



## A Case Study: Palliative Radical Mastectomy with Latissimus Dorsi Flap Reconstruction

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### Abstract

Breast cancer has ranked number one among Indian females with age adjusted rate as high as 25.8/100,000 women and mortality is 12.7/100,000 women, with 25% to 30% presenting with Locally Advanced Breast Cancer (LABC). Toilet Mastectomy is an excellent adjunct to palliative care in advanced breast cancer patients. This is useful for both a proper decrease (debulking) in the tumor cell load and in controlling a recurrent necrotic and/or fungating disease. Here, we share our experience with a patient presenting with MBC and complaining of a recurrent breast fungating disease, aiming to highlight the importance of palliative surgical treatment in systemic breast malignancy.

**Keywords:** Toilet mastectomy; Fungative breast; Breast cancer; Palliative radical mastectomy; LD flap reconstruction

### Introduction

Breast cancer is still the most common malignancy in women. Though management of local disease has been thoroughly studied, management of Locally Advanced Breast Cancer (LABC) is still under much debate. With 1.3 million new cases and almost half a million deaths annually worldwide, breast cancer is one of the most challenging malignancy [1]. Breast cancer has ranked number one among Indian females with age adjusted rate as high as 25.8/100,000 women and mortality is 12.7/100,000 women, with 25% to 30% presenting with Locally Advanced Breast Cancer (LABC) [2,3].

However, survival of patients with LABC is steadily improving [4], with a decrease of the risk of death by 1% to 2% yearly [5].

Locally advanced breast cancer, is a sub category of breast cancers that usually present with large fungating growth tumors with regional lymphadenopathy, and direct extension of the tumor to the chest wall and/or skin, in the absence of distant metastasis [6]. Fungating malignant lesions are a subclass with ulcerative and necrotic characteristics which manifest with pain, disfigurement, hemorrhage, odor, and infections [7-10].

Surgery is the main stage for LABC with NACT followed by. Toilet Mastectomy is an excellent adjunct to palliative care in Advanced Breast Cancer patients. This is useful for both a proper decrease (debulking) in the tumor cell load and in controlling a recurrent necrotic and/or fungating disease [11,12]. The aim of palliative care is to improve the quality of life and make the subject as comfortable as possible.

Here, we share our experience with a patient presenting with LABC and complaining of a breast fungating disease, aiming to highlight the importance of palliative surgical treatment in systemic breast malignancy. LABC is NACT followed by surgery and Radio therapy. A subset of patients where NACT does not show response tumor program is a challenging situation.

### Case Presentation

A young female patient of age 33 years presented with large fungating right breast mass with foul smell and discharge.

CT scan of the Chest with Contrast revealed

- i. Large irregular heterogeneously enhancing necrotic exophytic right breast mass causing deep ulceration.
- ii. Multiple necrotic nodules and mass lesion involving at right axilla. Metastatic nodes are

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Figure 1: Pre operative image showing ulcerative fungating breast mass.



Figure 2: Showing breast mass after surgery.

formed.

CT scan of abdomen and pelvis (Plain & Contrast) is normal.

**Histopathological examination:** On gross examination breast mass measuring 14.5 cm × 13.6 cm × 5.8 cm covered with a skin flap measuring 10.5 cm × 10 cm. Externally the skin flap shows a large ulcerated area measuring 10.5 cm × 8 cm. Nipple areola identified separately from ulcerated area. Distance of nipple from ulcerated area is 0.8 cm. Cut surface shows a lesion, which is a firm breast mass at right side measuring 8.6 cm × 6.5 cm × 5.2 cm grey white, with occasional hemorrhagic areas is seen.

Level II/III axillary lymph nodes contain globular mass measuring 6.5 cm × 5 cm × 4 cm. A cyst wall infiltration contains grey white-grey brown soft tissue measuring 2.5 cm × 2 cm × 0.3 cm.

Microscopic examination shows extensive areas of necrosis with viable lesion predominantly composed of large polygonal cells arranged around the vessels. There is marked nuclear pleomorphism. Lobules of cartilage with atypical cells are seen in lacunae. Level II/III axillary lymph node shows metastatic tumor deposits and chest wall shows involvement of tumor. Histopathology report reveals metaplastic carcinoma with Chondrosarcomatous Differentiation-ypT4 cN3a Mx of right breast.

