



Clube da  
**Mama**

R2 Mastologia HC-UFG  
Ana Paula Bastos de Carvalho

Orientação:

Dr Ruffo Freitas-Junior  
Dra Rosemar Macedo Sousa Rahal



# Caso Clínico

- Identificação:
  - B. D. A., 38 anos, estudante, natural e procedente de Goiânia- GO.
- 1ª consulta em 14/03/2019
  - Queixa Principal: Nódulo palpável em mama esquerda
  - HDA: Paciente informava nódulo palpável em mama esquerda, havia realizado investigação prévia com core biopsy que diagnosticou câncer de mama.

# Caso Clínico

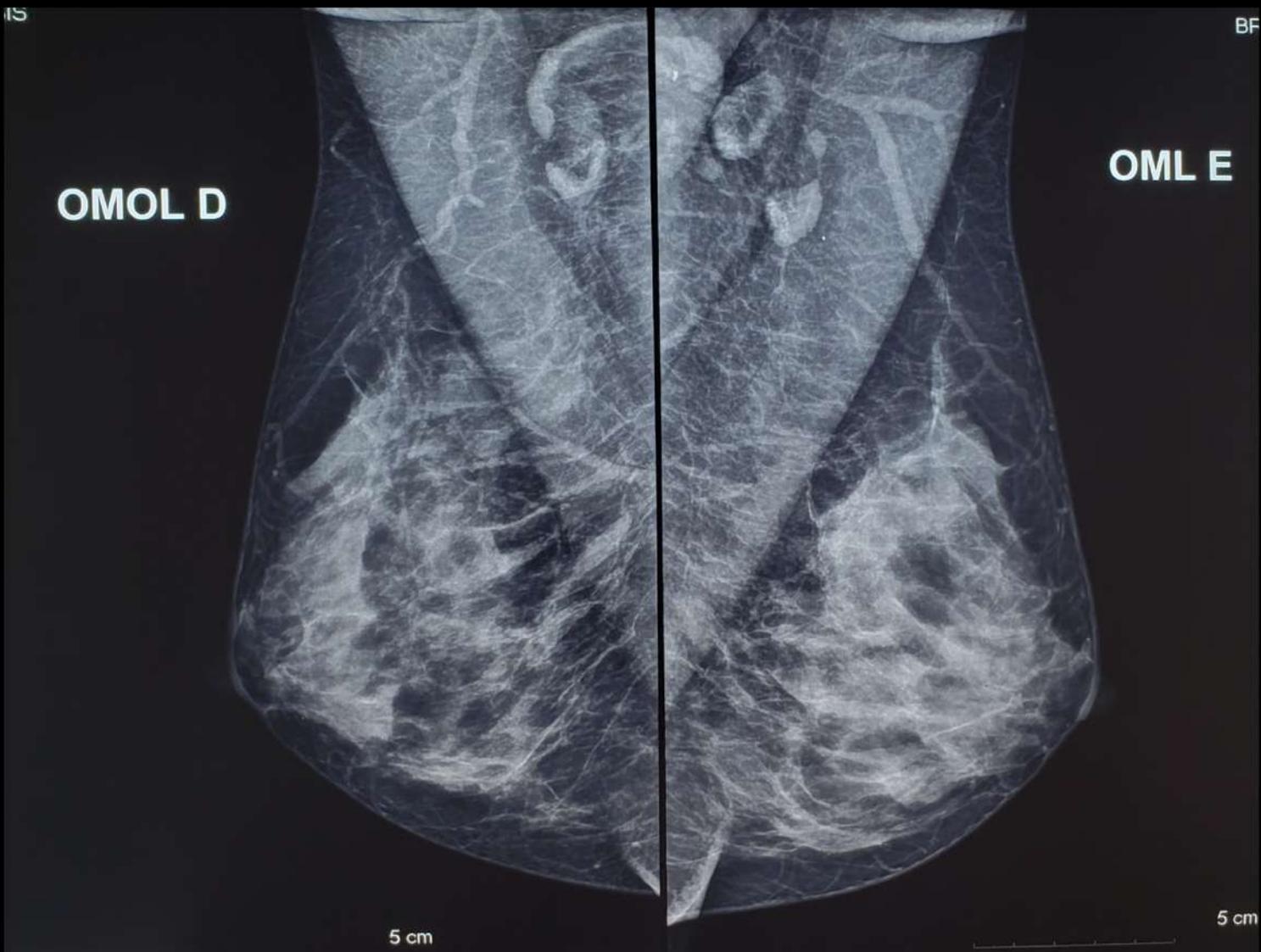
- História Médica Pgressa:
  - Sem comorbidades
  - Negava medicações de uso contínuo
  - Tabagista ativa por 18 anos, havia cessado há 2 semanas
- História Ginecológica
  - Menarca: 14 anos
  - G2C1A1
  - 1º filho aos 24 anos
  - Amamentação 9 meses
  - Ciclos menstruais regulares
  - Fez uso de ACO por 20 anos
- História Familiar
  - Negava HF + para CA de mama
  - Negava HF+ para outras neoplasias

# Caso Clínico

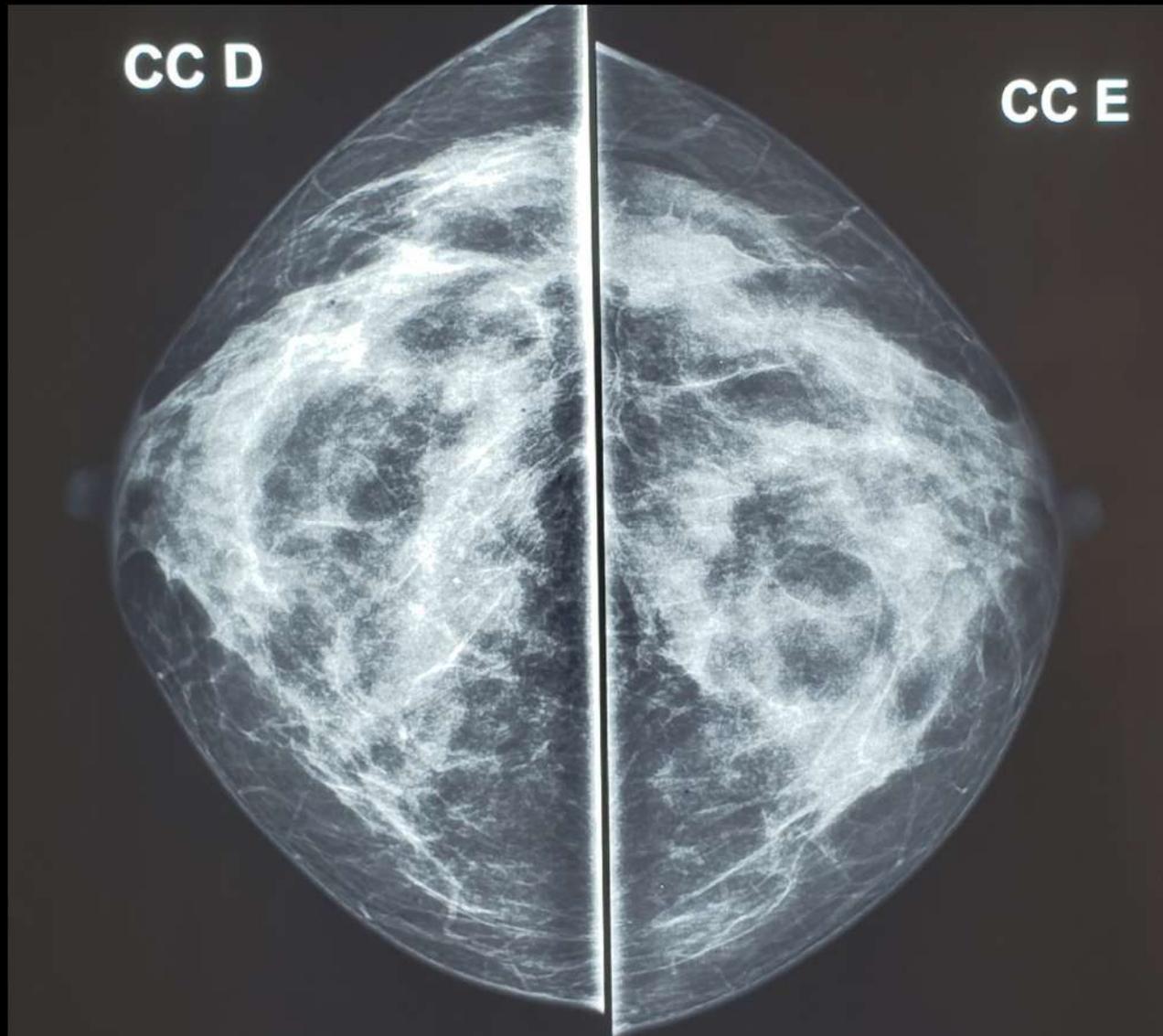


- Paciente em bom estado geral, lúcida e orientada, corada, hidratada, eupneica em AA, afebril. PSO
  - FSC livres
  - Mama direita: sem alterações
  - Mama esquerda: Presença de nódulo palpável em QSL/PA mama E, endurecido, móvel, limites mal definidos, superfície irregular, medindo 3,5 x 3cm.
  - Axila esquerda: adenomegalia axilar única, móvel, indolor – reacional? MTx?
  - Axila direita livre

# Mamografia 22/01/2019



# Mamografia 22/01/2019



# US de mamas 07/02/2019

**Mama direita:** Pequenos e esparsos cistos simples, o maior no QSL medindo 0,5cm.

**Mama esquerda:** Imagem nodular hipoecogênica e heterogênea, ovalada, orientação paralela a pele, sem fenômeno posterior, margens não circunscritas, localizada no QSL e medindo 3,4 x 2,8 x 1,3cm, dista 0,6cm da pele e cerca de 5cm do mamilo.

Cistos simples esparsos.



# Caso Clínico

- Estadiamiento clínico

**cT2N1(?)Mx**

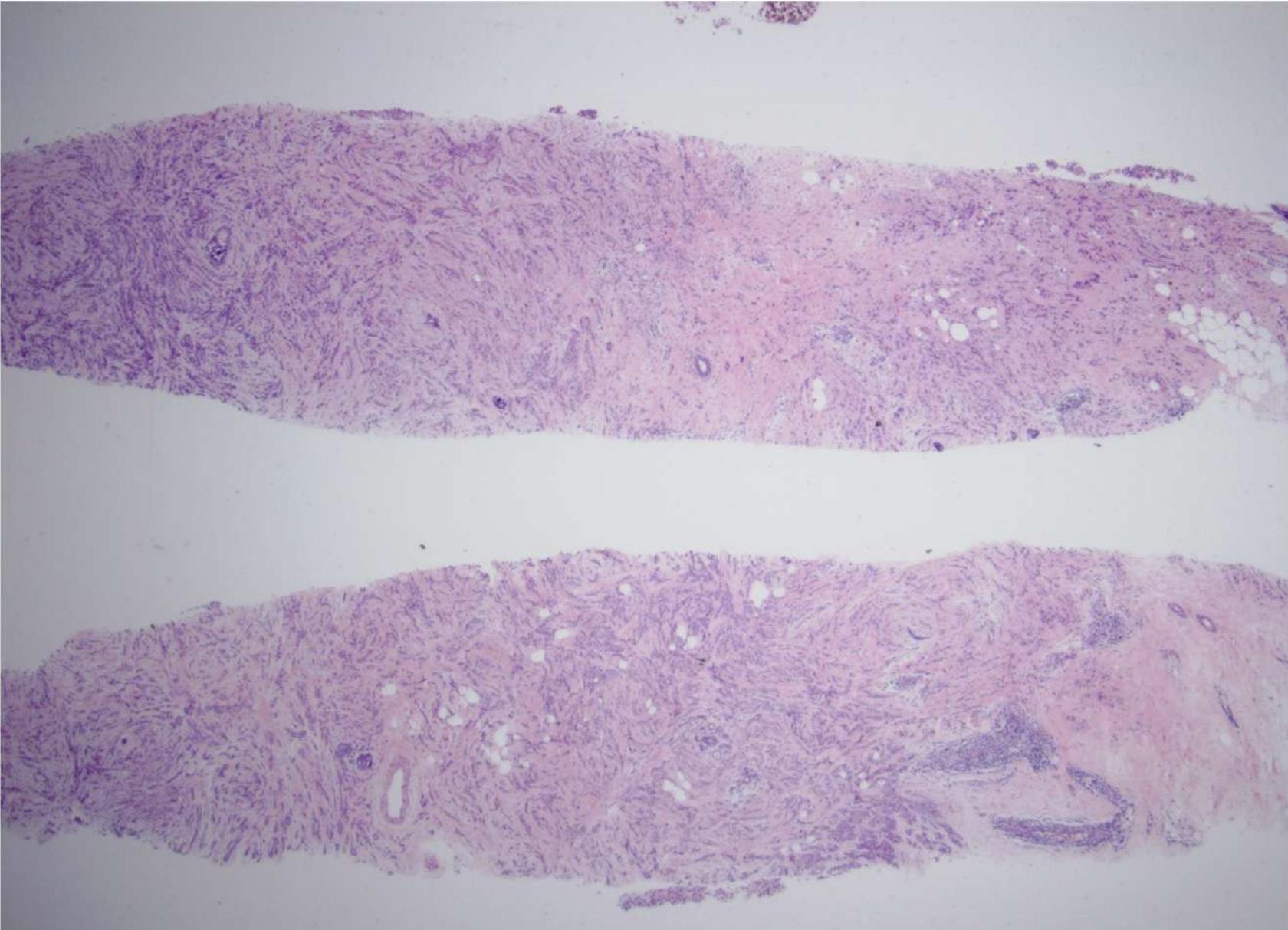
# Caso Clínico

- AP mama esquerda, Laboratório Padrão:
  - Carcinoma mamário infiltrante, com áreas sólidas, cordonais e com arranjos ductulares. Grau 2 (3;2;2)
- Imunohistoquímica INGOH:
  - Receptor de estrogênio: >90%
  - Receptor progesterona: 60%
  - HER2: negativo
  - Ki67: 20%

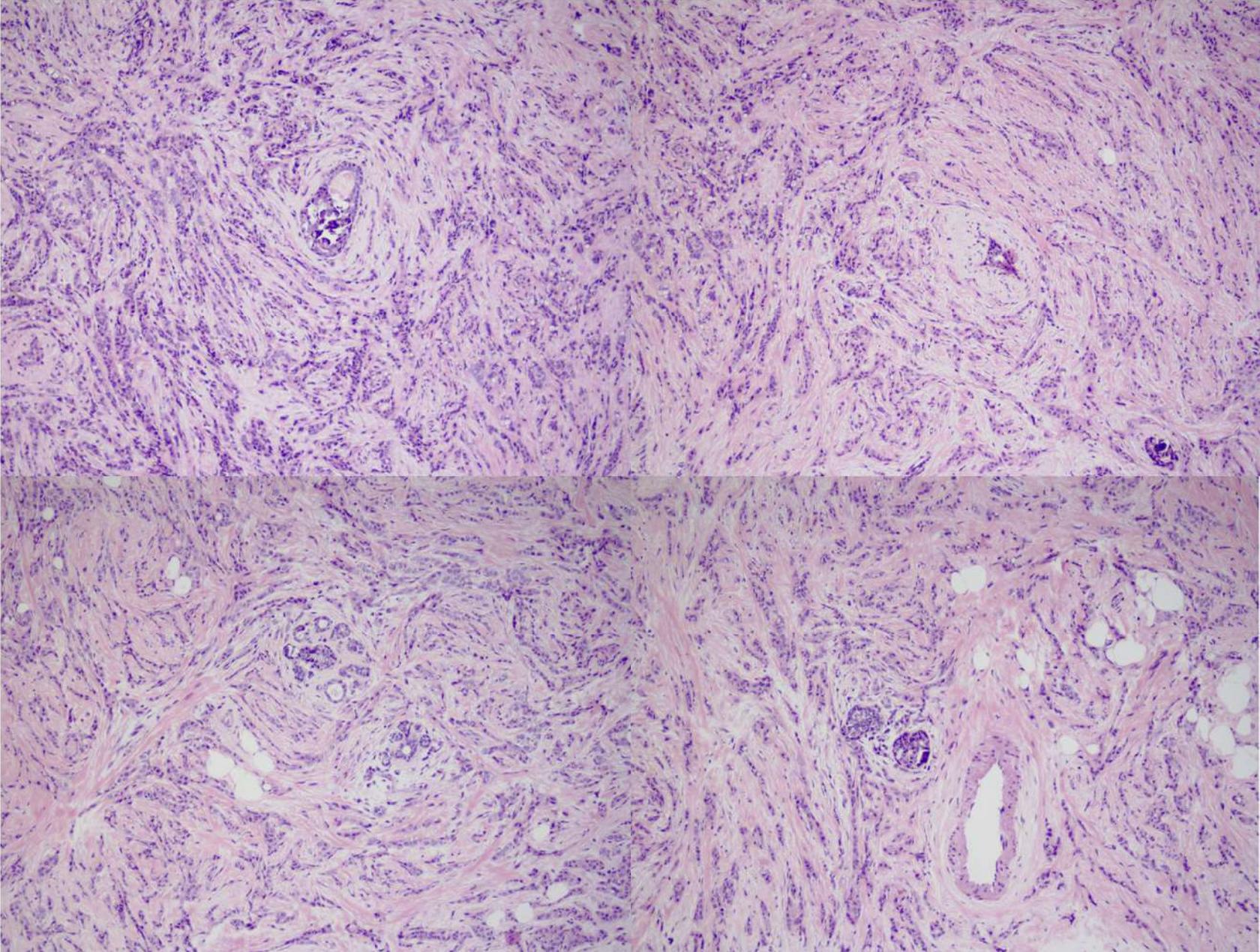
# Caso Clínico

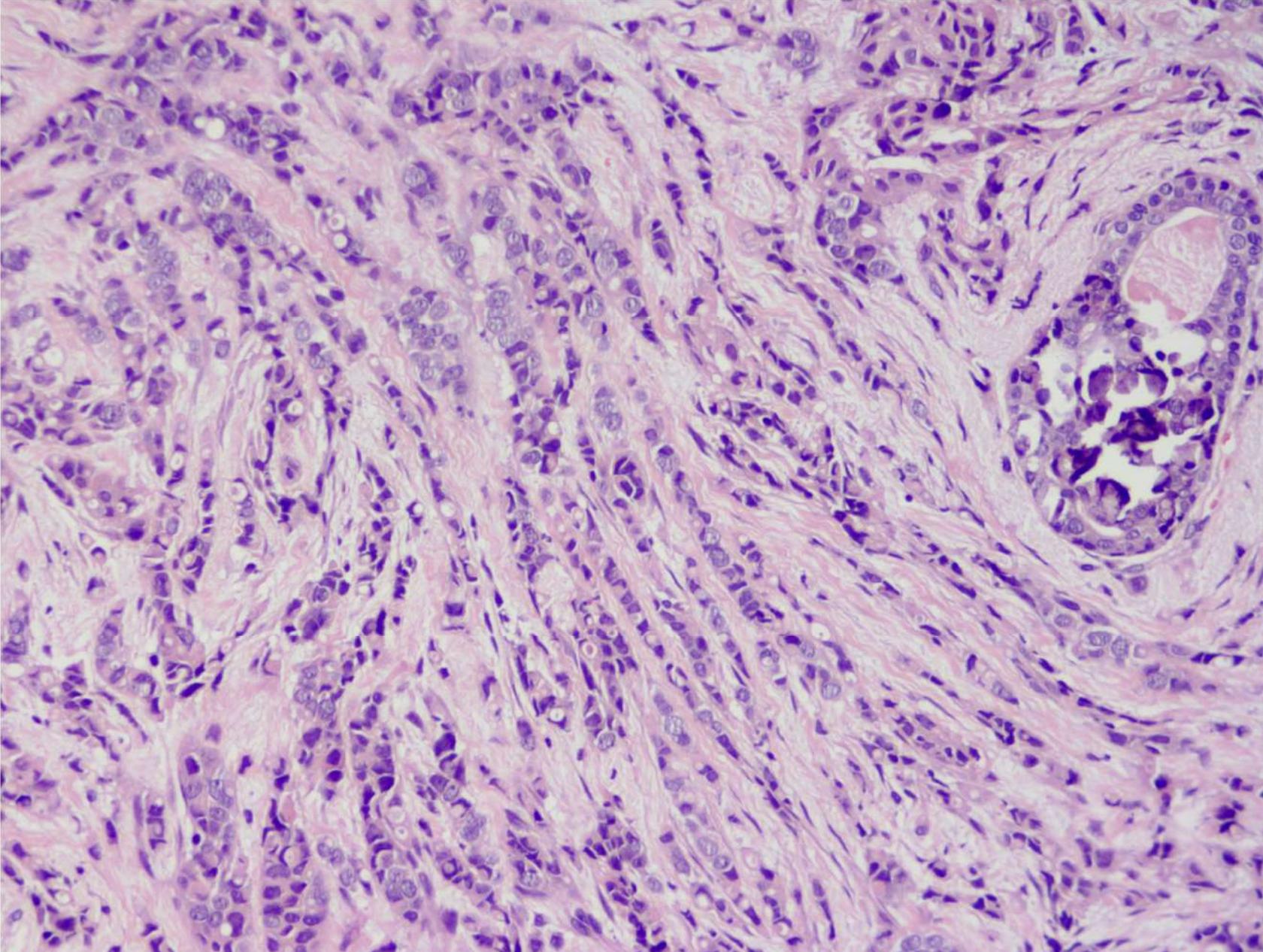
- Revisão de Lâminas – HC UFG
- AP nº 38/2018:
  - Carcinoma mamário invasor, SOE. Grau 2 (2;3;2)
- Imunohistoquímica:
  - Receptor de estrogênio: >90%
  - Receptor progesterona: 60%
  - HER2: negativo
  - Ki67: 10%

