

Metastatic Breast Cancer to the Uterine Cervix Mimicking Cervical Cancer

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Abstract

Metastasis to uterine cervix is a complication of breast cancer that is not commonly known. Detection of cervical metastasis before the diagnosis is even rarer. The present report describes a case of a 50 years old woman who had a large cervical growth mimicking a primary of cervix. However, simultaneously she also presented with bilateral breast lumps of one and half years duration. Histopathological examination of the cervical tumour showed patterns characteristics of invasive lobular carcinoma of the breast which was already diagnosed as the primary in the breast. She underwent chemotherapy and achieved good response.

Keywords: Breast cancer; Cervix; Lobular carcinoma; Metastasis.

Introduction

Metastasis to the female genital tract from extragenital primary cancers is uncommon. When they occur, the ovaries are most often affected, and the uterus, especially the uterine cervix, is rarely involved by metastatic tumours.¹ Invasive lobular carcinoma (ILC) spreads to gynaecologic organs more frequently than invasive ductal carcinoma.² ILC is more likely to be multi-centric, bilateral and has an increasing incidence in postmenopausal women.³ Although pathologically distinct, ILC appears to have similar clinical outcomes and prognosis as infiltrating ductal carcinoma (IDC) of the breast.⁴

We herein report a rare case of extensive metastasis of primary ILC of breast to multiple gynecological sites.

Case Report

A 50 year old post-menopausal female presented with bilateral breast lumps from one and a

half years and abdominal distension. She also complained of increased frequency of micturition for duration of six months. On clinical examination bilateral breasts were hard, nodular with peau d'orange appearance and fixed to chest wall, along with bilateral axillary lymphadenopathy (Fig. 1). FNAC from the breast lump was performed which was suggestive of low grade lobular carcinoma. On per vaginal examination, both the cervical lips were infiltrated with growth. Fornices were shallow but free, and vaginal walls were smooth. On per rectal examination bilateral parametria was involved just short of lateral pelvic wall. On MRI imaging, both ovaries were bulky with evidence of multiple follicles. Uterus measured 7.7x4.5x5.4cms. Gross ascites was seen, malignant cytology from the fluid however was negative. There was evidence of diffuse thickening of recto-sigmoid colon with maximum wall thickness 6.7mm. There were multiple enlarged superficial inguinal lymph nodes. She underwent exploratory laparotomy. Diffuse carcinomatosis was identified. Biopsies were taken from multiple sites including

fallopian tube and omentum. Ascitic fluid was collected. Cervical and endometrial biopsies were taken. The diagnosis of metastatic ILC was made through gross histopathological examination and immunohistochemistry (IHC) staining. Microscopic examination of the tissues showed carcinoma cells displaying the linear, "Indian-file" arrangement characteristic of ILC of the breast with rare cells of the "signet ring" type (Fig. 2). Further IHC staining showed that 95% of cells taken from all metastatic sites were highly positive for cytokeratin 7 (CK) and gross cystic disease fluid protein (GCDPF 15).



Fig. 1: Patient's bilateral breasts are hard, nodular with peau d'orange appearance and fixed to chest wall, along with bilateral Axillary lymphadenopathy.

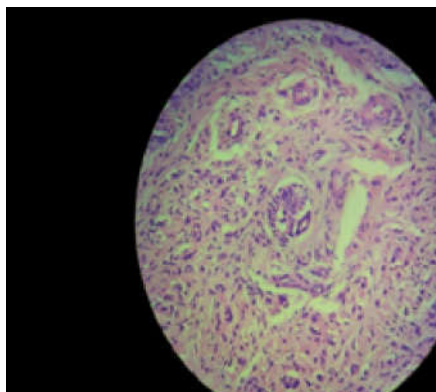


Fig. 2: Microscopic examination of the tissues shows carcinoma cells displaying the linear, "Indian-file" arrangement characteristic of ILC of the breast with rare cells of the "signet ring type".

Further, estrogen (ER) and progesterone receptors (PR) were positive in 80% of tumor cells. These findings were consistent with a diagnosis of ILC of breast with metastases to the omentum, fallopian tube, endometrium and cervix.

Keeping in view the extensive metastasis the patient was given gemcitabine along with paclitaxel regimen for 6 cycles which is the first

line chemotherapy in metastatic breast cancer. All cycles of chemotherapy were given in outpatient setting. Gemcitabine was given in dose of 1.4gm i.v. followed by paclitaxel 260 mg i.v. Cycles were repeated every 21 days. The patient tolerated chemotherapy well with one or two episodes of post chemotherapy neutropenia which was corrected by giving growth factors. It resulted in good response in that the size of lumps of both breasts decreased, ascites was resolved, cervix became soft and bulk of abdominal mass decreased. The patient was planned for subsequent modified radical mastectomy (MRM) which was successful and the patient is now being planned for MRM in the contralateral breast. Till the time of last follow up, the patient was ECOG - 1 with no evidence of progression of the disease.

