مقاله گزارش موردی

گزارش مورد بیماری یک بیمار کانسرپیشرونده پستان با گیرندگی های هورمونی منفی و منیتمز مزگی زودرس

فرنار آموزگار هاشمی. مرضیه ترکمانی

چکیده

معرفي: منیتمز مزگی با مشا کانسر پستان دومین علت شایع منیتمز مزگی می باشد. وجود منیتمز مزگی طول عمر بیماران مبتلا به سرطان را به صورت چشمگیری کاهش می دهد. ما موردی از منیتمز مزگی با مشا پستان را گزارش کردیم که در طی 6 سال پس از درمان نشانه ای از پیشرفت بیماری نداشته است.

توصیف معمول: بیمار خانم 47 ساله که در ادعای رستورهای هورمونی و زودرس، سپ از درمان اولیه جراحی و درمان ادجواگردی رادیوپرای اتمام مفعول طی 6 سال کاهش نشانه ای از پیشرفت بیماری نداشته است.

بحث: با توجه به گزارش های متعدد به نظر مربوط منیتمز مزگی کاهش دهنده طول عمر در هره سرطان باشد و انجام درمان تناها به فرد تنکیع عالتم و تسهیل شرایطی زندگی بیمار باشد اما در مواردی که انجام جراحی نوار با رادیوپرایی به ظناد ادجواگردی بوده است نتایج بهتری حاصل شده است.

کلمات کلیدی: کانسر پستان، منیتمز، مزگی، رادیوپرایی

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CASE REPORT

An Aggressive Triple Negative Breast Cancer With Early But Favorable Brain Metastatic Course

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ABSTRACT

Introduction: Breast cancer is the second most common cause of brain metastasis. Although patient prognosis is poor, isolated brain metastasis occasionally can be an option for treatment with curative intent in breast cancer patients.

Case Presentation: We report a patient with invasive ductal carcinoma of the breast who developed an isolated right frontal lobe metastasis within 5 months of finishing her breast cancer treatment. Despite aggressive course of primary disease the metastasis was successfully controlled by surgical excision and adjuvant whole brain radiation therapy. The patient is now quiet well and disease free approximately six years after treatment of brain metastasis.

Discussion: A small subgroup of brain metastasis with breast primary can have a considerable survival with adequate local treatment.

Keywords: Breast Cancer, Metastasis, Brain, Radiotherapy
INTRODUCTION

Brain metastasis is very common, with an annual incidence of approximately 170,000 to 200,000. The most common primary site is the lung followed by breast. An improvement in survival of metastatic breast cancer patients is seen with better chemotherapy and trastuzumab-based treatment. This has led to an increase in the incidence of central nervous system disease among breast cancer patients, especially those with HER-2 over expressing or hormone-receptor negative tumor. Metastatic brain tumors out number primary brain tumors by a factor of 10 to 1, with autopsy series demonstrating a 10% to 30% incidence rate for all patients with a diagnosis of cancer (1). Although patient prognosis is poor, isolated brain metastasis occasionally can be an option for treatment with curative intent in breast cancer patients. We report a case of woman with invasive ductal carcinoma of the breast with right frontal lobe metastases that was managed successfully and is completely disease free now.

CASE PRESENTATION

A 47 years old woman with diagnose of invasive ductal carcinoma in left breast was referred to radiation oncology department in January 2003. She received modified radical mastectomy. The pathologic report confirmed a 4 Cm tumor in upper inner quadrant with nine negative nodes in axillary dissection. There was no lymph vascular invasion and the disease was staged T2 N0M0. ER and PR and also HER2 were all negative. She also received chemotherapy consisting of four courses of AC and four course of Taxol. Three weeks later radiation treatment was started with two long tangential fields and by cobalt machine. The treatment was completed in March 2003 and the patient received 50Gy in 25 fraction. She was quiet well and under observation when in July 2003 she complained of sudden onset attack of headache and vomiting that was soon followed by mood disturbance.

A MRI of the brain revealed a hypo dense T2 weighted contrast enhanced 3 x 3.5 cm mass lesion in right frontal lobe associated with extensive peripheral edema and mass effect and shifting to central structure to the other side.(Figure 1)

The metastatic work up did not reveal any other metastases. Because of the localized nature of the lesion, surgical excisions of the tumor was planned. Following a right frontal craniotomy, the lesion was completely excised and histological examination of the mass was showed invasive ductal carcinoma consistent with known left breast cancer primary. Post-operative 30Gy in 10 fractions was given to whole brain as adjuvant radiation therapy. The patient has been followed every 4 months for 3 years and every 6 months since now. Neurological exam was carried out in each visit and brain MRI has been performed. It is approximately 6 years that, the patient is really symptom free with no significant finding on MRI (Figure 2).
Brain metastases are a common manifestation of systemic cancer, far outnumbering primary brain tumors, and are a significant cause of neurological problems (1). The overall incidence of brain metastases from various malignant tumors can vary from 13.5% to 37%. The lung, breast, kidney and gastrointestinal tract are the most frequent primary sites of brain metastasis (2). Sixty-two percent of metastatic breast cancer patients develop brain metastases to the central nervous system despite all the treatment of primary tumor such as surgery, combination chemotherapy, target therapies and radiotherapy (3). It is hypothesized that the incidence of brain metastases in breast cancer might be increasing, as a result of several factors: improved cancer treatments that lead to longer survival, earlier or more frequent brain screening for specific cancers that have a predilection for brain metastases, and increased capability of modern imaging to detect early brain metastases (4). Brain metastasis in breast cancer are usually multiple and frequently involve more than one brain lobes (4).

A few patients present with a solitary lesion in brain and can be rendered disease free by aggressive local treatment although their value has not been established in such cases. Despite successful local therapy, about 80% will die of metastatic cancer within five years (5). Numerous pre-CT era studies have shown that survival time in patients with symptomatic brain metastases is approximately 1 to 2 months without therapy, 2 to 3 months with corticosteroid therapy, and 3 to 6 months with WBRT. Those survival data are consistent with current outcome data in patients who do not meet selection criteria for focal brain therapy (1).

In general brain metastases are treated with corticosteroid and radiotherapy and sometimes by surgery (3). Patients with non-adjacent, multiple, or inoperable lesions are usually treated with palliative whole brain radiotherapy. Today, many diagnoses of brain metastases are made relatively early, while patients are asymptomatic and when aggressive focal therapy, such as surgery or stereotactic radio surgery (SRS), may be offered. Patients who satisfy selection criteria for focal therapy appear to have a more favorable prognosis. Sneed et al. (6) found that survival was substantially greater in patients receiving surgery, with or without WBRT, than that found in patients in the RTOG WBRT trials. Agboola et al. (7) found improved survival in all patients undergoing surgery with WBRT. Surgical excision is done in those cases with a solitary lesion or multiple metastasis lesions without definite diagnosis. Surgical excision of the solitary lesion combined with adjuvant postoperative radiotherapy yields a better survival than radiotherapy alone (8). But after such treatment median survival has been extended by 2-7 months in good performance status and controlled systemic disease, with a few cases in literature confirming longer survival (9).

In conclusions, our case provides an example of rare case with successful management of brain metastases in breast cancer with the use of surgery and adjuvant radiation therapy. This line of treatment should be strongly considered in patients of breast carcinoma with solitary, respectable brain metastases.
REFERENCES