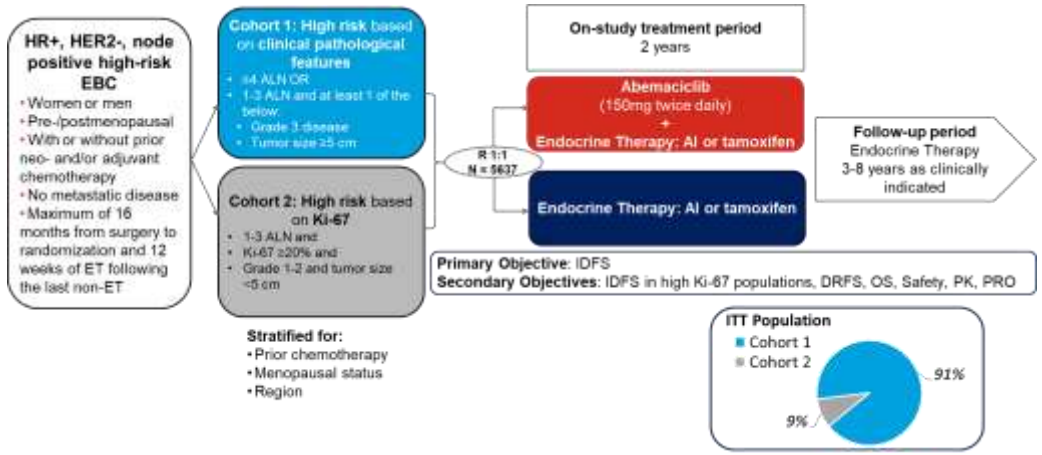
Et en Adjuvant?

monarchE Study Design (NCT03155997)

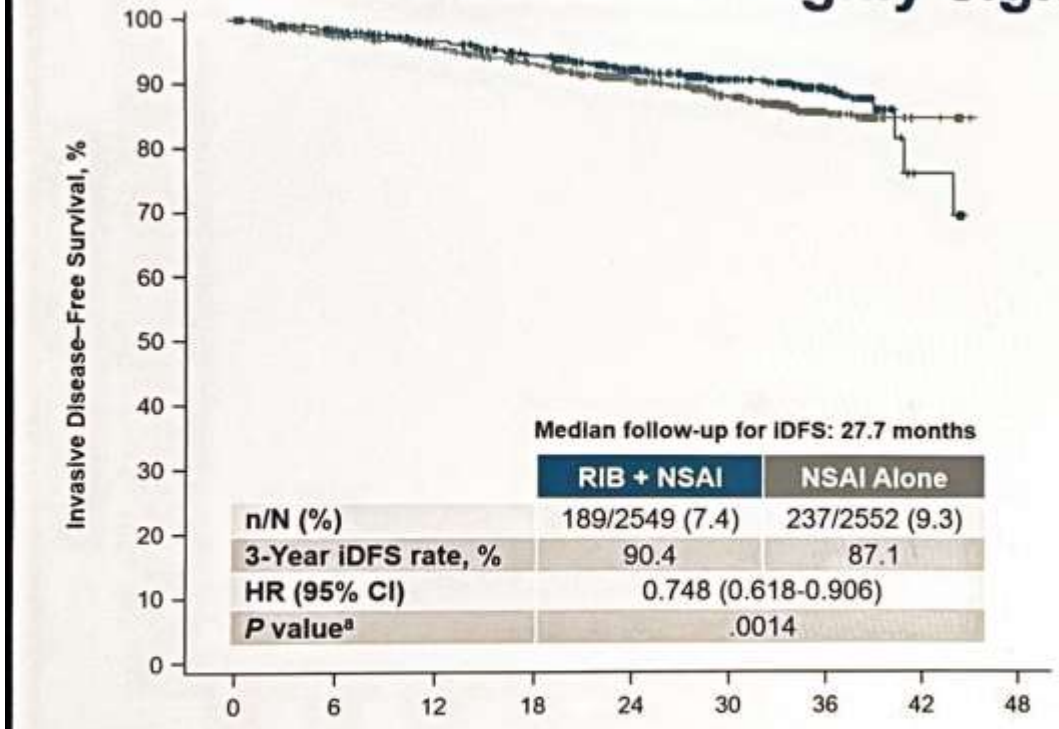




30.4% reduction in the risk of developing an IDFS event.
The absolute difference in IDFS rates between arms was 5.4% at 3 years.

Stephen R D Johnston, Lancet Oncol 2022

Ribociclib achieved highly significant iDFS benefit



Median follow-up for iDFS: 27.7 months

	RIB + NSAI	NSAI Alone
n/N (%)	189/2549 (7.4)	237/2552 (9.3)
3-Year iDFS rate, %	90.4	87.1
HR (95% CI)	0.748 (0.618-0.906)	
P value[a]	.0014	

No. at risk									
RIB + NSAI	2549	2350	2274	2193	1718	1111	311	12	0
NSAI alone	2552	2240	2166	2071	1631	1067	286	13	0

- Based on the *P* value of .0014, the IDMC concluded that the results met the criteria to demonstrate statistically significant and clinically superior efficacy
- Absolute iDFS benefit with RIB + NSAI at 3 years was 3.3%
- Risk of invasive disease was reduced by 25.2% with RIB + NSAI vs NSAI alone
- Ongoing patients will remain on treatment and follow-up will continue as prespecified

iDFS, invasive disease–free survival; IDMC, Independent Data Monitoring Committee; HR, hazard ratio; NSAI, nonsteroidal aromatase inhibitor; RIB, ribociclib.
[a] One-sided *P* value.

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PRESENTED BY: Dennis Slamon MD, PhD

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KNOWLEDGE CONQUERS CANCER

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Question 43: Cancers RH positifs et HER2 négatifs (2)

2023

- En cas de lésion pN2 ou pN1a avec un grade 3 ou une tumeur > 5cm, un traitement adjuvant ajoutant l'abémaciclib au traitement antihormonal est souhaitable.

	EXPERTS	SALLE
OUI	100%	89%
NON	0%	5%
ABSTENTION	0%	6%

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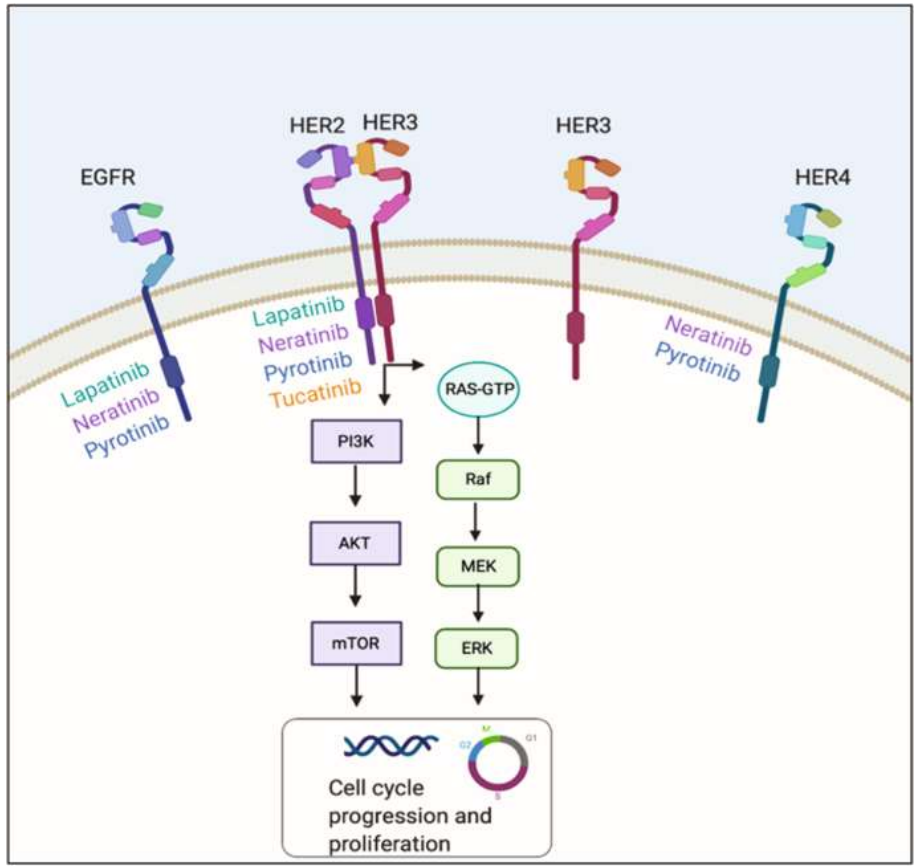
Actualités Femme âgée et cancer du sein Métastatique Her2+++ et Her2 LOW



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Cohorte ESME

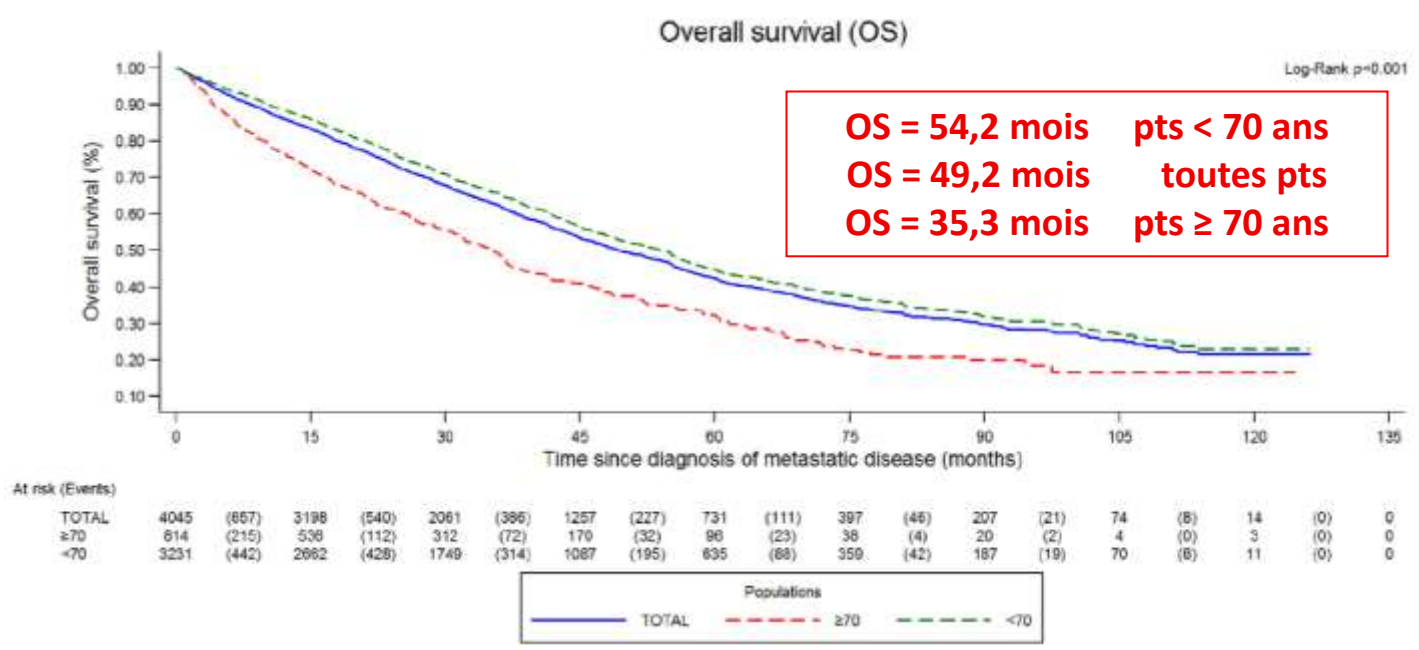
- 22 663 patientes
- 4 045 patientes HER2+ = 18 %
- Age médian = 57 ans
- 814 patientes ≥ 70 ans = 20,1 %

Pour la population ≥ 70 ans

- Tumeur RH+ plus fréquente (69 % vs 63 %, p = 0,01)
- 1ère ligne avec thérapie anti-HER2 moins fréquente (65 % vs 89 %, p < 0,01)
- 1ère ligne avec thérapie anti-HER2 et sans CT dans 11,5 % des cas

Annonay M et al., The Breast 2021

Cohorte ESME



OS = 54,2 mois pts < 70 ans
OS = 49,2 mois toutes pts
OS = 35,3 mois pts ≥ 70 ans

Annonay M et al., The Breast 2021

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Recommandations ABC7 – Evaluation gériatrique

NEW

For treatment decision making, careful evaluation of co-morbidities, performance status and geriatric assessment are crucial and more relevant than chronological age.
G8 assessment should be used initially, and a full geriatric assessment is needed if low G8 scores are found.

(LoE/GoR: I/A)

Total # of votes:		(42)	
1. YES:	90.4%	(38)	
2. NO:	4.7%	(02)	
3. ABSTAIN:	4.7%	(02)	

Quel traitement de première ligne?

1ère ligne standard	Option PERTAIN RH+	Option EORTC 75111
CLEOPATRA Taxane + Trastu + Pertu SSPm = 18 mois SGm = 57 mois	HT +Trastu + Pertu SSPm = 19 mois SGm = 60 mois	Cyclophosphamide+ Trastuzumab+Pertuzumab (CTP) SSPm = 12,7mois

Les recommandations de la SIOG M+

Table 2
Recommendations for the treatment of HER2+ metastatic breast cancer in older patients.

