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Male breast cancer exhibiting features of basal-like subtype female breast cancer

Suna Cokmert ^{a, *}, Fadime Bahadir ^c, Tunc Guler ^b, Ozgur Tanriverdi ^d^a Medicana International Ankara Hospital, Department of Medical Oncology, Ankara, Turkey^b Medicana Konya Hospital, Department of Medical Oncology, Konya, Turkey^c Sultanbeyli State Hospital, Department of Pathology, Istanbul, Turkey^d Sıtkı Kocman University School of Medicine, Department of Medical Oncology, Mugla, Turkey

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ABSTRACT

The molecular subtypes of male breast cancer are not well-known, but luminal A is generally regarded as the predominant subtype. We present the clinical and histopathological features in a man with triple-negative breast carcinoma.

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1. Introduction

Male breast cancer (MBC) is uncommon, accounting for approximately 1% of all breast cancers and male cancers.¹ The clinical and pathological understanding of male breast cancer is therefore limited, and its management has been extrapolated based on information from female breast cancer. MBC is generally thought to behave like estrogen receptor (ER)-positive breast cancer in post-menopausal women.² Recent immunohistochemical studies have identified luminal subtype as the most common subtype of MBC,^{3,4} with basal-like subtype occurring in only 4%–5% of cases,^{4,5} while HER2-overexpressing MBC has not been observed.⁶ We report an extremely rare case of a man with basal-like invasive ductal carcinoma of the breast.

2. Case report

A 57-year-old man presented to the outpatient surgical clinic with a mass in his right breast. The patient was a smoker, and there was no medical history of trauma, gynecomastia, liver disease, or drug use, and no family history of breast cancer. Physical examination revealed a 2 cm tumor located in the left breast, with no

retraction or ulceration of the overlying skin. The armpits showed no signs of lymphadenopathy. Fine needle aspiration cytology indicated malignancy. He underwent modified radical mastectomy and was referred to the oncology department. Pathological examination confirmed a 2 cm invasive ductal carcinoma, histologic grade 3 and nuclear grade 3 (Fig. 1). The breast surgical margins were clear, with no infiltration of the pectoralis muscle fascia and nipple. The axillary lymph nodes showed no signs of cancer (0/15), and there was no vascular or perineural invasion. Immunohistochemical staining of the tumor was negative for ER and progesterone receptor (PR), and c-erbB2 (Fig. 2), but positive for cytokeratin (CK) 5/6, P53, and epidermal growth factor receptor (EGFR) (Figs. 3–5). Chest computed tomography revealed a 4-cm lung mass in the right upper lobe. Fiberoptic bronchoscopy revealed no tumors within the visible field, and transbronchial biopsy was performed to rule out the possibility of second primary lung cancer in light of the patient's smoking history. The results of histological examination were consistent with lung metastasis of invasive ductal cancer of the breast. The patient was finally diagnosed with stage IV (T1N0M1) breast cancer and treated with six cycles of chemotherapy with docetaxel, doxorubicin, and cyclophosphamide. The size of the metastatic lesion in the lung decreased remarkably during chemotherapy and had almost disappeared by the end of treatment. However, follow-up revealed multiple brain metastases 7 months after the initial chemotherapy. The patient died of neurological seizures and associated aspiration pneumonia during palliative radiotherapy for brain metastases.

* Corresponding author. Medicana International Ankara Hospital, Department of Medical Oncology, Ankara, Turkey. Fax: +90 3122858648.

E-mail address: sunacok@gmail.com (S. Cokmert).

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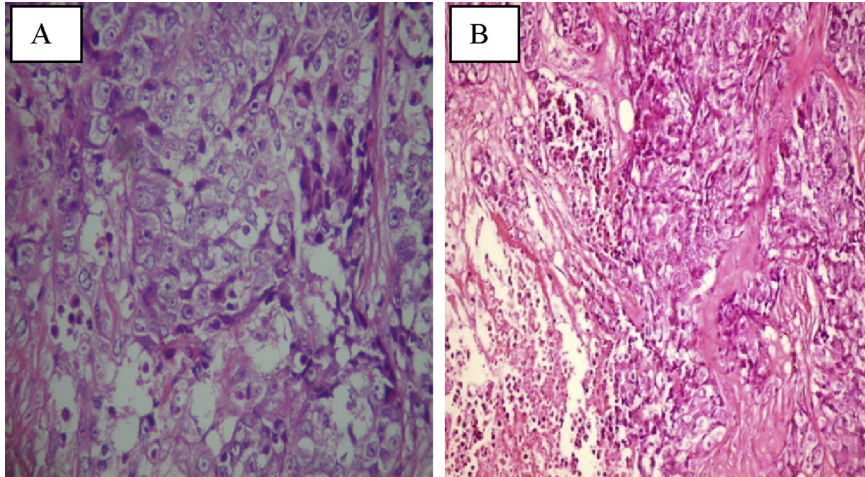


