ONCOBOLIVIA
Juntos contra el cáncer

Clínica de las Américas

SELNET

Seguro Social Universitario Santa Cruz

Virtual MDT Board October 2022

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Cases

- Dra. Lucia Richter Paz: Caja Petrolera Salud Bolivia

- Dra. Bruna David: INCA / Oncoclínicas – Brazil

- Dra. Carolina Da Silva Cardoso: INCA / Oncoclínicas – Brazil
- Dra. Bruna David: INCa / Oncoclínicas – Brazil

- Dr. Boris Itkin: Sultan Qaboos Comprensive Cancer Center OMAN

- Dra. Eliza Ramirez: National Institute of Cancer. (x2)

- Dr. Maycos L. Zapata M. Cancerology Institute Las Americas

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Sarcoma European and Latin American multidisciplinary NETwork (SELNET)

Medical Education

Case report

Lucia Richter Paz MD
Medical Oncologist

Santa Cruz - Bolivia

MARIA TERESA. 79 years. Postmenopausal.

HT in treatment with losartan 50mg BID

Diabetes Type 2 with metformin 850mg per day

Non familiar history of cancer

She notes an increase of the left breast, pain an erythema.

Mammogram (feb-4-21):

Right breast: focal asymmetry in CSE with poorly defined borders measuring 3.5cm associated with heterogeneous microcalcifications. BIRDAS V.

Left breast: retropectoral mass of 9.5cm.

Core biopsy (sept-2-21): CDI NOS GHF 2

RE + 100%

RP + 100%

HER2 negative

Ki67: 20%

Left breast biopsy (jun-7-21): Atypical lipoma

IHC: Liposarcoma of the breast

TC TAP: On the left breast sector, a mass of heterogeneous appearance of approximately 10 cm. Small nodular formation of 5 mm in the middle lobe, with well-defined borders and poor contrast uptake. Small mediastinal lymph nodes, the largest measuring 6mm.

Left mastectomy (22-7-21):

AP: 13x14x12.5cm tumor in CSE. Compromise of the skin in all its extension by tumor. Well differentiated liposarcoma.

Starts Letrozole 2.5mg

Aug/2022, tumor growth on mastectomy region, pain, limitation of movement of the left arm.

On physical examination: a 10cm tumor is seen on the mastectomy region , skin erythema, intense pain.

Seen by an oncologist surgeon who defines resecting the left mass in its entirety and studies are requested:

Pathology: The neoplasm contains abundant myxoid stroma with marked vascularization of a branched pattern and mucus lakes. tumor-free margins.

IHC: positive for vimentin and negative for smooth muscle actin, specific muscle actin and protein S-100.

Keratin markers (CAM 5.2 and CK7) do not show epithelial cellularity.

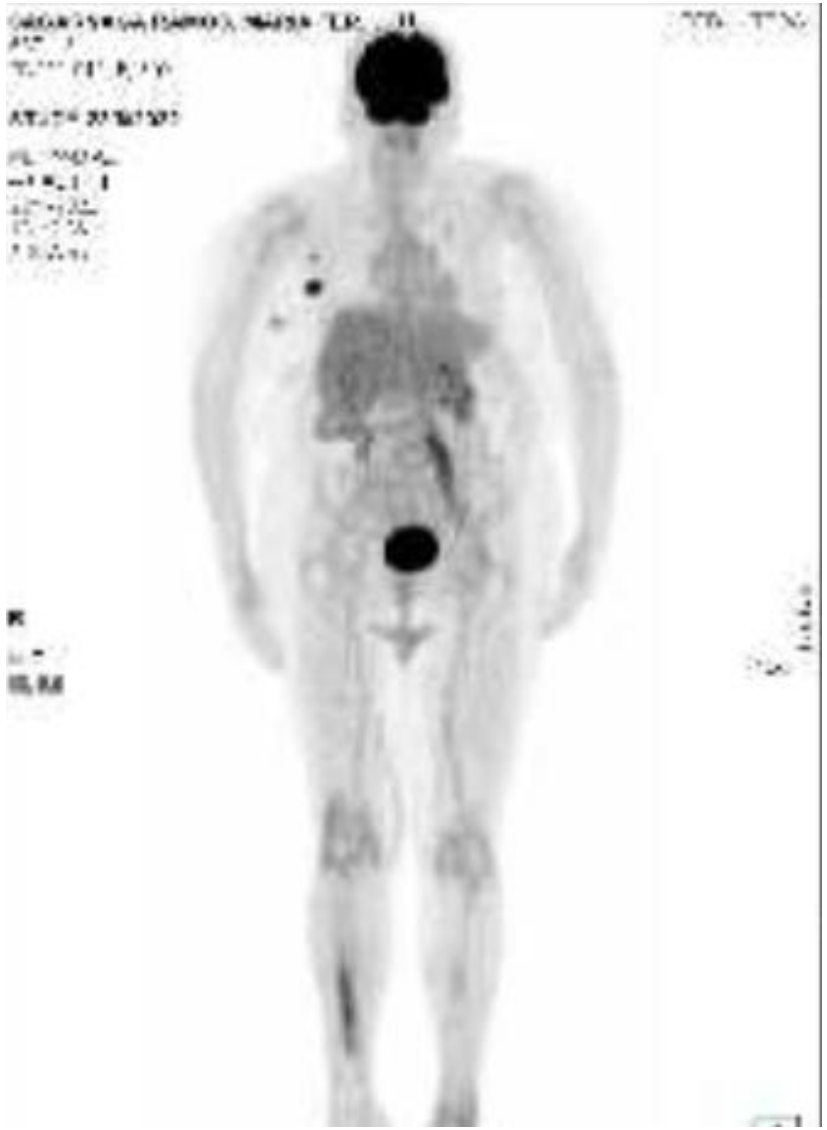
Ki-67: <5%.

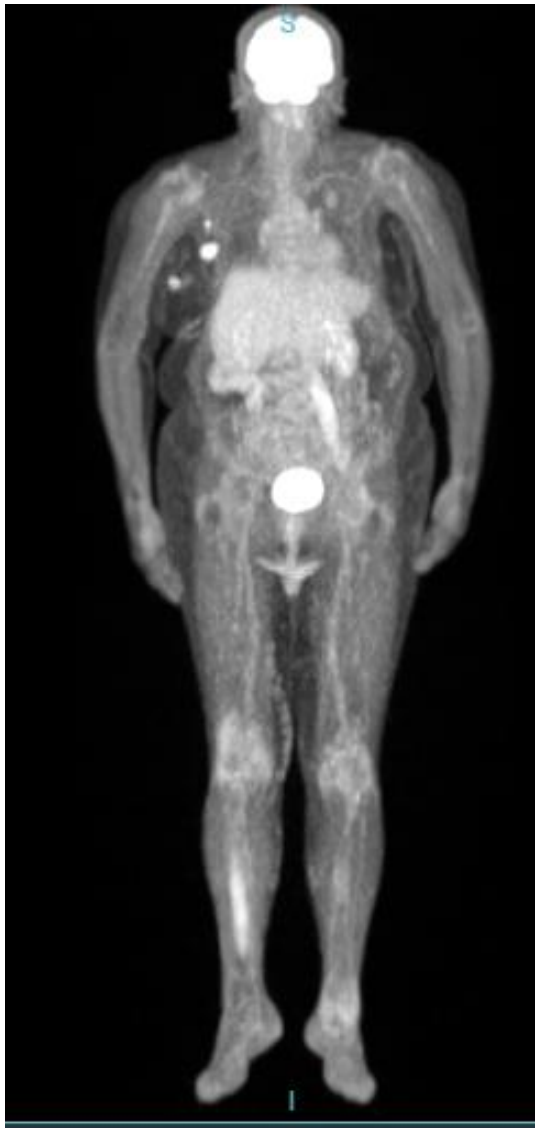
The definitive diagnosis is **high grade myxoid liposarcoma of the breast, histological grade III.**

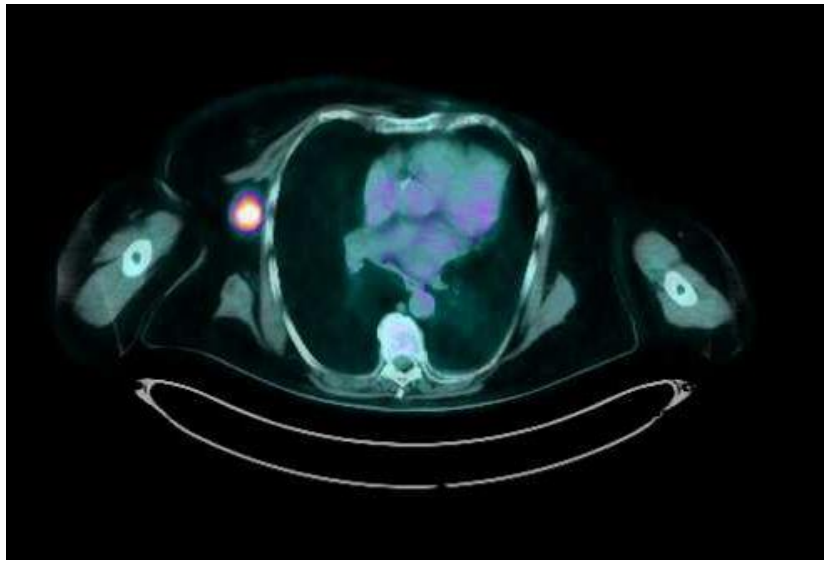
PET CT (jun-22-22): 2 small subcutaneous hypercaptant nodules in contact with the pectoral muscle plane on the mastectomy scar (SUV 2), the largest of 22.6 mm.

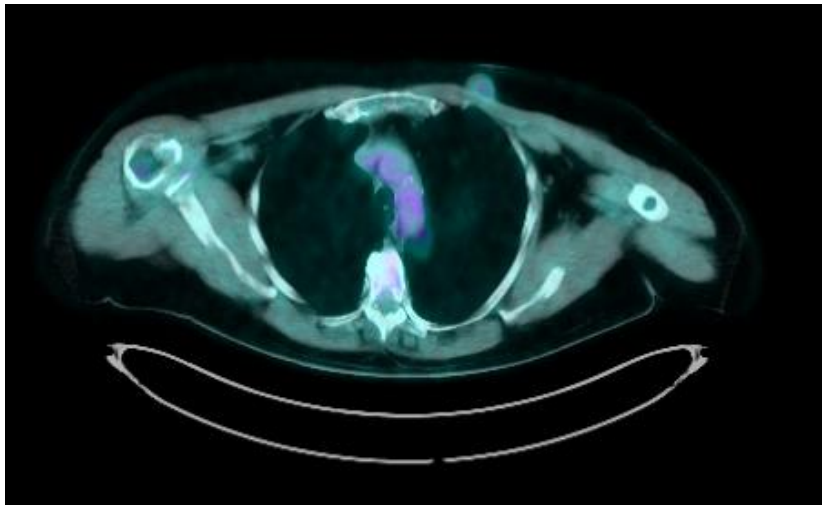
Hypermetabolic nodule in CSE of the right breast compatible with active primary neoplasia (SUV 3.5) measures 23.7mm. Hypermetabolic adenopathies in the right axilla, the largest measuring 29.2x26.4mm (SUV 7.6).

Bilateral lung lesions, the largest of 49mm in the left lung base (SUV 2.6) compatible with secondary. Mediastinal adenopathies compatible with secondary disease.









Right mammogram: spiculated mass on CSE with poorly defined borders measuring 3cm. BIRDAS VI

Breast ultrasound: hypoechoic nodular image with irregular edges of 2.8x1.2 cm. Doppler positive. Right axillary adenopathy of 25mm.

ECOG 1

Geriatrics: comprehensive geriatric assessment: non-fragile elderly adult.

Cardiology: the use of liposomal doxorubicin is suggested.

In summary

- Maria Teresa. 79 years. Postmenopausal
- HT, DMT2
- 2021: resected low-grade liposarcoma of the left breast. ICD NOS LuminalB of the right breast T2 N0 M0. Start letrozole.
- 2022: local and distant disease relapsed. Complete left mass resection: high-grade liposarcoma. In the right breast Nodule of 23.7mm. Hypermetabolic adenopathies in the right axilla, the largest measuring 29.2x26.4mm.
- Pathology of pulmonary nodule: breast myxoid liposarcoma, histological grade III
- Starts Qt based on liposomal doxorubicin, 2 cycles with excellent tolerance.

Questions

- How frequent is breast liposarcoma and what are its differential diagnoses?

- Do you recommend genetic test for this case?

- What is the best choice of chemotherapy 1ºline ?

- Doxorubicin
- Doxorubicin + Trabectedin / Ifosfamide
- Trabectedin

. How important is the identification of MDM2 and DDIT3 in this case?

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Tumor board – Oct/22

Bruna David
INCA / Oncoclínicas - Brazil

Case 1

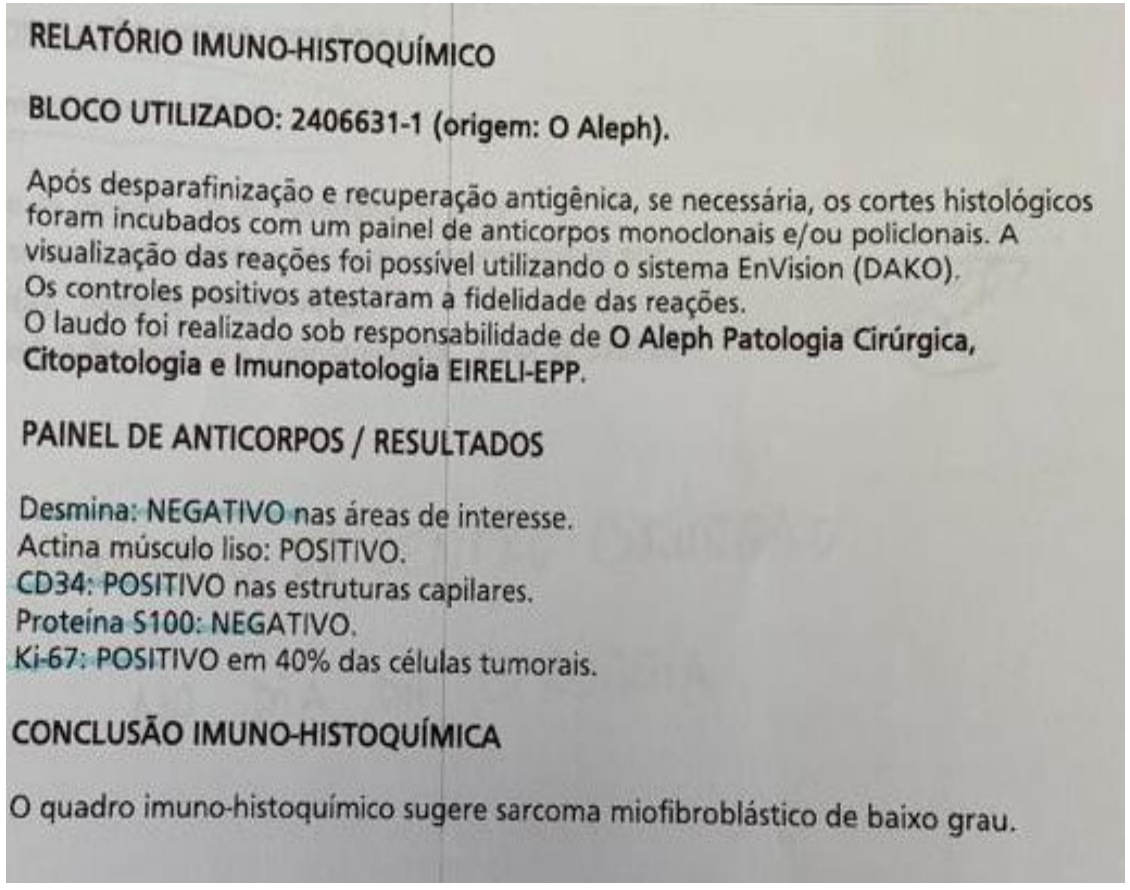
- RM, male, 79 yo, coronariopaty and revascularization, CHF, hypertension, DM, Parkinson?

- **Oct/2019**

-Resection of a 3.5cm paravertebral thoracic lesion (closest limit 7mm).

Pathology report: low-grade myofibroblastic sarcoma.

-Jan/20: Adjuvant RT 61.2Gy/34 fx.



RELATÓRIO IMUNO-HISTOQUÍMICO

BLOCO UTILIZADO: 2406631-1 (origem: O Aleph).

Após desparafinização e recuperação antigênica, se necessária, os cortes histológicos foram incubados com um painel de anticorpos monoclonais e/ou policlonais. A visualização das reações foi possível utilizando o sistema EnVision (DAKO).
Os controles positivos atestaram a fidelidade das reações.
O laudo foi realizado sob responsabilidade de **O Aleph Patologia Cirúrgica, Citopatologia e Imunopatologia EIRELI-EPP.**

PAINEL DE ANTICORPOS / RESULTADOS

Desmina: NEGATIVO nas áreas de interesse.
Actina músculo liso: POSITIVO.
CD34: POSITIVO nas estruturas capilares.
Proteína S100: NEGATIVO.
Ki-67: POSITIVO em 40% das células tumorais.

CONCLUSÃO IMUNO-HISTOQUÍMICA

O quadro imuno-histoquímico sugere sarcoma miofibroblástico de baixo grau.

- **Nov/2020:** Local recurrence - new resection

– Low-grade myofibroblastic sarcoma, free margins?

- **Aug/2021**: MRI thoracic spine: expansive lesion in the paravertebral musculature and the spinous process, level T8-9, measuring 3.9 cm (largest diameter). Another nodular focus of 1 cm in the subcutaneous tissue on D.

- **Oct/21:** new resection, this time bilateral.

-Right: myofibroblastic sarcoma (G2) 1.2cm; 1mm away from the nearest margin.

-Left: myofibroblastic sarcoma 4.9cm (G2), 1mm away from the nearest margin.

- New local recurrence - requires opioid analgesia.

- **MRI 02/22:**

left paravertebral expansive formation, measuring 11.7 cm, infiltrates muscles in the D7-8, erodes the D8 transverse process.

