CASE REPORT

Case Report: Breast cancer-associated paraneoplastic stiff person syndrome: anastrozole monotherapy insufficient for symptom improvement [version 1; peer review: awaiting peer review]

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Abstract
Stiff person syndrome (SPS) is a rare clinical disorder presenting with progressive muscle stiffness and painful spasms. Its ill-defined mechanism and variable presentation make diagnosis a challenge, though it is associated with a range of specific auto-antibodies. One particular antibody, anti-amphiphysin, is found in the presence of breast or lung malignancy and leads to a disorder termed paraneoplastic SPS (PSPS). Our patient, an 83-year-old woman, presented with bilateral leg weakness, spasms, and left clubfoot over a period of three months. She also reported a lump in her left breast for which she had not sought treatment over the past 10 years. Her ankle radiograph was negative for fractures and dislocations, while an MRI of the left leg was negative for plexopathies. Electromyography was suggestive of an SPS disorder and a positive anti-amphiphysin test indicated a diagnosis of PSPS. Her symptoms were managed with baclofen, diazepam, and five cycles of therapeutic plasma exchange (TPEX) over 10 days. Breast imaging revealed a 4.5-cm left breast lesion, later biopsy-confirmed as invasive ductal carcinoma (ER+, PR+, HER2−). The patient declined definitive surgical management, opting instead for once-daily anastrozole 1 mg as hormonal therapy. This regimen was not sufficient to lead to symptomatic improvement over a period of more than 30 days, and the patient expired less than 45 days after discharge. To our knowledge, this is the first case of PSPS to be treated in this manner. Our report illustrates that conservative management with anastrozole monotherapy was not sufficient to lead to symptomatic improvement in this form of paraneoplastic syndrome, suggesting the need for more aggressive pharmacological or definitive surgical intervention in order to produce symptomatic improvement.
and/or resolution.

**Keywords**
Stiff person syndrome, Paraneoplastic, Invasive ductal carcinoma, Anastrozole

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**Author roles:** Cordova J: Conceptualization, Investigation, Writing – Original Draft Preparation, Writing – Review & Editing; Nelson B: Conceptualization, Investigation, Supervision, Validation, Writing – Review & Editing; Brizendine A: Conceptualization, Investigation, Writing – Original Draft Preparation; Pacheco D: Investigation, Writing – Original Draft Preparation; Willis M: Funding Acquisition; Markowitz A: Supervision, Validation

**Competing interests:** No competing interests were disclosed.

**Grant information:** The author(s) declared that no grants were involved in supporting this work.

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**First published:** 10 May 2021, 10:366 https://doi.org/10.12688/f1000research.52189.1
Introduction

Stiff person syndrome (SPS) is part of an exceedingly rare spectrum of SPS disorders. Classic SPS presents with painful muscle spasms, increased sensitivity to stimuli, and gradual muscle stiffness, leading without intervention to spinal deformity and significant disability\(^1\)\(^2\). Though the pathophysiology is poorly understood, it is often accompanied by the presence of anti-glutamic acid decarboxylase antibodies or anti-glycine receptor antibodies. In rare cases of breast and lung malignancy, it can present with anti-amphiphysin antibodies and is termed paraneoplastic SPS (PSPS)\(^3\). These antibodies have also been associated with paraneoplastic cerebellar degeneration\(^4\) and a rare presentation of SPS with transverse myelitis\(^5\), both of which are beyond the scope of this current discussion. We present a case of PSPS in the setting of occult breast malignancy.

Current management typically involves a three-pronged approach consisting of immunotherapy, symptomatic control, and tumor eradication\(^1\)\(^3\). Our case is unique in that our patient declined definitive surgical intervention and radiation, opting instead for conservative therapy with anastrozole. To our knowledge, this is the first such case to be treated in this manner. This article was previously presented as a virtual poster at the 2020 American College of Physicians Texas Chapter Meeting on November 7, 2020.

