

Gastricmetastasis Of Breast Cancer: Clinical Case And Review Of The Literature.

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Abstract: Gastric metastases of breast cancer are rare; they represent less than 6% of all breast cancersmetastases. Their diagnosis is difficult because of the non-specific nature of the symptoms. Invasive lobularcarcinomais the mostincriminatedhistologicalsubtype.

Rare cases of gastric metastases of breast cancer have been reported in the literatur, We report here the case of a 68-years-old patient who had a gastric metastasis of infiltrating ductal carcinoma of the breast revealed by incoercible vomiting.

Keywords :Gastricmetastasis , breast cancer , immunohistochemistry

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I. Introduction :

Breast cancer is the mostcommon cancer in women, Metastasesof breast cancer occurmainlyin the bone, lungs and liver, The gastriclocalization of metastasesis rare (2).

Mechanism of disseminationisessentiallyhematogenous. It maybe important to

distinguishmetastaticgastrictumorsfromprimarygastric cancers based on clinical, endoscopic, radiological, and histopathologicalfeatures.

Gastricinvolvementduring the evolution of breast cancer empies the patient'sprognosisdespitemultidisciplinarytreatment(1).

II. Case Presentation :

in 2005 a 68-years-old womanwith no medicalhistorywasdiagnosed for right breastbreastneoplasia.

Sheunderwent radical mastectomy. Histopathologicalexaminationrevealed an infiltrating ductal carcinoma classified PT2N1M0 grade III of SBR expressing the hormonal receptorswithout HER2 expression.

Radiologicalwork up did not revealany distant metastasis . The patient wassubsequentlytreatedwithanthracycline and taxane adjuvant chemotherapy, radiotherapy and tamoxifen hormone therapy for five years.

In 2015 the patient presentedwithdyspnearelated to a pleural effusion , a pleural relapse occurred: whose breast origin was confirmed by a pleural biopsy, the pleural tumor strongly expresses the hormonal receptors, the HER2 neubeingalwaysnegative, Radiologicalassessmentrevealedmetastaticlesions at the lymphatic and bone.

Hormone therapywasstarted, a good clinical, biological and radiologicalresponsewerenoted.

The metastatic disease remained perfectly stable until September 2017, when the patient consulted for unresponsive vomiting. Esophagogastroduodenalfibroscoyrevealed an infiltrating process in the lower esophagus, the biopsy of which concluded that there was gastric metastasis of an infiltrating ductal carcinoma of the breast with hormone receptors positive and overexpression of the her2 proteinwith no staining of CK20 and p63 (Figure 3,4,5,6,7).

A thoracoabdominalpelvic CT scan showedgastric infiltration withmetastasespulmonary, lymphatic and bonemetastases (Figure 1,2).

The evolution was marked by the rapid progression of the disease and the deathafteronly one monthfrom the diagnosis.

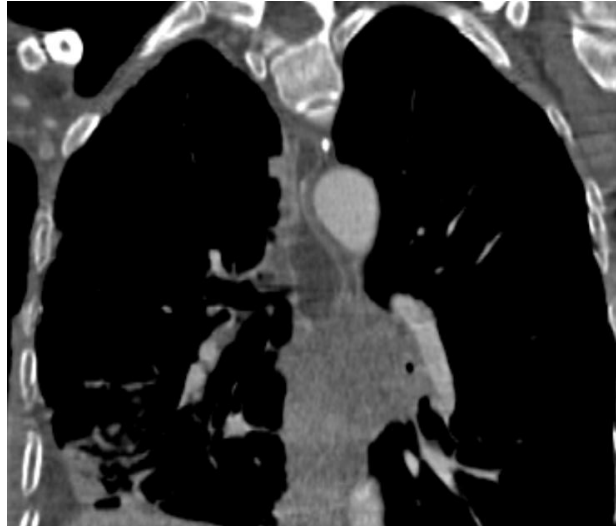


Figure 1 : Coronal CT scan sections after injection of the contrast medium showing a gastric tumor process with peri-tumor fat infiltration.