- After discussion in a multidisciplinary team:

-Radiotherapy 04/06/2022 - 04/18/22: 3000cGy (in 5 fractions)

- **June/22:**

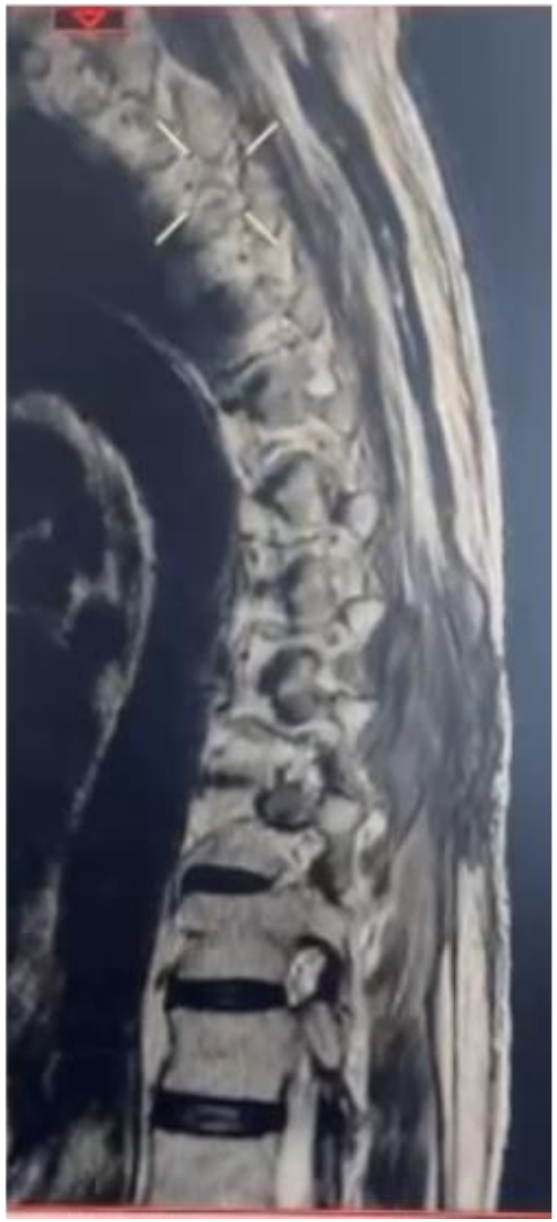
-Dorsal spine MRI: partial response

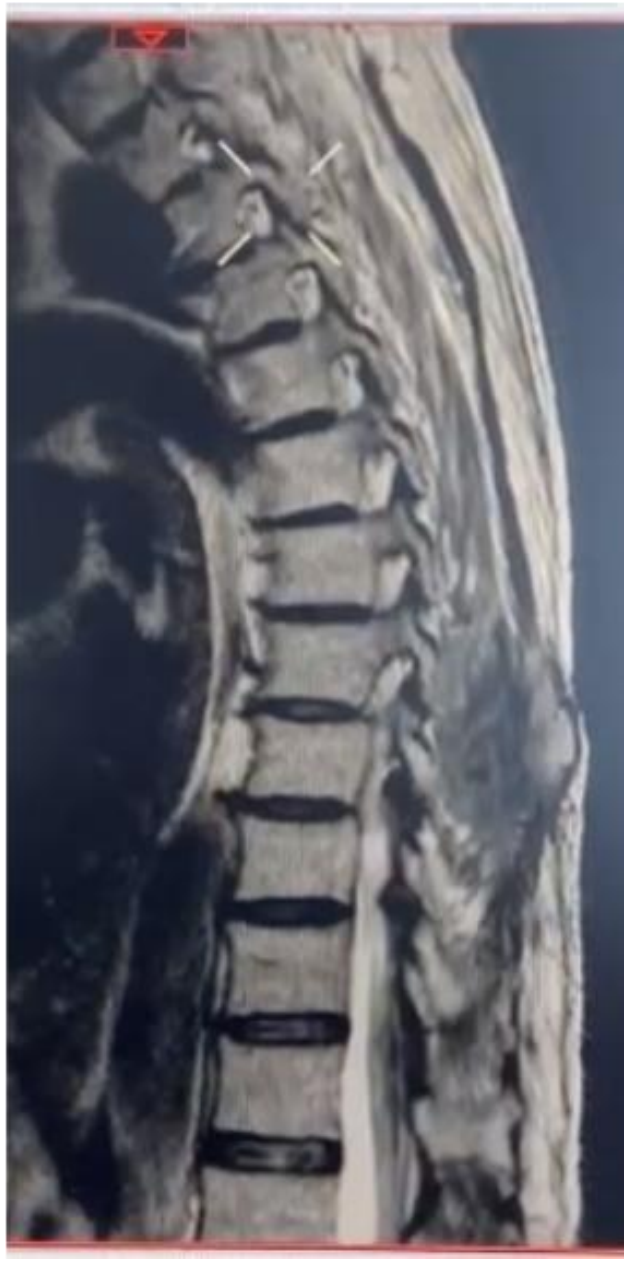
- **Sep/22: pain worsening**

-MRI: increased lesion in the D4-D11 paravertebral musculature, measuring 185x65x68mm determining bone erosions in the apophyses spines on D7 and 8, in addition to traces of fractures in the left transverse pores D9-10, extending to the vertebral canal on D8-9.

-**Emergence of pulmonary nodules** with soft tissue density, varying sizes, the largest measuring 12 mm in the LEL.

T2





- **Question:**

Frail patient, coronary artery disease and congestive heart failure, with no proposal for local treatment.

Which systemic treatment would you offer?

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Case 2

VVSM, 42 yo, ex-obese - bariatric surgery, no family history of câncer.

-2017: hyterectomy due to leiomyoma (no report).

-April/22: during routine gynecological examinations, iliac lymphadenopathy was identified in addition to a solid lesion in ovary D.

MRI: right ovary with a solid component (3.8 x 2.6 x 2, 5cm). Lymphnode located in the intercavo-aortic chain, about 8.0 cm; others in the right obturator chain (3.3 cm), external iliac chain (1,5 x 1.2 cm); in the left obturator chain(2.1 x 1.5 cm).

-July/22: oophorectomy and iliac lymphadenectomy

Pathology report: Low-grade ovarian endometrial stromal sarcoma;

WT1 + CD 10 + Calretinin - Alpha Inhibin - Ckit - Progesterone and Estrogen receptors + (strong)

Microscopia

Estudo imuno-histoquímico recebido:

Sequência	Antígenos (clone)	Resultados
1	CD10	Positivo
2	Proteína receptora de estrógeno (EP1)	Positivo
3	Calretinina	Negativo
4	Inibina	Negativo
5	CD117	Negativo
6	WT1	Negativo no núcleo das células neoplásicas

A análise dos cortes histológicos e do estudo imuno-histoquímico acima permite a seguinte conclusão:

Diagnóstico

A- Ovário direito:

- SARCOMA DO ESTROMA ENDOMETRIAL DE BAIXO GRAU INFILTRANDO TECIDO OVARIANO COM AS SEGUINTES CARACTERÍSTICAS:* **
  . TAMANHO: 3,0 cm (SEGUNDO LAUDO DO LABORATÓRIO DE ORIGEM).
  . NEOPLASIA LOBULADA COM INFILTRAÇÃO DE PADRÃO SERPIGNOSO NO ESTROMA OVARIANO.
  . PRESENÇA DE EXTENSÃO NEOPLÁSICA NOS TECIDOS CONJUNTIVO E MUSCULAR LISO PERIOVARIANOS.
  . INFILTRAÇÃO NEOPLÁSICA LINFOVASCULAR: PRESENTE (VIDE ITEM C).
- ACHADOS PATOLÓGICOS ADICIONAIS:
  . TECIDO OVARIANO ADJACENTE COM CISTOS FOLICULARES.
  . PRESENÇA DE FOCO DE REAÇÃO GIGANTOCELULAR DO TIPO CORPO ESTRANHO ENVOLVENDO FIOS CIRÚRGICOS NO TECIDO CONJUNTIVO PERIOVARIANO.

* Embora este tipo de neoplasia possa ocorrer na forma primária ovariana (Sarcoma estromal endometrioide do ovário),

August/22

Second opinion

Sequência	Antígenos (clone)	Resultados
1	CD10 (56C6)	Positivo
2	Proteína receptora de estrógeno (EP1)	Positivo intenso
3	Proteína receptora de progesterona (PgR 636)	Positivo intenso
4	WT1 (6F-H2)	Positivo
5	Actina de músculo liso (AML) (1A4)	Positivo em áreas
6	Ciclina D1 (EP12)	Positivo em focos
7	CD56 (123C3)	Positivo em áreas
8	TLE1 (1F5)	Positivo
9	Desmina (D33)	Negativo
10	Calretinina (DAK-Calret 1)	Negativo
11	Inibina (R1)	Negativo
12	CD117 (c-kit) (policlonal)	Negativo

A análise do estudo imuno-histoquímico acima permite a seguinte conclusão:

Conclusão

- O PRESENTE PERFIL IMUNO-HISTOQUÍMICO, ASSOCIADO AO QUADRO HISTOPATOLÓGICO, É COMPATÍVEL COM SARCOMA DO ESTROMA ENDOMETRIAL DE BAIXO GRAU INFILTRANDO OVÁRIO E TECIDOS CONJUNTIVO E MUSCULAR LISO PERIOVARIANOS.* **

* Embora este tipo de neoplasia possa ocorrer na forma primária ovariana (Sarcoma estromal endometrioide do ovário),

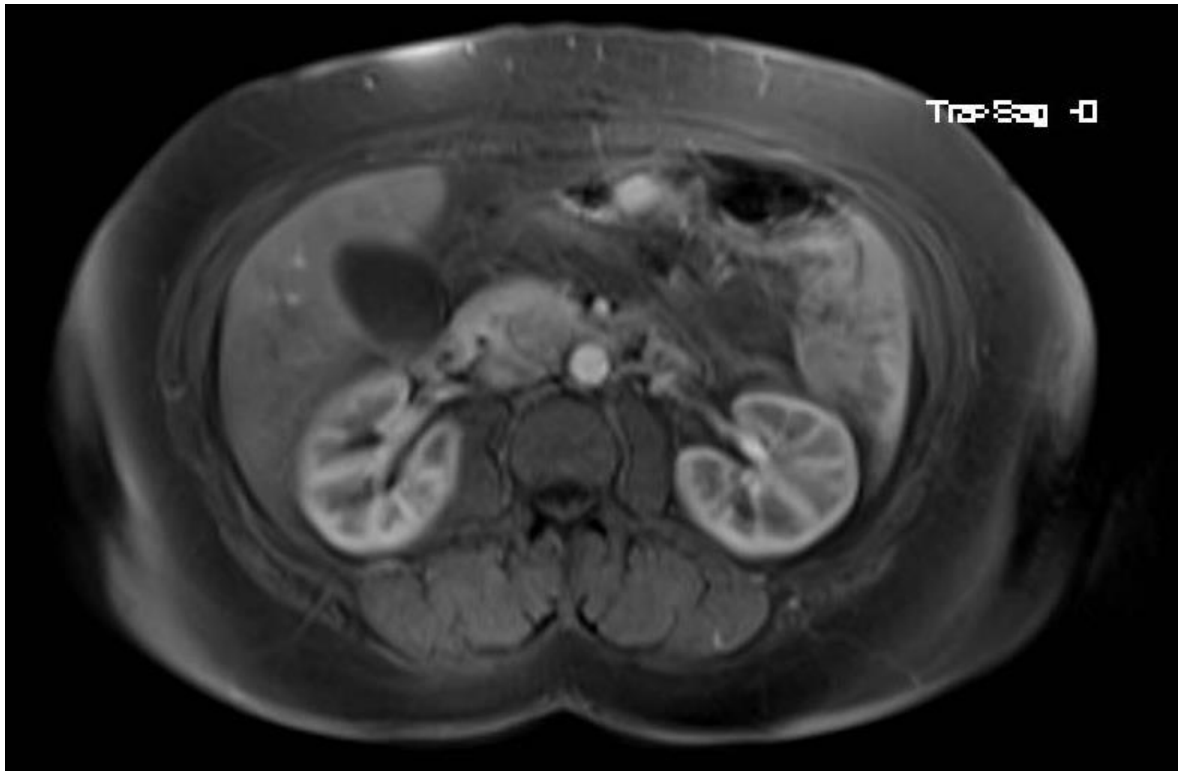
CT 09/22:

LN grouped intercavo-aortic, measuring 78x30x27 cm

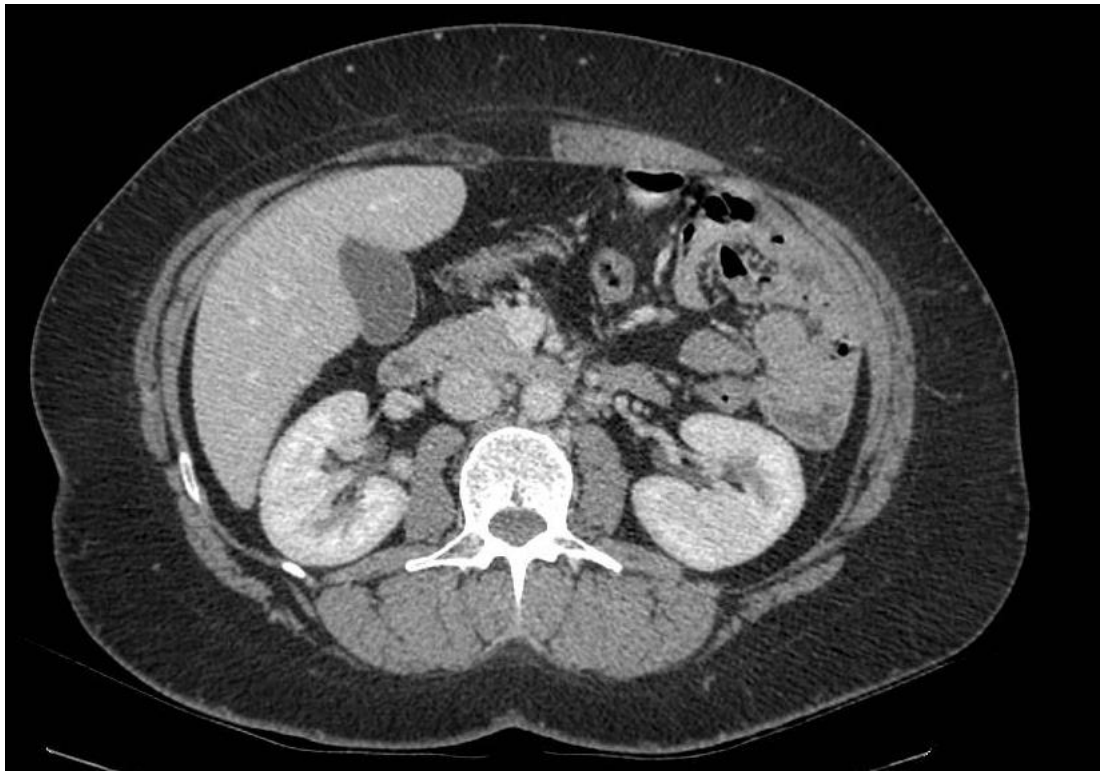
Obturatory right, measuring 20x17mm and left, 20x12mm

(same as April)

April/22



Sep/22



-Question:

New surgery and adjuvante hormonal therapy?

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Y.A.A 35-y-o, male. No significant comorbidity

SULTAN QABOOS COMPREHENSIVE CANCER CENTRE

- Diagnosis:
  Systemically relapsed MPNST with focal Rhabdoid differentiation, loss of H3K27me3. Progression after 2 lines of systemic therapy.

  Summary:

  - 18.09.2018: Excision of right flank soft tissue mass in Bumrungrad Hospital, Thailand.
  High grade STS. T= 11.5 cm, Grade 3 FNLCC. Margins 1 to 5 mm. IHC not provided,T3 N0 M0. Overall stage

  - 28.10.2018 – 06.12.2018: Adjuvant RT 50 Gy/2Gy plus boost to the tumor bed 10Gy/2Gy in Doha, Qatar

  -Then remained on follow-up with PET-CT every 6 mo, all negative till March 2022.

  - PET-CT March 2022 in Oman:
  Multiple bilateral lung metastases and 5 cm left hilar mass.

  - 17.04.2022: Bronchoscopy guided lung mass biopsy: malignant spindle cell neoplasm.
- Second onion on pathological diagnosis in Mayo Clinic : High grade sarcomatous neoplasm with loss of H3K27me3 expression and focal rhabdomyoblastic differentiation. The histopathology was interpreted in Doha as MPNST
-

- - Doxorubicin/Ifosfamide for 3 cycles up to 23.06.2022. == FIRST LINE, PD

  - Aug/22: PET scan: Hilar mass increased from 4cm to 7cm, right upper lobe mass currently measure 11 cm from 1cm, anot right lower lobe mass increased from 2.4cm to 4cm.

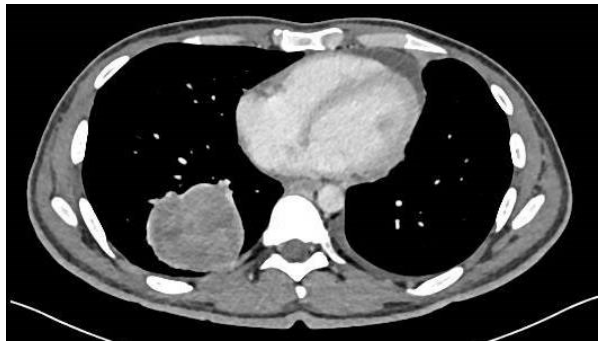
  MDT discussion 8.8.22 at SQCCCRC: No role neither for surgery nor for RT. Start new line of systemic therapy.

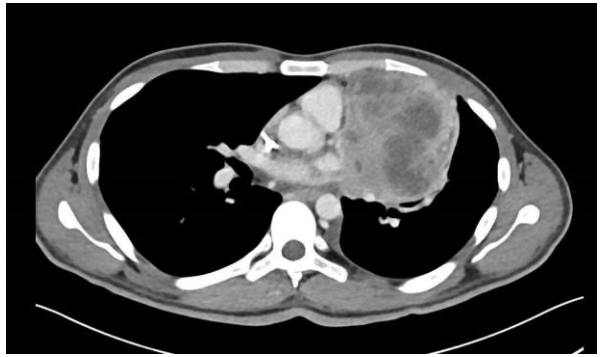
- GemDoce for 3 cycles in standard doses up to 11.10.2022. == SECOND LINE, PD with increase in size of previous lesions and new lesions.

