Return to Work After Breast Cancer Treatment: An Electronic Health Record-based Study in North Norway

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Key Words: Adjuvant treatment, breast cancer, Edmonton symptom assessment system, patient-reported symptoms, work ability.

Abstract. Background/Aim: Breast cancer treatment may interfere with work ability. Previous return-to-work studies have often focused on participants who were invited to participate after treatment completion. Participation varied, resulting in potential selection bias. This is a health-record-based study evaluating data completeness, both at baseline and one year after diagnosis. Correlations between baseline variables and return to work were also analyzed. Materials and Methods: This is a retrospective review of 150 relapse-free survivors treated in Nordland county between 2019 and 2022 (all-comers managed with different types of systemic treatment and surgery). Work status was assessed in the regional electronic patient record (EPR). A 65-years age cut-off was employed to define two subgroups. Results: At diagnosis, occupational status was assessable in all 150 patients. Almost all patients older than 65 years of age were retired (79%) or on disability pension for previously diagnosed conditions (19%). Data completeness one year after diagnosis was imperfect, because the EPR did not contain required information in 19 survivors. The majority of those ≤65 years of age at diagnosis returned to work. Only 14 of 88 patients (16%) did not return to work. Postoperative nodal stage was the only significant predictive factor. Those with pN1-3 had a lower return rate (68%) than their counterparts with lower nodal stage. Conclusion: Despite incomplete longitudinal information in a proportion of survivors, data availability was better than participation rates in several previous studies with invited participants. In our geographical region, relatively few survivors had not returned to work after one year.

Multidisciplinary breast cancer treatment is known to influence many survivors' work ability, related to any kind of paid work or self-employment (1-7). Especially in advanced, yet locoregionally confined, stages, neoadjuvant and adjuvant components of treatment extend over a long period of time. Long-term toxicities such as fatigue, peripheral neuropathy, lymphedema and impaired cardiac function may contribute to permanently reduced work ability with all its economic consequences for survivors and families, and also impact on social systems. At the time of diagnosis, some elderly patients report continuing to work beyond the regular retirement age. This may be due to financial reasons, social relations, or a desire to maintain their sense of identity. Therefore, studies employing an age cut-off such as 65 years for inclusion do not necessarily cover the full picture of work ability or return to work after treatment for breast cancer. The decision to return to work is also dependent on employers' willingness to contribute to the often complex and time-consuming process, *e.g.*, by adjusting work load and working hours (8).

Many previous studies have focused on the initial years after breast cancer diagnosis. Examples include a study from Brazil (women aged 18 to 57 with a diagnosis of locoregional invasive or in situ carcinoma), which required participants to be ≤5 months post-diagnosis (9). Of 723 eligible women invited to participate, only 125 eventually agreed. They were interviewed by telephone at 6, 12, and 24 months after their cancer diagnosis. Overall, 30% and 60% reported return to work at 12 and 24 months, respectively. The likelihood of returning to work was significantly higher in cases of higher household income and breast-conserving surgery, as well as when work adjustments were made. Conversely, factors such as adjuvant endocrine therapy and depression diagnosed after breast cancer had a negative impact on return to work.

Studies with longer follow-up also reported lack of willingness to participate in a proportion of survivors. Norwegian researchers identified women with stage I-III breast cancer diagnosed in 2011 or 2012 at a maximum age of 65 years (10). A survey was performed 8 years later, accounting for age and the legal retirement age of 67 years, resulting in 1,951 invited participants, of whom 1,007 responded after one reminder. These examples from Brazil and Norway illustrate that a large number of survivors may choose to refuse involvement in work-related studies. In-depth analyses comparing participants to non-participants are largely lacking. Lots of assumptions are possible, including but not limited to the hypothesis that those who returned to work may be more interested on reporting on it, but cultural and other differences between countries may also play a role.

Given that common methodological study aspects such as age cut-off and voluntary survey participation may result in selection bias, we were interested in a pilot study examining the usefulness of hospitals' standard electronic patient records (EPR) as the source of work/employment/pension status and short-term breast-cancer-related changes over time in patients of all ages. Endpoints of interest were data completeness, both at baseline and after one year, and correlations between baseline variables, including patient-reported symptoms, and return to work.

