Image of the Month

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A 64-YEAR-OLD WOMAN PRESENTED TO THE emergency department with abdominal pain, nausea, and bilious vomiting. The patient did not have any constitutional symptoms or current concerns. She denied having bone pain, cough, or shortness of breath. Review of systems was otherwise negative in detail. Her surgical history was negative for abdominal surgery.

Abdominal examination revealed a diffuse, mildly tender, distended abdomen with hypoactive bowel sounds. The remainder of her physical examination revealed a mottled, dimpled right breast with nipple retraction and a large 5.0-cm palpable mass. No palpable axillary lymphadenopathy was appreciated. Additional evaluation in the emergency department included an abdominal computed tomographic scan with oral and intravenous contrast (**Figure 1**).

The patient was admitted for conservative treatment with nasogastric tube decompression. Bilateral mammography and sonography were obtained. Breast mammography demonstrated a band of thickening with fibrotic changes and calcifications. The results of the breast ultrasound were right breast parenchyma, predominantly replaced with a vague hypoechogenicity, resulting in mild alteration of echogenicity consistent with an infiltrative mass. Axillary adenopathy was not visualized. Skin thickening was not noted. The left breast revealed no sonographic abnormalities.

Conservative treatment of the patient for 36 hours for partial small-bowel obstruction was not successful, and eventually she was taken to the operating room for an exploratory laparotomy and a Tru-cut needle biopsy of the right breast mass. The patient was found to have a bowel obstruction with a transition zone. She had small-bowel resection with a primary anastomosis. The pathology of this resected segment of small bowel is shown in **Figure 2**. A Tru-cut needle biopsy of the right breast was performed at the same time.

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What Is the Diagnosis?

A. Breast adenocarcinoma and small-bowel adenocarcinoma
B. Infiltrating ductal carcinoma metastasis to small bowel
C. Breast carcinoma and Crohn disease
D. Infiltrating lobular carcinoma of the breast with metastasis to the bowel

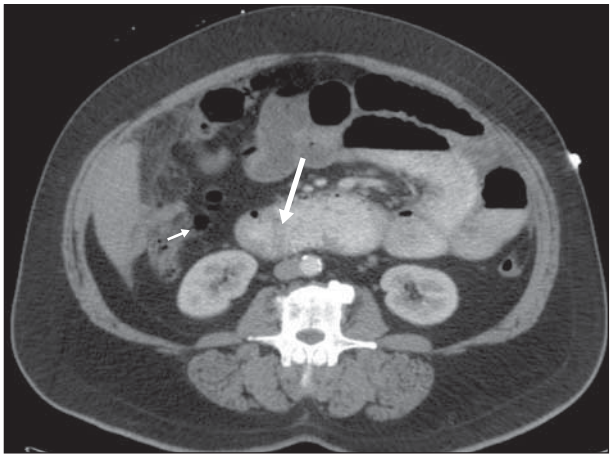

Figure 1. Transition zone between proximal dilated small bowels (large arrow) and distal collapsed ones (small arrow).

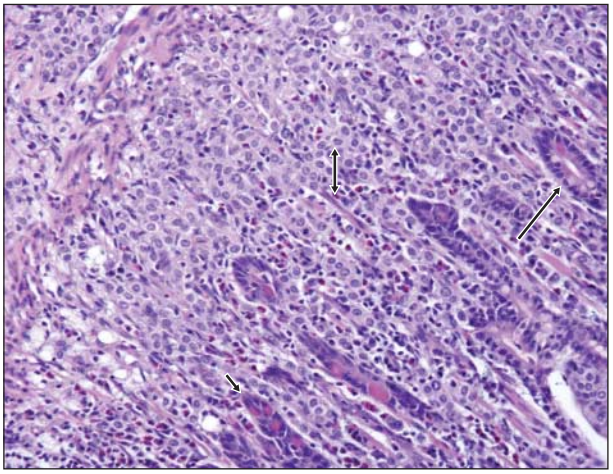

Figure 2. Image shows metastatic lobular carcinoma cells (double-headed arrow) infiltrating the mucosa and submucosa of the small bowel. Residual crypts with Paneth cells (long arrow) and goblet cells (short arrow) are also seen.