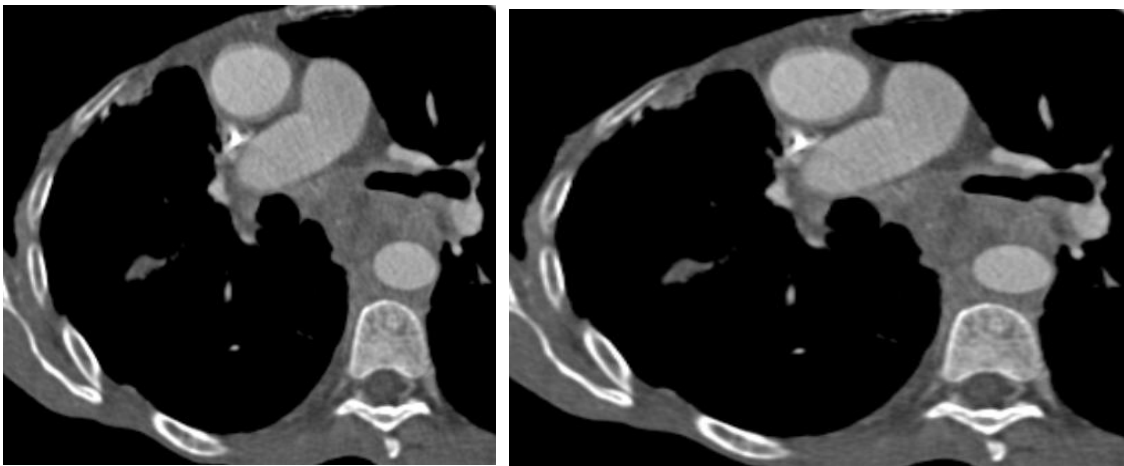


Figure 2 : Axial CT scan showing a tissue tumor process budding the middle third of the esophagus.

