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472 - MALE BREAST CANCER AFTER LIVER TRANSPLANTATION: A CASE REPORT

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Male breast cancer (MBC) is an uncommon disease representing only 1% of the total cases. This low incident rate could be due to the low amount of breast tissue and the hormonal differences between men and women. The Surveillance, Epidemiology and End Result (SEER) program reported that the incidence rate of breast cancer was 1.1 per 100,000 men in the mid-1970s and raised to 1.44 per 100,000 men by 2010. There are a lot of characteristics that are common to male and female breast carcinomas, especially given the fact that a lot of the factors that influence malignant changes are similar, but there are also some singularities. In this matter, it is important to understand the existence of risk factors for MBC, particularly the genetic abnormalities, such as BRCA-1 and BRCA-2 mutations. Therefore, a man with this type of predisposition is more likely to develop breast cancer, especially if submitted to an immunosuppressive therapy, normally used to prevent the rejection of transplanted organs. This study aimed to report a case of a patient with chronic alcoholism history, who later developed a liver tumor and breast cancer. This patient reported gynecomastia, which could be related to his health condition, given the fact that liver failure and cirrhosis probably started preventing the inactivation of the estrogens by the liver, causing and stimulating proliferation of the mammary tissue, and increasing the chance of gene mutations. We report a 56-year-old man with a history of smoking, chronic alcoholism, and gynecomastia with 10 years of evolution who was diagnosed with cirrhosis and liver tumor in 2014. He underwent two sessions of a chemoradiotherapy treatment, resulting in reduction of the tumor size as a result. In 2015, the patient had a liver transplant. To prevent organ rejection, it was established an immunosuppressive therapy with tacrolimus 10 mg/day and myfortic 720 mg/day. In 2016, the patient noticed a breast lump and searched for medical assistance. At the appointment, after physical examination, the presence of a 2-x2-cm lump in the right breast was confirmed. A few examinations were requested, such as ultrasonography, which showed a BIRADS4 as a result, chest tomography, and abdominal tomography. The examinations concluded that the lump had a high probability of malignancy. Then, to confirm the suspicion, it was proposed the performance of a fine-needle aspiration of the lump was followed by a core biopsy. The results showed an invasive breast carcinoma positive for estrogen receptors, negative for progesterone receptors, negative for HER-2 oncoprotein, and KI67 5%. Therefore, the molecular classification by immunohistochemistry is a LUMINAL A, which indicates the possibility of a better prognosis. A few days later, the patient was submitted for a radical mastectomy on the right breast. During the surgery, it was also performed a sentinel lymph nodes (SLN) scintigraphy and analysis of the material collected from the right breast. The conclusion expressed positive screening for malignant cells, two lymph nodes compromised by macrometastasis (large focus measuring 1.2 cm with capsular transposition associated) and positive screening for malignant cells suggestive of carcinoma. The tumor, according to a grading system, presented a Scarff-Bloom Richardson modified by Elston and Ellis grade III, with tubular grade 3, nuclear grade 3, and mitotic index 2. It was also identified as focal tumor necrosis, vascular invasion, and perineural invasion. The pathological staging of the tumor was pT2 pN1a (SN+) pMx.