	Grade of recommendation/description
First line	
Docetaxel 3-weekly + G-CSF or weekly paclitaxel, trastuzumab and pertuzumab is 1st line standard of care in fit older patients only	1B
In frail older patients, metronomic cyclophosphamide, vinorelbine or capecitabine with dual blockade can be considered	2C
Trastuzumab monotherapy, or dual anti-HER2 combinations (pertuzumab and trastuzumab, lapatinib and trastuzumab) without chemotherapy should be reserved for frail older patients at high risk of side effects and used in combination with endocrine therapy for crucial	2C

E Brain, JGO 2019

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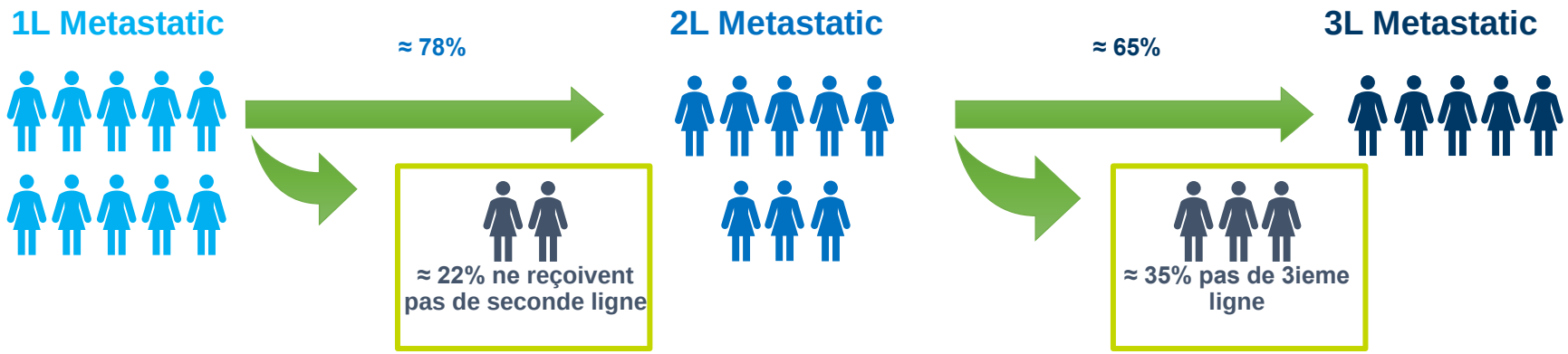
Seconde ligne et plus chez les Her2 surexprimés [1-3]



1L, first-line; 3L, third-line; THP, trastuzumab + pertuzumab + a taxane; TH, trastuzumab + a taxane.
[a] Percentage calculated from the total number of patients across both the THP and TH treatment arms in the CLEOPATRA study. [b] Percentage was calculated by subtracting the percentage of patients with HER2-positive mBC from the Flatiron Health Data Repository who did not go onto 3L therapy from 100.
1. Kunte S et al. *Cancer*. 2020;126(19):4278-4288. **2.** Swain SM et al. *N Engl J Med.* 2015;372(8):724-734. **3.** Collins J et al. SABCS 2020. Poster PS7-82. **4.** Modi S. ESMO 2021. Discussant for LBA1.

Faire mieux en troisième ligne !

Standard of Care Prior to DESTINY-Breast03[a]

1L **Trastuzumab + pertuzumab + taxane,**
CLEOPATRA: mPFS = 18.7 months[1]

- mBC 1L standard of care was established in the CLEOPATRA trial[1,2]

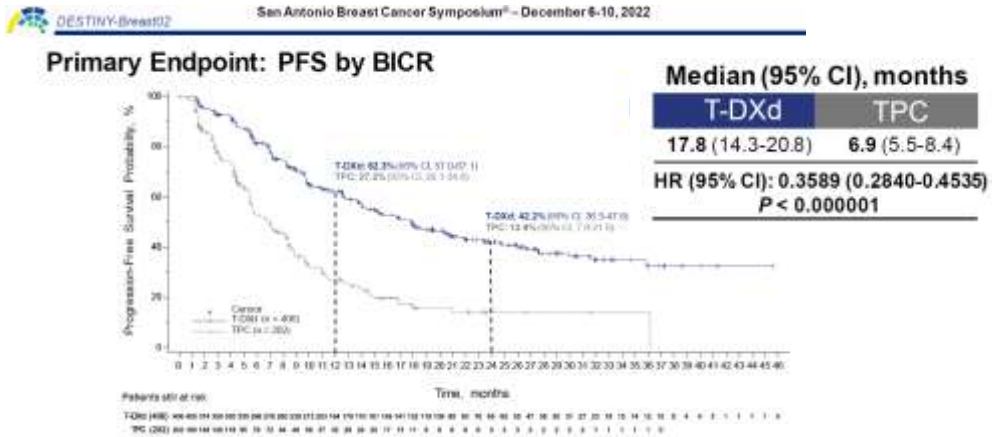
2L + **T-DM1, EMILIA:**
mPFS = 9.6 mo[3]

- EMILIA trial established T-DM1 as 2L+ standard of care
- In the changing treatment landscape, more recent clinical trials and real-world studies have demonstrated mPFS outcomes with T-DM1 in the range of 6-7 months[2,4-7]
  - mPFS for T-DM1 in the randomized KATE2 was 6.8 months (2020)[4]

3L + **T-DXd**
DESTINY-Breast01: mPFS = 19.4 months[8]

- T-DXd demonstrated robust activity in a 3L+ phase 2 single arm study, leading to regulatory approvals globally[2,8]

Confirmé par la phase III DESTINY-Breast 02 [9]



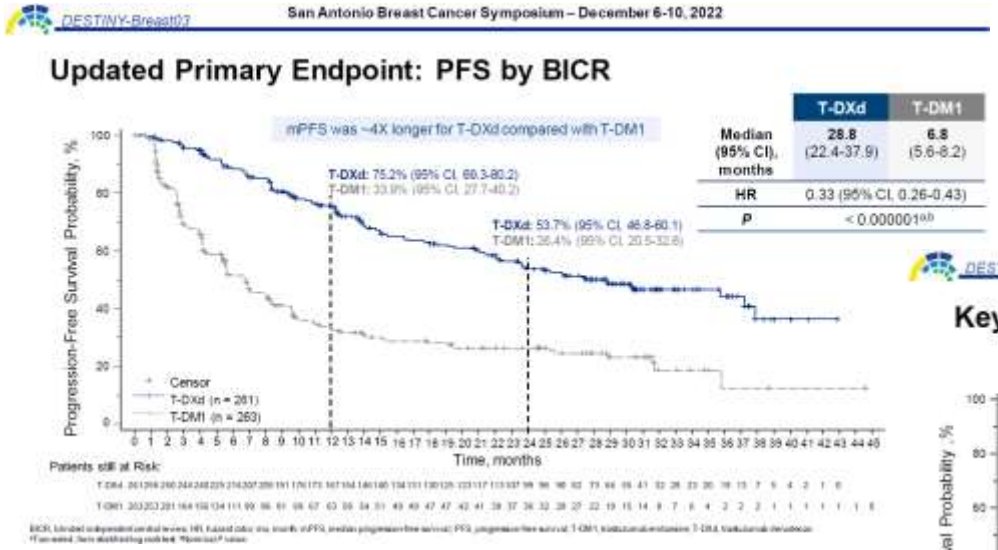
[a]Not intended for cross-trial comparison.

1. Swain SM et al. *N Engl J Med.* 2015;372:724-734. 2. Perez J et al. *Expert Opin Biol Ther*. 2021;21:811-824. 3. Verma S et al. *N Engl J Med*. 2012;367:1783-1791. 4. Emens LA et al. *Lancet Oncol*. 2020;21:1283-1295.
5. Daniels et al. *Breast*. 2021;58:106-112. 6. Lupichuk S et al. *Breast Cancer (Auckl).* 2019;13:1178223419879429. 7. Vici P et al. *Oncotarget*. 2017;8:56921-56931. 8. Modi S et al. Presented at San Antonio Breast Cancer Symposium 2020; December 8-11, 2020; San Antonio, TX, USA. Poster PD3-06. 9 Krop IE et al. Presented at: San Antonio Breast Cancer Symposium 2022; December 6-10, 2022; San Antonio, TX, USA. Presentation GS2-01.

DESTINY-Breast 03

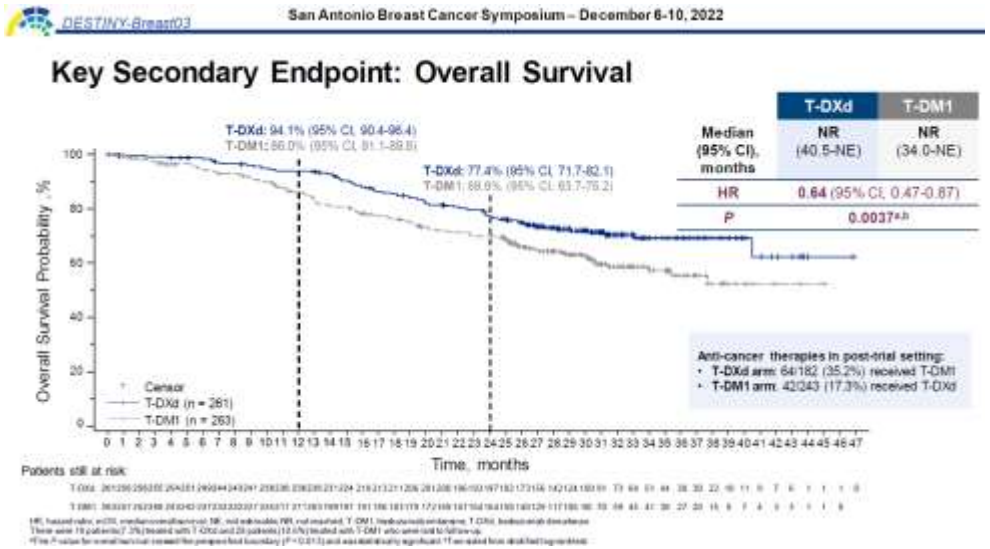
Survie Sans Progression (critère principal) et Survie Globale

Characteristic	T-DXd (n = 261)	T-DM1 (n = 263)
Age, median (range), years	54.3 (27.9-83.1)	54.2 (20.2-83.0)



Âge médian : 54 ans (27 – 83 ans)

Critère principal positif
SSP de 28,8 mois pour T-DXd vs. 6,8 mois pour T-DM1



Hurvitz SA et al. *The Lancet*. 2022;400 [in press].
Hurvitz SA et al. Presented at: San Antonio Breast Cancer Symposium 2022; December 6-10, 2022; San Antonio, TX, USA. Presentation GS2-02.

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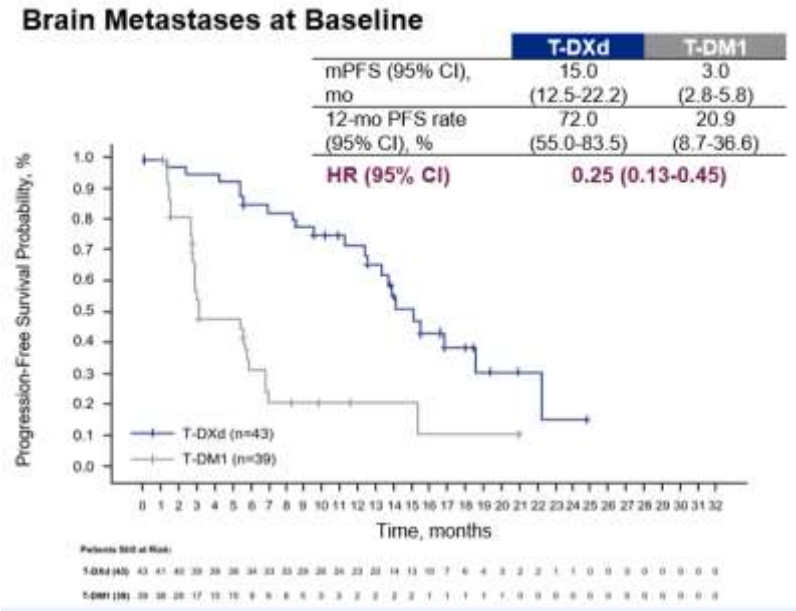
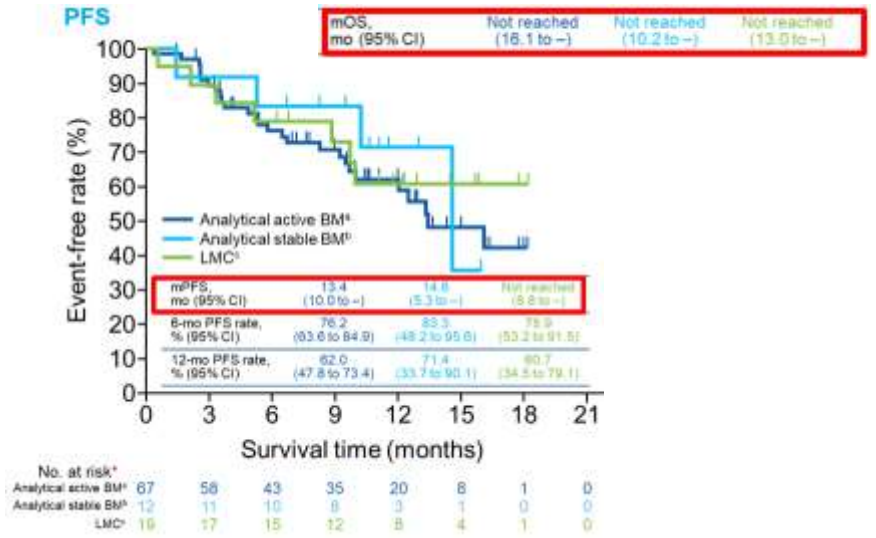
Activité cérébrale du Trastuzumab-déruxtécan

DESTINY-BREAST 03 : 16,5% des patientes traitées par T-DXd et 14,8% par T-DM1 ont des métastases cérébrales, **traitées et stables** à l'inclusion



Hurvitz SA et al. Presented at: San Antonio Breast Cancer Symposium 2021; December 7-10, 2021; San Antonio, TX, USA. Presentation GS3-01.

ROSET-BM : étude multicentrique rétrospective.
104 patientes traitées par T-DXd (MBC HER2-positive)
Ayant des MC **actives** (86,5%) avec un envahissement **leptoméningé** (16%).
Nombre de traitements reçus au préalable en métastatique : 4 (range 3-7)



* Of the 104 patients, 6 patients had a brain imaging data at baseline which were not classified by ICR. †Active (excluding patients who had undergone WBRT within 30 days of T-DXd administration). ‡Stable + active (including patients who had undergone WBRT within 30 days of T-DXd administration). §Active with LMC or LMC only.
Yamanaka T, et al., SABCS 2022_Poster presentation PD7-01. Supplement.

