

lizar obligatoriamente una biopsia de la lesión. En estadios tardíos puede evolucionar hacia la formación de una masa vegetante y sangrante, como heraldo de una neoplasia subyacente.

Desde el punto de vista terapéutico no se dispone actualmente de un protocolo de tratamiento unificado, por lo que la elección de cada manejo dependerá del tipo de la lesión (primaria vs. secundaria), de la extensión y de la experiencia clínica.

En los casos de EPP secundaria el éxito terapéutico dependerá del abordaje con finalidad oncológica del carcinoma asociado, combinando cirugía, radioterapia y/o quimioterapia. Aunque no disponemos todavía de ensayos clínicos aleatorizados que puedan comparar la cirugía a la radioterapia, esta última se puede considerar, en casos seleccionados, como una modalidad de tratamiento eficaz y una alternativa adecuada respecto a la extirpación quirúrgica amplia⁴.

En conclusión, la importancia de la EPP implica obligatoriamente no solo el diagnóstico diferencial con otras neoplasias cutáneas, sino el manejo temprano de un cuadro que puede suponer la primera manifestación metastásica de un carcinoma visceral subyacente.

Bibliografía

1. Carbotta G, Sallustio P, Prestera A, Laforgia R, Lobascio P, Palasciano N. Perineal Paget's disease: A rare disorder and review of literature. *Ann Med Surg (Lond)*. 2016;9:50–2.
2. Marchesa P, Fazio VW, Oliart S, Goldblum JR, Lavery IC, Milsom JW. Long-term outcome of patients with Perianal Paget's disease. *Ann Surg Oncol*. 1997;4:475–80.
3. William SL, Rogers LW, Quan SH. Perianal Paget's disease: Report of seven cases. *Dis Colon Rectum*. 1976;19:30–40.
4. Liu CF, Wang Q, Kong YY, Tu X, Wang J, Zhu X. A clinicopathological study of perianal Paget's disease associated with internal rectal adenocarcinoma. *Zhonghua Bing Li Xue Za Zhi*. 2004;33:11–5.

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Metastasis of lobular breast carcinoma in the bowel



Metástasis de carcinoma lobular de mama en el intestino

Breast cancer is the most common malignancy in women, but only 6% of newly diagnosed patients have distant metastasis at diagnosis.¹ Metastatic spreading disease to the gastrointestinal tract is very rare.² Here we report a case of bowel metastasis as the initial presentation of lobular breast carcinoma.

A 67-year-old female presented with six months of diffuse abdominal pain, diarrhea and weight loss. She had a past history of dyslipidemia, currently medicated with simvastatin. Abdominal examination was unremarkable. Laboratory investigation and upper endoscopy were normal. Colonoscopy revealed edema and loss of vascular pattern in the ascending colon and cecum; the ileocecal valve presented marked erythema and friability, preventing ileoscopy (Fig. 1A). Pathologic evaluation of biopsies from the ileocecal valve showed poorly cohesive tumor cells in lamina propria and some signet ring cells (Fig. 1B); immunohistochemistry was positive for estrogen receptor (Fig. 1C), cytokeratin 7 and AE1/AE3. These findings were consistent with metastatic lobular breast carcinoma to the colon.

The patient was sent to Gynecology clinic for examination and, in the upper outer quadrant of the left breast, it was palpable a hard, immovable, painless mass with irregular borders, associated with ipsilateral retracted nipple and axillary adenopathy. Breast ultrasound demon-

strated a hypoechoic nodule with posterior acoustic shadowing, measuring 29 mm × 17 mm (Fig. 1D). Histology of nodule biopsy confirmed invasive lobular carcinoma (estrogen receptor positive, progesterone receptor negative, Her2 negative, Ki-67 10%). Further staging imaging also revealed axillary lymph nodes and bone metastasis. The patient was proposed for palliative hormonal therapy.