  Current status: PS-1 ECOG. Dry cough. Multiple lung mets on CT

- Extended SNV and fusions panel (400 genes, Oncomine) = No pathogenic or likely pathogenic variant. No actionable alteration. Low TMB (4.8/MB)

- DOCK3 NM_004947.5 c.4390C>T p.(P1464S) 2.03% missense VUS
- MGA NM_001164273.1 c.2933_2934ins GCA p.(Q981dup) 49.95% non-frameshift Insertion VUS
- ELOB NM_207013.3 c.392_393delAC p.(T132Kfs*?) 49.90% frameshift Deletion VUS
- Discuss: management





16.10.2022

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SELNET INTERNATIONAL TUMOR BOARD – oct 2022.

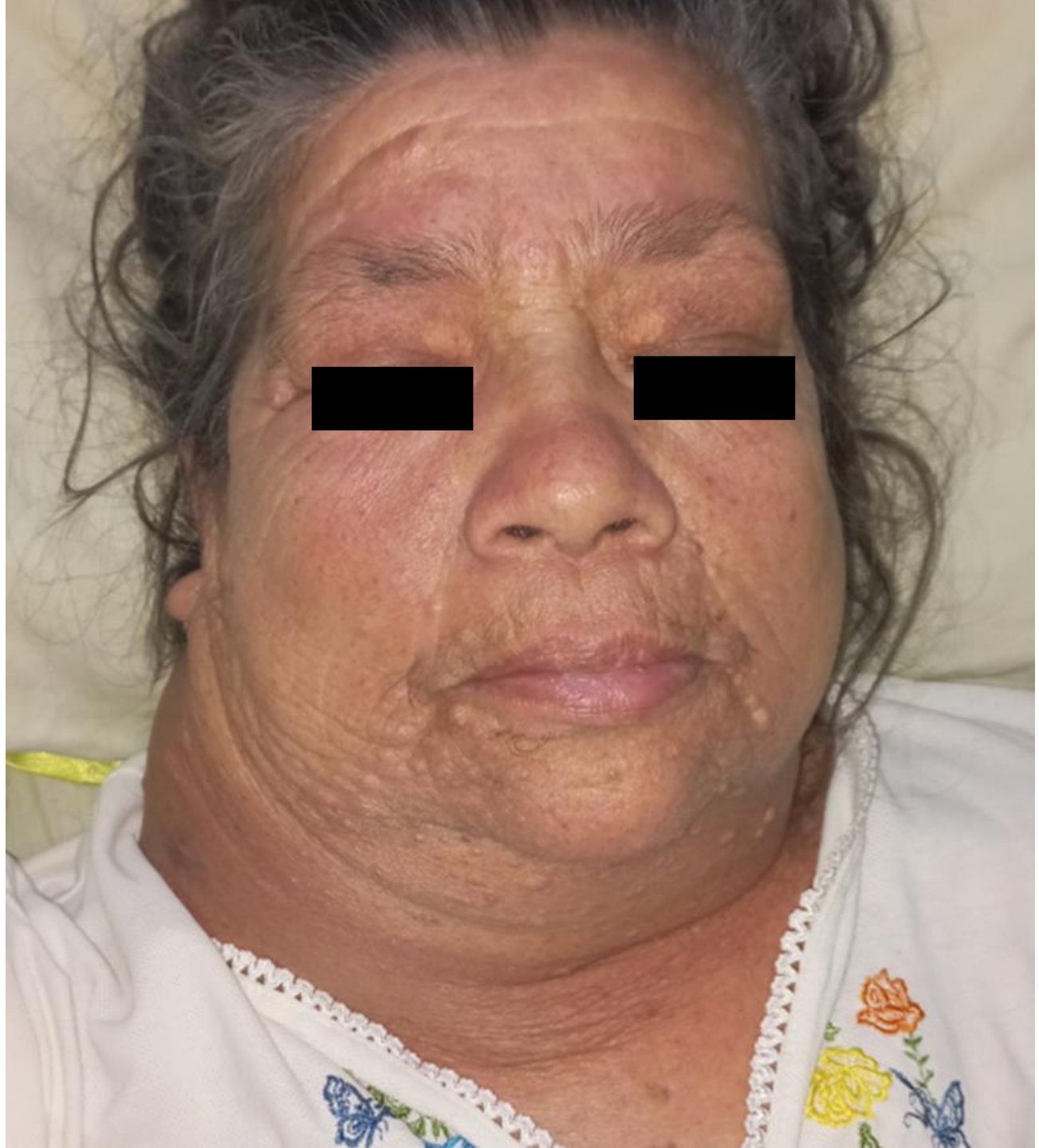
VON RECKLINGHAUSEN'S DISEASE

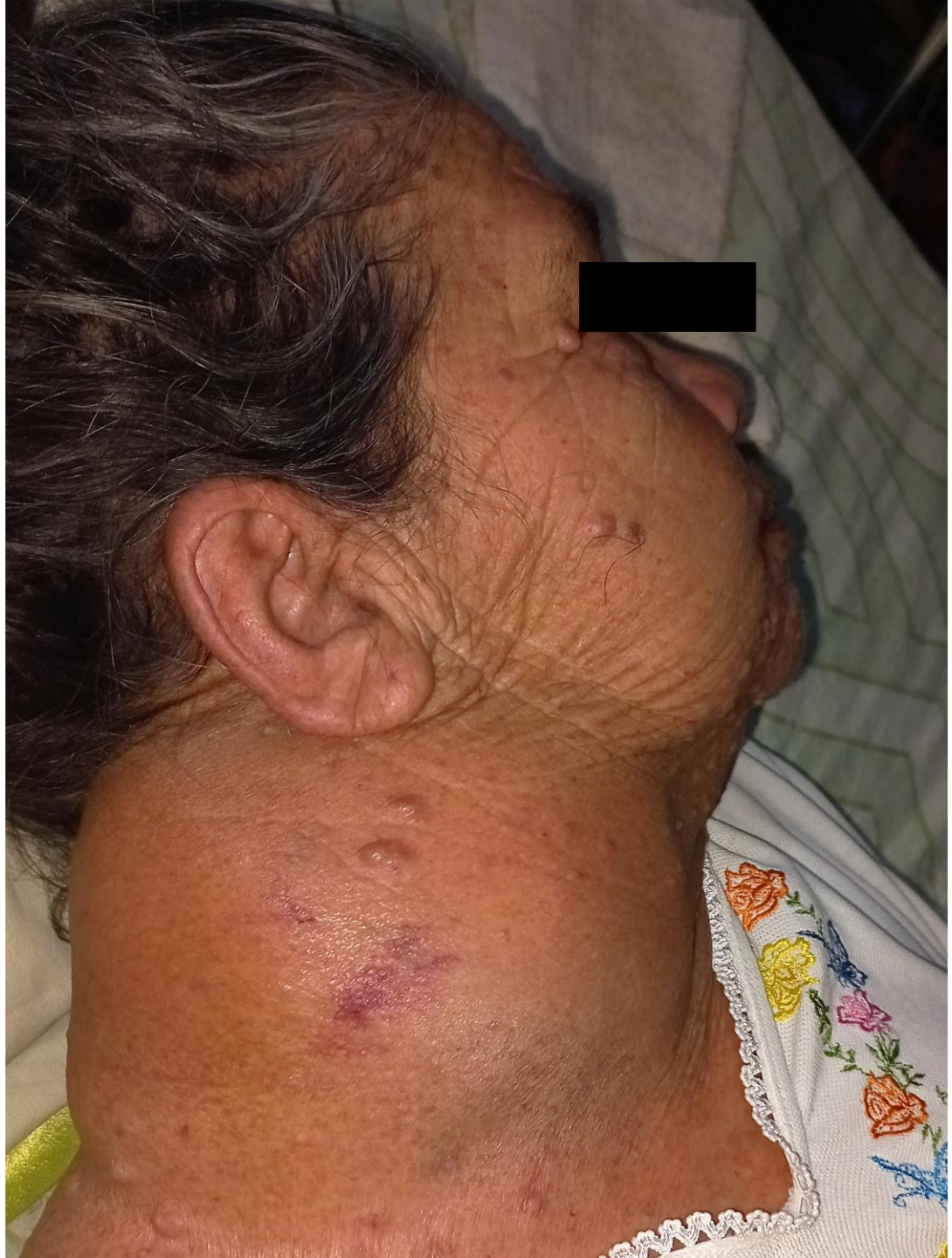
NATIONAL INSTITUTE OF CANCER – PARAGUAY

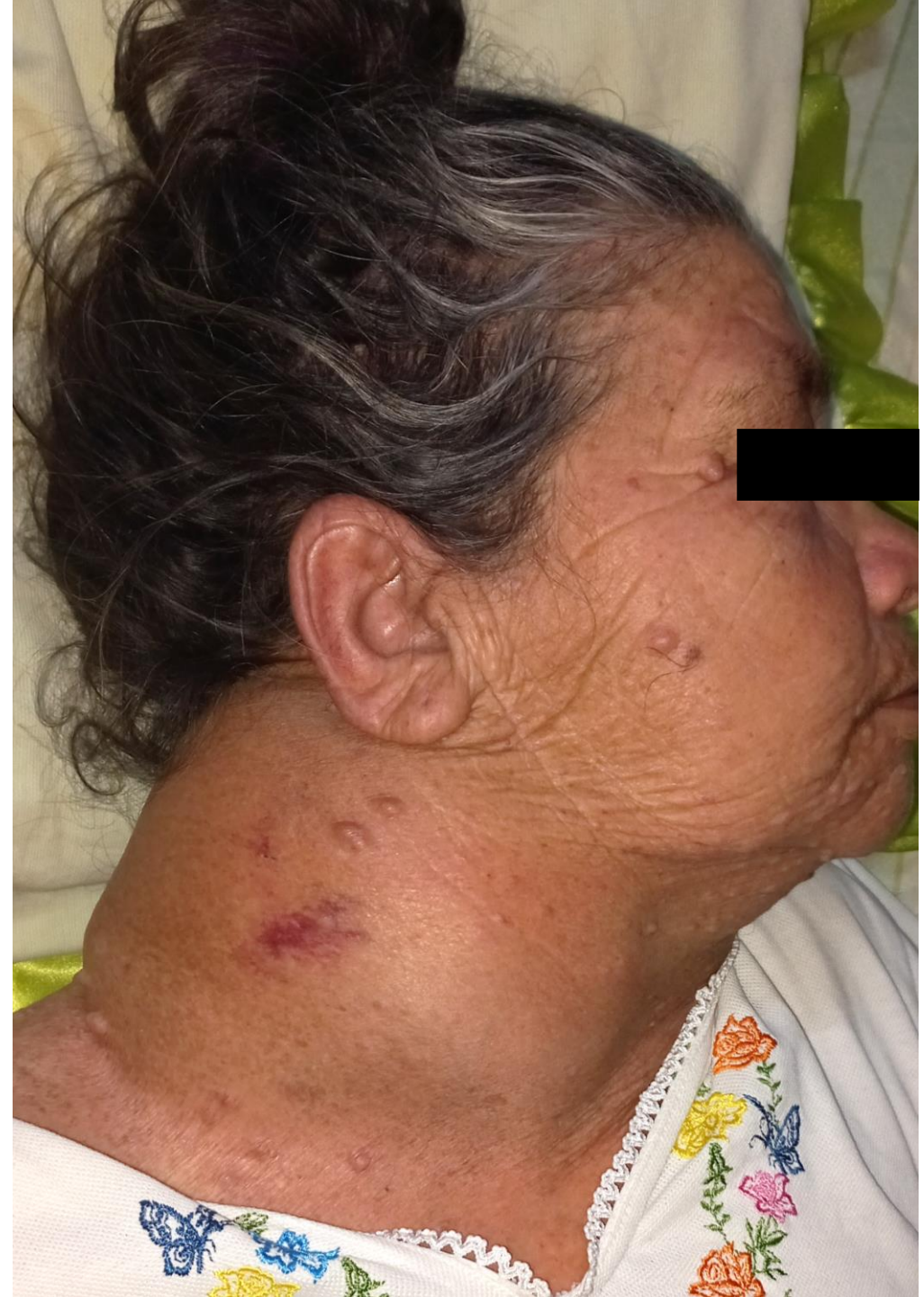
DRA. ELIZA RAMIREZ

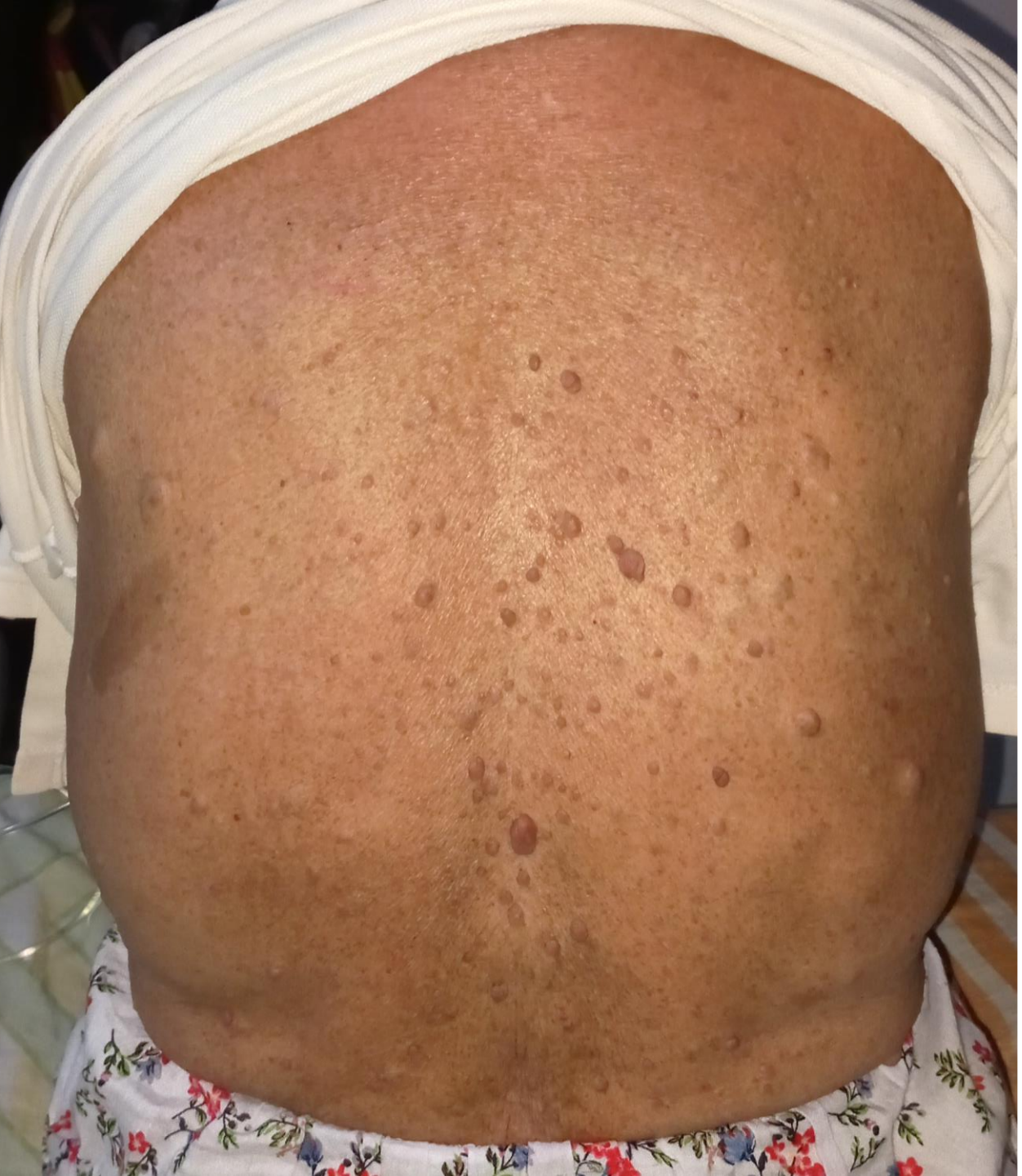
Clinical History

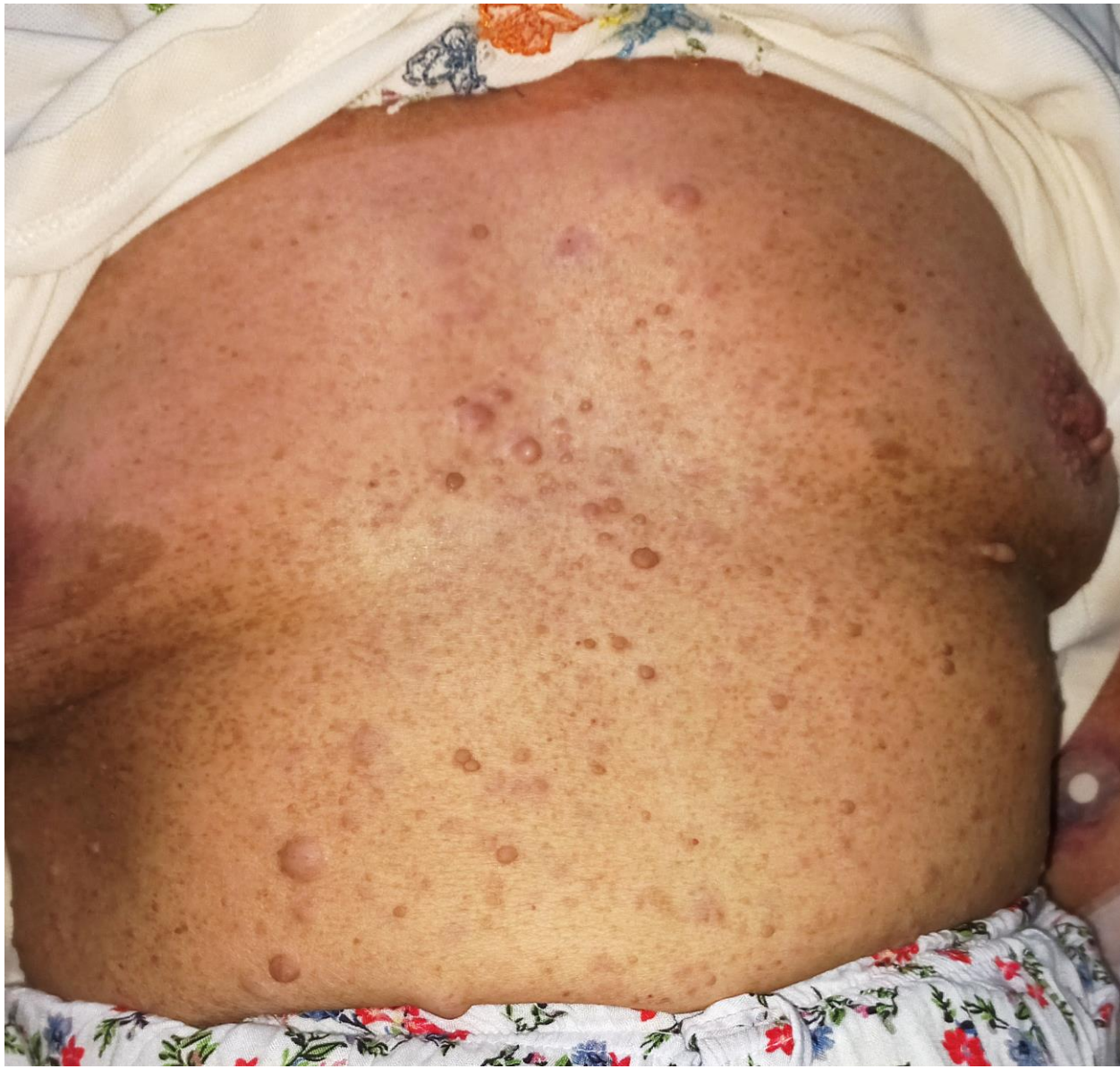
- 69 yo female
- 20 years evolution of a nodular lesion located in the right lateral cervical region, slow growing over time, painless and without skin’s ulceration injuries. After this appears other nodular lesions more in random places of the patient's body.
- The patient comes to our center due to dyspnea and dysphonia associated with the excessive growth of the first nodular lesion in the neck.

