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Case Report

Non small cell carcinoma of lung with metachronous breast metastasis and cardiac tamponade: Unusual presentation of a common cancer

Bhanu Prasad Venkatesulu [a], Supriya Mallick [a,*], Ashok Singh [b], P.K. Julka [a]

[a] *Department of Radiation Oncology, All India Institute of Medical Sciences, New Delhi, India*
[b] *Department of Pathology, All India Institute of Medical Sciences, New Delhi, India*

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KEYWORDS

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Abstract *Introduction:* Lung cancer is the most common cause of cancer related death worldwide. Mostly these tumors present with cough, chest pain weight loss. However, presentation as breast mass and cardiac tamponade is very rare.
Results: We are presenting a rare case of breast metastasis from primary lung cancer. This case presented as cardiac tamponade adding to the diagnostic dilemma.
Conclusion: The importance of this case is to highlight molecular profiling as an applicable tool to distinguish extra-mammary metastasis that masquerade as mammary neoplasm thereby preventing unnecessary need of surgery and radiation therapy.
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Introduction

Lung cancer is the most common cause of death from cancer worldwide [1]. Metastatic dissemination of lung cancer occurs in 56% of cases at presentation commonly to contra-lateral lung, liver, bone, adrenals, brain, lymph nodes [2,3]. We report a unique presentation of a lady with NSCLC with metachronous breast metastasis and cardiac tamponade emphasizing importance of IHC in differentiation of breast primary and breast metastasis.

Case report

A 30 year old female presented with complaints of persistent cough for 4 months. Evaluation with 2 samples of sputum for acid fast bacilli and chest radiograph was found normal. She was started on daily regimen of anti-tuberculosis therapy. After 2 months, she developed dyspnea grade 2 (New York Heart association classification). In our Institute, on evaluation, she was thin built with ECOG performance status 2, with no known co-morbidities and familial malignancies. Clinical

* Corresponding author. Tel.: +91 9899448450; fax: +91 11 26589243.
E-mail address: drsupriyamallick@gmail.com (S. Mallick).

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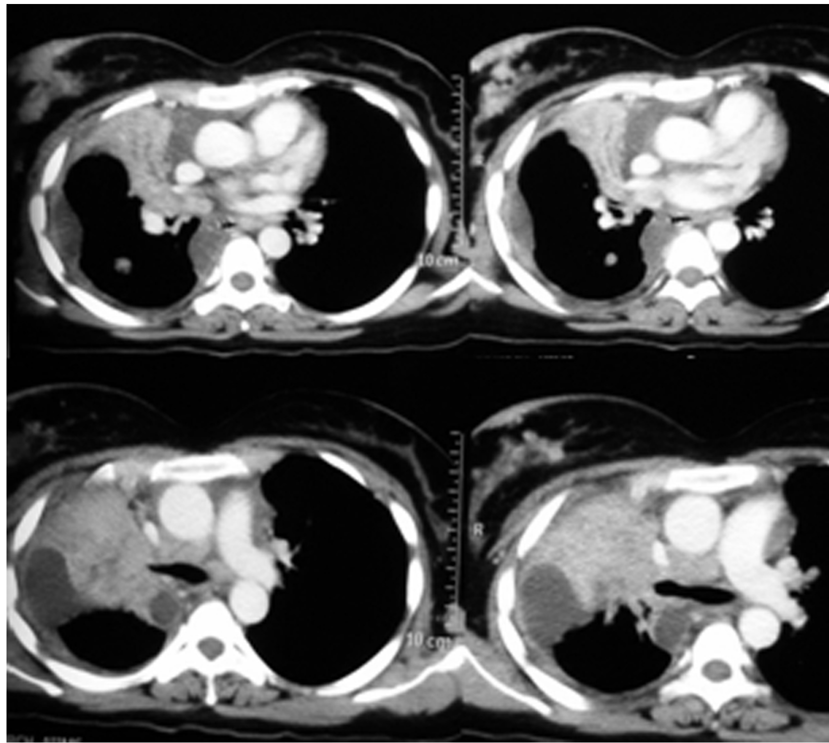

Figure 1 CECT scan image showing large heterogeneous enhancing mass lesion with speculated margin in lung parenchyma with marked right sided pleural effusion and pericardial effusion with impending cardiac tamponade.

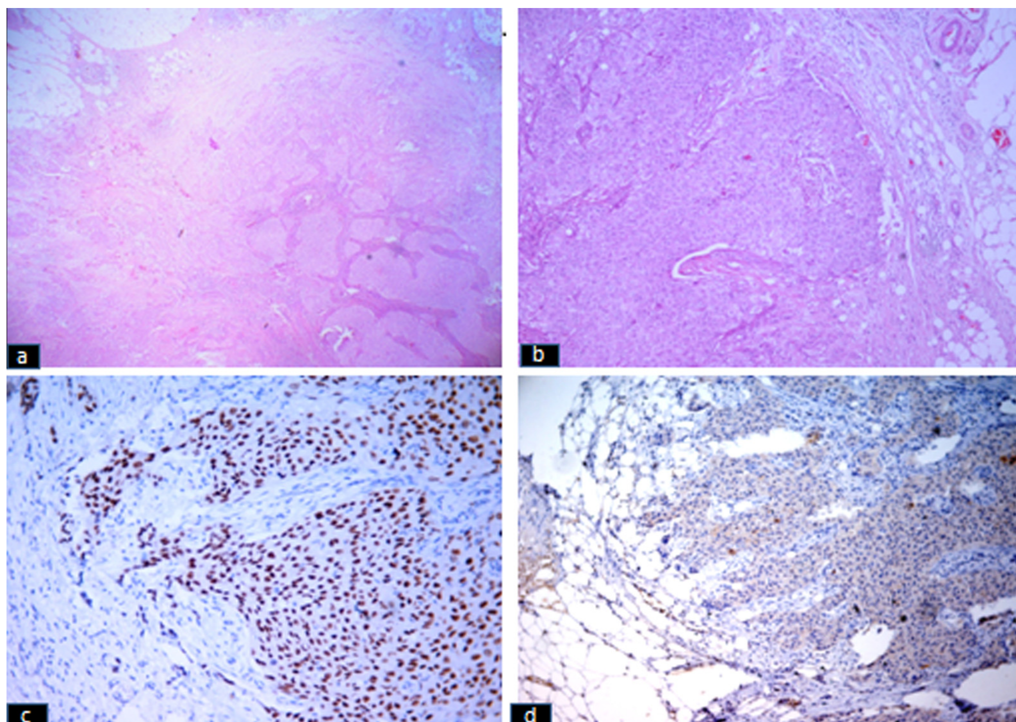

Figure 2 (a and b) Lymph node section shows an epithelial tumor replacing almost whole of lymphoid tissue and infiltrating into surrounding fibroadipose tissue. (c) Tumor cells show strong nuclear immunostaining for TTF-1, (d) no staining is seen for GCDFP-1.

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