Metastatic breast cancer is uncommon at the time of diagnosis,¹ usually spreading to the bone, lung, liver and brain.³ Gastrointestinal metastasis from breast cancer are rare and usually associated with lobular histology.² The most frequent site of metastasis on the gastrointestinal tract is the stomach, followed by the small bowel and the colon.² Clinical manifestations are non-specific and include abdominal pain, bowel obstruction or inflammatory diarrhea.² Endoscopic features include mucosal nodularity and rigidity, or lobulation and deformity caused by the presence of a mass. Therefore, diagnosis is challenging as metastasis may mimic inflammatory bowel disease or primary colon cancer.² In conclusion, we report a rare case of bowel metastasis as the initial presentation of lobular breast carcinoma, that requires a high index of suspicion for the diagnosis from the pathologist and the gastroenterologist.

Conflicts of interest

No conflicts of interest to declare.

Bibliografía

1. Waks AG, Winer EP. Breast Cancer Treatment: A Review. *JAMA*. 2019;321:288–300.

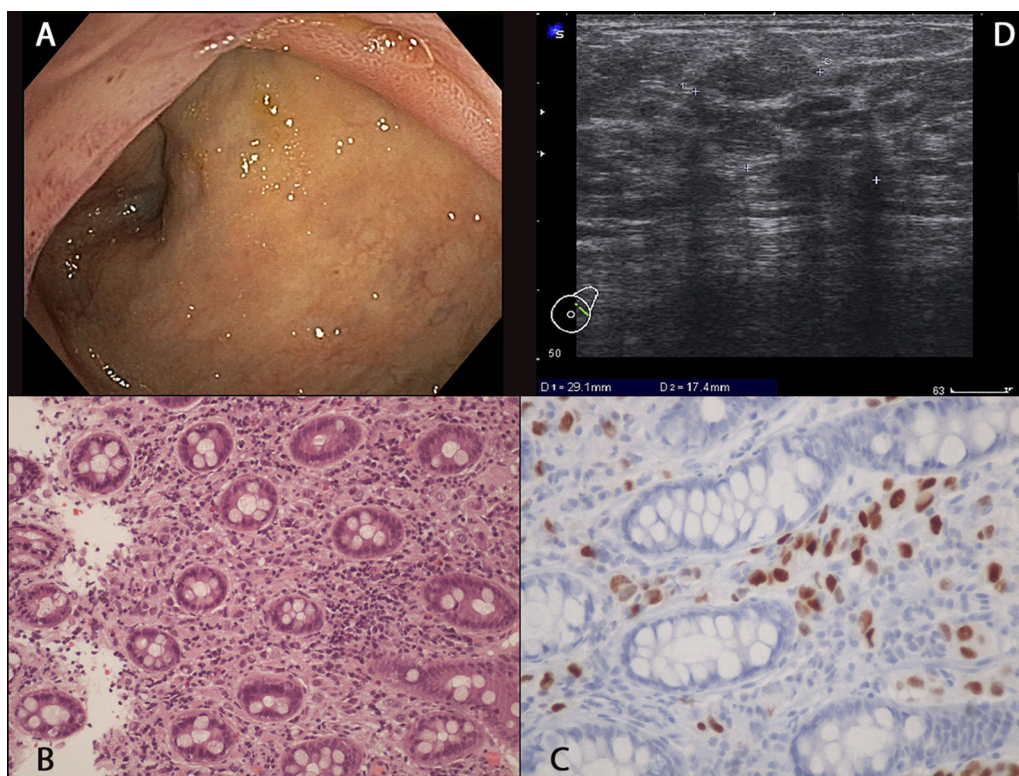


Figure 1 (A) Endoscopic image showing marked erythema of the ileocecal valve and edema and loss of vascular pattern of the cecum mucosa. (B) Histopathology of biopsies from the ileocecal valve showing poorly cohesive tumor cells in lamina propria and signet ring cells, 200 $\times$. (C) Positive immunohistochemistry for estrogen receptor. (D) Breast ultrasound image showing a hypoechoic nodule with posterior acoustic shadowing.

2. Ambroggi M, Stroppa EM, Mordenti P, Biasini C, Zangrandi A, Michieletti E, et al. Metastatic breast cancer to the gastrointestinal tract: report of five cases and review of the literature. *Int J Breast Cancer*. 2012; 2012:439023.
3. Xiao W, Zheng S, Yang A, Zhang X, Zou Y, Tang H, et al. Breast cancer subtypes and the risk of distant metastasis at initial diagnosis: a population-based study. *Cancer Manag Res*. 2018;10: 5329–38.

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