

7-3-2020

## BREAST CANCER IN MEN

L.T. Alimkhodjaeva

*Republican Specialized Scientific-Practical Medical Center of Oncology and Radiology, Tashkent, Uzbekistan., doclola-71@mail.ru*

M.Kh. Norbekova

*Tashkent Medical Academy, Tashkent, 100109, Uzbekistan, mxamrakulovna@mail.ru*

M.M. Mirolimov

*Tashkent Medical Academy, Tashkent, 100109, Uzbekistan*

Follow this and additional works at: <https://uzjournals.edu.uz/tma>

---

### Recommended Citation

Alimkhodjaeva, L.T.; Norbekova, M.Kh.; and Mirolimov, M.M. (2020) "BREAST CANCER IN MEN," *Central Asian Journal of Medicine*: Vol. 2020 : Iss. 2 , Article 4.

Available at: <https://uzjournals.edu.uz/tma/vol2020/iss2/4>

This Article is brought to you for free and open access by 2030 Uzbekistan Research Online. It has been accepted for inclusion in Central Asian Journal of Medicine by an authorized editor of 2030 Uzbekistan Research Online. For more information, please contact [sh.erkinov@edu.uz](mailto:sh.erkinov@edu.uz).

**BREAST CANCER IN MEN****Alimkhodjaeva L.T.,<sup>1\*</sup> Norbekova M.Kh.,<sup>2</sup> Mirolimov M.M.<sup>3</sup>**

**1** Republican Specialized Scientific-Practical Medical Center of Oncology and Radiology, Tashkent, Uzbekistan. (\*-corresponding author email: [doclola71@mail.ru](mailto:doclola71@mail.ru))

**2** Teaching assistant of The Department of Oncology, Tashkent Medical Academy, Tashkent, Uzbekistan. (email: [mxamrakulovna@mail.ru](mailto:mxamrakulovna@mail.ru))

**3** Master's degree student, Department of Oncology, Tashkent Medical Academy, Tashkent, Uzbekistan.

**ABSTRACT**

Breast cancer in men does occur. Although this pathology occurs rarely, it is most often associated with fatal consequences for life. Every year, hundreds of thousands of newly emerging breast cancer pathologies are diagnosed worldwide. Basically, this diagnosis is made to women, however, approximately one to two percent of the total number occurs in men. The degree of aggressiveness and timing of diagnosis in these cases varies, which is a high frequency of death. The etiological factors that lead to breast cancer in women have not been reliably studied; things are even more vague with this pathology in the stronger sex. Pathogens were identified that under certain conditions, including weakening of the body and immunity, can lead to the development of breast cancer in men.

**Keywords.** Breast cancer in men, breast cancer, gynecomastia, diagnosis, chemoradiotherapy, hormone therapy.

## INTRODUCTION

Breast cancer (breast) in men - a relatively rare disease, which occurs 100 times less than breast cancer in women [1]. Nevertheless, it attracts the attention of an increasing number of researchers every year. This disease has been known for a long time, and the first mention of it dates back to the XIV century. The English doctor Johuot Arderne described a right nipple ulcer in the priest, which slowly increased in size over 2 years [2]. The first monograph with a detailed description of the manifestations of breast cancer in men was published in 1720 by Z Laurentius Heister. The average age of men with breast cancer is slightly higher than women. In men, this disease is most often found in the sixth and seventh decades of life (55-65 years), but people of a younger age are also affected by this disease [3].

Breast cancer is a well-known breast pathology that occurs in women of different ages and most often successfully treats. In connection with the frequent misconception that men do not have this gland, it is believed that they simply do not have this disease. In fact, this is not so, because although it is underdeveloped, it resembles atavism more than a full-fledged organ, but the mammary gland is still present in men [4].

Experimental studies and clinical observations have proved the similarity of the onset and development of hyperplastic processes in the mammary glands in men and women, as well as the commonality of the etiological and pathogenetic mechanisms of development of breast cancer in male and female organisms [5]. The success of the treatment of cancer patients largely depends on the timely diagnosis of the tumor in the first stages of the patient's visit to the doctor. The diagnosis of gastric cancer in men is based both on clinical data and on the data of additional examination methods: X-ray, cytological examination of discharge from the nipple, punctate from the tumor, and prints from the surface of

---

the ulcer. The use of this diagnostic complex allows you to establish the correct diagnosis in 99% of patients [6].

