



# Abordagem cirúrgica do paciente metástático

Dra Maria Cecília Monteiro Dela Vega

Oncologista Clínica- CEBROM e Hospital Araujo Jorge





- Todos os pacientes em estágio clínico IV são paliativos?
- “O câncer de mama metastático pode ser curado ?”



- Ausência de estudos prospectivos randomizados
- Grande heterogenicidade tumoral
- Risco de morte por câncer de mama diminui ano a ano
- Importância saber identificar- pacientes que necessitam de análise multidisciplinar e abordagem paliativa mais agressiva com finalidade de remissão completa.
- Opiniões médicas distintas: tratamento agressivo X tratamento paliativo



# Conceito “Oligometastática”

- Lesão solitária ou < 5
- Geralmente limitada a um órgão

## Locoregional treatment versus no treatment of the primary tumour in metastatic breast cancer: an open-label randomised controlled trial.

Badwe R<sup>1</sup>, Hawaldar R<sup>2</sup>, Nair N<sup>3</sup>, Kaushik R<sup>3</sup>, Parmar V<sup>3</sup>, Siddique S<sup>2</sup>, Budrukkar A<sup>4</sup>, Mitra I<sup>3</sup>, Gupta S<sup>5</sup>.

### Author information

#### Abstract

**BACKGROUND:** The role of locoregional treatment in women with metastatic breast cancer at first presentation is unclear. Preclinical evidence suggests that such treatment might help the growth of metastatic disease, whereas many retrospective analyses in clinical cohorts have suggested a favourable effect of locoregional treatment in these patients. We aimed to compare the effect of locoregional treatment with no treatment on outcome in women with metastatic breast cancer at initial presentation.

**METHODS:** In this open-label, randomised controlled trial, we recruited previously untreated patients ( $\leq 65$  years of age with an estimated remaining life expectancy of at least 1 year) presenting with de-novo metastatic breast cancer from Tata Memorial Centre, Mumbai, India. Patients were randomly assigned (1:1) to receive locoregional treatment directed at their primary breast tumour and axillary lymph nodes, or no locoregional treatment, by a computer-generated block randomisation sequence (block size of four). Randomisation was stratified by site of distant metastases, number of metastatic lesions, and hormone receptor status. Patients with resectable primary tumour in the breast that could be treated with endocrine therapy were randomly assigned upfront, whereas those with an unresectable primary tumour were planned for chemotherapy before randomisation. Of the patients who had chemotherapy before randomisation, we randomly assigned patients who had an objective tumour response after six to eight cycles of chemotherapy. The primary endpoint was overall survival analysed by intention to treat. This study is registered with ClinicalTrials.gov, [NCT00193778](https://clinicaltrials.gov/ct2/show/study/NCT00193778).

**FINDINGS:** Between Feb 7, 2005, and Jan 18, 2013, of the 716 women presenting with de-novo metastatic breast cancer, we randomly assigned 350 patients: 173 to locoregional treatment and 177 to no locoregional treatment. At data cut-off of Nov 1, 2013, median follow-up was 23 months (IQR 12·2-38·7) with 235 deaths (locoregional treatment n=118, no locoregional treatment n=117). Median overall survival was 19·2 months (95% CI 15·98-22·46) in the locoregional treatment group and 20·5 months (16·96-23·98) in the no-locoregional treatment group (HR 1·04, 95% CI 0·81-1·34; p=0·79), and the corresponding 2-year overall survival was 41·9% (95% CI 33·9-49·7) in the locoregional treatment group and 43·0% (35·2-50·8) in the no locoregional treatment group. The only adverse event noted was wound infection related to surgery in one patient in the locoregional treatment group.

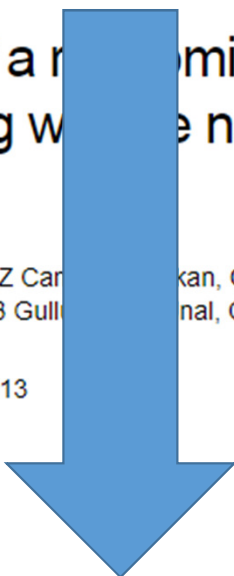
**INTERPRETATION:** There is no evidence to suggest that locoregional treatment of the primary tumour affects overall survival in patients with metastatic breast cancer at initial presentation who have responded to front-line chemotherapy, and this procedure should not be part of routine practice.

