

# EORTC

STUDY GROUP ON DATA MANAGEMENT (SGDM)

## ONE-DAY INTRODUCTION TO EORTC STUDIES

3 June, 1994

(10.00 am - 05.00 pm)

at the EORTC Data Center, Av. E. Mounier 83, 1200 Brussels, Belgium

The "introductory" workshop will give guidance for working with EORTC clinical trials.

**Programme :** EORTC structure and organization - Role of the EORTC Data Center - Different steps of clinical research - EORTC protocols and case report forms - Randomization, registration and EuroCODE - Quality Control, GCP and EORTC studies - Evaluation of tumor response - Reporting of toxicity - Demonstrations and informal discussion with Data Center staff

**Who should attend ?** Any persons who are new to the clinical research area or have recently started working with EORTC protocols.

**Registration :** the workshop is free of charge for hospital personnel involved in EORTC studies. Otherwise a registration fee of 10.000,- BEF is required.

**For further information, please contact :** A. Marinus, EORTC Data Center,  
Av. E. Mounier 83, Bte 11, 1200 Brussels, Belgium  
tel. : +32 2 774.16.54 - fax : +32 2 772.35.45

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## Letters

### Monoarthritis of the Ankle: an Unusual Presentation of Metastatic Breast Carcinoma

S. Menon, C.R. Smith and M. Baum

BREAST TUMOURS rarely metastasise to the bones of the foot. We report the case of a patient previously treated for breast carcinoma, who presented with a monoarthritis of the ankle. The 53-year-old patient had a painful swelling of the right foot and ankle for 5 months, which had been attributed to reflex

sympathetic dystrophy (Sudek's atrophy). Systemic examination was unremarkable, but her right ankle and foot were swollen. There was no allodynia, but ankle and subtalar joint movements were painful.

She had been followed regularly for 3 years after wide local excision of a left breast ductal carcinoma. The tumour was grade III and oestrogen receptor negative. Perineural and vascular invasion had occurred, and four out of 20 lymph nodes were infiltrated. She received local radiotherapy and conventional adjuvant chemotherapy, but thereafter was on no medication.

Laboratory investigations were normal. Ankle radiographs revealed diffuse osteoporosis and abnormal bone texture (Fig. 1a) and a computed tomography (CT) scan showed a large lesion within the right talus (Fig. 1b). On biopsy, 20 ml sterile pus was aspirated and bone histology showed adenocarcinoma identical to her previous cancer. Her symptoms improved with 20 Gy local radiotherapy and tamoxifen, but 6 months later she developed a pleural effusion. A bone scan showed uptake in three ribs. She has responded to local treatment, and remains active and mobile 18 months after the onset of symptoms in the right ankle.

Correspondence to S. Menon.

S. Menon and C.R. Smith are at the Bloomsbury Rheumatology Unit, Dept of Medicine, University College London, Arthur Stanley House, 40-50 Tottenham Street, London W1P 9PG; and M. Baum is at the Academic Department of Surgery, The Royal Marsden Hospital, London SW3 6JJ, U.K.  
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Fig. 1. (a) X-ray right ankle, showing diffuse osteoporosis and abnormal bone texture, and (b) computed tomography of right tarsal joints, showing a large cavity within the talus and an irregular medial border.

Metastases to the small bones of the hands and feet are uncommon, and in a review of 41 833 patients only 7 cases were found [1]. In the foot, the tarsus is commonly involved, and nearly a quarter of cases affect the calcaneus [2]. The commonest primary neoplasms were those of the colon, rectum, kidney and lung. Of 94 cases of metastases to the foot [3], only 9 (10%) cases were breast metastases, and more than one bone was often involved.

Distal metastases usually occur with widespread metastatic disease and are, therefore, relatively easy to recognise. Where the patient presents with a distal secondary deposit, or where there is no other evidence of metastasis, diagnosis is more difficult. Reported initial misdiagnoses include osteomyelitis, reflex sympathetic dystrophy and crystal-induced synovitis [2–4], and in one report the patient was treated for rheumatoid arthritis for 2 years [5].

Distal bony metastases are often associated with a marked inflammatory reaction, and a non-neoplastic joint effusion is common. In our patient, the initial radiological appearance was of diffuse osteoporosis without erosion of the joint. Characteristically, a thin margin of subchondral bone remains even in the presence of large lytic lesions. Subsequently, marked destruction and collapse may occur, making the diagnosis obvious.

There is finally an historical resonance about this case — the original justification for the Halstead radical mastectomy was based on the belief that breast cancer spreads centrifugally along lymphatic channels and tissue planes. Halstead adduced as corroborative evidence the fact that patients died before the disease spread to the distal limbs, and stated that metastases never occurred in the hands and feet [7]. This letter is sadly published approximately 100 years too late to have influenced the bandwagon of radical surgery that dominated the first seven decades of this century.

1. Wu KK, Guise ER. Metastatic tumours of the foot. *Southern Med J* 1978, 71, 807–812.
2. Zindrick MR, Young MP, Daley RJ, Light TR. Metastatic tumours of the bones of the hand and foot. *Skeletal Radiol* 1987, 16, 387–392.
3. Bunkis J, Mehrof AI, Stayman JW. Metastatic lesions of the hand and foot. *Orthopaedic Rev* 1980, 9, 97–101.
5. Jacox RF, Tristan TA. Carcinoma of the breast metastatic to the bones of the foot: a case report. *Arthritis Rheum* 1960, 3, 170–177.
6. Chakravarty KK, Webley M. Monoarthritis: an unusual presentation of renal cell carcinoma. *Ann Rheum Dis* 1992, 51, 681–682.
7. Halstead WS. The results of operation for the cure of cancer of the breast. *Ann Surg* 1907, 1, 46–61.