

Late Colon Involvement by Lobular Carcinoma of the Breast: A Diagnosis to Keep in Mind!

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Keywords

Breast cancer · Invasive lobular carcinoma · Colonic metastases

Envolvimento tardio do cólon por carcinoma lobular da mama: um diagnóstico a considerar!

Palavras Chave

Cancro da mama · Carcinoma lobular invasivo · Metástases do cólon

Breast cancer is a heterogeneous disease with two main types: invasive ductal carcinoma (the most frequent type) and invasive lobular carcinoma (that comprises approximately 10% of all cases) [1, 2]. Lobular carcinoma is more than just a histologic variant of breast cancer, since it has distinct molecular, morphologic, biologic, and epidemiologic characteristics, which have clinical and prognostic implications [2].

We report the case of a 60-year-old female with a medical history of invasive lobular carcinoma of the breast 12 years before. At that time, the patient was submitted to resection surgery and adjuvant chemotherapy. Recurrence-free survival was documented for 12 years. Due to recent onset of chronic diarrhea and weight loss, colonoscopy was performed and documented diffuse edema in-

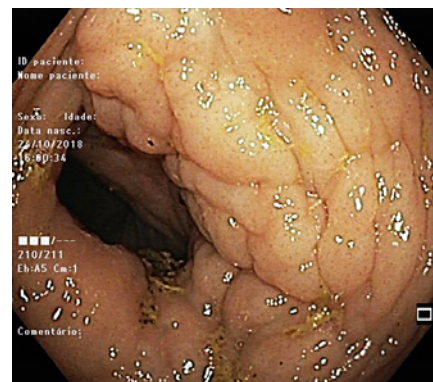


Fig. 1. Diffuse edema involving the ascending colon and ileocecal valve, with thick and rigid folds and without ulceration.

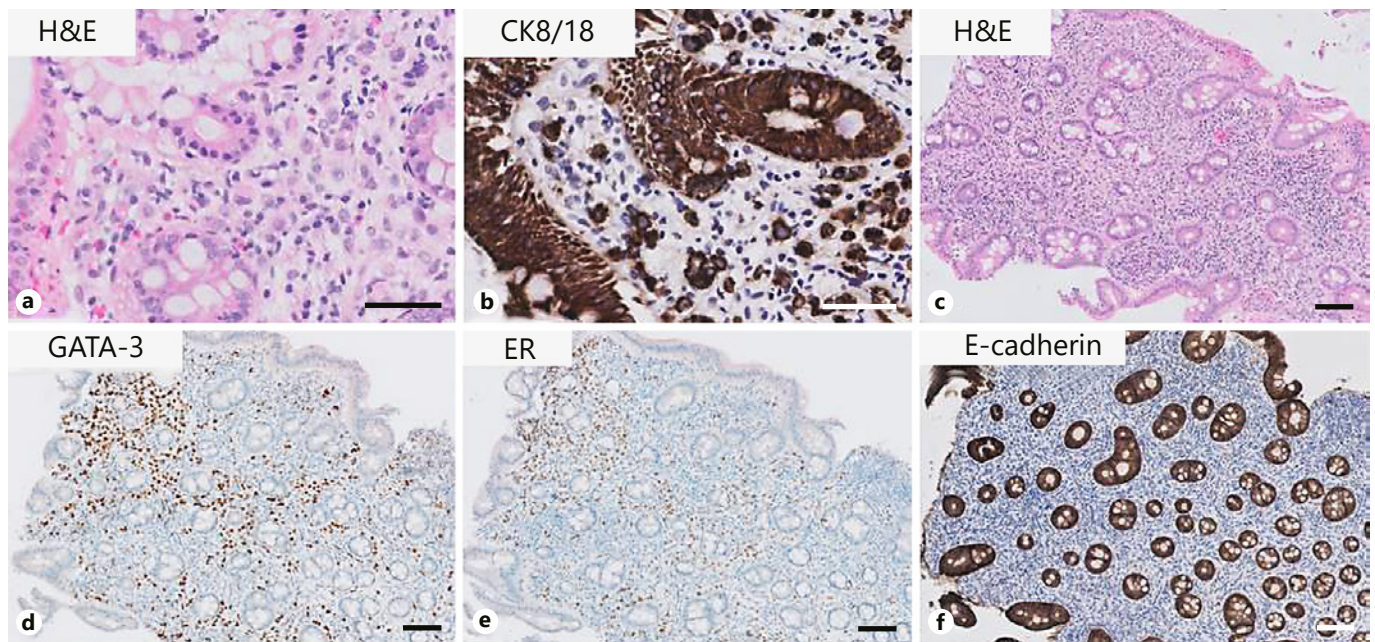


Fig. 2. Neoplastic infiltration of the colonic lamina propria. **a** Tumor cells are homogenous and relatively small and show a single-cell pattern of invasion. **b** CK8/18 highlights the presence of disperse neoplastic cells in the lamina propria. **c-f** Tumor cells show an immunohistochemical phenotype consistent with breast lobular carcinoma, with expression of GATA-3 (**d**) and estrogen receptor (ER; **e**), and loss of e-cadherin (**f**). Scale bars correspond to 100 μ m (**a**, **b**) and 50 μ m (**c-f**).

volving the right colon and the ileocecal valve with asymmetric thickening/hypertrophy and rigidity of the folds, without ulceration (Fig. 1). Pathology identified diffuse infiltration of the lamina propria by scattered small and homogeneous cells, with a immunohistochemistry profile consistent with primary lobular carcinoma of the breast (Fig. 2). Computed tomography documented peritoneal and right colon involvement with ascites. The patient is currently under palliative chemotherapy, with a favorable response on computed tomography evaluation.

Invasive lobular carcinoma of the breast has a less predictable pattern of metastatic spread than ductal carcinoma, frequently involving unusual sites such as the gastrointestinal tract (stomach, small bowel, and colon), the ovary, and the peritoneum [2–4]. Although lobular carcinoma usually has a more favorable response to therapy and a longer recurrence-free survival compared to ductal carcinoma, recurrence may occur more than 10 years following therapy [3]. In case series of colorectal metastases from lobular breast cancer, the average interval between the diagnosis of the primary tumor and colonic involvement was 7 years, but late recurrence, as late as 17 years following the diagnosis of the primary tumor, in resem-

blance to the present case report, have been previously reported [5, 6]. An exceedingly late recurrence of lobular breast cancer presenting with gastric metastasis 23 years after the initial diagnosis and treatment has recently been described [7]. The infiltrating pattern of this tumor with scattered non-cohesive cells that lack cellular atypia infiltrating the submucosa, may result in false-negative results from endoscopic biopsies and delay the diagnosis [3, 5]. Keeping in mind the peculiar characteristics of invasive lobular carcinoma of the breast regarding gastrointestinal involvement might increase the diagnostic yield for its detection and allow prompt initiation of therapy.

Statement of Ethics

The authors have no ethical conflicts to disclose.

Disclosure Statement

The authors have no financial disclosures to report.

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