ESMO/AFRICA 2019

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UNIVERSITY OF NAIROBI

KENYA

MM –DOB 1966 (Age 42 Years)

April 2009: Referral because of left breast mass noticed in December 2008.

Para 2+0

Past medical history unremarkable

Social worker married to an accountant

Social drinker, no cigarettes; husband is heavy smoker and drinker, no hormonal contraceptives.

No family history of cancer

Examination: 3 x 4 cm mobile mass in left breast just lateral to the areola.

FNA Cytology had shown ductal carcinoma.

ECOG 0.

Referral to a surgeon who suggested a **mastectomy** but she **declined**.

Wide local excision was carried out.

She was **lost to follow-up**.

No adjuvant treatment.

Several months later she went for reconstruction.

Said she was ‘rebelling’

Reconstruction surgeon found persistent malignancy with skin and supraclavicular lymph node involvement.

Referred her back for chemotherapy.

No distant metastases demonstrated.

Treated with AC X 6

Lost to follow-up

26/09/2014

Reviewed because of generalized bone pains.

Physical examination showed shrunken, scarred left breast.

U/S-guided tru-cut biopsy → ductal carcinoma: Her2 positive, ER/PR negative.

Could not afford sustained her2-directed therapy.

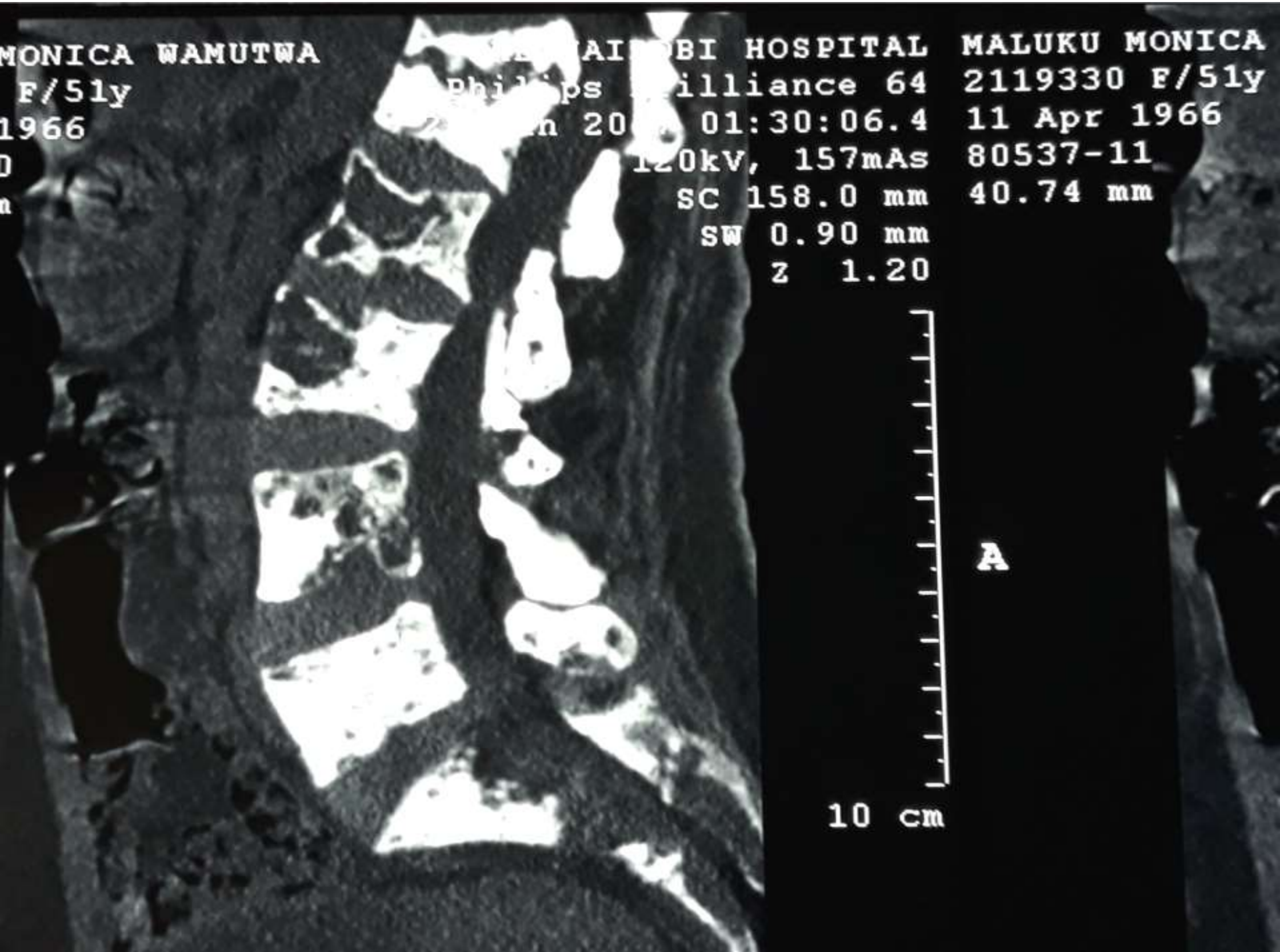
TCH X 2 courses given then:

lost to follow-up -financial

02/09/15 : Resurfaced with persistent bone pains.

Physical examination was still unremarkable **1 year** later

X-rays showed multiple bone lesions → palliative irradiation in patches till March 2016.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16/09/16

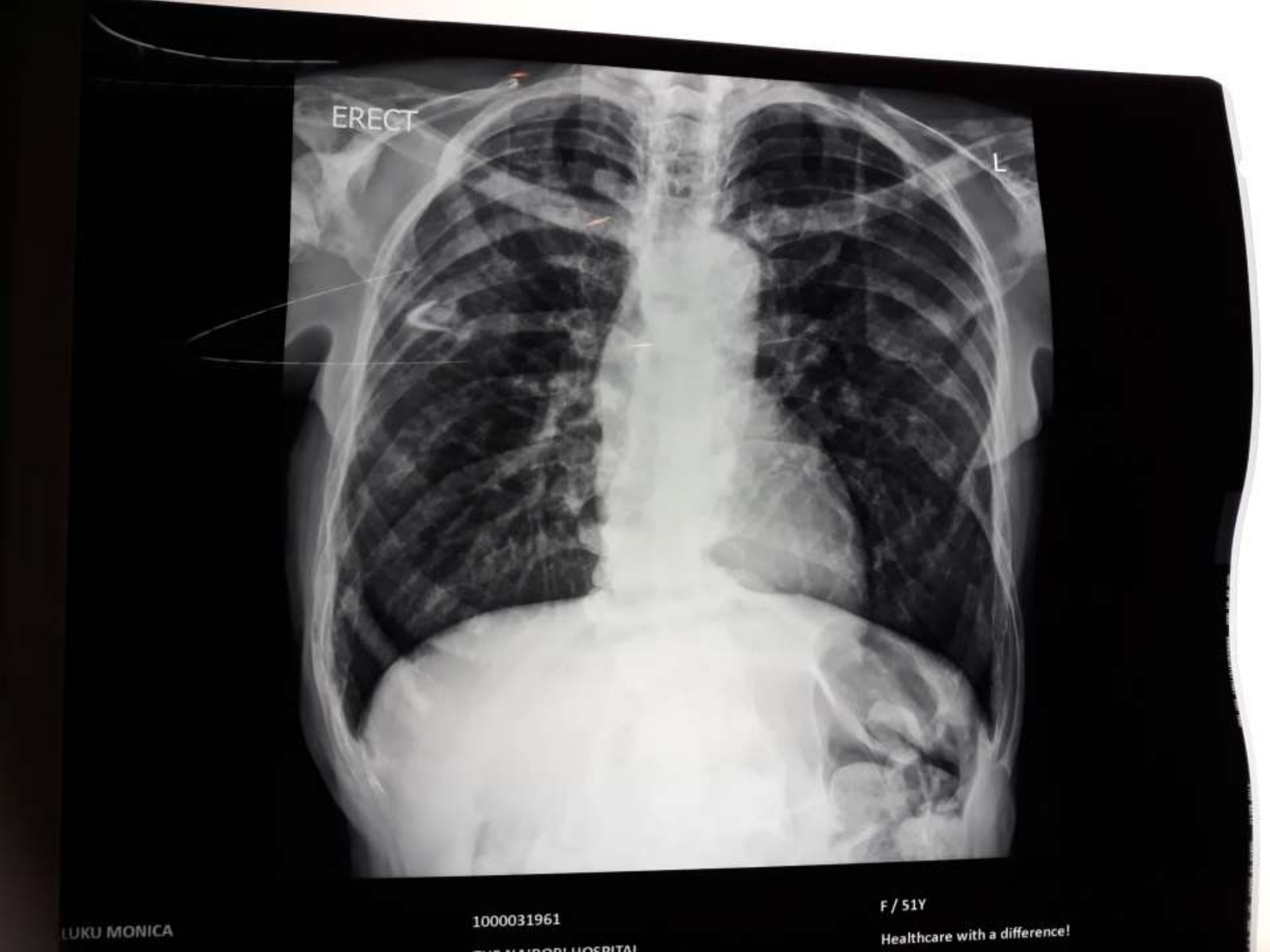
Left orbital pain

Proptosis noted.