Examination of the patient begins with a study of complaints and anamnesis. The most common complaint is the detection of a seal in or near the nipple or areola without any other signs of illness. Often, breast cancer in men develops against the background of gynecomastia, which can manifest itself either by diffuse enlargement of the mammary glands, or have a nodular shape [7]. With gynecomastia, some retraction and fixation of the nipple may be noted. Other skin symptoms with gynecomastia are not observed. It is necessary to obtain data on past diseases, especially pay attention to liver diseases and urological diseases; find out if occupational hazards exist [8]. Inspection of the patient is carried out in a standing position and lying down. When examining, it is necessary to pay attention to the size of the mammary glands, the shape of the nipples and areoles, their symmetry, the presence or absence of deformation. When examining a patient in a position with his arms raised up, it is easier to detect skin retraction over a tumor or retraction of the nipple. Next, the doctor proceeds to palpation of mammary glands.

In men, even with superficial palpation, it is possible to detect a cartilaginous density formation with uneven contours, which is located centrally behind the nipple or areola, or near them. When compaction is detected, a more thorough palpation of this area is performed to determine the size, shape, consistency, mobility of the tumor, the condition of the skin above it.

Weaker than in women, the development of subcutaneous fat, the proximity of the gland to the skin and to the underlying tissues lead to the fact that the tumor very early becomes limited mobility in relation to the anterior chest wall, the skin over the tumor is quickly fixed, wrinkled. Studying the condition of the nipples and areoles, it is necessary to pay attention to the thickening of the areola folds (symptom of Krause), the presence or absence of discharge from the nipples, to identify possible symptoms of wrinkling, retraction or the symptom of “lemon peel”. In men, ulceration of the skin over the tumor occurs much earlier than in

women. According to our data, in 21% of cases, patients first went to the doctor for a long non-healing ulcer in the mammary gland [9]. An examination of the second breast is necessary. After examination and palpation of the mammary glands, axillary, supraclavicular and subclavian areas are examined and palpated on both sides in order to detect metastases in the lymph nodes. The defeat of regional lymph nodes is a fairly common occurrence in breast cancer in men. This is due both to the anatomical structural features of the male mammary gland, and “with more frequent and stronger contractions of the muscles in the anterior chest wall with increased local lymph and blood circulation” (S. A. Holdin, 1962). Therefore, it is the enlargement and densification of axillary lymph nodes that may be one of the first signs [10] .



**Fig 1 . Breast cancer of the IV degree.**

The appearance of enlarged lymph nodes can also change the clinical picture of the disease, which depends on both the size and localization of metastases. With small sizes of lymph nodes, the patient may not even know about their existence. With an increase in the size of metastases, the clinical picture associated with compression of blood vessels and nerves by conglomerates of metastatic nodes grows. With generalized breast cancer, complaints and the clinical picture of the disease depend on the localization of metastases. This primarily occurs with

bone metastases, when local pain often appears earlier than changes are detected by X-ray examination [11].



**Fig 2 . Breast cancer of the IV degree.**

Currently, there are a fairly large number of effective methods used to treat primary breast cancer, such as surgical, radiation treatment, chemotherapy and hormone therapy, as well as their various combinations and combinations [12]. The art of an oncologist is to select from the huge arsenal of methods and tools those that are optimal for the treatment of each particular patient.

Treatment of the patient should be strictly individual. Depending on the stage of the disease, localization and prevalence of metastatic lesions, age and related diseases, an individual treatment plan is made with the most rational combination of the above funds [13].

And yet, no matter how great the successes were in the development of new methods of treatment, [14,15] the long-term results primarily depend on the extent of the tumor process at the beginning of treatment.

At the initial manifestations of the disease, only surgical intervention is sometimes enough to fully recover.

