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529 - TUMORAL EMBOLIZATION IN THE THERAPY OF LARGE BREAST TUMORS

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Phyllodes tumors (PTs) of the breast correspond to about 1% of women's breast tumors. Predominantly, benign has a high rate of local recurrence. The diagnosis is usually clinical, showing up as a voluminous tumor. Treatment, in most cases, is surgical alone; chemotherapy and radiotherapy are still uncertain on PT. Treatment based on arterial embolization of the tumor prior to surgery to improve morbidity is a practice that is rarely used, but this technique can be suggested as a saving measure. M.C.J.S., female, 39 years old, in 2013, presented with a nodule in the left breast, measuring 4 cm, mobile, painless, oval, which did not retract the skin. A nodulectomy was performed, with an anatomopathological diagnosis of benign PT. In 2015, there was a new recurrence, with a small volume, and the surgical margin was enlarged. In 2016, the patient evolved with a local recurrence of about 9 cm, being opted for neoadjuvant chemotherapy and radiotherapy and a total left mastectomy. In 2017, the left breast reconstruction with prosthesis placement was performed. In 2018, the patient was admitted to the mastology clinic of the Hospital Guilherme Álvaro (Santos, SP), with a new tumor recurrence, in the left axillary region, with only 3 months of evolution, and after chemotherapy treatment for regression in another service, without clinical improvement. The tumor measured about 36 cm in the left axillary region. It was then opted for radiotherapy for tumor regression. After 25 sessions, the patient returned with a tumor of the same dimensions; she was emaciated with a decline in her general condition, local pain, and unable to move her left upper limb. The patient was hospitalized for clinical stabilization and interdisciplinary planning for appropriate management. After attesting to the failure of the attempt to regress the tumor size with systemic treatment and failure to stabilize the tumor progression with radiotherapy, with no clinical improvement, the patient began to increasingly decline in general condition due to great wasting syndrome. In August 2018, after surgical planning, a tumor angiography was performed, and the poor vascularization of the tumor was noted, which after the radiotherapy had a necrotic clinical aspect, being opted for a surgical approach to the lesion. The autonomized Tram technique, with increased blood supply by an arterial and venous microvascular anastomosis of the deep inferior epigastric artery, was deprecated for covering the surgical wound. The procedure was done the week before the surgery. Two days before surgery, tumor embolization was performed via catheterization, with the application of intratumoral hemostatic gelfoam and with immediate radiological result of a section of the blood flow in the tumor. On the day after the procedure, the patient's main complaint was a pain in the tumor bed, which was easily controlled with nonsteroidal anti-inflammatory drugs. The surgery was performed on August 24, 2018, with a tumor excision that compromised a large part of the adjacent musculature; there was no major bleeding and the procedure lasted for about 8 h, with the surgical wound being covered by flaps I, II, III, and IV of the Tram. The main postoperative complications were chronic left arm lymphedema and difficulty in mobilizing it, without other significant complications.