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2ième Ligne	2ème ligne	
DESTINY-Breast03 Trastu-Deruxtecan SSPm = 25,1 mois	EMILIA Trastuzumab-Emtansine SSPm = 9 mois SGm = 30 mois	

HER2-positive

Mise à jour des recommandations de pratique clinique

ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

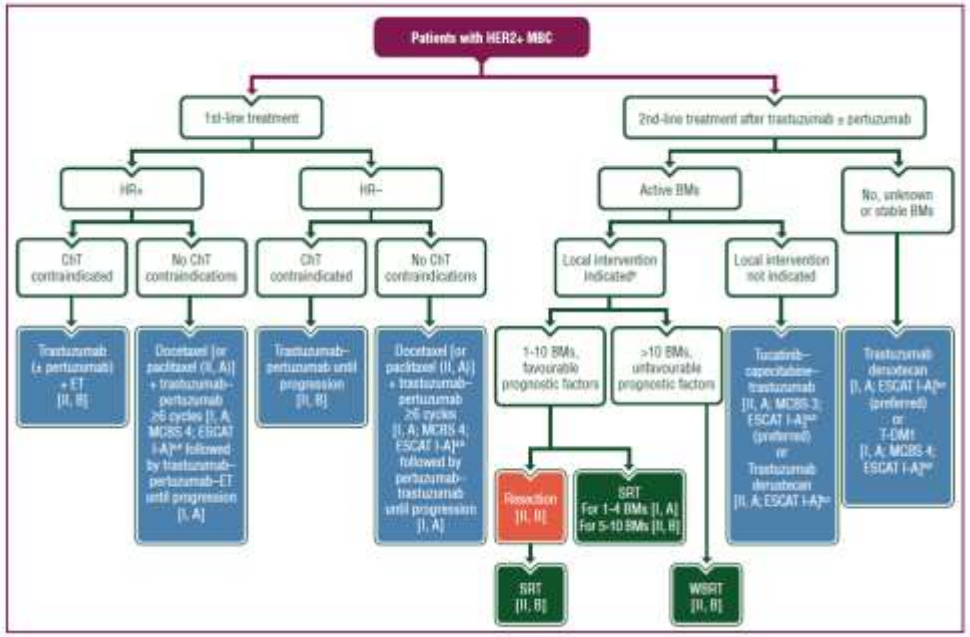
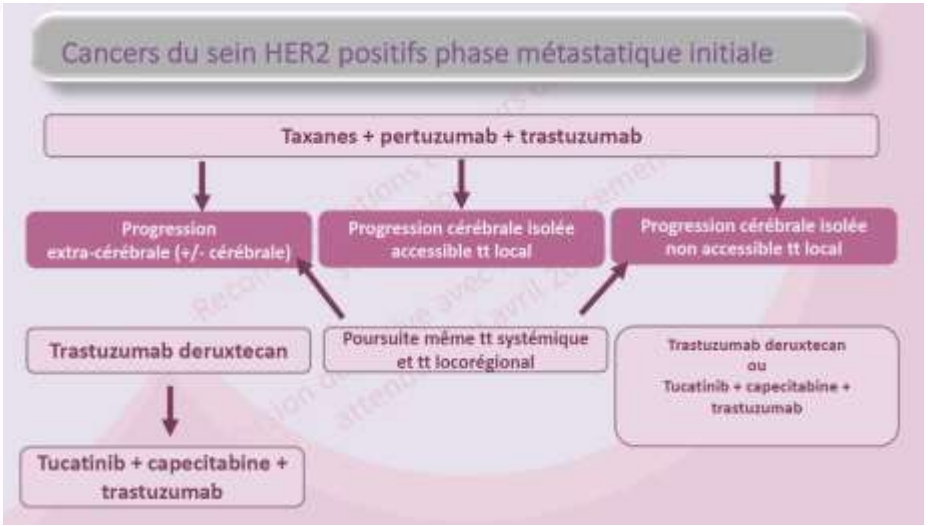


Figure 3. First- and second-line treatment of HER2-positive MBC.

Gennari A et al. Ann Oncol. 2021;32(12):1475-1495.

21ème COURS ST-PAUL 2023

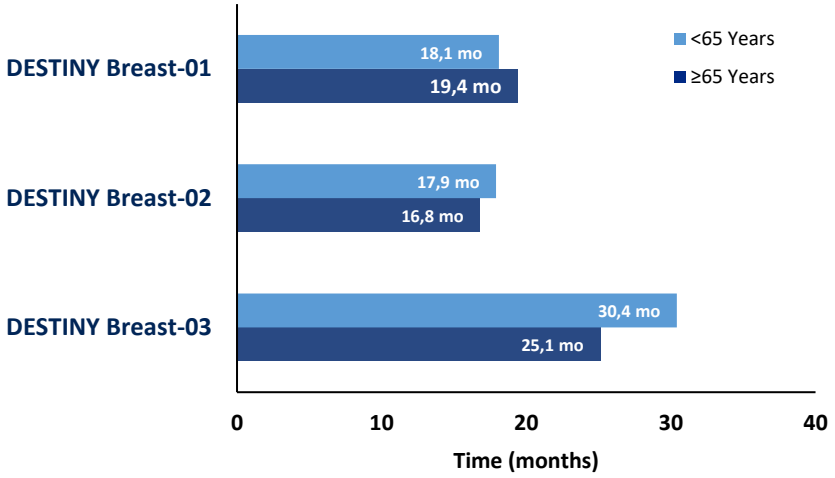


Saint Paul de Vence 2023 - Recommandations en cours de soumission
Version définitive avec référencement attendue d'ici avril 2023

HER2-Positive mBC: Age-Specific Pooled Analysis (DB-01/02/03)

Descriptive Efficacy According to Age for T-DXd[a]

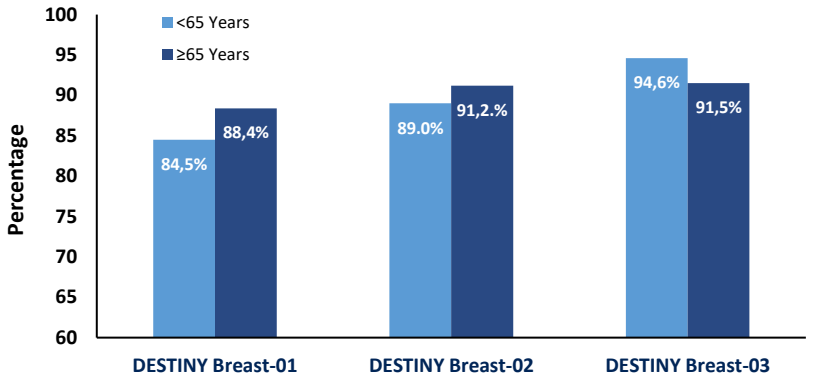
Median Progression-Free Survival



Median Overall Survival

	DESTINY-Breast01		DESTINY-Breast02		DESTINY-Breast03	
	<65 (n = 140)	≥65 (n = 44)	<65 (n = 321)	≥65 (n = 85)	<65 (n = 212)	≥65 (n = 49)
mOS, months (95% CI)	28.1 (23.3-36.1)	30.9 (21.9-NE)	NR (35.5-NE)	30.2 (22.3-39.2)	NR (40.5-NE)	NR (26.3-NE)

12-Month Landmark Overall Survival



- Efficacy in patients aged ≥65 and <65 years treated with T-DXd was generally similar; however, no formal comparison was made

[a]Efficacy data was not pooled due to bias induced by the heterogeneity of the study population. Trial data cutoffs: DESTINY-Breast01: March 26, 2021; DESTINY-Breast02: June 30, 2022; DESTINY-Breast03: July 25, 2022.
Krop I et al. Presented at: American Society of Clinical Oncology Annual Meeting 2023; June 2-6, 2023. Presentation 1006.

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HER2-Positive mBC: Age-Specific Pooled Analysis (DB-01/02/03)

Most Common Grade ≥3 Drug-Related TEAEs in ≥5% of Patients

	T-DXd Pool			TPC (DB-02)			T-DM1 (DB-03)		
	<65 (n = 668)	≥65 (n = 177)	≥75 (n = 33)	<65 (n = 157)	≥65 (n = 38)	≥75 (n = 8)	<65 (n = 204)	≥65 (n = 57)	≥75 (n = 8)
Grade ≥3[a] drug-related TEAEs, n (%)	**291 (43.6)**	**96 (54.2)**	**13 (39.4)**	**48 (30.6)**	**12 (31.6)**	**5 (62.5)**	**82 (40.2)**	**28 (49.1)**	**3 (37.5)**
Neutropenia[b]	117 (17.5)	41 (23.2)	4 (12.1)	5 (3.2)	1 (2.6)	1 (12.5)	6 (2.9)	3 (5.3)	0
Fatigue[c]	52 (7.8)	20 (11.3)	5 (15.2)	1 (0.6)	1 (2.6)	1 (12.5)	2 (1.0)	0	0
Nausea	43 (6.4)	15 (8.5)	4 (12.1)	3 (1.9)	0	0	0	1 (1.8)	0
Anemia[d]	42 (6.3)	20 (11.3)	3 (9.1)	1 (0.6)	0	0	6 (2.9)	6 (10.5)	1 (12.5)
Leukopenia[e]	42 (6.3)	15 (8.5)	2 (6.1)	0	0	0	3 (1.5)	0	0
Lymphopenia[f]	28 (4.2)	11 (6.2)	1 (3.0)	2 (1.3)	0	0	2 (1.0)	1 (1.8)	0
Thrombocytopenia[g]	28 (4.2)	9 (5.1)	0	2 (1.3)	0	0	47 (23.0)	19 (33.3)	2 (25.0)
Transaminases increased[h]	18 (2.7)	1 (0.6)	0	1 (0.6)	1 (2.6)	0	16 (7.8)	4 (7.0)	0
Diarrhea	9 (1.3)	4 (2.3)	0	10 (6.4)	2 (5.3)	1 (12.5)	2 (1.0)	0	0

- Patients ≥65 years of age experienced more grade ≥3 TEAEs across all trials

[a]Grade ≥3 drug-related TEAEs present in ≥5% of patients, sorted in descending order of frequency in the T-DXd pooled arm for the <65 years age group. Grade ≥3 drug-related TEAEs calculated in all patients in the analysis set. . [b]Neutropenia includes the preferred terms neutrophil count decreased and neutropenia. [c]Fatigue includes the preferred terms fatigue, asthenia, malaise, and lethargy. [d]Anemia includes the preferred terms hemoglobin decreased, red blood cell count decreased, anemia, and hematocrit decreased. [e]Leukopenia includes the preferred terms white blood cell count decrease and leukopenia. [f]Lymphopenia includes the preferred terms lymphocyte count decreased and lymphopenia. [g]Thrombocytopenia includes the preferred terms platelet count decreased and thrombocytopenia. [h]Transaminases increased includes the preferred terms transaminases increased, aspartate aminotransferase increased, alanine aminotransferase increased, gamma-glutamyltransferase increased, liver function test abnormal, hepatic function abnormal, and liver function test increased.

Krop I et al. Presented at: American Society of Clinical Oncology Annual Meeting 2023; June 2-6, 2023. Presentation 1006.

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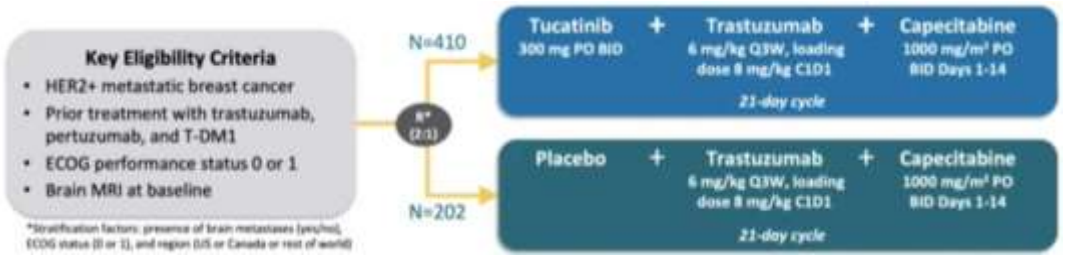
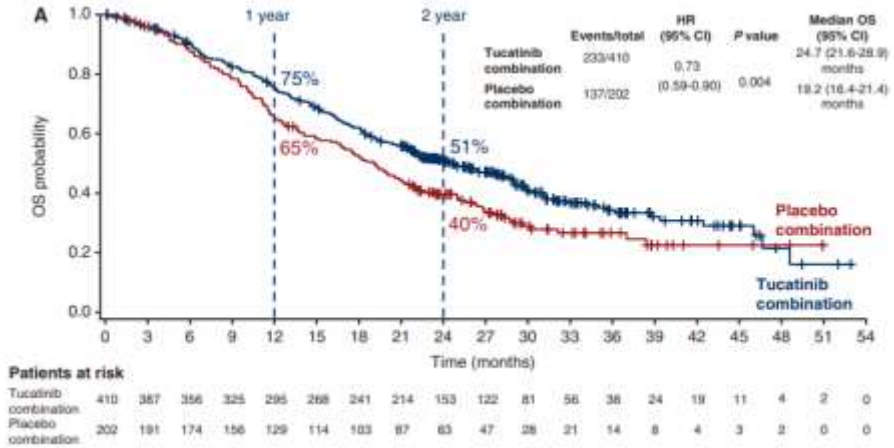
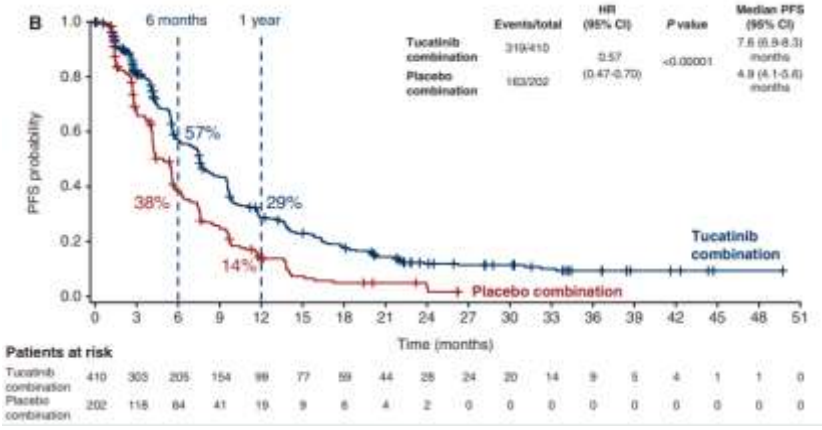
HER2-positive

HER2CLIMB 3ième ligne
Analyse finale de la survie







Suivi median de 29,6 mois

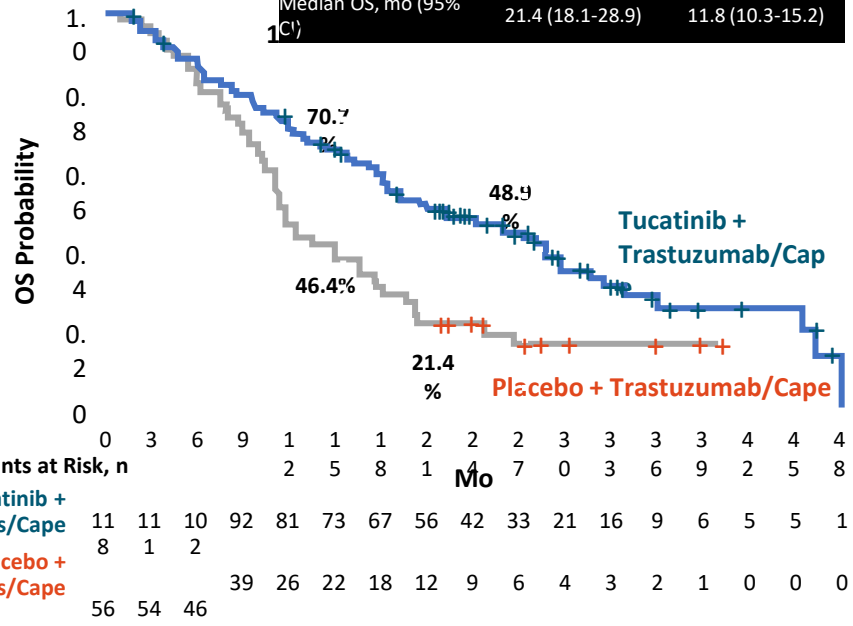
Curigliano et al. Ann Oncol 2022 Mar;33(3):321-329

