Small-Bowel Metastasis From Infiltrating Lobular Breast Cancer

Abdominal computed tomography (Figure 1) shows partial small-bowel obstruction at the mid jejunal level with proximal dilated loops and distal collapsed small bowel.

The pathology of the small bowel (Figure 2) revealed evidence of metastatic lobular breast cancer as the cause of the transition zone and bowel obstruction. The Trucut needle biopsy of the right breast mass was diagnostic for invasive lobular carcinoma of the breast. The patient’s breast cancer was found to be estrogen- and progesterone-receptor positive and human epidermal growth factor 2 negative. There was no evidence of further metastatic disease on an extent-of-disease evaluation of the patient.

The patient was treated with Anastrozole, an antiestrogen therapy. The patient underwent a prophylactic toilet mastectomy of the right breast 2 months after her abdominal surgery. She was alive 1 year after her diagnosis with metastatic lobular breast carcinoma at the time of submission of this article.

Approximately 10% of all breast cancer is invasive lobular cancer (ILC),\(^5\)\(^6\) which has a predilection to spread to the gastrointestinal tract.\(^4\)\(^6\)\(^8\) Forty percent of patients who die of ILC have metastatic spreading to the bowel.\(^7\) Symptomatic bowel metastases often manifest with signs of obstruction.\(^8\)

Invasive lobular cancer gastrointestinal metastases can be challenging to identify with imaging because they often present as diffuse thickening or stricture rather than a solitary mass.\(^9\) Microscopically, infiltration of ILC is characterized by single-file cell invasion known as Indian filing.

Initial management in this case of stage 4 ILC included resection of the metastatic lesion to release the bowel obstruction. Simple mastectomy is appropriate when the primary site has ulcerated or progressed to the extent that it interferes with chemotherapy. Endocrine therapy is usually recommended for a minimum of 5 years for endocrine-responsive tumors, or chemotherapy only for non–endocrine-responsive tumors.\(^8\)

Overall, the 5-year survival rate for patients with ILC is 94%.\(^8\) The prognosis of ILC is still controversial, with most studies documenting a prognosis comparable with that of stage-matched and grade-matched invasive ductal carcinomas.\(^10\)

The connection between ILC and bowel metastasis is important to remember. When a patient presents with 2 different symptoms, the etiology can often be traced back to a common origin. Patients with bowel obstruction and risk factors for breast cancer warrant a careful historical and physical evaluation, especially a breast examination. Patients with ILC should receive vigilant attention to abdominal symptoms and follow-up study.

Accepted for Publication: January 14, 2009.
Correspondence: Emad Kandil, MD, Division of Endocrine and Oncologic Surgery, Tulane Medical School, 560 First Ave, New York, NY 10016 (ekandil@tulane.edu).
Author Contributions: Study concept and design: Kandil and King. Acquisition of data: Kandil and Moroz. Analysis and interpretation of data: Kandil, King, Alabbas, Moroz, and Wright. Drafting of the manuscript: King, Alabbas, and Moroz. Critical revision of the manuscript for important intellectual content: Kandil and Wright. Administrative, technical, and material support: Alabbas. Study supervision: Kandil, Moroz, and Wright.
Financial Disclosure: None reported.

REFERENCES