↓

Abstract S2-03: Early follow up of a randomized trial evaluating resection of the primary breast tumor in women presenting with de novo stage IV breast cancer; Turkish study (protocol MF07-01)

A Soran, V Ozmen, S Ozbas, H Karanlik, M Muslumanoglu, A Igci, Z Can, C Ozaslan, T Evrensel, C Uras, E Aksaz, A Soyder, U Ugurlu, C Col, N Cabioglu, B Bozkurt, T Dagoglu, A Uzunkoy, M Dulger, N Koksal, O Cengiz, B Gullu, C Atalay, E Yildirim, E Erdem, S Salimoglu, A Sezer, A Koyuncu, G Gurleyik, H Alagol, N Ulufi, U Berberoglu, E Kennard, S Kelsey, and B Lembersky

DOI: 10.1158/0008-5472.SABCS13-S2-03 Published December 2013



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# Fígado

- Sitio comum metástase
- 4-5 % metástase hepática isoladas
- Maior parte recorrência metástase hepática é no próprio fígado
- Metástasectomia esta consolidada nos tumores colon retais.
- Fatores de pior prognóstico: tumores triplo negativos, PD <24 meses e > 3 lesões

Eur J Cancer. 2011 Oct;47(15):2282-90. doi: 10.1016/j.ejca.2011.06.024. Epub 2011 Jul 7.

Duan XF1, Dong NN, Zhang T, Li Q. Int J Clin Oncol. 2013 Feb;18(1):26-32. doi: 10.1007/s10147-011-0336-x. Epub 2011 Oct 27.

The prognostic analysis of clinical breast cancer subtypes among patients with liver metastases from breast cancer.



## Fígado

- Fatores de melhor prognóstico: SLP > 2 anos, metástases únicas, boa resposta à quimioterapia e margens cirúrgicas livres
- Opções de tratamento local incluem : ablação, quimioembolização
- Quimioembolização- descrito taxa de sobrevida de 3 anos foi de 47,6% no grupo de tratamento combinado versus 7,4% no grupo tratamento sistêmico isolado sozinho





# Metastasectomia pulmonar

- Estudos com poucos pacientes
- Avanços em relação a técnicas cirúrgicas
- Menor morbidade cirurgica

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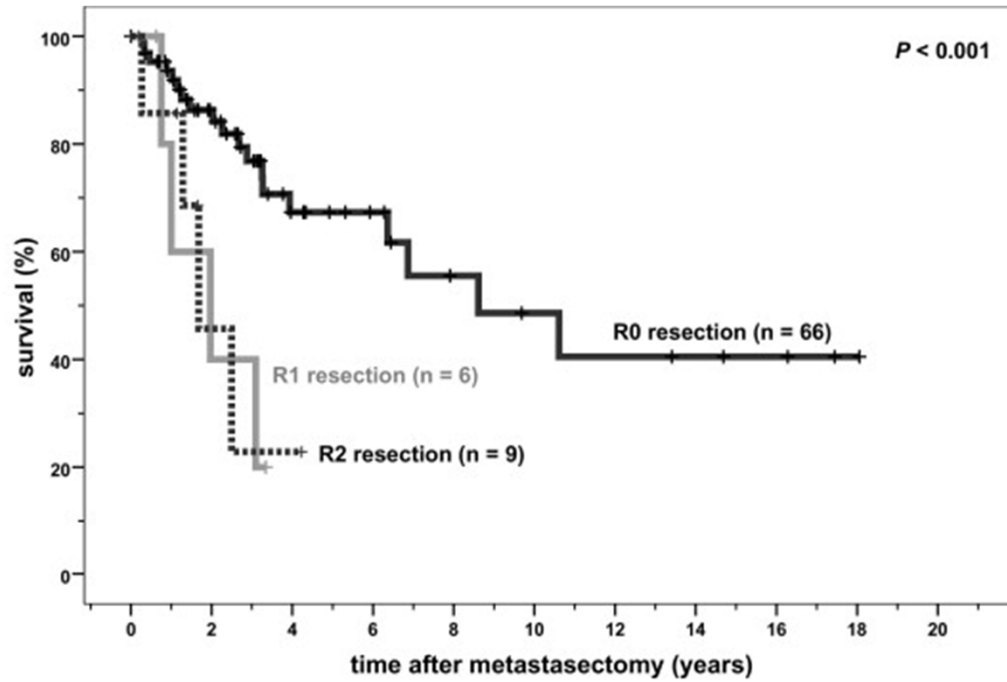
[April 2013](#) Volume 95, Issue 4, Pages 1170–1180

