Qualitative Analysis of Interviews with Patients on Facilitators and Barriers to Reducing Chemotherapy for Early Stage Breast Cancer

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Research

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Abstract

Background As the combination of systemic and targeted chemotherapies is associated with severe adverse side effects and long-term health complications, there is interest in reducing treatment intensity for patients with early stage breast cancer (EBC). Clinical trials are needed to determine if it is feasible to reduce treatment intensity while maintaining 3-year recurrence-free survival of greater than 92%. In order to recruit patients for de-implementation trials, it is important to understand patient perspectives on barriers and facilitators to reducing treatment intensity.

Methods We collected qualitative interview data from patients with Stage II-III breast cancer (N=24) and patient advocates (N=16). Interviews explored interest in de-implementation trial participation and identified potential barriers and facilitators to participation. 17 participants were asked about the potential impact of COVID-19 on de-implementation efforts. Interviews were audio-recorded and transcribed, and researchers used qualitative content analysis (NVIVO and Atlas.ti) to code for dominant themes.

Results 17 participants (42.5%) expressed interest in participating in a trial of reduced chemotherapy. Barriers to reducing chemotherapy included (1) fear of recurrence and inefficacy, (2) preference for aggressive treatment, (3) disinterest in clinical trials, (4) lack of information about expected outcomes, (5) fear of regret, and (6) having young children. Facilitators included (1) avoiding physical toxicity, (2) understanding the scientific rationale of reducing chemotherapy, (3) confidence in providers, (4) consistent monitoring and the option to increase dosage, (5) fewer financial and logistical challenges, and (6) contributing to scientific knowledge. Of those asked, nearly all participants said they would be more motivated to reduce treatment intensity in the context of Covid-19, primarily in order to avoid exposure to the virus while receiving treatment.

Conclusions We recommend framing de-implementation strategies and recruitment to trials in terms of customizing treatment to the individual patient and added benefit—reduced toxicities, higher quality of life during treatment and lower risk of long-term complications—rather than in terms of taking treatments away or doing less than the standard of care. Doctor-patient rapport and provider support will be crucial in this process.

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