

## Intestinal Metastasis of Breast Lobular Carcinoma

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### Abstract

**Introduction:** The Breast cancer is the most common cancer in women, both in incidence in mortality. 40% of female deaths before age 65 are due to metastatic breast cancer. The gastrointestinal tract is an uncommon site metastatic for this type of Cancer.

**Observation:** We report KN a patient 65y; followed since 2013 for the right mammary neoplasia who received 08 courses of Neoadjuvant chemotherapy (carcinomatous mastitis) type 4AC/4T followed by a right mastectomy with ipsilateral axillary dissection on 26.06.2014 whose histological study concluded carcinoma infiltrating mixed ductal and lobular grade II according to the classification of Scarff Bloom Richardson with someone 5 of 5 nodes dissection of lymph nodes removed axillaire. Hormonal receptors were positive (HR +); HER (-) classified T2N2M0. Followed by radiotherapy adjuvant locoregional at a dose of 50 Gy then receiving antiaromatase type of hormonotherapy (Letrozole). After 2 and a half years back, and since November 2016, she presented paroxysmal abdominal pain, transit disorders.

**Discussion:** In breast cancer, the occurrence of metastatic lesions at the digestive level is rare. It is the second leading cause of this type of metastasis after melanoma. Gastrointestinal metastases account for only 0.7% of metastatic breast cancer sites. The colic attacks are much rarer than the gastric attacks. In our observation, it was multiple colic and small bowel metastases. The diagnosis of digestive metastasis is difficult. The clinical presentation is often non-specific. Symptoms can range from simple nausea, vomiting, digestive bleeding, epigastralgia and weight loss to an abdominal mass or ascites. Endoscopy with biopsy for an anatomopathological examination with an immunohistochemical study of the hormonal receptors is therefore necessary thus allowing to connect the digestive lesions to its mammary origin.

**Conclusion :** The breast cancer metastases in the digestive tract and the peritoneum are rare. They are more frequent in cases of invasive lobular carcinoma. The occurrence of gastrointestinal symptoms for a patient with breast cancer history should suggest the possibility of metastases in the digestive system even in the absence of other sites.

**Keywords:** *Breast Cancer; Carcinomatous Mastitis*

### Introduction

The Breast cancer is the most common cancer in women, both in incidence in mortality. 40% of female deaths before age 65 are due to metastatic breast cancer. Metastases are mainly localized in the bone, lung and liver. The gastrointestinal tract is an uncommon site metastatic for this type of Cancer.

### Observation

We report KN a patient 65 years old with cholecystectomy history 30 years ago; followed since 2013 for the right mammary neoplasia who received 08 courses of Neoadjuvant chemotherapy (carcinomatous mastitis) type 4AC / 4T followed by a right mastectomy with ipsilateral axillary dissection on 26.06.2014 whose histological study concluded carcinoma infiltrating mixed ductal and lobular grade II

according to the classification of Scarff Bloom Richardson with someone 5 of 5 nodes dissection of lymph nodes removed axillaire. hormonal receptors were positive (HR +); HER(-) classified T2N2M0. Followed by radiotherapy adjuvant locoregional at a dose of 50 Gy then receiving antiaromatase type of hormonotherapy (Letrozole).

After 2 and a half years back, and since November 2016, she presented paroxysmal abdominal pain, Transit disorders.

An upper gastrointestinal fibroscopy made with biopsies found esophageal papilloma +chronic non atrophic gastritis helicobacter pylori +.

**The colonoscopy + biopsy**

Adenocarcinoma found in the right colon + tubular polyadenoma with low-grade dysplasia of the colon transverse.



Figure 1

**The CT TAP:** Three parietal tumoral thickening with extension to pericolic fat looking suspicious of malignancy; the larger interest the right side of the transverse colon bit stenosing the two other type polypoid in the left colon and a tumoral thickening of a loop of the small intestine of the left upper quadrant with multiple para aortic and primitive iliac adenomegalies.

