De
defining age cut off age
for "Young patients" with
breast cancer

Dear Sir,

Breast cancer that develops at a young age is different from that arising in older menopausal patients. These differences are attribute to the faster tumor growth, [represented by the short doubling time], expression of markers of metastatic potential like MMP2, and high levels of markers for the drug resistance.[1] On the other hand, there have been earlier reports that suggested that there was no significant difference in outcome between younger, versus older women with breast cancer.[1,2] However, the weight of literature appears to support generally worse behavior in breast cancer in younger women. The question that was overlooked by many was "the age cut off ". Majority of the literature suggest that patients younger than 40 are considered as the young patients. This assumption was achieved based on the earlier reports stating that the women under 40 are unlikely to achieve menopause after chemotherapy, and the benefit in Hormone receptor positive patients was less.[3] However, as the mean age of the patients with breast cancer in India is almost 5 years less than that of the western world,[4] the same might not be true across the globe. The Indian data too suggest a relatively worse prognosis from the western Indians and no/little differences from the reports of Adayar cancer institute. The careful review suggested that in studies where the cut off age of 40 years was chosen, the difference was not as pronounced as it was observed in those studies where cut off age was chosen as 35.[1-6] Probably the only study that addressed this issue was by OJ et al, who also found on multivariate analysis, that age <35 years was associated with a statistically significant increased risk of loco regional recurrence even when compared to those who were between 35 and 40. The five-year rate of loco regional control was 87.9% in patients <35 years old compared with 91.7% in patients 35 to 40 years old (P = 0.042).[5] Similarly the systematic review of various studies yielded similar results. In the results published in a recent conference in the metastatic setting, which suggested that younger patients have a worse disease course, even matching for the other known prognostic variables.[6]

Reddy CO, Anuradha V1, Mukherjee G, Bapsy PP
Department of Pathology, Kidwai Memorial Institute of Oncology, Bangalore, 1Department of Pathology, Osmania Medical College, Hyderabad, India.

Correspondence to:
Dr. Anuradha V,
E-mail: dranu92000@yahoo.co.in

References


Ipsilateral axillary tubercular lymphadenopathy, contralateral osseous tuberculosis in a case of ductal carcinoma of breast

Dear Sir,

The coexistence of breast cancer and tuberculosis has been described in over 100 cases[1-6] however its coexistence in the axillary node is rare.[1,4-6] We present a case of, 43-year-old housewife presented with complaint of diffuse swelling over right distal forearm associated with dull pain of 4 months duration, for which she received conservative management but without relief. Around a month later she developed pathological fracture in the forearm after following trivial trauma. [Figure 1] Following FNAC report that suggested the lesion to be of chronic granulomatous lesion she was
started on antibiotic therapy and at the same time underwent fixation of the fracture by interlocking nail.

Her all hematological and biochemical tests were normal. To rule out tuberculosis versus malignancy, the bone scan with 20 ml of tracer was performed and it showed hot spots involving right radius, the findings consistent with post-operative status and rest all bones showed physiological distribution of tracer. Serum IgG, IgM, IgA levels for Mycobacterium Tuberculosis were found to be within normal limits. For HIV, IgM antigen was reactive and IgG non-reactive but status confirmed negative by Western Blot technique, but window period could not be but ruled out. Mammography, X-ray chest, USG abdomen were found to be normal. After consultation with second orthopedic surgeon, she underwent removal of right radial nail with excision of growth with fibular graft. Grossly cut section of specimen showing hemorrhagic cavity with friable bone. Histopathological examination of the excised tissue showed numerous granulomas, epitheloid cells, Langhan’s giant cells at places and caseation necrosis, the findings consistent with tuberculosis.

However she further noticed solitary, non-tender, firm lump situated in the lower medial quadrant of the left breast, which measured 2 x1.5 cm, having restricted mobility adherent to skin and also 5th costal cartilage. Right axilla revealed enlarged lymph nodes in the anterior, central and apical groups, four in number, largest measuring 1x1.5cm. They were firm, non-tender, discrete and mobile. The right breast, right axilla and supraclavicular fossa were normal. Other systems revealed no abnormalities. A clinical diagnosis of carcinoma of left breast with TNM (tumor, node and metastasis) stage T1N1M0 was made. FNAC from lump in left breast suggestive of Ductal carcinoma, so underwent for left modified radical mastectomy with axillary dissection of 18 nodes. Histopathology of breast lump [Figure 2A] showed grossly scirrhous irregular lump, fibrofatty mass, gritty grey white tumor mass; microscopically invasive duct cell carcinoma with diffuse infiltration of tumor in fibromuscular and fatty tissue. Modified Richardson bloom score 5; suggestive of Invasive ductal carcinoma with well differentiated grade I, with clear margins. There was no evidence of tubercular foci in the breast specimen. Borders of lump, skin, apical tissue free from malignancy and all 18 axillary lymph nodes dissected out of which all negative for metastasis; but 6 positive for tuberculosis [Figure 2B].

In the postoperative period, the patient was started on chemotherapy with CMF (Cyclophosphamide, Methotrexate, 5-Fluorouracil) regimen while awaiting the status of estrogen/progesterone receptors that turned out to be negative. Following this the Methotrexate was changed to Adriamycin for a total of 6 cycles along with anti tubercular chemotherapy (Rifampicin-450mg, Isoniazide 300 mg, Pyrazinamide 1000 mg,
Ethambutol-800 mg and Pyridoxine 40 mg for initial three months to followed by Rifampicin and Isoniazide for nine months). Follow-up is going on.

In our case the involvement of the contra lateral lymph nodes can be explained by the facts that hematogenous spread from an obvious or subclinical focus can lead to the systemic spread and involvement of the other organs. A possibility of tuberculosis should always be borne in mind especially in patients from endemic areas. The simultaneous occurrence of carcinoma and tuberculosis can lead to many problems regarding diagnosis and treatment.

Wani BN, Jajoo SN
Department of Surgery, Jawaharlal Nehru Medical College, Sawangi (Meghe), Wardha-442 004, Maharashtra, India.

Correspondence to: Dr. Bhushan N Wani,
E-mail: drbnwani@yahoo.co.in

References