Materials and Methods

Certain aspects of this study resemble a large cancer registry analysis, because all patients from a well-defined geographical region (Nordland county, a large part of rural North-Norway) were included. The region is served by only one oncology care provider, the public Nordland Hospital Trust, whose EPR (DIPS; DIPS, 8006 Bodø, Norway) is shared with that of all the smaller local hospitals, resulting in access to all documents at all sites (11, 12). Based on the

EPR, the Department of Oncology administers a separate quality-of-care database, which has been employed for previous breast cancer research (13). The hospital also reports to the national cancer registry. The current analysis was restricted to 150 consecutive female patients who underwent adjuvant radiotherapy for invasive breast cancer, regardless of age, type of surgery and systemic therapy, and were relapse-free during early follow-up (time interval of interest: 18 months). Four patients with early relapse were excluded, assuming that starting a new line of treatment would result in a new sick leave. The number of patients was based on an arbitrary decision, hypothesizing that 150 relapse-free survivors would be sufficient to judge data completeness and detect signals, before one decides to allocate resources for a large study. Radiotherapy was employed as a selection criterion because patient-reported symptoms were consistently recorded at the time of treatment planning, and we were particularly interested in exploring potential correlations between certain symptoms such as depression, pain, and fatigue, and work status. The patients answered the Edmonton symptom assessment system (ESAS) questionnaire, originally developed in the palliative care setting (14), but also employed in curatively treated patients with breast cancer (15-18). ESAS is a short, one-sheet questionnaire addressing major symptoms and wellbeing using a numeric scale of 0-10.

The time period of radiotherapy was January 2019-September 2022. First diagnosis was typically made 2-6 months before radiotherapy, depending on the sequence of neoadjuvant and adjuvant systemic therapy. Given that all patients had a regular follow-up examination one year after surgery, together with stage-dependent follow-up in 6-months intervals, we expected work status after approximately 12-15 months from diagnosis to be consistently recorded in the EPR, where also baseline status could be found. Age-based stratification was performed (older than 65 years *versus* 65 or younger). Statistical analysis was performed using IBM SPSS Statistics 29 (IBM Corp., Armonk, NY, USA). In addition to relevant ESAS items of interest [continuous

variables expressed as mean with standard deviations (SD)], we analyzed a large number of categorical baseline variables (dichotomized present/absent or categorized by quartiles or treatment groups). ANOVA tables or chi-square tests were employed for inter-group comparisons. A *p*-value ≤0.05 was considered statistically significant.

Results

At breast cancer diagnosis, the mean age was 57 years (SD 13), range=24-88. Forty-three patients (29%) were older than 65 years. The mean body mass index (BMI) was 27.6 (SD 5), range=16.6-42.2. Table I shows additional baseline information. The ESAS data are displayed in Table II. Symptom burden was most pronounced for fatigue, sleep problems and impaired overall well-being. To reduce the likelihood of spurious findings from multiple testing, several items (appetite, nausea, constipation, dyspnea, dry mouth) were not included in further analysis.

At breast cancer diagnosis, occupational status was assessable in the EPR in all 150 patients. Almost all patients older than 65 years were retired (79%) or on disability pension for previously diagnosed conditions (19%) (Figure 1). The single patient who was employed continued working after cancer therapy. The picture was much more heterogeneous in younger patients (n=107). Three of these (3%) were excluded from further analysis because they had not yet finished university qualification (n=2) or committed suicide shortly after cancer therapy. Early retirement before breast cancer (3%) or disability pension for other reasons (12%) was relatively uncommon. The remaining 88 patients ≤65 years of age formed the population of interest for longitudinal assessment. Data completeness was imperfect, because the EPR did not contain information about return to work in 19 patients (Figure 2). The majority returned to work (full-time in 19, part-time as before in 5, reduced in 22, undocumented amount in 9). Only

14 of 88 patients (16%) did not return to work (20% if looking at patients with available information only).

Baseline and treatment-related parameters (Table I) were tested for correlation with dichotomized work status after treatment (returned *versus* not returned to work). The vast majority of parameters were not statistically significantly associated. Age, menopausal status, BMI, ESAS scores, primary tumor size, hormone receptor status, and Her2 positivity did not predict continued absence from work. The same was true for the type of surgery (breast conservation *versus* mastectomy, sentinel node biopsy versus axillary dissection), neoadjuvant systemic treatment (yes/no), and adjuvant systemic treatment (chemotherapy-containing *versus* endocrine alone). Return to work was more common in patients with pN0/mi status (92%) compared to pN1-3 (68%), p=0.01. Postoperative nodal status was the only predictive factor in this study.