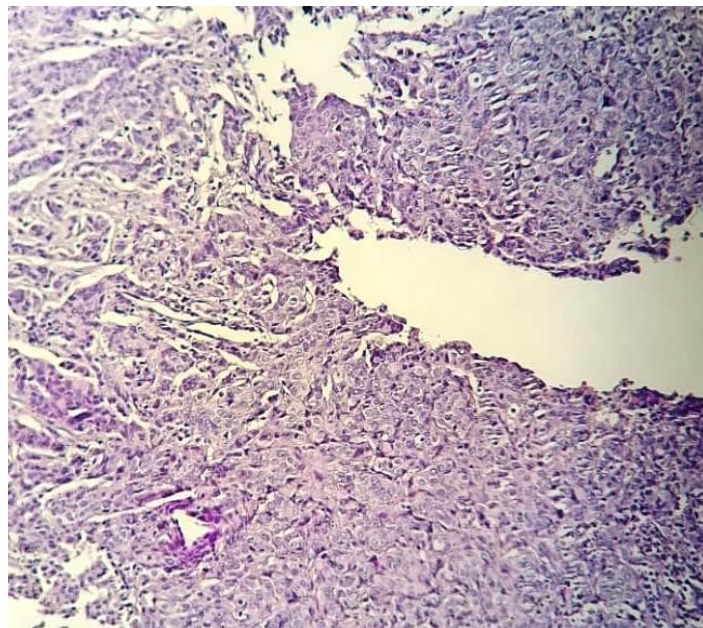


Figure N : 3HESx200: Carcinomatous tumor proliferations in layers and masses

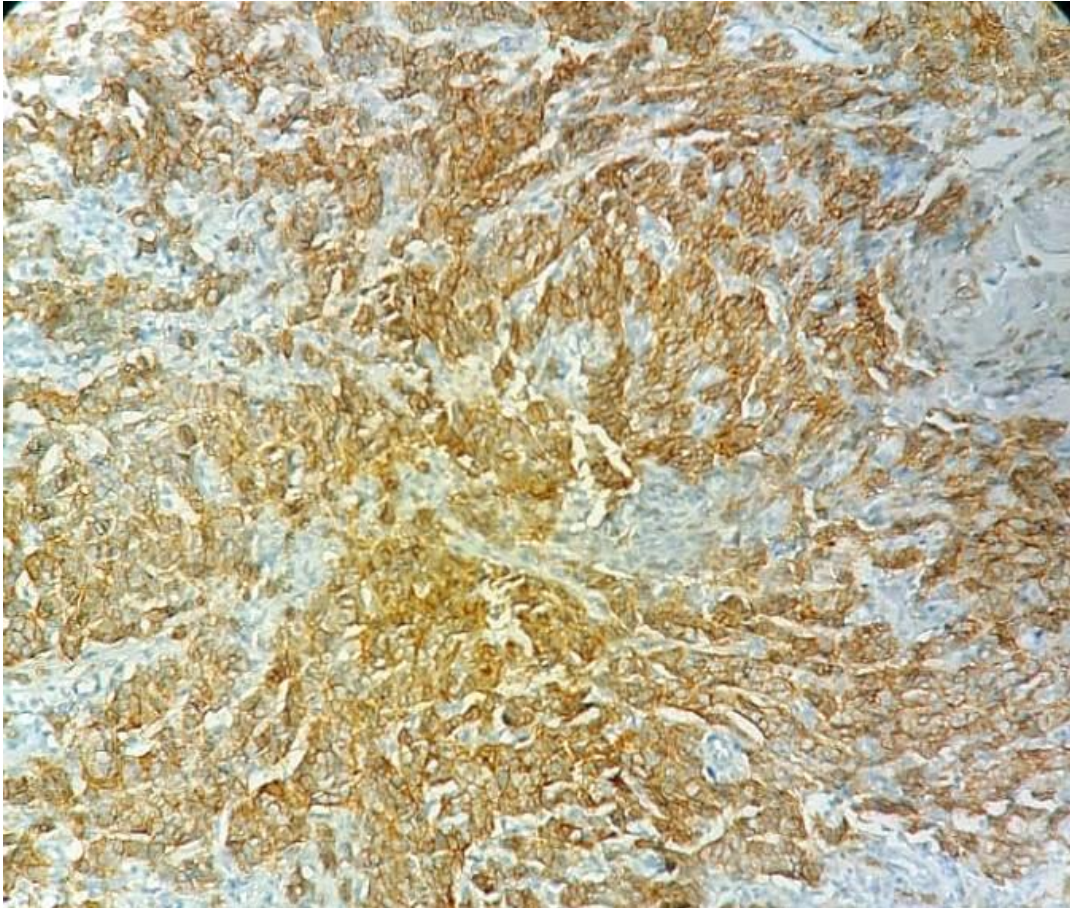


Figure N : 4HESX400 : immunostaining of tumorcells by anti-CK7 antibody

