Watchful Waiting: Well Behaved Breast Cancers Non-Surgical Management of Breast Cancer

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Case 1

In December 2007, a 71 year old female with no family history of breast cancer had a screening mammogram showing a new subcentimeter mass along the 3 o’clock axis of the left breast, posterior depth. Follow up ultrasound in February of 2008 showed an 8 mm solid mass at 3 o’clock, 9 cm from the nipple, which correlated with the mammographic mass. Ultrasound of the axilla was unremarkable. Biopsy of the mass showed: moderately differentiated invasive ductal carcinoma, grade 2, ER+ (90%), PR+ (50%), her2neu- (1+), Ki-67 10% (low proliferative rate). The patient was referred to surgical oncology, radiation oncology, and medical oncology for consultation; however, she declined any surgical intervention or radiation therapy. Furthermore, the patient stated that she was only willing to take oral therapy, so aromatase inhibitors were thoroughly discussed with the patient including the side effects of osteoporosis. The patient and her daughter voiced understanding and she started Arimidex therapy 1 mg daily in May of 2008.

On initial physical exam no dominant breast mass was palpated and the axillary exam was unremarkable. The 2007 screening mammogram showed (Figures 1-3) a new lobular mass in the along the 3 o’clock axis of the left breast, posterior depth. No additional imaging or intervention was performed and a period of healing was advised given her recent history of multiple right breast interventions.

Although the patient declined surgical intervention and radiation therapy, she agreed to annual surveillance mammography to evaluate for tumor progression. Follow up mammograms from 2010-2015 show no mammographic evidence of tumor growth (circled) and the axilla appears stable (Figure 4).

Case 2

A 92 year old G4, P1, A0 female with prior history of left intraductal papilloma and atypical ductal hyperplasia diagnosed in 2002, however excision was not performed due to patient’s comorbidities including CHF, hypertension, atrial fibrillation and coronary artery disease. Other relevant past medical history includes cervical cancer status post hysterectomy (no other therapy per patient), stage I vulvar carcinoma status post local excision, and stage T3, N, and M0 colon adenocarcinoma s/p hemicolecystomy.

Received: December 18, 2015; Accepted: December 28, 2015; Published: January 04, 2016
In August of 2009, the patient presented to an outside facility with a chief complaint of a left breast mass. Mammogram was negative for malignancy, but survey ultrasound demonstrated a 2.1 x 1.1 x 2.1 cm mass at 10 o’clock, 9 cm from the nipple. Core biopsy of the 10 o’clock mass revealed IDC, intermediate grade, ER/PR positive, HER-2/neu negative.

Given the patient’s co-morbidities, the patient was given the choice of (a). Surgical management (total mastectomy), (b). Oral therapy with Arimidex and close imaging follow up, (c) or no intervention. After extensive risk/benefit discussions, the decision was made to proceed with oral daily Arimidex for 3 months with reassessment via ultrasound.

Initial mammogram and ultrasound from August 2009 was not available, however, the follow up ultrasound from the 3 month follow up in November 2009 reveals a 0.6 x 0.5 x 0.5 cm mass at 10 o’clock, 9 cm from the nipple. This has significantly decreased in size from comparison survey ultrasound in August of 2009 (the reported size in August 2009 was 2.1 x 1.1 x 2.1 cm) (Figures 5 and 6).

November 2009 ultrasound images show biopsy proven IDC at 10 o’clock, 9 cm from the nipple; correlating with mammographic findings (Figures 7 and 8). The mass measures 0.6 x 0.5 x 0.5 cm and a post biopsy clip are noted within the mass.

Figure 9 (February 2010) US show that the mass has decreased in size and measures 0.4 x 0.3 x 0.5 cm. Figure 10 (December 2010) shows that the mass is no longer visible by US.

Patient continued annual US surveillance at our institution until September of 2015 at which time she completed 5 years of her oral Arimidex therapy. No recurrence of cancer was noted at this time. Only the clip (arrow) is identified is on the most recent 2015 left breast US, adjacent to the dystrophic calcification (star) (Figure 11).
Left MLO. Show the wing clip at the site of the biopsy proven invasive ductal cancer (IDC). Mammogram and Ultrasound from November 2009.

Figure 5

November 2009 Left Breast US.

Figure 6

Left CC. Show the wing clip at the site of the biopsy proven invasive ductal cancer (IDC). Mammogram and Ultrasound from November 2009.

Figure 7

November 2009 Left Breast US.

Figure 8

November 2009 Left Breast US.

Figure 9

February 2010 Left Breast US.

Figure 10

December 2010 Left Breast US.
Discussion

Breast cancer therapy has evolved very quickly over the past decade. We have approached the cancer with more less invasive treatments. The standard of for now is to remove breast cancer with breast conserving surgery when appropriate and then radiate the capsule for small tumors. We consider chemotherapy if the tumor is above one centimeter. We then follow up with 5 to 10 years of hormonal therapy. In post menopausal women greater efficacy has been shown with Aromatase inhibitors [1-8].

These patients have chosen a non standard approach and have lived a normal life for the last seven without many side effects. We use hormonal therapy alone in a great deal of metastatic breast cancer cases with great efficacy. These cases show us that we may be able to spare some elderly postmenopausal women with small tumors surgery, radiation and chemotherapy. The tumor profiles for these cases are perfect for this treatment with it having low Ki-67 and high ER percentage. When we put their profile in Adjuvant on line her score was favorable for hormonal therapy [7].

This not standard of care but may be a good choice for elderly post-menopausal women with significant co morbidities or who choose not to have aggressive intervention. In these cases the patients choose not to have surgery, but have been a very compliant patient before the diagnosis of cancer and have been very compliant since. In our present medical model patient want to play a part in determining what therapies are best for them. In some cases we have many choices [9]. Sometimes patients will make choices when there is not much evidence to support their choice and we usually advise against such choices. In these cases the patients have made the right choices.
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