EXPERT MEDICAL OPINION REPORT

Docspert Health

Medical opinions from leading international doctors

Client Name

Date dd/mm/yyyy

DOCSPERT HEALTH CASE REPORT

Dear client,

This is your expert opinion report.

How to read the report?

- Always consult and discuss the findings with your doctor.
- Kindly bear in mind that the report is based only on the information you provided and that the expert consultant has not had the opportunity to examine you personally.
- If you or your doctor may have questions related to this report, you can ask the expert consultant any follow up questions within 10 days of receiving this report.
- For more in-depth discussion, you can request a video consultation with the expert consultant to discuss your questions. Please note that there is an extra fee for this service.
- If you want to receive treatment or have an operation in the US, UK or Europe, you can contact us to assist you and arrange all inquiries and procedures.
- Please feel free to contact us anytime. We are here to support you on your way to recovery.

Docspert Health team

Case number: [redacted]

Created On: [redacted]

Consultant

Prof. Jaak Janssens

Professor of oncology at the University of Hasselt & Maastricht and Head of Oncology department – Limburg Oncological Center, Salvator Hospital, Hassel, Belgium.

Profile link:
https://www.docspert.com/en/experts/Prof.-Jaak-Janssens

Patient's information

Name: [redacted]

Gender: Female

Date of birth: [redacted]

Personal history

[redacted] 55 years old female patient living in [redacted]. She is married 29 years ago, with 3 offsprings, the youngest is 20 years old. She works as gynecologist, no smoking or other special habits of medical significance, no DM, occasional hypertension. menopause occured at the age of 52.

weight: 89 kg

Hieght: 173 cm

Patient's complaint

Recurrent breast cancer on the left side at 3 O'clock position

History of present illness

The case started 3 years ago in 3/2017, when the patient felt a mass at 3 Oclock position. It was 3.3* 2.5 cm and immobile, firm and the skin was free, no dimbling, no puckering, no discharge, no ulceration, no redness. 2 L.Ns were palpated at the tip of left axilla. each was firm and 1 cm diameter. The right breast and axilla were completely free. few weeks later, the patient sought medical advice, mammography and MRI were done, then cut biopsy was done confirming Duct carcinoma grade 2, it was ER positive, PR negative and HER2 positive (Triple positive). The patient started FEC Chemotherapy sessions, She took 8 sessions, but at the 4th session, targeted cell therapy, taxotere, was introduced, she took 17 sessions in addition to 30 sessions of radiotherapy. After the 8th session of chemotherapy, on 3-8-2017, the patient had conservative breast surgery in which the mass was removed in addition to level 1 and 2 L.Ns, 18 L.Ns ere removed . After the surgery the, the patient completed the course of targeted cell therapy till 5-2018. Then, the patient took arimidex , anti-estrogen, she is still taking it till now. The patient was completely free, till 16-6-2020 when Mammography was done as a part of her follow up, the results was doubtful, so MRI was done, there is a mass at the same site of the first one of 1.3*1.5 cm , Cut biopsy was done confirming Duct carcinoma grade 2, it was ER positive, PR negative and HER2 positive

(Triple positive). There was edema at the site of cut biopsy, as complication to a wrong technique. CT of bed was free, there is only skin thickness, no other symptoms.

General enquiry

Constitutional –No change

Eyes –NO jaundice, mild changes in vision, no double vision, no blurry vision, She is wearing glasses.

ENT – No congestion, changes in hearing, does not wear hearing aids.

Mouth–No fetor hepaticus or any other abnormal mouth odor, no dental cares.

Skin/Breast – No rashes/ petechiae / pigmentations / spider nevi /nodules/ or discharge.

Cardiovascular – The patient had Mitral Valve Prolapse with Mitral regurgitation without any complication. The patient has occasional Hypertension, for which she is on bisoprolol 2.5 mg once daily.

Pulmonary – No breathing problems, no cough.

Gastro–Intestinal – No nausea/vomiting/diarrhea or constipation, ((No/Yes)) changes in the appetite, No melena/fresh bleeding per rectum

Genito Urinary – No increased frequency or pain on micturition.