Discussion

This study was performed in Nordland county, a rural region in Norway with an extraordinarily low unemployment rate of <3%. This situation creates a challenging market for employers, who often recruit workers from other regions or countries. Travel distances are large in this part of Norway, and all oncologists are located in the main hospital, Nordland hospital in Bodø. All hospitals in the region are connected through a shared EPR. These peculiarities allow for population-based studies, resembling those employing cancer registry databases, although with smaller population sizes (11-13). We utilized our breast cancer database for this pilot study with a limited number of 150 relapse-free survivors and addressed questions regarding data completeness and added value of EPR-based studies, which are less common than invitation-based surveys.

Recently, Norwegian researchers performed a traditional large-scale study, which showed that 63% of survivors maintained their work status eight years after diagnosis (10, 19). They included women with stage I-III breast cancer diagnosed in 2011 or 2012 at a maximum age of 65 years. A survey was performed eight years later, with 1,951 invited participants. However, only 1,007 responded after one reminder. The relatively modest participation rate raises questions about generalisability of the results. In other words, does a systematic difference lead certain survivors to participate, thus creating potentially biased results? In a previous Norwegian study, which included a cancer-free control group, breast cancer survivors were significantly more likely to receive disability pension [hazard ratio (HR)=2.7, 95%CI=2.3-3.2] (20). Adjusted HR in women with stage I breast cancer was 1.8 (95%CI=1.5-2.3) and 3.0 (95%CI=2.4-3.8) in stage II/III compared to controls. The risk increased with mastectomy compared to breast-conserving surgery (HR=1.5, 95%CI=1.2-1.9). Employment rates were higher in non-disabled breast cancer survivors than in non-disabled controls (82% *vs*. 77%, p=0.008).

In the more recent large-scale Norwegian study (10), 89% of participants were employed at the time of diagnosis (83% in the present ≤65 years of age population), but only 59% continued to be at the time of this survey. Disability pension rate increased from 6 to 31%. Our study had a shorter follow-up (1 instead of 8 years), but comparable employment rate at 1 year after diagnosis (62.5% of survivors with available data, not counting students as employed). However, many survivors had a reduced number of working hours or an undocumented amount. Our EPR study largely resembled the results of the larger survey (employed at diagnosis: 83 *versus* 89%, later on 62.5 *versus* 59%). Therefore, either approach may be suitable in future studies. Surveys are limited by suboptimal participation rates [1,007 of 1,951 (52%) in Norway (10)], while EPRs are incomplete in some cases [19 of 88 (22%) in our study]. Both approaches

are relatively time-consuming. Exclusion of patients older than 65 years appears warranted, because the present results showed that 98% were no longer working at breast cancer diagnosis.

In a prospective, multicenter cohort study conducted in Germany, 577 breast cancer patients were surveyed three times: shortly after surgery, at 10 weeks post-surgery, and at 40 weeks post-surgery (21). Two-hundred-and-three (35%) patients did not return to work within 40 weeks of surgery, whereas 374 (65%) patients did return to work. The association of return to work at 40 weeks following discharge with sociodemographic and disease-related characteristics was examined. Significant factors included age group 55-59 years compared to 18-44 years, having children, rehabilitation attendance, self-rated health "good" and "excellent" compared to "bad", and stage II plus stage III/IV in comparison to stage 0/I.

In Denmark (n=14,750; population-based), 81% of patients remained part of the work force two years after treatment, with 10% of them being unemployed (22). Increasing duration of unemployment before breast cancer was associated with an adjusted HR of 4.4 (95%CI=3.9-4.9) for unemployment after breast cancer. Other risk factors for unemployment included low socioeconomic status and demography, while adjuvant therapy did not increase the risk of unemployment. In a study conducted in the USA, 3,133 individuals were sent surveys. Of these, 2,290 (73%) completed a baseline survey soon after diagnosis. Among these participants, 1,536 (67%) completed a follow-up questionnaire four years later (23). Of the 1,026 patients aged <65 years at the time of diagnosis whose breast cancer did not recur and who responded to both surveys, 76% were employed before diagnosis. Of these, 30% were no longer working at the time of the follow-up survey. Women who received systemic chemotherapy as part of their multi-modal treatment were less likely to be working at the time of the follow-up survey (38 *versus* 27%, p=0.003). During the survivorship period, many women who were not employed

expressed a desire to work: 50% reported that it was important for them to work and 31% were actively seeking work.

