

Extensive Intraabdominal Metastasis of Inflammatory Breast Cancer

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Key Words

Metastasis, intraabdominal · Breast cancer · Interdisciplinary management

Summary

Background: Intraabdominal metastasis is a rare complication of metastatic breast cancer. **Case Report:** We report a case of extensive intraabdominal metastasis with neurologic symptoms of the left leg in a patient who was treated for breast cancer 2 years before. Diagnosis of metastasis was based on imaging techniques and confirmed by histology. Treatment options were discussed in an interdisciplinary tumor board and chemotherapy with a combination of vinorelbine and capecitabine was initiated. After 3 cycles, the patient showed clinical partial response with reduced tumor volume. **Conclusion:** An interdisciplinary approach is vital to tailor the best treatment option for the individual patient.

Schlüsselwörter

Metastase, intraabdominelle · Brustkrebs · Interdisziplinäres Management

Zusammenfassung

Hintergrund: Intraabdominelle Metastasen beim Mammakarzinom sind selten. **Fallbericht:** Wir berichten über den Fall einer ausgedehnten intraabdominellen Metastase mit neurologischen Symptomen im linken Bein bei einer Patientin, bei der zwei Jahre zuvor ein Mammakarzinom diagnostiziert worden war. Die Diagnose der Metastase wurde mittels CT und MRT verifiziert und stanziobiotisch histologisch gesichert. Die Behandlung wurde in einem interdisziplinären Tumorboard diskutiert und eine Chemotherapie mit Vinorelbin und Capecitabin begonnen. Nach drei Zyklen zeigte sich eine klinische partielle Remission. **Schlussfolgerung:** Bei solch komplexen Fällen ist eine interdisziplinäre Zusammenarbeit unerlässlich, um ein optimales individualisiertes Therapiekonzept für die Patientin zu entwickeln.

Background

Intraabdominal metastasis is a rare complication in metastatic breast cancer. As the location of the tumor often excludes complete resection, therapy options should be discussed in an interdisciplinary board.

Case Report

We report on a 51-year-old patient who presented with a one-year history of increasing left-sided abdominal pain, weakness and strong ischialgia of the left leg in August 2005. No sensory symptoms were present.

The patient had been diagnosed with invasive ductal inflammatory breast cancer in August 2001. The tumor had not responded to 3 cycles of primary systemic chemotherapy with epirubicin (150 mg/m², q14d) and paclitaxel (250 mg/m², q14d) [1]. Therefore, radical mastectomy with axillary dissection had been performed. Postoperative tumor stage was ypT3 ypN1biii (5/19) G3 R0 M0 L1, ER and PgR positive, Her2neu 2+ (FISH negative). Adjuvant chemotherapy consisted of 3 cycles of cyclophosphamid, methotrexate und 5-fluorouracil (CMF, 500/ 40 /600 mg/m² d1+8, q28). Due to hormone receptor positivity, the patient received tamoxifen 20 mg/d and a GnRH analogon. Otherwise her medical history was unremarkable.

One week before admission to our hospital she had undergone laparoscopy and bilateral ovariectomy for the increasing abdominal pain in a community hospital. However, the ovaries looked normal intraoperatively and histologic examination showed no abnormalities. No biopsy was taken of the large abdominal tumor detected during the operation. The

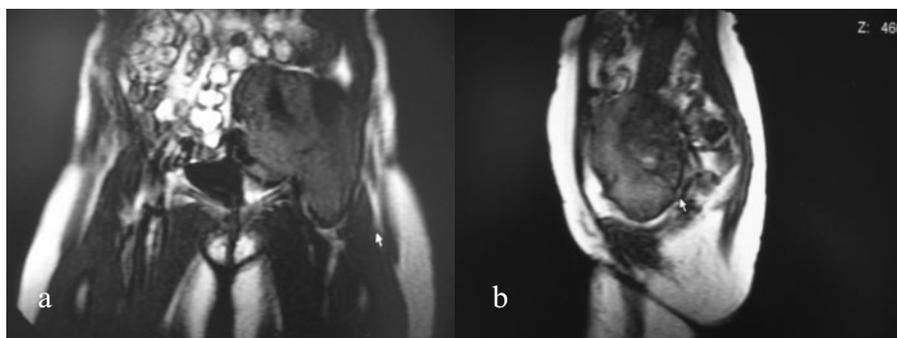


Fig. 1. Intraabdominal metastasis before treatment, **a** frontal, **b** sagittal view.