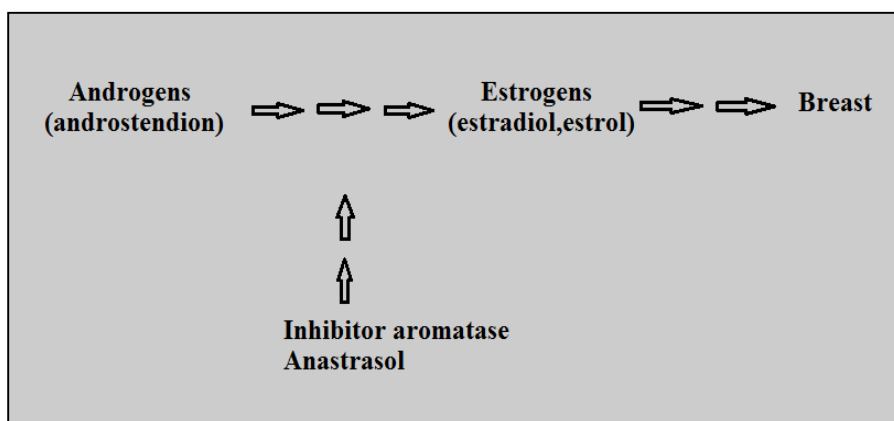
The most widely used surgery found: Mastectomy with removal of the axillary and subclavian fiber areas and the preservation of the pectoralis major muscle [16,17].

Unfortunately, the number of patients in whom treatment could be limited only by surgical intervention is small. Most men with breast cancer seek medical help if they have regional or distant metastases.

In recent years, clinical practice implemented method defined hormone receptors in the tumor tissue. The results of previous studies have shown a high hormonal dependence of breast cancer in men [18, 19]. It is these data that explain the pronounced effectiveness of endocrine therapy for breast cancer in men. Clinical experience with the use of endocrine therapy suggests that in some cases, even with the presence of bone metastases in 69% of patients, a pronounced remission with an average duration of 1 year 5 months can be obtained. Moreover, remission in men is often achieved faster than with a similar pathology in women [20, 21].

Currently, drugs from the group of antiestrogens (tamoxifen, toremifene, etc.) are widely used. [22, 23] At the end of remission, it is possible to prescribe drugs from the group of progestins (megestrol, acetate, medroxyprogesterone), which are best used against the background of castration [24, 25].

Today, surgical castration can be successfully replaced by the use of the drug goserelin, which is an agonist of the releasing hormone luteinizing hormone, a synthetic analogue of natural LH [26,27] and is injected once every 28 days into the subcutaneous tissue of the anterior abdominal wall at a dose of 3.4 mg [28].



The use of aromatase inhibitors and a particularly selective 4th-generation anastrozole drug opens up further promising opportunities in the treatment of generalized forms of this pathology. Powerful 4th generation highly selective

drugs selectively act only on the aromatase enzyme and block the transition of androgens to estrogens [14].

In particular, the use of the drug anastrozole at a dose of 1 mg once a day orally inhibits aromatase by 96% and does not affect the production of steroid hormones by the adrenal glands, without requiring corticoid replacement therapy.

As for chemotherapy, it is widely used as a preoperative treatment in conjunction with radiation therapy, especially in cases when primary breast cancer has gone beyond the body and there is a lesion of the regional lymph nodes. Both preoperative and postoperative chemotherapy often use the well-known and approved CMF regimen - a combination of cyclophosphamide, methotrexate and 5-fluorouracil. For adjuvant purposes, treatment is started 12 to 14 days after surgery. Conducted 6 eight-day courses at 3-week intervals. The choice of chemotherapeutic drugs today is great. These are alkylating compounds, antimetabolites, antitumor antibiotics.

### **PRACTICAL RECOMMENDATION**

Treatment of men should be carried out in accordance with all modern concepts of treatment of breast cancer. For treatment, it is necessary to apply surgical, radiation, chemotherapeutic methods. Therapeutic tactics should be strictly individualized, and the art of the doctor consists in choosing an individual treatment plan for each specific patient. Adequate treatment of early stage cancer in men provides a 5-year survival rate of 70% of patients. With an increase in the stage of the disease and with the generalization of the tumor process, the 5-year survival rate decreases sharply and amounts to no more than 45%.

### **REFERENCE**

1. Alekseev B.Ya., Kaprin A.D., Vorobyev N.V., Nyushko K.M., Polyakov V.A. , Polyakov V.A., Kalpinsky A.S. // Observation of primary multiple tumors of the reproductive system. *Oncology. Journal named after P.A. Herzen*. 2014; 2 (1): 63-66.