HER2-positive

HER2CLIMB : Données sur les métastases cérébrales

OS: Patients With Active Brain Metastases

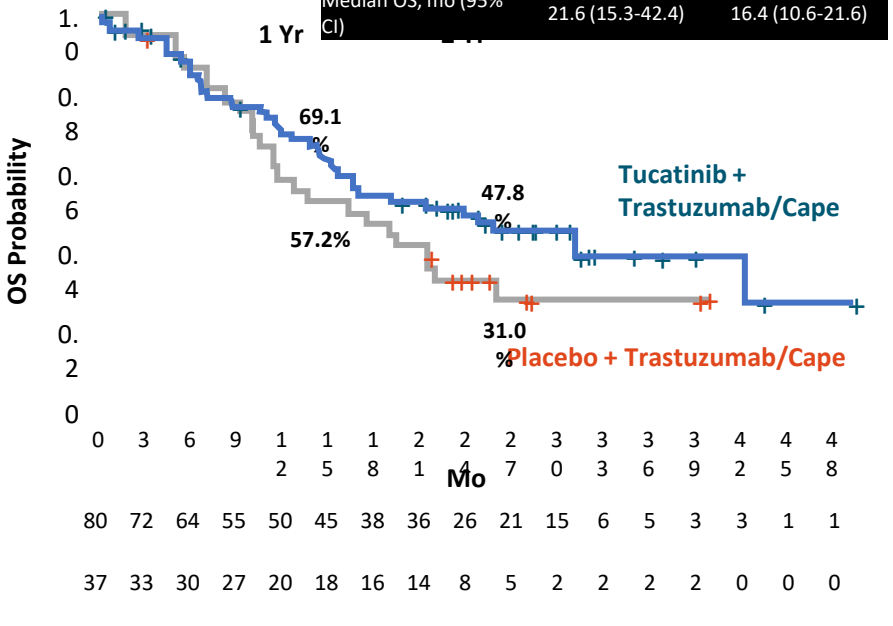
	Tucatinib + Trastuzumab/Cape	Placebo + Trastuzumab/Cape
Events/total	75/118	46/56
HR (95% CI)	0.524 (0.256-0.771; *P* = .00087)	
Median OS, mo (95% CI)	21.4 (18.1-28.9)	11.8 (10.3-15.2)



Patients at Risk, n																	
Tucatinib + Tras/Cape	118	111	102	92	81	73	67	56	42	33	21	16	9	6	5	5	1
Placebo + Tras/Cape	56	54	46	39	26	22	18	12	9	6	4	3	2	1	0	0	0

OS: Patients With Treated/Stable Brain Metastases

	Tucatinib + Trastuzumab/Cape	Placebo + Trastuzumab/Cape
Events/total	43/80	25/37
HR (95% CI)	0.695 (0.416-1.160; *P* = .16223)	
Median OS, mo (95% CI)	21.6 (15.3-42.4)	16.4 (10.6-21.6)



	80	72	64	55	50	45	38	36	26	21	15	6	5	3	3	1	1
	37	33	30	27	20	18	16	14	8	5	2	2	2	2	0	0	0

CIPEG Congrès Interdisciplinaire des Professionnels en GÉRIATRIE

HER2-positive

Mise à jour des recommandations de pratique clinique

ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

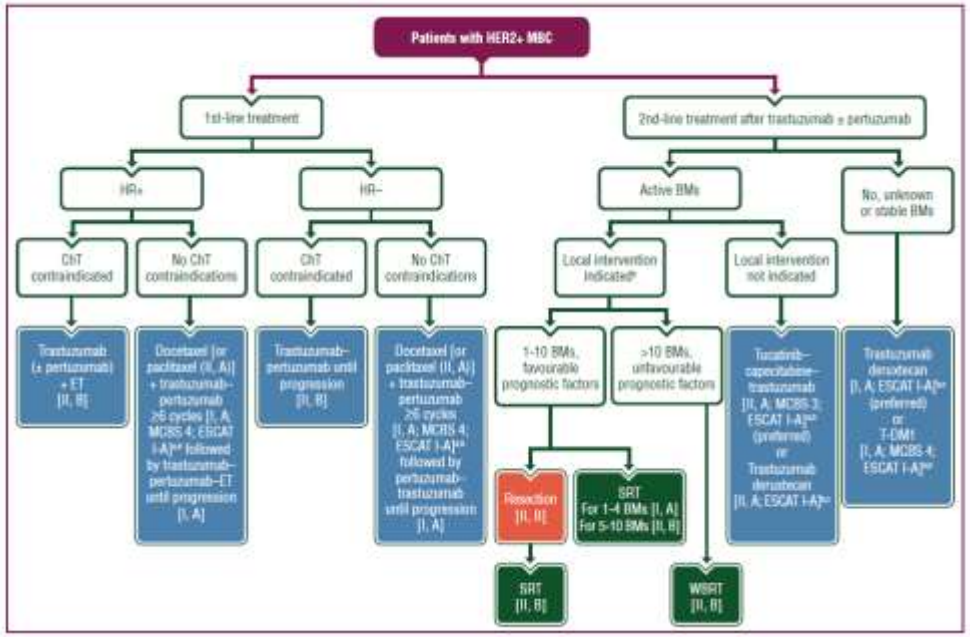
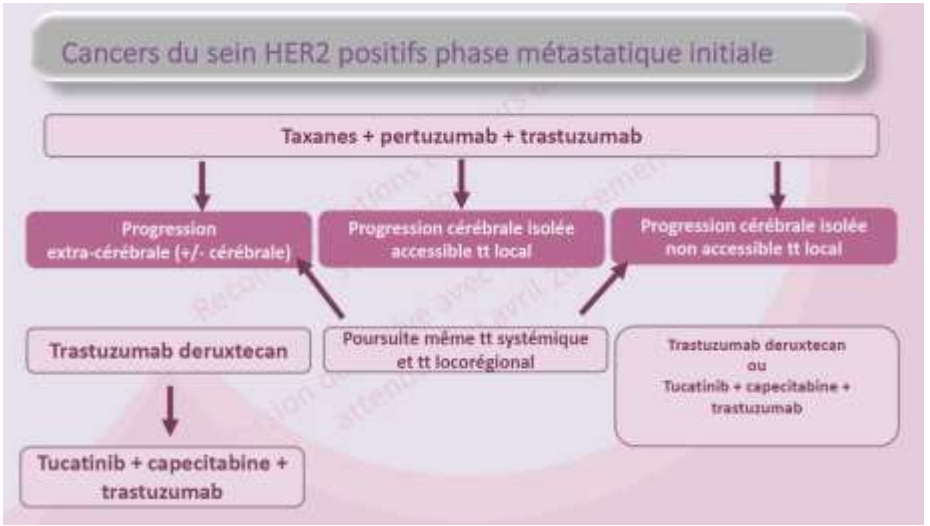


Figure 3. First- and second-line treatment of HER2-positive MBC.

Gennari A et al. Ann Oncol. 2021;32(12):1475-1495.

21ème COURS ST-PAUL 2023



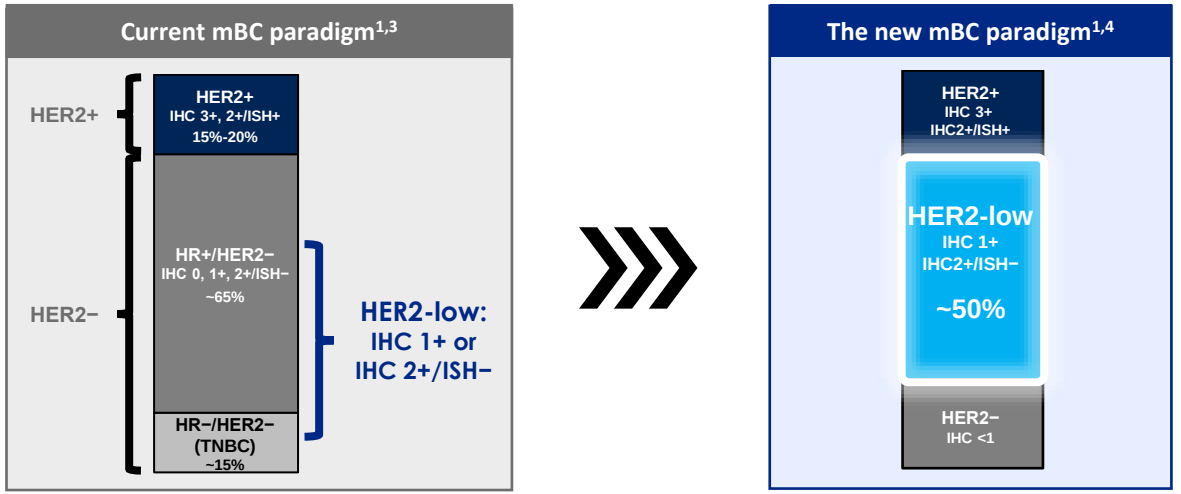
Saint Paul de Vence 2023 - Recommandations en cours de soumission
Version définitive avec référencement attendue d'ici avril 2023

HER2-faible

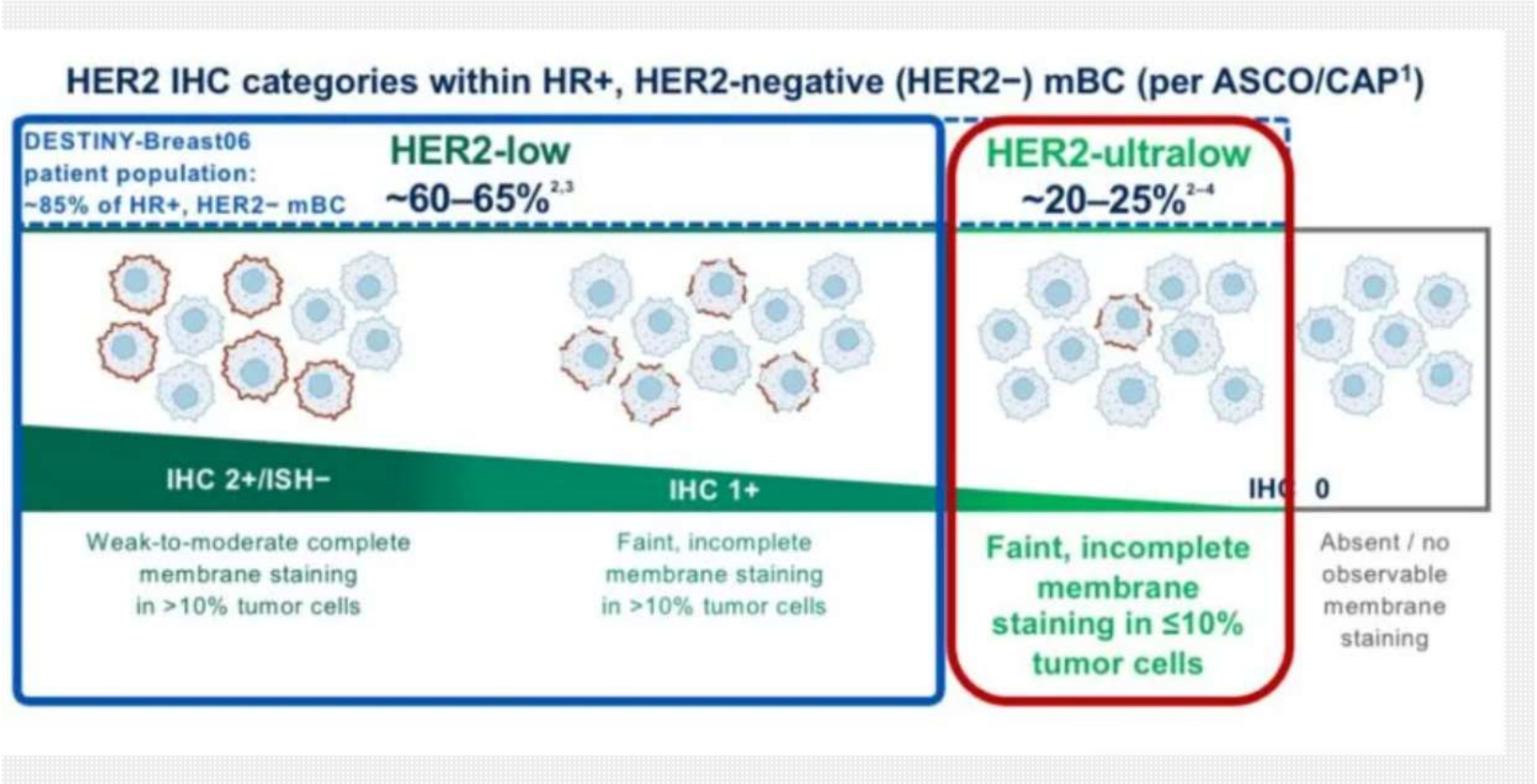
Un nouveau paradigme

Around 60% of metastatic breast cancers categorized as HER2 negative express low levels of HER2 (HER2-low), which is clinically meaningful[1]

Guidelines recommend assessment of HER2 status in all newly diagnosed patients with BC and those patients who develop metastatic disease[2]



1. Schettini F et al. NPJ Breast Cancer. 2021;7(1):1. 2. Wolff AC et al. J Clin Oncol. 2018;36(20):2105-2122.
3. Tarantino P et al. J Clin Oncol. 2020;38(17):1951-1962. 4. Modi S et al. N Engl J Med. 2022; 387:9-20.