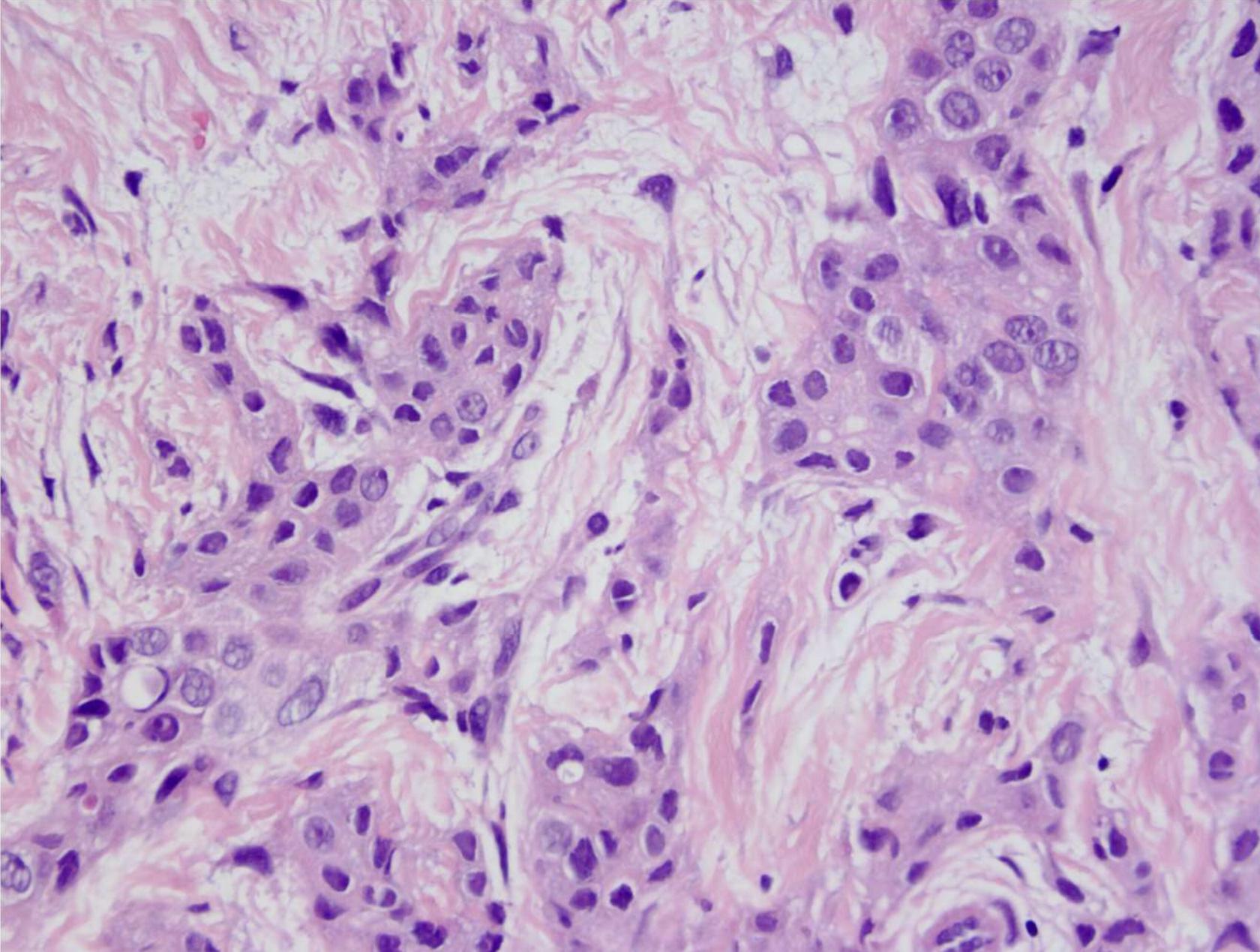
Lâminas do anatomopatológico - biópsia

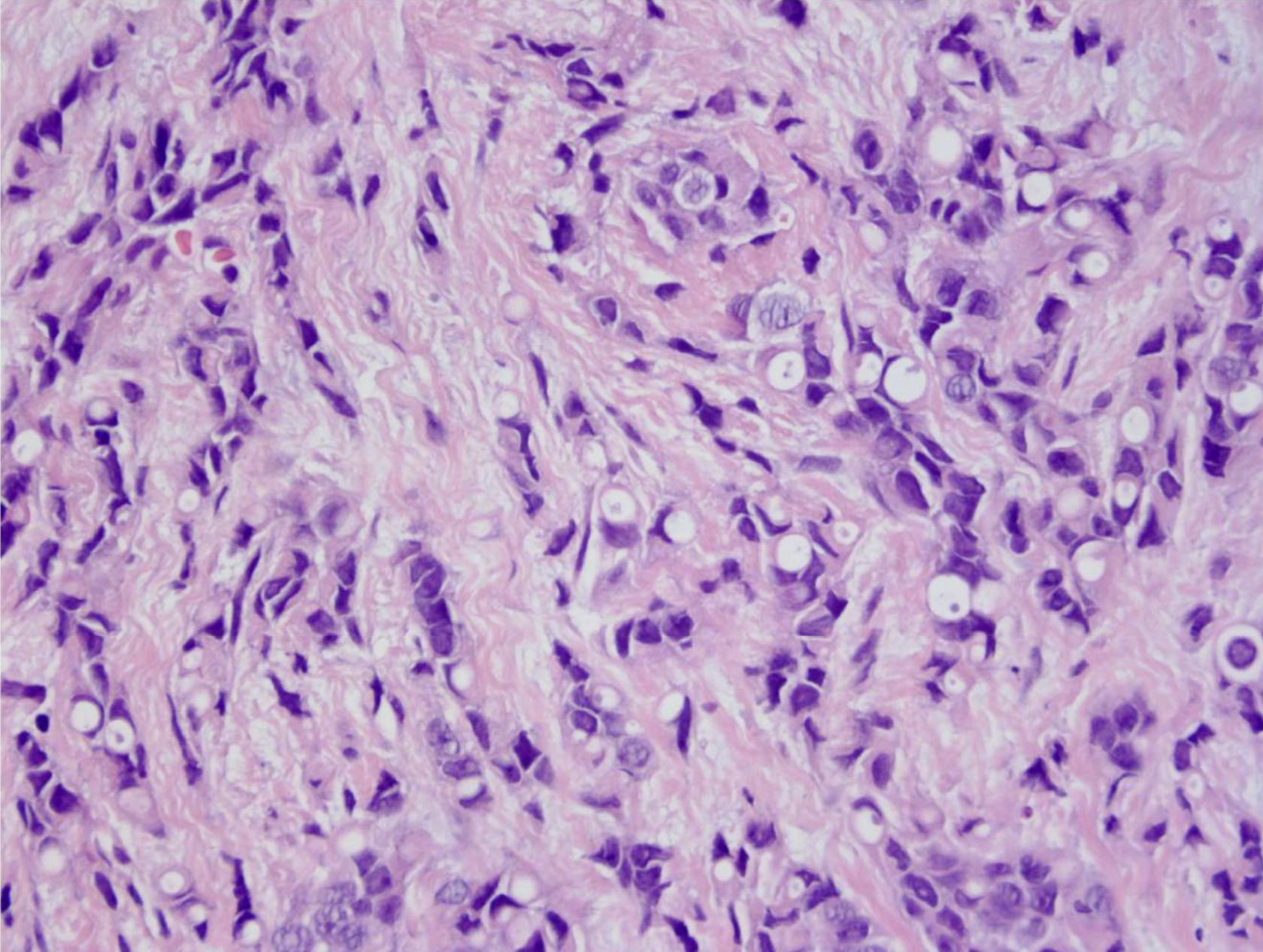


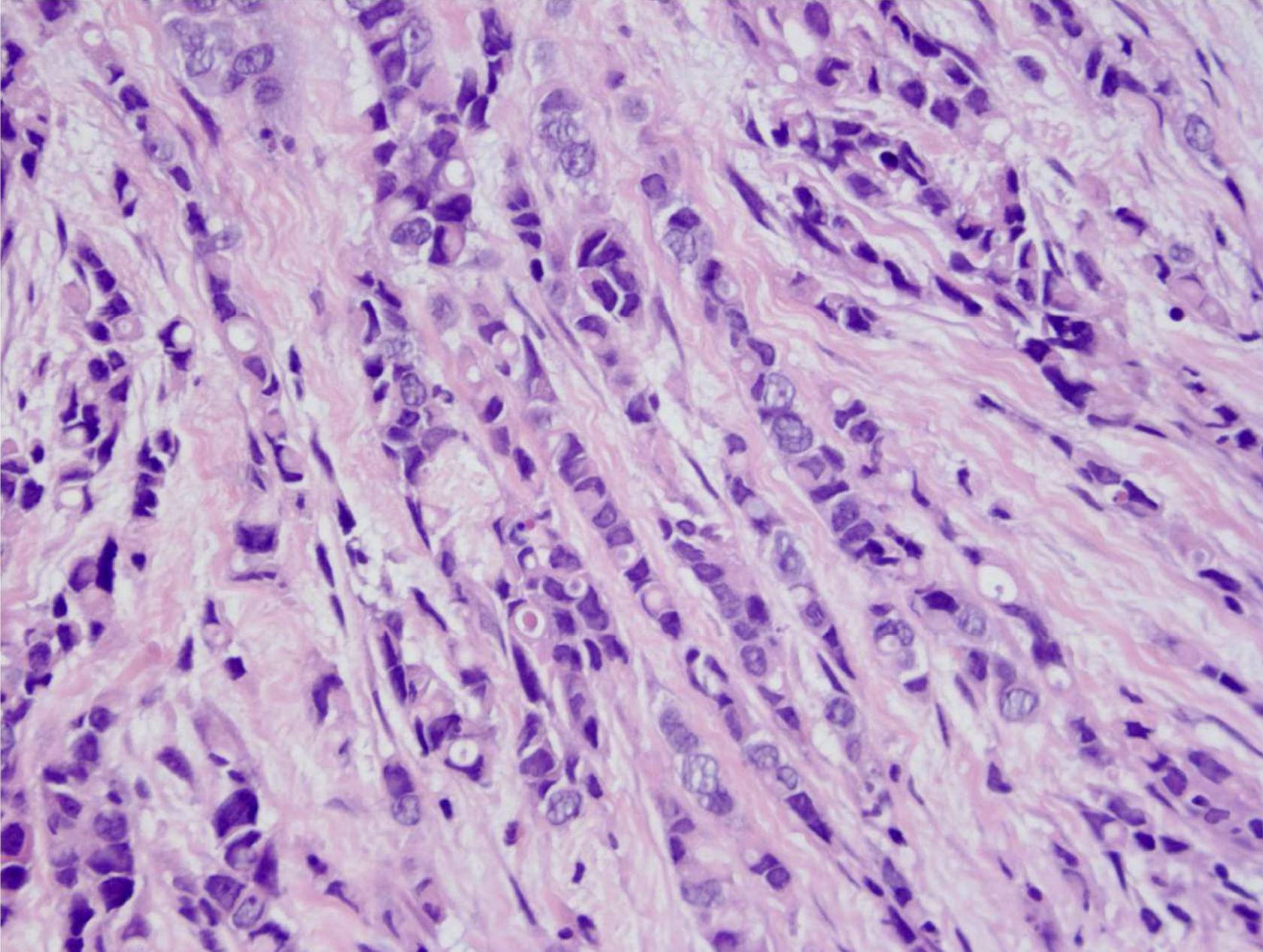
481892-00. BDA, 39 anos, core biopsy de ME (RL-HC: 38/2018).

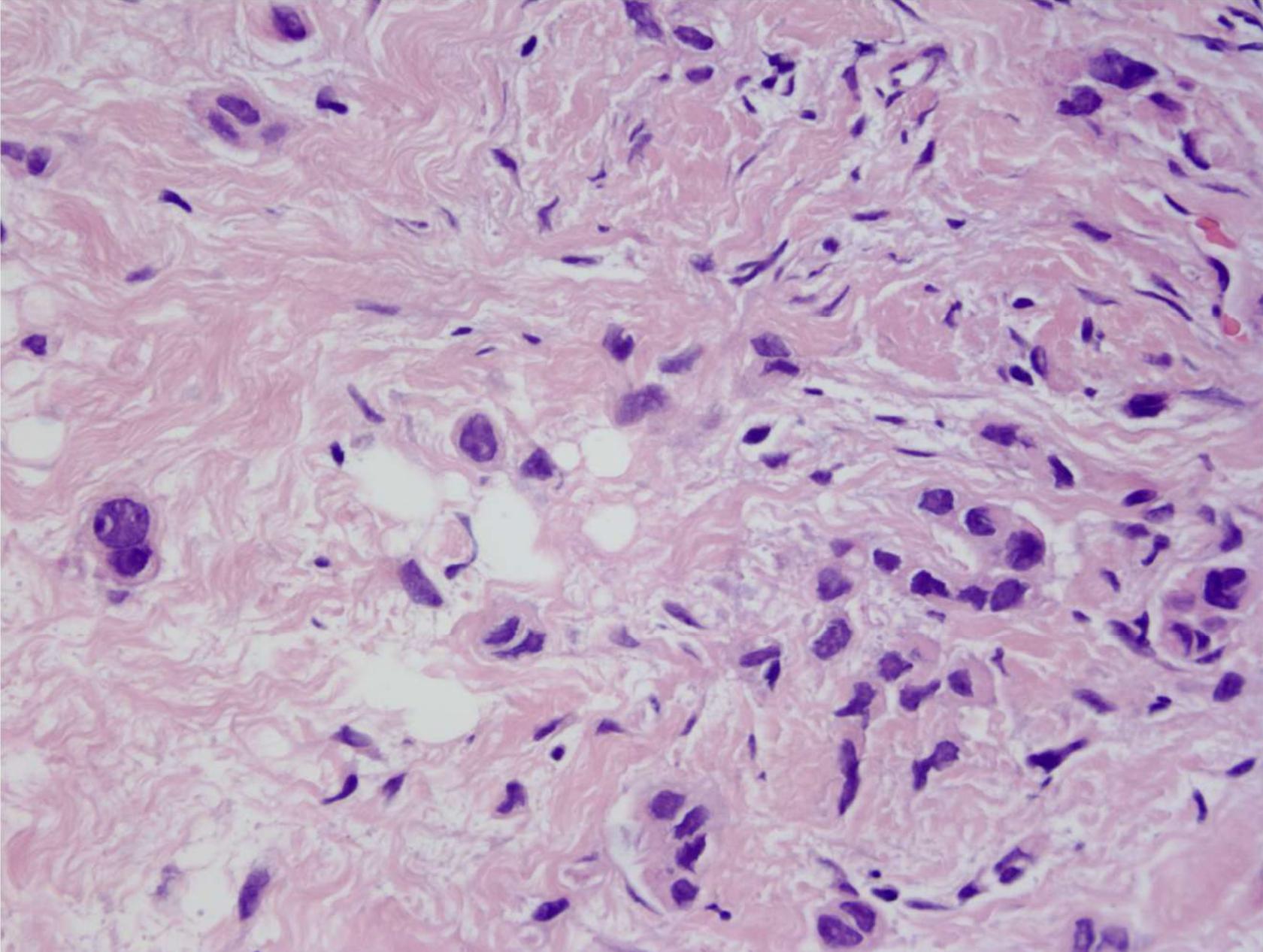


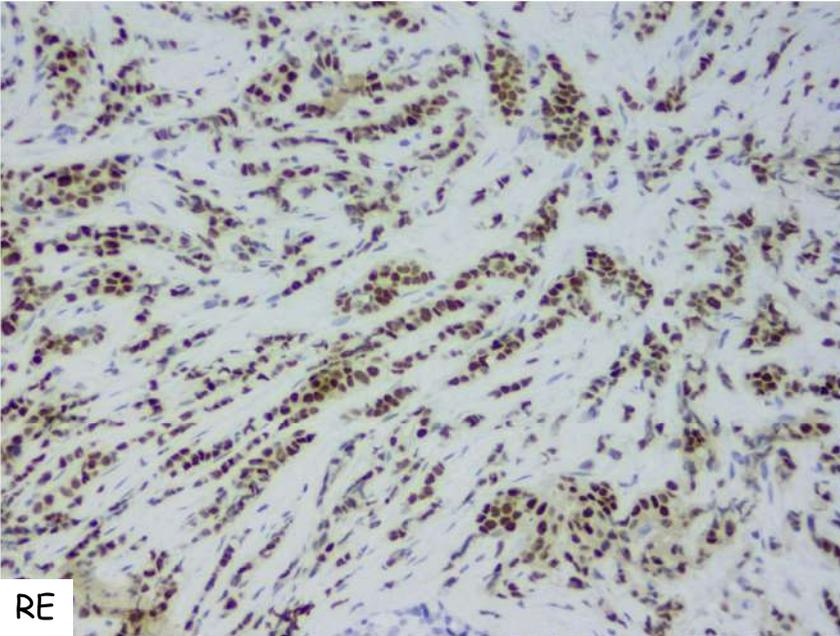




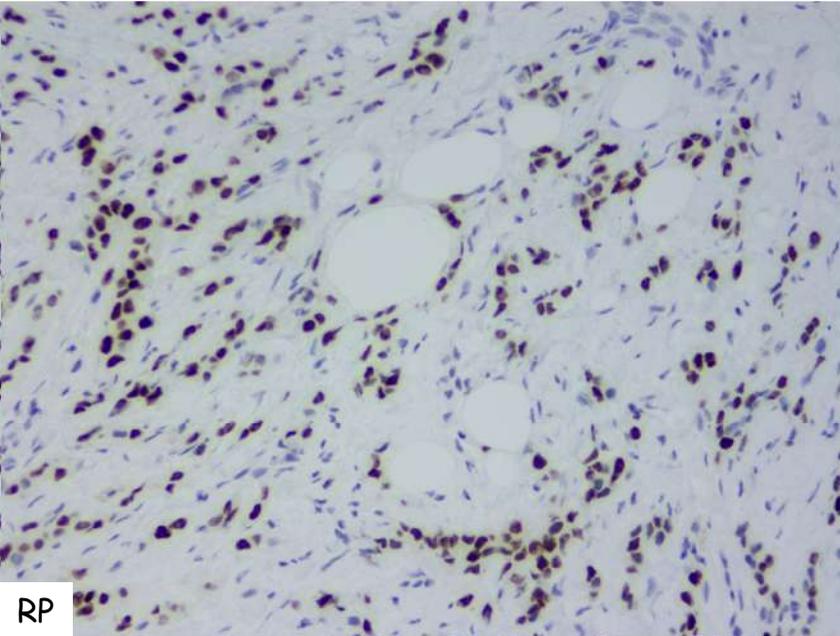




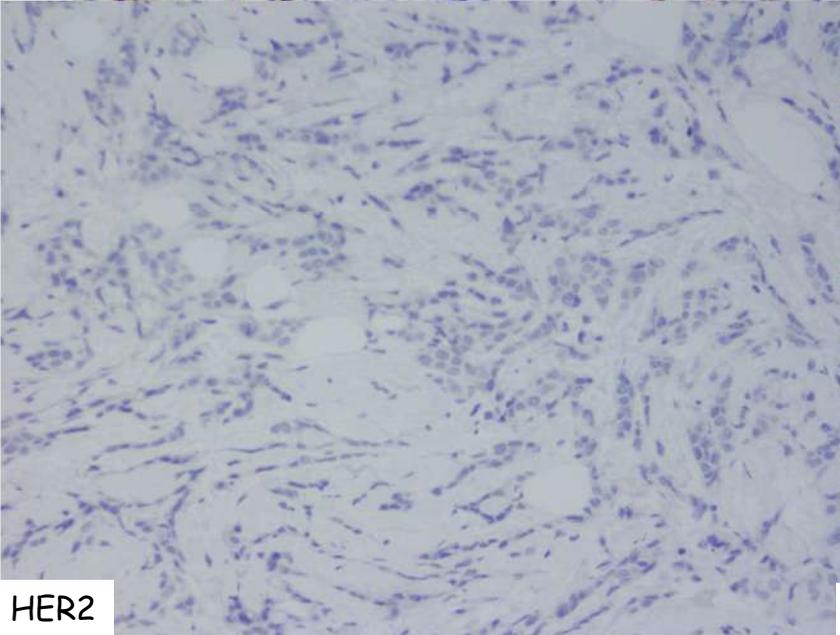




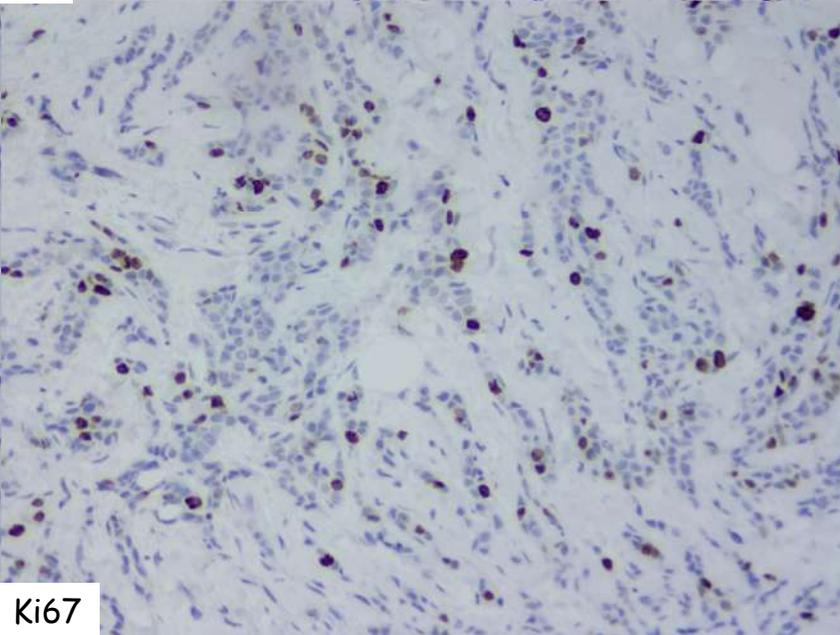
RE



RP

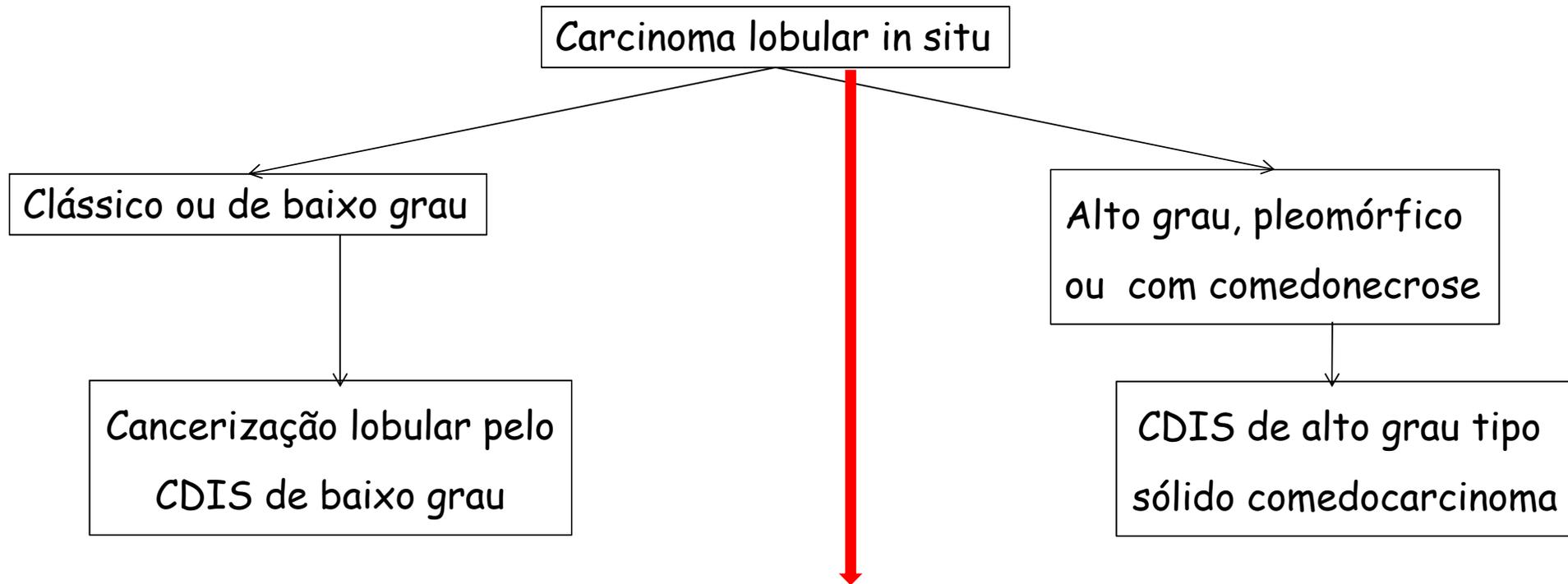


HER2



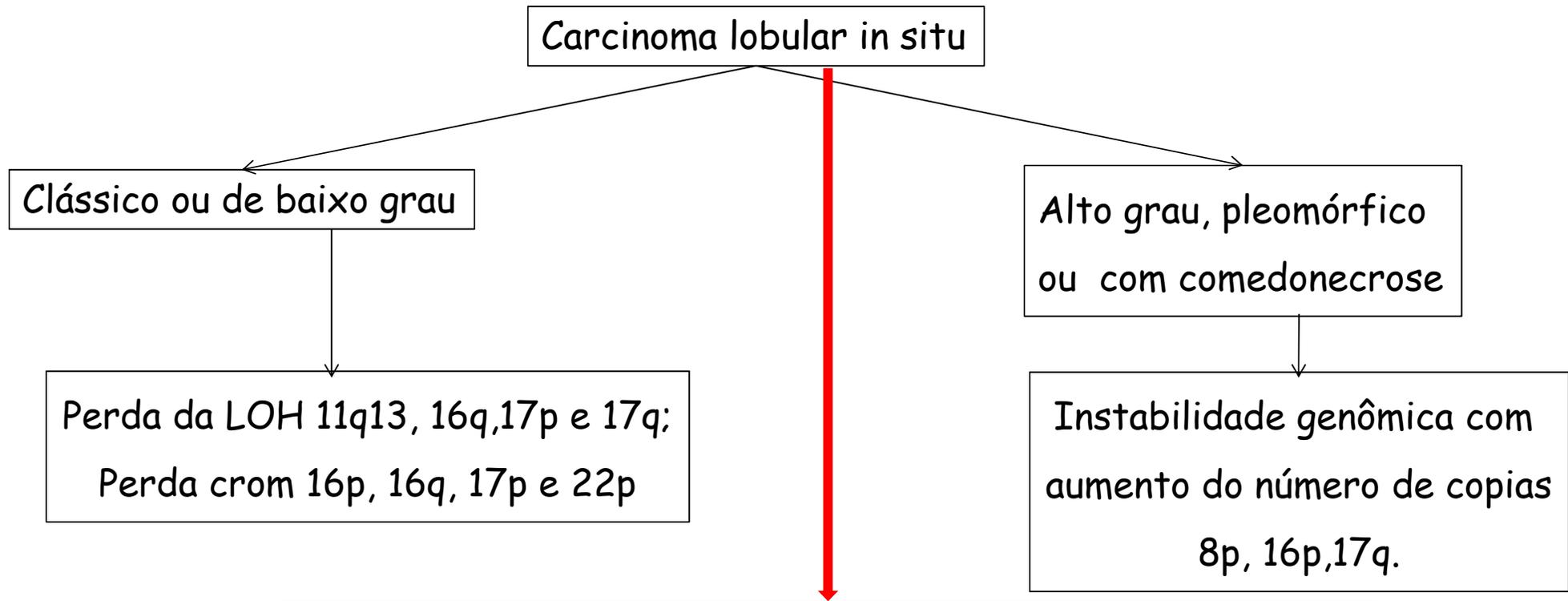
Ki67

## Lesões lobulares da mama: diagnósticos diferenciais



Associada a adenose esclerosante:  
diagnóstico diferencial é com carcinoma  
invasor; usar marcadores (p63, CK14, calpon)  
basais. Eventualmente chamar de carcinoma misto

## Lesões lobulares da mama: padrões genéticos



Proliferações neoplásicas monoclonais precursoras do carcinoma lobular invasor.

As alterações genéticas também são encontradas nas lesões invasoras.

## Carcinoma lobular invasor

- Definição:

- É uma neoplasia epitelial invasiva de células descoesas, isoladas, dispostas em fila indiana em meio a estroma desmoplásico. Usualmente esta associado com o carcinoma lobular *in situ*.

