Metastatic Breast Carcinoma with Treatment-Resistant Hypocalcemia

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Abstract

Introduction: Hypocalcemia is a condition that can occur in malignant diseases due to tumor lysis syndrome or chemotherapy agents. Hypocalcemia due to hypoparathyroidism accompanying malignancy is very rare. We, in this report are sharing a case of metastatic breast carcinoma with treatment-resistant hypocalcemia.

Case Report: A 37-year-old woman who was diagnosed and followed-up with panhypopituitarism and contractions throughout the body after a recent child delivery. On the basis of the positive chvostek and trousseau findings on the physical examination of the patient we did hypocalcemia work-up and found plasma calcium: 5.4mg/dl, phosphorus: 7.8mg/dl, albumin: 4g/dl, 25-OH vitamin D3: 18.7ng/ml and parathormone as <3pg/ml. Considering primary hypoparathyroidism, calcium carbonate and calcitriol treatments were applied. However, ca-gluconate infusion was initiated on the basis that calcium levels remained at 6.5mg/dl. In the cranial-pituitary MRI examination there were multiple millimetric nodular lesions of in cerebral and cerebellar hemispheres. PET/CT revealed a hypermetabolic area of malignant character in the lower quadrant of the left breast which can represent the primary tumor and multiple hypermetabolic areas in axial skeleton showing the most prominent activity in C2 and T6 vertebra. The biopsy result from the mass in the breast was reported as invasive lobular carcinoma and the patient was referred to the oncology department.

Discussion: Hypoparathyroidism may develop due to surgery, autoimmune or destruction in the parathyroid gland. The cause of hypoparathyroidism, which further complicated the treatment of hypocalcemia in our patient, may be due to metastasis or to the possible autoimmune mechanisms or PTHrP. Osteoblastic metastasis and PTHrP may have been found at the same time, and this cycle may have shifted towards osteoblastic activity. We can’t find any association between breast cancer and autoimmune hypoparathyroidism in the literature.

Conclusion: Although there are other reasons that complicate the clinical status in treatment-resistant hypocalcemia patients, it should be considered that there may be an underlying malignancy.

Introduction

Hypocalcemia is a condition that can occur in malignant diseases due to osteoblastic bone metastasis, tumor lysis syndrome or chemotherapy agents. Hypocalcemia due to hypoparathyroidism accompanying malignancy is very rare. Clinical presentations of cancer patients may develop depending on the local and paraneoplastic effects of the tumor and the immunological response to the tumor. We, in this report are sharing a case of metastatic breast carcinoma with treatment-resistant hypocalcaemia.

Case Report

A 37-year-old woman who was diagnosed and followed-up with panhypopituitarism at an external center, admitted to our emergency polyclinic with complaints of hand and foot numbness, and contractions throughout the body after a recent child delivery. On the basis
levels were normal in this patient. In our patient, the onset of metastases such as prostate and breast cancer [1,6-8]. Magnesium hypoparathyroidism and malignancies that cause osteoblastic bone in bone like bi-phosphonate and denosumab, autoimmune hypoparathyroidism, utilization of calcium-deprivation agents present as part of other endocrine disorders. Treatment resistant to surgery, autoimmune or genetic causes that cause destruction reported in patients [4]. Hypoparathyroidism may develop due frequency after IDC, and atypical metastatic sites have been and invasive lobular carcinoma (ILC). ILC is in second place by subtypes of breast cancer are invasive ductal carcinoma (IDC) cancer-causing death in women worldwide [3]. The most common deaths in women in developed countries and is the most common in the lower quadrant of the left breast which can represent the primary tumor and multiple hipermetabolic areas in axial and appendicular skeleton showing the most prominent activity in C2 vertebra, corpus sterni and T6 vertebra. The biopsy result from the mass in the breast was reported as invasive lobular carcinoma with pleomorphic type and the patient was referred to the oncology department for follow-up and treatment.

Discussion

Breast cancer is the second leading cause of cancer-related deaths in women in developed countries and is the most common cancer-causing death in women worldwide [3]. The most common subtypes of breast cancer are invasive ductal carcinoma (IDC) and invasive lobular carcinoma (ILC). ILC is in second place by frequency after IDC, and atypical metastatic sites have been reported in patients [4]. Hypoparathyroidism may develop due to surgery, autoimmune or genetic causes that cause destruction in the parathyroid gland. Surgery done for thyroid diseases is the most common reason [5].

Those of autoimmune origin tend to be more permanent and may present as part of other endocrine disorders. Treatment resistant hypocalcemia may be seen in magnesium deficiency, postoperative hypoparathyroidism, utilization of calcium-deprivation agents in bone like bi-phosphonate and denosumab, autoimmune hypoparathyroidism and malignancies that cause osteoblastic bone metastases such as prostate and breast cancer [1,6-8]. Magnesium levels were normal in this patient. In our patient, the onset of symptoms was explained with severe hypocalcemia due to primary hypoparathyroidism, and the diagnosis was made as metastatic breast carcinoma in the course of follow-up and treatment. Bone metastasis of malignancies is most often described by the hypothesis of ‘seed and soil’, which is related to both the characteristics of the tumor cell and the microenvironment of the bone tissue [9]. Among the mediators that explain osteoblastic mechanisms are ET-1, BMPs, uPA, PSA, and TGF-B, which are particularly associated with prostate cancer [10]. The accompanying hypoparathyroidism has made treatment difficult. The cause of hypoparathyroidism, which further complicated the treatment of hypocalcemia in our patient, may be due to metastasis or to the possible autoimmune mechanisms or PTHrP. Many tumors that metastasize to the parathyroid gland have been identified, with breast cancer being the most common with an incidence of 40%. However, we could not find an additional mechanism in the literature other than invasion or metastasis to parathyroid gland that may cause hypo functioning. There was no histopathologic evidence of metastasis to the parathyroid gland in our patient and we did not find any involvement in PET/CT that would suggest this as well. In our case, osteoblastic metastasis and PTHrP may have been found at the same time, and this cycle may have shifted towards osteoblastic activity. Subsequently added to the clinical picture, the hepatitis and ANA positivity were resulted us leading to autoimmune-induced syndromes.

When we look at autoimmune based findings of breast cancer; antibodies against P185 oncoprotein secreted from the Her/ neu-derived transmembrane protein in the serum of 50% of breast cancer patients were detected but could not be clinically meaningful because they were detected in healthy volunteers as well [11]. In addition, antibodies against anti-2-g, anti-ri, anti- hu, anti-mA, and anti-amphiphysin have been associated with various neurological syndromes [12,13]. According to the general hypothesis of neurological paraneoplastic syndromes in breast cancer, degeneration of cell debris, which is turned on after the death of genetically altered tumor cells, is thought to be recognized by scavenger receptors, and that these proteins trigger the autoimmune response through the T and B cells in the lymph node [14]. Two nephrotic syndrome cases in the literature in association with breast cancer were reported to loss of their disease after cancer treatment [15]. However, we cannot find any association between breast cancer and autoimmune hypoparathyroidism in the literature.

The most common metastatic subtype of breast cancer to endocrine organs is lobular carcinoma. Among these, adrenal gland and pituitary gland metastases are most frequently seen [16]. In the differential diagnosis of the mass in the clivus, thickening of the pituitary infundibulum, nodularities in the cranial and pituitary gland metastases are most frequently seen [16]. In the cranial and pituitary MRI examination of the patient, metastatic malignancies have been
Conclusion

Although there are other reasons that complicate the clinical status in treatment-resistant hypocalcemia patients, it should be considered that there may be an underlying malignancy.

References