Only residual vision: CF 1 metre

CT scan showed orbital metastases

Palliative irradiation to left orbit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Healthcare with a difference!

01/12/16

Chemotherapy with **gemcitabine/vinorelbine**

2 courses given then she **disappeared -financial**

20/06/17 – Neck and lower back pain

July 2017 – radiotherapy to cervical and lumbar spine

From 18/01/2018

Capecitabine and zoledronic acid when she feels she needs them.

Last dose was on 08/01/18

She remains emaciated and weak **(ECOG 1 - 2)** but still goes to work to sustain treatment.

J. W. C.-DOB:03/07/70 (39 Years)

September 2009: Referred because of left breast mass.

Previous medical history: mild attacks of asthma in childhood

Single mother of 2

Accountant at a multinational firm based in Nairobi

5th of 7 siblings; 4M/3F

2 brothers deceased

Father deceased

No known family H/O cancer

Takes occasional wine, no cigarettes

Examination/Pathology

A **2X3 cm** mass in the left breast with nipple retraction.

FNAC breast mass and axillary node were positive for ductal carcinoma NOS.

Stage as T4N2MO

Treatment

Neoadjuvant AC X 4 followed by docetaxel x 2 (4 planned).[1]

Referring surgeon snatched her arguing that she had had enough chemotherapy.

1. Henderson IC, et al. J Clin Oncol 2003;21:976-983

Surgery

Breast conserving surgery with axillary nodal '**dissection'** was performed.

1/7 nodes was positive postoperative.

Margins were free.

ER **positive(**4+3), PR **negative**, Her2 **equivocal** by IHC **(2+)** and **negative** by FISH

Further chemotherapy was discussed but the surgeon would hear none of it.

Referred abroad for radiotherapy.

Radiotherapy

Left breast treated with medial and lateral tangential fields using 6mv photons

50 Gy in 25 fractions

Posterior axillary boost field added at 48 Gys in 25 fractions in conjunction with the supraclavicular field

Tumour bed given a boost of 1.6 Gys in 8 fractions.

Hormonal therapy

Adjuvant tamoxifen

More chemotherapy should have been administered.

But she could hear none of it (surgeon's advice).

21/02/2013

Asymptomatic

Surgeon did follow-up bone scans, found positive

Physical examination normal.

MRI – multiple skeletal metastases

Changed to zoladex + letrozole. 1

Zoledronic acid added.

1. Klijn JG, et al. J Clin Oncol 2001.

18/03/13

Left hip discomfort persists

Ref to RT

24/04/13

C/O light headedness when hungry

Loss of weight

Was on a mixture of vegetable concoctions

P/E - NAD

24/10/13

Feeling heavy on the right hip

25/08/14 – Left lumbar pain

22/04/16 – Tipped liver.

CT scan: Unremarkable

27/07/17

Abdominal discomfort

Liver palpable

CT scan still unremarkable, letrozole continued.

Analgesics

22/09/17 – Wasted (**Weight 56 Kg previously 75**)

