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Clinical Image

The Magnitude of Time in Untreated Breast Cancer

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Abstract: Not applied.

Keywords: Breast Cancer; Pleural effusion; Neoplasm Metastasis; Delayed Diagnosis.

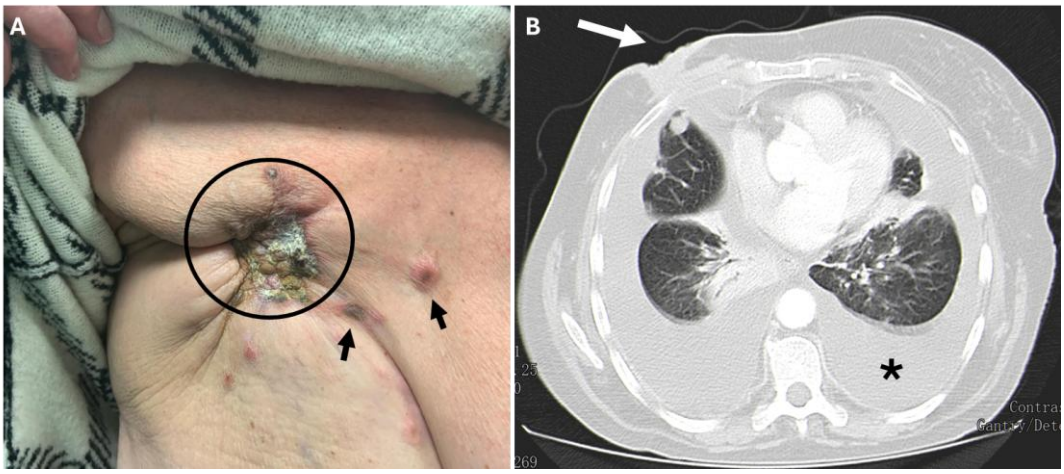

Figure 1: A. The clinical image depicts extensive local destruction of the right breast with necrosis (circle) and multiple cutaneous metastatic implants (arrows). B. Chest computed tomography showing extensive bilateral pleural effusion, partially loculated, with associated compressive atelectasis (*). Complete absence of the right breast tissue is observed, corresponding to advanced local tumoral invasion and mimicking the appearance of prior mastectomy (arrow).

A 78-year-old woman presented to the Emergency Department with progressive dyspnoea, anorexia and unintentional weight loss for over a year. She reported a palpable right breast nodule, first identified approximately two years earlier. She was fully aware of a possible neoplastic disease but refused to seek medical help justifying that she had taken care of her sister that had died during chemotherapy, while treating an ovarian cancer. Since then, she had been under follow-up in a Psychiatry outpatient clinic. Physical examination revealed complete destruction, retraction and ulceration of the right breast, which was surrounded by multiple violet annular plaque lesions suggestive of dermal implants (Figure 1A). The patient had no signs of acute respiratory distress and had a peripheral oxygen saturation of 96% without supplementary oxygen therapy.

Her blood analysis was relevant for inflammatory anaemia (Hb 9.2 g/dL, transferrin saturation of 20%, ferritin of 250 ng/mL); without leucocytosis or elevation of C-reactive protein or sedimentation rate. Creatinine phosphokinase value was within normal range.

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Chest computed tomography revealed a bilateral pleural effusion; complete absence of the right breast parenchyma secondary to extensive tissue necrosis with a radiological appearance of a mastectomy; the necrosis extended to the right pectoral muscle; right axillary and internal mammary lymphadenopathies were also described (Figure 1B).

She agreed to a diagnostic thoracocentesis. The pleural fluid was an exudate according to Light criteria, and histopathological exam revealed cells expressing epithelial membrane antigen containing oestrogen receptors (ER). She also allowed to punch biopsy a cutaneous lesion that was compatible with breast carcinoma metastasis, ER, GATA3 and mammaglobin positive and HER2 negative After the diagnosis and the advanced stage of the disease were explained, the patient declined palliative chemotherapy. Management was therefore focused on symptom control and optimisation of quality of life, which she felt had been lacking in her sister's case. She was referred to a hospice but died three weeks after admission with a pulmonary embolism.

Breast cancer remains the most common malignancy in women worldwide. In advanced stages, pulmonary and pleural metastases are frequent and may present with dyspnoea due to malignant effusion [1]. Cutaneous metastases and extensive local destruction represent late manifestations of disease progression and are typically associated with delayed diagnosis and poor prognosis [2]. This case illustrates the extreme local evolution of untreated breast carcinoma, resulting in spontaneous destruction of breast tissue and an "auto-mastectomy" appearance on imaging. It highlights the clinical and radiological consequences of prolonged diagnostic delay and underscores the importance of early detection and timely oncologic intervention [3].

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Supplementary Materials: None.

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