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Concomitant endometrial and gallbladder metastasis in advanced multiple metastatic invasive lobular carcinoma of the breast: A rare case report

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ABSTRACT

INTRODUCTION: At time of presentation, fewer than 10% of patients have metastatic breast cancer. The most common sites of metastasis in order of frequency are bone, lung, pleura, soft tissue, and liver. Breast cancer metastasis to the uterus or gallbladder is rare and has infrequently been reported in the English literature.

PRESENTATION OF CASE: A 47 year old female with a recent history of thrombocytopenia presented with abnormal vaginal bleeding. Pelvic ultrasound revealed multiple uterine fibroids and endometrial curettings revealed cells consistent with lobular carcinoma of the breast. Breast examination revealed edema and induration of the lower half of the right breast. Biopsy of the right breast revealed invasive lobular carcinoma. Bone marrow aspiration obtained at a previous outpatient visit revealed extensive involvement by metastatic breast carcinoma. Shortly after discharge, the patient presented with acute cholecystitis and underwent cholecystectomy. Microscopic examination of the gallbladder revealed metastatic infiltrating lobular carcinoma. The final diagnosis was invasive lobular carcinoma of the right breast with metastasis to the bone marrow, endometrium, gallbladder, regional lymph nodes, and peritoneum.

DISCUSSION: The growth pattern of invasive lobular carcinoma of the breast is unique and poses a challenge in diagnosing the cancer at an early stage. Unlike other types of breast cancer, it tends to metastasize more to the peritoneum, ovary, and gastrointestinal tract. Metastasis to the endometrium or gallbladder is rare.

CONCLUSION: Metastatic spread should be considered in the differential diagnosis of patients with invasive lobular breast carcinoma presenting with abnormal vaginal bleeding or acute cholecystitis.

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1. Introduction

Fewer than 10% of patients have metastatic breast cancer at time of presentation [1]. The most frequent site of breast cancer metastasis is bone, followed by lung, pleura, soft tissue, and liver. Metastasis to the gallbladder has been reported to occur in about 4–7% of breast carcinoma cases [2]. The endometrium accounts for 4.7% of metastatic sites to the female genital tract from extragenital tumors [3]. Invasive lobular carcinoma comprises 10% of all types of invasive breast cancers, and is the second most common type of invasive carcinoma of the breast after invasive ductal carcinoma. Invasive lobular carcinoma has a wide array of initial presentations ranging from inconspicuous disease to masses that involve the

entire breast. It has the propensity to be multifocal, multi-centric, and involve bilateral breasts [4]. Invasive lobular carcinoma is more likely to metastasize to the peritoneum, ovary, and gastrointestinal system [5]. Sixty percent of patients with invasive lobular carcinoma will already have metastatic disease at time of diagnosis [6]. Patients with metastatic invasive lobular carcinoma may have a delay in the diagnosis and management of their disease as they may present with nonspecific symptoms. Here, we report a rare case of invasive lobular carcinoma with metastases to the bone marrow, endometrium, gallbladder, regional lymph nodes, and peritoneum.

2. Case presentation

A 47-year-old African American female with a BMI of 40 presented to the emergency department with a 10 day history of abnormal vaginal bleeding. She had a history of thrombocytopenia 26 days earlier attributed to NSAID use and history of a

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similar episode one year earlier attributed to uterine fibroids that were planned for surgical treatment, but the patient was lost to follow-up. Past medical history consisted of systemic lupus erythematosus, rheumatoid arthritis, thalassemia, fibromyalgia, migraine headaches, and back pain. Reproductive history consisted of menarche at age 13, one full-term pregnancy at age 42 and one abortion. Family history was doubtful for cervical or breast cancer. Medication history included 2 weeks of ibuprofen use for back pain prior to presentation. Social history was positive for occasional use of alcohol and marijuana. The patient had a bone marrow aspirate and biopsy performed after a prior evaluation for thrombocytopenia, the results of which were pending at time of presentation. A mammogram performed one year earlier was negative.

On examination, vital signs revealed tachycardia (102 beats/min) and were otherwise normal. Physical examination revealed pale conjunctiva, skin pallor, suprapubic tenderness, and tenderness surrounding the vagina with moderate dark red vaginal bleeding. With the past history of bleeding uterine fibroids, this was provisionally suspected to be the cause of re-bleeding and breast examination was missed being done at this point. Laboratory values revealed low hemoglobin (7.2 g/dL), low platelet count (20,000/mm³), and an elevated white blood cell count (13,800/mm³) with a left shift including metamyelocytes and bandemia. Chemistry panel revealed an elevated total calcium (11.6 mg/dL) and was otherwise normal. Urinalysis revealed white blood cells (15–25/HPF) and red blood cells (15–25/HPF) as well as few bacteria. Pelvic ultrasound revealed multiple uterine fibroids, with the largest measuring 3.7 cm, and an irregular endometrium measuring 13 mm in thickness. The patient was admitted for symptomatic anemia, red blood cell and platelet transfusions, and obstetrical and gynecological consultation.