Tipped liver

12/12/2017

Emaciated **(Weight 54 Kg)**

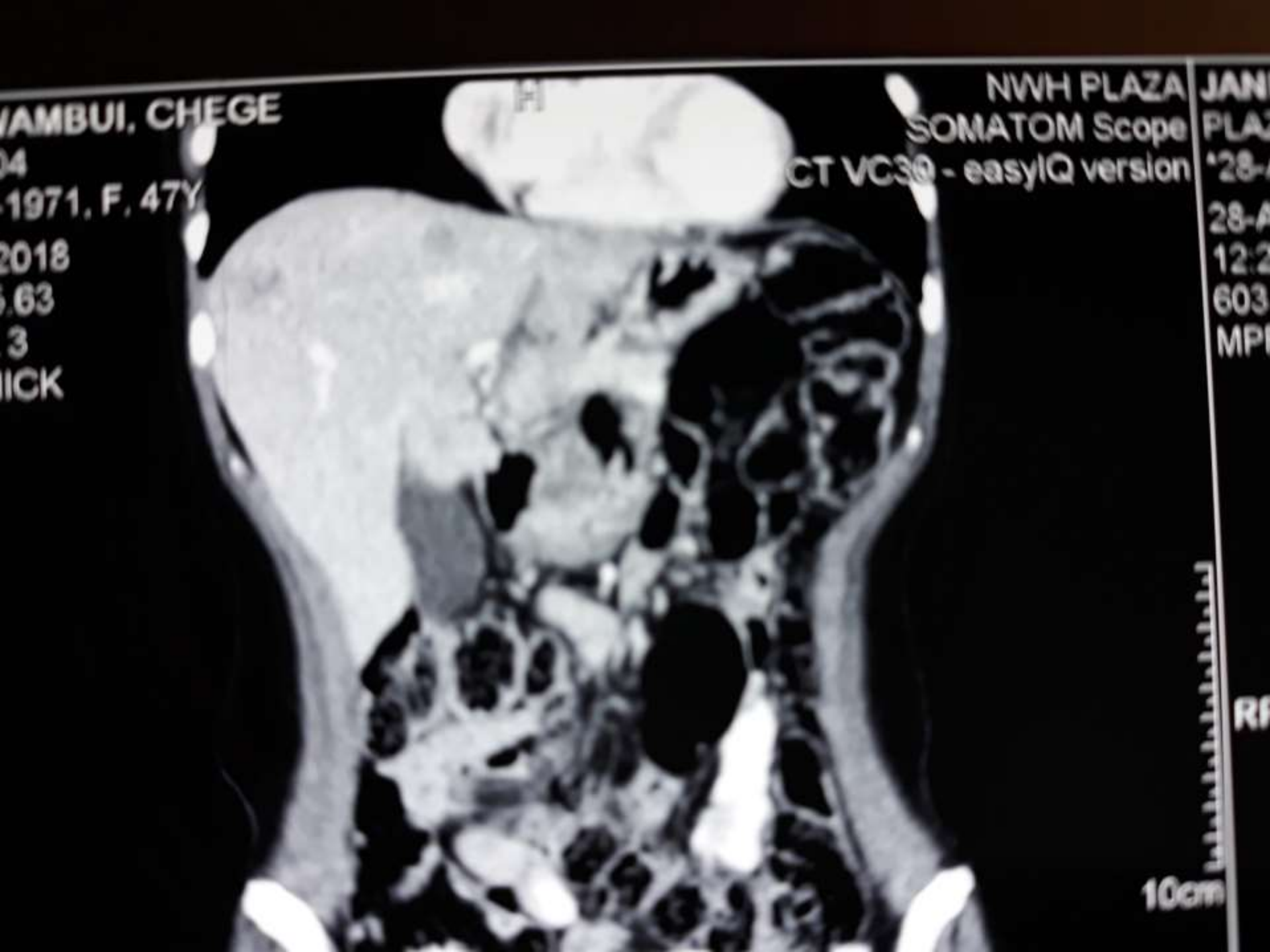
Massive hepatomegaly

CT scan: Liver metastases

Letrozole discontinued.

Put on vinorelbine and gemcitabine.