- Generalidades:

- Descrito em 1865 por Cornil A., neoplasia de células pequenas redondas difusamente infiltrante;
- Foote e Stewart em 1945 reconheceram o como CLI;
- Foi referido por longo tempo como carcinoma cirroso da mama;

- Epidemiologia:

- Representa de 5 - 15% de todos carcinomas mamários invasores;
- Desde 1980 houve aumento de incidência em relação aos tipo NST;
- Terapia de reposição hormonal e o aumento do consumo de álcool;
- Pico de incidência entre 57 - 65 anos de idade.

## Carcinoma lobular invasor

### ○ Padrões histológicos:

#### • OMS em 2012:

- 1 - Clássico;
- 2 - Pleomórfico;
- 3 - Alveolar;
- 4 - Sólido;
- 5 - Tubulolobular;
- 6 - Misto.

#### • Alguns autores referem:

- a - Células em anel de sinete;
- b - Histiocitóide;
- c - Apócrino.

Não há interferência no prognóstico, pois todas estas variantes são de alto grau, equivalente ao grau III.

- Tipo misto do CLI: corresponde ao tipo clássico associado as outras variantes;
- CLI tipo clássico + o tipo misto correspondem a 75% do CLI;
- Apenas 25% dos casos são do tipo variantes especiais puras;
- Todos os tipos podem ser multifocais e ou bilaterais.



# Lesões lobulares da mama

## 1.B - Carcinoma lobular *in situ*.

### ○ Generalidades:

- Conceito morfológico: quando mais metade do ácino da unidade ductolobular encontra-se comprometido pela proliferação de células atípicas, monomórficas, descoesas, produzindo a dilatação e deformação estrutura acinar.

Podem estar presentes células vacuoladas, ou células em anel de sinete e células apócrinas.

Pode apresenta crescimento pagetóide para os ductos terminais (Cloverleaf-like).

- Padrões morfológicos: clássico, pleomórfico e com comedonecrose;
- Padrões imuno-histoquímicos:
  - CLIS Clássico: RE e RP positivos em mais de 90% dos casos, HER-2 quase sempre negativo, E-Caderina negativa e proteína p120 positiva;
  - CLIS Pleomórfico e com comedonecrose: HER, p53 e E-Caderina positivos; Ki67 variável, RE, RP e p120 negativos. Ceratinas de alto peso - positivas.

# Cytokeratin Immunoreactivity in Lobular Intraepithelial Neoplasia<sup>1</sup>

Gary L. Bratthauer, Markku Miettinen, and Fattaneh A. Tavassoli<sup>2</sup>

Departments of Gynecologic and Breast Pathology (GLB), and Soft Tissue Pathology (MM), Armed Forces Institute of Pathology, Washington, DC

**Table 1** Monoclonal antibodies used: dilutions, pretreatments, and sources

Clone	Keratin	DIL	Pretreat	Source
34 $\beta$ E12	1,5,10,14	1:40	Reveal	DAKO (Carpinteria, CA)
34 $\beta$ B4	1	1:20	Reveal	Vector Labs (Burlingame, CA)
Ks 2.342.7.1	2e	1:20	Reveal	Maine Biotech (Portland, ME)
6B10	4	1:20	Reveal	Vector (Novocastra)
XM26	5	1:40	Reveal	Vector (Novocastra)
LHK6B	6	1:20	Trilogy	Vector (Novocastra)
OV-TL-12/30	7	1:80	Enzyme	DAKO
K8.8	8	1:80	Reveal	Lab Vision (Fremont, CA)
Ks 9.7/Ks 9.16	9	1:10	Reveal	Maine Biotech
DE-K10	10	1:20	Reveal	DAKO
KS-1A3	13	1:40	Reveal	Vector (Novocastra)
LL002	14	1:20	Reveal	Vector (Novocastra)
LHK15	15	1:20	Reveal	Vector (Novocastra)
LL025	16	1:20	Trilogy	Vector (Novocastra)
E3	17	1:10	Reveal	Lab Vision (Neomarkers)
DC 10	18	1:40	Reveal	DAKO
RCK108	19	1:40	Reveal	DAKO
IT-Ks 20.8	20	1:40	Enzyme	DAKO

**Table 2** Results of keratin clone applications to the cells of LIN, DIN, and normal TDLU<sup>a</sup>

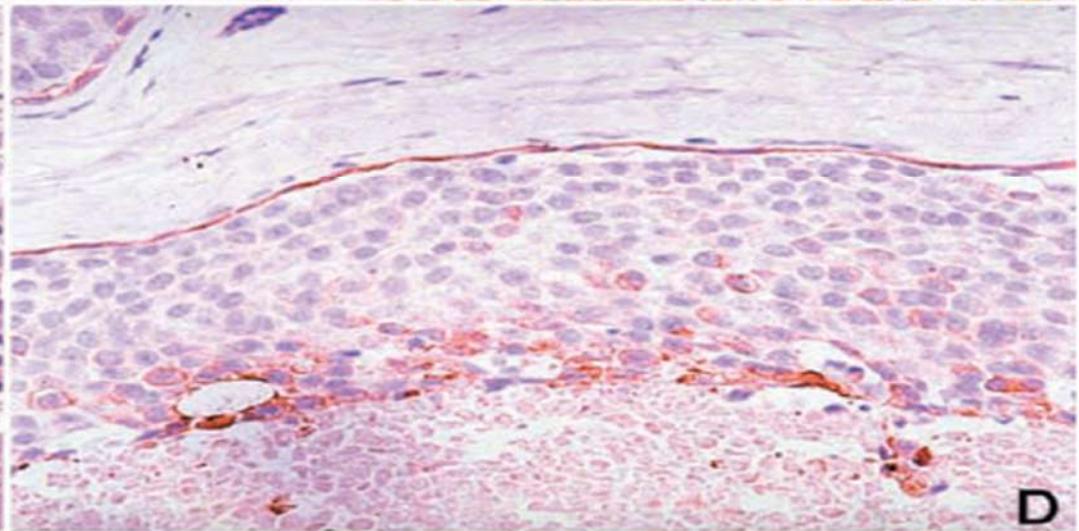
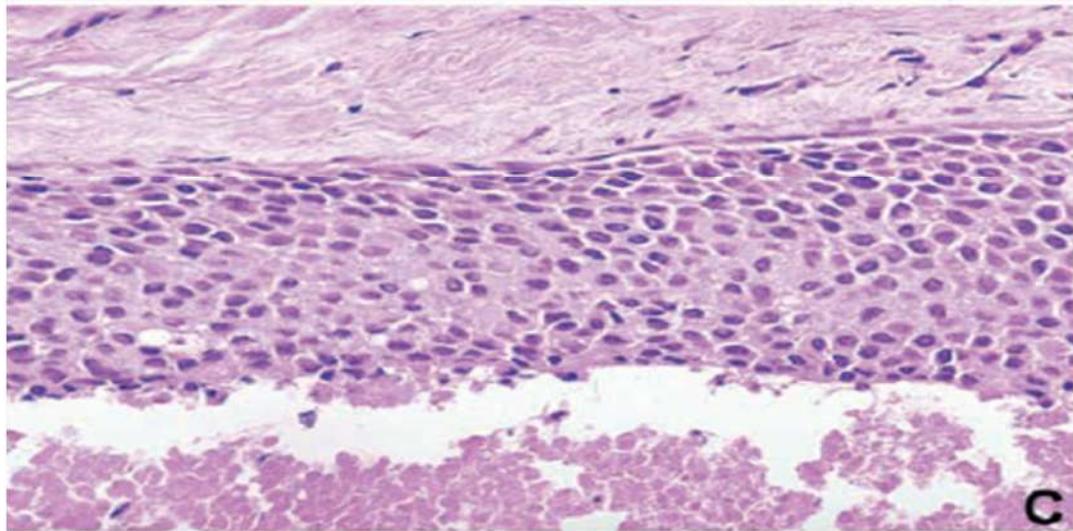
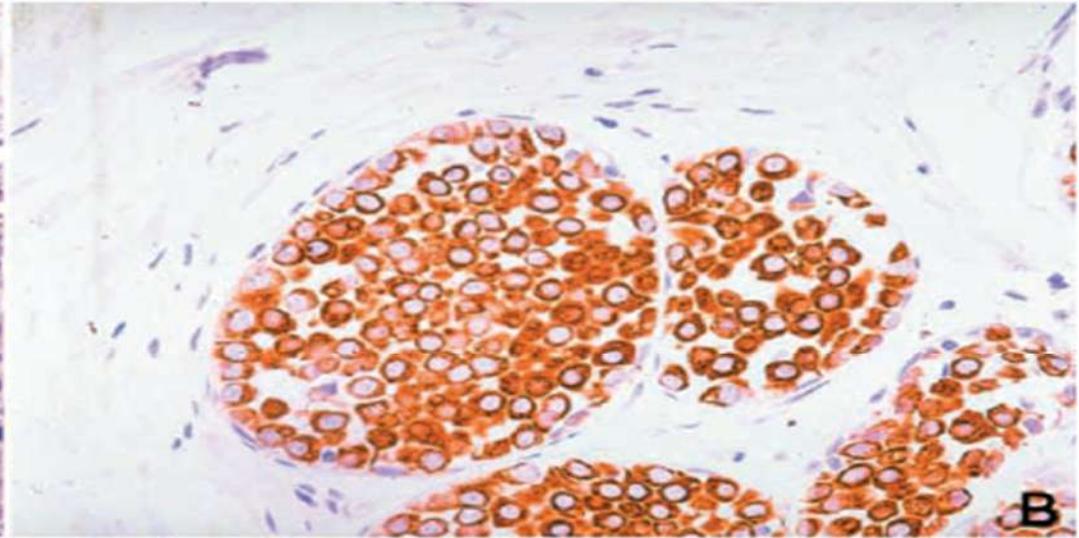
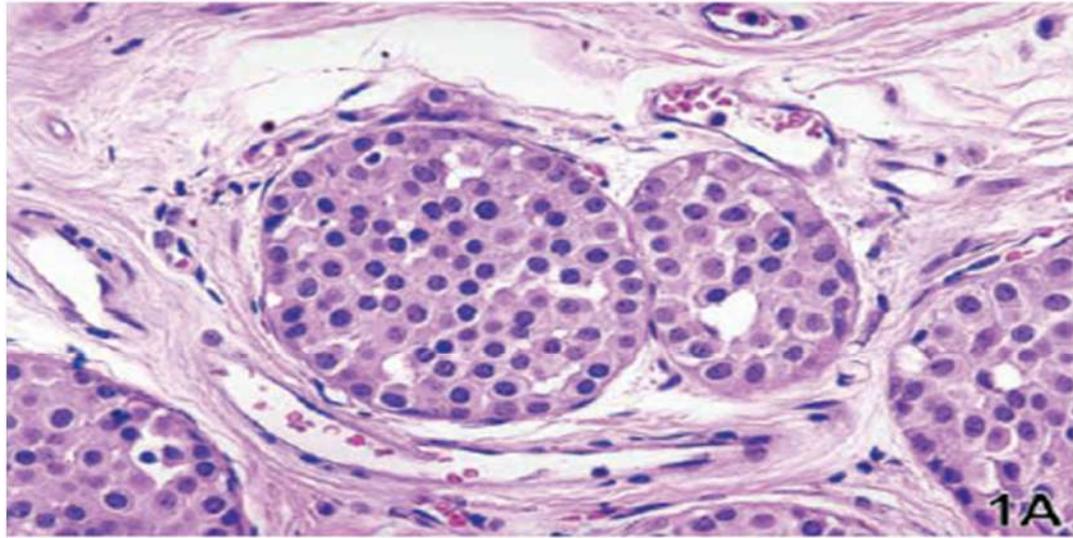
Keratin	LIN	DIN	TDLU LUM <sup>b</sup>	TDLU MYO <sup>c</sup>
(34 $\beta$ E12)	+	-	+	+
1	-	-	-	-
2(e)	-	-	-	-
4	+ -	+ -	+	-
5	-	-	+	+
6	-	-	-	-
7	+	+	+	+
8	+	+	+	-
9	-	-	-	-
10	-	-	-	-
13	-	-	-	-
14	-	-	+ -	+
15	-	-	+	-
16	-	-	-	-
17	-	-	+ -	+ -
18	+	+	+	-
19	+	+ -	+	-
20	-	-	-	-

<sup>a</sup>LIN, lobular intraepithelial neoplasia; DIN, ductal intraepithelial neoplasia; TDLU, terminal duct lobular unit.

<sup>b</sup>Luminal epithelial cells.

<sup>c</sup>Myoepithelial cells.

CLIS x CDIS - 34 $\beta$ E12 ( CK 4,7,8,18 e 19)



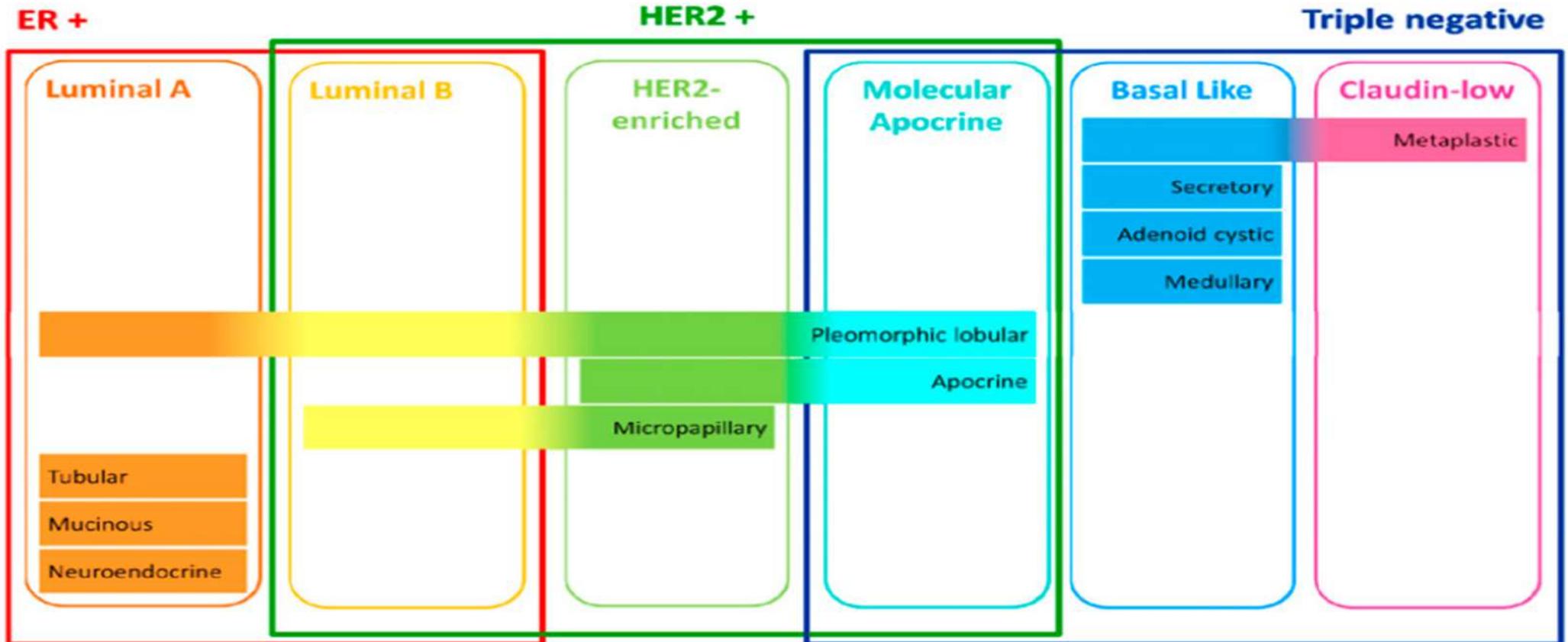
## Rare Breast Cancer Subtypes: Histological, Molecular, and Clinical Peculiarities

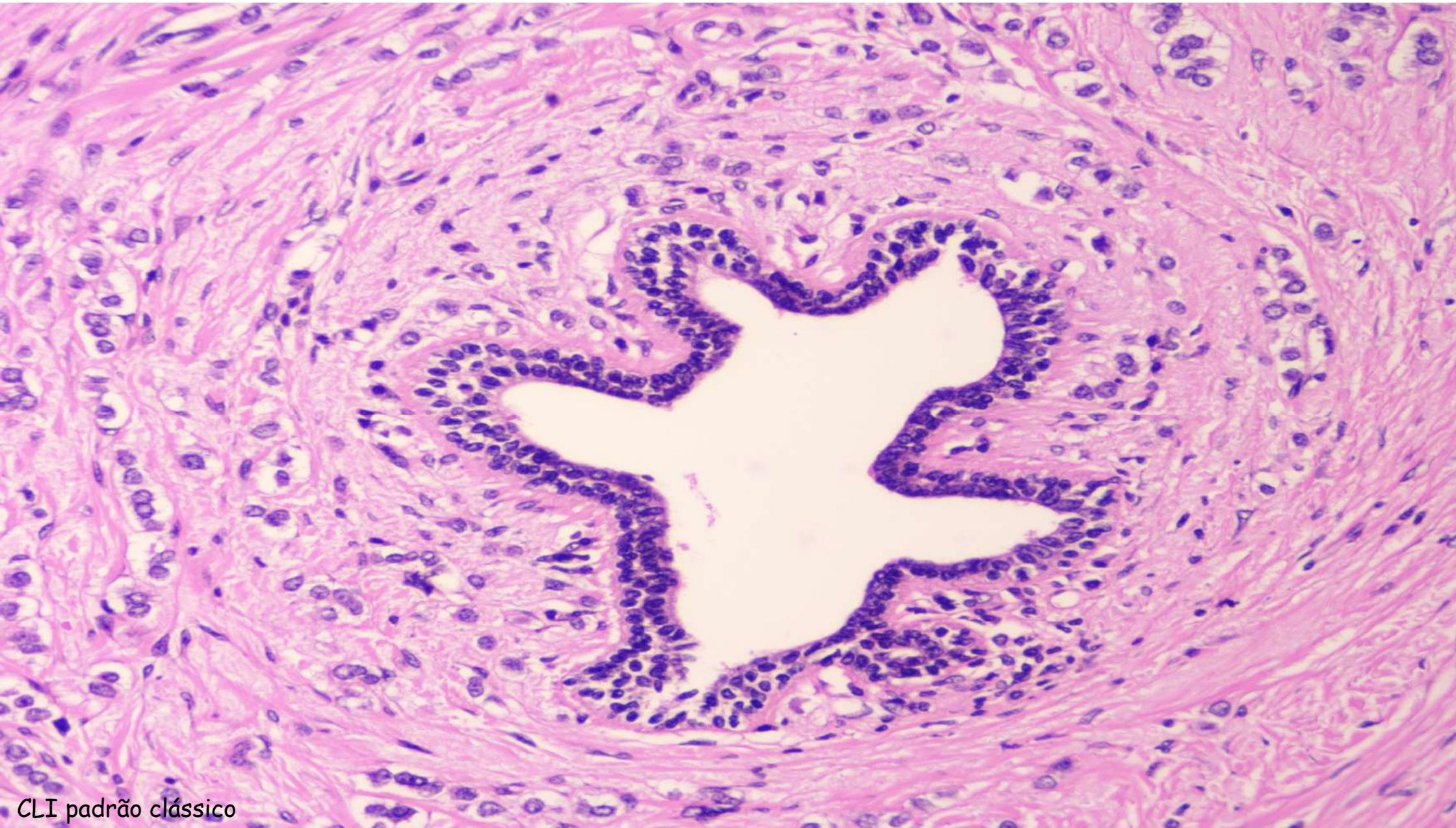
MARIA VITTORIA DIECI,<sup>a</sup> ENRICO ORVIETO,<sup>b</sup> MASSIMO DOMINICI,<sup>c</sup> PIERFRANCO CONTE,<sup>a</sup> VALENTINA GUARNERI<sup>a</sup>

<sup>a</sup>Department of Surgery, Oncology and Gastroenterology, University of Padova, Padova, Italy; and Istituto Oncologico Veneto IRCCS (Istituto di Ricovero e Cura a Carattere Scientifico), Padova, Italy; <sup>b</sup>Department of Pathology, University Hospital of Padova, Padova, Italy;

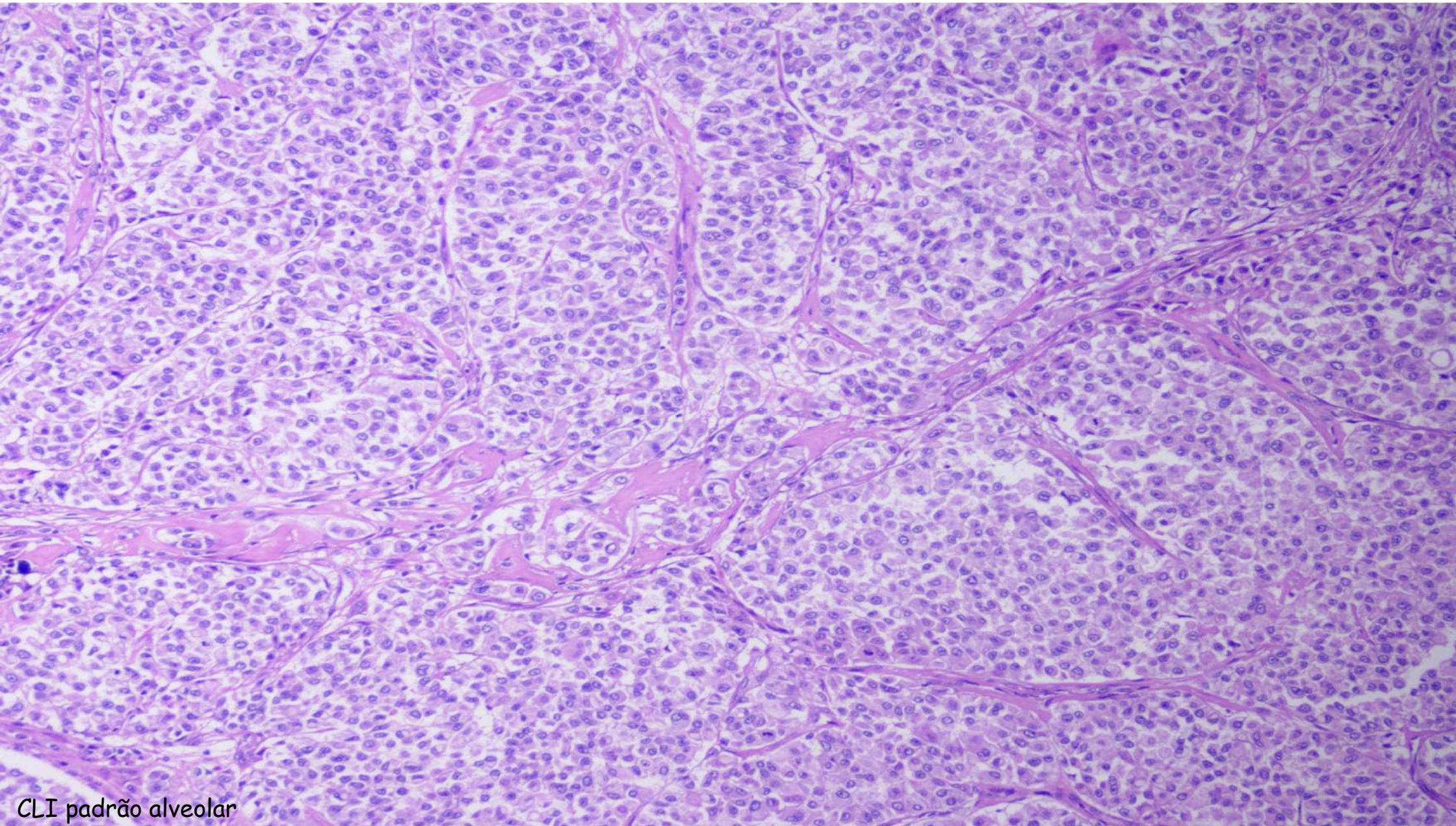
<sup>c</sup>Department of Medical and Surgical Sciences for Children & Adults, University of Modena and Reggio Emilia, Modena, Italy

Disclosures of potential conflicts of interest may be found at the end of this article.