Musculo Skeletal – no changes in strengths, there is joint tenderness and swelling at small joints of both hands and osteoarthritis of knees

Neurologic – No changes in memory/ disturbed conscious level/ motor dysfunction/seizures/ confusion or coma.

Psychology – No changes in mood

Haem/Lymph – No easy bruising, history of hematemesis/hemorrhoids, Anemia, Polycythemia

Menstrual history – Regular Cycles then sudden stoppage after the second session of the chemotherapy with no other complication

Past medical history

No history of HCV/ HBV/ HIV.

No history of previous surgical operations.

No history of Hypertension, DM nor Hypo/ Hyperthyroidism.

No history of Hypercholesterolemia nor Dyslipidemia.

No history of previous blood transfusion.

Medications history

FEC chemotherapy, 5 fluorouracil , Epirubicin. Cyclophosphamide. For 8 sessions

targeted cell therapy, taxotere for 17 sessions

Anti-estrogen 1 mg once for 3 years ago till now

Calcium supplements

Alfacalcidol, 0.25 MCG once daily

Bisoprolol 2.5 mg occasionally when the blood pressure is raised

Patient's hospitalization history

Laporoscopic Cholecystectomy in 2000.

CS on labor of the third offspring in 2000.

Conservative breast surgery in 2017

Family history

No Consanguinity

Family history of similar condition, her cousin had a similar condition in 2008 when she had breast cancer of grade 3 triple negative , unmentioned type, she had a radical mastectomy.

Family history of diseases run in family, the patient suffers from Arthropathy of small joints like her mother, it is not of Rheumatoid pattern.

Allergies to drugs and other allergies

No history of drug or food allergy

Working diagnosis

Recurrent duct carcinoma grade 2 of the left breast.

Patient Investigations

1. ### Investigations in 2017

Pathology

- Pathology Report (07.04.2017)
- Immunochemistry Report (07.04.2017)

Others

- Surgery Report (03.08.2017)

2. ### Investigations in 2020

Bloods

- CBC (02.07.2020)
- Coagulation profile (02.07.2020)
- LFT (02.07.2020)
- KFT (02.07.2020)
- Vit D (02.07.2020)

Scans

- MRI of both breasts (24.06.2020)
- Echocardiography Report (04.07.2020)
- Whole body PET/CT (06.2020)

Pathology

- pathology Report (25.06.2020)
- Immunochemistry Report (25.06.2020)

Patient's queries

1- What is the best management option of this case? Please, mention the advantage and disadvantages of the option you choose.

2- What is the protocol should be followed in the next days?

3- What is your opinion regarding these protocols:

1) Surgery then 10 session of radiotherapy then herceptin targeted therapy for one year. Is 10 sessions of radiotherapy harmful to the patient taking into consideration that she had 30 sessions 3 years ago ?

2) Surgery then 2 chemotherapy drugs, carboplatin and taxol for six months and pertuzumab+ Herceptin as targeted cell therapy at the beginning of chemotherapy and for one year. Is taking only one drug of the mentioned targeted therapy enough and useful for this case? Is it harmful to take both drugs?

3)surgery then pertuzumab+ Herceptin as targeted cell therapy for one year without use of chemotherapy. Does the absence of chemotherapy decreases the possibility of cure?

4)Chemotherapy and targeted cell therapy together then Surgery.

5) What is best for HER +ve, pertuzumab or Herceptin?

6)How many sessions should the patient take of targeted cell therapy and chemotherapy?

4- Which type of surgery should be done? Radical mastectomy of both breasts or removal of the breast leaving only nipple and skin?

5- Is there specific Diet Regimen should be followed for this case?

6- Is it possible not to do surgery and pt take only target therapy and or chemotherapy?

7- If mastectomy is to be done could breast reconstruction be done in the same setting?

8- If reconstruction is done after operation, what is the time interval?

9- What is the regime of follow up during and after end of treatment?

10-Is there is risk of having endometrial or ovarian carcinoma,what can patient do

to avoid this?

11- What is the percentage of recurrence for any of the protocols?

12-What type of food should patient take and what type should l avoid totally?