After 6 courses, liver not palpable: she opted out of therapy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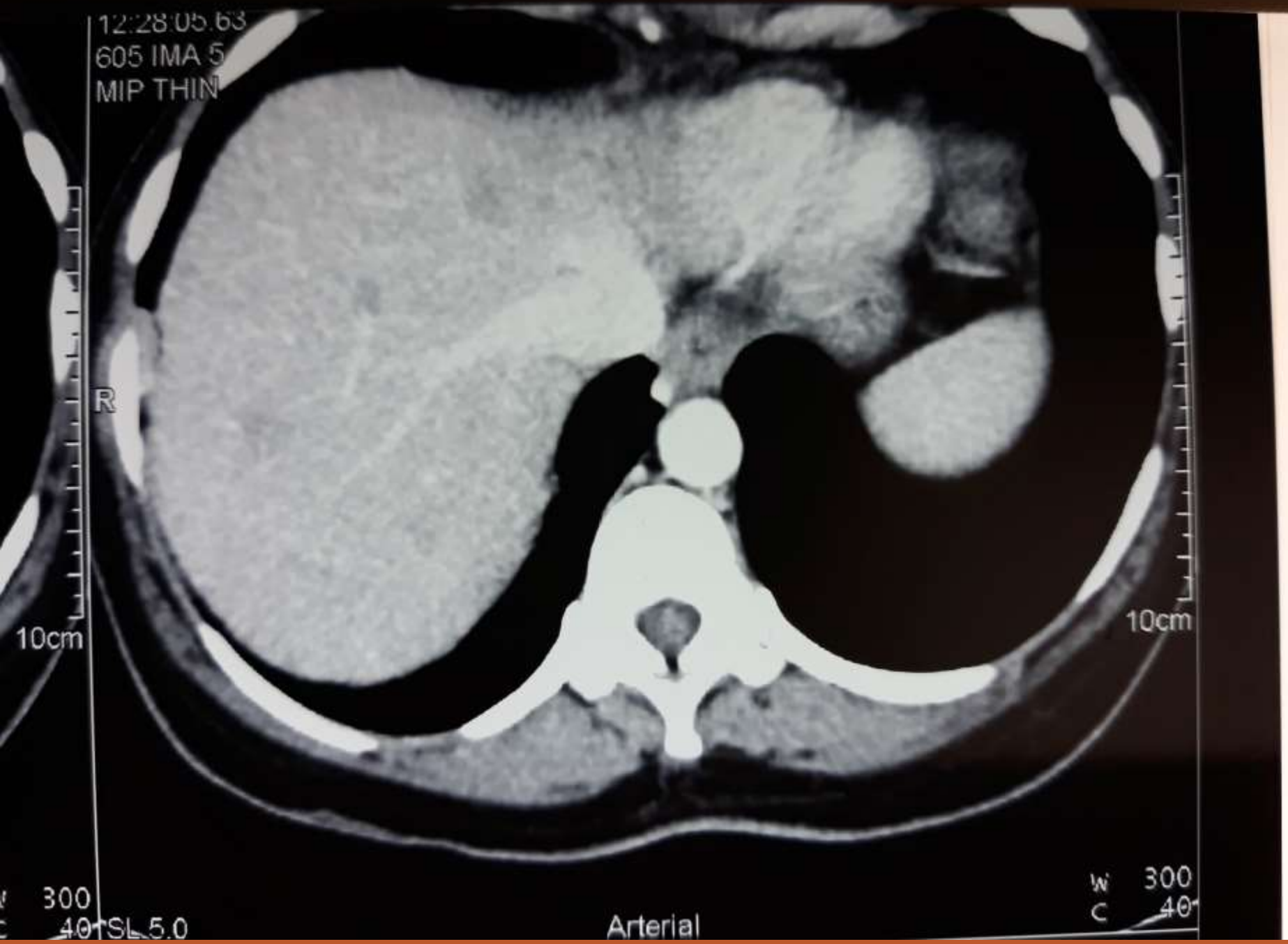
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01/09/18

Back with progressive disease, ECOG 2, **Weight 47 kg.**

Converted to taxotere/gemcitabine, then taxotere/capecitabine

Has had 8 courses with G3/4 neutropenia in between and has promised for the **umpteenth time** that she will never get any more chemotherapy.

December 2018: took a holiday in Namibia and Australia (Weight now 66kg).

Comments

Standard of care for ER/PR Positive metastatic disease is hormonal therapy unless there is rapid progression or visceral crisis.

Hormone receptor status was weak for the second patient.

Hormone refractory cases can be treated with PI3K pathway inhibitor, or CDK4/6 inhibitor plus hormone (AI or enzalutamide) **.1,2,3,4**

These are costly and not readily available to us.

1.Lauring J, et al. J Natl Compr Canc Netw 2013

2. Bachelot T, et al. L Clin Oncol 2012

3. Baselga J, et al. N Engl J Med 2012

4. Dickler MN, et al. Clin Cancer Res E Pub 2017

Her2-positive metastative breast cancer

Treatment for Her2-positive metastatic breast cancer is her2-directed therapy with chemotherapy +/_ hormonal therapy.

When hormone receptors are also positive in the premenopausal woman, treatment sequencing can be challenging.

Outcome

The median survival for metastatic breast cancer is 24-48 months, depending on biology and treatment.

The first patient has done 54 months with metastatic disease, the second patient 72 months, both despite suboptimal therapy.

Individual tumour biology may be a major determinant in patient outcomes.

These two cases call into question definition of clinical benefit from various agents in clinical trials.