Dear Editor,

Metastases of breast carcinomas are usually found in the lung, central nervous system, bone, and liver (1,2). Few cases of colonic metastases from breast cancer have been reported, and the non-specific presentation and variable radiological findings in these cases make diagnosis difficult (2,3).

Case report

We present a case of metastatic breast cancer in the sigmoid colon: A 69-year-old woman with a history of modified radical mastectomy (MRM), followed by adjuvant chemotherapy, performed 18 years ago (1994) by infiltrating the lobular carcinoma in the right breast. She attended the emergency room for abdominal pain, which over 48 hours became associated with nausea, vomiting and lack of flatulence. The physical examination showed abdominal distension and generalized pain with signs of peritoneal irritation. Laboratory tests showed a discrete leukocytosis (13.62x10³). The emergency abdominal/pelvic CT scan with IV contrast showed a lesion with a neoplastic appearance in the proximal portion of the sigmoid colon, with imaging suggesting a collection of about 4x2.5 cm on the left margin, and another of about 4.3x2.2 cm in the left supra adjacent paracolic gutter. The latter had a hydro-aerobic aspect suggesting a perforation of the lesion (Fig. 1A). Given the findings described, emergency surgery was performed during which was observed fecal peritonitis secondary to neoplastic perforation of the sigmoid colon. A sigmoidectomy and end colostomy were performed in the left flank. During the postoperative period, the patient recovered favorably and was discharged from the hospital seven days after surgery. The subsequent anatomopathological study of the tumor showed metastasis of the carcinoma that was poorly differentiated and compatible with the primary breast carcinoma (Fig. 1B). The neoplasia presented immunohistochemistry negative for estrogen receptors, progesterone and HER-2/neu (Hercep test), showing positive for the anti-CK7 antibody usually present in breast carcinomas and absent in most colon carcinomas. The patient underwent postoperative systemic chemotherapy and has remained asymptomatic and disease-free one year after surgery (negative PET-CT during follow-up). At present, she is awaiting bowel reconstruction surgery.

Discussion

Diverse studies have examined the pattern of dissemination of the different histological subtypes – the gastrointestinal, osseous or gynecological disseminations being more frequent in lobular subtypes, and the central nervous system, liver, and lung metastases in ductal subtypes (4). Despite the high prevalence of infiltrating ductal carcinoma, infiltrating lobular breast carcinoma is responsible for most gastrointestinal tract metastases (4-6). Multiple lesions, unilateral defects and extrinsic conditions with healthy mucosa are suggestive signs of metastasis (5-7). Colonoscopy with biopsy is the test of choice to differentiate metastases and primary colonic tumors (4,5,7). An intact mucosa with serous membrane invasion by tumor cells histologically identical to those of the primary breast tumor confirms the diagnosis of metastasis (7). Using immunohistochemical techniques is useful when doubts exist over origin of the tumor and the appropriate adjuvant treatment (chemotherapy and/or hormonal therapy) (8-10). There is no consensus on the management of these uncommon lesions (4). Surgical treatment...
is reserved for cases of perforation, hemorrhage or intestinal obstruction (4,5).

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References