Case Report

ABSTRACT

Carcinoma of the male breast is responsible for less than 1% of all malignancies in men, but the prognosis is poor. Being diagnosed at an older age and advanced stage both affect the prognosis. Surgical treatment of elderly patients with co-morbid diseases is challenging. Unfortunately, these patients do not receive chemotherapy due to poor overall status. Mastectomy with local anesthesia may be an option for these patients. We aimed to present an elderly male patient who underwent successful mastectomy and axillary dissection under local anesthesia.

Keywords: Breast cancer, mastectomy, local anesthesia

Introduction

Breast cancer is the most common type of cancer in women, while constituting less than 1% of all malignancies in men (1). Its incidence is 1 in 100,000 men (2). Male patients are diagnosed at advanced stages and at an older age than women (2–5). Surgery and chemotherapy can result in serious problems in elderly patients with co-morbid diseases. Herein we presented a male breast cancer patient who underwent modified radical mastectomy (MRM) with local anesthesia since he was not suitable for general anesthesia due to chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF).

Case Presentation

An 82-year-old patient who was being followed-up by the urology clinic due to hematuria was consulted with surgery due to a right sided breast lump. The patient stated that he noticed the lump about 2 years ago, that it enlarged in size, and that he noticed skin redness and discharge over the mass a week ago. He underwent TUR with spinal anesthesia due to prostate hyperplasia three years ago, and was being followed-up by the urology clinic with complaints of intermittent hematuria. He had COPD for thirty years, and CHF for 5 years, and was receiving doxazosin mesylate (Cardura XL®) 8 mg 2×1, fexofenadine (Fexofen®) 120 mg 1×1, valsartan hidrochlorothiazid (Premium Plus®) 160/12.5 mg x1, budesonid formoterol (Foradil combi®) 400 mcg 2×1, tiotropium bromide inhaler (Spirava®) 18 mcg 1×1. He was unable to walk due to impaired exercise capacity. He had central obesity, dyspnea, and pitting edema of the lower extremity. On physical examination he had arrhythmic heart sounds, tachycardia, and disseminated rhonchus in both lungs. A malignant lesion, 5×4 cm in size was observed in his right breast that infiltrated the skin. He had right axillary lymphadenopathies, the largest being 3×3 cm in size. His laboratory results revealed: leukocyte count: 9790 / mm³ (H), hemoglobin 10.2 g/dL (L), hematocrit: 35% (L), fasting blood glucose 116 mg/dL (H), calcium 8.3 mg/dL (L) , aspartate aminotransferase: 50 U / L (H), carcinoembryonic antigen: 7.96 ng/mL (H), prostate specific antigen (PSA): 5.94 ng/mL (H), and free PSA: 1.1 ng/mL. Other routine biochemical parameters and CA 15-3 were normal. The chest X-ray showed prominent aortic arch, with an increased cardiothoracic index. The breast ultrasound showed a 50×40 mm in size heterogeneous solid mass in the right breast retroareolar area, with lobulated contours and vascularization. There were a few lymph nodes with a diameter of 30 mm and thick cortex in the right axilla. The tru-cut biopsy revealed an invasive ductal carcinoma (grade II/III, Bloom-Richardson). The immunohistochemical study showed staining of 90% tumor cells as ER (+++), PR (+++), and c-erbB2 (-). Ki-67 was positive in 10%. The whole body positron emission tomography showed pathological FDG accumulation in the right breast lesion of 54×36 mm size, with an increase in prostate size and pathological FDG accumulation in the prostate. The patient was consulted with medical oncologist for neoadjuvant chemotherapy (CT). However, the patient was not eligible for CT due to advanced age and co-morbid diseases. After preoperative evaluation for surgery, the patient was classified as ASA IV. Thereupon, MRM with local anesthesia was considered. Upon obtaining patient informed consent, 2 mg intravenous benzodiazepine (Dormicum*) was used to provide sedation. Local

Modified Radical Mastectomy under Local Anesthesia in High-Risk Male Breast Cancer

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Carcinoma of the male breast is responsible for less than 1% of all malignancies in men, but the prognosis is poor. Being diagnosed at an older age and advanced stage both affect the prognosis. Surgical treatment of elderly patients with co-morbid diseases is challenging. Unfortunately, these patients do not receive chemotherapy due to poor overall status. Mastectomy with local anesthesia may be an option for these patients. We aimed to present an elderly male patient who underwent successful mastectomy and axillary dissection under local anesthesia.

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Breast cancer is the most common type of cancer in women, while constituting less than 1% of all malignancies in men (1). Its incidence is 1 in 100,000 men (2). Male patients are diagnosed at advanced stages and at an older age than women (2–5). Surgery and chemotherapy can result in serious problems in elderly patients with co-morbid diseases. Herein we presented a male breast cancer patient who under-
Definitive treatment of breast cancer in male patients is surgery, as in women. Regional anesthesia can be used in patients who are not candidates for general anesthesia due to advanced age or co-morbid diseases. For this purpose, high thoracic epidural anesthesia, cervical epidural anesthesia and paravertebral block can be used (8). However, in patients with high cardiac risk even regional anesthesia may pose a risk. Hypotension, bradycardia and cardiac arrest can be observed due to Sympathetic block following epidural anesthesia (9). Pollard et al. (10) stated that male gender, basal heart beat <60/min, ASA III or IV, beta-blocker therapy, sensory block above T6, patients younger than 50 years of age, prolonged PR interval were risk factors for cardiac arrest during epidural anesthesia.

Local anesthesia does not have serious side effects other than the rare methemoglobinemia and allergic reactions. MRM can be implemented with local anesthesia in high-risk and elderly patients with advanced breast cancer; however, the data on this issue is limited. Most of the reported studies included patients who underwent early-stage breast conserving surgery and sentinel lymph node biopsy (11, 12). Carlson (13) treated four female patients with stage 4 disease by total mastectomy under local anesthesia. However, these patients had advanced disease and did not undergo axillary dissection. Similarly, Oakley et al. (14) performed simple mastectomy with local anesthesia in 36 high-risk patients. A male patient with advanced stage breast who underwent mastectomy and axillary dissection was not included in these series. This case report will contribute to the literature in this regard.

In conclusion, MRM under local anesthesia is feasible in elderly patients with advanced disease who are not candidates for general surgery and this option should be kept in mind especially in male patients with breast cancer.

Informed Consent: Written informed consent was obtained from patient who participated in this study.

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References


