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A CASE SERIES ANALYSIS OF LATE LOCAL AND DISTANT RECURRENCE IN BREAST CARCINOMA PATIENTS

Oncology/Radiotherapy

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KEYWORDS

INTRODUCTION:

Breast carcinoma remains the most common malignancies affecting women worldwide[1]. Despite advances in detection, treatment, and patient care, the recurrence of breast carcinoma poses significant challenges for healthcare providers and patients alike[2]. Recurrent breast carcinoma can manifest in various forms, such as local, regional, or distant metastases, each presenting distinct clinical characteristics and therapeutic challenges[3]. This case series aims to elucidate the patterns, prognostic factors, and clinical outcomes associated with recurrent breast carcinoma by analyzing a collection of diverse cases. Through detailed examination and analysis, we aim to provide insights into the management strategies and survival outcomes, contributing to a better understanding of this complex and persistent disease.

Material And Methodology:

This is a retrospective analysis in form of case series report from hospital data of patients with Carcinoma Breast presented from January 2002 to December 2010. This study is conducted at JK Cancer Institute, GSVM Medical College, Kanpur, UP, India. Records of the all patients with a histological diagnosis of Carcinoma Breast, who underwent treatment at JKCI, Kanpur, during this time duration, were included in the study. We collected data on patient related factors like age at presentation, menopausal status, site of the lesion, presence of any comorbid conditions, tumour related factors like size at presentation, resection margin status, treatment factors like type of surgery, adjuvant radiotherapy and histological factors ER/PR/HER2neu status of tumour. The disease status at the last follow up visit was noted.

Case 1: A 28 year old female presented to our hospital JK Cancer Institute Kanpur 0n 10/09/2002 with complaint of lump in Right Breast for 4 months. It was insidious in onset, painless in nature, progressive in size. No history of breast cancer in family. On clinical assessment 5x5cm well defined lump was palpable in upper outer quadrant of right breast. It was hard in consistency, non-tender, not fixed to chest wall, anteriorly skin not involved. Left Breast and bilaterally axillary lymph nodes and Supraclavicular lymph nodes were not palpable.

USG bilateral breast and axilla suggested a well defined hypoechoic micro-lobulated mass lesion (5x3x4cm) in right breast at 2'oclock position. Bilateral Axilla and Supraclavicular fossa are clear. USG whole abdomen- Normal Scan. Chest Xray PA view was clear. Fine needle aspiration cytology was suggestive of Infiltrating Ductal Adenocarcinoma.

Diagnosis of Carcinoma Right Breast, cT3N0M0, Stage IIB. She was planned for Breast conserving surgery with axillary lymph node dissection followed by adjuvant chemotherapy followed by loco-regional radiotherapy with hormonal therapy. On HPE suggestive of infiltrating ductal carcinoma, ER positive, PR positive, Her2neu negative confirmed the diagnosis and staging pT3N0M0, Stage IIB, molecular group Luminal A type.

Patient further received 3 cycles adjuvant chemotherapy CMF regime followed by Radiation 50Gy/ 25# from 2/12/2002 to 7/12/2003 then further 3 cycles same chemotherapy regime till 24/4/2003 . Patient as started on Hormonal Therapy Tab tamoxifen 20 mg OD on July 2003 till 2008. Then patient was on regular follow up till 2010.

Patient presented to our hospital OPD in 11/11/2019 with complain of breathlessness on and off. CECT Thorax was done which revealed multiple nodular lesion in both lungs. A lytic lesion in body of sternum. CT guided fine needle aspiration cytology from right lung lesion was suggestive of metastatic adenocarcinoma. Pt was started on palliative chemotherapy TP regime.

Case 2: A 40 year old female presented to our hospital JK Cancer Institute Kanpur 0n 06/06/2004 with complaint of lump in Right Breast for 5 months. It was insidious in onset, painless in nature, progressive in size. No history of breast cancer in family. On clinical assessment 6x5cm well defined lump was palpable in upper outer quadrant of right breast. It was hard in consistency, non-tender, not fixed to chest wall, anteriorly skin not involved. Left Breast and bilaterally axillary lymph nodes and Supraclavicular lymph nodes were not palpable.

Mammography revealed a relatively well circumscribed hyperdense lesion in the upper outer quadrant of right breast with microcalcification.

USG bilateral breast and axilla suggested a well defined hypoechoic micro-lobulated mass lesion (5x6x4cm) in right breast at 1'oclock position. Microcalcifications present. Bilateral Axilla and Supraclavicular fossa are clear. USG whole abdomen- Normal Scan. Chest Xray PA view was clear. Fine needle aspiration cytology was suggestive of Infiltrating Ductal Carcinoma.

Diagnosis of Carcinoma Right Breast, cT3N0M0, Stage IIB. She was planned for Breast conserving surgery followed by adjuvant chemotherapy followed by loco-regional radiotherapy with hormonal therapy. Patient underwent Lumpectomy, on HPE suggestive of infiltrating ductal carcinoma, ER positive, PR positive, Her2neu negative confirmed the diagnosis and staging pT3N0M0, Stage IIB, molecular group Luminal A type.

Patient further received 3 cycles adjuvant chemotherapy CMF regime and defaulted in 2005. Patient presented after 19 years at our Institute with complaint of lump in right breast, on examination – 6x6cm hard tender lump was palpable involving all quadrants, fixed to chest wall and involving overlying skin, nipple areola region was ulcerated and associated with foul smelling discharge and point bleeding. Right Axillary lymph nodes multiple, 3x3cm matted lymph node were present.

