INTRODUCTION

Ductal carcinoma in-situ (DCIS) is a pre-cancerous condition carrying high risk of progression to invasive cancer. Mainstay of treatment for this condition is multimodality consisting surgery, radiation and hormonal treatment. It confers a very good prognosisicatively whereby 5-year survival rate is 95%. Being a condition supposedly confined to the breast with no evidence of invasion, distant metastasis is a very rare occurrence for such case.

CASE REPORT

This patient is a 60-year-old lady first presented 5 years ago to a private hospital with right breast lump, wide local excision done, histopathological examination (HPE) came back as high grade DCIS with small foci of invasive components, however no further treatment was offered to her. 3 years post operation patient had recurrent swelling of the same side at retroareolar region in addition complaining pain at right shoulder, ultrasound revealed BIRAD IV lesion, done wide local excision in the same private centre, HPE came back as DCIS with clear margin. Subsequently she completed radiotherapy, however upon completion, new lump recurred. The following mammogram showed BIRADS V at retroareolar region. Patient then underwent mastectomy and axillary clearance. HPE returned as foci of low to intermediate grade DCIS, and axillary nodes were free of metastases. Following that CT TAP showed presence of metastases at liver, mediastinal nodes and lytic lesion at right humerus. Whole body scan done confirmed of metastasis at the proximal right humerus. Afterwards she underwent wide resection of right proximal humerus with prosthesis insertion, HPE report came back as metastatic carcinoma with positive for Estrogen Receptor, implying a metastasis from the DCIS change to breast. Patient then was subjected to chemoradiotherapy.

DISCUSSION

With the confinement of a neoplastic lesion to the breast ducts, DCIS usually will not metastasize, though there are few reported cases, for instance only 6 of 814 patients developed distant metastasis (DM) after diagnosis of DCIS (1).

Factors for this patient to have DCIS with DM possibly due to the microinvasion which she had on the first excision, even though other factors such negative estrogen receptor, young age, or poorly differentiation was not present (2). Analysis of DCIS cases had shown the possibility of minute cancer to metastasize even before invasion into the breast, in instances when breast was not considered the source of DM (3)

For this patient, the possibility of having the DM was during the first excision when the HPE was high grade DCIS with microinvasion. The DM was not manifested until when she had recurrence right DCIS 3 years later with complaint of shoulder pain. High index of suspicion based on the xray with lytic lesion brought about further imaging of CT scan.

DCIS and DCIS with micro-invasion both has good similar prognostication if treated accordingly (4). As reported by Champion et al, DCIS with micro-invasion are more similar to invasive disease which we should be more vigilant of (4).

CONCLUSION

This case showed the possibility of a DCIS to metastasis and potential grave outcome. This make it pertinent for regular examination and surveillance even though the distant metastasis rate in DCIS is low.

REFERENCES