HER2 IHC categories within HR+, HER2-negative (HER2−) mBC (per ASCO/CAP[1])
DESTINY-Breast06 patient population: ~85% of HR+, HER2− mBC
HER2-low ~60–65%[2,3]
HER2-ultralow ~20–25%[2–4]
IHC 2+/ISH−
IHC 1+
IHC 0
Weak-to-moderate complete membrane staining in >10% tumor cells
Faint, incomplete membrane staining in >10% tumor cells
Faint, incomplete membrane staining in ≤10% tumor cells
Absent / no observable membrane staining

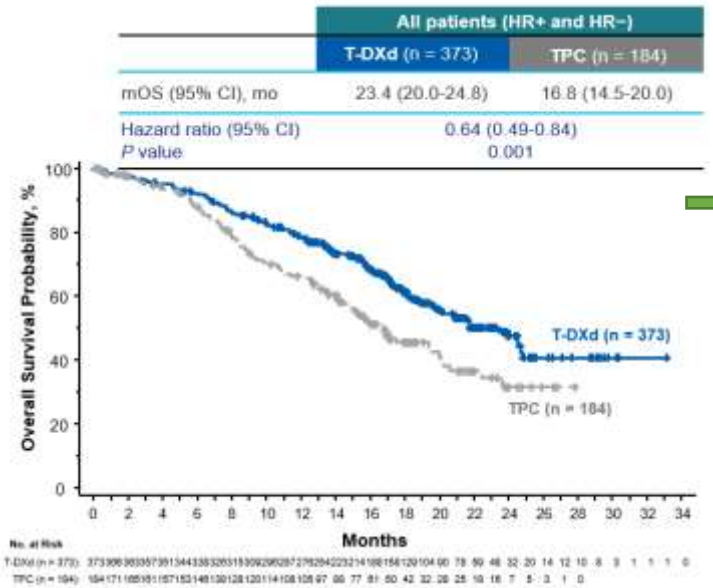
HER2-faible

DESTINY-BREAST 04

Trastuzumab-déruxtécan

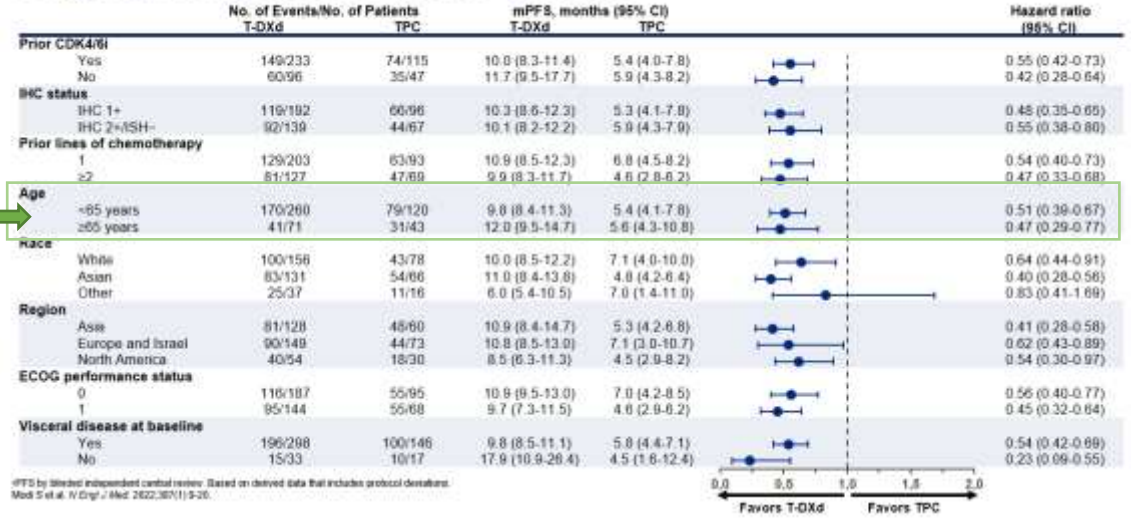
Survie Globale et SSP (sous-groupe ≥ 65 ans)

Survie Globale sur toute la population



January 11, 2022, DCO

Subgroup analysis: PFS in HR+ patients[a]



January 11, 2022, DCO

Modi S et al. N Engl J Med. 2022;387(1):9-20.
Modi S et al. Presented at American Society of Clinical Oncology (ASCO) 2022, June 2022, LBA3.

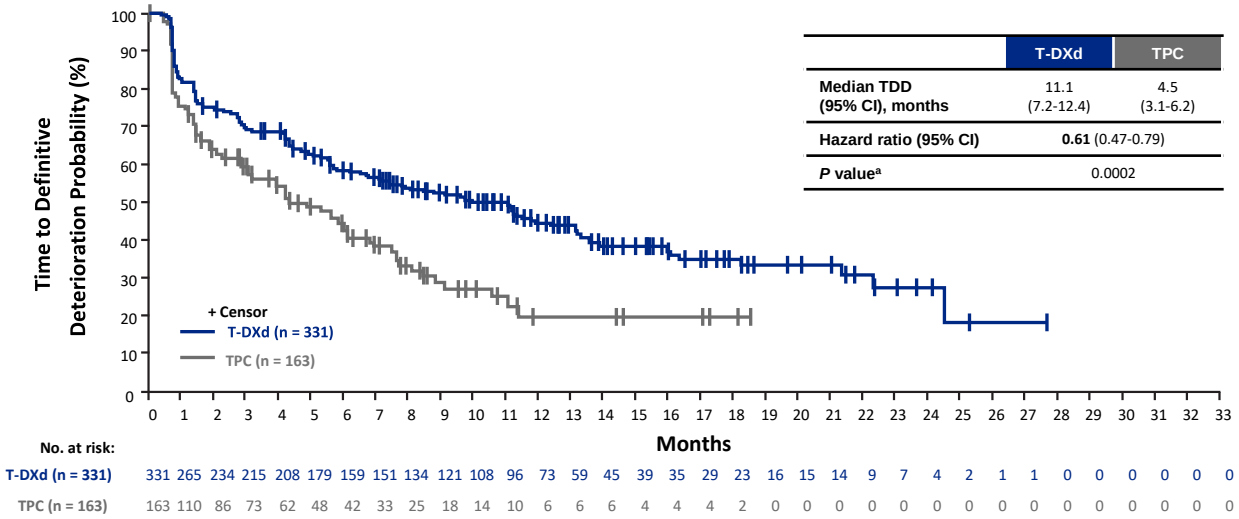
HER2-faible

DESTINY-BREAST 04

Trastuzumab-déruxtécan

Qualité de vie

Time to definitive deterioration of fatigue (QLQ-C30)



	T-DXd	TPC
Median TDD (95% CI), months	11.1 (7.2-12.4)	4.5 (3.1-6.2)
Hazard ratio (95% CI)	**0.61** (0.47-0.79)	
P value[a]	0.0002	

No. at risk:																															
T-DXd (n = 331)	331	265	234	215	208	179	159	151	134	121	108	96	73	59	45	39	35	29	23	16	15	14	9	7	4	2	1	1	0	0	0	0	0	0
TPC (n = 163)	163	110	86	73	62	48	42	33	25	18	14	10	6	6	6	4	4	4	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Clinically meaningful definitive deterioration is defined as a change of ≥10 points from baseline at either two or more consecutive time points, last PRO assessment, or death by the first survival follow-up visit.
[a]Nominal *P* value not adjusted for multiple testing.

January 11, 2022,
DCO

Ueno N et al. Presented at: European Society for Medical Oncology 2022; September 9-13, 2022; Paris, France. Presentation 217O Supplement.

Destiny 6

The NEW ENGLAND JOURNAL of MEDICINE

Trastuzumab Deruxtecan in Metastatic Breast Cancer

A PLAIN LANGUAGE SUMMARY

Based on the NEJM publication: Trastuzumab Deruxtecan after Endocrine Therapy in Metastatic Breast Cancer by A. Bardia et al. (published September 15, 2024)

In this trial, researchers evaluated whether trastuzumab deruxtecan prolonged progression-free survival among patients with hormone receptor–positive metastatic breast cancer with low expression of HER2 (human epidermal growth factor receptor 2) who had received endocrine therapy.

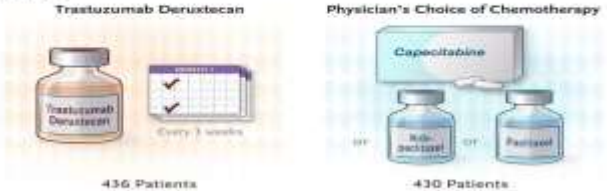
HER2-low breast cancer is defined as a score on immunohistochemical (IHC) analysis of 1+ or 2+ with negative results on in situ hybridization, while **HER2-ultralow** has been proposed to encompass IHC 0 with membrane staining.

WHAT WAS THE TRIAL DONE?

Outcomes in patients with hormone receptor–positive metastatic breast cancer who have received endocrine-based therapy worsen after progression. Trastuzumab deruxtecan has shown efficacy in patients with metastatic breast cancer with low HER2 expression who have received chemotherapy, but its efficacy earlier in treatment (after endocrine-based therapy) is not known.

HOW WAS THE TRIAL CONDUCTED?

Adults with hormone receptor–positive metastatic breast cancer with low or ultralow HER2 expression who had received one or more lines of endocrine-based therapy and no previous chemotherapy were randomly assigned to receive trastuzumab deruxtecan (5.4 mg per kilogram of body weight intravenously) once every 3 weeks or the physician's choice of single-agent chemotherapy (capecitabine, nab-paclitaxel, or paclitaxel) until disease progression or unacceptable toxic effects occurred. The primary end point was progression-free survival among the 713 patients with HER2-low disease.



436 Patients | 430 Patients

PATIENTS

WHO: 866 patients

Median age: approximately 58 years

White: 53%; Asian: 35%; Black: 1%

CLINICAL STATUS: Metastatic breast cancer

HER2-low or HER2-ultralow tumors

Disease progression after previous endocrine therapy

No previous chemotherapy for metastatic disease

TRIAL DESIGN

- PHASE 3
- OPEN-LABEL
- RANDOMIZED
- LOCATIONS: 164 SITES WORLDWIDE

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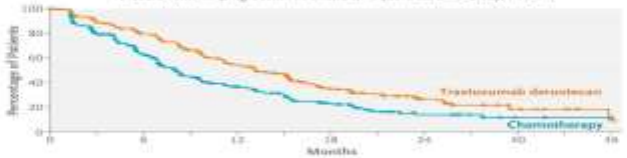
RESULTS

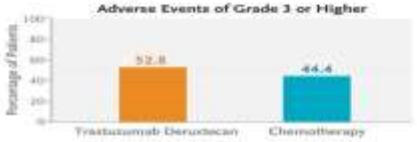
Among patients with HER2-low disease, progression-free survival was significantly longer in the trastuzumab deruxtecan group than in the chemotherapy group.

Progression-free Survival in the HER2-Low Population

Hazard ratio for progression or death, 0.62 (95% CI, 0.52–0.75); P<0.001



Adverse Events of Grade 3 or Higher



No new safety signals were observed; roughly half the patients in each group had adverse events of grade 3 or higher, with neutropenia, leukopenia, and anemia commonly reported.

INTERSTITIAL LUNG DISEASE

Among the patients who received trastuzumab deruxtecan, 11% had drug-related interstitial lung disease or pneumonitis, with a median time to onset of 141 days (range, 37 to 835).

LIMITATIONS AND REMAINING QUESTIONS

- Black patients were underrepresented in the trial.
- The trial was not powered to show significance in patients with HER2-ultralow tumors.
- Whether trastuzumab deruxtecan could replace first-line chemotherapy in hormone receptor–negative disease remains unclear, since these patients were not included in the trial.

CONCLUSIONS

Among patients with hormone receptor–positive, HER2-low metastatic breast cancer who had received one or more lines of endocrine-based therapy, treatment with trastuzumab deruxtecan extended progression-free survival, as compared with the physician's choice of chemotherapy.

LINKS: FULL ARTICLE | NEJM QUICK TAKE

FURTHER INFORMATION

Trial registration: ClinicalTrials.gov number, NCT04494425
Trial funding: AstraZeneca and Daiichi Sankyo
Full citation: Bardia A, Hu X, Dent R, et al. Trastuzumab deruxtecan after endocrine therapy in metastatic breast cancer. N Engl J Med 2024;391:2110-22. DOI: 10.1056/NEJMoa2407086

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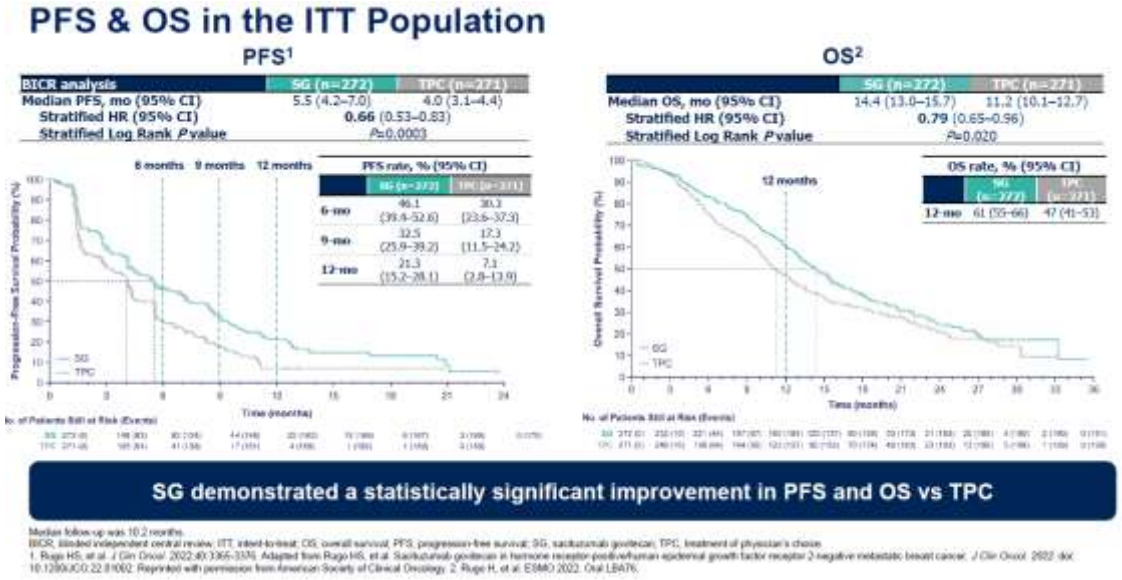
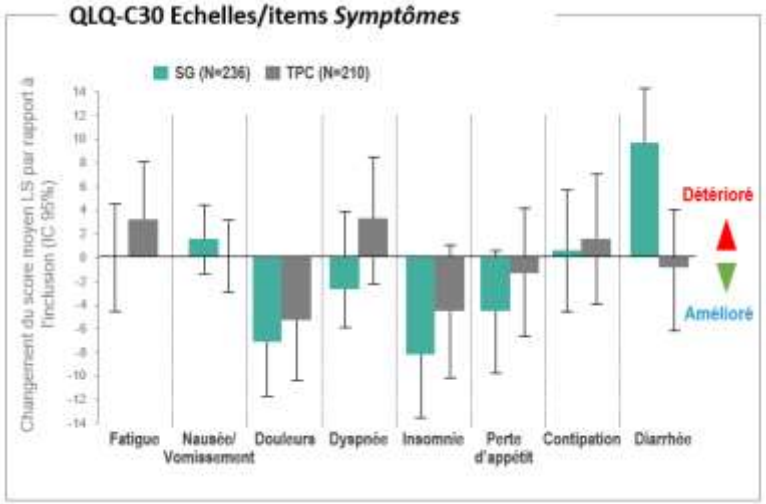
HER2-négatif HR+

