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534 - DERMATOMYOSITIS AS PARANEOPLASTIC SYNDROME OF A BREAST CANCER

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Paraneoplastic syndromes (PS) are entities whose symptoms are not directly attributed to primary or metastatic tumors. They are usually triggered by immunological mechanisms in response to tumor antigens or by hormonal factors. Their appearance may precede, be synchronous, or follow the diagnosis of a neoplasm. Breast cancer can also manifest itself through such syndromes. Dermatomyositis (DM), a rare disease, is an inflammatory myopathy that presents with progressive, symmetrical, proximal muscle weakness, and characteristic cutaneous findings. It is believed that approximately 10%–25% cases are healthy PS, and therefore are associated with a risk of cancer up from 5 to 7 times greater. In almost 20% of cases of DM associated with malignancy, a concomitant breast cancer is diagnosed. MCFS, 26 years old, nulliparous, without a family history of cancer was referred to the Mastology Clinic for an ulcerated nodule in the left breast (LM). She could not walk because of generalized muscle weakness. She reported an ulcerated nodule in the LM for a month, with rapid growth. On physical examination, she presented an exophytic nodule of 10 cm in the LM in the upper lateral quadrant, without palpable axillary's nodules. She also reported a diagnosis of DM from 8 months, which was the cause of myopathy and her skin lesions. She was hospitalized in the emergency department of the medical clinic 8 months ago, in which the hypothesis of DM was corroborated by the muscle injury enzymes and diffuse symmetric and bilateral edema of the thigh muscles and myoadiposis planes evidenced by nuclear magnetic resonance. Both are incisional biopsy of an exophytic lesion. Analysis revealed invasive carcinoma with extensive squamous differentiation, Grade 3, necrosis in 30% of the sample. CT of the chest, abdomen, and pelvis and a scintigraphy did not show metastases. Simple mastectomy and sentinel lymph node biopsy were followed by axillary dissection. The anatomopathological examination confirmed that metaplastic carcinoma with squamous differentiation had an associated intraductal component. In total, 20 lymph nodes were examined and 16 were involved. Immunohistochemistry: Estrogen and progesterone receptors were positive, HER2 was negative, and Ki-67 was positive in 25%. Invasive carcinoma of the nonspecial type. The patient is being followed up with the clinical oncology department of the University Hospital of Brasília to continue the treatment. Unlike primary conditions that generally affect middle-aged women, paraneoplastic myositis tends to affect very young or older patients, with more severe cutaneous-muscular implications. Malignancy risk factors are severe skin disease with necrosis, capillary damage on muscle biopsy, absence of lung disease, resistance to treatment, and absence of myositis-specific antibodies. The exact role of antibody tests for cancer screening in patients with myositis is not well established. In contrast, the presence of myositis-specific antibodies was related to a decreased risk of malignancy. Established DM diagnosis: cancer screening should be performed and consists of complete blood count, renal function, transaminases, mammography, oncotic colpocytology, chest x-ray, fecal occult blood, or colonoscopy. Surveillance for the possibility of cancer should be maintained in the first 5 years of muscle disease. We present this report as a warning that a frequent disease (breast cancer) can present unusual features (signs and symptoms of DM). It is important for clinicians to have the wit to consider occult cancer in the systemic process of DM, being that breast carcinoma is an important diagnosis due to its high frequency among women.