

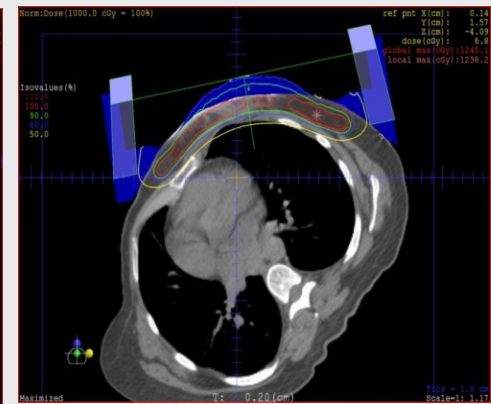
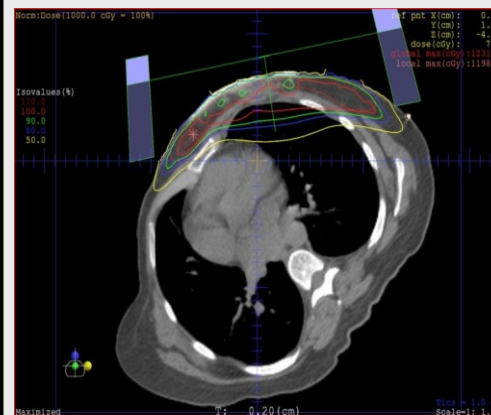
PATIENT HISTORY

- 41 yr old female good health
- Presented with left breast mass in Dec 08
- Pathological Stage T2, N1, M0 (stage III-A), poorly differentiated invasive ductal carcinoma of the left breast, receptor negative, HER-2/ neu negative
- Feb 09 the patient underwent left modified radical mastectomy with axillary dissection (and prophylactic right mastectomy).

DOSE PRESCRIPTION

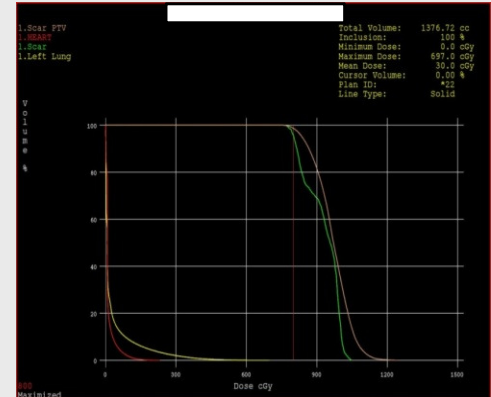
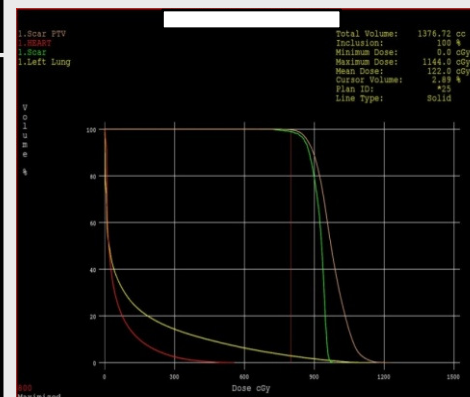
- 5040cGy/28 fx to left chest wall and peripheral lymphatics
- Left chest wall treated with photon tangents fields, with sufficient SuperFlab bolus material to insure the development of satisfactory skin dose.
- Boost to left chest tumor bed using 9MeV electrons with Bolus ECT for additional 1000cGy/5 fx

DOSE PLANNING



Planning Process

- Imported Data Set into RTP
- Contoured PTV and critical structures
- Created beam and centered on PTV.
- Tumor Bed PTV was defined as Scar plus a 2cm margin while clipping inside the patient skin surface 1mm and the entire thickness of the chest wall, avoiding the ribs along the chest wall.
- Used 105cm SSD and a 9MeV. This was an energy that covered the max extent of the PTV within the 90% isodose.



FOLLOW UP (17 Months)

- Patient tolerated treatment well, acutely developing RTOG Grade 2 skin reaction. Effects on skin healed nicely
- At 17 months post-radiation therapy, chest wall skin is intact and well-healed, no evidence of chest wall recurrence

SUMMARY

- Initial simulation is much more critical and technical than a typical chest wall boost.
- Reproducibility of set-up is much more important.
- Skin dose can be higher, but is well tolerated
- Isodoses are much more conformal than without ECT bolus, also allowing better sparing of underlying heart and lung.

BOLUS SETUP

