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Case Report

A case report: role of curative toilet mastectomy with latissimus dorsi flap recostruction in locally advanced breast cancer

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ABSTRACT

Breast Cancer is a systemic disease with rising incidence all over World. In India where most of the patients present with advanced stage. Multimodal treatment with evolving research in breast cancer showed an evidence of increase in survival in Locally Advanced Breast Cancer (LABC). Based on this selected patients with LABC which are inoperable may have a survival benefit with Local Surgery and Adjuvant treatment. We present a case from Semi-Urban locality in India where facilities are poor.

Key Message: A Case Report of curative Mastectomy in Fungating Breast Cancer which progressed on Chemotherapy from a tier- 2 city with limited resources showed increased survival which can be taken as pilot study for advanced trials and research.

1. Introduction

With 1.3 million new cases and almost half a million deaths annually, Breast Cancer is one of the most important health concerns Worldwide·In India Breast Cancer has ranked number one among females, with 25 -30% patients presenting as Locally Advanced Breast Cancer (LABC). The age adjusted rate is as high as 25.8/100,000 women and mortality is 1.27/100,000.[1–5] However survival of patients with LABC is steadily improving with a decrease in death rate by 1-2% annually.[6,7]

Locally Advanced Breast Cancer (LABC) is a heterogeneous group of tumors with varying clinical presentation such as presence of a large primary tumor or involvement of skin & chestwall or extensive regional lymph node involvement and absence of any evidence of metastasis. Some patients may have a rapid Neoplastic evolution where as others present with long history of tumor growth. Fungating malignant lesions are a subclass, presenting with large ulcerative growth which manifests with pain, disfigurement, hemorrhage, odor and infections.[8–14]

1.1. Classification

Patients with stage IIB, III and IV of the TNM classification are included in LABC. In this Classification system patients are included if they have T_3 or T_4 tumors with any N stage or any T category with N_2 or N_3 or regional M_1 involvement.[15]

Surgery is the main stay for LABC with NeoAdjuvant Chemotherapy followed by Radiotherapy. Toilet Mastectomy is an excellent adjunct to palliative care in LABC patients. This is useful for debulking of the tumor and for controlling infections and sepsis. The aim of the Palliative care is to improve the quality of life by controllimg infections and pain.[16,17]

Here we share our experience of a young patient with LABC presenting with fungating Breast Cancer which progressed on Chemotherapy.

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2. Case History and Discussion

A young female patient of age 33 years presented with large fungating right breast mass with foul smell and discharge.

2.1. Past history

She was evaluated outside at a private hospital, where she was diagnosed as a Carcinoma of Breast and a trail of 2 cycles of NACT chemotherapy was given which showed progression of disease and patient was planned for supportive palliative care and sent home.

In view of young age of patient a palliative definitive Toilet Mastectomy was done after taking informed consent of patient and patient attendars, to increase the survival rate and give a benefit of cure. The raw area was closed with LD flap reconstruction.

Post operatively, patient recovered well and discharged. Further patient was given 8 cycles of Adjuvant chemotherapy treatment followed by 50gy of radiation to chest wall and supra clavicular area. After 3years of survival and follow up, patient is doing well.

2.2. CT scan of the chest with contrast revealed

Large irregular heterogeneously enhancing exophytic soft tissue density mass measuring 99×80mm.

Diffuse surrounding fatty inflammation is noted. The lesion is invading the skin causing thickening & large deep ulceration. Few Calcifications are noted within.

Posterior the lesion is noted abutting the Pectoralis muscle along the right lateral wall. Multiple heterogeneously enhancing nodules mass lesion in the right axillary region at level-I, II &III. Largest one measuring 53×49mm. Non enhancing hypo density lesion is noted within as Necrosis

CT scan of abdomen and pelvis (Plain & Contrast) is normal.

2.3. Histopathological examination

On gross examination Breast mass measuring 14.5×13.6×5.8cm covered with a skin flap measuring 10.5×10cm. Externally the skin flap shows a large ulcerated area measuring 10.5×8cm. Nipple areola identified separately from ulcerated area. Distance of nipple from ulcerated area is 0.8cm. Cut surface shows a lesion, which is a firm breast mass at right side measuring 8.6×6.5×5.2cm grey white, with occasional hemorrhagic areas is seen.

Level ll/lll axillary lymph nodes contain globular mass measuring 6.5×5×4cm. A cyst wall infiltration contains grey white-grey brown soft tissue measuring 2.5×2×0.3cm.