Discussion

Breast cancer continues to be the most common carcinoma diagnosed in women (30% of all cancers),^{5,6} and is the second leading cause of cancer deaths in women.⁶

ILC is the second most common histology of invasive breast cancers diagnosed (15%),³ and has a rising incidence in postmenopausal women,⁸ which may be related to hormone replacement therapy.⁹ It is more likely to be multicentric and bilateral.^{3,8,10,11} Due to standardized screening protocols and improved imaging technology, most of the tumours are detected early and only 10% of breast cancers present as metastatic disease.^{12,13} But at the same time mammographic findings are often nonspecific,^{4,14} leading to a known propensity for ILC to present at a later stage, with synchronous bilateral or metastatic disease.¹⁵

Incomparing the metastatic patterns of ILC versus IDC, Borst et al. found that ILC was significantly more likely to spread to the GI tract, gynecologic organs, peritoneal surface, and retroperitoneum¹⁶ but metastasis to cervix is extremely rare.¹⁷ The reason for its rarity are that the cervix is a small target organ with a small blood supply and only an afferent lymph drainage system.¹⁸ The fibromuscular tissue of the cervix is a poor culture medium. Most of the extragenital metastasis to cervix arises from primary tumours of the gastrointestinal tract, lung, pancreas, melanoma, urethra. Only 4.5% of cervical secondaries arise from breast primaries.

Mazur et al. reported that, among 149 metastatic tumours to the female genital tract from extragenital primaries, the ovary and vagina were the most

frequent locations of metastases (75.8% and 13.4%, respectively), and only 8.1% were to the uterus (4.7% to the endometrium, 3.4% to the cervix).¹ Breast was the second most common primary site next to gastrointestinal tumours. Limoine and Hall found 33 cases of distant metastasis to the cervix, four of which (12.1%) were from a breast primary.¹⁹ In our case we noted metastasis to the fallopian tube, endometrium and cervix, but not to the ovary and vagina.

Although pathologically distinct from infiltrating ductal carcinoma in terms of local and distant spread,^{20,21} ILC appears to have similar clinical outcomes and prognosis as infiltrating ductal carcinoma (IDC) of the breast.²² This has led to the suggestion that ILC be treated in the same multimodality fashion as IDC.²³

It is important to consider metastatic ILC in the diagnostic evaluation of peritoneal surface malignancies (PSM). Although metastasis from an ovarian or intestinal primary²⁴ or primary peritoneal tumours²⁵ are high on the differential for PSM, our review of the literature demonstrates that a high index of suspicion for metastatic ILC must be maintained in this situation. Peritoneal involvement from metastatic breast cancer carries a poor prognosis, with a median survival (MS) in a series of 44 patients reported by Tuthill et al. of 1.5 months as compared to a 20.5 months MS for patients with metastatic breast cancer at other sites.²⁶

Due to the rarity of this disease entity, there is no standardized approach to management of PSM arising from a primary breast cancer, although current approaches to gynaecologic²⁷ and intestinal^{28,29} PSM suggest that complete cytoreduction and heated intraperitoneal chemotherapy may provide a survival advantage.

While there are no studies evaluating aggressive surgical management of PSM or evaluating strategies for gynaecologic, GI tract and peritoneal evaluation to be implemented for patients with ILC, this case report raises an interesting prospective area of study. First line chemotherapy with Gemcitabine and paclitaxel has proved to be beneficial in this particular case with significant response. Due to the unique characteristics of ILC, we propose a closer follow up.

Conclusion

ILC of the breast is a distinct pathologic entity as compared to IDC. ILC harbours increased potential for late local recurrence and metastatic disease to omentum and gastrointestinal tract and gynaecological organs especially ovaries and metastasis to cervix is rare.^{30,31}

To illustrate these situations, we presented a typical case of ILC metastatic spread to the fallopian tubes, endometrium, cervix and peritoneal surface.

We propose that in patients with a known history of ILC, a high index of suspicion for metastatic disease needs to be entertained. In addition, metastatic ILC should remain high on the differential in female patients presenting with gynaecologic malignancies of unknown origin.

Physicians need to be cognizant of this metastatic masquerade and we advocate closer follow up and specifically more intense gynaecologic follow up for patients diagnosed with ILC and intensive treatment with chemotherapy.

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