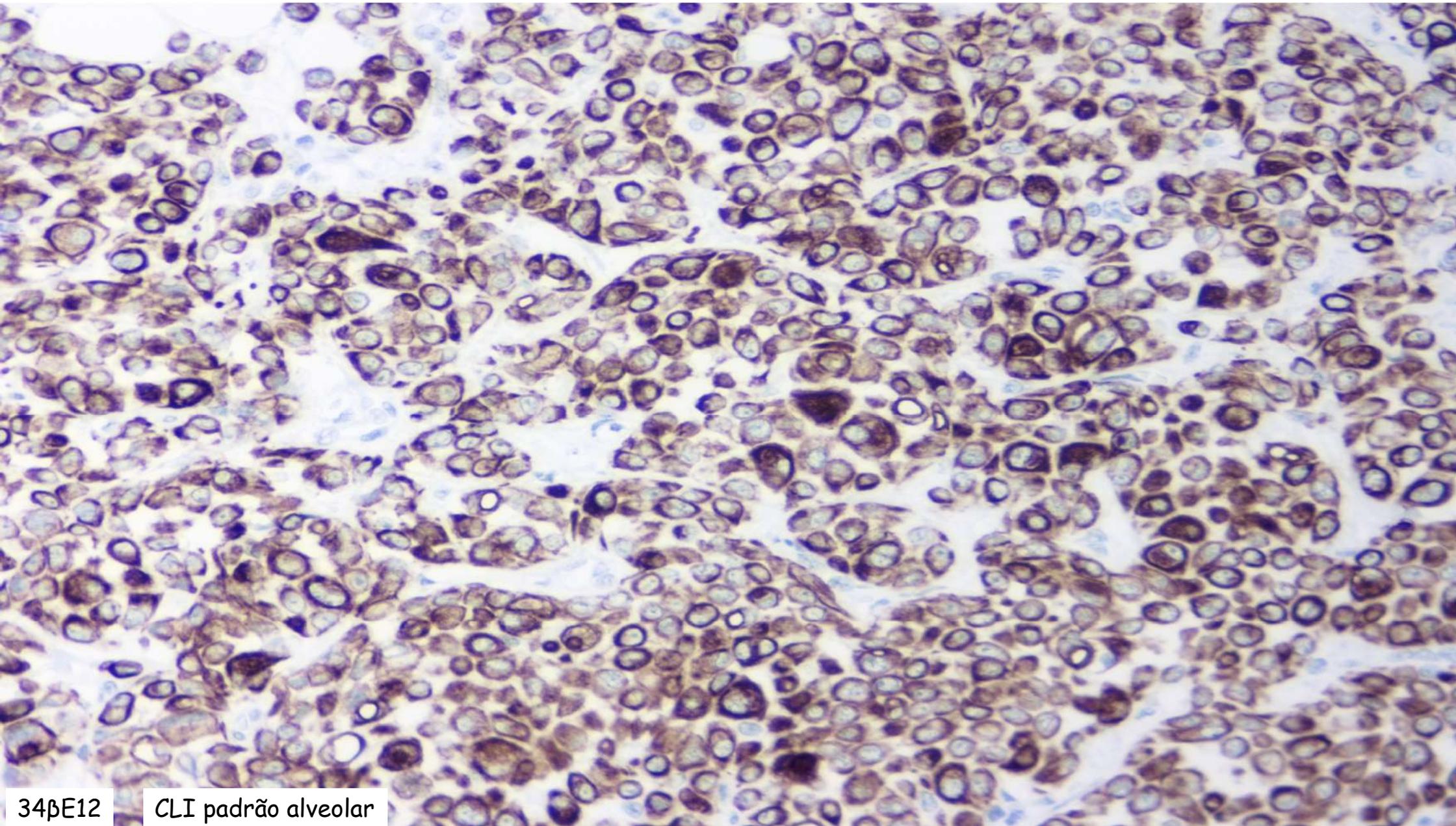




CLI padrão clássico

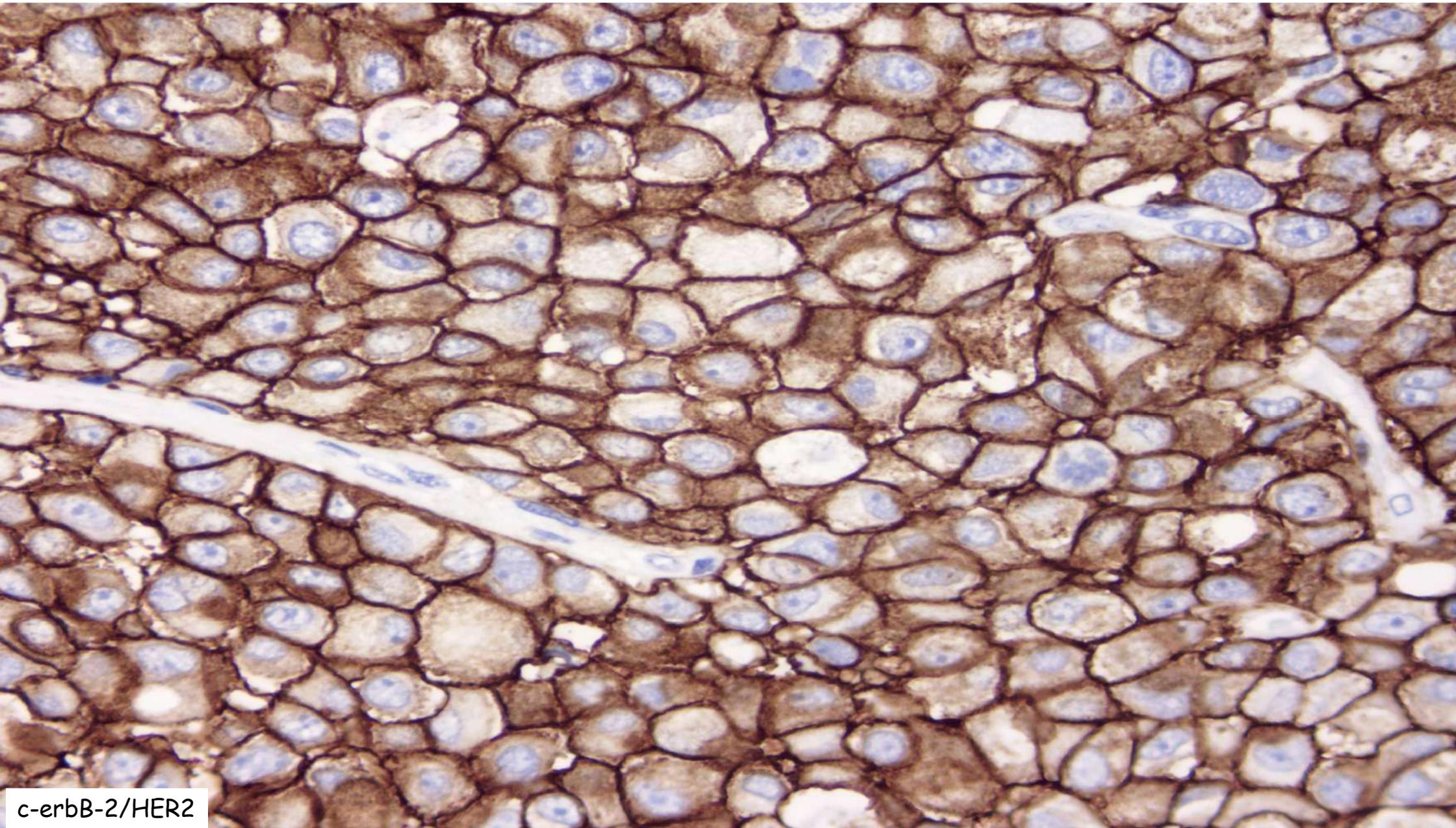


CLI padrão alveolar



34βE12

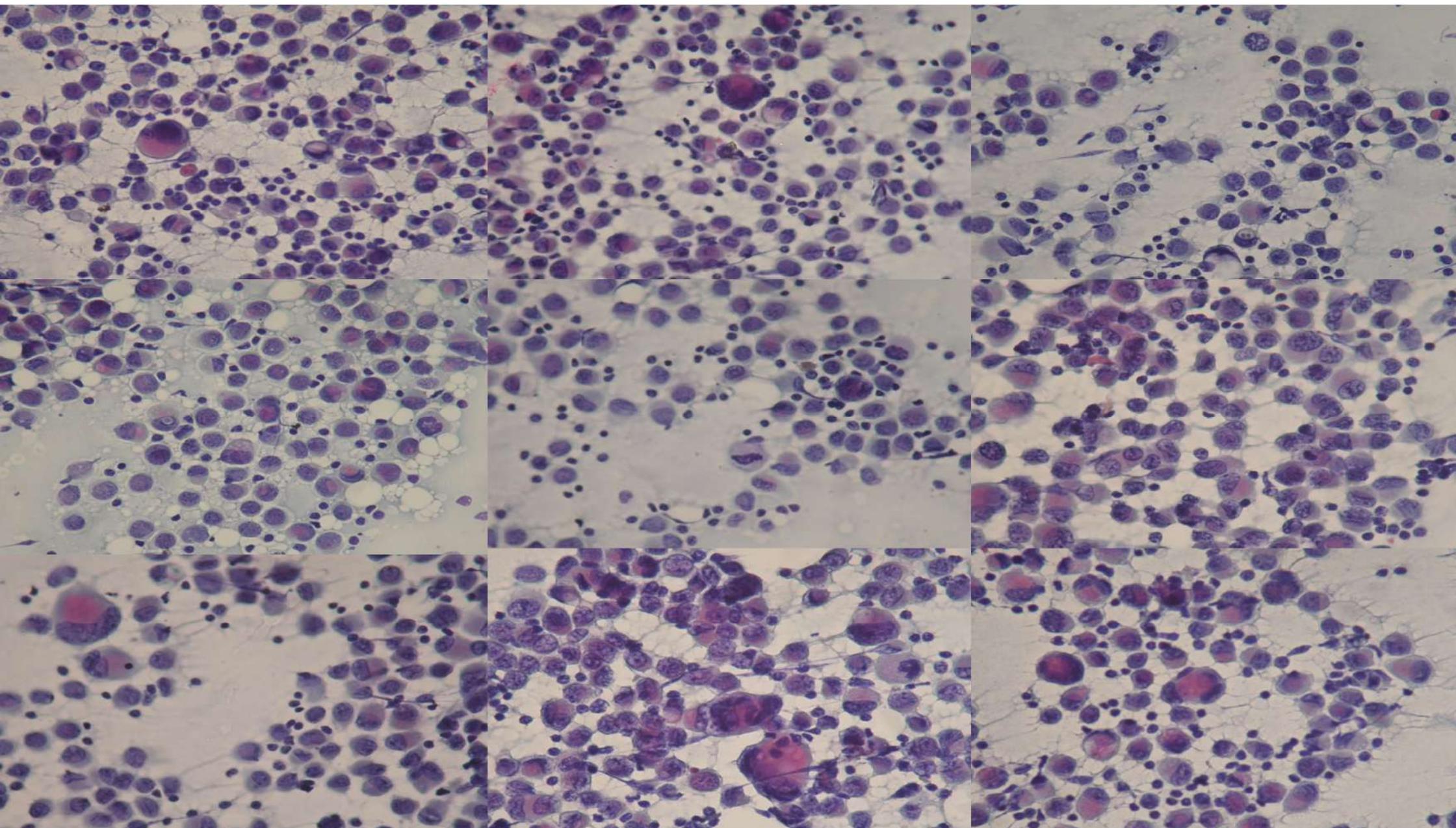
CLI padrão alveolar

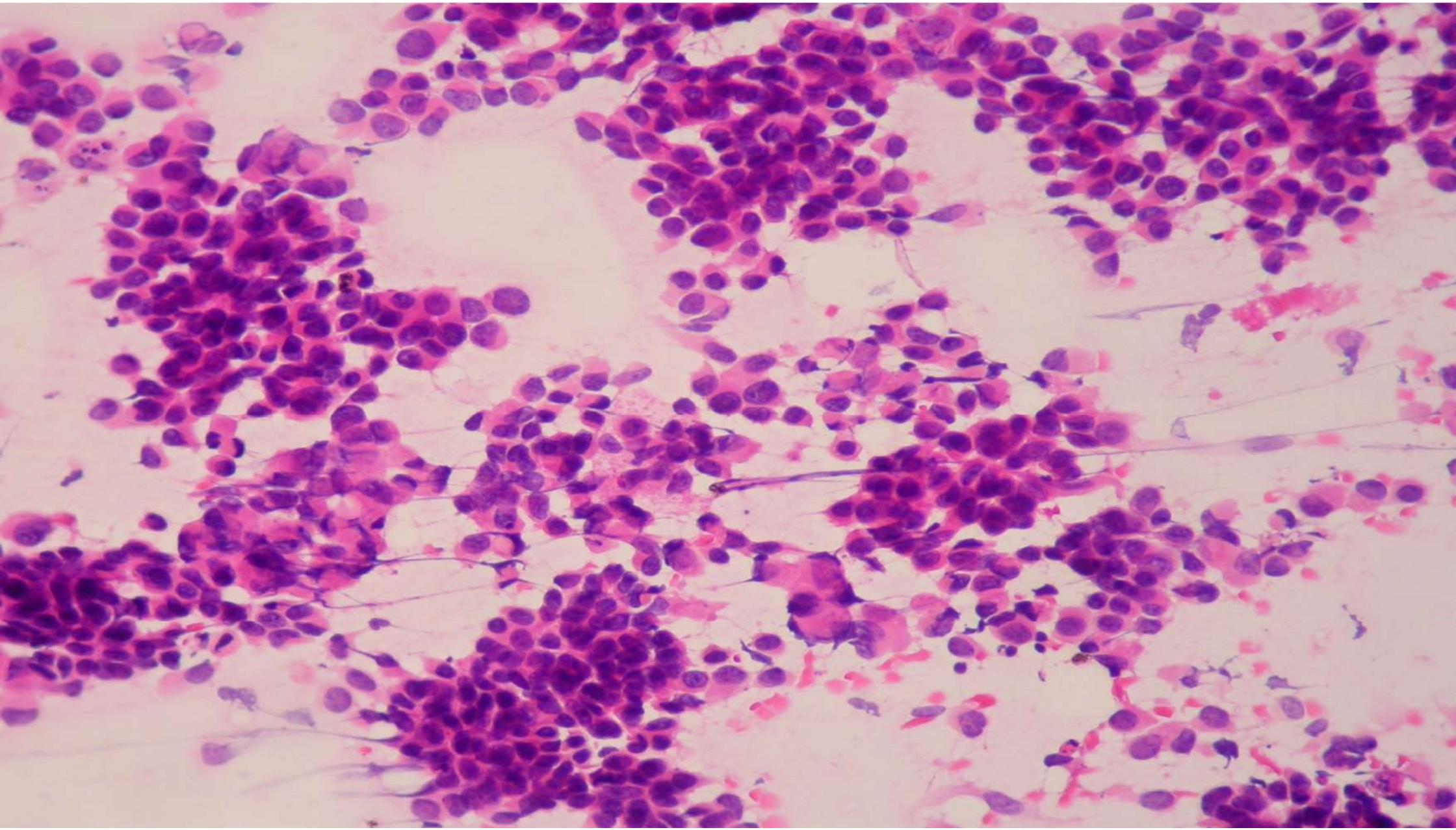


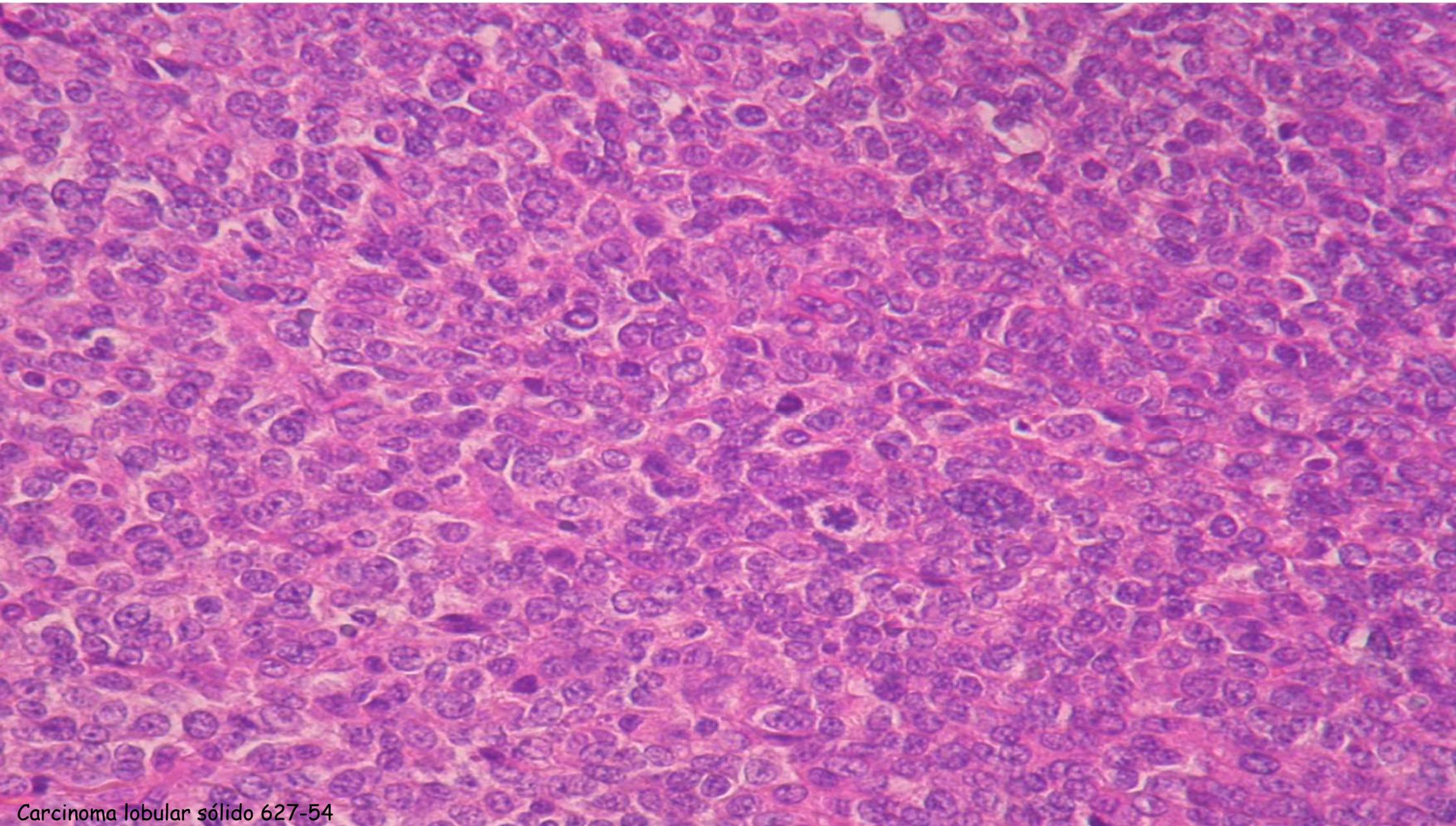
c-erbB-2/HER2

Carcinoma lobular variante pleomórfico

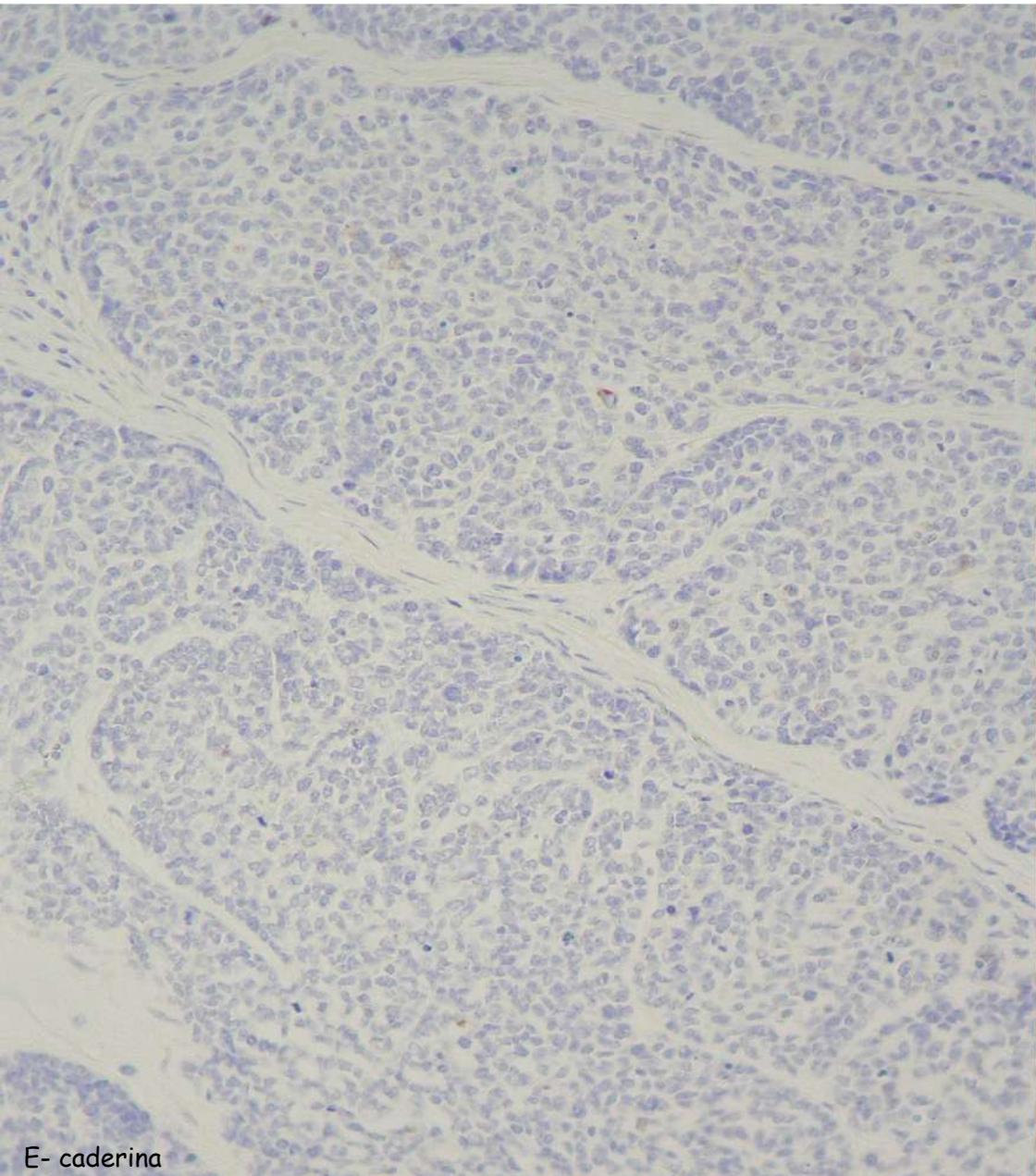




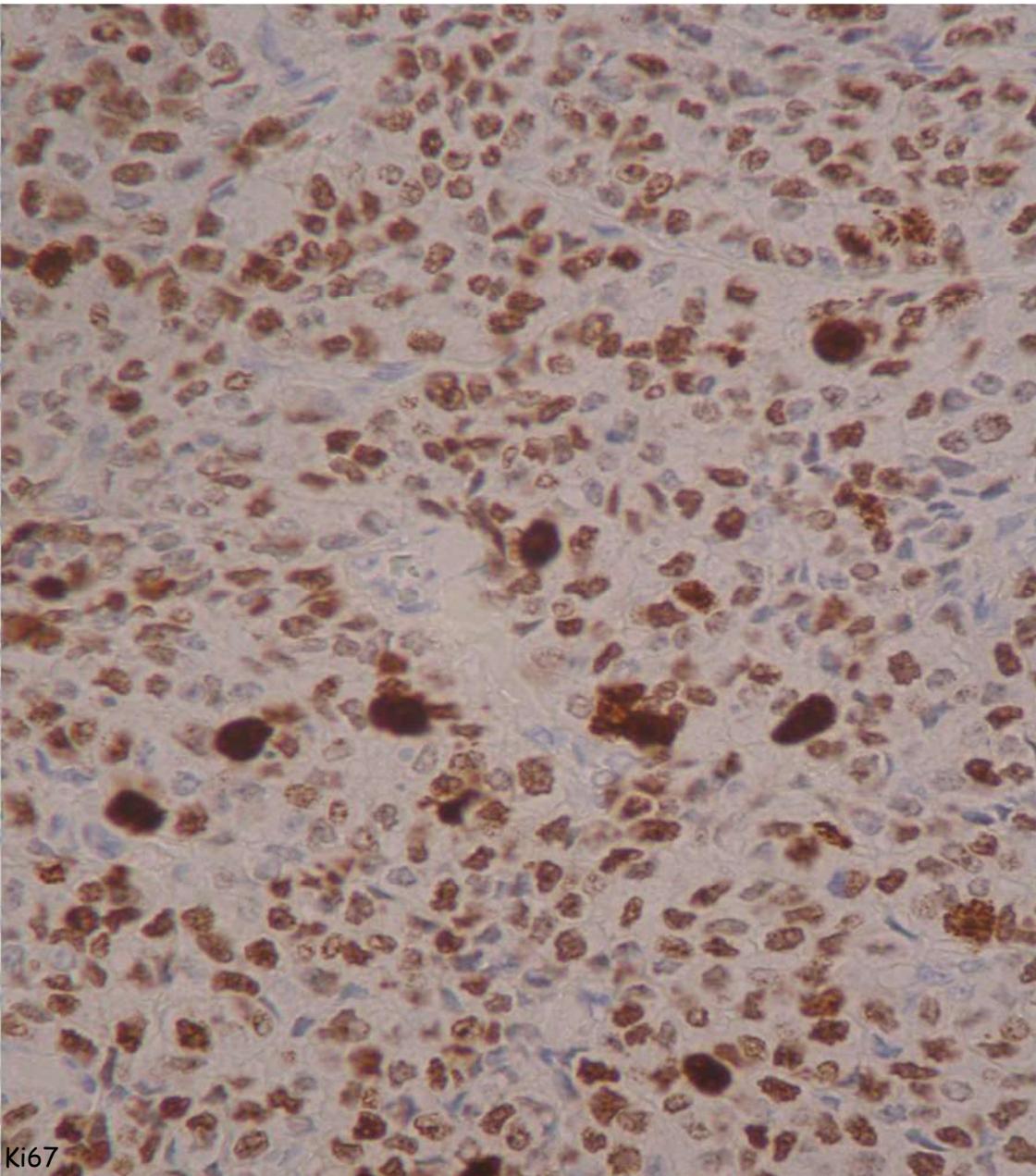




Carcinoma lobular sólido 627-54



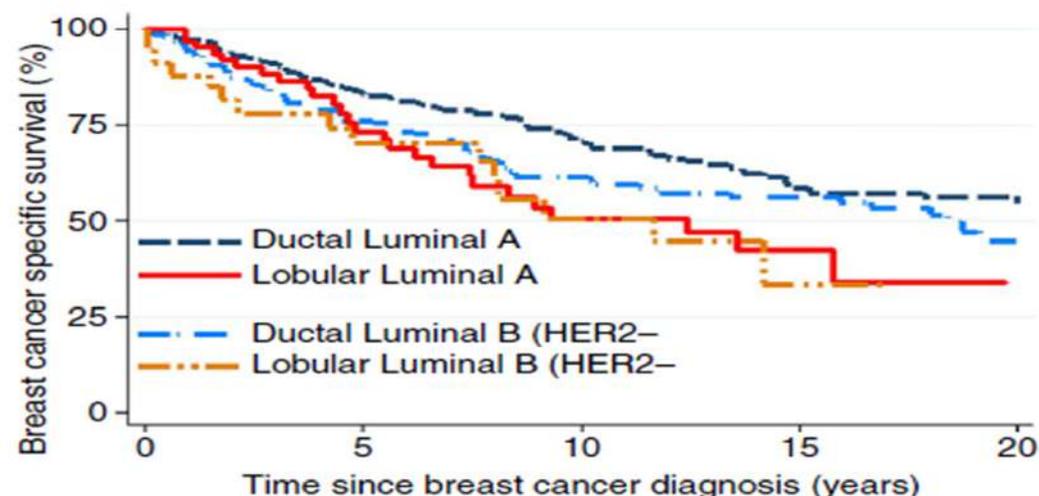
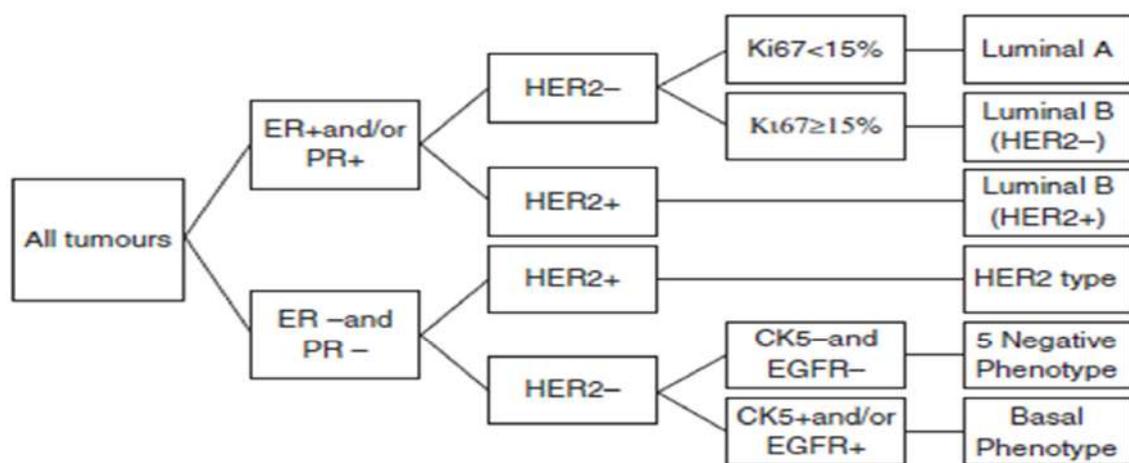
E- caderina