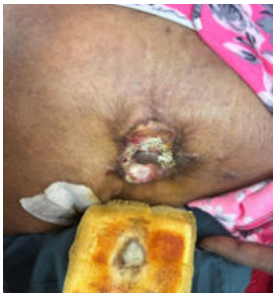

Fig : Showing Reccurent Lump In Right Breast

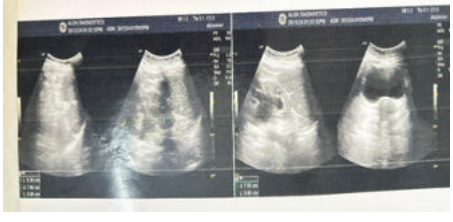

Fig: USG whole abdomen showing multiple liver SOL's

On USG whole abdomen multiple hepatic space occupying lesions were present. FNAC from largest liver SOL was suggestive of metastatic deposit of Ductal carcinoma. Chest scan was normal. Patient was upstaged to ycT4cN2aM1, Stage IV. Patient was planned on palliative chemotherapy TP Regime.

Case 3: A 42 year old female presented to our hospital JK Cancer Institute Kanpur 0n 23/06/2010 with complaint of lump in Right Breast for 2 and half years. It was insidious in onset, painful in nature, progressive in size. No history of breast cancer in family. On clinical assessment 6x4 cm ill marginated lump was palpable in lower outer quadrant of right breast. It was hard in consistency, tender, not fixed to chest wall, anteriorly skin not involved, nipple was retracted in right breast Left Breast and bilaterally axillary lymph nodes and Supraclavicular lymph nodes were not palpable.

Mammography revealed a relatively well circumscribed hyperdense lesion in the lower outer quadrant of right breast with microcalcification. Bilateral Axilla and Supraclavicular fossa are clear, unremarkable for any suspicious finding.

USG whole abdomen- Normal Scan. Chest X-ray PA view was clear. True cut biopsy was suggestive of Duct Carcinoma. Diagnosis of Carcinoma Right Breast, cT3N0M0, Stage IIB. She was planned for surgery followed by adjuvant chemotherapy followed by loco-regional radiotherapy with hormonal therapy. Patient underwent modified radical mastectomy on 27/8/2010, HPE suggestive of invasive ductal carcinoma, ER positive, PR positive, Her2neu negative confirmed the diagnosis and staging pT3N0M0, Stage IIB, molecular group Luminal A.

Patient further received 4 cycles adjuvant chemotherapy TEC regime followed by locoregional Radiotherapy 50Gy in 25#. Patient was started on Hormonal therapy Tab Tamoxifen 20mg from 2011 till 2016. Patient was on annual follow up since 2016 with routine scans. Pt complained of anorexia and weight-loss in 2024. PET Scan showed left lung multiple lesions largest-25x24mm (SUV max – 4.4), liver showed multiple increased uptake lesions largest 30x25mm. FNAC from largest liver SOL was suggestive of metastatic deposit of Duct carcinoma. Chest scan was normal. On Examination- right chest wall: Healthy surgical scar present, no lump, induration or skin changes seen or felt. Bilateral axilla and supraclavicular fossa no palpable lymphadenopathy. Patient was upstaged to carcinoma right breast (post-Op)(post CT-RT)with liver and lung metastasis, upstaged to ycT3N0M1, Stage IV. Patient was planned on palliative chemotherapy TP Regime received 6 cycles. Currently on palliative chemotherapy Tab Capecitabine 500mg BD day1- day 21, 4 weekly.

Case 4: A 32 year old female presented to our hospital JK Cancer Institute Kanpur on 20/09/2010 with complaint of lump in Right Breast for 1 year. It was insidious in onset, painless in nature, progressive in size. No history of breast cancer in family. On clinical assessment 8x8cm well defined lump was palpable in retro-areolar region involving all quadrants of right breast. It was hard in consistency, non-tender, not fixed to chest wall, anteriorly fixed to skin with peau'd orange appearance of skin. Right Axillary lymph node palpable 3x2cm, firm, mobile, non-tender in central group. Left Breast and left axillary lymph nodes and Supraclavicular lymph nodes were not palpable.

USG bilateral breasts and axilla revealed a relatively ill defined, irregular mass lesion (8x7x8cm) in the right breast centrally with microcalcification. Right axilla 2x2cm node present.

USG whole abdomen- Normal Scan. Chest Xray PA view was clear. Fine needle aspiration cytology was suggestive of Infiltrating Ductal Carcinoma. Diagnosis of Carcinoma Right Breast, cT4bN1M0, Stage IIIB. She was planned for Neoadjuvant chemotherapy followed by surgery followed by loco-regional radiotherapy with hormonal therapy. Patient underwent 4 cycles Neoadjuvant chemotherapy FEC regime followed by Modified Radical Mastectomy 0n 11/01/2011, on HPE suggestive of infiltrating ductal carcinoma, ER positive, PR positive, Her2neu negative confirmed the diagnosis and staging pT4bN1M0, Stage IIIB, molecular group Luminal A type.

Patient further received 2 cycles adjuvant chemotherapy FEC regime followed by 50Gy/25# and was started on Hormonal therapy tab letrozole 2.5mg OD which she continued for next 5 years till 2016. Patient was on annual follow up for 8 years when she complained of severe headache and dizziness on and off. A Contrast Enhanced Magnetic Resonance Imaging scan done in December 2024 showed multiple enhancing lesions in the bilateral parietal- temporal lobe. Pt was given whole brain palliative radiotherapy dose 20Gy/5# and supportive treatment was given.

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