We also analyzed predictive factors for returning to work and were able to include patient-reported symptoms (ESAS scores, albeit at only one timepoint, *i.e.*, before the start of adjuvant radiotherapy). Comparable data were not available in previous studies. Postoperative nodal status was the only predictive factor in our study. In contrast, none of the cancer-related variables, including treatment, were associated with work ability eight years after diagnosis in the previous Norwegian study (10). Results from Brazil were not consistent (9). These researchers identified breast-conserving surgery as favourable, and adjuvant endocrine therapy as negative. In a French study (n=273), the significant factors affecting return to work were: age, educational level, colleagues' support, chemotherapy, lymphedema, and the physical and psychological constraints of the job (24). Divergence increased even more in the already discussed studies from Germany, Denmark, and the USA (21-23). Obviously, different countries with different socioeconomic conditions are difficult to compare. It is also important to emphasize that not all studies examined all the different potential predictive factors. Typically, a limited number of explanatory variables were assessed.

Limitations

Our study cohort was comprised of patients covered by the national publicly-funded health care system. Almost all patients had indications for adjuvant systemic therapy. Since the study size and consequently statistical power was limited, we may have overlooked additional correlations that a larger study would have revealed. EPRs can be configurated in diverse manners, which may impact data completeness in the future.

Longitudinal data from long-term survivors may provide additional insights into the complex challenges of returning to work. Interventions focusing on comprehensive, individualized supportive measures such as physical exercise, physiotherapy, psycho-oncology referral, rehabilitation, and others may result in better role-functioning and less interference of breast cancer treatment with survivors' daily life and work ability (25).

Conflicts of Interest

The Authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Figure 1. Age-stratified overview of work status after breast cancer treatment (n=43, 107).

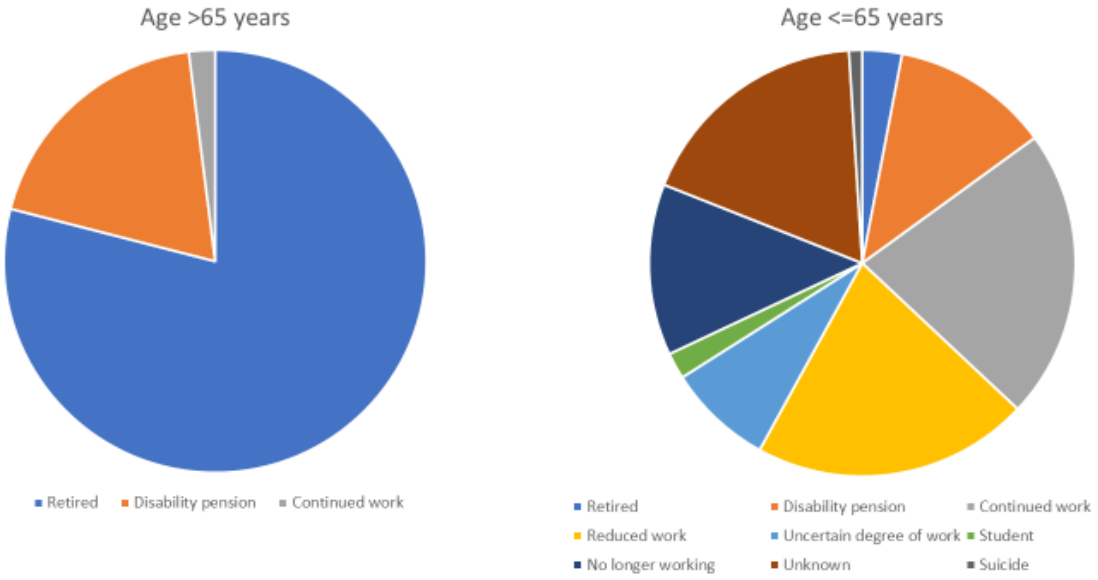

Figure 2. Work status in 107 patients ≤65 years including: 1) Already retired or on disability pension before breast cancer diagnosis (n=16); 2) Continued studies after treatment (n=2);
3) Working (n=88 + 1 patient who committed suicide).