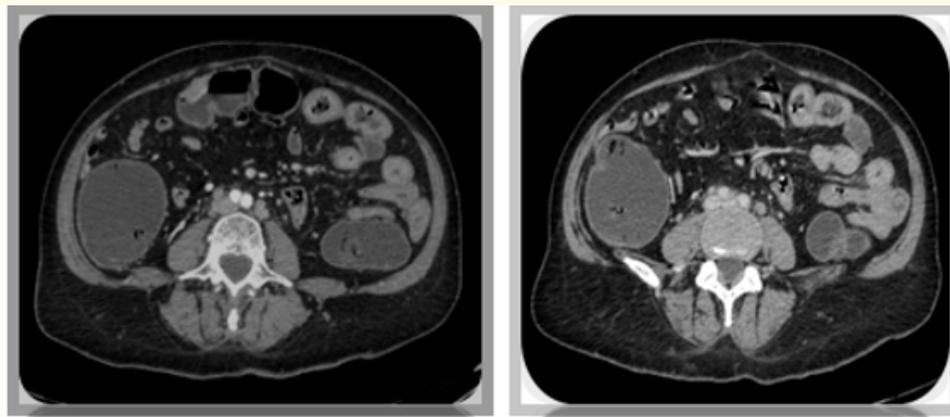


Figure 2

**The tumor markers:** CA19-9; CA15-3 and CEA are normal. patient operated on 02.07.2017: Subtotal colectomy + ileo left colic anastomosis + resection of small bowel loop at 100 cm from the ileocecal valve a + bowel anatomosis.

The histologic study and IHC was in favor of an intestinal metastasis of lobular breast carcinoma.

The CK7 and GGDFP15 shows a candid positivity, mamaglobine +, And the CK20.Dog1 and Ckit are negative.

### Discussion

In breast cancer, the occurrence of metastatic lesions at the digestive level is rare. It is the second leading cause of this type of metastasis after melanoma. Gastrointestinal metastases account for only 0.7% of metastatic breast cancer sites. The colic attacks are much rarer than the gastric attacks.

In our observation, it was multiple colic and small bowel metastases.

In a series published in 1993 over 18 years, Borst et al. report 17 cases of metastases in the gastrointestinal tract among 2500 patients followed for metastatic breast carcinoma with a frequency of less than 1% of cases. In the literature, we found in a series in 1998, 14 cases: all are invasive lobular carcinomas of the breast. Only two cases are indicative of metastatic evolution.

McLemore et al. reported in 2005, in a series of Mayo Clinic concerning 1,2001 patients with metastatic breast cancer, digestive metastases in 73 cases (ie 0.6%). There were 23 cases of metastases in the digestive tract and 32 cases of peritoneal carcinomatosis. Only 18 cases had gastrointestinal involvement with associated peritoneal carcinomatosis (0.15%).

The metastases of the digestive tract mainly concerned the stomach and small intestine and less frequently the colon and rectum. In the Mayo Clinic series, of the 23 cases of gastrointestinal metastases, the stomach was the first site at 28%, followed by the small bowel (19%), colon and rectum (45%). Then the esophagus (8%).

Digestive metastases of breast cancer are more frequent in autopsy series with a frequency that varied between 6 and 35% depending on the series. This may be due to an often difficult diagnosis of this type of lesion due to the non-specific clinical presentation and the late onset of this type of metastasis. Indeed, the delay of onset of digestive metastasis ranged from 2 months to 32.8 years depending on the series.

The diagnosis of digestive metastasis is difficult. The clinical presentation is often non-specific. Symptoms can range from simple nausea, vomiting, digestive bleeding, epigastralgia and weight loss to an abdominal mass or ascites. Endoscopy with biopsy for an anatomopathological examination with an immunohistochemical study of the hormonal receptors is therefore necessary thus allowing to connect the digestive lesions to its mammary origin [1-4].

### Conclusion

The breast cancer metastases in the digestive tract and the peritoneum are rare. They are more frequent in cases of invasive lobular carcinoma. The occurrence of gastrointestinal symptoms for a patient with breast cancer history should suggest the possibility of metastases in the digestive system even in the absence of other sites.

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