Breast examination was performed and revealed edema and induration of the lower half of the right breast and was unremarkable in the left breast. Shortly after admission, the results of her bone marrow biopsy were retrieved and revealed a hypercellular bone marrow with marked diffuse fibrosis and extensive involvement by metastatic carcinoma of the breast. Mammography was performed and revealed no concerning findings in the left breast and multi-centric lesions in the right breast with non-muscle like abnormal enhancements in the upper and lower right quadrants suspicious for malignancy (BI-RADS 4A). Bilateral axillary lymph nodes were detected in the infra-pectoral and retro-pectoral regions. CT of the chest was performed and revealed skin thickening of the right breast, bilateral axillary lymphadenopathy with the largest measuring 1.8 cm × 1.3 cm, diffuse heterogeneous sclerotic changes involving the sternum, thoracic vertebrae, multiple ribs, bilateral scapula, and mild free fluid in the upper abdomen. CT of the abdomen and pelvis was performed and revealed prominent retroperitoneal lymph nodes and diffuse lytic lesions with heterogeneous bone marrow in the lumbar spine. MRI of lumbar spine revealed metastatic disease of lumbar spine, sacrum, and iliac bones. Bone scan was performed and revealed no evidence of bone metastasis. Biopsy of the right breast revealed a Grade 2 invasive lobular carcinoma in multiple cores, with a maximum single core linear length of 1.8 cm (Figs. 1 and 2). Endocrine receptor assays revealed the tumor to be ER positive (50%) and PR positive (70%). The malignancy was further found to be HER2/neu negative. Additionally, the patient underwent dilatation and curettage of the uterus with microscopic examination of endometrial curettings that revealed cells consistent with lobular carcinoma of the breast that were positive for AE1/3 and GATA-3 (Figs. 3–6). Her final diagnosis prior to discharge described a right breast invasive lobular carcinoma with metastasis to the bone marrow and endometrium (stage 4). She was discharged to follow-up with the oncology service and consideration of chemotherapy and hormonal management.

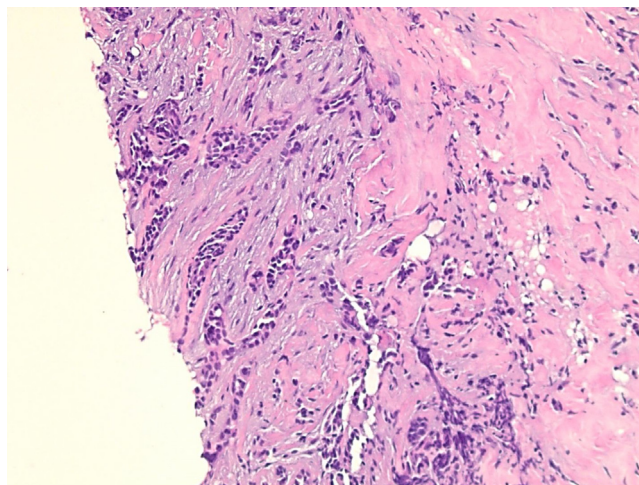


Fig. 1. Initial biopsy showing an infiltrating lobular carcinoma of the breast (100× magnification, H&E stain).

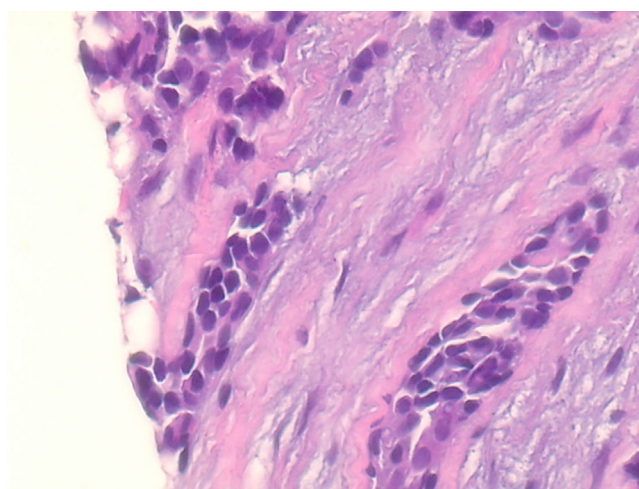


Fig. 2. Infiltrating lobular carcinoma of the breast (400× magnification, H&E stain).

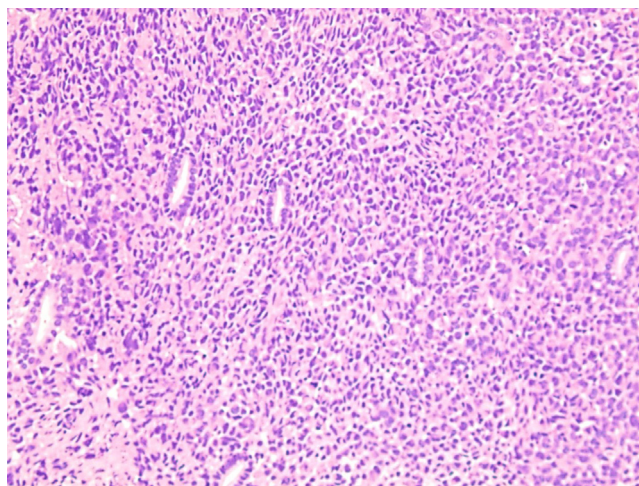


Fig. 3. Endometrial biopsy (D&C) showing stromal tumor (40× magnification, H&E stain).

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