Expert Opinion on [redacted]

Kindly Note,

This is a second opinion and not a prescription or a treatment plan. We always advise that all treatment and follow up should be undertaken by your local doctor.

Prof. Jaak Ph. Janssens
BV Dr. Jacques Janssens
p.h.c. Oncology

Dear Colleague,

It is my pleasure to provide you the results of the medical record study of:

[redacted] born on [redacted]

CORE DATA	
Medical History	- 2000 Laparaoscopic cholecystectomy - 2000 SC - A0P3G3 - MI insufficiency – asymptomatic - Hypertension - Osteoarthritis (small joints and knees)
Relevant Medication	- Bisoprolol 2.5 mg - Arimidex - Calcium - Alfacalcidol
Allergy	None
Blood group	
DNR-Code	0
Vaccination status	Normal

Attention	NA
Physiognomy	89 kg, 173 cm

March 2017: mass of 3.3*2.5 cm in the left breast at 3B with 2 lymph nodes (⦸ 1 cm) in the left axilla.

06-04-2017 Breast biopsy (tru-cut): IDC2 (infiltrating duct carcinoma) grade II. [ERpos SCORE 8/8, PR SCORE 3/8, HER2pos OVEREXPRESSION 3+) - no molecular biology

- Chemotherapy FEC*8. Taxotere*17 until May 2018.
- 03-08-2017 Lumpectomy and axillary dissection: (pN = 0/18) no positive margins
- Radiotherapy *30 (no further specifications)
- May 2018: Start Arimidex

16-06-2020 RX Mammography: suspicious lesion (10*10 mm) left breast - BIRADS 0 (indeterminate)

24-06-2020 MRI: suspect mass 15*13 mm left breast - BIRADS 4

06-2020 PET-CT scan: low grade metabolically active left breast operative bed speculated lesion. No other (distant) lesions.

25-06-2020 tru-cut biopsy: IDC2 (ERpos SCORE 8/8, PR SCORE 3/8, HER2pos OVEREXPRESSION 3+) -

02-07-2020 Blood exam: no CA 15.3 or CEA tumor marker

04-07-2020 ECG:

Discussion:

Based on the available data: the patient suffers from a locally recurrent Luminal B type breast cancer. No sign of metastasis on PET-CT scan.

The diagnosis of luminal B seems solid. In addition, some open questions remain:

- HER2: Immunohistochemistry overexpression – how is the ISH and score
- Was there a decrease in tumor size after FEC chemotherapy?
- Why no Herceptin immediately after surgery in 2017?
- How was radiotherapy done: dose on the breast (should be at least 45 Gray), dose on the tumor bed (should be at least 66 Gray), dose on the lymph nodes (should be at least 45 Gray in conventional fractions of 2 Gray)?

In the absence of generalized disease, I would recommend starting with **simple mastectomy** (including overlying skin and nipple area) at the left side with reconstruction after one year.

Thorough pathology and molecular biology of the resected cancer (we assume that this recurrent cancer has the same molecular type as the first one.

Postoperative **hormone therapy** (e.g. tamoxifen 20 mg per day for 10 years) and **Herceptin SC** (subcutaneously) monthly for 1 year.

Expert opinion:

Diagnosis	Recurrent luminal B type breast cancer 'in situ'
Recommended treatment	Radical surgery, hormone treatment, Herceptin
Alternative treatments	Chemotherapy (if there was measurable reduction in size after FEC therapy)
Expected natural history and prognosis	50 % of patients with local recurrences show distant metastasis. So, a bone scintigraphy, RX thorax and ultrasound of the abdomen is mandatory. The PET-CT scan is useful if the recurrent cancer is visible in the left breast (now described as "low metabolic activity".
Any further information	More molecular biology should be done to evaluate all alternatives, including BRCA somatic mutations,…
Patient's questions	See Below

Patient's queries:

What is the best management with advantages/disadvantages?

