HCC bony metastases are characteristically osteolytic and hypervascular and thus may rupture spontaneously, causing hemorrhage. Chen *et al*.[7] reported a case of a life-threatening hemorrhage from sternal metastasis from HCC. Similarly, Huang *et al*.[8] have reported a case of intractable bleeding from an isolated mandibular metastasis, which was controlled by palliative radiotherapy.

Very rarely, bony metastases from an unknown primary HCC have been reported. The exact mechanism is not known, but various theories have been postulated such as metastasis from micro HCC, which is later destroyed by the immune system, spontaneous regression of HCC, or HCC developing in ectopic liver tissue.[9] The etiology of HCC in our case was chronic Hepatitis B infection. In view of the raised AFP, a large liver mass and a characteristic osteolytic lesion in sternum with biopsy suggestive of HCC, the diagnosis was confirmed and an FNAC from the hepatic mass was not required.

Sorafenib is one of the first-line drugs used in the treatment of advanced metastatic HCC. Sorafenib is a tyrosine kinase inhibitor which inhibits cell growth in a dose- and time-dependent manner by altering the expression of genes involved in angiogenesis, apoptosis, and transcriptional regulation.[10] Various other treatment modalities have been reported for bone metastasis such as chemoembolization as for a primary HCC, systemic chemotherapy, radiotherapy or surgical resection.[6] Unfortunately, prognosis remains poor. Median survival for HCC with bone metastasis is reported to be 6.2 months.[6]

To conclude, we here report an unusual presentation of HCC as an isolated sternal mass. A high index of suspicion is required to accurately diagnose the disease at this point. Thus, authors have recommended that metastatic HCC should be included in the list of differential diagnosis of progressively growing bony lesions at unusual sites, even in the absence of signs of liver disease.

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Conflicts of interest

There are no conflicts of interest.

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