2. Bozhok A.A., Semiglazov V.F., Semiglazov V.V. Prognosis factors for breast cancer // *Modern Oncology*.-2005.-No. 1-C.4-9.
3. Gotko E.S. // *Experiment. Onkol.* -2000. - 22, Suppl .- c . 238.
4. Malignant neoplasms in Russia in 2013 (morbidity and mortality). // Ed. Kaprina A.D., Starinsky V.V., Petrova G.V. M .: MNII them. P.A. Herzen; 2015.
5. Letyagin V.P., Laktionov K.P., Vysotskaya I.V., Pogodina E.M. // *Modern problems of oncology*. M., 1996 .-- 150 p.
6. Musabaeva A.I., ZhoginaZh.A., Slonimskaya E.M. The role of modern methods of radiation therapy in the complex treatment of patients with locally advanced forms of breast cancer // *Mater. I Congress of Oncologists of the Republic of Uzbekistan-Tashkent, 2005*.-C 428-429.
7. S. M . Tailor "Russian Cancer Research Center. N.N. BlokhinRAMN ", Moscow // *Treatment of locally advanced breast cancer, Siberian Oncology Journal*. 2008. Appendix No. 2
8. Tadia R. // *Experiment. Onkol. Breast cancer in Russia (statistical analysis)*. - 2000. -22, Suppl . - from. 265.
9. CaglijaP ., VerourP . The F ., CardilloP ., NicosiaA . // *the G . Chir .* -1998. - 19 , No. 8-9. - with . 358-362
10. Chiappo L., Bergantino A., Colla M. et al. // *Minerva chir.*-1998. - 53, No. 9. - p. 767-768.
11. Chvallier A., Boissy C., Rampal A. et al. // *Arch anat.et. cytolog. Pathol.* - 1999. - 47, No. 2. - c. 88-91.
12. Gadrobbi R, Guerini A., Battaglino D. et al. // *Acta chir. Ital.* - 2000. - 56, No. 2. - c. 131-138.
13. Gupta Raj K. // *Diagn. Cytopathology.* - 1999. - 21, No. 3. - p. 167-169.
14. Herman K., Lobazievouz W., Skotnicki P., Fortuna J. // *Neoplazma* - 2000 .-- 47, No. 3. - c. 191-195.
15. Janckovic S., Petricevic A., Bilic J., Andelicovic S. // *Eur. Radiol.* 1999. - 9, adj. No. 1. - p. S413.

- 
16. Levi F, Lucchini F, Vecchia CL. Epidemiology of male breast cancer. *Eur J Cancer Prev*. 2002; 11 (4): 315-318. doi: 10.1097 / 00008469-200208000-00001.
  17. Osteen RT, Kamell LH. // *Cancer* 73: 1994. - 2000, 1994
  18. Progestin action and progesterone receptor structure in human breast cancer: a review / KB Horwitz [et al.] // *Recent Prog. Horm. Res.* - 1985. - Vol. 41. - R. 249 - 316.
  19. Rabanal E., Rosell R., Salvies J., Garcia R. // *Eur. Radiology* - 1999. - 9, adj. No. 1. - with. S414.
  20. Ribeiro G, Swindell R. // *Br J Cancer* 65: 252-254, 1992.
  21. Salerni B. // *detachir. Ital.* - 2000. - 56, No. 2 - p. 125-129.
  22. Speriongano P, Pisaniello D. // *Ann Hal Chir* - 2000 Mar-Apr; 71 (2): 165-6.
  23. Titus J, Sillar RW, Fenton LE. // *Aust NZJ Surg* 2000 Feb; 70 (2): 144-6.
  24. Tischkowitz MD, Hodgson SV, Fentiman IS. Male breast cancer: etiology, genetics and clinical management. *Int J Clin Pract*. 2002; 56 (10): 750-754. doi: 10.1111 / cge.12517.
  25. Wallace WA, Balsitis M, Harrison BJ. // *Eur J Surg Oncol* 2001 Jun; 27 (4): 429-31.
  26. Weiss JR, Moysich KB, Swede H. Epidemiology of male breast cancer. *Cancer Epidemiol Biomarkers Prev*. 2005; 14 (1): 20-26. doi: 10.1158 / 1055-9965.epi-05-0457.