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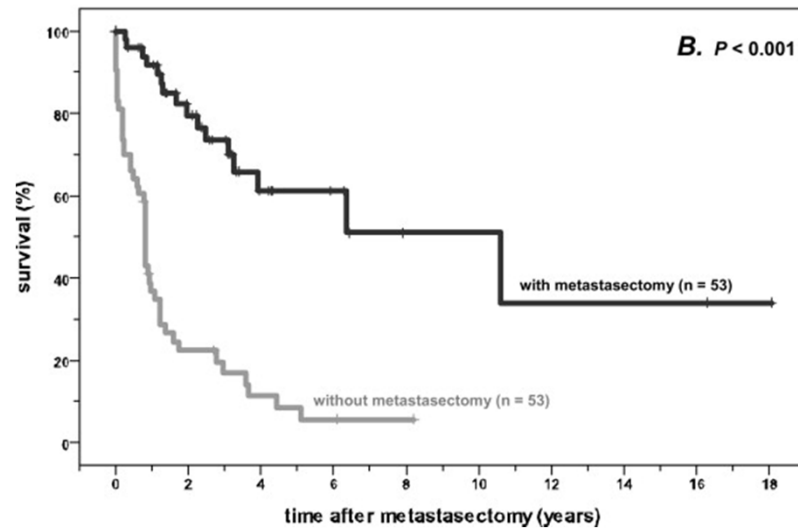
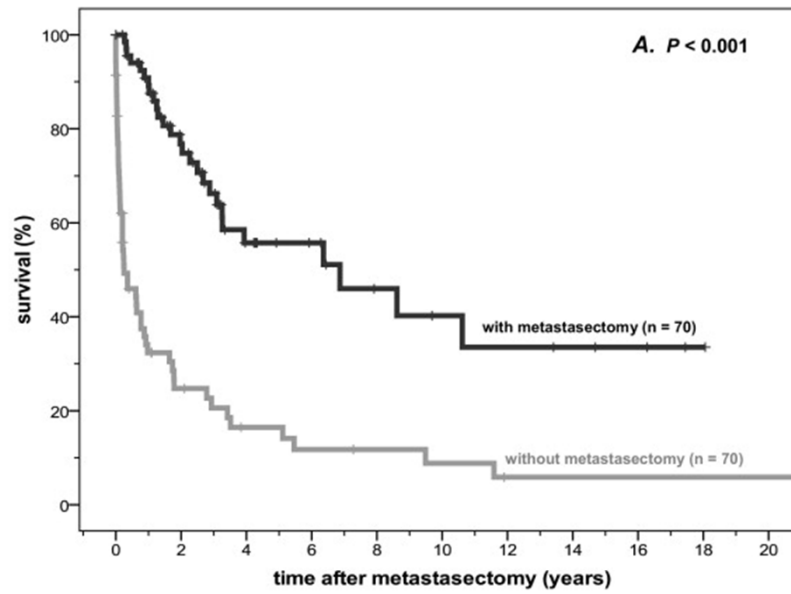
## Prolonged Overall Survival After Pulmonary Metastasectomy in Patients With Breast Cancer

[Georgios Meimarakis, MD](#)  , [Dominik Rüttinger, MD, PhD](#), [Joachim Stemmler, MD, PhD](#), [Alexander Crispin, MD, MPH](#), [Rolf Weidenhagen, MD](#), [Martin Angele, MD, PhD](#), [Jan Fertmann, MD](#), [Rudolf A. Hatz, MD, PhD](#), [Hauke Winter, MD, PhD](#)

Drs Meimarakis and Rüttinger contributed equally to this work.



