(5 × 180 cGy) concurrent with taxol-carboplatin. Treatment ends on April 2004. CURRENT STATUS: it is alive and free of cancer disease. No pulmonary toxicity, genitourinary or gastrointestinal.

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Squamous cell carcinoma of cervix

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Woman, 45 years old. APP: No medical or surgical history interest. Oncologic history: In July 1997 she inquires about abdominal pain and was diagnosed with stage IIIB large cell cervical cancer. Physical examination: KI: 100 gynecological pelvic tumor 4-5cm in diameter, with involvement of 2/3 of vagina. TR: normal right parametrium, with infiltration of 3/3 of left parametrium . Oncologic treatment: EBRT-2D on PTV (pelvis), isocentric, 4 fields (2AP-2LAT) with 25 MV photons, dose 50 Gy, later on overprint on PTV2 (left parametrium), two fields (AP-PA) Dose 16 Gy. Total dose 66 Gy (5 × 200 cGy). Cervical overprinting with intracavitary radiotherapy by means of Delouche colpostate of No.2 divergent loaded with Cs-137 dose 15 Gy. Finishing treatment in December 1997. Complete remission was achieved body CT and MTs. EVOLUTION: August 2008: Elevated levels of SCC (up 2.8) and in a pelvic MRI, a retroperitoneal limph node measuring 21 mm × 18 mm × 33 mm was observed located to the right of the cava vein and anterior to the psoas. In December 2008 a para-aortic lymphadenectomy is performed with removal of a right adenophatic conglomerate that measures 3.5 cm × 3 cm. AP: 3 nodes with metastatic large cell squamous carcinoma of nonkeratinizing predominance consistent with a primary cervicouterine carcinoma. EBRT-3D on PTV (para-aortic), isocentric 4 fields (2 AP + 2 LAT) with 18 MV photons. Dose 45 Gy (5 cGy × 180 cGy) from January 2009 to February 2009. Current status: the patient remaining asymptomatic and disease-free. ILE (36 months).

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Squamous cell carcinoma of cervix and breast cancer

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Woman, 52 years old. Oncologic history: in October 1997 she is diagnosed with a stage IIIB cervical cancer, grade III. ONCOLOGIC TREATMENT: EBRT-2D on PTV (pelvis) isocentric, 4 fields (2 AP + 2 LAT) with 25 MV photons. Dose 50 Gy, later on overprint PTV2 (right parametrium), 2 fields (AP-PA) Dose: 16 Gy. TD: 66 Gy (5 × 200 cGy). Cervical overprinting with intracavitary radiotherapy by means of Delouche colpostate of No. 2 convergent loaded with 3 sources of Cs-137.Dose: 15 Gy 0.5 of vaginal cuff. Concurrent chemotherapy with cisplatin × 6 cycles. Treatment ends in January 1998 with complete response in TAC TAP and MTs EVOLUTION: April/2000: breast lump 1 cm × 0.5 cm in SEC of left breast intervened by quadrantectomy + lymphadenectomy. PA: infiltrating ductal carcinoma. pT1b No Mo. limph nodes 0/16. RE+, RP−, Herb2+. EBRT-3D on PTV (left breast), 4 fields (2 IT and 2 ET) with 4 MV photons. Total dose: 50 Gy (5 × 200). Treatment ends August 2000. March/2001: SCC has increased and on physical examination a 2.5 cm × 1.5 cm × 2 cm nodule is palpable in the left supra-clavicular fossa. PA: epidermoid metastasis. EBRT on PTV (left supra-clavicular fossa) with 6 and 18 MV, total dose: 46 Gy; then overprint to 66 Gy (5 × 200 cGy). Was associated Tegafur. Treatment ends June 2001 with complete clinical response (adenopathy and SCC) February/2002: SCC has increased and abdominopelvic MRI shows paraaortic recurrence. EBRT-3D on PTV (paraaortic lymph node chain) with 18 MV photons; TD: 45 Gy and later on overprint (affected adenopathies) up to 55 Gy (5 × 180 cGy). Concurrent with cisplatin × 6 cicles. Treatment ends June 2002. CURRENT STATUS Continuous revisions in the Radiation Oncology service. She is alive and free of disease.

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Surviving after five years of a brain metastases diagnostic

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Brain is the most common metastatic sites of breast cancer. Brain metastases developed 10–15% of patients with this pathology and are associated with poor prognosis. Overexpression of HER2 is a risk factor for the development of brain metastases. Whole brain radiotherapy (WBRT) has been historically a standard of care for those patients, which extends the survival time to an average of 4–7 months. A marked increase in the incidence of brain metastases was observed in HER2-positive because trastuzumab (Herceptin) molecular size limits the ability to pass through the blood–brain barrier, rendering the CNS a tumour cell sanctuary. Case report: female 45 years old, who was diagnosed of a right breast cancer in 2003. A bilateral mastectomy and right lymphadenectomy were practiced. The right breast showed an invasive ductal carcinoma, negative hormonal receptors and positive HER2. Four lymph nodes were affected. She was treated with six cycles of chemotherapy (adriamycin and docetaxel) subsequently received radiotherapy at doses 5040 cGy on breast, axilla and supraclavicular area. Two years later she had an axillary recurrence; Vinorelbine and Herceptin were prescribed with armpit reirradiation (3000 cGy). In March 2008, she developed a brain metastasis, so Herceptin in combination with gemcitabine treatment were prescribed and subsequent WBRT, treatment

was completed in February 2009. Today, after ten years of diagnosis of breast cancer, eight years after axillary recurrence and five years after brain metastases was developed, the patient is in radiological complete response and continues treatment with Herceptin. How long will you continue with this treatment?

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Very late relapse in Hodgkin lymphoma: A case report

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Introduction. In recent decades, the survival of Hodgkin Lymphoma (HL) has increased significantly as a result of improved radiotherapy techniques and the introduction of new chemotherapy schedules. It is calculated that 30% of patient relapse, particularly the first two years after treatment. However there is an important patient population that suffers from late relapse (LR). We report the case of a patient who relapsed 20 years after treatment.
Material and methods. A 34 year old man was diagnosed in 1992 (when he was 15) of HL nodular sclerosis-mixed cellularity clinical stage IIIA. He was treated with 5 cycles of MOPP-ABVD plus external beam radiotherapy (EBRT): Mantle (40 Gy) inverted-Y with spleen (15 Gy). As late side effects the patient developed a subclinical Hypothyroidsm as well as effects on muscle and bone covered with mantle field. After 20 years in complete remission, the patient noticed a subcutaneous nodule at axillary edge of pectoralis, less than 1cm, without evidence of B symptoms or illness to another site. Biopsy showed a lymph node infiltrated by classical HL nodular sclerosis subtype. Clinical staging with complete laboratory test and PET-CT demonstrated no evidence of disease (Stage IA). Treatment given: ABVD x2 plus involved field EBRT 20.4 Gy at 1.7 Gy/fx.
Discussion and conclusion. The patient had an excellent tolerance to the treatment. Currently he is asymptomatic and in remission. Although there is no consensus on the definition of LR in HL is necessary to encourage active monitoring of these patients beyond 5 years to detect LR. Evidence based on a literature review suggests that long-term survival was not significantly different in patients who relapsed 5 years after first treatment compared with patients without relapse.

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