Ki67

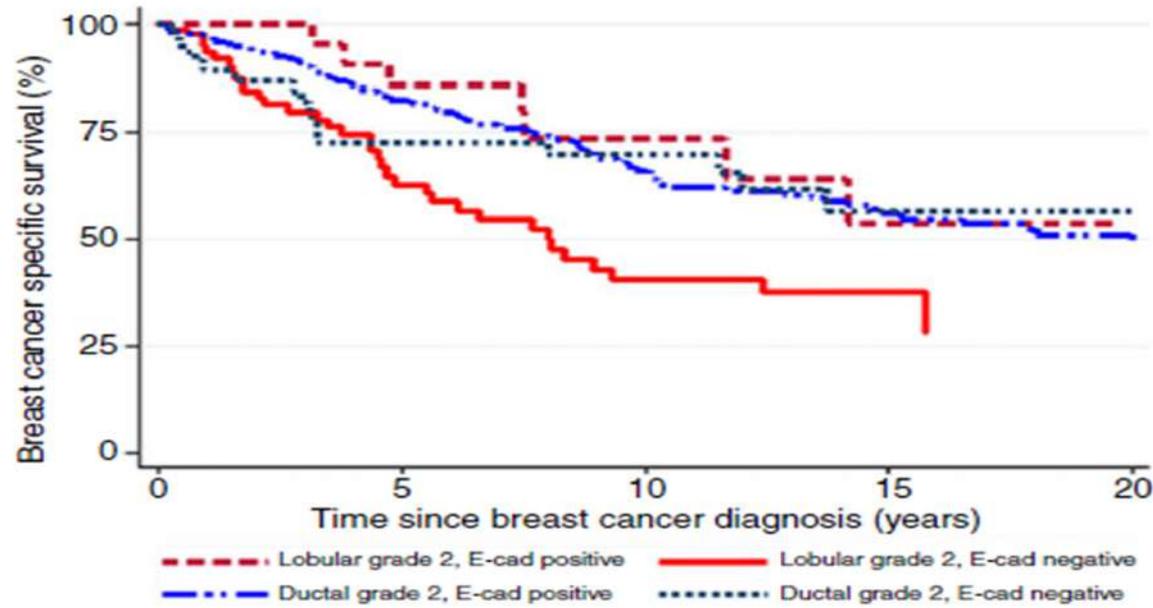
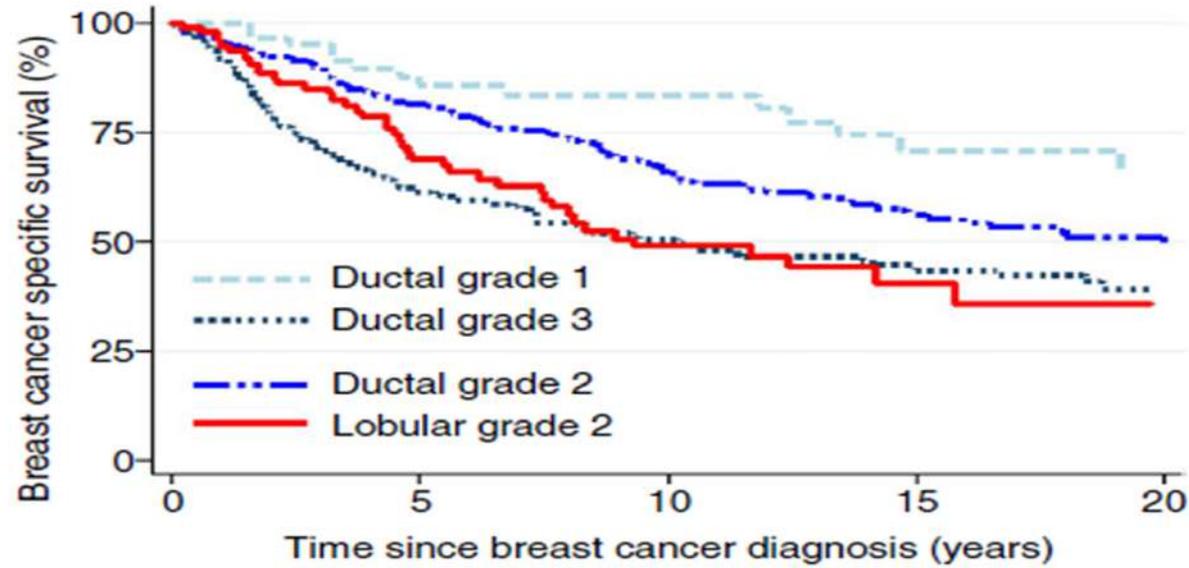
## Invasive lobular breast cancer: the prognostic impact of histopathological grade, E-cadherin and molecular subtypes

Monica J Engstrøm, Signe Opdahl,<sup>1</sup> Lars J Vatten,<sup>1</sup> Olav A Haugen & Anna M Bofin  
 Department of Laboratory Medicine, Children's and Women's Health, Faculty of Medicine, Norwegian University of Science and Technology, Trondheim, Norway, and <sup>1</sup>Department of Public Health and General Practice, Norwegian University of Science and Technology, Trondheim, Norway



**Figure 1.** Classification algorithm for molecular subtyping.<sup>17</sup>

Engstrom MJ, Opdahl S, Hagen AI *et al.* Molecular subtypes, histopathological grade and survival in a historic cohort of breast cancer patients. *Breast Cancer Res. Treat.* 2013; 140: 463–473.



# Caso Clínico

- E a axila? Biópsia pré tratamento?

**CONDUTA?**

# Caso Clínico

- PAAF linfonodo axila esquerda: imagem hipoeecóica, com imagem hipereecóica central, contornos regulares, limites definidos, medindo 1,4x 0,8cm
- Citologia nº 440/2019: Esfregaços hemorrágicos e paucicelulares, com artefatos de dessecação, contendo alguns linfócitos e polimorfonucleares de fundo, bem como blocos estromais dispersos. Não evidenciamos células epiteliais, neste material. Citologia oncótica negativa.

# Caso clínico

- Estadiamento
  - TC de abdome ( 26/03/2019): sem alterações
  - TC de tórax (26/03/2019): sem alterações sugestivas de implantes secundários. Broncopatia inflamatória.
  - Cintilografia óssea (03/04/2019): sem captações sugestivas de implantes secundários

# Caso Clínico

- Estadiamiento clínico

**cT2N0M0**

**Luminal A**

# Caso Clínico

- Cirurgia up front? QT?

**CONDUTA?**

# Caso Clínico

- Optado por cirurgia up-front
- Quadrantectomia + Biópsia de linfonodo sentinela

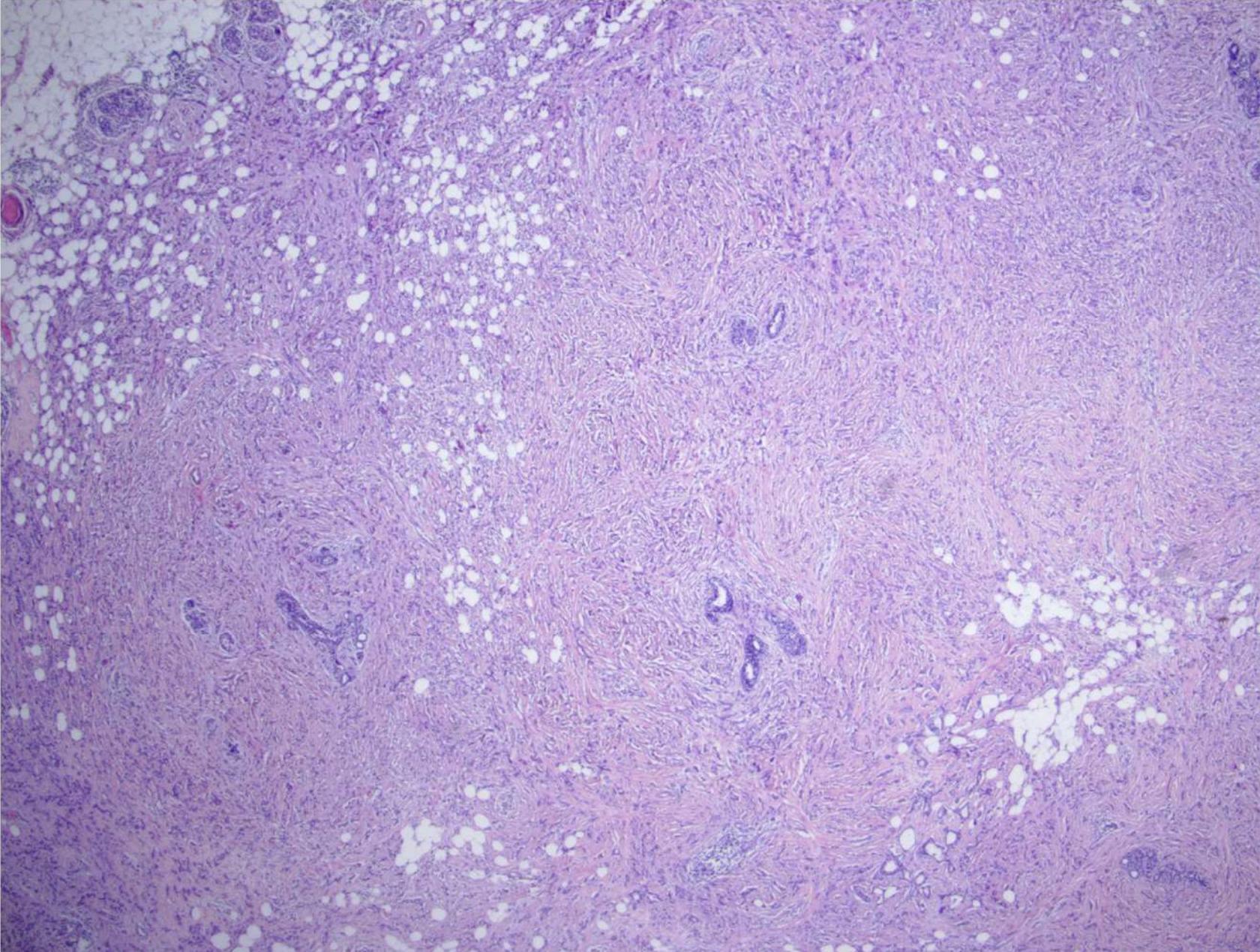
# Caso Clínico

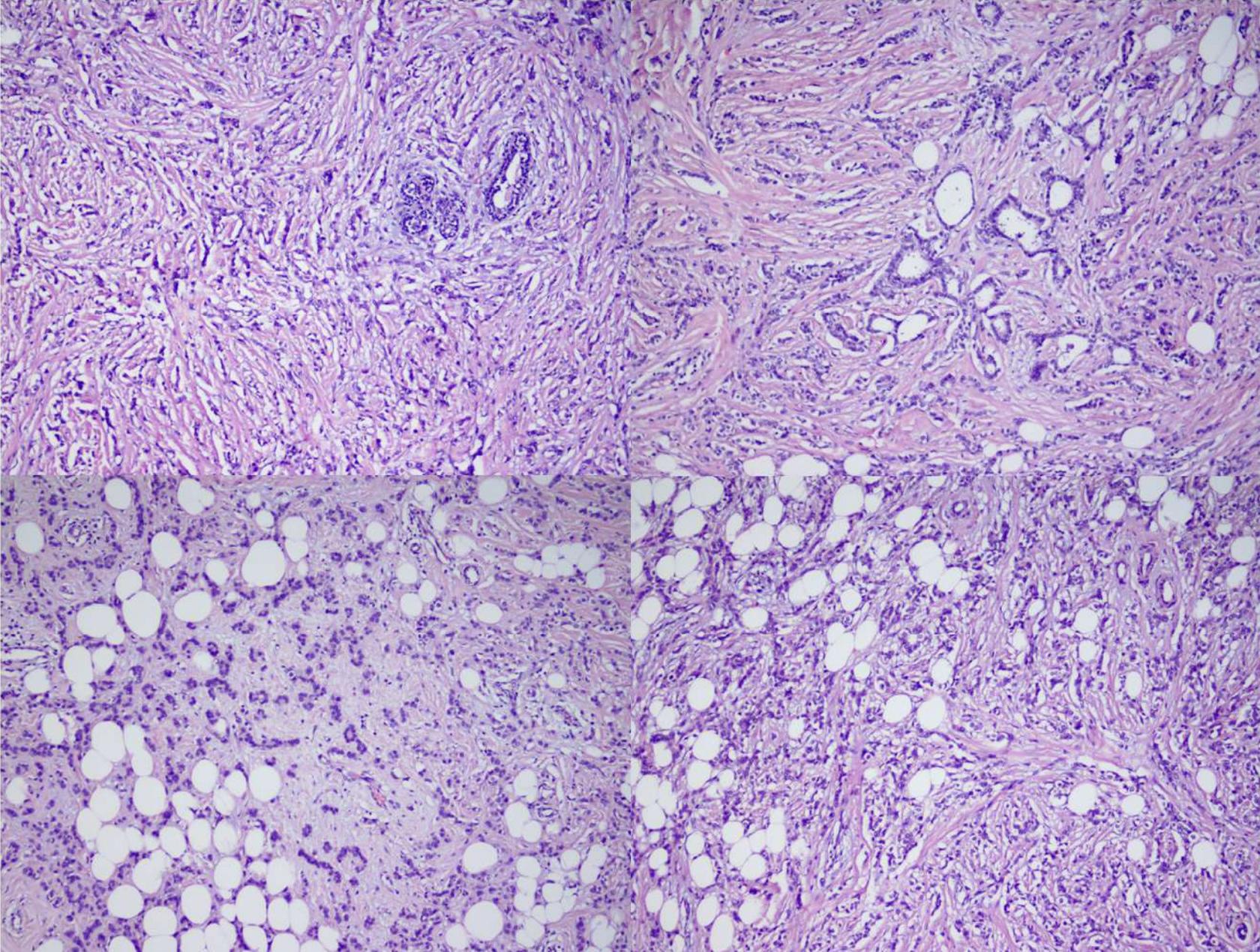
- AP de peça cirúrgica nº 2783/2019
  - Carcinoma mamário invasor
  - Lobular, tipo especial: túbulo-lobular
  - Grau histológico: 2
  - Dimensão tumor: 1,0 cm (área invasora)
  - Componente in situ: ausente
  - Angioinvasão: ausente
  - Invasão de filetes nervosos: ausente
  - Margens: livres

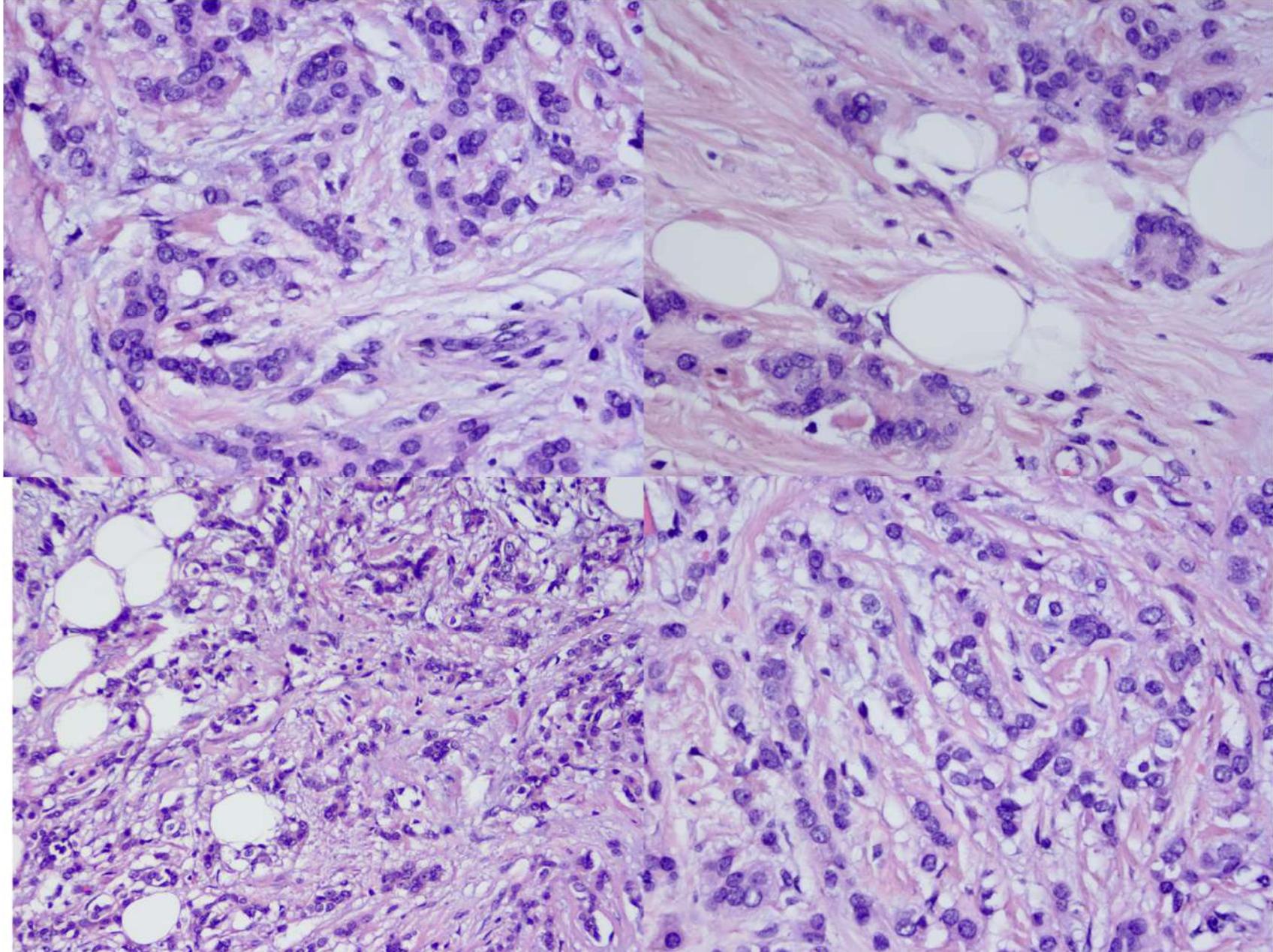
# Caso Clínico

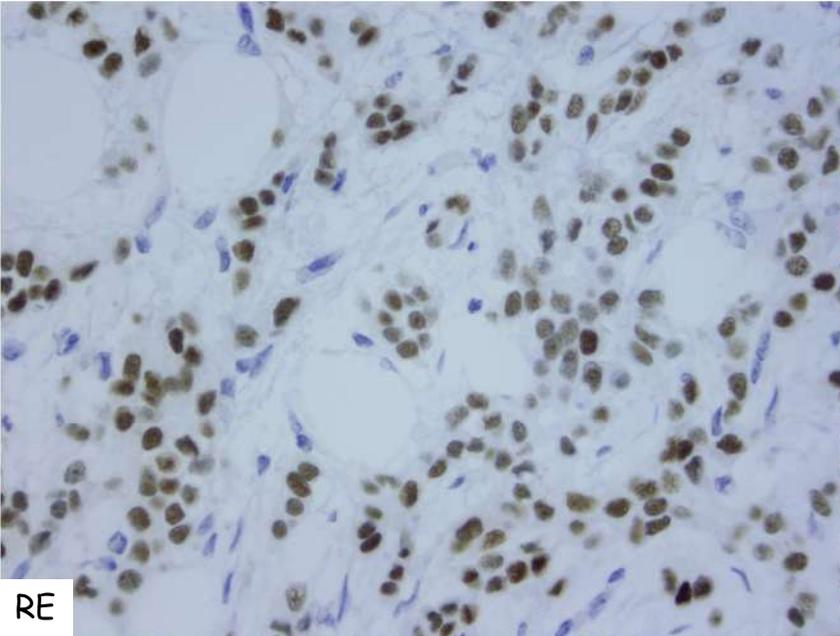
- Biópsia de linfonodo sentinela nº 2782/2019
  - 2 linfonodos isolados, livres de metástases
- Imunohistoquímica nº 1325/2019
  - Receptor de estrogênio: 100%
  - Receptor progesterona: 90%
  - HER2: negativo
  - Ki67: Positivo 5%