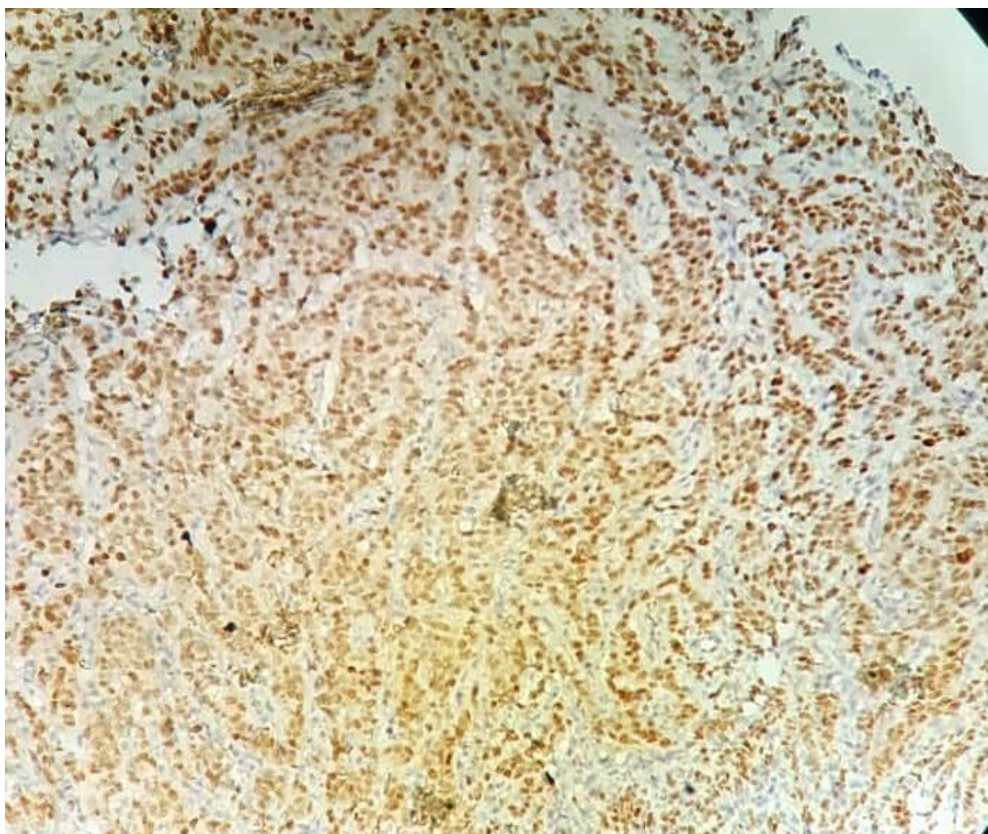


Figure N :5 HESX400: expression of progesterone receptors by more than 90% of tumor cells

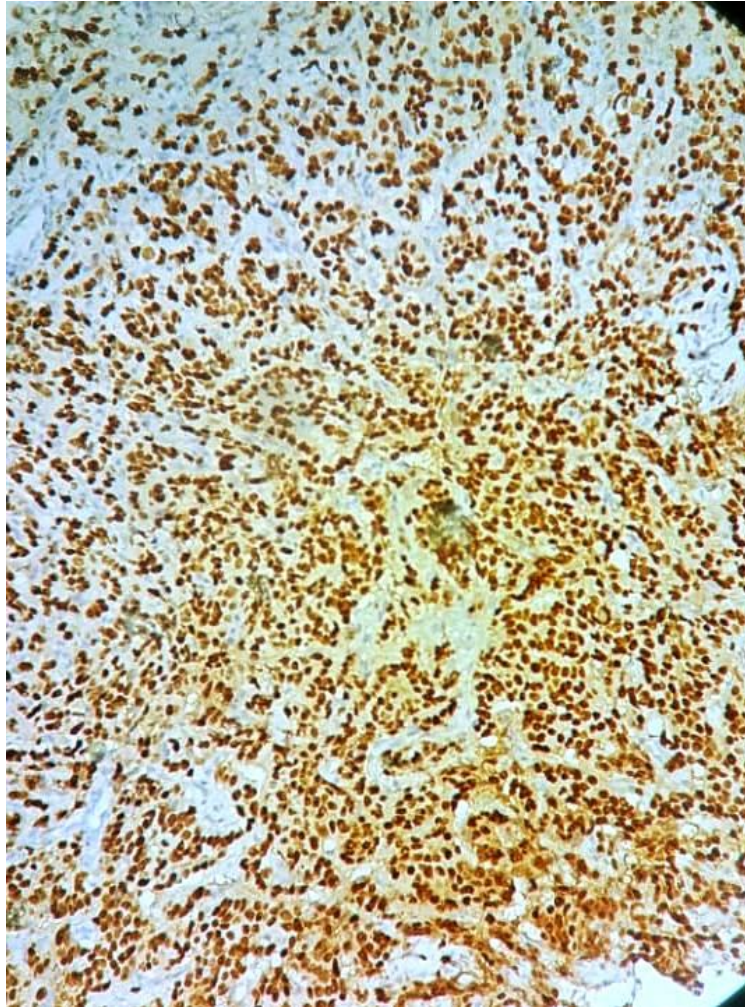


Figure N :6 HESX400: expression des récepteurs oestrogénique par plus de 90% des cellules tumorales