Case presentation

The patient was an 83-year-old Caucasian woman who presented with bilateral leg weakness, painful leg spasms, and left talipes equinovarus (Figure 1). Her symptoms started three months prior to presentation, but worsened rapidly and severely limited her ambulation. She was a retired postmistress and was most alarmed by her reduced mobility, as she transitioned from walking unassisted to using a cane and eventually to a wheelchair over a period of two weeks. Her past medical history included celiac disease and an unspecified thyroid disorder, while a review of her family history revealed two sisters with prior episodes of breast cancer. On physical examination, her cranial nerve exam was normal, as was her motor exam in the bilateral upper extremities. On examination of her lower extremities, however, 3/5 strength was noted in her proximal left lower extremity with 4+/5 on the right. She also showed 3/5 strength in ankle dorsal and plantar flexion on the left side, along with absent ankle reflex and extensor plantar response. She reported a lump in her left breast, present for the past 10 years. Further workup included a left ankle radiograph, which was negative for fractures or dislocations (Figure 2), a spinal MRI without evidence of plexopathy, a negative test for ganglioside antibodies, and a negative myositis panel. Electromyography showed spontaneous ongoing muscle activity at rest, and co-activation of agonist/antagonist muscle groups in the bilateral lower extremities, indicating a central process like SPS. She was given diazepam and baclofen for symptom relief and, after confirmation of positive neuronal anti-amphiphysin antibodies in the cerebrospinal fluid, the patient underwent five cycles of therapeutic plasma exchange (TPEX) over a period of 10 days. She did not report any functional lower leg improvement during this time. Breast imaging identified a 4.5-cm left breast mass (Figure 3), with regional spread to the left axillary lymph nodes but without distant metastasis. Pathology confirmed invasive ductal carcinoma (ER+, PR+, HER2−) with a Ki-67 index of 50%, grade T2cN3aM0, clinical prognostic stage IIB. The patient declined chemotherapy and surgical resection, agreeing instead to hormonal therapy in the form of once-daily anastrozole 1 mg. She passed away less than 45 days after discharge without showing significant improvement in symptoms of PSPS.
Figure 3. Left breast mammography revealing a 4.5-cm lesion, later confirmed as invasive ductal carcinoma (ER+, PR+, HER2−).

Discussion

Despite the debilitating nature of PSPS, it is a clinically rare disorder without a clear delineation of optimal treatment practices. Disorders that fall upon the SPS spectrum have an estimated incidence of 1 case per million per year, but the paraneoplastic variant of the disease is particularly uncommon, comprising less than 10% of all SPS cases. A review of current literature reveals a wide range of management options for PSPS, focusing primarily on treatment of the underlying malignancy and on symptomatic control. For muscle spasms and improvement in functional status, GABA agonists like diazepam or baclofen seem to be the preferred choice, though there is also a role for therapeutic plasma exchange and immunotherapy in refractory cases.

A myriad of approaches has been proposed for the treatment of underlying malignancy, based largely on the characteristics of the cancer itself and on the condition of the patient. The management options range from surgical intervention alone, as one case report detailed drastic symptomatic improvement after tumor resection in a woman with PSPS, while many others included an aggressive chemotherapy regimen with or without radiation therapy. One treatment plan coupled an intensive rehabilitation program with a regimen of chemotherapy, leading to significant symptomatic improvement in a matter of weeks.

The chemotherapeutic agents which appear to be favored are doxorubicin, docetaxel, and cyclophosphamide, though rituximab, carboplatin, and trastuzumab have also been reported. The major takeaway from the literature is that all reports of symptomatic improvement have included aggressive management of the underlying malignancy, whether through surgical resection, chemotherapy, radiation, or a combination of the three. No previous cases have reported on the use of anastrozole monotherapy in treating breast cancer-associated PSPS, which led us to report our results.

Conclusions

The case we present here is unique in that it developed from occult malignancy, present for as many as 10 years, and that the patient elected to pursue hormonal treatment of her breast cancer rather than definitive surgical or chemotherapeutic intervention. She unfortunately did not show any measurable symptomatic improvement on anastrozole, which we feel indicates a need for a more aggressive treatment regimen or a more prolonged course of hormonal therapy. In this particular case, anastrozole alone was not sufficient to produce clinical improvement or symptomatic resolution. To our knowledge, this is the first such report of breast-cancer associated PSPS to be treated with anastrozole and our hope is that it will be the grounds for further exploration of management options for this rare disease process.

Data availability

Underlying data

All data underlying the results are available as part of the article and no additional source data are required.

Consent

Written informed consent for publication of their clinical details and/or clinical images was obtained from the patient.

References

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