TROPICS-02

Sacituzumab-govitecan



H S Rugo et al., SABCS 2022



Amélioration de l'ensemble des thématiques sous Sacituzumab Govitécan sauf pour la diarrhée en comparaison du traitement au choix du praticien

A. Bardia, et al., ESMO 2022, Abs. #1553O

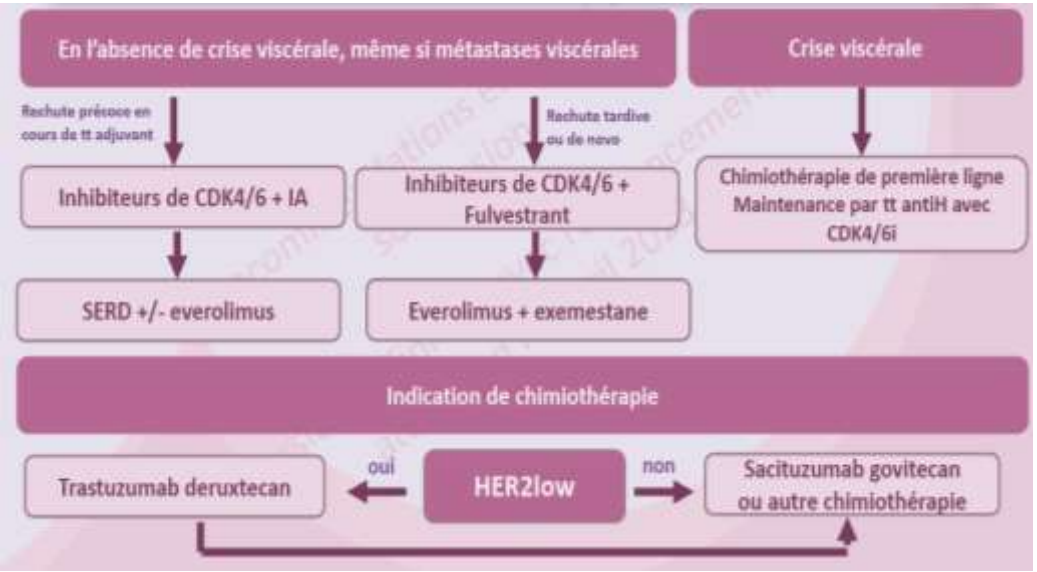
CIPEG Congrès Interdisciplinaire des Professionnels en GÉRIATRIE

Impact des nouveaux traitements sur les recommandations internationales et nationales

21ème COURS ST-PAUL 2023

NCCN Clinical Practice Guidelines In Oncology (NCCN Guidelines®)

The NCCN Guidelines® for breast cancer recommend fam-trastuzumab deruxtecan-nxki (T-DXd) as a Category 1 preferred regimen for HER2-low (IHC 1+ or 2+/ISH−) recurrent unresectable (local or regional) or metastatic breast cancer



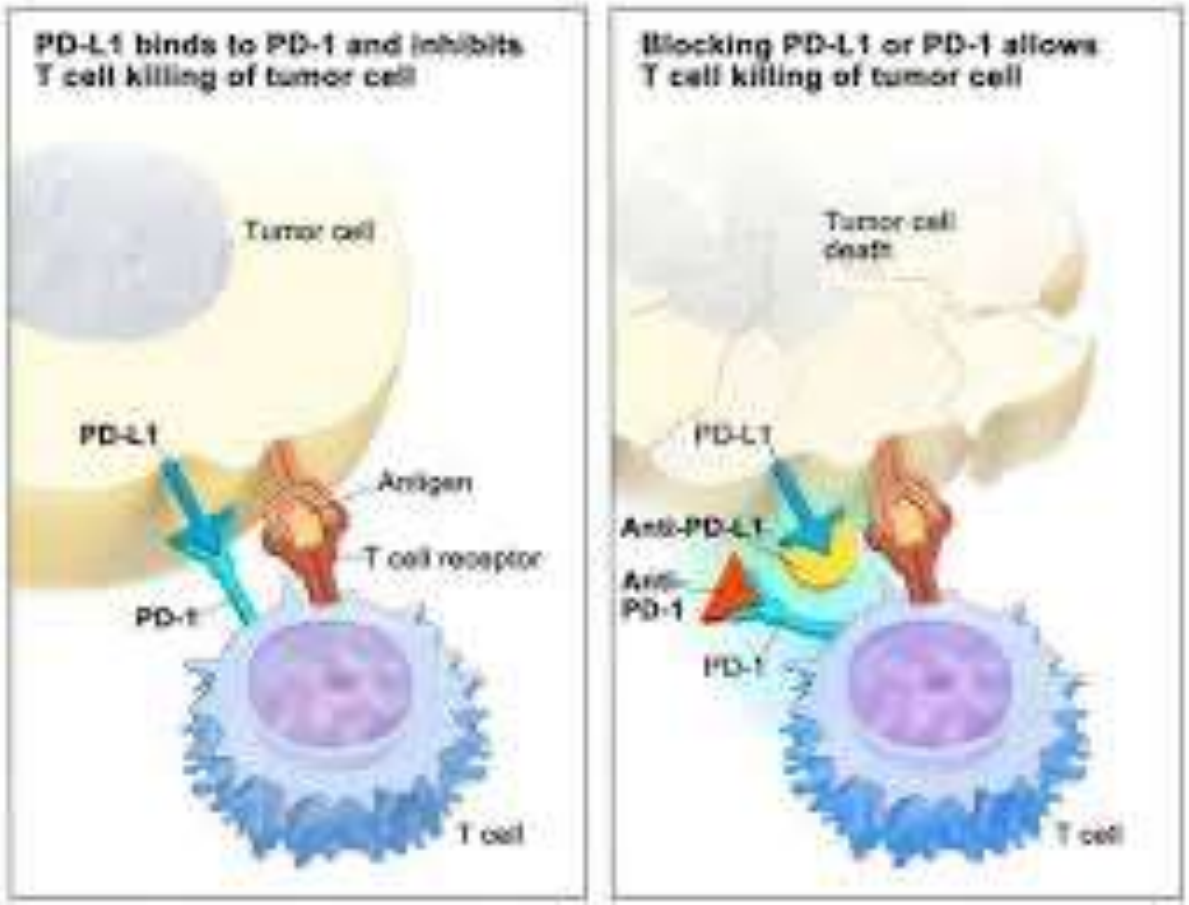
Saint Paul de Vence 2023 - Recommandations en cours de soumission
Version définitive avec référencement attendue d'ici avril 2023

ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

Recommandations ESMO en cours de mise à jour

Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Breast Cancer V.4.2022. ©National Comprehensive Cancer Network, Inc, 2022. All rights reserved. Accessed June 29, 2022. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use or application and disclaims any responsibility for their application or use in any way.
1. Modi S et al. *N Engl J Med*. 2022; 387:9-20. 2. Enhertu® (fam-trastuzumab deruxtecan-nxki) for injection, for intravenous use. Prescribing Information. Daiichi Sankyo; Basking Ridge, NJ, USA, 2022.

Maladie triple Négative



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The NEW ENGLAND JOURNAL of MEDICINE

RESEARCH SUMMARY

Pembrolizumab plus Chemotherapy in Advanced Triple-Negative Breast Cancer

Cortes J et al. DOI: 10.1056/NEJMoa2202809

CLINICAL PROBLEM

In an interim analysis in the KEYNOTE-355 trial, pembrolizumab plus chemotherapy resulted in longer progression-free survival than chemotherapy alone among patients with advanced triple-negative breast cancer whose tumors expressed a programmed death ligand 1 (PD-L1) combined positive score (CPS; the number of PD-L1–staining tumor cells, lymphocytes, and macrophages, divided by the total number of viable tumor cells, multiplied by 100) of 10 or more. Results from the final analysis of overall survival are needed.

CLINICAL TRIAL

Design: The international phase 3, double-blind, randomized, placebo-controlled KEYNOTE-355 trial examined the efficacy and safety of pembrolizumab plus chemotherapy among patients with previously untreated, locally recurrent inoperable or metastatic triple-negative breast cancer.

Intervention: 847 patients were assigned in a 2:1 ratio to receive pembrolizumab (200 mg every 3 weeks for up to 35 infusions) plus chemotherapy or placebo plus chemotherapy. Primary end points included overall survival among patients whose tumors expressed PD-L1 with a CPS of 10 or more (CPS-10 subgroup), among those whose tumors expressed PD-L1 with a CPS of 1 or more (CPS-1 subgroup), and in the intention-to-treat population.

RESULTS

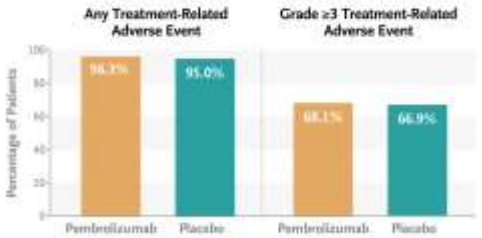
Efficacy: Overall survival was significantly longer with pembrolizumab–chemotherapy than with chemotherapy alone in the CPS-10 subgroup. In the CPS-1 subgroup, the between-group difference was not significant; significance was not assessed in the intention-to-treat population.

Safety: The incidence of any adverse event related to the trial regimen was similar in the two trial groups; anemia, neutropenia, and nausea were most common. The incidence of adverse events of grade 3, 4, or 5 was also similar in the two groups.

LIMITATIONS AND REMAINING QUESTIONS

- The benefit of pembrolizumab was observed with both paclitaxel-based and nanoparticle albumin-bound paclitaxel–based chemotherapy, but the small number of patients who received paclitaxel precludes firm conclusions.

Links: Full Article | NEJM Quick Take | Editorial



CONCLUSIONS

Among patients with previously untreated advanced triple-negative breast cancer and PD-L1 expression scores of 10 or more, pembrolizumab plus chemotherapy resulted in longer overall survival than chemotherapy alone, and no new safety signals emerged.

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« Pourquoi pas moi? »

Christiane 88 ans

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Adaptation des thérapeutiques concomitantes aux thérapies anti cancéreuses chez la patiente âgée ayant un cancer du sein