Lâminas do anatomopatológico – peça  
cirúrgica

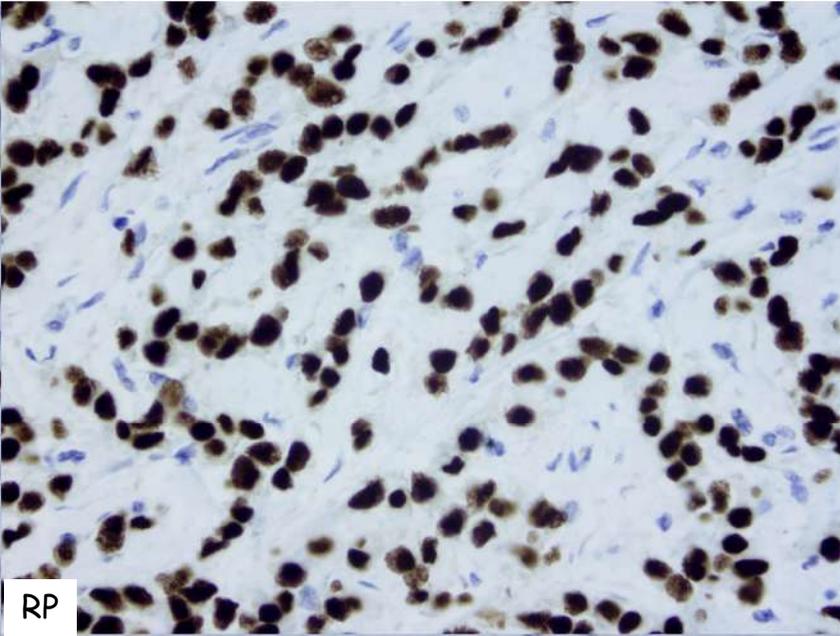




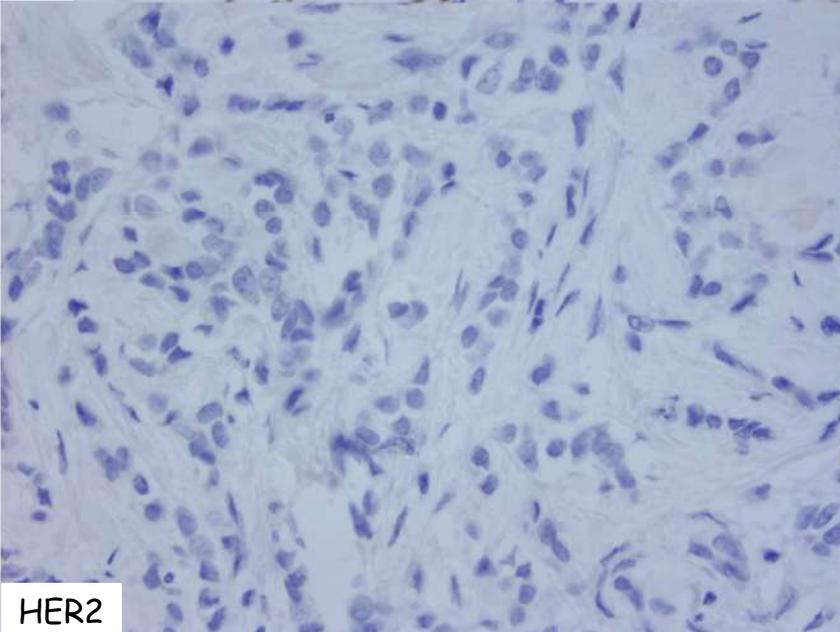




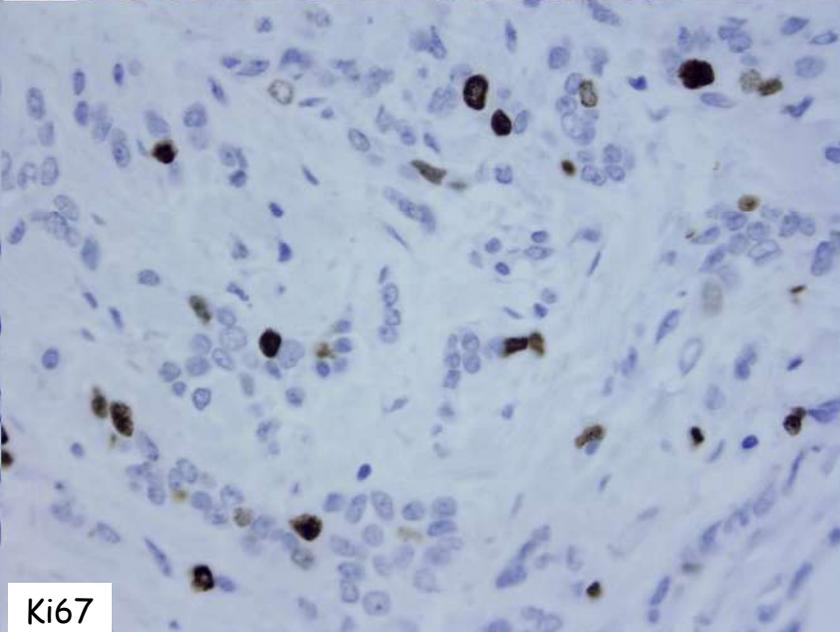
RE



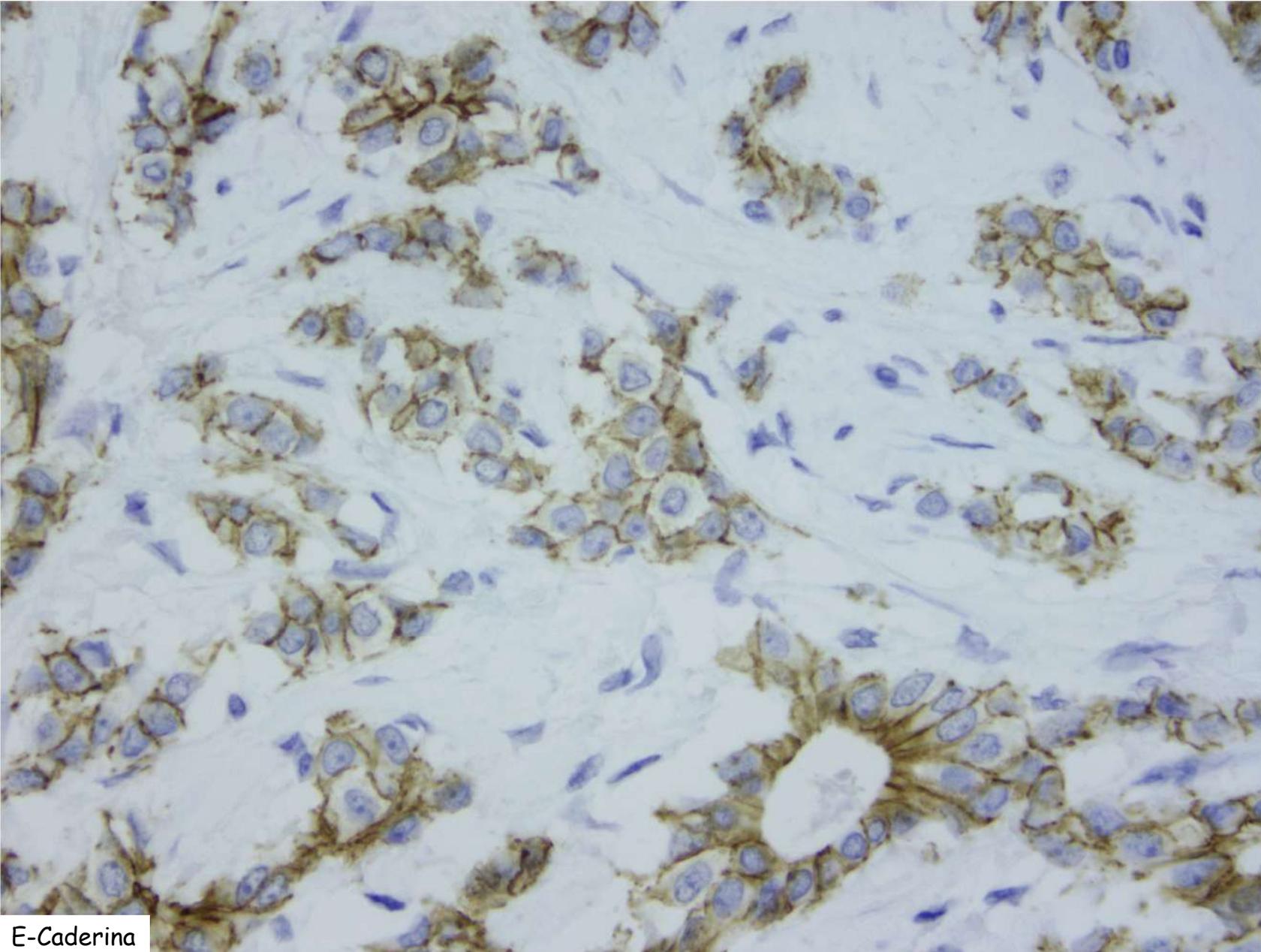
RP



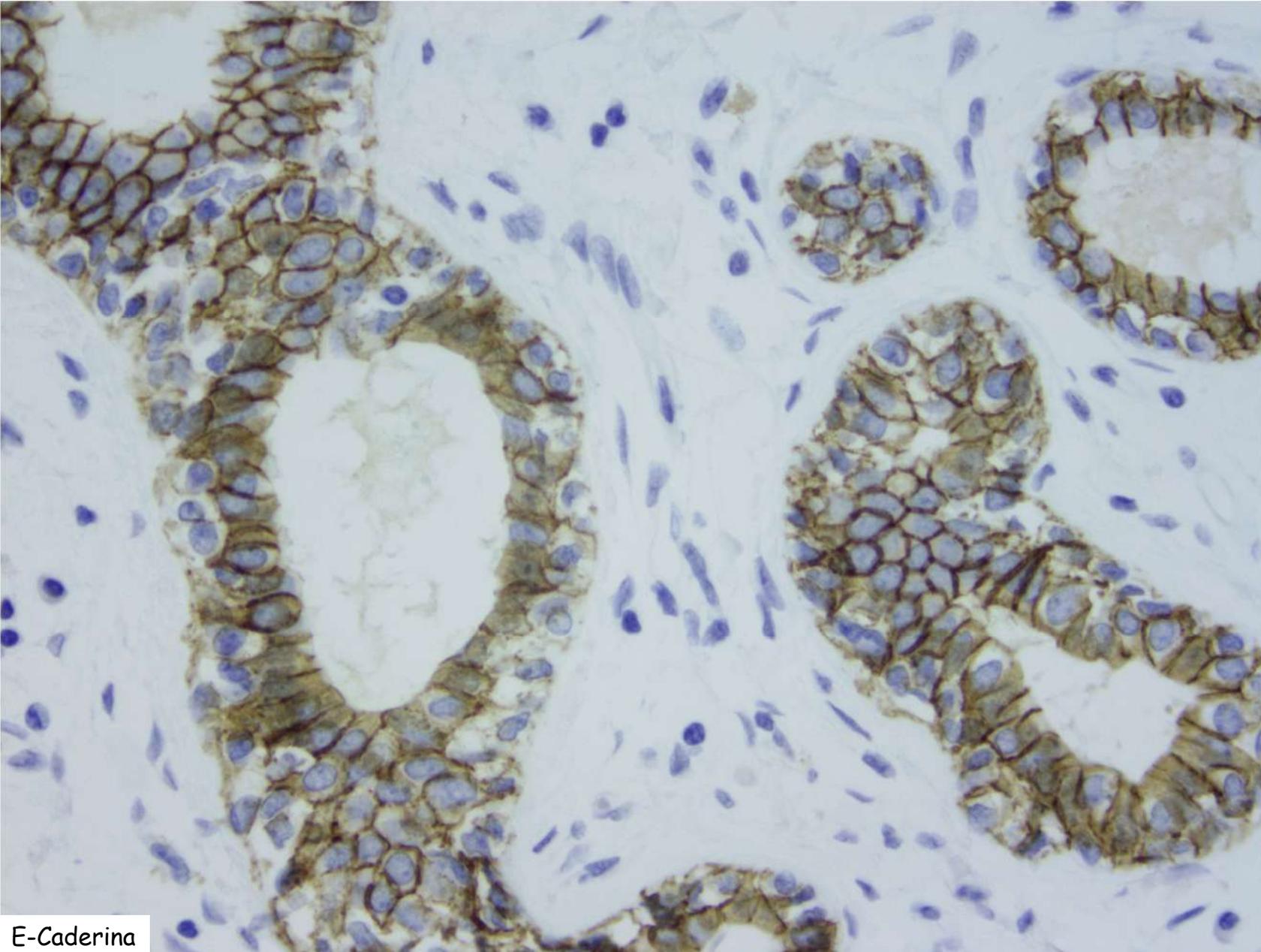
HER2



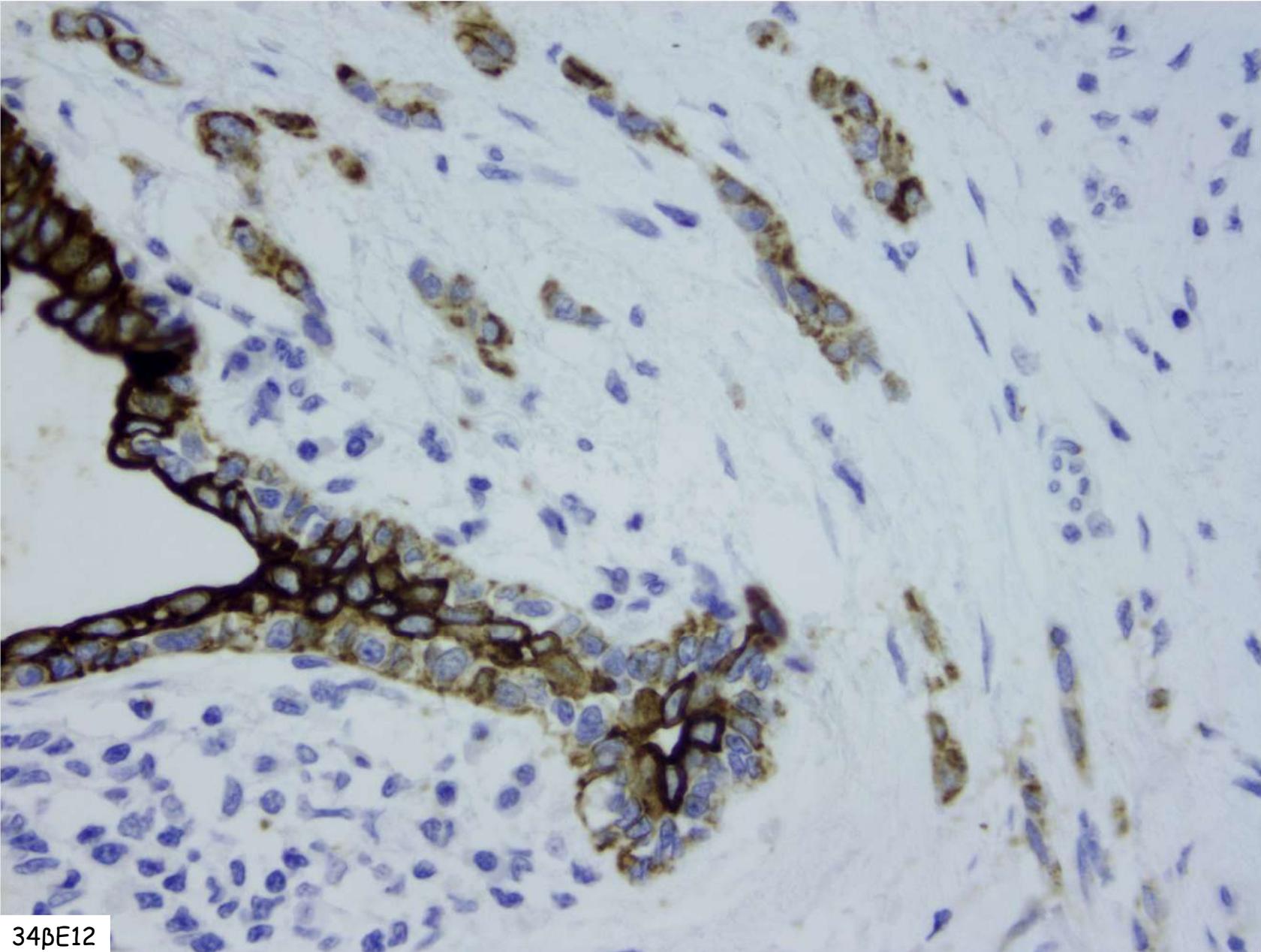
Ki67



E-Cadherin

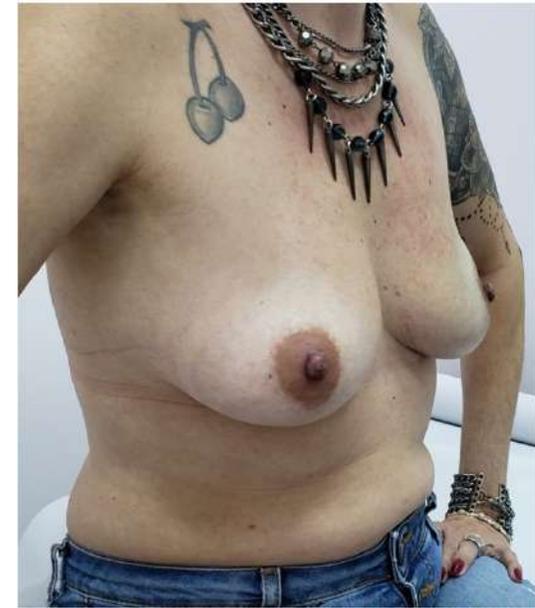


E-Caderina



34βE12

# Caso Clínico



# Caso Clínico

- Estadiamiento patológico

**CLL, pT1bN0M0**  
**Luminal A**

# Caso Clínico

- Adjuvância?
  - QT? Mammaprint x Oncotype?
  - Paciente resistente a indicação de QT
  - Endocrinoterapia +- supressão ovariana?
- Sequenciamento genético
  - Cirurgia Redutora de Risco

**CONDUTA?**

# Caso Clínico

## Protocolo de adjuvância HC/UFG

Iniciar o tratamento adjuvante o mais breve possível.

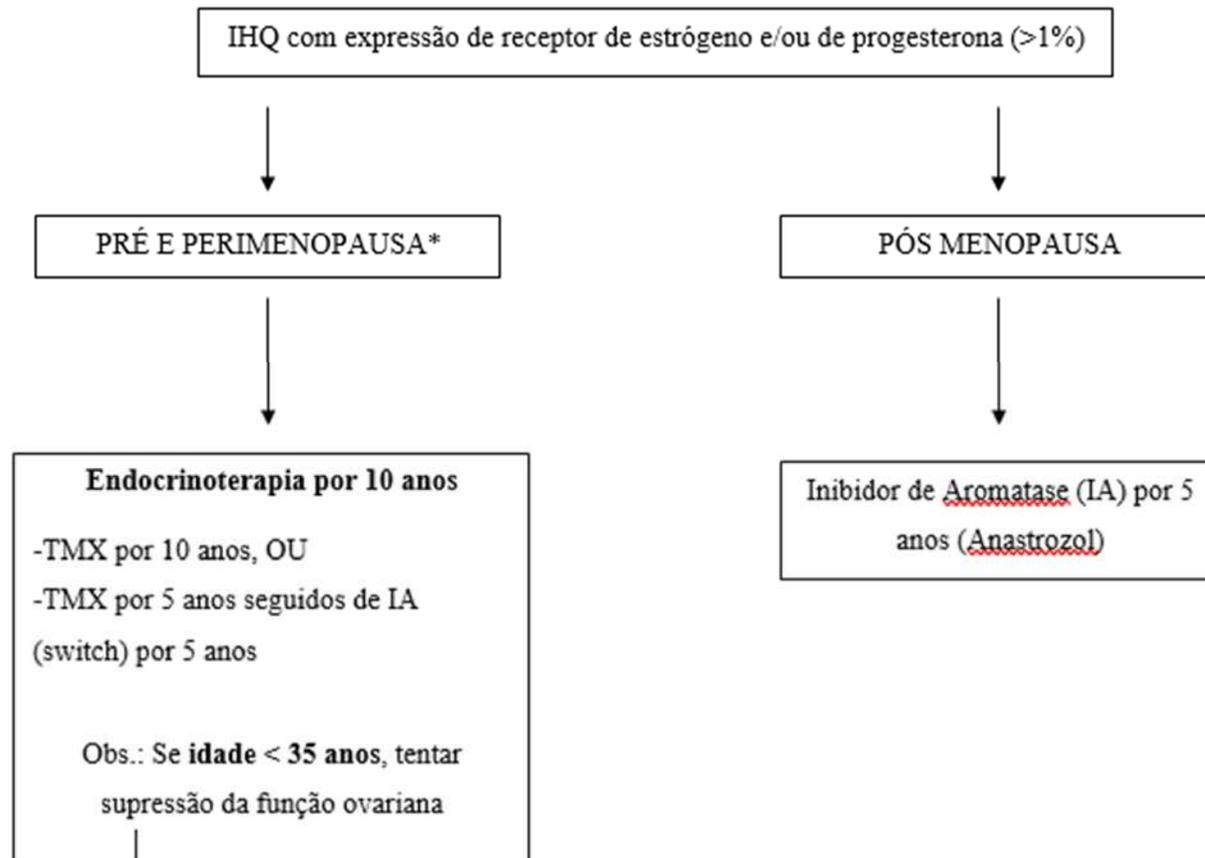
(A) **RH+, HER2 negativo**

>> **Realizar avaliação clínica de risco seguindo critérios do estudo MINDACT:**

<b>Estadiamento</b>	<b>Classificação</b>	<b>Conduta</b>
pN0, GI, até 3,0cm pN0, GII, até 2,0cm pN0, GIII, até 1,0cm	Baixo risco	Endocrinoterapia adjuvante
pN0, mas fora dos critérios para baixo risco	Risco intermediário	Quimioterapia* → Endocrinoterapia
Axila positiva	Alto risco	Quimioterapia** → Endocrinoterapia

# Caso Clínico

**ENDOCRINOTERAPIA ADJUVANTE** (iniciar após a quimioterapia)





Clube da  
**Mama**

## Tratamento do câncer de mama luminal EC II: Neoadjuvância x Cirurgia Up front



# Quando optamos pela QTx neoadjuvante...

- Avaliar resposta tumoral a QTx in vivo
- Diminuir T com intenção de cirurgia conservadora, em casos de relação tumor x mama desfavoráveis
- Descalonar tratamento em axila
- Tratamento/proteção sistêmica precoce

# Pathological complete response and long-term clinical benefit in breast cancer: the CTNeoBC pooled analysis

*Patricia Cortazar, Lijun Zhang, Michael Untch, Keyur Mehta, Joseph P Costantino, Norman Wolmark, Hervé Bonnefoi, David Cameron, Luca Gianni, Pinuccia Valagussa, Sandra M Swain, Tatiana Prowell, Sibylle Loibl, D Lawrence Wickerham, Jan Bogaerts, Jose Baselga, Charles Perou, Gideon Blumenthal, Jens Blohmer, Eleftherios P Mamounas, Jonas Bergh, Vladimir Semiglazov, Robert Justice, Holger Eidtmann, Soonmyung Paik, Martine Piccart, Rajeshwari Sridhara, Peter A Fasching, Leen Slaets, Shenghui Tang, Bernd Gerber, Charles E Geyer Jr, Richard Pazdur, Nina Ditsch, Priya Rastogi, Wolfgang Eiermann, Gunter von Minckwitz*

*Lancet* 2014; 384: 164-72

Published Online

February 14, 2014

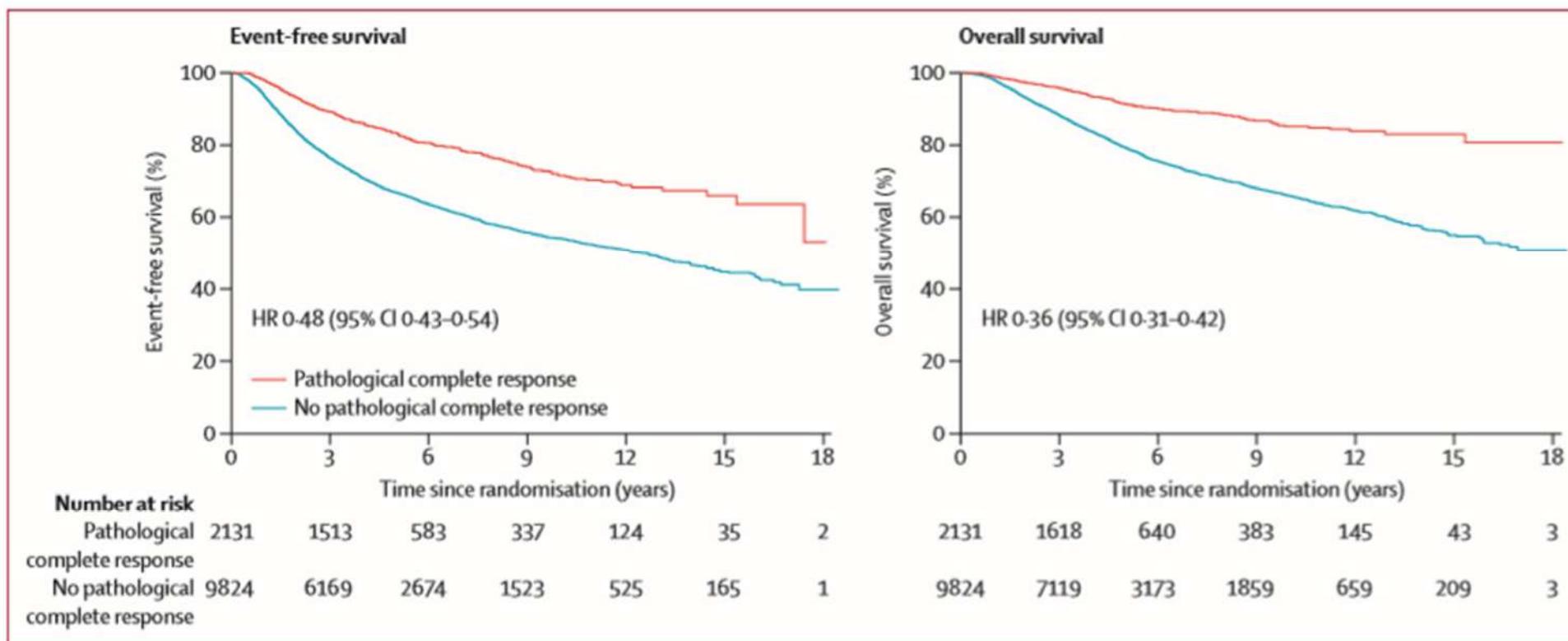
<http://dx.doi.org/10.1016/>

S0140-6736(13)62422-8

# Delineamento

- Metanálise – estudos com:
  - Ao menos 200 pacientes em QTx neo
  - Dados sobre pCR, sobrevida livre de doença e sobrevida global
  - Seguimento de ao menos 3 anos
  - Medline, PubMed, Embase
  - Incluídos 12 estudos, somando 11.955 pacientes
  - Publicados entre Janeiro/1990 e Agosto/2011
- Objetivos principais
  - Definir correlação entre pCR e sobrevida livre de doença e sobrevida global
  - Estabelecer qual definição de pCR se correlaciona melhor com melhores desfechos a longo prazo (ypT0N0 x pT0/isN0 x pT0/is)
  - Identificar os subtipos tumorais em que pCR se correlaciona com melhores desfechos