**Histological grade:** Nottingham Histologic score

- Tubule differentiation-3
- Nuclear pleomorphism-3



Figure 3 & 4: Intra operative image showing the axillary lymph node.



Figure 5: Shows raw area after lymph node dissection.

-Mitosis figure -3

Total score -9

**SBR grade III:**

Tumor focality - Unifocal

Margins - separately sent superior & inferior margins including posterior surface are uninvolved.

Treatment effect in lymph node - No definite response ion presurgical therapy in metastatic carcinoma.

Lymphovascular emboli - Present

Extranodal extension - Present

**Pathologic staging (pTNM):**

Primary tumor - ypT4c



**Figure 6:** Shows large axillary lymph node mass.

Regional lymph nodes - ypN3a (metastasis to level III axillary lymph node)

Distant Metastasis - ypMx

**Immunohistochemistry (IHC) report:**

ER - Negative

PR - Negative

HER2/neu - Negative

She was evaluated outside at a private hospital, where she was diagnosed as a carcinoma of breast and a trail of 2 cycles of NACT chemotherapy treatment given which showed progression of disease and patient was planned for supportive palliative care. In view of young age of patient a palliative definitive toilet mastectomy was done after taking informed consent of patient and patient attendars, to increase the survival rate and give a benefit of core. Toilet Mastectomy was done with level I to III lymph node dissection. The raw area was closed with LD flap reconstruction.

Post operatively, patient recovered well and discharged. Further patient was given 8 cycles of adjuvant chemotherapy treatment

followed by 50 Gy of radiation to extra chest wall and supra clavicular area. After 3 years of survival and follow up, patient is doing well.

**Conclusion**

Based on the survival rate of greater than 3 years, a subset of young patients can be planned for palliative radical mastectomy with LD flap reconstruction.

**References**

1. Bray F, Ferlay J, Soerjomataram I, Siegel RL, Torre LA, Jemal A. Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA Cancer J Clin.* 2018;68(6):394-424.
2. Malvia S, Bagadi SA, Dubey US, Saxena S. Epidemiology of breast cancer in Indian women. *Asia Pac J Clin Oncol.* 2017;13(4):289-95.
3. Valero VV, Buzdar AU, Hortobagyi GN. Locally advanced breast cancer. *Oncologist.* 1996;1(1&2):8-17.
4. Andre F, Slimane K, Bachelot T, Dunant A, Namer M, Barrelier A, et al. Breast cancer with synchronous metastases: Trends in survival during a 14-year period. *J Clin Oncol.* 2004;22(16):3302-8.
5. Giordano SH, Buzdar AU, Smith TL, Kau SW, Yang Y, Hortobagyi GN. Is breast cancer survival improving? *Cancer.* 2004;100(1):44-52.
6. Garg PK, Prakash G. Current definition of locally advanced breast cancer. *Curr Oncol.* 2015;22(5):e409-10.
7. Merz T, Klein C, Uebach B, Kern M, Ostgathe C, Bükki J. Fungating wounds - multidimensional challenge in palliative care. *Breast Care (Basel).* 2011;6(1):21-4.
8. Halverson KJ, Taylor ME, Perez CA, Myerson R, Philpott G, Simpson JR, et al. Survival following breast-conserving surgery and irradiation or modified radical mastectomy in patients with invasive breast cancers with a maximum diameter of 1 cm. *Mo Med.* 1993;90(12):759-63.
9. Halsted CP, Benson JR, Jatoi I. A historical account of breast cancer surgery: Beware of local recurrence but be not radical. *Future Oncol.* 2014;10(9):1649-57.
10. Delpech Y, Barranger E. Breast cancer surgery. *Rev Prat.* 2013;63:1395-9.
11. Charles Brunnicardi F, editor. *Schwartz's Principles of Surgery.* 9<sup>th</sup> Ed. Mc Graw Hill; 2010. Chapter17.
12. Fischer, Josef E, editors. *Mastery of Surgery.* 5<sup>th</sup> Ed. Lippincott Williams & Wilkins; 2007. Chapter 41-46A.