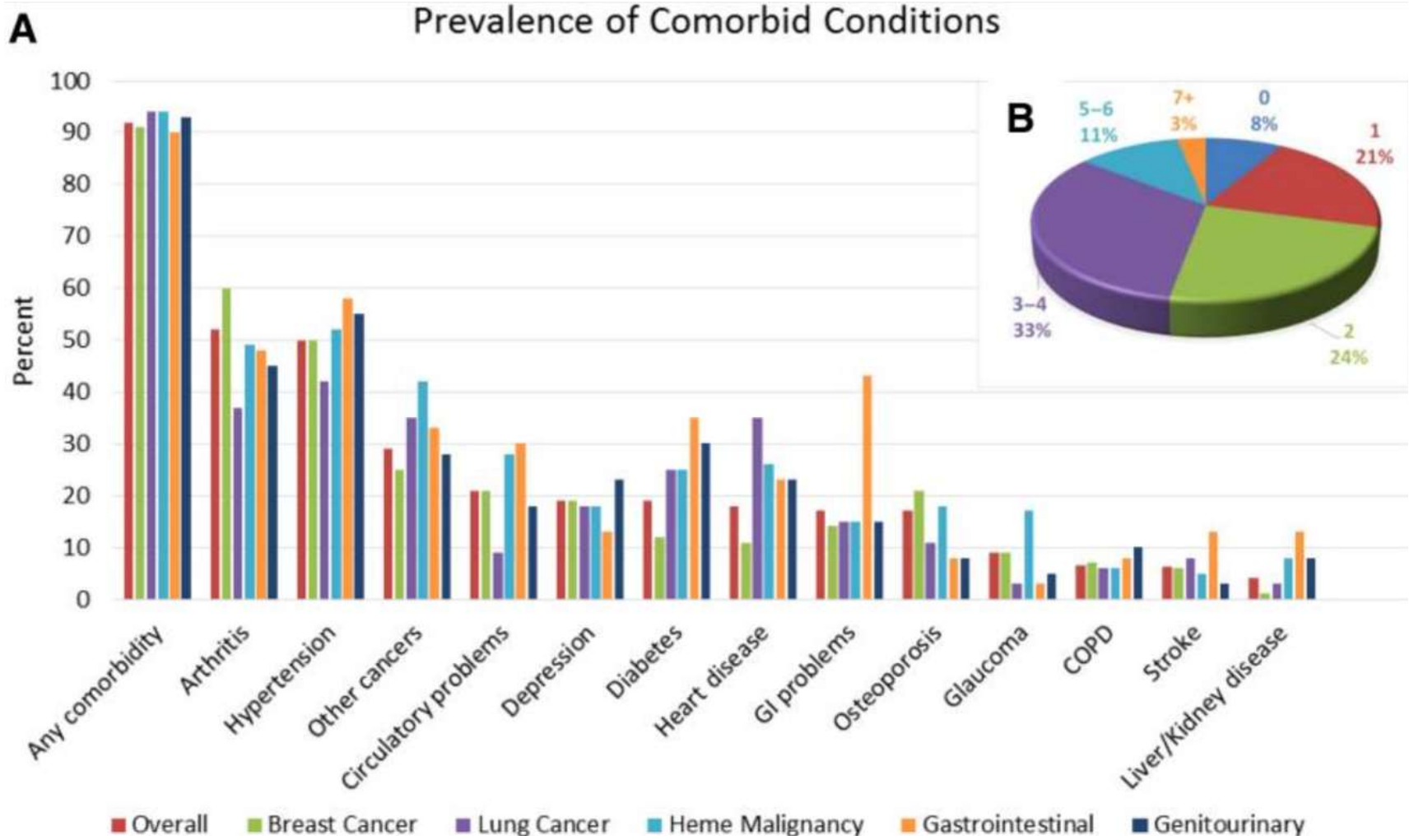
Pr Laure de Decker

Pole de gérontologie clinique

Université/CHU nantes

Lien d’intérêts

Aucun

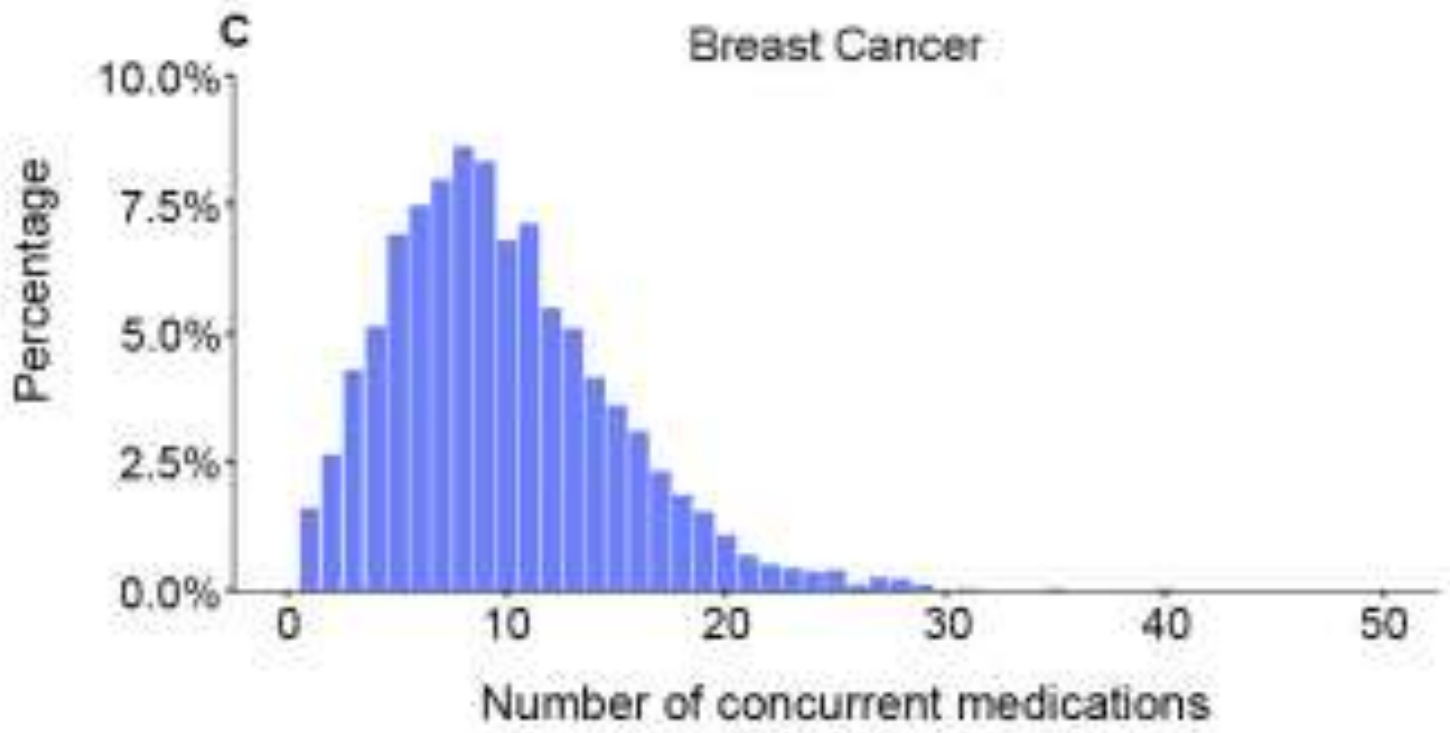


Williams GR, Deal AM, Lund JL et al. Oncologist. 2018 Apr;23(4):433-439.

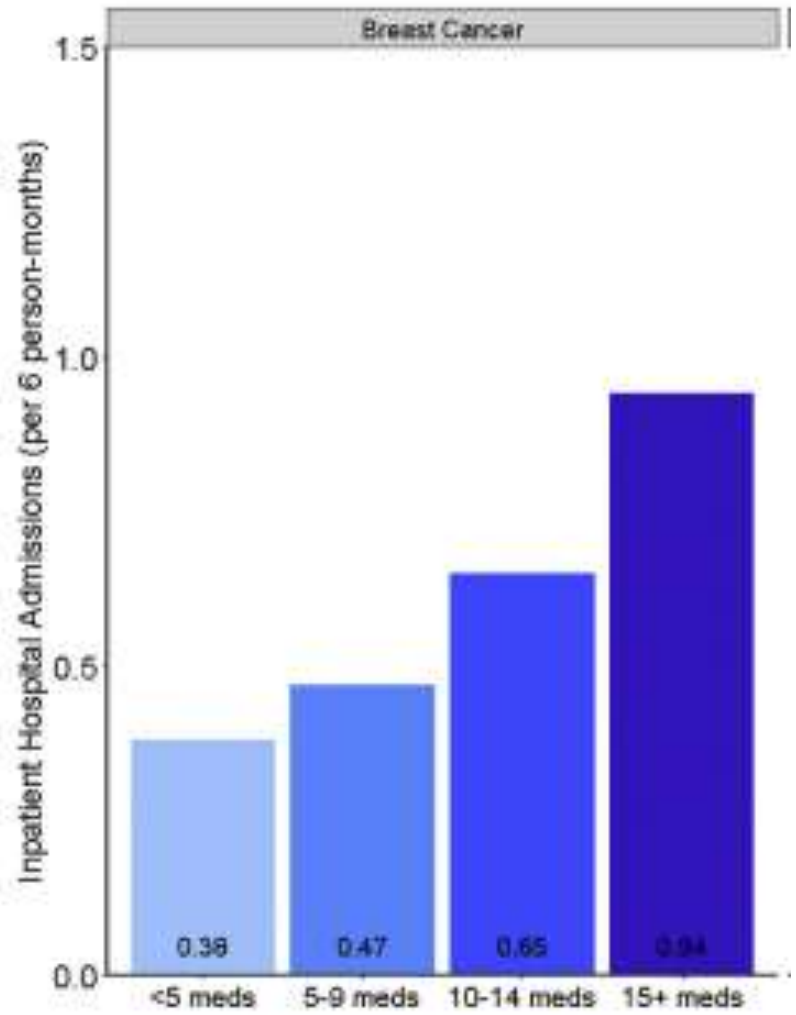
J Geriatr Oncol. 2020 May;11(4):579-585. doi: 10.1016/j.jgo.2020.03.001. Epub 2020 Mar 19.

Relationship between polypharmacy and inpatient hospitalization among older adults with cancer treated with intravenous chemotherapy

Grace Lu-Yao [1], Ginah Nightingale [2], Nikita Nikita [3], Scott Keith [4], Krupa Gandhi [4], Kristine Swartz [5], Ralph Zinner [6], Swapnil Sharma [3], W M Kevin Kelly [3], Andrew Chapman [5]



Distribution of number of prescription medications six-months pre-IV chemotherapy initiation.



Crude hospitalization rates post-IV chemotherapy initiation based on polypharmacy status

J Geriatr Oncol. 2020 May;11(4):579-585. doi: 10.1016/j.jgo.2020.03.001. Epub 2020 Mar 19.

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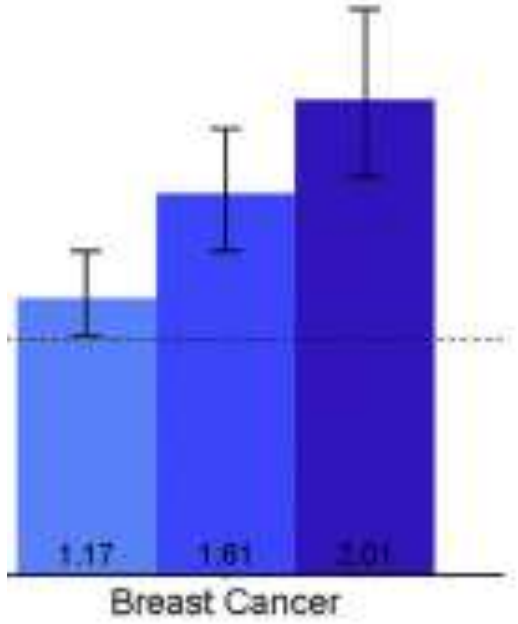
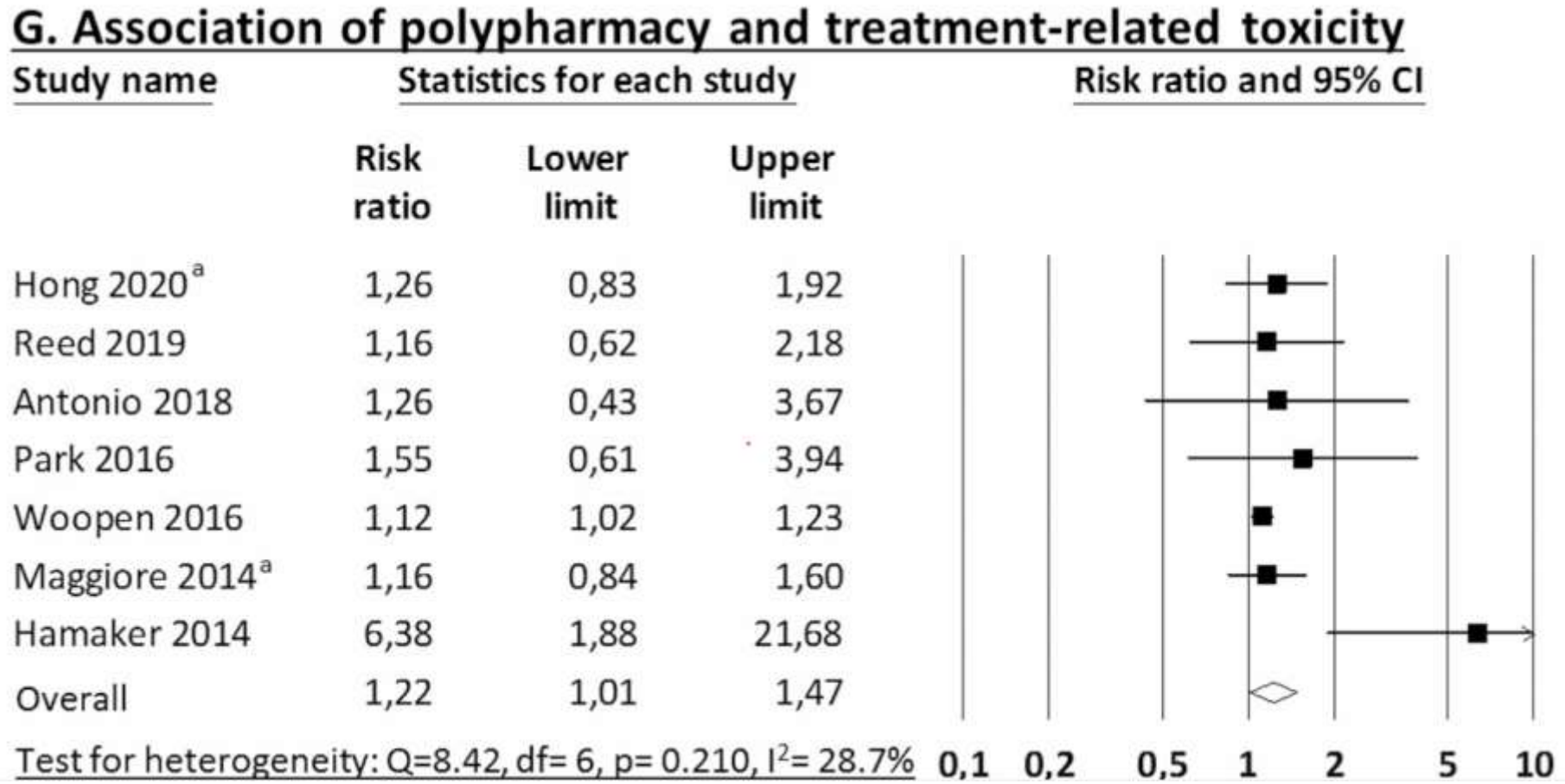


Incidence rate ratio of post-chemotherapy hospitalization by cancer site and polypharmacy status.

Toxicités médicamenteuses

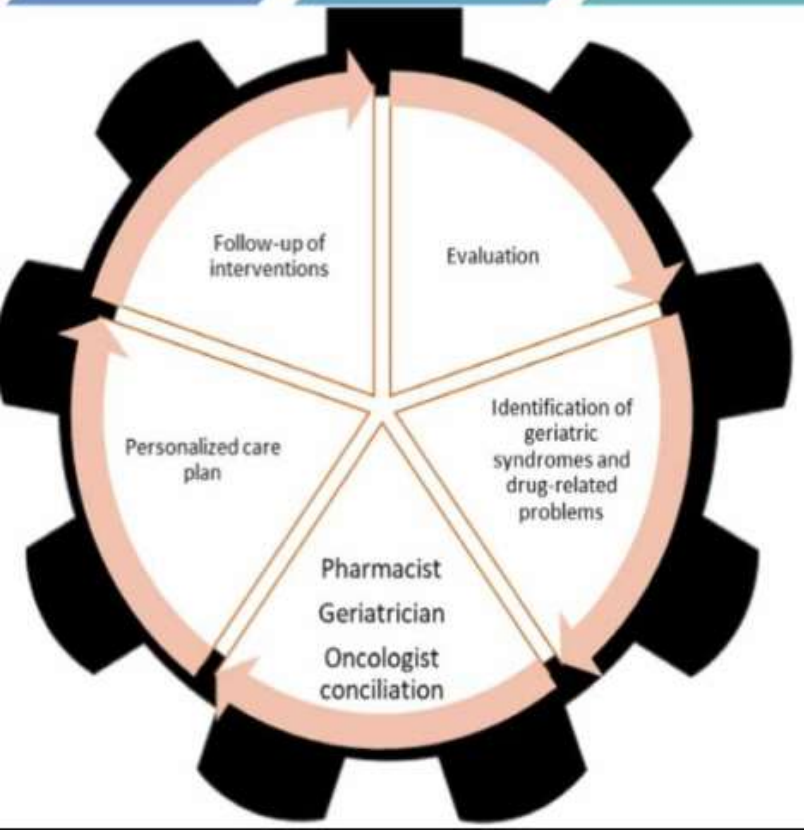


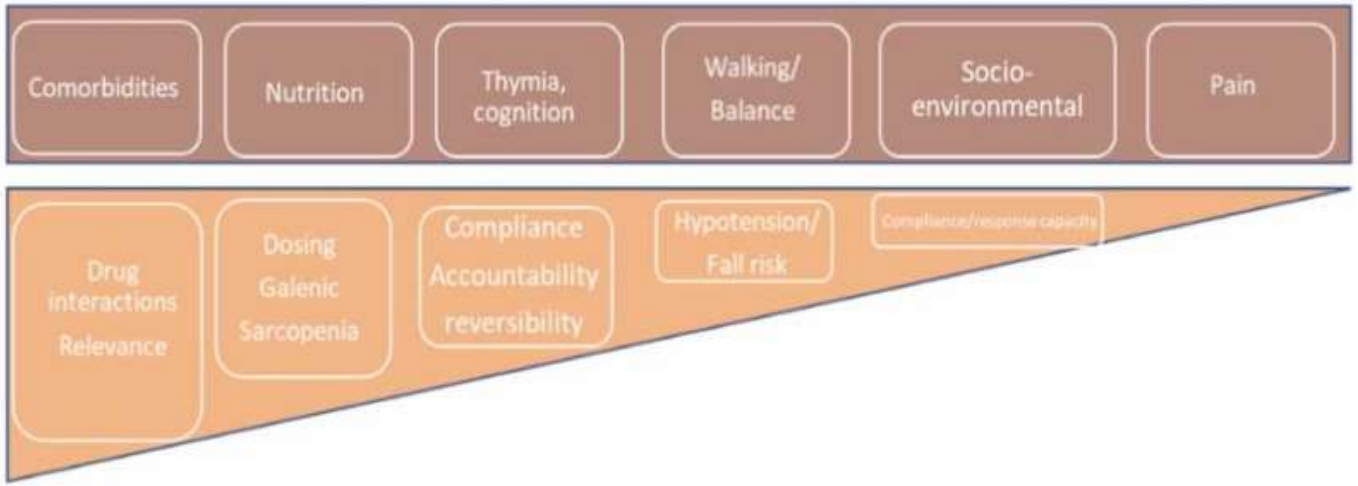
Li-Ju Chen, Kira Trares, Dana Clarissa Laetsch et al. The Journals of Gerontology: Series A, Volume 76, Issue 6, June 2021, Pages 1044–1052,