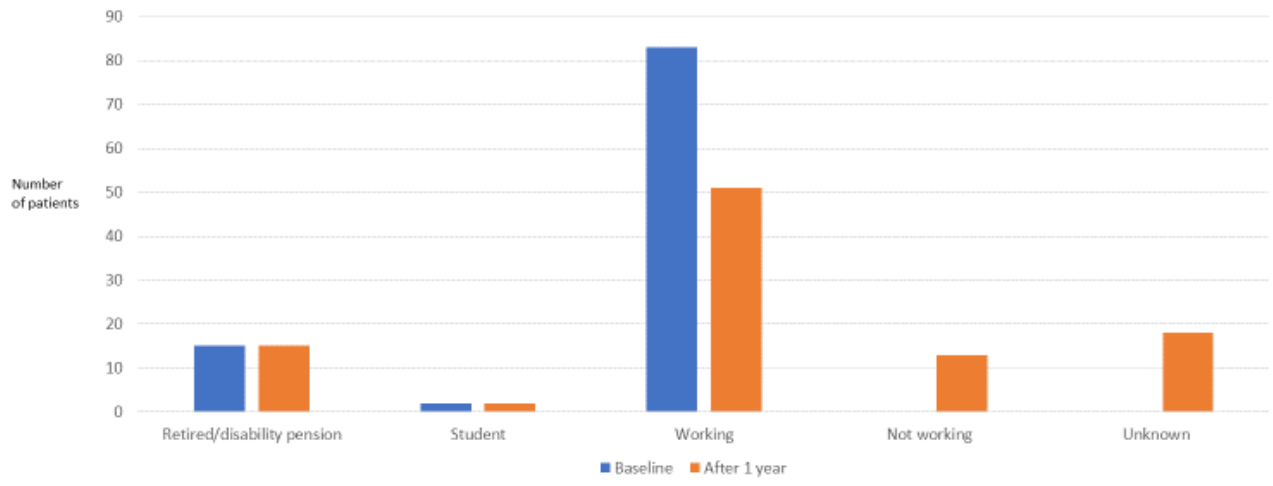

Table I. Baseline characteristics before adjuvant radiotherapy in 150 female patients.

Variable	**No**	**%**
Screening detected	31	21
Pathological stage		
pT0	21	14
pT1	69	46
pT2	51	34
pT3	5	3
pT4	4	3
pN0	41	27
pN1	72	48
pN2	22	15
pN3	3	2
Microscopic nodal disease only	12	8
Histology		
Ductal carcinoma	112	75
Lobular carcinoma	19	13
Both	10	7
Others	9	6
Histological grade		
G1	21	14
G2	64	43
G3	36	24
Uncertain after NATx[1]	29	19

Receptor status		
Estrogen negative	39	26
Progesterone negative	66	44
Triple negative	22	15
Her2 positive	33	22
Others		
BRCA mutation	5	3
Premenopausal	38	25
Perimenopausal	18	12
Postmenopausal	94	63
Treatment		
Neoadjuvant systemic therapy	79	53
Mastectomy	80	53
Breast conservation	70	47
Axillary dissection	74	49
Sentinel node biopsy	76	51
Hypofractionated radiotherapy	50	33
Tumor bed boost	26	17
Adjuvant systemic therapy	145	97

[1]NATx: neoadjuvant systemic therapy

Table II. ESAS before adjuvant radiotherapy.

Item	**Mean**	**Standard deviation**	**Range**
Pain (not moving)	1.7	2.2	0-8
Pain (while moving)	2.2	2.3	0-9
Fatigue	3.1	2.4	0-9
Nausea	0.5	1.1	0-7
Dyspnea	1.2	1.8	0-8
Dry mouth	2.3	2.4	0-8
Appetite	1.1	2.0	0-7
Constipation	0.8	1.6	0-7
Anxiety/restlessness	1.6	2.2	0-8
Sleep	2.8	2.9	0-10
Sadness/depression	1.3	2.0	0-9
Overall wellbeing	2.5	2.2	0-8