	survival (years)																			
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
number at risk	66	54	40	30	19	16	13	9	8	7	6	5	5	5	4	3	3	2	1	0
R0 resection	66	54	40	30	19	16	13	9	8	7	6	5	5	5	4	3	3	2	1	0
R1 resection	6	3	2	2	0															
R2 resection	9	6	2	1	1	0														

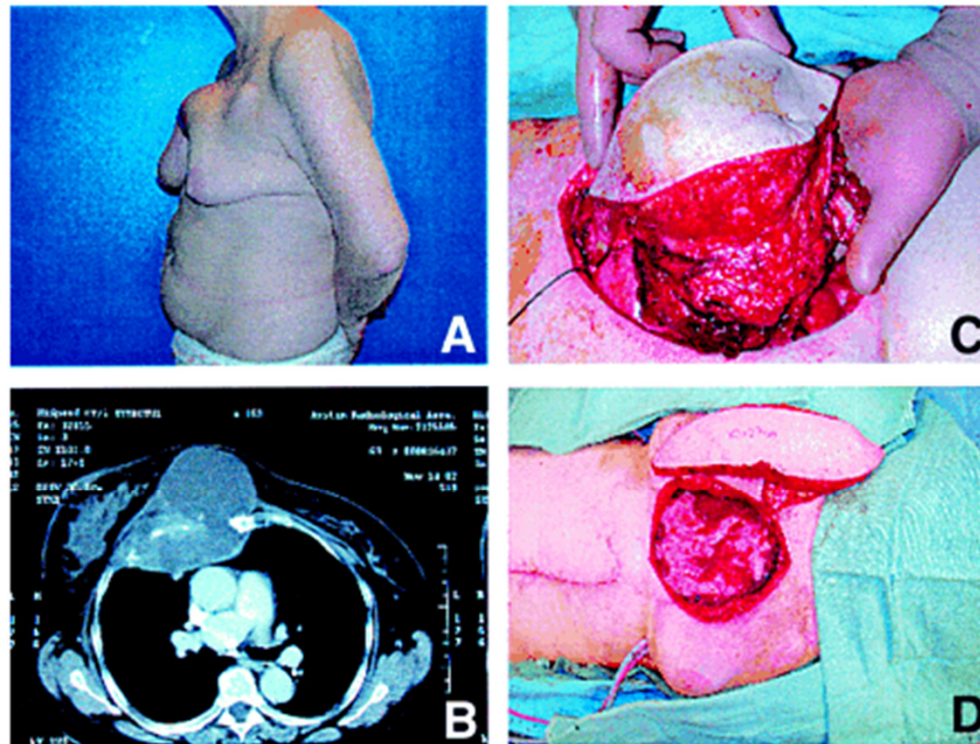


The Annals of Thoracic Surgery 2013 95, 1170-1180 DOI:  
(10.1016/j.athoracsur.2012.11.043)



# Metástases Ósseas

- Metástases ósseas isoladas- melhores desfechos em relação metástase visceral
- Cirurgia indicada quando há fratura patológica
- RT papel importante controle de dor
- Impacto acido zoledrônico e denosunabe



**Figure 1.**

***A suspected sternal metastasis in a 69-year-old woman previously treated for cancer in the right breast. A) Preoperative photograph showing sternal lesion protruding from chest wall (lateral view). B) Computerized tomography scan of***

# Papel QT “adjuvante”



## Fluorouracil, Doxorubicin, and Cyclophosphamide Followed by Tamoxifen as Adjuvant Treatment for Patients with Stage IV Breast Cancer with No Evidence of Disease

Edgardo Rivera MD [✉](#), Frankie A. Holmes MD, Aman U. Buzdar MD, Lina Asmar PhD, Shu-Wan Kau RN, Giuseppe Frascini MD, Ronald Walters MD, Richard L. Theriault DO, Gabriel N. Hortobagyi MD

First published: January 2002 [Full publication history](#)

DOI: 10.1046/j.1524-4741.2002.08002.x [View/save citation](#)

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- 45 foram avaliados. Houve uma diferença altamente estatisticamente significativa ( $p < 0,001$ ) SG e SLP 3 anos em comparação com o grupo controle (84% vs. 55% e 66% vs. 11%, respectivamente).



## Conclusão

- Poucas respostas para muitas perguntas!
- Importância abordagem multidisciplinar



Obrigada