Why Am I Being Treated Like a Female Breast Cancer Patient?

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PATIENT PERSPECTIVE

Breast cancer has been one of my life's greatest blessings. Its highs and lows, prospects, and disappointments have only strengthened my faith and turned me more to God.

In March 2012, I had a bad cold, and while I was coughing and grabbing my chest, I discovered a small knot in my left breast, and for whatever reason, I suspected it was cancer. I immediately woke my wife. She, groggy and in usual humor exclaimed, "Oh great! You have breast cancer! Well guess what? I have prostate cancer… now go back to sleep!" I laughed at the prospect of her having prostate cancer. It certainly would've changed a few dynamics in our relationship.

Two weeks later my fears were confirmed. I was told that I needed to have a mastectomy of my left breast. I wanted nothing but to have this poison removed. Yesterday would not have been too soon.

My surgery was scheduled a month later; it was a long wait. And it soon became clear that as I recovered from the impending mastectomy, I also would be in line for open-heart surgery.

The mastectomy was a textbook procedure with no complications. My surgeon apprehensively warned me that follow-up visits would be at the Women's Health Center. I must admit, it was awkward every time I went. Realistically though, I cared more about my health than about others' perceptions.

While I prepared for my cardiac surgery, the blood test revealed triglyceride levels that were through the roof. In fact, the cardiac surgeon described them as "industrial strength." After an exhaustive review, it was determined that my adjuvant therapy with tamoxifen was the culprit! I immediately stopped taking it, and within days my levels returned to normal. I was now left to fight any future bouts of cancer with just my body's own defenses.

It probably seems strange, but if I had not found the breast lump, the problems with my heart would have gone undetected. I most likely would've died. Had the cancer not been a part of my life, I wouldn't have been able to keep on living.

In the middle of March 2016, during preliminary testing for surgery to remove a skin tag, my chest X-ray displayed abnormalities. The workup showed that my breast cancer had returned. Worse yet, it had metastasized to my lungs. It had gone into my lymph nodes and lower spine.

The fight was on. A treatment plan was outlined; 12 weeks of chemotherapy infusions was a reasonable plan of attack. A second opinion was not necessarily an opportunity to find a differing plan, but as in my case, it was comforting affirmation of a good plan. I remember wondering if the rest of my life was going to be a mix of hospital visits, blood transfusions, chemotherapies, and injections.

While fear of the unknown works on one's psyche, I made a decision to focus on my faith and God. My cancer experiences are probably no worse or different from the experiences of most other patients. I do believe that my perception of how cancer affected me psychologically is a different story. I know and trust that I am in the capable and knowledgeable hands of my doctor.

While the experience of good health care is remarkable, living with cancer does not end with medical care. I am blessed to have a partner who loves me infinitely. I cannot imagine my life without her.

I am grateful my cancer has allowed me to remain alive. The prospect of death does not shake me. I plan on living my life to the fullest.

ONCOLOGIST PERSPECTIVE

Yes, men do get breast cancer! Unlike female breast cancer (FBC), male breast cancer (MBC) makes up about 1% of all cases in the U.S. The lifetime risk of a man developing breast cancer is about 1 in 1,000 vs 1 in 8 women.[1] Little is known about MBC because its rarity renders prospective randomized trials problematic. As a result, the management of breast cancer in males from diagnosis to treatment is based on research on FBC. Patients with MBC have higher mortality, and the incidence is rising 1.1% per year; by

comparison both trends are decreasing for females with breast cancer.[2,3]

Males are usually older and present with an advanced stage of the disease at the time of the diagnosis. Most MBC is ER+/PR+ and HER2–.[4] Comparison data of 1,123 male veterans with 5,320 females revealed that the mean age at diagnosis was 70 years for MBC and 57 years for FBC, respectively ($P < .01$); 95% of patients with MBC and 72% of patients with FBC were aged > 50 years ($P < .01$). Patients with MBC were more likely to present with stage III or IV disease (40% vs 24%, respectively). Eighty percent of patients with MBC had ER+/PR+ tumors. Mortality was 31.6% in males vs 14.9% in females.

Given the high prevalence of ER/PR positivity, MBC usually is considered to have a better prognosis, but that does not explain the high mortality. Unlike FBC, delay in diagnosis due to lack of MBC awareness and no screening guidelines for MBC, older age at diagnosis, and comorbidities have been considered the etiology of higher mortality in MBC, but there has to be more than that. I believe that the differences in MBC biology and pathology also have to be contributing factors to MBC mortality.

As a VA oncologist, I have treated a number of patients with MBC. Surprisingly, my experience treating these patients has been different from treating FBC. In 2011, when I first met Mr. Lewis, he laughed and questioned his diagnosis—how could he have breast cancer if males don't have breasts, and none of his family member had any type of cancer. Prior to his cancer diagnoses, he had gone through multiple cardiac stents and had a history of hypertriglyceridemia. His cancer workup and treatment plan were the same as that of females with breast cancer, and he questioned me again, "Why am I being treated like a female breast cancer patient?"

Unlike females with breast cancer, he had to have a complete mastectomy given the small breast tissue. His final diagnosis was stage IIA invasive ductal carcinoma of the left breast.

Because of Mr. Lewis' cardiac history and recent stent placement, I was hesitant to give him first-line adjuvant anthracycline. The Oncotype DX test is highly recommended and easily done for FBC, but I had to go through great difficulty to order this test for him. The Oncotype Dx RS score for him was 17 (a so-called low score) with distant recurrence risk of 11%. I interpreted the test the same way as I would for a patient with FBC. We were happy that he did not have to be exposed to toxic chemotherapies.

Because of the lack of data for aromatase inhibitors (AIs) use in males, adjuvant tamoxifen was given but had to be stopped after a month because of hypertriglyceridemia > 8,000 mg/dL and cholesterol > 700 mg/dL. Tamoxifen as well as an AI was deemed not to be the right adjuvant treatment for him. There were no data on adjuvant fulvestrant; not even for females in 2012. Mr. Lewis was among the unlucky 11% and presented with stage IV disease in his lungs and bones 4 years after the initial diagnosis. He has not had a great response to taxanes and now is being treated with fulvestrant. He remains positive and hopeful, he told me only God—not medical science—has the power to take back the gift of life.

My experience with Mr. Lewis and others has underscored that MBC is not the same disease as FBC. I am hopeful we will see more clinical trials to further identify MBC biology and genomics.

AUTHOR DISCLOSURES

The authors report no actual or potential conflicts of interest with regard to this article.

DISCLAIMER

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