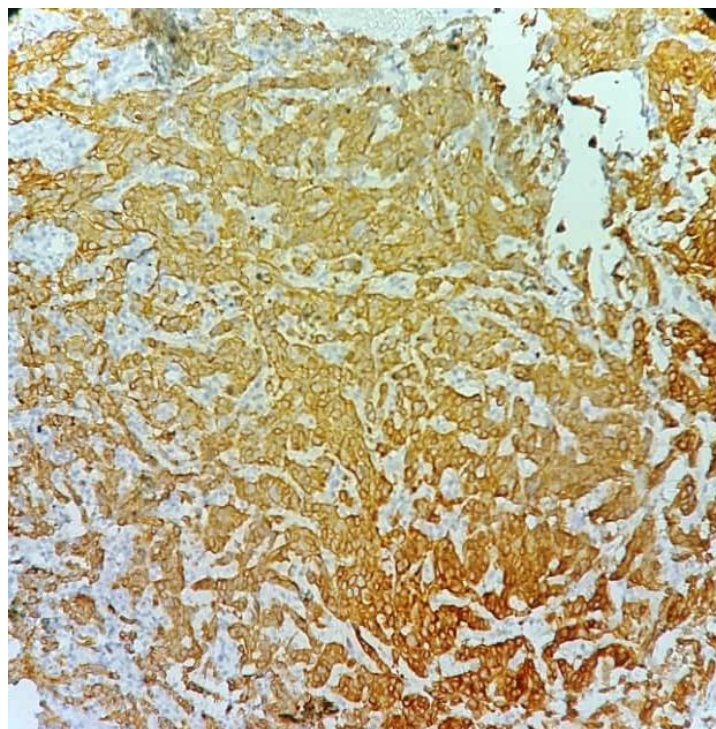


Figure N :7 HESX400: intense labeling of tumor cells by the anti-HER2 antibody

III. Discussion :

Gastric metastases remain rare approximately 300 cases of gastric metastases from extra mammary sites have been reported in contrast to the frequent bone, lung and liver metastases of breast cancer (2),

In a retrospective study that included more than 10,000 patients followed for breast cancer, only 28% developed metastases in the stomach [3]

The diagnosis of gastric metastasis is difficult and mostly late. Its discovery is often late or fortuitous, due to the symptomatology which remains poor and nonspecific.

Our patient benefited from a digestive endoscopy with biopsies whose anatomopathological examination confirmed the diagnosis.

However, digestive endoscopy and biopsies can be negative in more than 50% of cases [5,6].

Histologically, the Taal experiment that included 51 patients followed for metastases gastric of breast origin; 70% of patients had infiltrating lobular carcinoma of the breast [4]. While our patient was being followed for ductal carcinoma of the breast. Tumor histology may become one of the predictors of metastatic spread, lobular carcinoma is more likely to metastasize to the gastrointestinal tract, although metastatic gastric tumors are less common than ductal carcinoma and the mechanisms involved are not clear [11,12].

The immunohistochemical study makes it possible to orient the diagnosis (anti-CK 7 + and anti-CK 20- antibody) [10] and to specify the histological subtype (expression of the E-cadherin and p120 receptors for ductal carcinoma) [7].

Digestive involvement during the course of breast cancer makes the prognosis poor despite multidisciplinary management with a median survival not exceeding a few months [8-9].

IV. Conclusion :

gastric metastases of breast cancer are very rare associated with poor prognosis; the presence of gastrointestinal symptoms in a patient with a history of breast cancer should cause gastric involvement to be suspected and confirmed by digestive endoscopy.

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