



POSTER PRESENTATION

ONCOLOGY

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HYPOTHYROIDISM AND HYPOPARATHYROIDISM SECONDARY TO METASTASIS OF BREAST CARCINOMA TO THE NECK

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BACKGROUND

Metastases to thyroid and parathyroid glands are uncommon. While both thyrotoxicosis and hypothyroidism have been reported in literature, hypoparathyroidism due to metastatic infiltration is very rare.

CASE

We report a female who developed hypothyroidism and hypoparathyroidism secondary to metastatic breast carcinoma.

A 57-year-old female was diagnosed with left breast infiltrative ductal carcinoma Stage 3 (T2N3aM0). She underwent left mastectomy and axillary clearance, followed by adjuvant chemotherapy and regional radiotherapy. She was treated with letrozole but defaulted. Two years later, she presented with progressive swelling over her anterior chest wall and neck, causing airway obstruction and requiring emergency tracheostomy. Biopsy of the neck mass reported metastatic high grade invasive breast carcinoma. Systemic chemotherapy (gemcitabine and cisplatin) was commenced. She complained of numbness over the extremities and was noted to have severe hypocalcemia with prolonged QTc (488ms) on ECG. Corrected calcium was 1.57 mmol/L (N 2.2-2.6), phosphate 0.81 mmol/L (N 0.81-1.45), magnesium 0.64 mmol/L (N 0.66-1.07), ALP 100 U/L (N 40-129), 25-OH Vitamin D 51.73 nmol/L and intact parathyroid hormone (iPTH) level was inappropriately normal at 2.5 pmol/L (N 1.6-6.0). Thyroid function showed hypothyroidism [fT4 <0.5 pmol/L (N 12.3-20.2), TSH 64.6 mIU/L (N 0.3-3.94)]. Anti-thyroid peroxidase was negative. She received intravenous calcium initially and was later commenced on oral levothyroxine, calcium carbonate and calcitriol, with normal calcium level and thyroid function on outpatient follow-up.

CONCLUSION

This case highlights the rare endocrine complications of hypothyroidism and hypoparathyroidism secondary to metastatic malignancy. Prompt recognition is important for timely treatment initiation to prevent life-threatening complications.