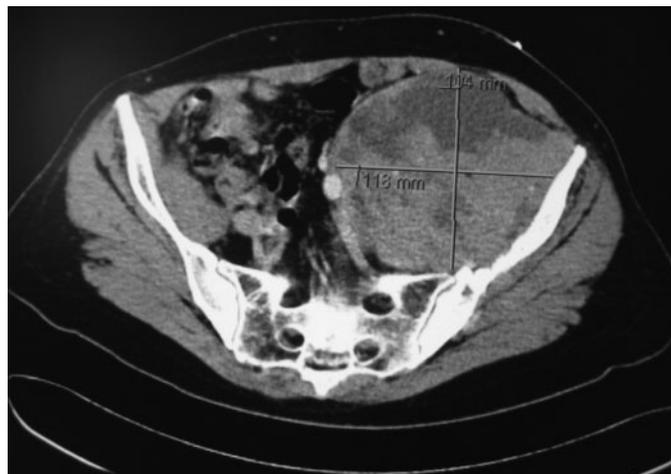


Fig. 2. Intraabdominal metastasis before treatment, transversal view.



Fig. 3. Intraabdominal metastasis after 3 cycles of chemotherapy.

patient was then referred to our hospital for pain control and further treatment. On gynecological examination, an intraabdominal mass larger than 10 cm was palpable. There was no renal obstruction.

CA 15-3 was above normal limits (534 U/ml). Abdominal CT scan showed a pelvic mass measuring 14×10×10 cm with suspicious infiltration of the left iliac crest (fig. 1, 2). A CT-guided biopsy was performed and histologic examination showed metastasis of the formerly diagnosed breast cancer, G2, hormone receptor positive, Her2neu 2+ (FISH negative). The abdominal MRI showed a 14×11.8×10.4-cm tumor, which had caused dislocation of the pelvic vessels and infiltrated the left iliac crest. There were no other distant metastases and breast imaging showed no relapse or locoregional disease. Treatment options for the patient were discussed in our interdisciplinary tumor board with gynecologists, general surgeons, medical oncologists, radiation therapists and orthopedic surgeons to tailor the best individual therapy. Operation with extensive surgical tumor debulking would reduce the tumor size but certainly leave tumor tissue in situ. There was also considerable risk that the remaining tumor would grow again while the patient was recovering from surgery. Moreover, the operation might increase morbidity and subsequently reduce quality of life. Thus, the option of choice was palliative chemotherapy to reduce the tumor volume first with the option of subsequent surgery.

Since the patient was pretreated with anthracyclines and taxanes and had not responded, we opted for a non-cross-resistant combination chemotherapy of vinorelbine (25 mg/m² d1+8, q21d) and capecitabine (2,000 mg/m², d1–14, q21d) [2, 3]. After 3 cycles of this combination regimen, the tumor showed clinical and radiological partial response (fig. 3). Therefore, treatment will be continued for at least another 3 cycles. Bis-

phosphonates (Zometa®, Novartis Pharma GmbH, 90429 Nürnberg, Germany, 4 mg, q28) are given in addition to chemotherapy and radiation therapy of the left iliac crest is planned because of suspected infiltration.

Conclusion

This report shows that interdisciplinary cooperation is vital in clinical decision-making in complicated cases such as this to tailor the best individual treatment for each patient.

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