Fig. 1. A: Tumor tissue showing the medullary tumor features (HE X200). B: Tumor consists of oval, polygonal cells with vesicular nucleus and nucleolus with eosinophilic cytoplasm and shows tumor necrosis and solid groups (HEX200)

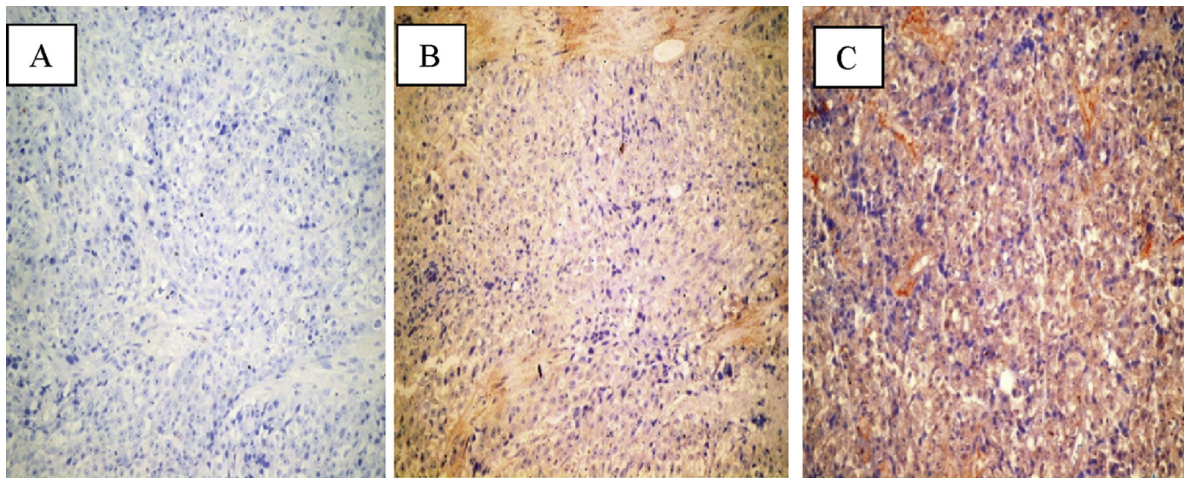


Fig. 2. A: ER negativity (HEX20), B: PR negativity (HEX20), C: cerb-B2 negativity (HEX20)

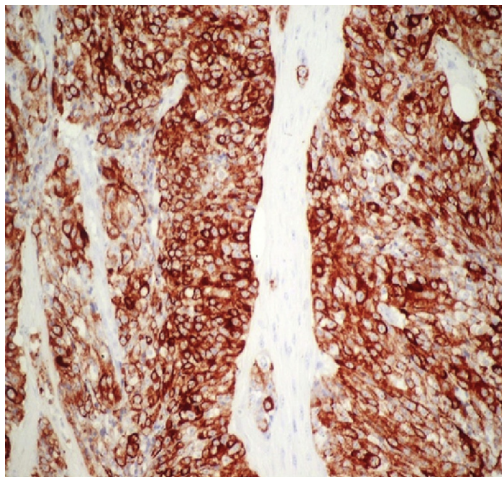


Fig. 3. Immunostaining for CK5/6 shows a positive reaction in all tumor cells (HEX200)

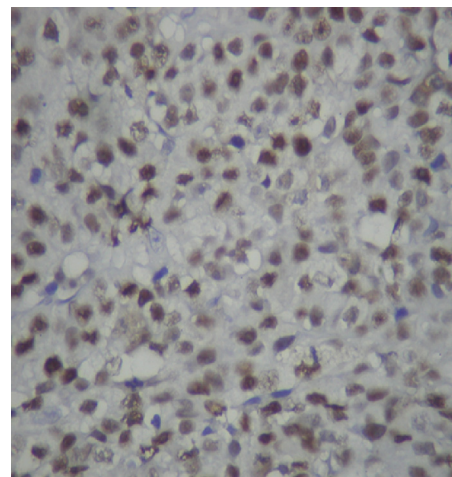


Fig. 4. Immunostaining for P53 shows a positive reaction in tumor cells (HEX200)

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