# Resultados



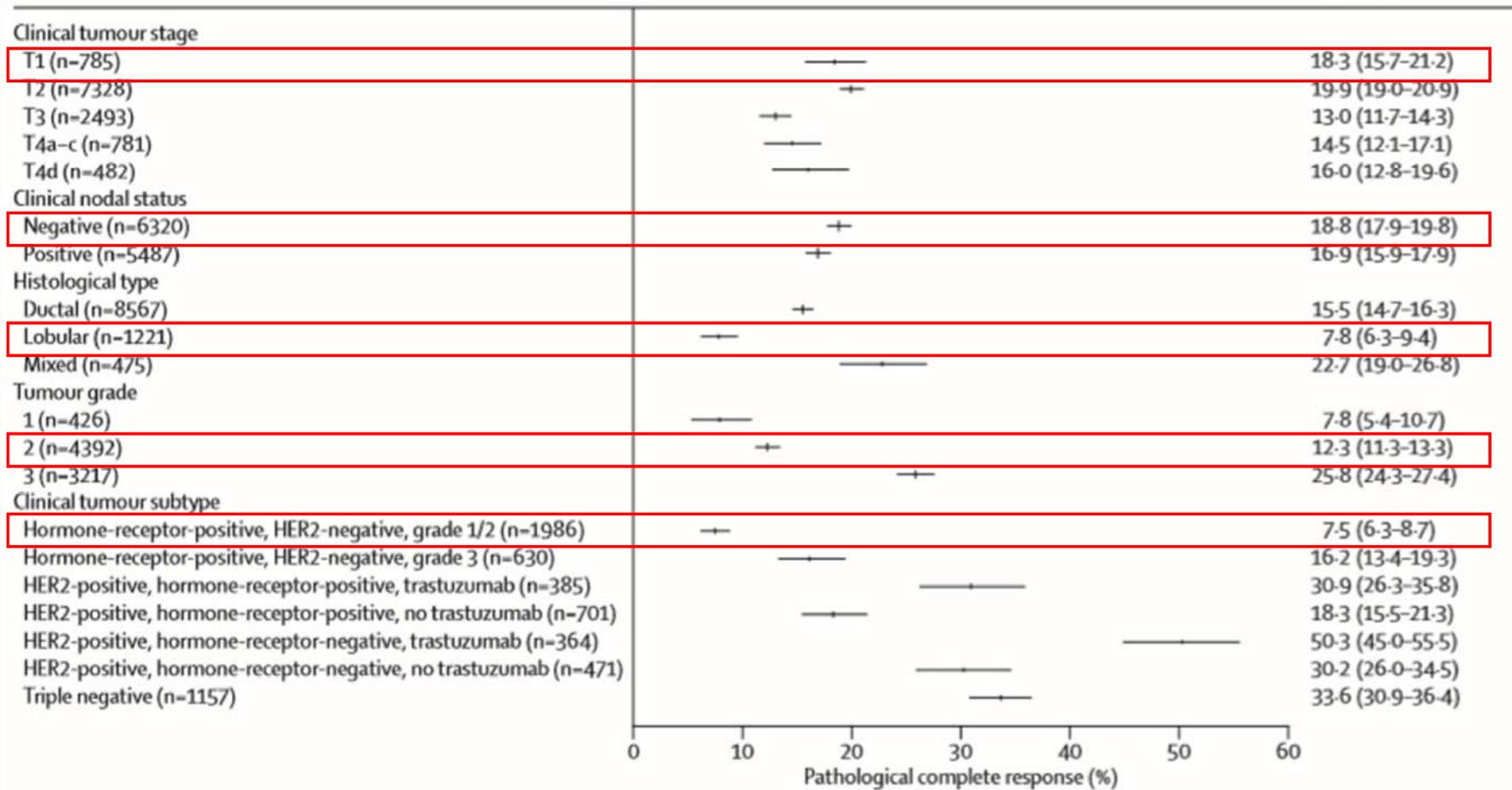
**Figure 2: Associations between pathological complete response and event-free survival and overall survival**

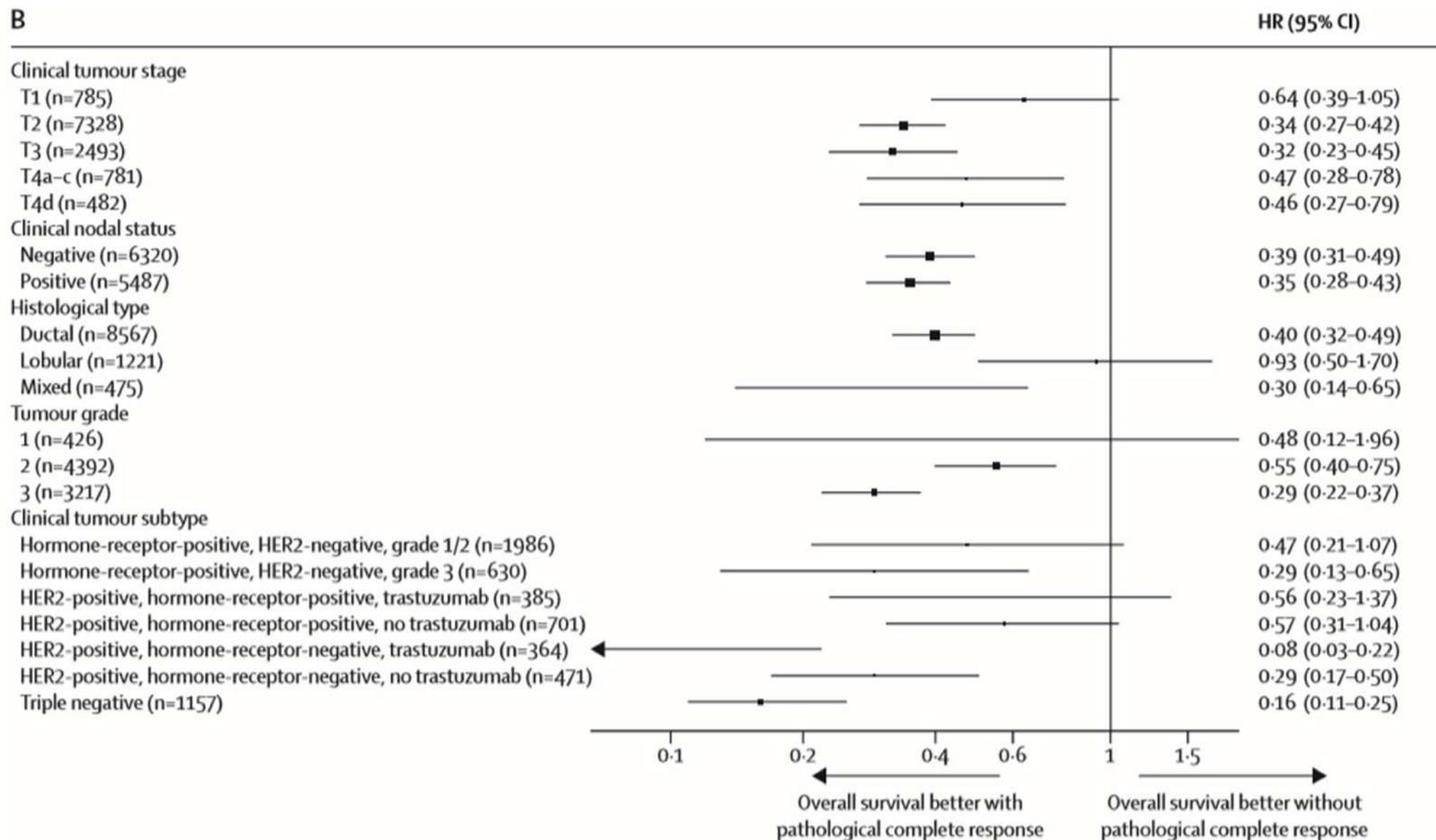
ypT0/is ypN0 definition of pathological complete response (ie, absence of invasive cancer in the breast and axillary nodes, irrespective of ductal carcinoma in situ).

HR=hazard ratio.

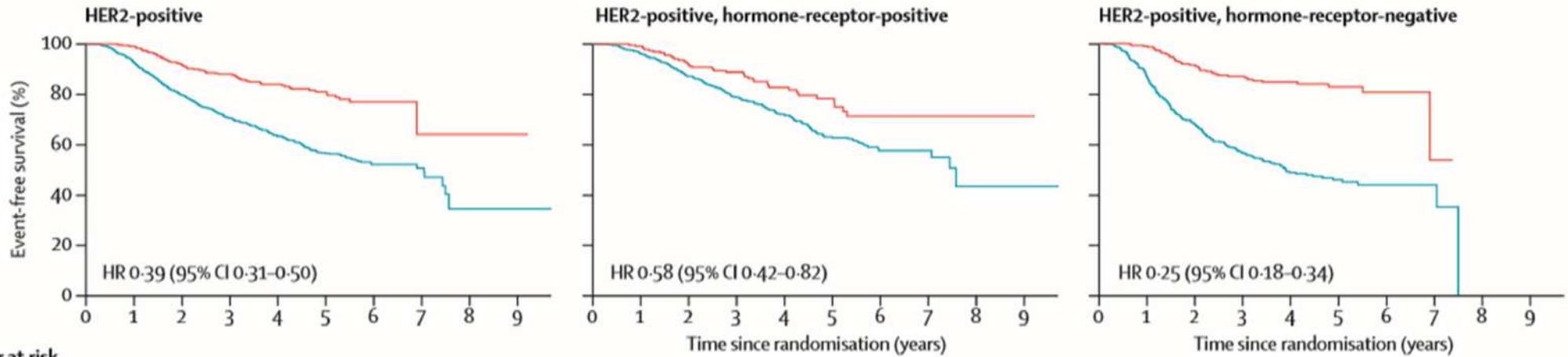
A

Percentage of patients  
achieving pathological  
complete response  
(95% CI)



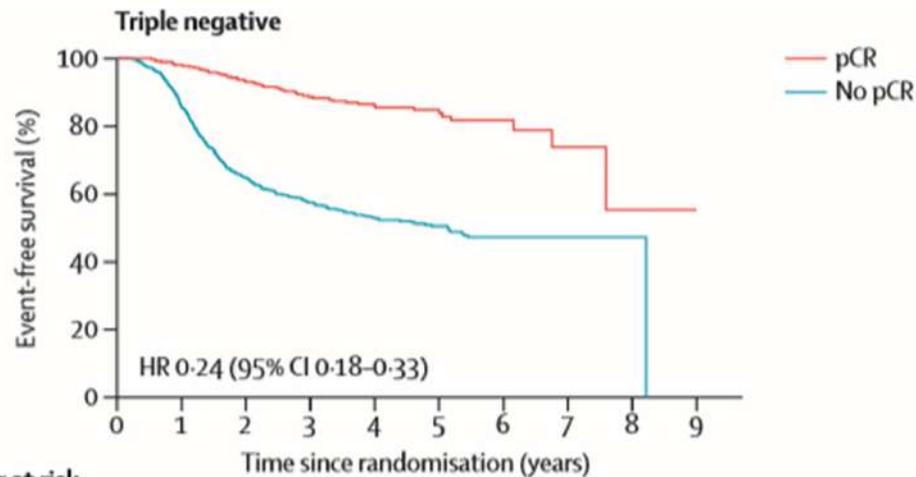
**B**





**Number at risk**

	0	1	2	3	4	5	6	7	8	9		0	1	2	3	4	5	6	7	8	9		0	1	2	3	4	5	6	7	8	9
pCR	586	527	454	371	212	120	37	4	2	1	247	224	194	157	91	50	17	2	2	1	325	293	250	205	115	65	19	2				
No pCR	1403	1157	918	713	436	269	106	33	3	1	839	723	617	484	306	198	79	24	3	1	510	392	269	200	111	59	22	6				



**Number at risk**

	0	1	2	3	4	5	6	7	8	9
pCR	389	349	310	250	166	88	29	11	1	
No pCR	768	604	429	317	198	125	50	13	1	

# Resultados - pCR

- Frequência de pCR foi baixa e diminuiu conforme tornou-se a definição de pCR mais estrita:
  - ypT0/is: 22% (95% CI 21–22)
  - ypT0/is ypN0: 18% (17–19)
  - ypT0 ypN0: 13% (12–14)
- Erradicação do tumor da mama e dos linfonodos (ypN0 or ypT0/is ypN0):
  - Aumento sobrevida livre de recidiva
    - ypT0 ypN0: HR 0·44, 95% CI 0·39–0·51;
    - ypT0/is ypN0: HR 0·48, 0·43–0·54
  - Aumento sobrevida global
    - ypT0 ypN0: HR 0·36, 0·30–0·44;
    - ypT0/is ypN0: HR 0·36, 0·31–0·42.

- ypT0/is;  
Sobrevida livre de recidiva: HR 0·60;  
95% CI 0·55–0·66;  
Sobrevida global: HR 0·51;  
0·45–0·58

# Long-term outcomes for neoadjuvant versus adjuvant chemotherapy in early breast cancer: meta-analysis of individual patient data from ten randomised trials

*Early Breast Cancer Trialists' Collaborative Group (EBCTCG)\**

*Lancet Oncol* 2018; 19: 27–39

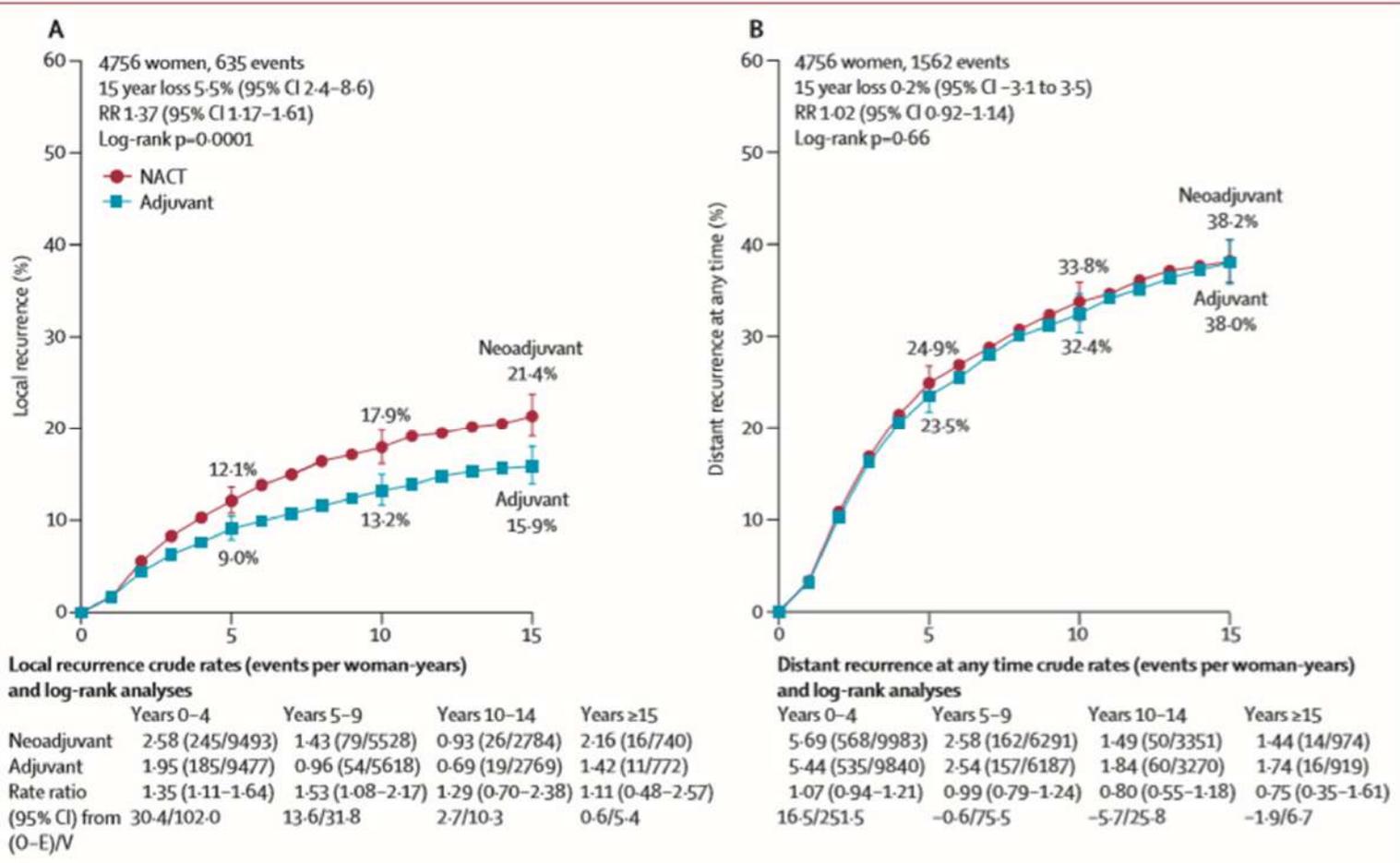
Published Online

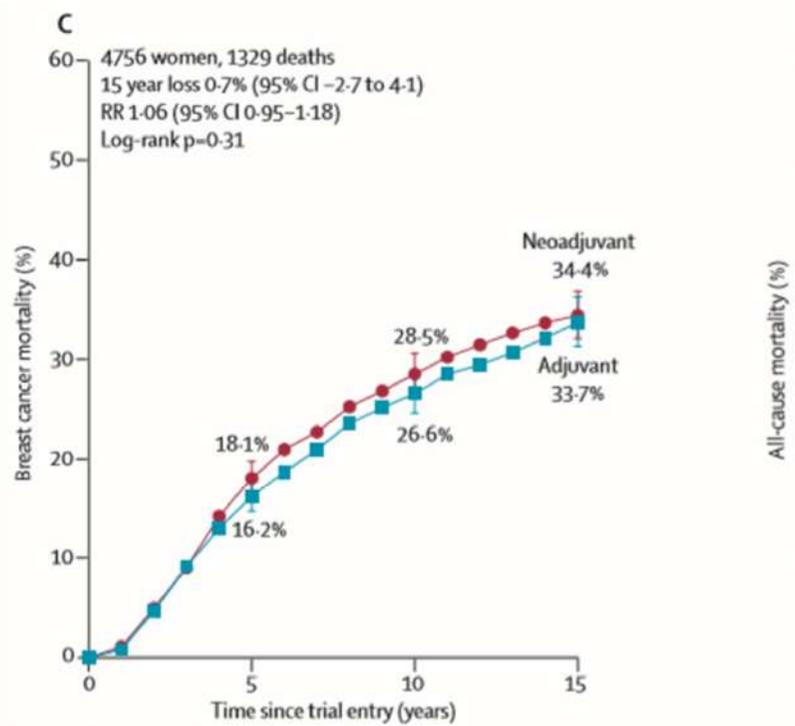
December 11, 2017

[http://dx.doi.org/10.1016/](http://dx.doi.org/10.1016/S1470-2045(17)30777-5)

[S1470-2045\(17\)30777-5](http://dx.doi.org/10.1016/S1470-2045(17)30777-5)

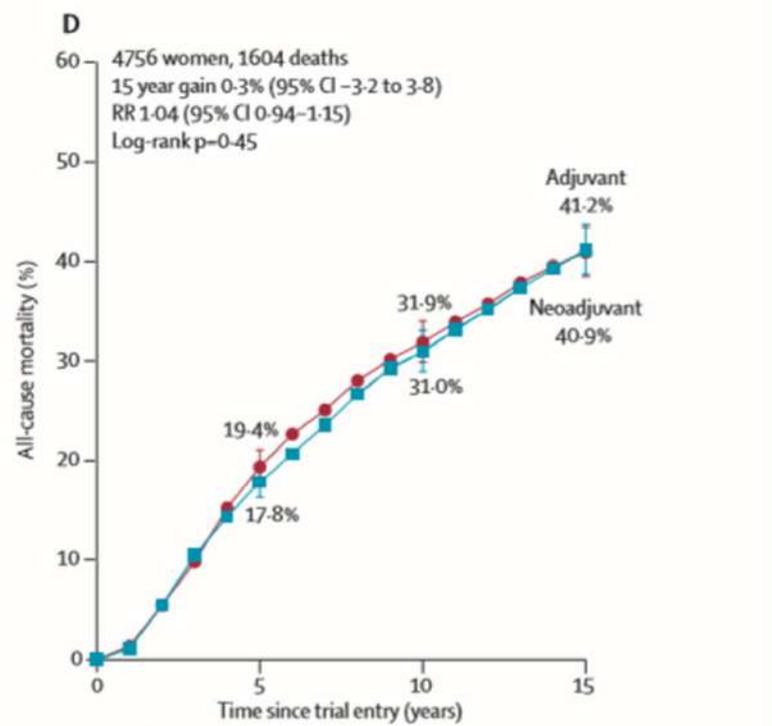






**Breast cancer mortality crude rates (events per woman-years) and log-rank analyses**

	Years 0-4	Years 5-9	Years 10-14	Years ≥15
Neoadjuvant	3.90 (412/10567)	2.82 (191/6785)	1.93 (69/3570)	1.24 (13/1050)
Adjuvant	3.49 (364/10432)	2.81 (190/6771)	2.19 (78/3559)	1.18 (12/1014)
Rate ratio (95% CI)	1.12 (0.97-1.30)	1.03 (0.84-1.27)	0.88 (0.63-1.21)	0.90 (0.41-1.97)
from (O-E)/V	20.5/179.6	2.8/91.6	-4.8/36.6	-0.7/6.2



**Any death crude rates (events per woman-years) and log-rank analyses**

	Years 0-4	Years 5-9	Years 10-14	Years ≥15
Neoadjuvant	4.22 (446/10567)	3.51 (238/6785)	2.91 (104/3570)	3.52 (37/1050)
Adjuvant	3.86 (403/10432)	3.56 (241/6771)	3.20 (114/3559)	2.07 (21/1014)
Rate ratio (95% CI)	1.09 (0.95-1.25)	0.98 (0.81-1.17)	0.90 (0.68-1.18)	1.69 (0.95-2.99)
from (O-E)/V	16.7/196.6	-2.7/112.2	-5.6/51.3	6.1/11.7

# Axila – EC II

Published in final edited form as:

*JAMA*. 2017 September 12; 318(10): 918–926. doi:10.1001/jama.2017.11470.

## Effect of Axillary Dissection vs No Axillary Dissection on 10-Year Overall Survival Among Women With Invasive Breast Cancer and Sentinel Node Metastasis:

The ACOSOG Z0011 (Alliance) Randomized Clinical Trial

Armando E. Giuliano, MD, Karla V. Ballman, PhD, Linda McCall, MS, Peter D. Beitsch, MD, Meghan B. Brennan, RN, ONP, PhD, Pond R. Kelemen, MD, David W. Ollila, MD, Nora M. Hansen, MD, Pat W. Whitworth, MD, Peter W. Blumencranz, MD, A. Marilyn Leitch, MD, Sukamal Saha, MD, Kelly K. Hunt, MD, and Monica Morrow, MD



## NIH Public Access

### Author Manuscript

*Lancet Oncol.* Author manuscript; available in PMC 2014 February 26.

Published in final edited form as:

*Lancet Oncol.* 2013 April ; 14(4): 297–305. doi:10.1016/S1470-2045(13)70035-4.