Microscopic examination shows extensive areas of necrosis with viable lesion predominantly composed of large polygonal cells arranged around the vessels. There is marked nuclear pleomorphism. Lobules of cartilage with atypical cells are seen in lacunae. Level II/III axillary lymphnode shows metastatic tumor deposits and Chest wall shows involvement of tumor. Histopathology report reveals Metaplastic Carcinoma with Chondrosarcomatous Differentiation-ypT4cN3aMx of right breast.

2.3.1. Histological grade

Nottingham Histologic score- Tubule differentiation-3

1. Nuclear pleomorphism-3
2. Mitosis figure -3

   Total score -9

2.3.2. SBR Grade III

1. Tumor focality- Unifocal
2. Margins- separately sent superior& inferior margins including posterior surface are uninvolved
3. Treatment effect in lymphnode- No definite response ion presurgical therapy in metastatic carcinoma
4. Lymphovascular emboli- Present
5. Extranodal extension- Present

2.3.3. Pathologic staging (pTNM)

1. Primary tumor- ypT4c
2. Regional lymph nodes- ypN3a (metastasis to level III axillary lymphnode)
3. Distant Metastasis – ypMx

2.3.4. Immuno Histo Chemistry(IHC) Report

1. ER—Negative
2. PR—Negative
3. Her2neu– Negative

Fig. 1: Pre operative image showing ulcerative fungative breast mass

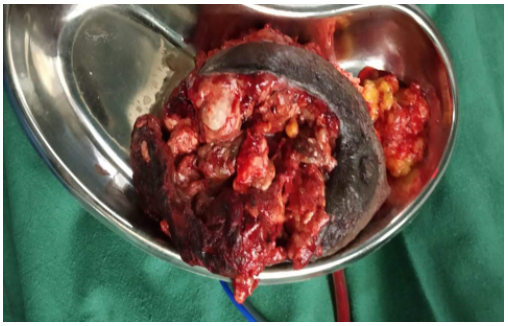

Fig. 2: Showing breast mass after surgery

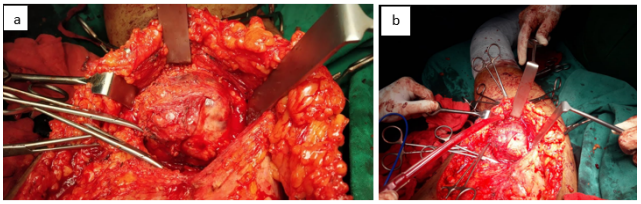

Fig. 3: a,b: Intra operative image showing the Axillary lymphnode

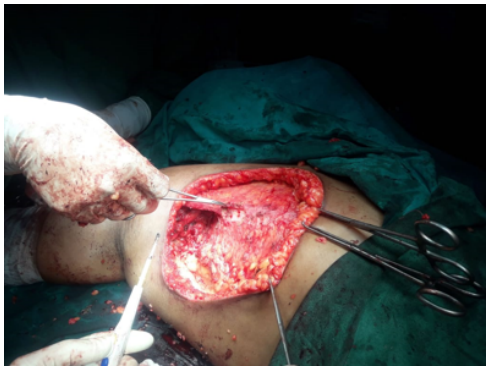

Fig. 4: Shows raw area after lymphnode dissection

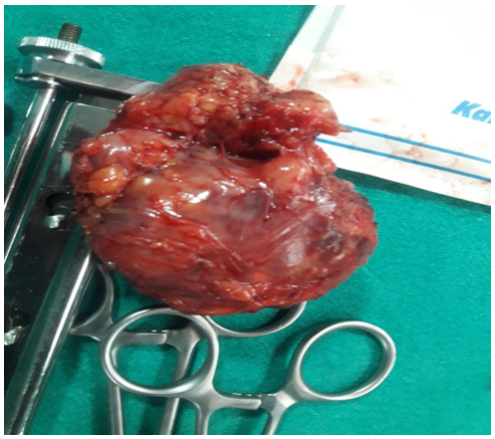

Fig. 5: Shows large Axillary lymphnode mass

3. Conclusion

Based on the survival rate of greater than 3 years, a subset of young patients can be planned for palliative radical mastectomy with LD flap reconstruction.

4. Conflict of Interest

The authors declare that there is no conflict of interest.

5. Source of Funding

None.

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