Critical Reviews in Oncology / Hematology

Enhancing collaboration between geriatricians, oncologists, and pharmacists to optimize medication therapy in older adults with cancer: A position paper from SOFOG-SFPO

Chloé Herledan, Anne Toulemonde, Anne-Laure Clairet, Mathieu Boulin, Claire Falandry, Laure De Decker, Catherine Rioufol, Arnaud Bayle, Nicolas Bertrand





Les mécanismes

Pharmacodynamiques :

− interactions synergiques : effet global supérieur (par ex. :5-fluoro-uracile et acide folique),

− interactions antagonistes : effet global inférieur (par ex. : corticoïdes et immunothérapie),

− interactions additives : l'effet global est la somme des effets de chaque médicament (par ex. augmentation de la néphrotoxicité du cisplatine par l'administration d'aminosides)

Pharmacocinétiques :

- interaction au niveau des mécanismes de métabolisation, d'élimination, de transport (cytochromes, glycoprotéine P)

− modification du profil pharmacocinétique d'un médicament par un autre,

− modification de l'exposition systémique,

− possible modification de l'effet thérapeutique/toxique.

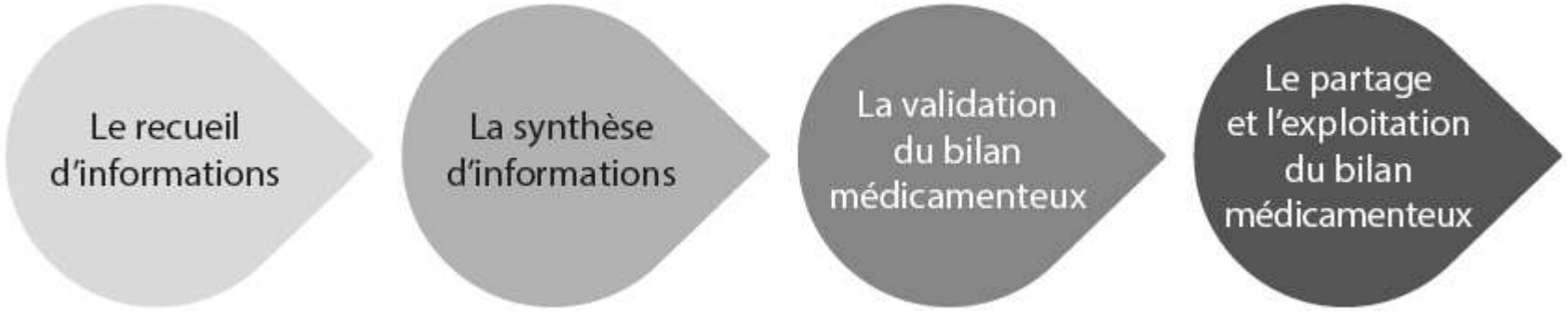
Donamaria C, de Decker L. Apport pharmaceutique dans la gestion et l'anticipation des toxicités : Une innovation. Vieillissement et cancer dirigé par de Decker L et Soubeyran P. John Libbey. 2023.

Les mécanismes en lien avec le vieillissement

- *sur l'absorption :*
  - vidange gastrique ralentie, pH gastrique plus élevé ;
- *sur la distribution :*
  - dénutrition (hypo-albuminémie) : modification de la fraction libre des traitements fortement liée aux protéines plasmatiques,
  - répartition masse grasse / masse maigre : augmentation de la demi-vie pour les traitements liposolubles,
  - perméabilisation de la barrière hémato-encéphalique ;
- *sur la métabolisation :*
  - fonction hépatique : impact sur la métabolisation/ transformation des traitements impliquant les cytochromes notamment ;
- *sur l'élimination :*
  - fonction rénale (masse, volume, perfusion) : traitement dont la posologie est à adapter selon la fonction rénale.

Donamaria C, de Decker L. Apport pharmaceutique dans la gestion et l'anticipation des toxicités : Une innovation. Vieillissement et cancer dirigé par de Decker L et Soubeyran P. John Libbey. 2023.

Conciliation médicamenteuse



Haute Autorité de santé. La conciliation des traitements médicamenteux en cancérologie. HAS, 2019 : https://www.has sante.fr/upload/docs/application/pdf/2017-01/dir1/guide_conciliation_des_traitements_medicamenteux_en_etablissement_de_sante.pdf.

Les 2 modes de Révision du Traitement

consultation spécifique

Analyse des Pathologies en Cours

- PATIENT : Pathologies? Environnement? Risques ?
  - histoire médicale et médicamenteuse
  - autonomie, environnement, espérance de vie
  - qualité de vie, préférences du malade
  - risque iatrogénique, risque de défaut d' observance
- BENEFICES/ RISQUES pathologie par pathologie?
- EN PRIORITE, quelles pathologies traiter?
  - existe t'il alors des alternatives non médicamenteuses?
  - quelles sont alors les posologies optimales ?

revue de l'ordonnance

Analyse des Médicaments en Cours

- INDICATION : chaque médicament est-il toujours bien indiqué? (pathologie présente, service médical rendu)
- CONTRE INDICATION : chaque médicament est-il non contre-indiqué? (comorbidités, interactions)
- POSOLOGIE: chaque médicament est-il à posologie optimale?
- GALENIQUE : chaque médicament présente t-il une galénique et un packaging adaptés ?
- AUTOMEDICATION?

Liste Hiérarchisée des Pathologies à Traiter ← *? Correspondance ?* → **Liste des Médicaments à Prescrire**

HAS
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Interactions médicamenteuses et thérapies fréquemment utilisées chez le sujet âgé

- **Les inhibiteurs de la pompe à protons** peuvent largement modifier l'absorption des traitements anticancéreux, notamment des thérapies ciblées orales.
- **Les statines** métabolisées par les cytochromes P450, principalement le 3A4, interagissent avec de nombreux traitements anticancéreux, augmentant le risque de rhabdomyolyse.
- **Les anticoagulants oraux directs**, fortement liés aux protéines plasmatiques, métabolisés par les cytochromes et éliminés par la voie de la P-gp sont à fort risque d'interaction avec :
  - dans le cancer du sein : des anticancéreux injectables (tels que cyclophosphamide,paclitaxel, docétaxel), mais aussi des hormonothérapies (anastrozole, tamoxifène) ou une thérapie ciblée, le lapatinib

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Préconisations gériatriques après évaluation gériatrique

Proportion of patients with (recommendations for) non-oncologic interventions after geriatric evaluation.

	Type of geriatric evaluation[a]	Any intervention	Nutritional interventions	Psychological interventions	Delirium prevention, cognitive exploration and/or treatment	Polypharmacy optimisation	Social Interventions	Interventions aimed at mobility and falls	Investigations for previously unidentified or not optimized comorbidity
Palicio [34]	C	43%	–	–	–	–	–	–	–
Schulkes [40]	C	43%	25%	7%	7%	1%	7%	15%	5%
Schiphorst [39]	C	56%	26%	14%	21%	17%	14%	15%	8%
Kalsi [27]	C	70%	37%	11%	9%	19%	15%	12%	≥49%
Chaibi [14]	C	76%	47%	19%	18%	37%	20%	–	–
Caillet [13]	C	83%	70%	36%	21%	31%	46%	42%	55%
Ommundsen [33]	C	83%	34%	–	11%	30%	–	23%	30%
Horgan [24]	C	93%	7%	23%	–	63%	–	13%	33%
Hurria [26]	A	–	52%	–	–	–	67%	20%	≥19%
Magnuson [29]	A	–	30%	19%	35%	38%	57%	68%	–
Kenis [28]	A	26%	15%	10%	5%	–	5%	6%	9%
Bastos-Oreiro [10]	A	67%	–	–	–	–	–	–	–
Mertens [31]	A	51%	–	–	–	–	–	–	–
Aparicio [9]	A	72%	19%	–	5%	71%	38%	–	19%
Frennet [19]	A	77%	34%	23%	–	25%	49%	21%	19%
Weltermann [42]	A	95%	18%	10%	14%	24%	6%	19%	3%
Andreozzi [8]	M	–	–	–	–	–	39%	33%	14%
Chapman [15]	M	–	–	–	–	75%	50%	–	–
Extermann [17]	M	100%	91%	45%	18%	64%	55%	–	64%

– not reported.

[a] Geriatric consultation (C) refers to the assessment as used in standard geriatric care, performed by a geriatrician; an assessment (A) refers to an assessment performed by the cancer specialist/nurse; multidisciplinary evaluation (M) refers to a geriatric evaluation performed by two or more (para)medical health care professionals.

Hamaker M, Lund C, Te. J Geriatr Oncol 2018

Troubles digestifs : les nausées et vomissements

Hautement émétisant (> 90 %)	Modérément émétisant (30-90 %)
• Anthracycline + cyclophosphamide** • Amsacrine (≤ 300 mg/m²) • Carmustine (> 250 mg/m²) • Cisplatine* • Cyclophosphamide (> 1,5 g/m²)* • Dacarbazine (DTIC) • Dactinomycine • Ifosfamide (≥ 10 g/m²) • Melphalan • Méthotrexate (≥ 1 g/m²) • Streptozocine	• Amifostine (> 300 mg/m²) • Arsenic trioxide • Azacytidine • Bendamustine • Busulfan • Carboplatine* • Carmustine (≤ 250 mg/m²) • Clofarabine • Cyclophosphamide (≤ 1,5 g/m²)* • Cytarabine (> 200 mg/m²) • Daunorubicine • Doxorubicine* • Épirubicine* • Éribuline • Idarubicine • Ifosfamide (< 10 g/m²) • Interféron alpha (≥ 10 MU/m²) • Irinotécan • Méthotrexate (≥ 250 mg/m2 et < 1 g/m²) • Oxaliplatine

Albrand G, Cudennec T, de Decker L. Les troubles digestifs : des effets indésirables fréquents pouvant être très délétères chez le sujet agé. Vieillissement et cancer dirigé par de Decker L et Soubeyran P. John Libbey. 2023.

Troubles digestifs : Diarrhée

La diarrhée est un effet indésirable fréquent des chimiothérapies et des thérapies ciblées, en particulier avec les protocoles contenant des fluoropyrimidines (5-fluoro-uracile, capécitabine), de l'irinotécan, du docétaxel ou paclitaxel, des anti-ALK (crizotinib, lorlatinib, etc.), des anticorps monoclonaux (rituximab, etc.).

Albrand G, Cudennec T, de Decker L. Les troubles digestifs : des effets indésirables fréquents pouvant être très délétères chez le sujet agé. Vieillissement et cancer dirigé par de Decker L et Soubeyran P. John Libbey. 2023.

Conséquences

Catégorie	Complication
Physique et physiologique	• Anorexie ou malnutrition pouvant entraîner une diminution du poids • Faiblesse/léthargie pouvant entraîner une limitation des activités (sociales, physiques) • Déshydratation pouvant conduire à un déséquilibre électrolytique • Perte de moral et dépression • Diminution de la qualité de vie (perception négative de son traitement) • Nausées/vomissements par anticipation • Mauvaise adhésion aux schémas thérapeutiques et limitation de leurs effets bénéfiques • Retard concernant les cycles futurs de chimiothérapie, qui peuvent aller jusqu'au refus
Autres (plus rares, mais plus graves)	• Pneumonie d'aspiration • Cachexie secondaire à l'anorexie • Perforation de l'œsophage • Déchirures œsophagiennes (syndrome de Mallory-Weiss) • Fractures pathologiques

Albrand G, Cudennec T, de Decker L. Les troubles digestifs : des effets indésirables fréquents pouvant être très délétères chez le sujet agé. Vieillissement et cancer dirigé par de Decker L et Soubeyran P. John Libbey. 2023.

Et encore


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Enhancing collaboration between geriatricians, oncologists, and pharmacists to optimize medication therapy in older adults with cancer: A position paper from SOFOG-SFPO

Chloé Herledan [a,b,*,1], Anne Toulemonde [a,c,2], Anne-Laure Clairet [a,d,3], Mathieu Boulin [a,e,4], Claire Falandry [f,g,5], Laure De Decker [f,h,6], Catherine Rioufol [a,b,7], Arnaud Bayle [f,i,8], Nicolas Bertrand [f,i,9]

- Diabète et comorbidités cardiovasculaires
  - Le cancer et/ou ses traitements peuvent être associés à une anorexie, une dénutrition : Hypoglycémie.
  - La composition corporelle et la pharmacocinétique/pharmacodynamique modifient l'exposition aux médicaments.
  - Les thérapies anticancéreuses peuvent augmenter le risque d'hypoglycémie sévère, d'arythmie/modifications de la fréquence cardiaque, d'hémorragies…
  - Observance des traitements des comorbidités
- Risque de chutes
  - Sarcopénie/ Polymédications
- Dépression et anxiété
  - Interaction avec les psychotropes des thérapies cancéreuses

Conclusion

La conciliation médicamenteuse
Gestion des interactions et de l'observance
grâce à des soins centrés sur le patient