Therapy	Advantages	Disadvantages
Simple mastectomy	Best option for cure Best option of reconstruction	Loss of breast
Hormone therapy	Best option against recurrent disease	Postmenopausal symptoms Osteoarthritis

Herceptin	Decreases risk for recurrence with at least 10%	Cardiac function (ventriculography) should be monitored

What protocol should be followed in the next days?

Simple mastectomy

What is your opinion regarding these protocols?

Surgery + 10 sessions of radiotherapy + Herceptin

In view of the early recurrence (within 3 years) after former radiotherapy the addition of limited radiotherapy seems not relevant now.

Surgery + chemotherapy (carboplatin taxol * 6) + pertuzumab + Herceptin simultaneously for 1 year. One cytostatic enough?

Carbotaxol is a chemotherapy that proved to be useful for triple negative breast cancer but might work in all breast cancers. In particular, for BRCA mutated breast cancers. Therefore, molecular biology should be expanded to also include somatic BRCA mutations.

Surgery + pertuzumab + Herceptin for 1 year without chemotherapy

Is an option, provided that hormone therapy is included.

Chemotherapy + Herceptin; then surgery

In the absence of data that FEC reduced the size of the cancer in 2017, there is no reason to believe that chemotherapy for recurrent disease would be the first choice. It is an option though because the effect of chemotherapy on the size of the tumor can be measured now. But if no regression after 2 months, no further time should be lost and surgery should be done immediately.

What is best: pertuzumab or Herceptin?

Herceptin remains the first choice although recent data show a synergism between the two (Richard S, Selle F, Lotz JP, Khalil A, Gligorov J, Soares DG. Pertuzumab and trastuzumab:

the rationale way to synergy. *An Acad Bras Cienc*. 2016;88 Suppl 1:565–577. doi:10.1590/0001-3765201620150178 and von Minckwitz G, Procter M, de Azambuja E, et al. Adjuvant Pertuzumab and Trastuzumab in Early HER2-Positive Breast Cancer [published correction appears in N Engl J Med. 2017 Aug 17;377(7):702] [published correction appears in N Engl J Med. 2018 Oct 18;379(16):1585]. *N Engl J Med*. 2017;377(2):122–131. doi:10.1056/NEJMoa1703643). In a head to head comparison, Herceptin remains first choice.

How many cycles chemotherapy – how many cycles pertuzumab – Herceptin?

A typical adjuvant chemotherapy has 6 cycles (6 months). A normal Herceptin (with or without pertuzumab) is 1 year.

What type of surgery: mastectomy of both breasts or mastectomy leaving nipple and skin (subcutaneous mastectomy)

Simple mastectomy confers the lowest risk for local recurrences

Is there a specific diet to follow?

A diet high in fatty fish, vegetables and fruits with **weight control** is advisable. Mediterranean diet is an alternative. Refined sugars and animal fat should be lowered.

Is no surgery an option?

No, because it is the only way to cure.

Simultaneous surgery with breast reconstruction?

Is possible but needs a team (oncologic and plastic surgeons) that is used to these interventions. Time loss due to wound problems should be avoided to have maximal benefits from Herceptin therapy

Ideal time breast reconstruction after mastectomy?

1 year

Regime to follow during and after treatment?

Regular follow up. PET-CT can be done every year for the first 5 years if the recurrent cancer was well visible on the 2020 PET-CT scan.

Risk of endometrial or ovarian carcinoma? And how to avoid?

Breast cancer patients without germline BRCA mutation do not carry increased risk for endometrial or ovarian cancer. Obesity should be avoided since both, endometrial and ovarian cancer, are related to overweight.

What is the percentage of recurrence for any of the protocols?

Patients with local recurrent disease confer a 50% risk for systemic metastasis. If no surgery, the risk is almost 100%. With the addition of Herceptin to surgery the risk for recurrent disease is lowered to 40% and with the addition of hormone therapy for an additional 10%.

What is the type of food to be taken? What food is to be avoided?

See above.

Yours sincerely

Prof. Jaak Janssens
Professor of oncology at the University of Hasselt & Maastricht and Head of Oncology department – Limburg Oncological Center, Salvator Hospital, Hassel, Belgium.

Appendix

Investigation Reports Provided

Investigations removed from the report for the patient's privacy

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