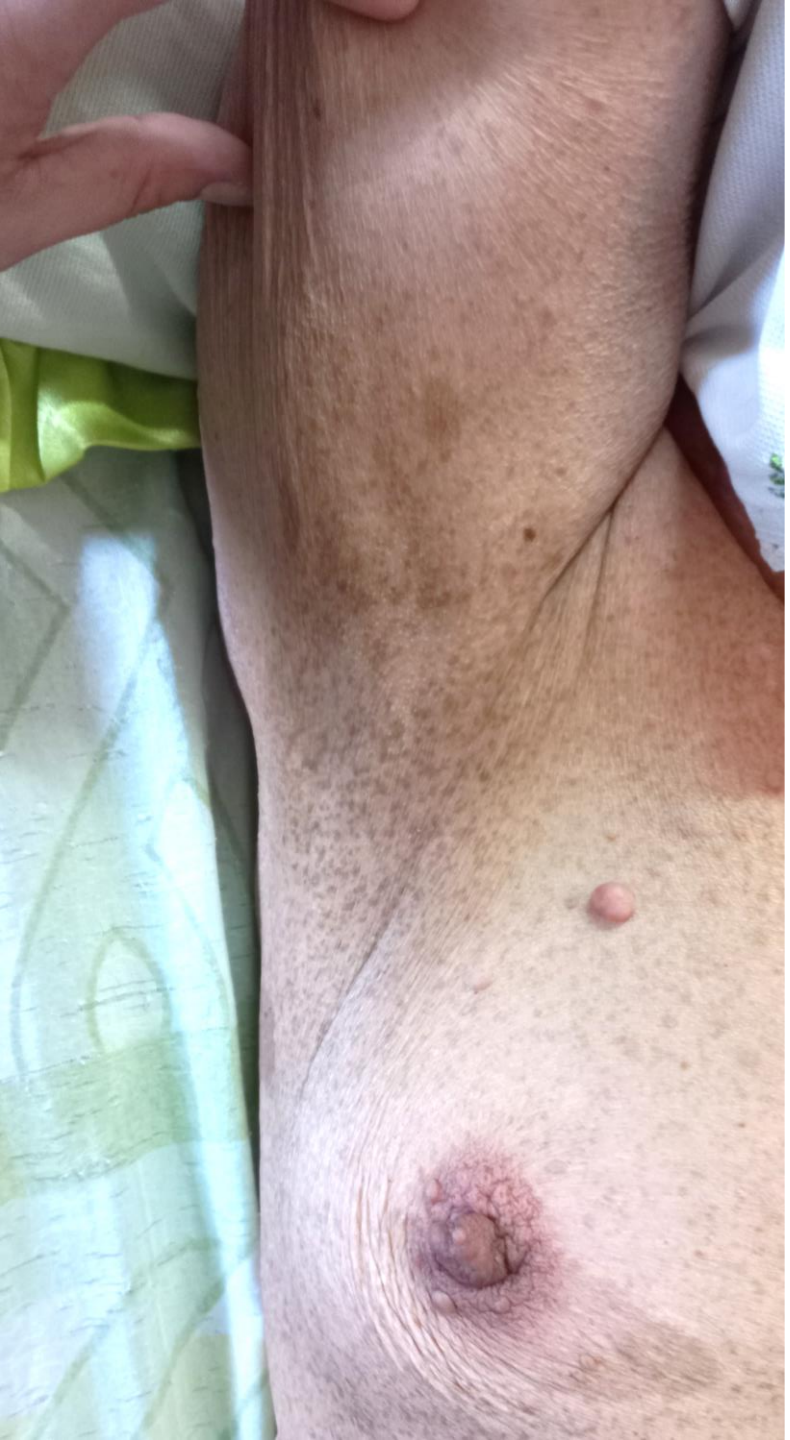


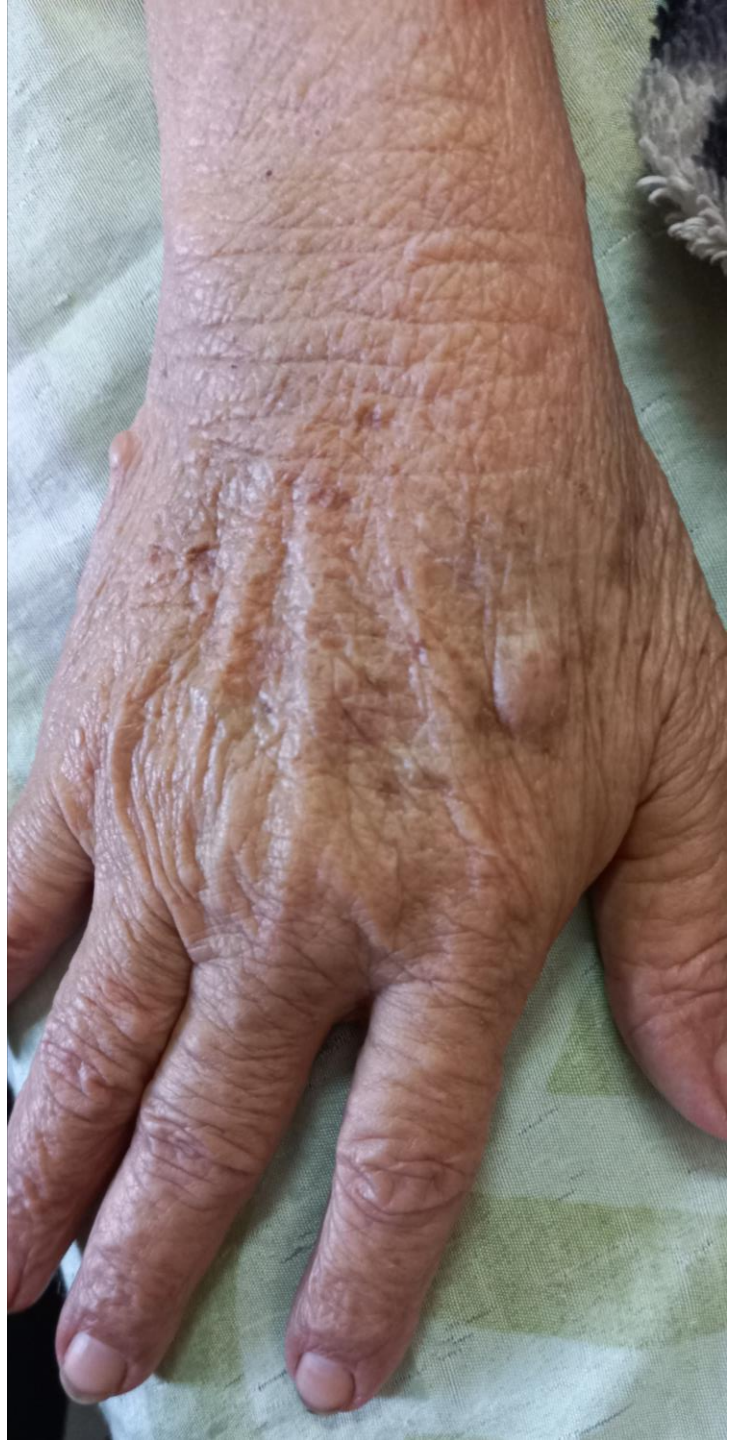


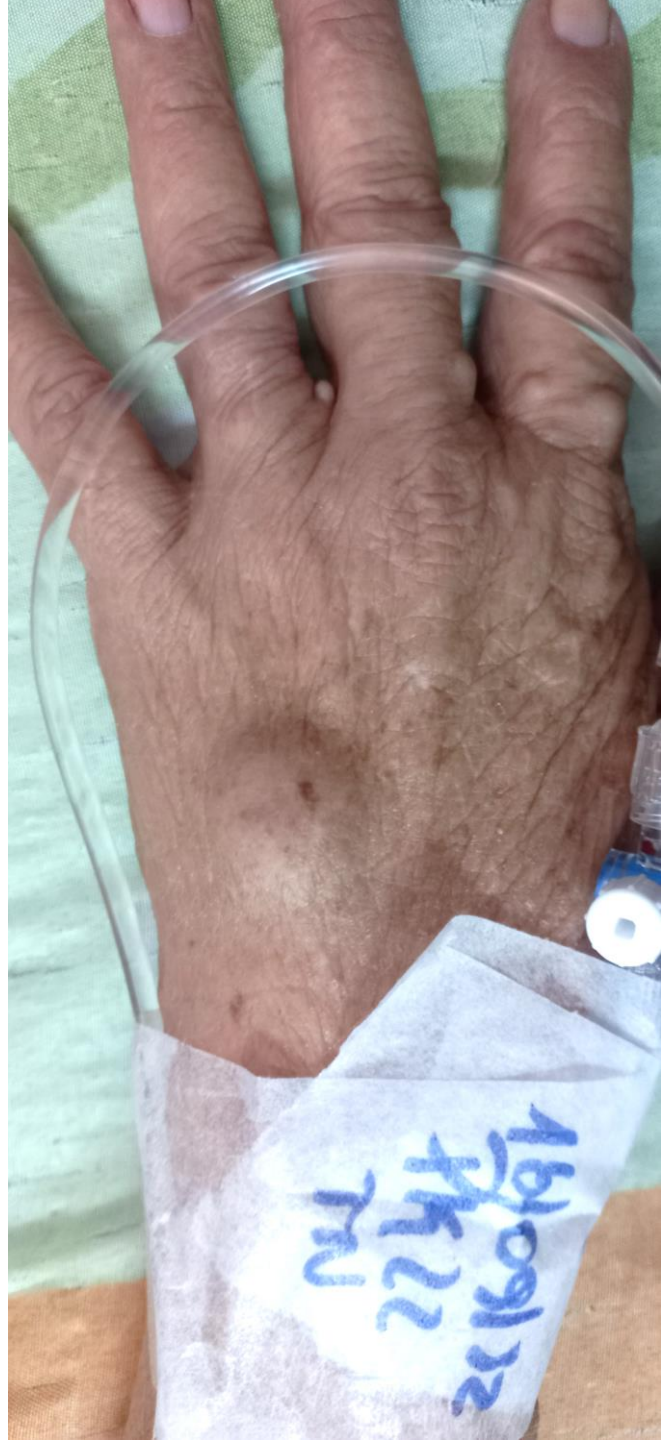


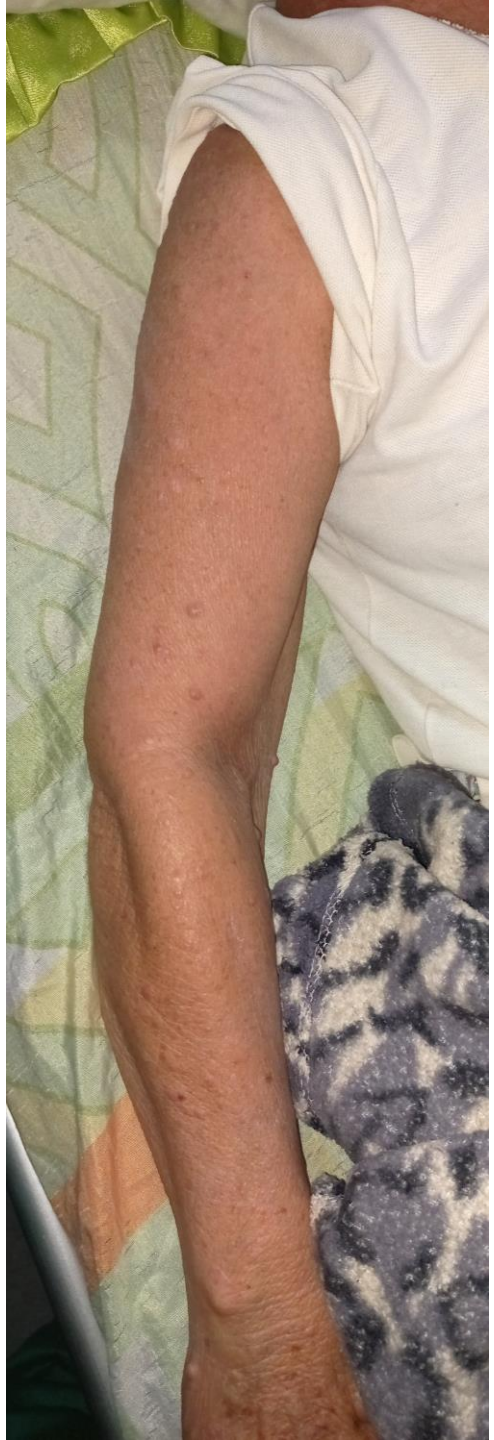


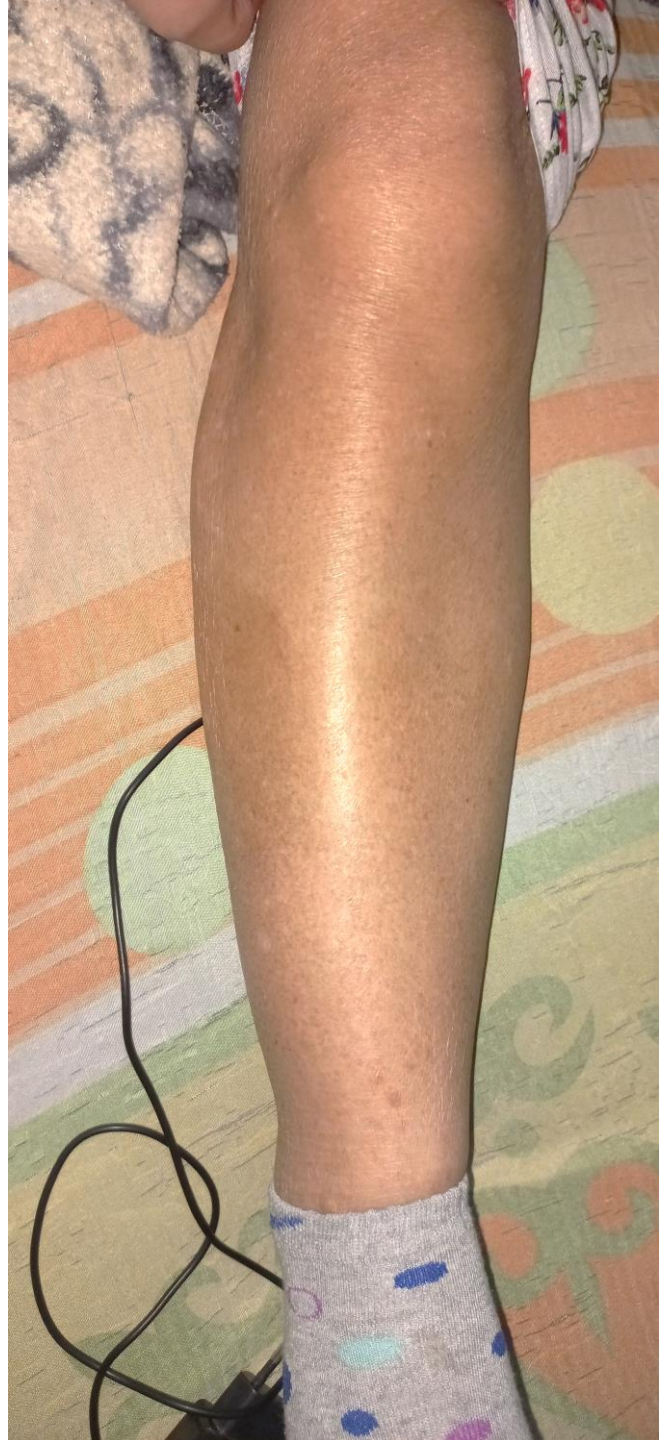


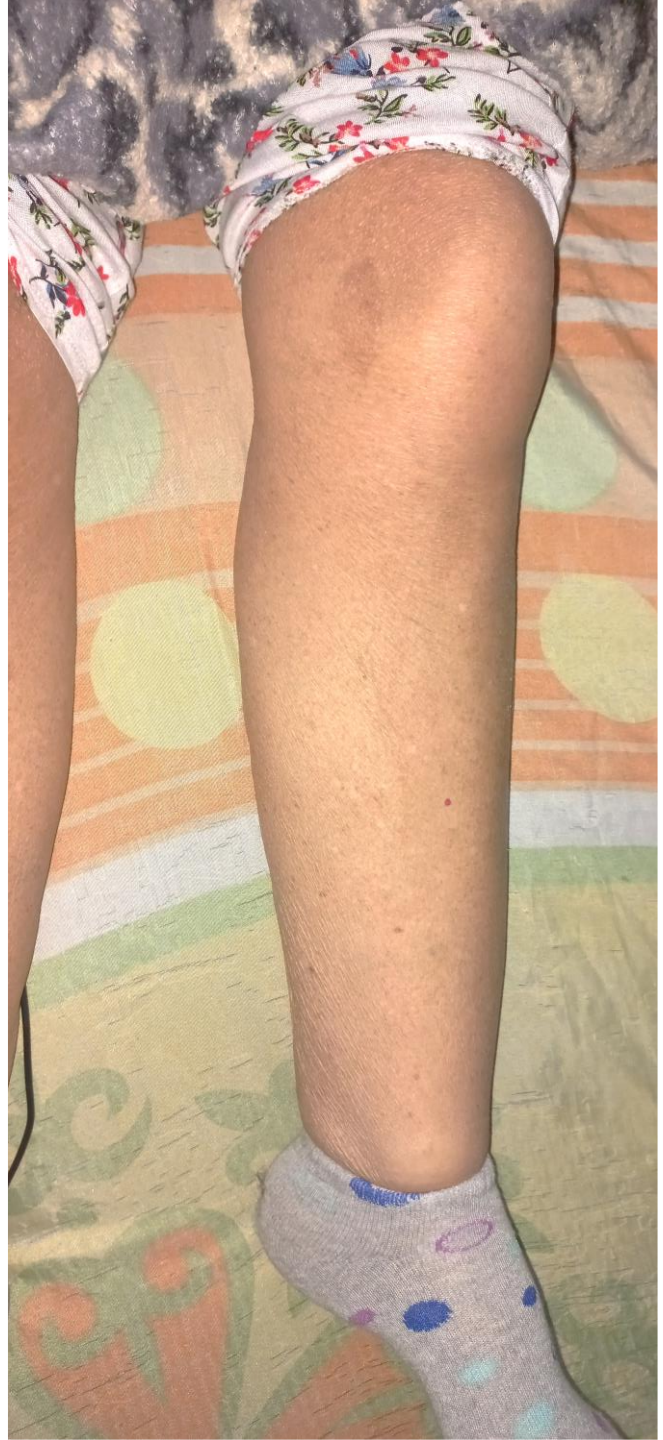




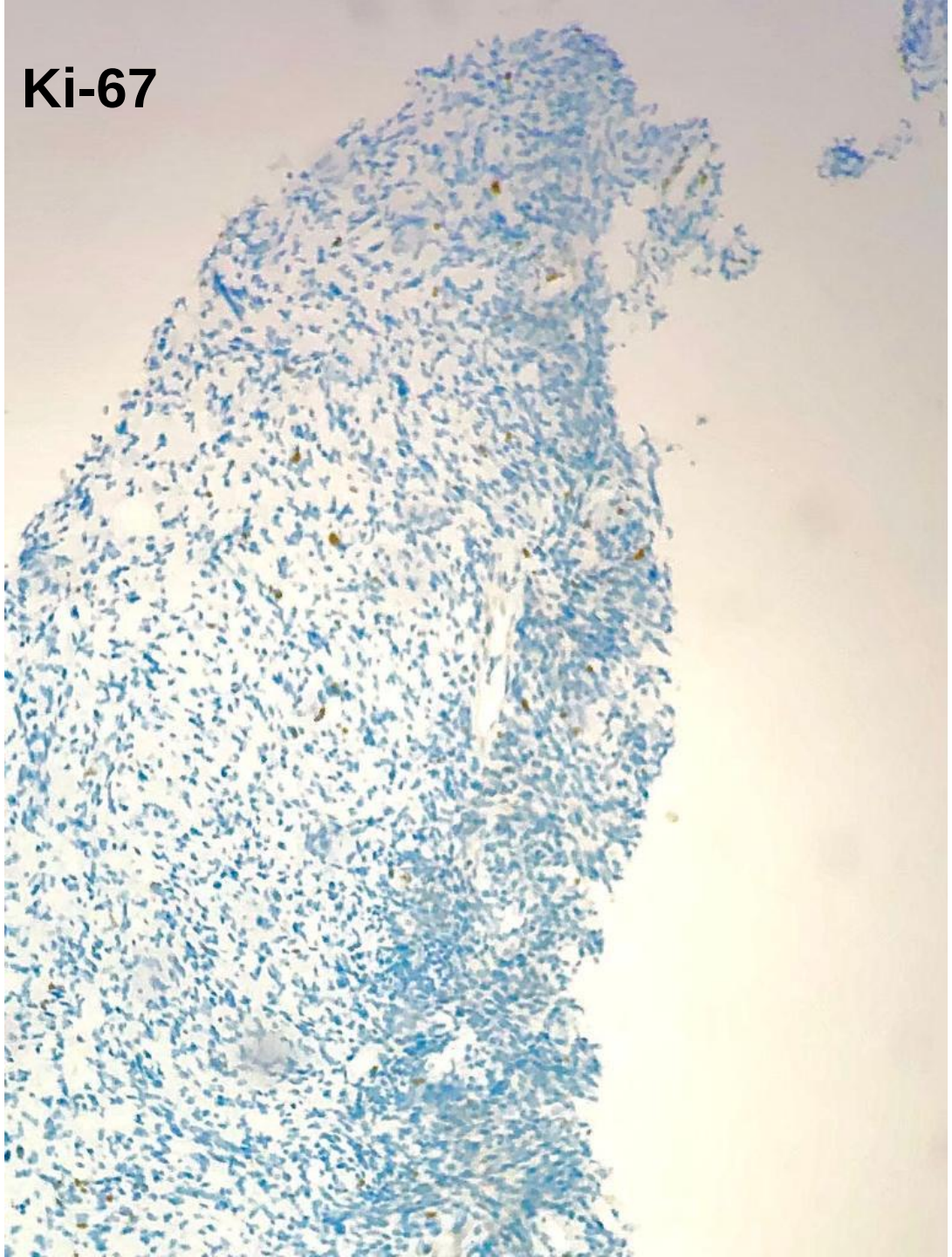


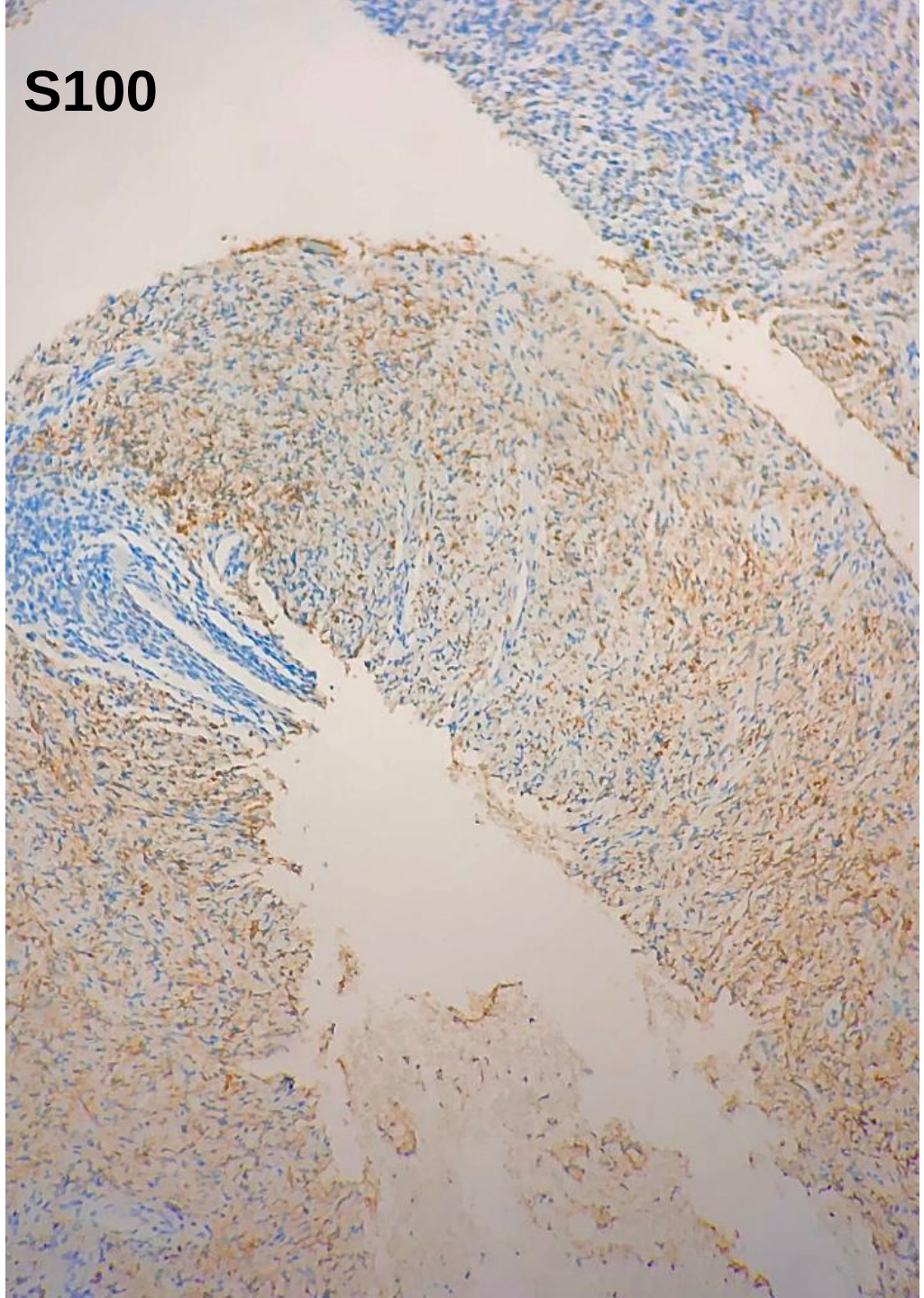






- On September 2022 : was someted to a ecoguidance biopse of the principal lesion and a excisional biopse of other aleatory lesions of the pantience’s body.
- **Pathology Report of the cervical lateral right lesion:**
- Low grade fusocellular proliferation (Schwannoma/Neurofibroma)
- 3 cylinders.
- Mitosis: none.
- No necrosis.
- **IHC:**
- **DX:** Neurofibroma


Ki-67


S100

- **Pathology Report of the others body's lesion:**
- Cutaneus losange of lumbar region of 1,8x1 cm: Neurofibroma
- Cutaneus losange of right shoulder lesion of 1,9x1 cm: Neurofibroma

cT SCAN report

- Mass located in the right lateral cervical region, below the right mandibular region, 10x13x8 cm, heterogeneous, in contact with the cervical vertebrae and osteolytic images in them. Conservation of the airways.
- Multiple nodular lesions in the lung parenchyma on both sides, suggested as secondary, associated with pleural effusion on the right side.
- There are no other injuries under this method. No lymphadenopathy.

Discussion

- Is resection of the cervical mass indicated?
- Is the diagnosis of neurofibroma real or is it really a malignant presentation?
- What is the meaning of the nodular lesions of the lungs?

SELNET INTERNATIONAL TUMOR BOARD – oct 2022.

