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Case Study

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UNUSUAL PRESENTATION OF BREAST CANCER: CASE REPORT

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INTRODUCTION

Breast cancer is the most common cancer in women worldwide, and the most common cause of cancer-related morbidity and mortality.[1] The presence of metastasis in breast cancer is responsible for more mortality and morbidity.[2,3] The most common site for metastasis are lung, bone, liver, and brain.[3] But rarely metastasize to gastrointestinal tract (GIT).[4] The prevalence of GIT metastasis is 1.55%, while colon metastasis ranging from 0.07% to 0.2%.[5,6]

Invasive lobular breast carcinoma is more potentially metastasize to GIT compared with other breast cancer subtype.[6] Patients with isolated small bowel metastasis of breast cancer are responsive to tamoxifen.[5]

CASE PRESENTATION

A 50-year-old post-menopausal female patient not known to have any medical illness, present in March 2020 complaining of vague abdominal pain for one month duration associated with constipation, in the last week of abdominal pain she complained of bleeding per rectum, she denied any weight loss.

Upon physical examination, she had abdominal mass, and was not tender, per rectal examination revealed hard stool with fresh blood, and no palpable mass.

She underwent chest, abdomen, and pelvis CT scan with contrast showed rectal wall thickening, abdominal mass, and bilateral breast masses. PET/CT scan was done showed hypermetabolic rectal wall thickening, hypermetabolic abdominal mass, and hypermetabolic bilateral breast masses. Figure 1.

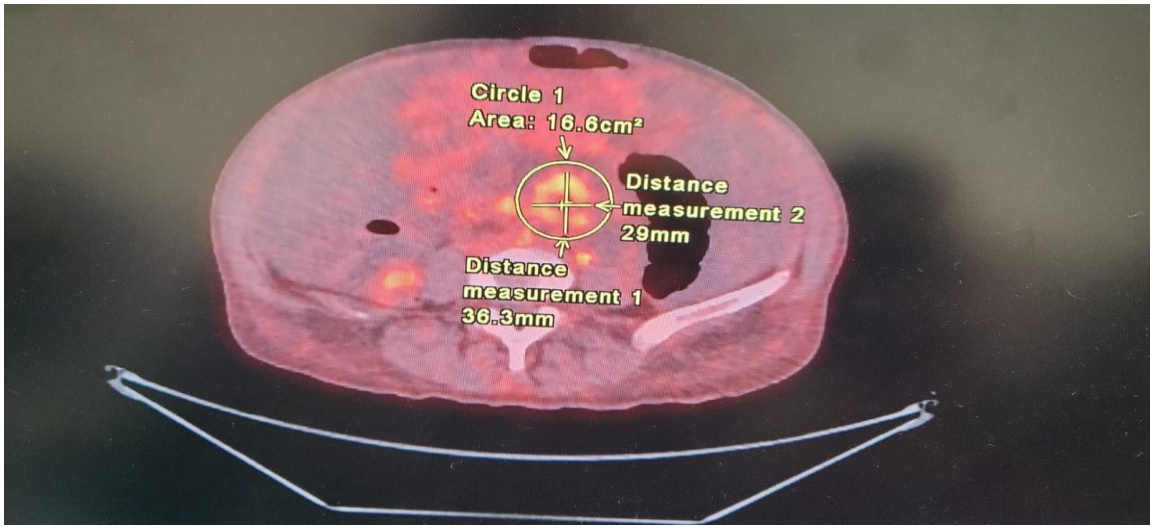

Figure 1: hypermetabolic abdominal mass.

Colonoscopy was done and biopsy was taken, the histopathology report was confirmed the presence of adenocarcinoma of breast origin.

Bilateral mammogram was done showed bilateral breast masses of BI-RAD 5, ultrasound guided biopsy for bilateral masses was done. The diagnosis of bilateral invasive lobular carcinoma of breast, grade 1, estrogen

receptor presented with strong stain in 100%, progestin receptor presented with strong stain in 100%, and HER2 score was +1 was made according to histopathology report.

As this patient present with breast cancer hormonal positive, HER2 negative without visceral crisis, hormonal therapy (Anastrazole) 1 mg once daily was started. After three months of treatment, patient had clinical improvement regarding abdominal pain, constipation, and bleeding per rectum, PET scan follow up showed good partial response to treatment. Figure 2.

