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# 471 - LIVER TRANSPLANTATION IN A FEMALE PATIENT WITH PREVIOUS HISTORY OF BREAST CANCER

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Bile duct injury is a complication of cholecystectomy and may lead the patient to develop secondary biliary cirrhosis (SBC), an irreversible damage to the liver parenchyma caused by the chronic interruption of bile flow. Clinically, cirrhosis manifests when 80% of the liver parenchyma is affected with symptoms like pruritus, jaundice, coagulopathy, and ascites in advanced stages. Liver transplantation is an option of the treatment for SBC, especially when its progression leads to liver failure but there are conditions that strongly contraindicate the procedure, such as an active extrahepatic malignancy. We report a situation in which a patient with breast cancer underwent a liver transplant with good results over 10 years of follow-up. We report a 63-year-old woman, retired, healthy until 2001, when she was submitted for a cholecystectomy. After 15 days, the patient underwent a bile duct reconstruction due to an iatrogenic lesion of the bile duct. After 5 years of asymptomatic, she began to present anorexia, weight loss, jaundice, choluria, and fecal acholia, being diagnosed with SBC. The treatment with endoscopic retrograde cholangiopancreatography and the placement of stents in the bile ducts was initiated with no success. Therefore, she was referred to the liver transplant clinic of the Hospital Universitário Walter Cantídio, placed in Fortaleza-Ceará. On admission, the patient presented a regular general condition, oriented, icteric (++/4), and slimmer. The physical examination showed a symmetric thorax with a palpable lump in the right breast. Cardiac and pulmonary auscultations were normal. The patient had plane, flaccid, painless abdomen, with the presence of incisional hernia with spleen and palpable bowel loops. The laboratory tests showed the following results: creatinine 0.4 mg/dL; international normalized ratio (INR) 1.68; total bilirubin 17.9 mg/dL, being classified as CHILD B MELD 23. The patient also underwent an upper digestive endoscopy that exhibited esophageal varices. The abdominal ultrasound (US) presented signs of chronic liver disease, splenomegaly, and dilated intrahepatic bile ducts. In this case, it was also requested a breast US that revealed a lump on the right breast, measuring 1.5×1.1 cm. Then, she was referred to a mastologist, who requested a mammogram that showed an irregular, spiky, and high-density lump in the upper side quadrant of the right breast, measuring 12 mm. It was requested for a positron emission tomography, whose results excluded the possibility of metastasis. Then, the patient was submitted to a breast quadrantectomy with axillary dissection and removal of five lymph nodes, with freeze biopsy, confirming breast cancer with free margins and sentinel lymph node research. Histopathology of the breast piece revealed grade 2 infiltrating ductal carcinoma of the right breast, measuring 1.8×1.5 cm with angiolymphatic invasion and metastasis to 1 axillary lymph node of 3 mm. Immunohistochemistry examination was positive for estrogen and progesterone receptors, with low Ki-67 and negative HER-2, subtypes of LUMINAL A breast carcinoma. She underwent hormonal treatment, and adjuvant chemotherapy was not indicated. Due to the high risk of mortality associated with SBC, the patient was released by oncology and, in a multidisciplinary meeting with the participation of surgeons, hepatologists, and radiologists, it was decided to include the patient on the liver transplant list, performed 2 months after breast cancer surgery. After 10 years, the patient was monitored by the liver transplant service without recurrence of breast disease and with good liver graft function, using immunosuppressive therapy with everolimus 3.5 mg/day.