Inflammatory breast cancer

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DESCRIPTION

A 55-year-old woman presented with a few months' complaints of weight loss, fatigue, shortness of breath and a rapidly growing right breast mass. She had no family history of breast cancer. Physical examination showed a cachectic patient with a firm, indurated, immobile right breast with diffuse erythema and oedema of the skin (peau d'orange). Other findings included palpable matted fixed right axillary lymphadenopathy (figure 1), dullness to percussion of both hemithoraces, bulging of the flanks with shifting dullness and bilateral lower extremity oedema. A total body CT scan showed diffuse oedema of the right breast with markedly thickened skin, bilateral pleural effusions, multiple tumour deposits in the omentum, marked ascites and numerous sclerotic areas within the thoracic spine and ribs. Serum carcinoma antigen (CA) 15-3 and CA 27-29 (figure 2) were markedly increased (8590 U/ml (normal <38.6) and 4302 U/ml (normal <30), respectively). Breast biopsy confirmed an oestrogen receptor positive invasive poorly differentiated breast carcinoma.

Figure 1 Right breast mass.

Figure 2 Enhanced-chest CT scan demonstrating breast oedema, skin thickening and right pleural effusion.

Learning points

- ▶ Despite increased breast cancer awareness and education, women still present with advanced breast cancer.^{1–3}
- ▶ Deferring of breast lesion evaluations can be detrimental.¹

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