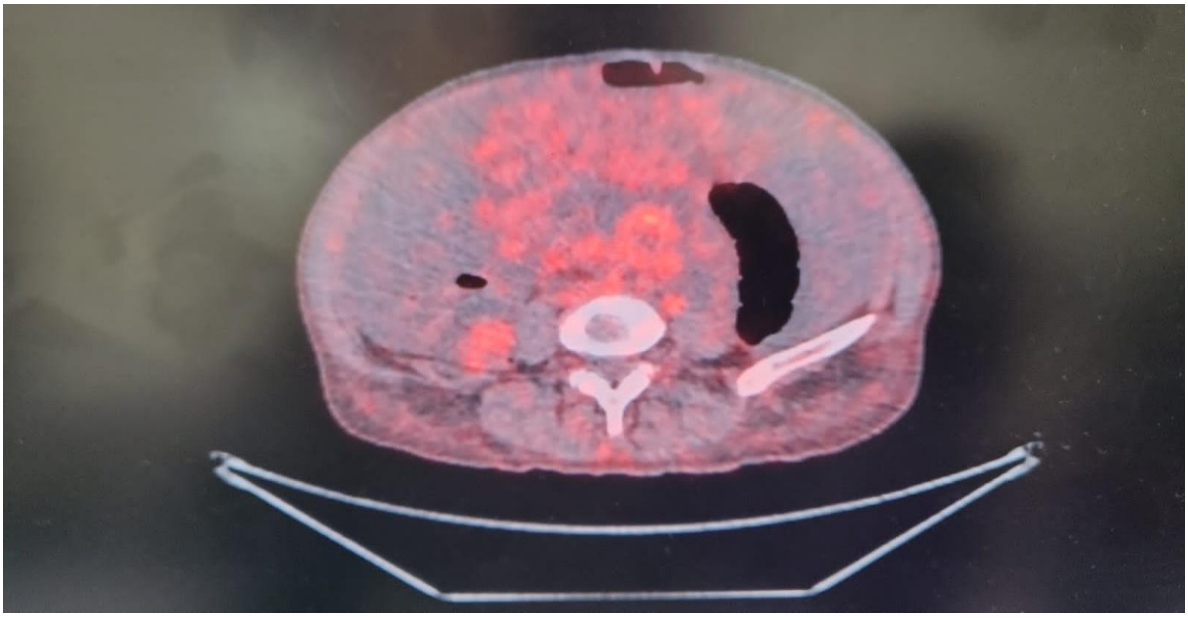

Figure 2: good partial response to treatment.

PET scan follow up later on showed complete radiological response. Figure 3.

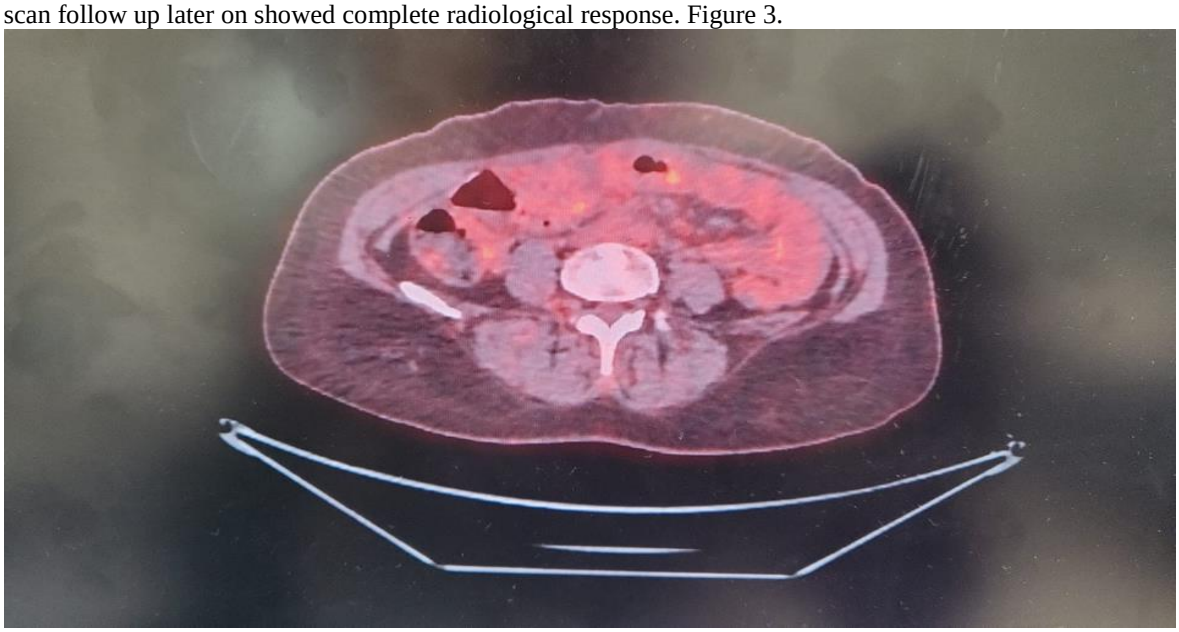

Figure 3: complete radiological response.

DISCUSSION

Breast cancer can rarely metastasize to GIT, the incidence of metastasis ranging from 0.07% to 18%.[7] While colon metastasis ranging from 0.07% to 0.2%.[6]

Lobular histological subtype is more frequently metastasize to GIT than ductal type.[8] As our patient had bilateral invasive lobular carcinoma with metastasis to GIT.

Breast cancer patients with GIT metastasis had short median overall survival ranging from 3 to 41 months, which is shorter than breast cancer patients with other metastatic sites.[7]

The most common site of metastasis in GIT is colon and rectum accounting 45% of all GIT metastasis, followed by stomach in 28%, small intestine in 19%, and the least one is esophagus in 8%.[9] The most two factors that affect survival in patient with breast cancer and GIT metastasis are advanced age at diagnosis and gastric metastasis.[9]

The treatment of breast cancer with GIT metastasis include palliative surgery for intestinal obstruction or bleeding, systemic therapy including hormonal therapy and chemotherapy, tamoxifen had a positive effect on survival for breast cancer with GIT metastasis, and the surgery did not affect the survival.[5,9]

Our patient was treated with Anastrazole 1 mg once daily with complete radiological response and good clinical improvement.

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