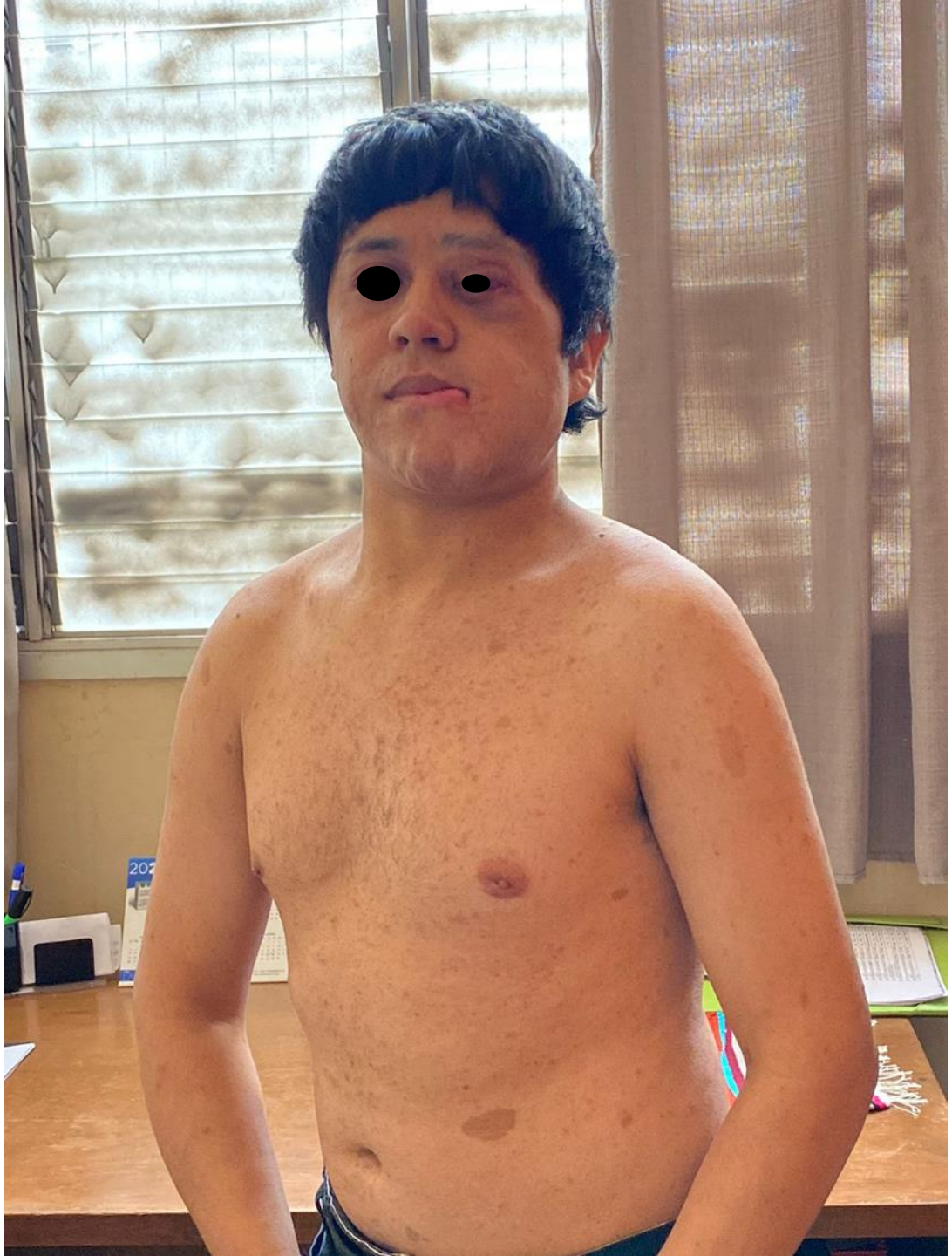
VON RECKLINGHAUSEN'S DISEASE

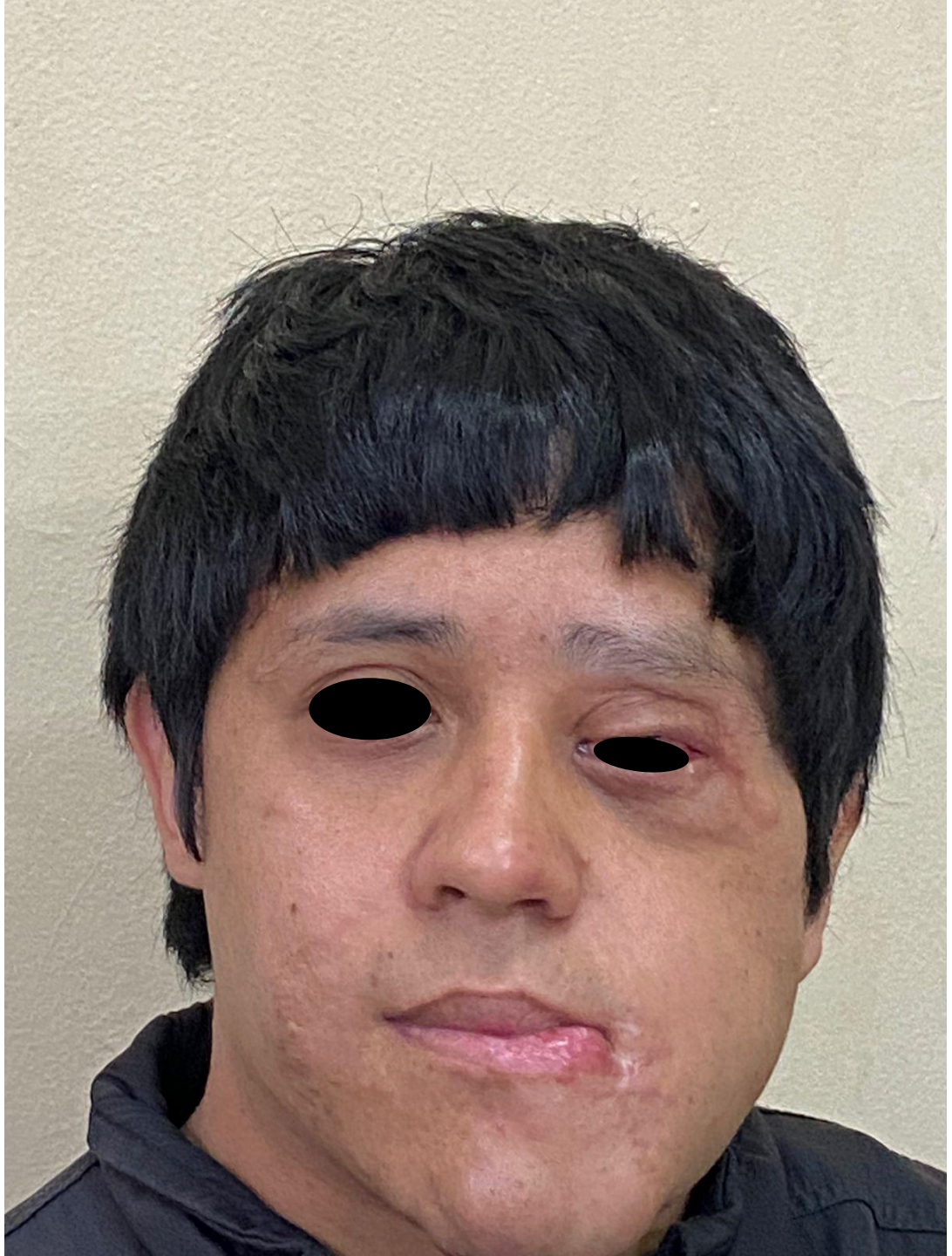
NATIONAL INSTITUTE OF CANCER – PARAGUAY

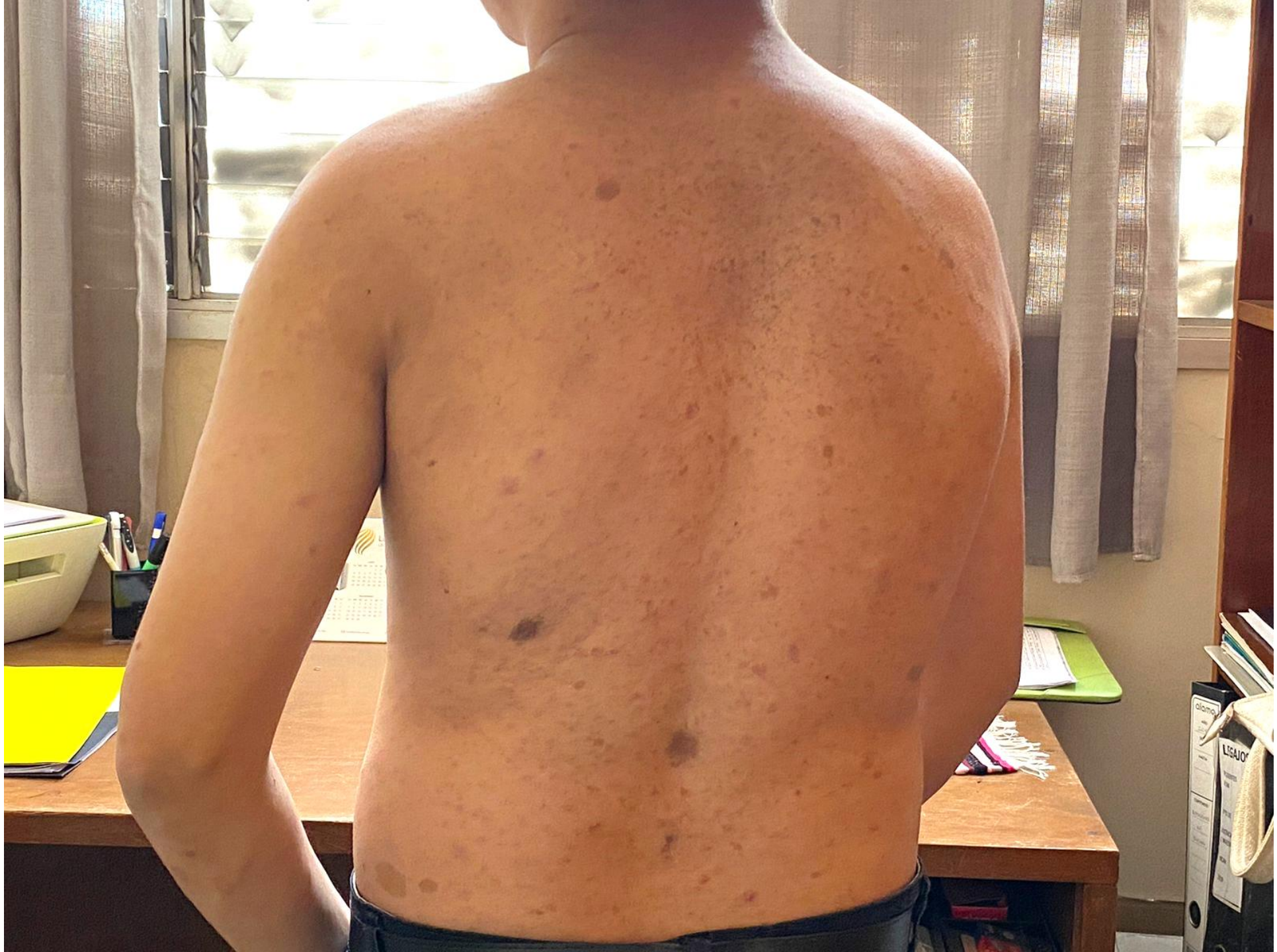
DRA. ELSA AMARILLA

Clinical History

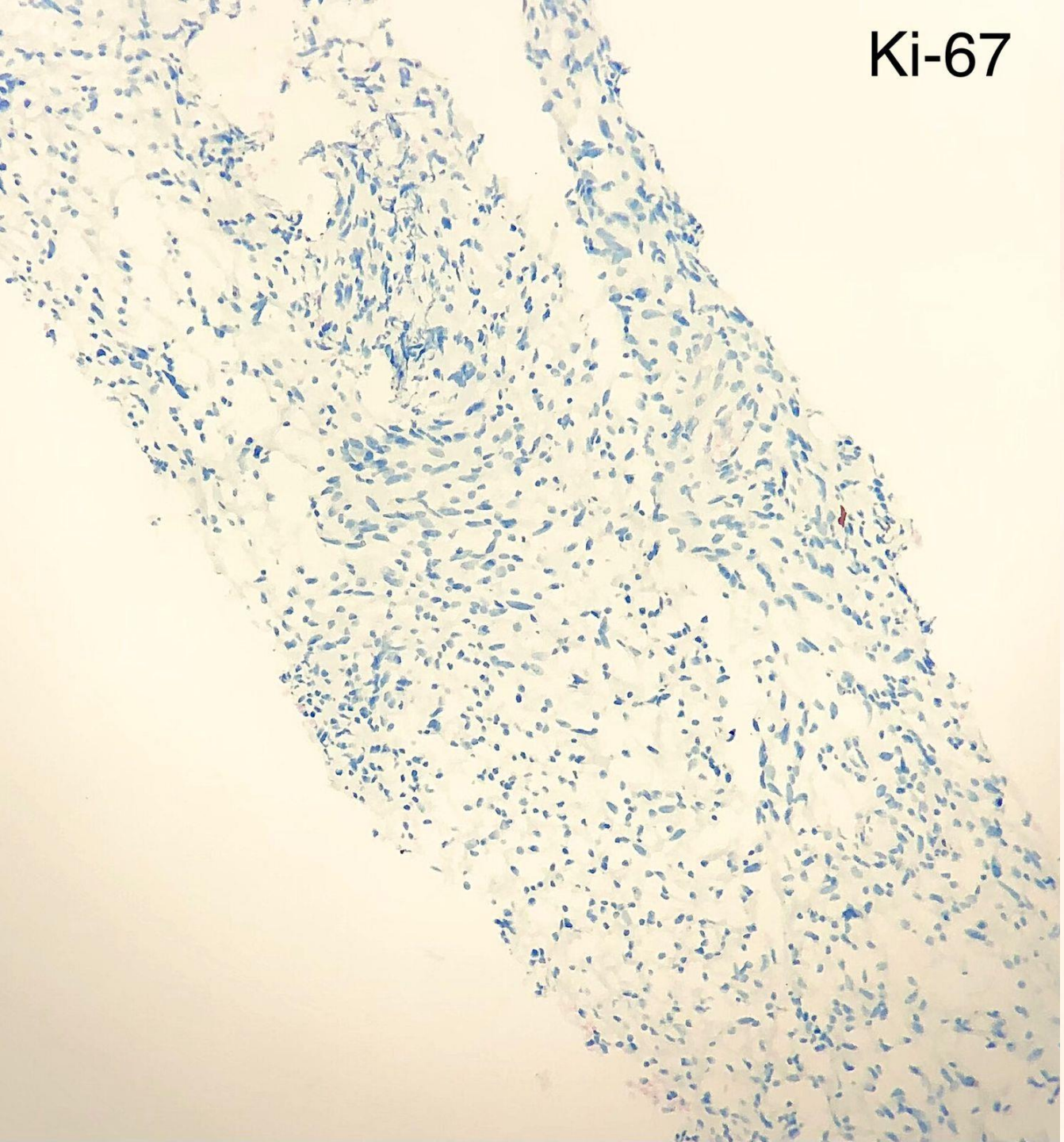
- 22 yo male
- Typical case of NF 1, with initial main lesion appearing in January 2014 on the left upper eyelid. He underwent 4 exeresis surgeries for facial lesions.
- **Pathology Report of the facial lesion:**
- Plexiform Neurofibroma

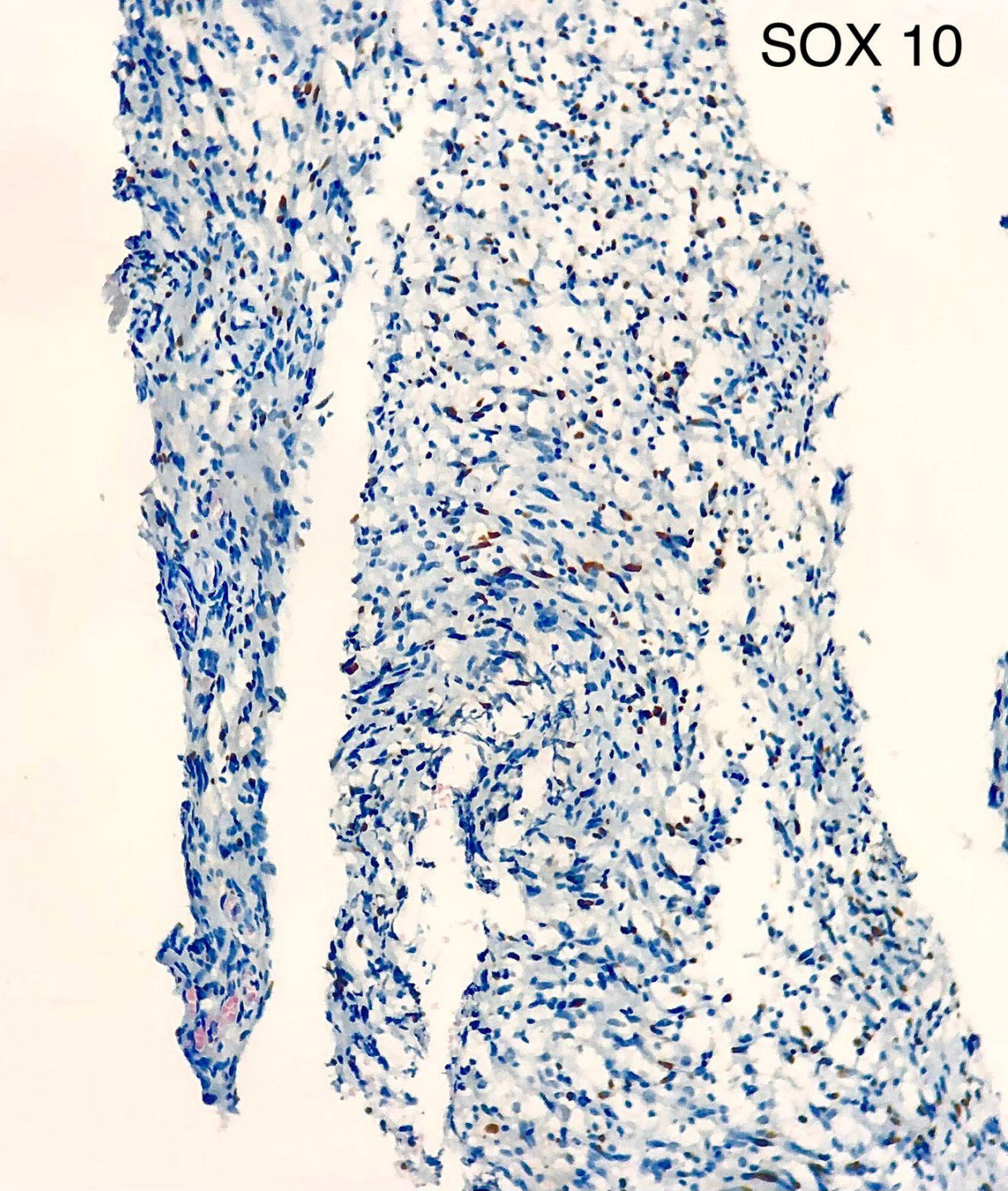


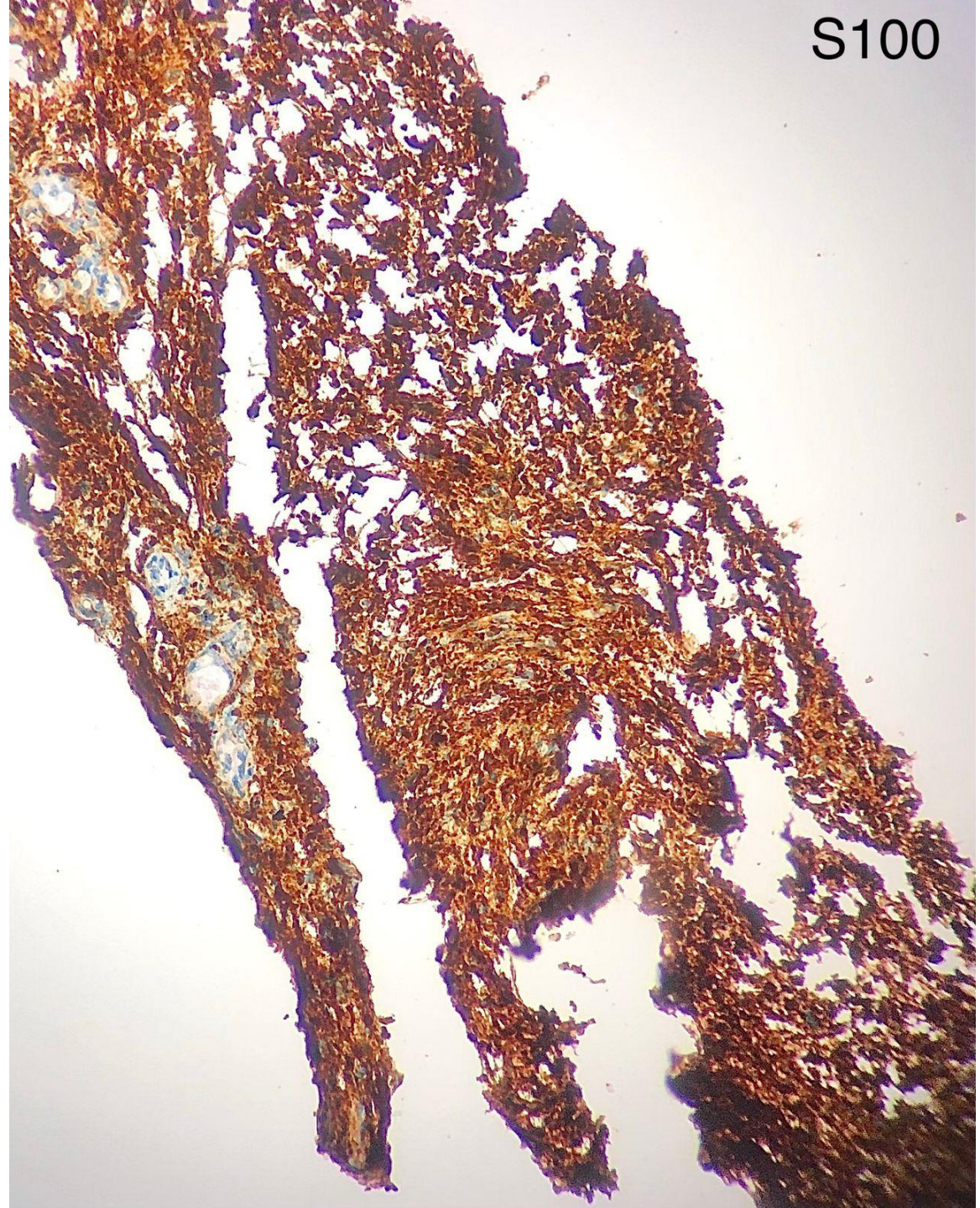


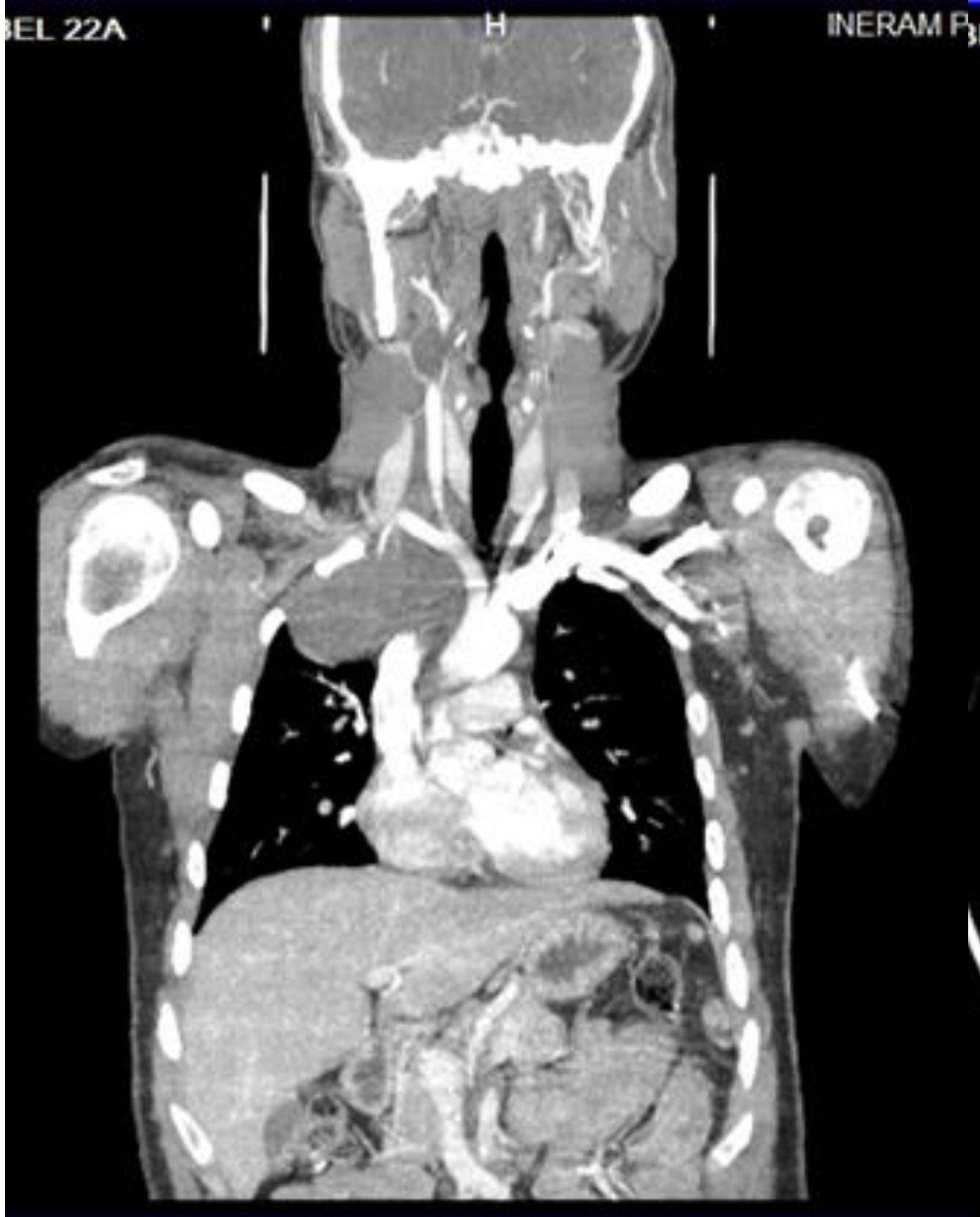


- In August 2022: the patient underwent a mediastinal biopsy, due to an imaging finding on a computed tomography performed for an asymmetry in the chest.
- **Pathology Report of the mediastinal lesion:**
- Atypical neurofibromas and atypical neurofibromatous neoplasms of uncertain biologic potential (ANNUBP)
- 3 cylinders.
- Mitosis: 2 mitosis/50HPF with a low atypia.
- No necrosis.
- **IHC:** S100 + / SOX10 + / Ki67 < 1%
- **DX:** ANNUBP