## IBCSG 23-01 randomised controlled trial comparing axillary dissection versus no axillary dissection in patients with sentinel node micrometastases

Viviana Galimberti, MD<sup>1</sup>, Bernard F. Cole, PhD<sup>2,3</sup>, Stefano Zurrada, MD<sup>4</sup>, Giuseppe Viale, MD<sup>5,6</sup>, Alberto Luini, MD<sup>7</sup>, Paolo Veronesi, MD<sup>6,8</sup>, Paola Baratella, MD<sup>7</sup>, Camelia Chifu, MD<sup>7</sup>, Manuela Sargenti, MD<sup>7</sup>, Mattia Intra, MD<sup>7</sup>, Oreste Gentilini, MD<sup>7</sup>, Mauro G. Mastropasqua, MD<sup>5</sup>, Giovanni Mazzarol, MD<sup>5</sup>, Samuele Massarut, MD<sup>9</sup>, Jean-Remi Garbay, MD<sup>10</sup>, Janez Zgajnar, MD<sup>11</sup>, Hanne Galatius, MD<sup>12</sup>, Angelo Recalcati, MD<sup>13</sup>, David Littlejohn, MBBS, FRACS<sup>14</sup>, Monika Bamert, MD<sup>15</sup>, Marco Colleoni, MD<sup>16</sup>, Karen N. Price, BS<sup>3,17</sup>, Meredith M. Regan, SD<sup>3,18</sup>, Aron Goldhirsch, MD<sup>19</sup>, Alan S. Coates, MD<sup>20</sup>, Richard D. Gelber, PhD<sup>3,17,18,21</sup>, and Umberto Veronesi, MD<sup>22</sup> for the International Breast Cancer Study Group Trial 23-01 investigators

# Resultados ACOSOG Z0011

## • Seguimento 5 anos

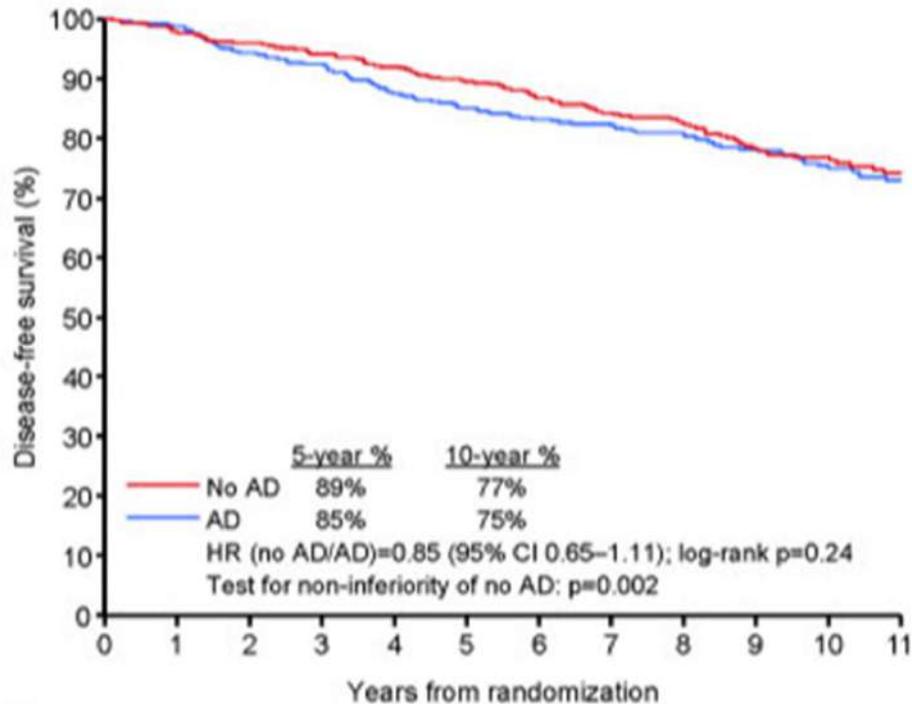
- Sobrevida global
  - 92,5% BLS X 91,8% EA
- Sobrevida livre de doença
  - 83,9 % BLS X 82,2% EA
- Recorrência Local
  - 1,6% BLS X EA 3,1%
- 2005: mediana seguimento 6.3 anos
  - Pacientes RH + - recidiva tardia

## • Seguimento 9.3 anos

- Sobrevida global
  - 86,3% BLS X 83,6 EA
- Sobrevida livre de doença
  - 80,2% BLS x 78,2 EA
- Morbidade Cirúrgica
  - EA 70% X BLS 25%

# IBCSG 23-01 – Follow up 10 anos

## Disease-Free Survival



Number at risk	0	1	2	3	4	5	6	7	8	9	10	11
No AD	467	455	443	428	412	389	367	336	278	215	168	131
AD	464	456	433	419	392	371	353	335	282	231	169	130

- Sobrevida livre de doença
  - EA: 75%
  - Sem EA: 77%
- Incidência cumulativa de eventos relacionados ao cancer de mama
  - EA: 17,3%
  - Sem EA: 17,6%
- Recorrência axilar ipsilateral
  - EA: 1,7%
  - Sem EA: 0,4%
- Sobrevida global
  - EA 88%
  - Sem EA 91%

# Discussão

- IBCSG - Pacientes submetidas ao EA → 87% sem outros LFN acometidos
- Diferença entre linfonodos axilares acometidos em pacientes com EA (13%) e baixa taxa de recorrência axilar (1%) em pacientes que não realizaram EA
  - Adjuvância – Radioterapia (AMAROS/OTOASOR)
  - Mecanismos de imunovigilância
  - Terapias multimodais

# Se cirurgia up-front...

- QUART?
  - Papel da Oncoplastia
- Adenomastectomia?
  - Unilateral – prótese x expansor
  - Bilateral – cirurgia redutora de risco

# The impact of breast cancer surgery on quality of life: Long term results from E5103

Shoshana M. Rosenberg, Anne O'Neill, Karen Sepucha,  
Kathy D. Miller, Chau T. Dang, Donald W. Northfelt,  
George W. Sledge, Bryan P. Schneider, Ann H. Partridge

ECOG – ACRIN E5103  
Bevacizumab  
4.994 pacientes.

## QoL analysis: BCS vs. Mastectomy

	Mean score*		p**
	BCS	Mastectomy	
FACT-B	114	109	0.01
EQ-5D-3L Index	0.84	0.80	0.04
EQ-VAS	82	78	<0.01

\*Higher scores=Better QoL

\*\*Wilcoxon rank sum test p-value

Minimally important differences:

**FACT-B:** 7-8 points

**EQ-5D-3L Index:** 0.06 points

**EQ-VAS:** 7 points

# Local therapy and quality of life outcomes in young women with breast cancer

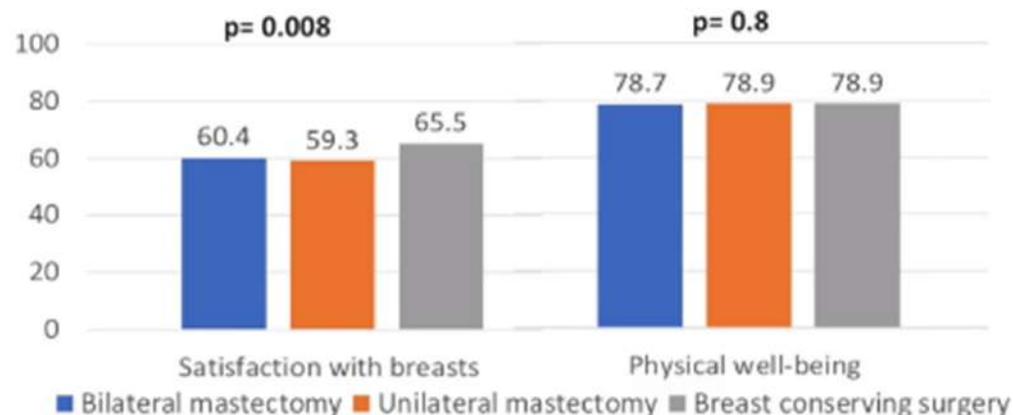
Laura Dominici, Jiani Hu, Tari King, Kathryn J. Ruddy, Rulla M. Tamimi,  
Jeffrey Peppercorn, Lidia Schapira, Virginia F. Borges, Steven E. Come,  
Ellen Warner, Ann Partridge, Shoshana Rosenberg

## The Young Women's Breast Cancer Study (YWS)

- Multicenter, prospective cohort study
- 12 participating hospitals (academic and community)

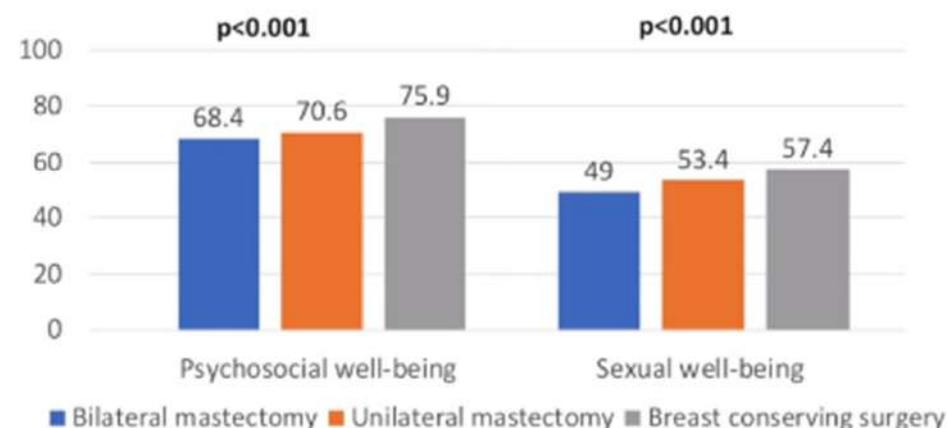


## BREAST-Q Mean Scores



Higher score = Better QOL

## BREAST-Q Mean Scores



Higher score = Better QOL

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San Antonio Breast Cancer Symposium<sup>®</sup>, December 4-8, 2018

## Multivariate Analysis: Satisfaction with Breasts

	$\beta^*$ (95% CI)	P-value**
<b>Surgery factors:</b>		
Unilateral mastectomy vs. BCS	-8.7 (-13.1, -4.3)	<0.001
Bilateral mastectomy vs. BCS	-9.3 (-14.4, -4.2)	<0.001
<b>Other treatment factors:</b>		
Radiation: Yes vs. No	-7.5 (-11.3, -3.6)	<0.001
<b>Patient factors:</b>		
Financial status: Uncomfortable vs. comfortable	-5.4 (-9.8, -1.0)	0.02

\* $\beta$  Difference in BREAST-Q score

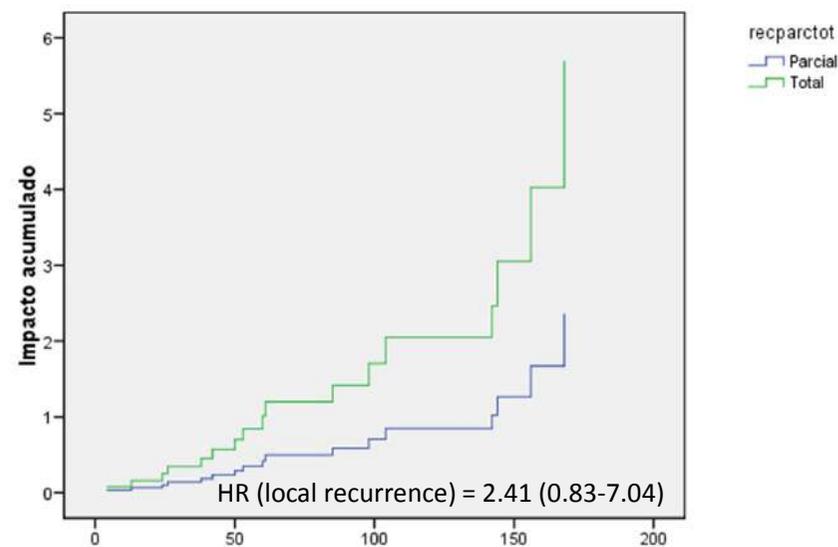
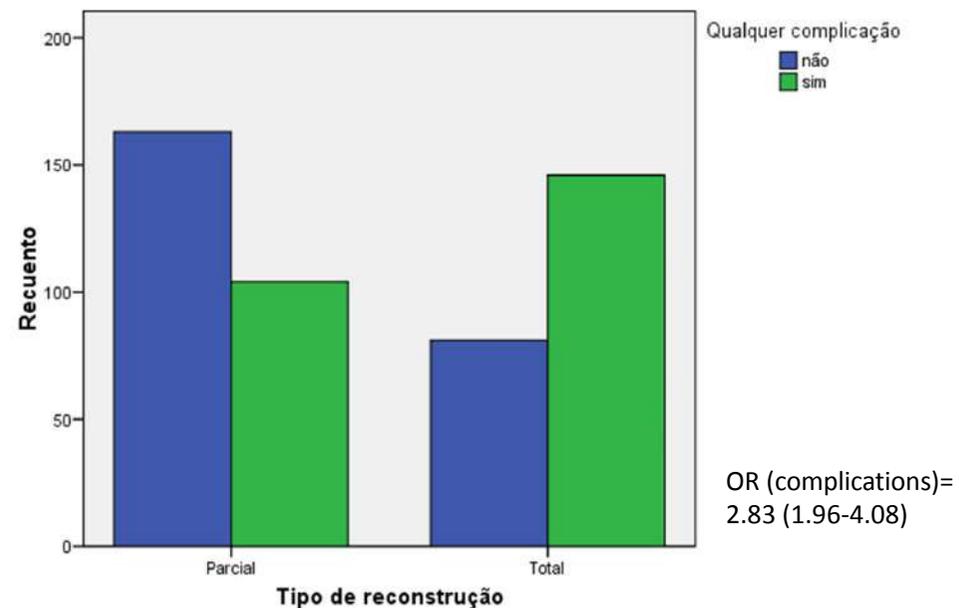
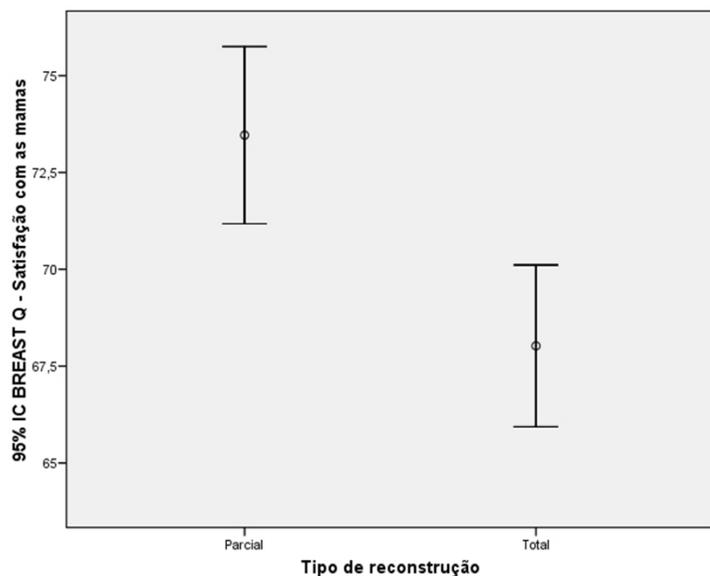
\*\*Not significant for age, race, marital status, work status, education level, stage, chemotherapy, endocrine therapy, time since surgery, lymphedema

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## COSMETIC OUTCOMES IN BREAST ONCOPLASTY: RETROSPECTIVE COHORT TO COMPARE OBJECTIVE AND SUBJECTIVE METHODS OF AVALIATION

*Paulinelli, RR; Carvalho, APB; Santos, TD; Prates, ACL; Freitas-Junior, R*

- 509 pacientes arroladas
- Coorte retrospectiva multicêntrica
  - 01/2015 a 02/2019
- Resultados foram considerados bons e excelentes em 338 (66,4%) dos casos pela avaliação dos cirurgiões, em 368 (72.3%) pelo BCCT e em 447 (87,8%) pelo BAT.



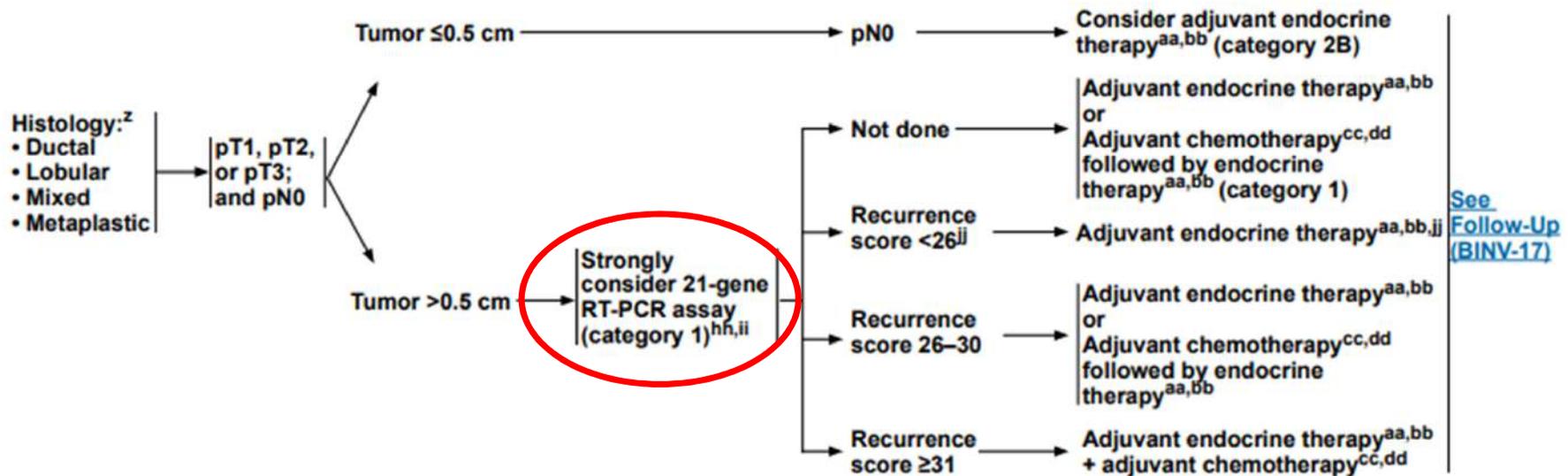
# Ferramentas Genômicas na indicação de QTx

- Mammaprint (MINDACT)
  - Redução na indicação de QT adjuvante em alto risco clínico pelo baixo risco genômico em 46,2% da amostra
- Oncotype (TAYLOR X)
  - Redução na indicação de QT adjuvante em até 85%, especialmente em > 50 anos + RS < 25 e em mulheres ≤ 50 anos com RS ≤ 15
- Oncotype Dx in the SUS:
  - Result of 125 cases – H. Pérola Byington – Mattar, A.
  - T1-T2, N0-N1, RE + e HER2 -, candidatas a adjuvância
  - Média de tamanho tumoral: 2,5cm
  - 33% pacientes com ao menos 1 LFN positivo
  - 76% pós menopausa

Reduziu indicação de QT em 68,8% (84/122) dos casos

	Indicação HT pós Oncotype	Indicação QT pós Oncotype
Indicação HT pré Oncotype 3	1	2
Indicação QT pré Oncotype 122	84	38

SYSTEMIC ADJUVANT TREATMENT: NODE-NEGATIVE - HORMONE RECEPTOR-POSITIVE - HER2-NEGATIVE DISEASE<sup>d,v</sup>



[See Follow-Up \(BINV-17\)](#)

<sup>d</sup>See Principles of HER2 Testing (BINV-A).

<sup>v</sup>See Special Considerations for Breast Cancer in Men (BINV-J).

<sup>z</sup>Mixed lobular and ductal carcinoma should be graded based on the ductal component and treated based on this grading. For metaplastic carcinoma, the prognostic value of the histologic grading is uncertain. However, when a specific histologic subtype of metaplastic carcinoma is present and accounts for more than 10% of the tumor, the subtype is an independent prognostic variable.

<sup>aa</sup>Consider adjuvant bisphosphonate therapy in postmenopausal (natural or induced) patients receiving adjuvant therapy.

<sup>bb</sup>Evidence supports that the magnitude of benefit from surgical or radiation ovarian ablation in premenopausal women with hormone receptor-positive breast cancer is similar to that achieved with CMF alone. [See Adjuvant Endocrine Therapy \(BINV-K\)](#).

<sup>cc</sup>Chemotherapy and endocrine therapy used as adjuvant therapy should be given sequentially with endocrine therapy following chemotherapy. Available data suggest that sequential or concurrent endocrine therapy with radiation therapy is acceptable. [See Adjuvant Endocrine Therapy \(BINV-K\)](#) and [Preoperative/Adjuvant Therapy Regimens \(BINV-L\)](#).

<sup>dd</sup>There are limited data to make chemotherapy recommendations for those >70 y of age. [See NCCN Clinical Practice Guidelines for Older Adult Oncology](#).

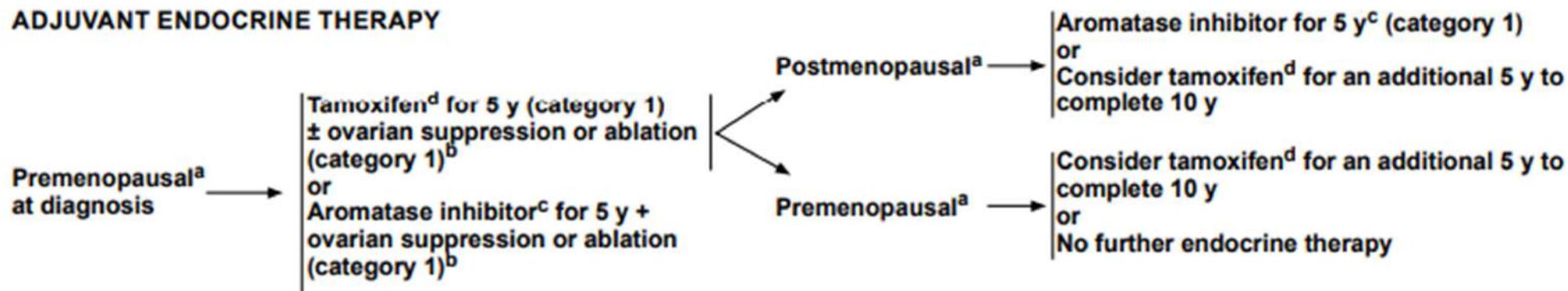
<sup>hh</sup>Other prognostic multigene assays may be considered to help assess risk of recurrence but have not been validated to predict response to chemotherapy. [See Multigene Assays for Consideration of Addition of Adjuvant Systemic Chemotherapy to Adjuvant Endocrine Therapy \(BINV-N\)](#).

<sup>ii</sup>Patients with T1b tumors with low-grade histology should be treated with endocrine monotherapy as the TAILORx trial did not include patients with such tumors.

<sup>jj</sup>Consider the use of adjuvant chemotherapy in women 50 years of age or younger with a recurrence score of 16–25 based on an exploratory analysis from the TAILORx study demonstrating lower distant recurrences in women 50 years of age or younger randomized to chemotherapy.



### ADJUVANT ENDOCRINE THERAPY



<sup>b</sup> A balanced discussion of the risks and benefits associated with ovarian suppression therapy is critical. Aromatase inhibitor or tamoxifen for 5 y plus ovarian suppression should be considered, based on SOFT and TEXT clinical trial outcomes, for premenopausal women at higher risk of recurrence (ie, young age, high-grade tumor, lymph node involvement).

**CRITERIA FOR FURTHER GENETIC RISK EVALUATION<sup>a</sup>**

- An individual at any age with a known pathogenic/likely pathogenic variant in a cancer susceptibility gene within the family, including such variants found on research testing<sup>b</sup>
- An individual at any age with a known pathogenic/likely pathogenic variant in a cancer susceptibility gene found on tumor testing ([See BR/OV-A 3 of 3](#))
- An individual diagnosed at any age with any of the following:
  - ▶ Ovarian cancer<sup>c</sup>
  - ▶ Pancreatic cancer
  - ▶ Metastatic prostate cancer<sup>d</sup>
  - ▶ Breast cancer or high-grade (Gleason score ≥7) prostate cancer and of Ashkenazi Jewish ancestry
- An individual with a breast cancer diagnosis meeting any of the following:
  - ▶ **Breast cancer diagnosed age ≤50 y**
  - ▶ Triple-negative (ER-, PR-, HER2-) breast cancer diagnosed age ≤60 y
  - ▶ Two breast cancer primaries<sup>e</sup>
  - ▶ Breast cancer at any age, and
    - ◊ ≥1 close blood relative<sup>f</sup> with:
      - breast cancer age ≤50 y; or
      - invasive ovarian cancer<sup>c</sup>; or
      - male breast cancer; or
      - pancreatic cancer; or
      - high-grade (Gleason score ≥7) or metastatic prostate cancer<sup>d</sup>
    - ◊ ≥2 close blood relatives<sup>f</sup> with breast cancer at any age
- An individual who does not meet the above criteria but has a first- or second-degree relative with any of the following:<sup>g</sup>
  - ▶ Breast cancer ≤45 y
  - ▶ Ovarian cancer<sup>c</sup>
  - ▶ Male breast cancer
  - ▶ Pancreatic cancer
  - ▶ Metastatic prostate cancer<sup>d</sup>
  - ▶ ≥2 breast cancer primaries in a single individual
  - ▶ ≥2 individuals with breast cancer primaries on the same side of family with at least one diagnosed ≤50 y
- An individual with a personal and/or family history on the same side of the family of three or more of the following (especially if diagnosed age ≤50 y; can include multiple primary cancers in same individual):<sup>g</sup>
  - ▶ breast cancer, sarcoma, adrenocortical carcinoma, brain tumor, leukemia ([see LIFR-1](#)),
  - ▶ colon cancer, endometrial cancer, thyroid cancer, kidney cancer, dermatologic manifestations,<sup>h</sup> macrocephaly, or hamartomatous polyps of gastrointestinal (GI) tract ([see COWD-1](#)),
  - ▶ lobular breast cancer, diffuse gastric cancer (see CDH1 guidelines, [GENE-2](#)),
  - ▶ breast cancer, gastrointestinal cancer or hamartomatous polyps, ovarian sex chord tumors, pancreatic cancer, testicular sertoli cell tumors, or childhood skin pigmentation (see STK11 guidelines, [GENE-4](#))

Consider referral to cancer genetics professional<sup>i</sup>

See [Assessment \(BR/OV-2\)](#)

<sup>a</sup>The criteria for further risk evaluation and genetic testing are not identical. For the purposes of these guidelines, invasive and ductal carcinoma in situ breast cancers should be included.



[anacarvalho19@gmail.com](mailto:anacarvalho19@gmail.com)

Obrigada!