04/21/25 Morning Report with @CPSolvers

"One life, so many dreams" Case Presenter: (Dr.Andrew Knight@) Case Discussants: (Rahul@RahulPottabath1) and (Dr. Neelima Vidula@)

Scribing (SEEME)

CC: 56 y.o. female with a pmhx of triple negative breast cancer diagnosed 1 year prior who declined further workup or treatment presents with a fungating breast mass, lower extremity weakness and numbness

HPI: **March/April 2023**: Noticed L breast mass and axilla mass.
10/5/2023: L breast mammogram: Spiculated mass in LUQ, 4 cm from nipple
10/17/23: L breast biopsy: poorly differentiated invasive ductal carcinoma, 1.6 cm. Triple Negative axillary LN biopsy: + metastatic carcinoma.
11/8/2023: PET Scan c/w metastatic disease: FDG avid L breast mass (SUV 10.9) abutting the cutaneous surface, enlarged L axillary Lns larges 1.8 cm, FDG avid R posterior 6th rib 4.8 cm osseous lesion and FDG avid LLL pulmonary nodule
11/10/2023: Saw Oncology at outside hospital. She was told that she needed chemotherapy,which she was afraid to receive, and so did not follow-up further.
11/22/2023 Rib biopsy metastatic TNBC
Feb 2024: Noted L breast ulceration
-She states approximately 5 days ago she noted gradual onset of paresthesias and lower extremity weakness, stating it is now progressed to the point where she can no longer ambulate. She has been using a wheelchair and relying on the assistance of family to move her around. She reports diminished sensation of the lower extremities, associate with multiple episodes of urinary incontinence such that she now wears diapers. She also reports fecal retention and fatigue. Also presence of breast ulceration on left breast..

ROS: no fever, palpitations or SOB

PMH:
Uterine fibroids (myomectomy 2018)
migraines

Fam Hx: no family history of cancer

Soc Hx: not significant

Health-Related Behaviors: no smoking, alcohol or drugs

Allergies: NKDA

Vitals: T: 97.2 BP: 130/78 **RR:** 19 **HR:**87 **Sat: 99**
Exam: Gen: Frail-appearing
CV: RRR. No murmurs
Pulm: Normal resp rate. Lungs CTAB, no increased work of breathing
Abd: Distended abdomen without tenderness to palpation. No guarding, rebound, rigidity. No CVA tenderness bilaterally.
Neuro: 0/5 strength in BLE. Diminished sensation over the BLE.Sensory deficits over the anterior abdomen superior to the level of the umbilicus.
MSK: Midline thoracic and lumbar spine tenderness to palpation
Skin: Large 4 x 4 centimeter wound over left anterior chest wall. Erythema surrounding wound,without any obvious bleeding or drainage

Notable Labs & Imaging:
Hospital course:
Spinal MRI notable for T6-T7 epidural metastasis, T6 compression fracture with spinal stenosis. She was initiated on palliative spinal and breast radiation and steroids.
Hematology:
WBC: 7.61 Hgb: 9.6 Plt:276 MCV: 83.2

Chemistry
Na:132 K: 4.5 Cr: 0.7BUN:13 Ca: nl Ph: nl Mg:nl Glu: 96 Cl: 95 HCO3: nl
CRP: ESR: 84 LDH: AST: ALT: ALP:136 Bili:nl
Imaging:
CT chest, abdomen, pelvis: diffuse liver involvement (hepatic mets) and spinal (osseous mets) spread of cancer
Liver biopsy: metastatic carcinoma, ER PR negative
MRI brain and spine: enhancing mass at sacral wing with spinal stenosis
Breast biopsy:poorly differentiated invasive ductal carcinoma, 1.6 cm. ER and PR negative

Opioids and muscle relaxants given for pain, weekly taxol (paclitaxel) and radiotherapy started.

Dx Spinal cord compression secondary to breast cancer.

Problem Representation:
56y old FM with history of triple negative breast cancer presented with fungating breast mass, bilateral lower extremity weakness and numbness.

Teaching Points (Hee):
Noted in hx - progression in the mass, ANS symptoms, general sx

Large untreated triple-negative breast cancer → metastasis (lung, bone, rib) → spinal cord compression → complications: lower extremity weakness, numbness, urinary incontinence, fecal retention./ GBS - demyelination also to consider-> decompression and spinal MRI imaging

Steroids can be considered if the patient is not febrile or leukocytotic and abscess or infection is ruled out.

Assess past medical history for prior treatments, breast or other cancers, family history, triple-negative status, germline mutations (e.g., BRCA), smoking exposure, and history of spinal stenosis or spinal disease (e.g., herniated disc).

Perform CT abd and brain MRI to rule out metastasis; bladder scan and Foley catheter for urinary incontinence; start IV dexamethasone and obtain spinal imaging for lesion or abscess(decreased lower extremity sensation, spine tenderness,)and always check rectal tone.

Anemia (Hgb 9.6) may be due to iron deficiency or bleeding from breast cancer(cancer-related bleeding)

Breast biopsy is important to check for distant extensive lesion and lymph node involvement, confirming diagnosis and staging of metastatic breast cancer

Total spine MRI helps assess full extent of metastasis; management begins with neurosurgery to relieve spinal cord compression and prevent neurologic decline, though surgery may be less likely if motor deficits are severe and ambulation is lost.

Address patient's fear of treatment, understand her background, and emphasize the importance of treating her current state with palliative care, radiotherapy for breast spinal compression, and systemic therapy for disease control.->pain control (opioid) and taxol

Triple-negative (ER-, PR-, HER2-) breast cancer is treated with chemotherapy (e.g., taxanes) and may include pembrolizumab if PD-L1 positive(PD-L1 is testing since liver involvement)