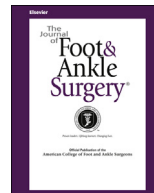




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Case Reports and Series

Erosive Breast Cancer Metastasis to the Ankle: A Case Report

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ABSTRACT

Intra-articular tumors in the ankle are a rare presentation for metastatic disease. Metastatic breast disease presenting distal to the knee or within any joint is especially rare. We present a case of a painful intra-articular breast metastasis in a 56-year-old female with known breast carcinoma. The patient presented with anterior ankle pain and was found to have an intra-articular ankle tumor that was eroding into the anteromedial talus. The distinct soft tissue tumor was excised from the ankle and the talar lesion curetted and treated with adjuvant chemical ablation. The void in the talus was filled with cement. Despite the patient's poor prognosis, she did not have ankle pain at 6 months postoperatively and was able to ambulate without assistive devices. When treating unknown tumors in the ankle, the treating surgeon must be prepared with different operative plans that will depend on the preliminary pathology report to best treat their patients safely.

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Although the incidence of metastatic disease to the bone has been reported to be as high as 85% in patients with a diagnosis of carcinoma (1), metastasis distal to the knee is a very rare entity. Reports of acrometastases have varied from <1% to 7% (1,2). Typically, the most common sources of metastatic disease to the foot are the lung, colon, and kidney, with breast cancer rarely metastasizing to the foot or ankle (3–6). In addition to the rarity of distal metastasis from breast cancer, intra-articular metastasis is exceedingly rare (7,8). We present a case of an erosive, intra-articular breast metastasis involving the soft tissues of the tibiotalar joint and eroding into the talus itself.

It is critical to consider a broad differential diagnosis when treating tumors that present in the foot and ankle. When a diagnosis lacks absolute certainty, a tissue biopsy is required. The treating surgeon must be prepared with different operative strategies that are dependent on the histologic diagnosis. Because metastatic breast disease is rare to the ankle joint, the present case demonstrates the importance of preparation and adequate multidisciplinary personnel.

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Case Report

A 56-year-old female with a known history of 2 distinct diagnoses of breast cancer presented for evaluation of a painful left ankle mass. She was experiencing intermittent ankle pain that had progressed during the course of the previous year. The pain was anterior and was exacerbated by weightbearing and dorsiflexion of the ankle. Her oncologic history included an original diagnosis of HER2-negative, estrogen receptor-positive, infiltrating ductal carcinoma of her right breast 3 years previously (stage T1N1M0). She had undergone surgical lumpectomy and a subsequent 6 cycles of docetaxel/cyclophosphamide with adjuvant tamoxifen and radiation therapy. She responded well to treatment; however, 2 years later, she was diagnosed with a new, triple-negative (estrogen receptor-, progesterone receptor-, and HER2-negative) carcinoma of her left breast. At the consultation for the ankle mass, she was actively receiving chemotherapy and had recently been diagnosed with new, pulmonary metastases.

The patient's other medical history included morbid obesity and hypertension. Her surgical history was limited to her previous right breast lumpectomy. Her medications included oral lisinopril 20 mg daily and oral oxycodone 5 mg as needed for pain. She had no known drug allergies. She denied tobacco, alcohol, and illicit drug use and was retired from her career as a medical assistant. She had no family history of cancer, and her family was negative for the *BRCA* gene.

On physical examination, the patient was morbidly obese and generally appeared well. She ambulated with an antalgic gait but was



Fig. 1. (A) Anteroposterior and (B) lateral radiographs demonstrating a well-defined cystic lesion contained within the medial talus.

unable to bear weight through her left extremity. No obvious masses or effusions were appreciated on her foot or ankle, although this was limited by her body habitus. No axillary or inguinal lymphadenopathy was appreciated. She experienced significant pain with passive dorsiflexion of the ankle beyond neutral.

The imaging studies, including radiographs, magnetic resonance imaging, and a bone scan of the left ankle, were reviewed. The

radiographs showed a lytic lesion in the anteromedial talus (Fig. 1). Magnetic resonance imaging further detailed this talar lesion and its significant associated bony edema. In addition, the magnetic resonance imaging scan identified a distinct large, anterior soft tissue mass that appeared to be eroding into the talus (Fig. 2). This lesion was seen to be incredibly active on the bone scan, and no other bony lesions were present (Fig. 3). A chest computed tomography scan was

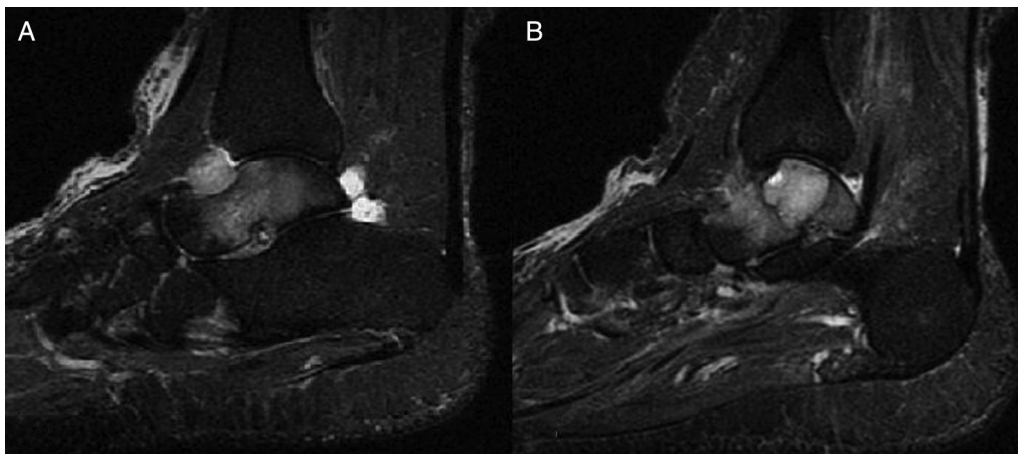


Fig. 2. T₂-weighted sagittal magnetic resonance images demonstrating (A) a distinct intra-articular soft tissue mass with erosion into the talar cortex and (B) a separate cystic lesion of the talus with extensive surrounding edema.

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