METASTATIC BREAST CANCER TO THE BONES
(de novo)
DISCLOSURE OF INTEREST

- No conflict of interest
A 50 year old female presented to the surgical clinic with history of left breast lump for 8 years and severe lower back pain associated with inability to walk for 3 months, she did not seek medical care until she was in pain and was unable to walk. Her only significant medical history was poorly controlled hypertension. The patient had received elementary education. She denied any history of cigarette smoking or alcohol intake. There was no history of exposure to ionizing radiation or trauma. She had no family history of malignancy.
Clinical findings

- Patient appeared stable though had a performance status of 3 and BMI 18. Physical examination of the left breast and axilla showed swollen left breast with no skin changes nor nipple retraction, hard palpable mass 8*8 cm occupying all quadrants, irregular margins, rough surface, tender not fixed to the skin or chest wall. Axillary LN of the left side were palpable, hard, fixed, non tender with measurement of approximately 1.5 cm. The contra lateral breast was normal as well as axilla and supraclavicular LN. She had a reduced power of grade 3 with normal muscle tone.
Laboratory investigations/ imaging done

- A core biopsy of the breast lump was done and the histopathology result showed an infiltrating ductal carcinoma, grade 2 IHC ER-positive (PR/HER2 negative).

- MRI of the whole spine showed: T3 and L3 vertebral planar metastasis associated with mild spinal stenosis and broad based disc bulge L3/4.

- Radionuclide bone scan: Lesions involving the shoulders, proximal humeri, spine (severe, extensive lesions L2-L5), sternum, multiple ribs, pelvis and shaft of right femur consistent with widespread osteoblastic skeletal metastases.

- No visceral metastases (CXR/Abdominal pelvic ultrasound)

- Liver function test (ALP 524, ALT 23, AST, Total bilirubin- 5.9, direct bilirubin 2.3)

- Kidney function test (urea 7.4, creatinine 166)

- Complete blood count (WBC- 3.46, HB- 7.0g/dl, NEU-2.66, PLT 256)
Treatment

- The patient was referred to the clinical oncologist, she received Palliative Radiotherapy: 30GY/10# to the thoracic and lumbar spine for 10 days and dexamethasone 8mg BD for 2 week.
- Chemotherapy: intravenous gemcitabine 1.5g D1D8 every 3 weeks for 6 cycles. Intravenous zolendronic acid 4mg initially monthly but later changed to 3 monthly (She has so far received 6 cycles).
- Tabs anastrozole 1mg once daily till present. Oral Tramadol 50mg twice daily for pain.
- Anemia was treated with blood transfusion 3 units and tabs ferrous sulfate.
- 1st follow up to the clinic after 3 months: Clinically she showed significant improvement (reduction of pain) and her performance status changed to ECOG 2.
- 2nd follow up to the clinic after 6 months: she had a repeat bone scan which showed features of an impending pathological fracture of the left femur. She was then referred for orthopedic review where limb immobilization.
Thank you for your attention