Ki-67


SOX 10


S100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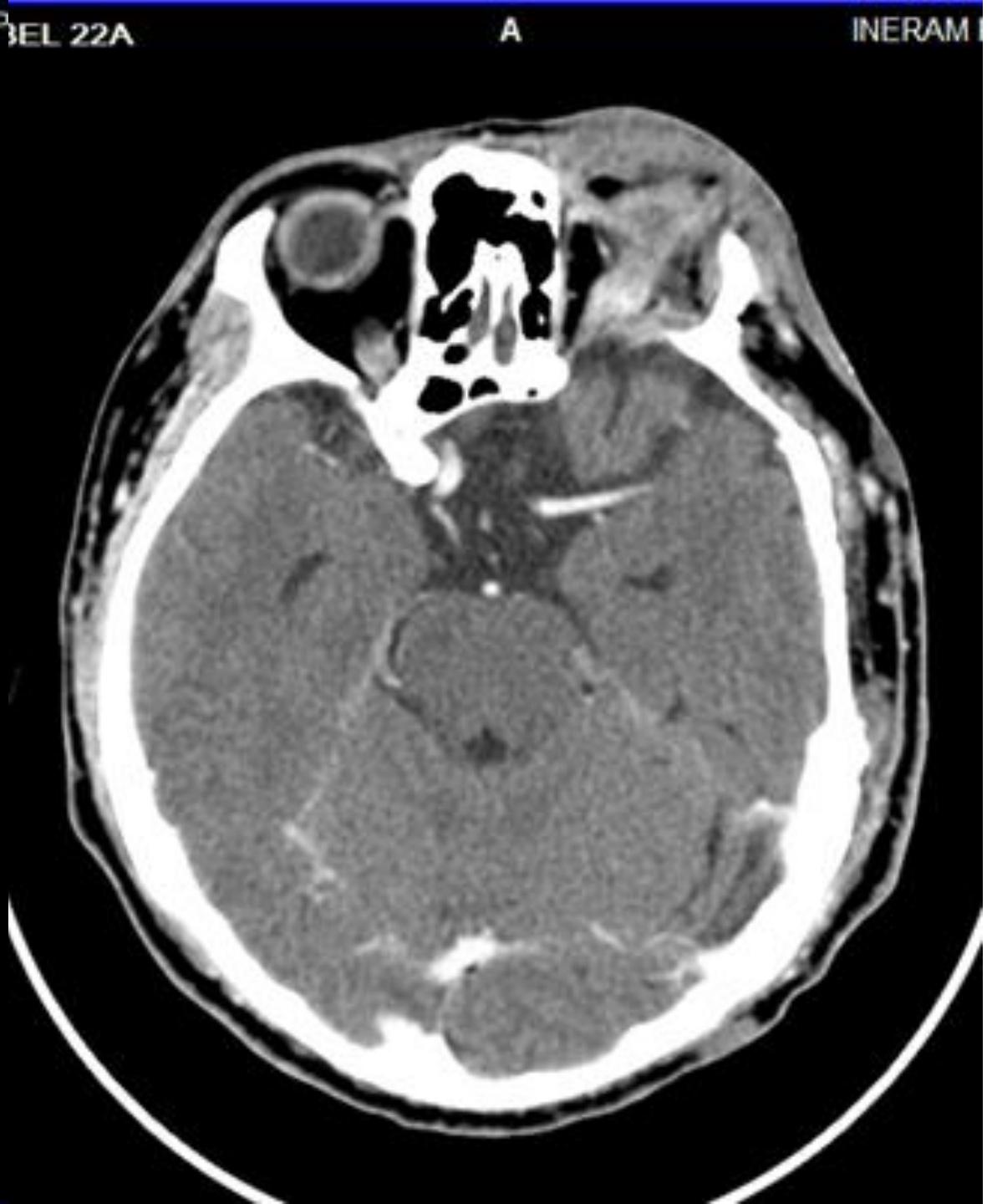
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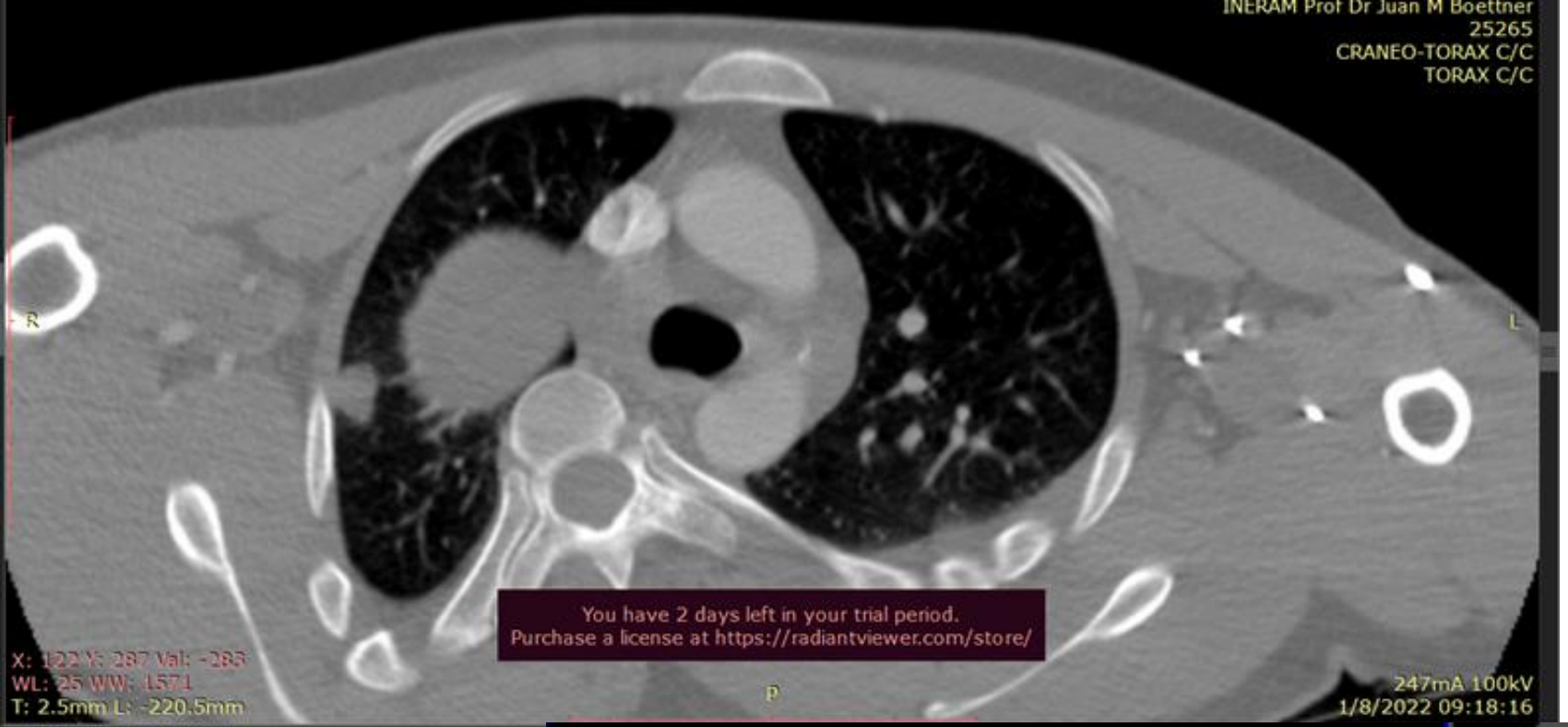
INERAM Prof Dr Juan M Boettner
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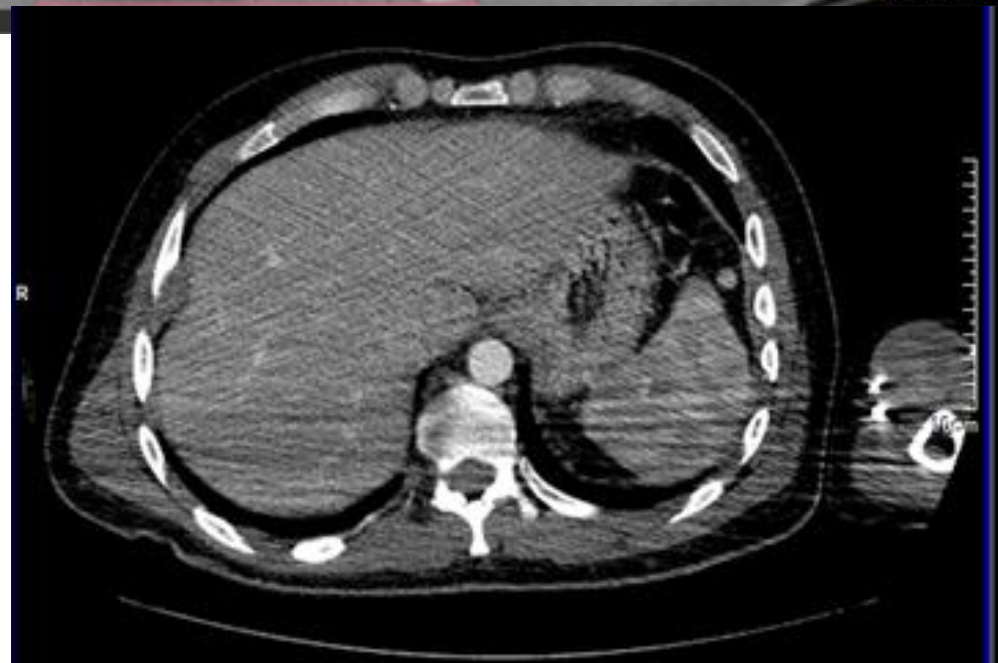
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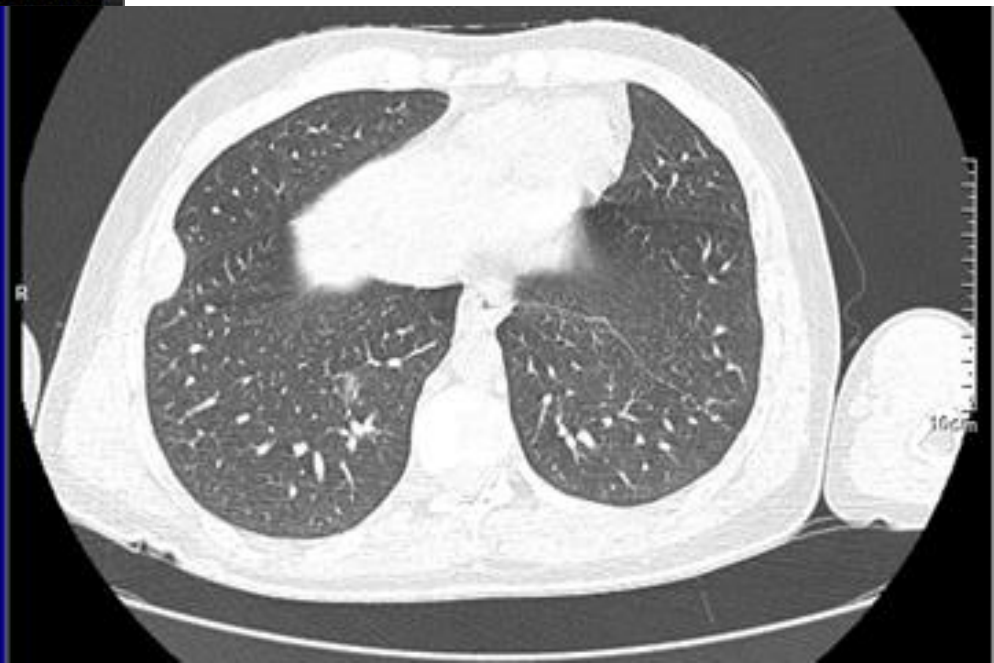
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Discussion

- What else can we offer to this patient ?
- Treatment with MEK inhibitors ?

Cases

- Dra. Lucia Richter Paz: Caja Petrolera Salud Bolivia

- Dra. Bruna David: INCA / Oncoclínicas – Brazil

- Dra. Carolina Da Silva Cardoso: INCA / Oncoclínicas – Brazil
- Dra. Bruna David: INCa / Oncoclínicas – Brazil

- Dr. Boris Itkin: Sultan Qaboos Comprensive Cancer Center OMAN

- Dra. Eliza Ramirez: National Institute of Cancer. (x2)

