**OS 217 ONCOLOGY MODULE: Breast Cancer**

AM, 58 year-old female from Calamba, Laguna

**Chief complaint**: lump in right breast

**History of Present Illness**

4 months prior to admission, patient palpated a small lump on her right breast. There were no associated pain or skin changes at the time. No consult was done.

2 months prior to admission, she noted an increase in the size of the breast mass. She then consulted a local clinic. She was advised consult at PGH Breast Clinic with the impression of a possible breast tumor.

At the breast clinic, biopsy was done which revealed invasive ductal carcinoma. Laboratory examinations were done and she was then prepared for surgery, hence admission.

**Review of Systems**

(-) headaches, seizures, nausea and vomiting, blurring of vision

(-) difficulty breathing, cough, chest pains

(-) abdominal pain, changes in bowel habits, GI bleeding, dysuria

(-) musculoskeletal pains, weakness

**Past Medical History**

Patient is a known hypertensive for 5 years, maintained on Losartan 100mg PO once a day with good BP control. Patient reports no allergies to food and drugs. Patient has undergone myomectomy at PGH when she was 42 years-old. She has taken OCPs for the past 14 years.

**Family Medical History**

Patient’s father died of acute MI at 56 year-old. No other disease noted in the family. She has three children, all adults. Patient’s sister was also diagnosed with breast cancer in 1998 when she was 35 years old.

**Personal and Social History**

Patient reports no vices. Patient is a high-school teacher since she was 25 years-old.

**Obstetric and Gynecologic History**

Patient is nulligravid. Menarche at age 13. Menopause at age 56. No history of any post-menopausal spotting/bleeding. Coitarche at Age 18. Patient has had only one sexual partner and has no history of sexually-transmitted diseases.

**Physical Examination**

On admission, the patient was awake, not in distress with the following vital signs and physical examination findings:

HR 88 RR 20 temp 36.7 C, BP 130/70

Pink conjunctivae, anicteric sclerae, no tonsillopharyngeal congestion or exudates, no cervical lymphadenopathy

Symmetric chest expansion, clear breath sounds, distinct heart sounds, regular rhythm, no murmurs

(+) 3 x 2 cm movable hard mass on the right breast, no nipple and skin changes noted

(+) 1 x 1 cm movable nodule on the right axilla. No other nodes palpated in left axilla and supraclavicular areas

Soft, non-tender abdomen, no palpable masses, no hepatosplenomegaly

Full and equal peripheral pulses, no skin lesions, no jaundice

Neurological PE was unremarkable



**Diagnostic examinations**

CBC: Hgb 120 Hct 0.3 WBC 9.0 Platelet 350

Na 142 K 3.6 Crea 71 Alb 38 Ca 2.34

PT 99% activity, INR 1.4 PTT normal

Chest X-ray: No cardiomegaly, No pulmonary opacities/nodules

Mammogram, left: BI RADS 1

Core needle biopsy: Invasive ductal carcinoma, no special type, Grade 2, right breast