local relapse of lung tumor. Patient underwent lobectomy. The patient has currently a good performance status and is free of disease.

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A case of a long-survival multitreated breast cancer patient
Institut Català D’Oncologia, Oncologia Radioterapica, Spain

Breast cancer is the most common cause of cancer in women, accounting for about a third of all cancer in women. It is the most frequently diagnosed cancer in women, primarily due to utilization of screening mammography programs. Breast cancer ranks the second place among cancer deaths in women. In recent years, directly related to the progress of antineoplastic therapy and earlier detection, mortality from breast cancer has begun to decrease substantially in developed countries. We report a 81 year-old Woman diagnosed in 1996 of a left breast neoplasia as a case of a multitreated long survivor breast cancer patient. The patient was initially treated with lumpectomy and lymphangetis and massive nodal metastasis pT4N2Mx. Completing adjuvant radiotherapy (50 + 20 Gy) and subsequent tamoxifien from 1996 to 2002. In 2009 bone metastases were diagnosed by scintigraphy and minimum pulmonary metastasis. Femara and Zometa were administered. In September 2010, bone scintigraphy showed bone progression. Aromasil was prescribed. Posterior latercervical tumor diagnosed in April 2011. Change to Faslodex. Treated with RDT (50 Gy) in November 2011 with good response. In January 2012 CT scan evidenced multiple adenopathic tumors and two new tumor mass in right gluteus region. 4 cycles of capecitabine were administered with secondary G3 palm-plantar disease. CT scan post-capecitabine in June 2012 showed stable disease. In July 2012 multiple subcutaneous tumors, the biggest, in right inguinal fossa were diagnosed. Tamoxifen and pamidronate were prescribed. In January 2013 the patient was assessed by the Radiation Oncology Department to treat right inguinal subcutaneous bleeding tumor who finally planned 60 Gy at 2 Gy/fr. The radiotherapy started on 07/02/2013 with good tolerance.

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Breast cancer. A chronic disease?
A. Moreno
Hospital 12 de Octubre, Oncología Radioterapica, Spain

71 year old woman, previously healthy, she was diagnosed in 1992 CDI right breast, grade 1, T1 N0 M0, (AP CDI 0.5 cm grade 1 with free edges and intense intraductal component) treated with lumpectomy plus axillary clearance (18 lymph nodes without tumor), adjuvant RT (with classical fractionation) and hormone therapy. She has continuing periodic checks in this service. In July 2009, being asymptomatic, showed elevated tumor marker CA 15.3 and was diagnosed with bone dissemination (scintigraphy: is the pathological accumulation of radioactive material in skullcap, thoracic spine, fifth left anterior rib and right scapula) PET demonstrated an injury in D11 and, pathological uptake in the descending colon that later it was made a Colonoscopy showing diverticula in the sigmoid. In February of 2012, was made treatment RT, in the injury, D11 DT 30 Gy and with good tolerance to the treatment. The patient started aromatase inhibitor therapy and, zoledronic acid from then until now, with good clinical. Currently the patient is completely asymptomatic with ECOG 100%. Why this case is interesting? It is about a patient with a 20-years follow up and an active normal life, the highlights in this case are a long evolution of a breast cancer that subsequently showed bone metastases and a demonstration of how one could have a chronic illness and still maintain a good quality of life.

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Central nervous system tumors: Medulloblastoma and meningioma
Hospital 12 de Octubre, Oncología Radioterapica, Spain

Male, 25 years old Oncological history: When he was 6 years old, after headache and vomiting episodes, a brain TC is performed in 03/17/94 and it findings are a posterior fossa tumor with secondary hidrocephaly for which was completely surgically removed with a PA compatible with medulloblastoma. Complicated therefrom with meningitis which left him with important neurological sequels that improved progressively. In control cranial CT 27/06/94 nodular area is half goal in the floor of the fourth ventricle tumor relative to rest. Oncological treatment RTE-2D with Cobalt 60 by means of two lateral fields that encompass all the craneal volume. Simultaneously the neuroaxis is radiated by means of a direct posterior field, with a total dose of 4.000 cGy to all volumes with an overprint in the posterior fossa until reaching a total dose of 5.500 cGy (5 × 180 cGy). During the treatment, and after presenting with neurological worsening, an IRM is performed in which it is obvious a relapse in the neuroaxis of T11-L1 which required the administration of a dose of overprinting in that area until reaching a dosage of 4.500 cGy. Treatment duration from 08/01/94 to 09/15/94. Presented good tolerance. Evolution: He remains in follow ups persisting with neurological symptoms.