- Dr. Maycos L. Zapata M. Cancerology Institute Las Americas

MTB Selnet October 2022

Maycos Leandro Zapata M

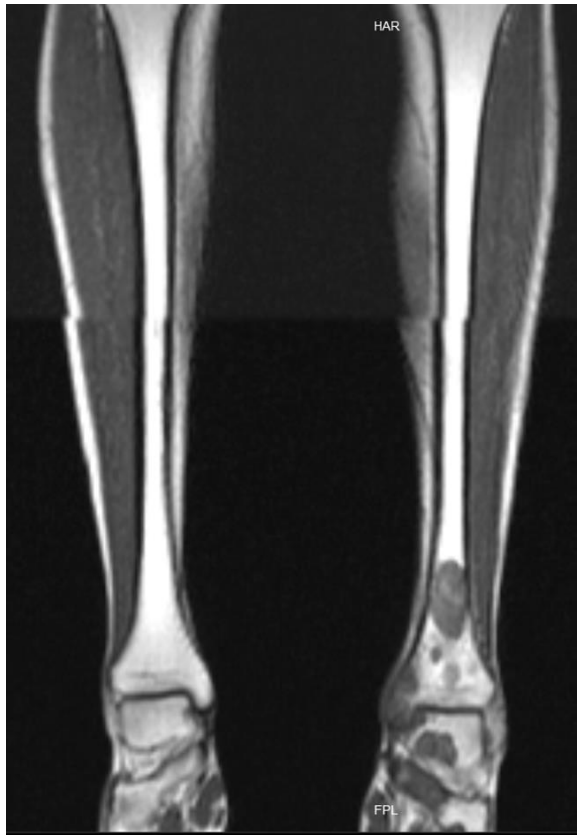
Medical Oncology

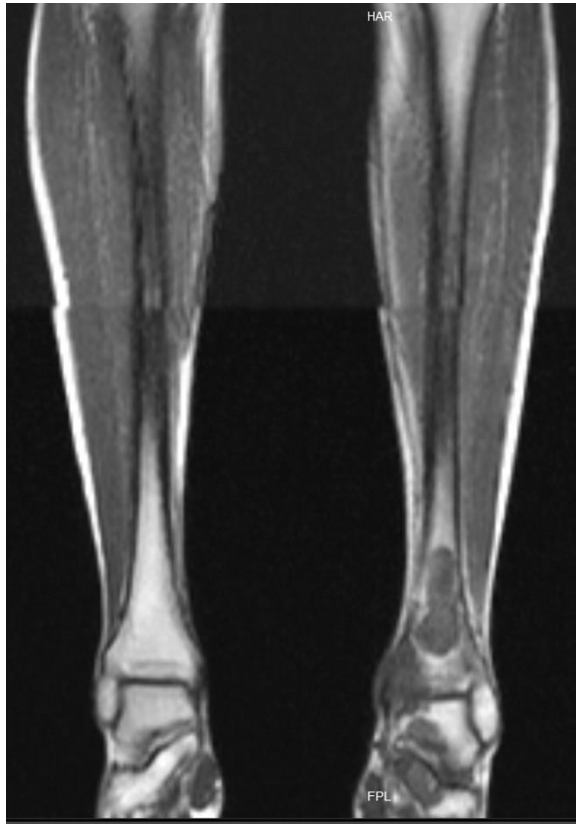
IDC Auna – Las Américas

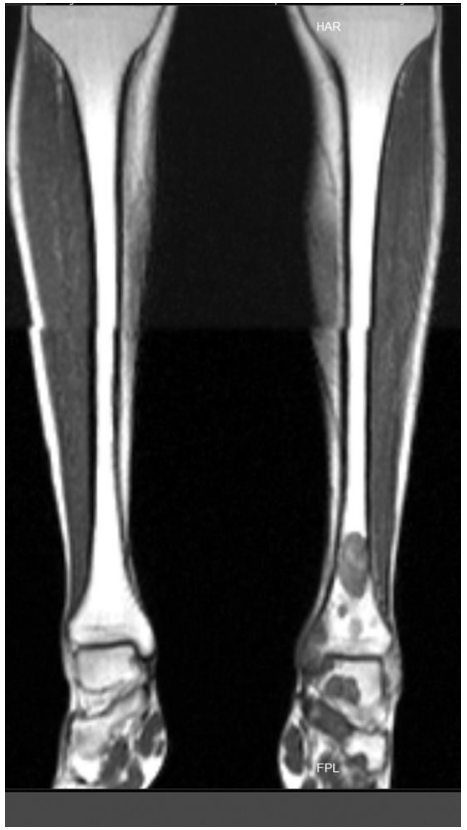
Internal Medicine UdeA

23yo Male

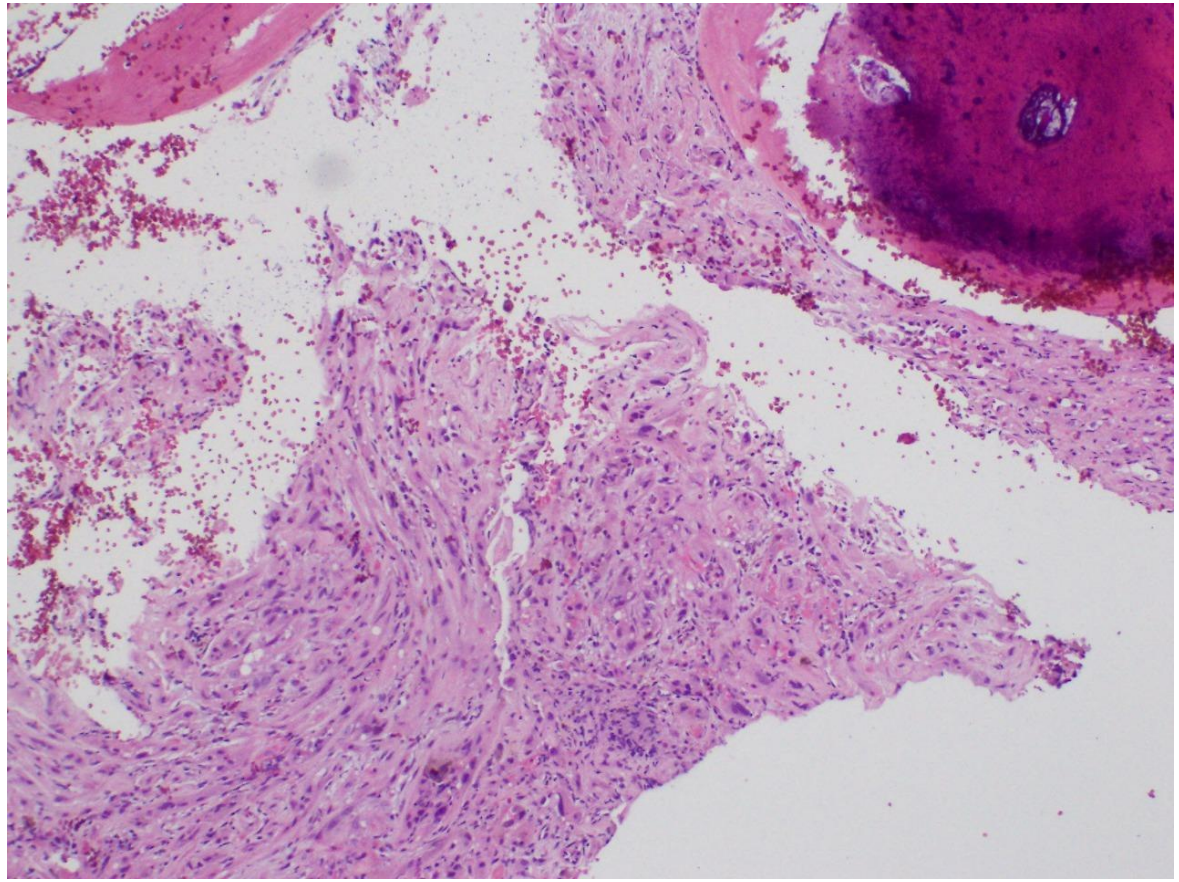
- 2 months left ankle pain

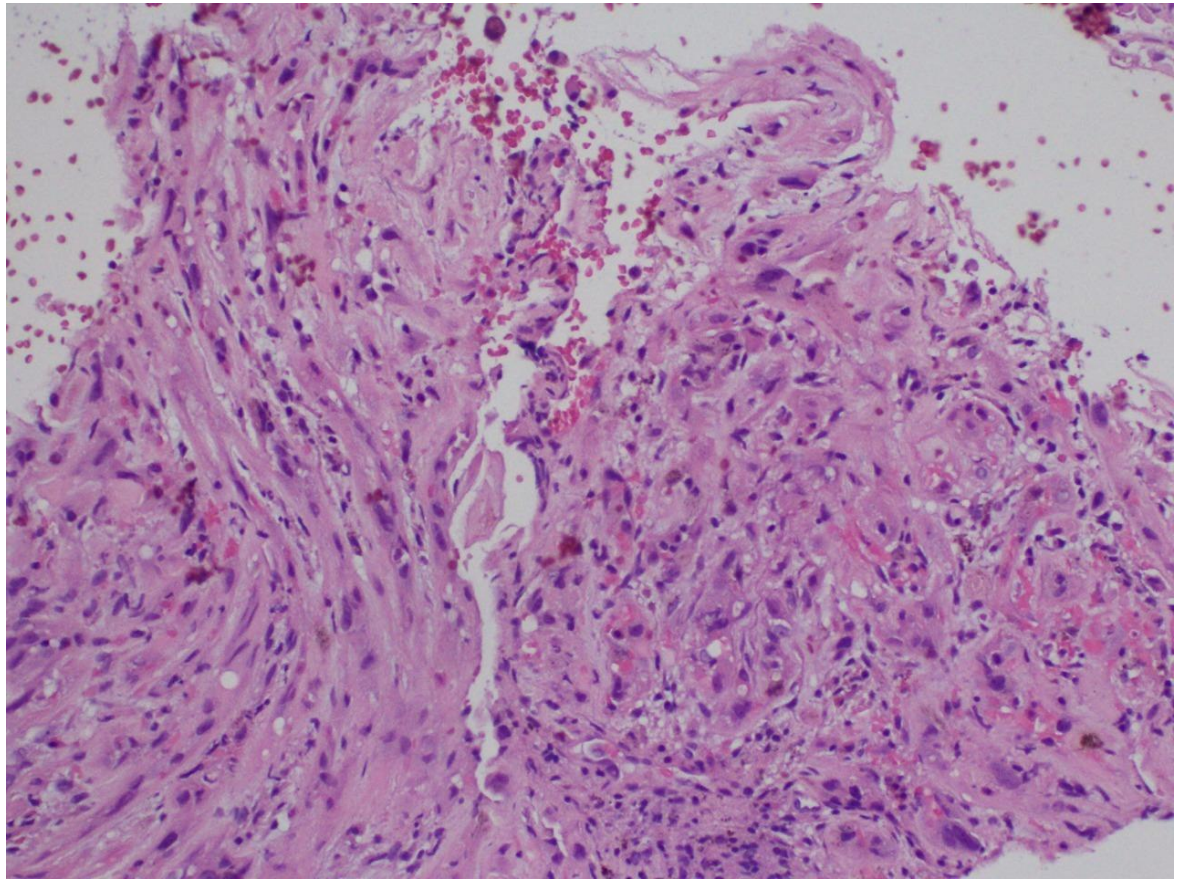


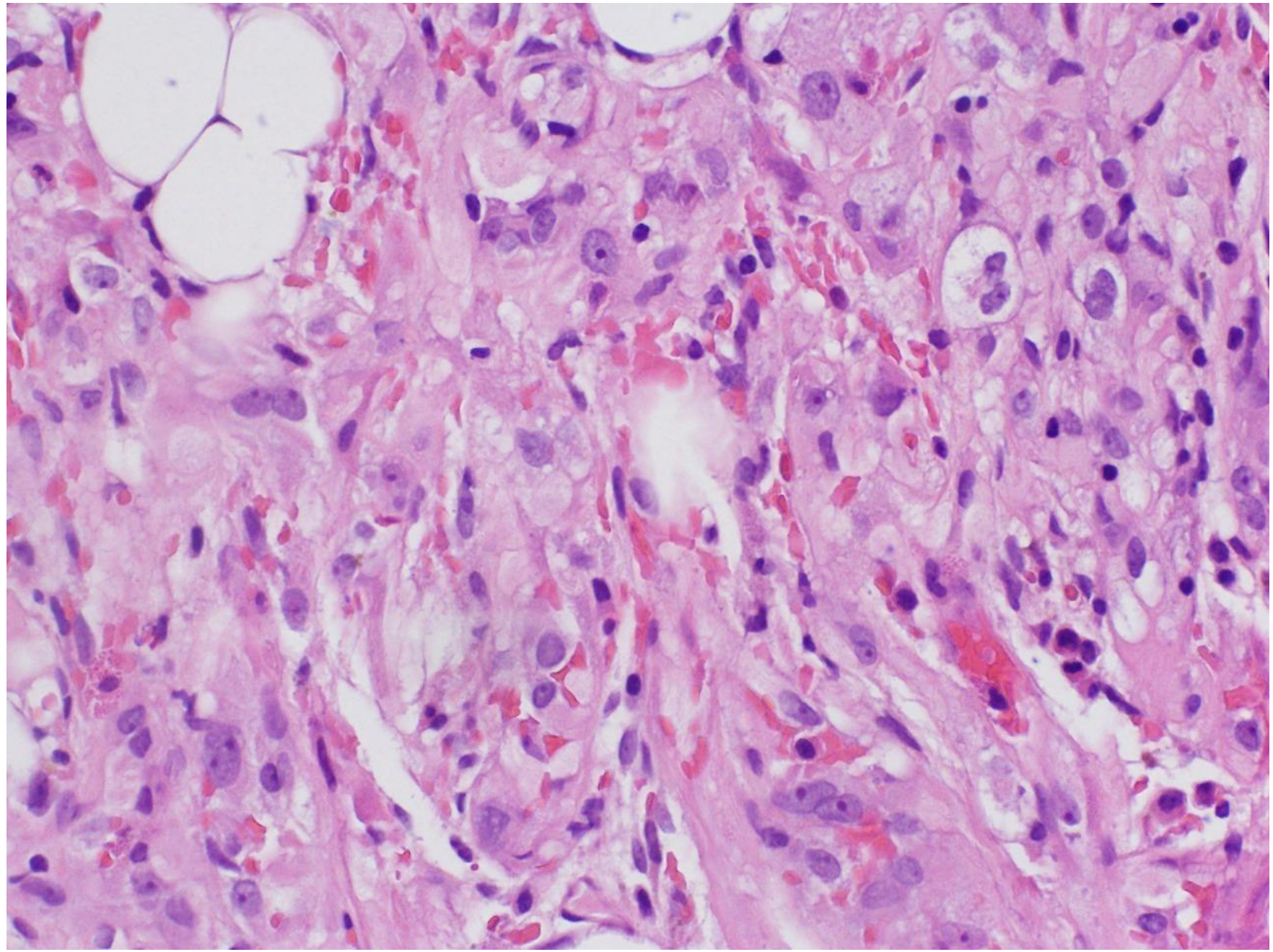




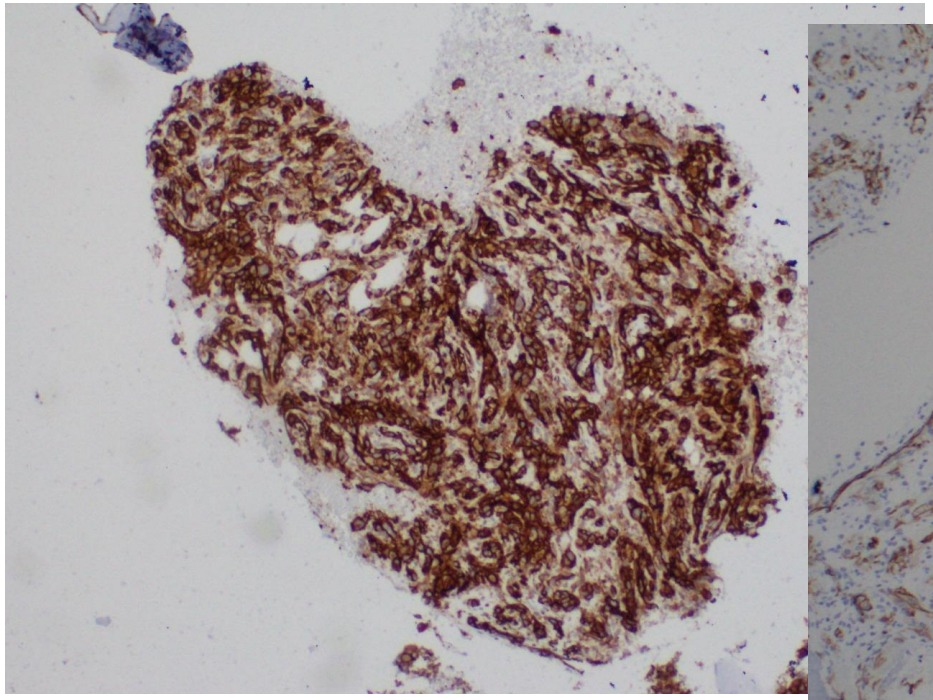
Bone Biopsy



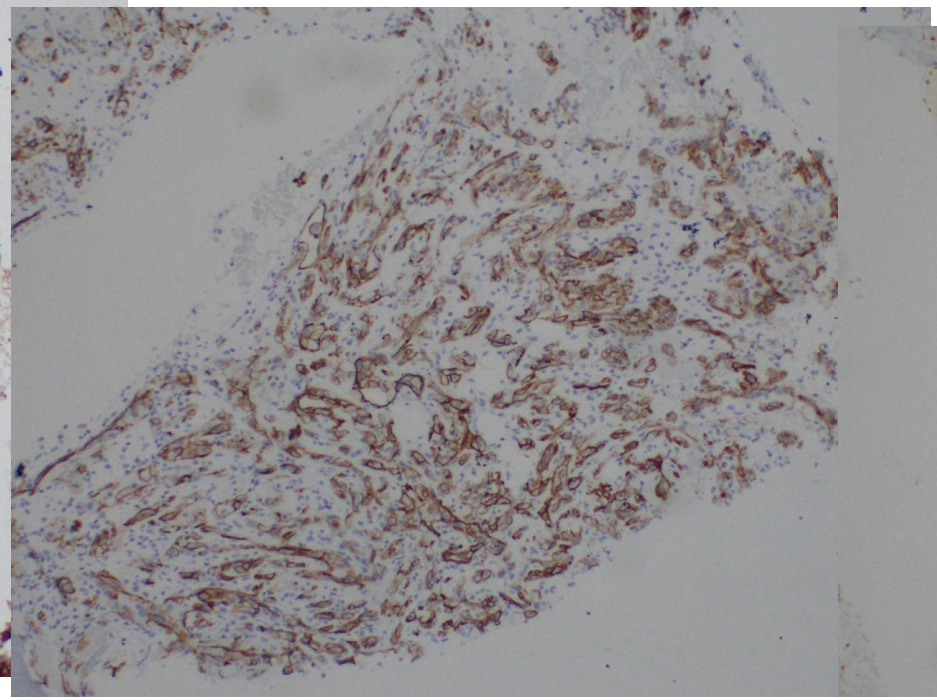




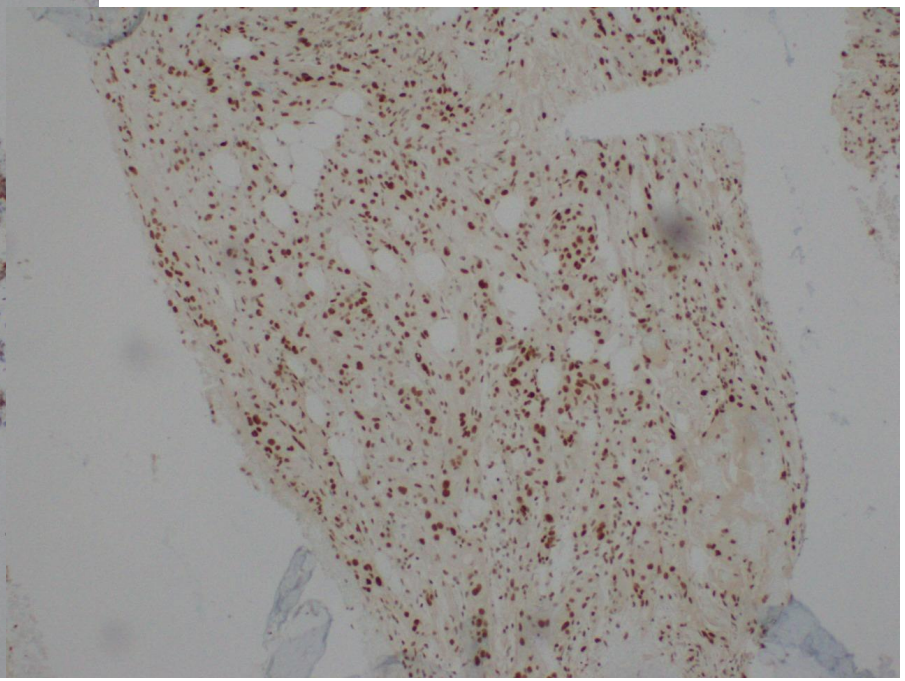
Epithelioid Hemangioendothelioma.



CD31



CD34

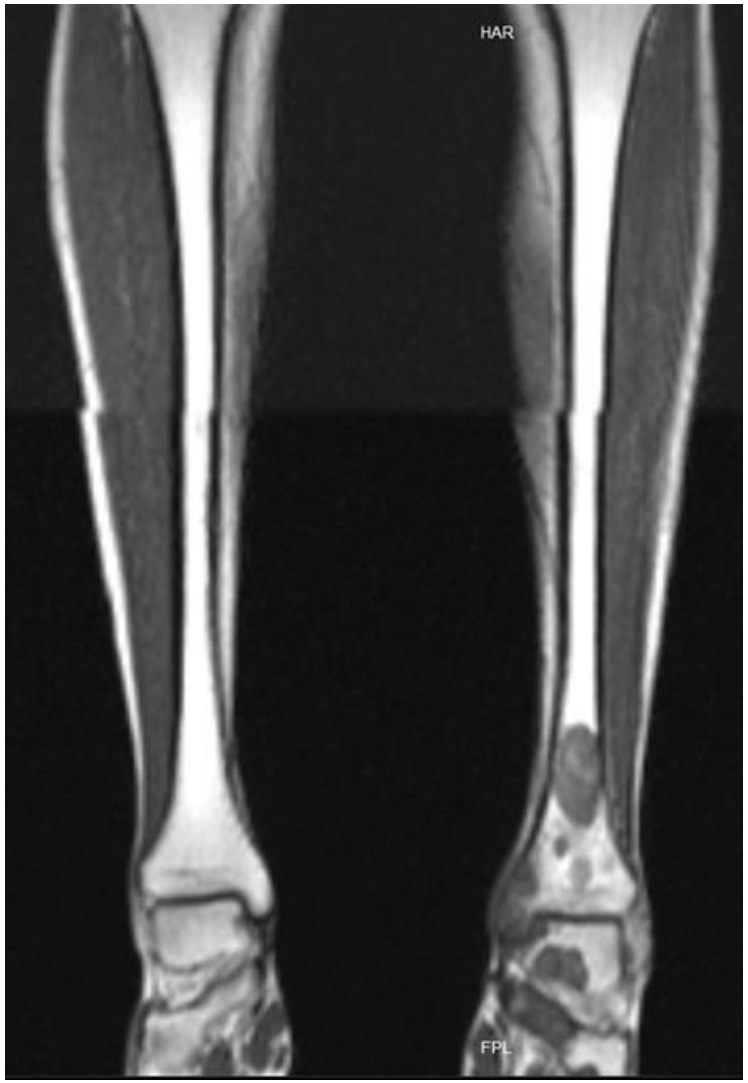


ERG

Negative: AE1/AE3, CAM5.2, EMA, AML, SALL4, CD45, CD20, PAX5, CD3, CD30, S100, CD1a

Discussion

- Amputation?
- Surveillance in localized only bone disease
- Ancillary test to check “aggressivity”



Muchas gracias

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