Unusual Presentation of Gastric Metastasis in the Setting of Breast Carcinoma
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INTRODUCTION
• Breast carcinoma is the most common malignancy in women. A rare complication of
  the disease course is gastric metastasis with the rate of breast cancer metastasis to the
  GI tract being 0.3%1
• Individuals with invasive lobular breast carcinoma are at an increased rate of
  experiencing metastasis to the GI tract, here we present a case of an unusual
  presentation of gastric metastasis in the setting of breast carcinoma

CASE PRESENTATION
• 56-year-old female with a history of acid reflux requiring multiple previous
  esophageal dilations and invasive lobular breast carcinoma diagnosed 15 years
  prior treated with chemotherapy, bilateral mastectomy and chemoradiation
• She presented with worsening back pain in 2020 after being in remission for 10
  years with Arimidex therapy completed in 2018
• Sacral biopsy demonstrated ER positive, PR negative, HER2 negative breast
  carcinoma and was started on chemotherapy and palliative radiation
• Within 1.5 years of her treatment course, she began experiencing dysphagia and
  odynophagia to both solids and liquids with epigastric pain during meals
• Computerized tomography of the abdomen/pelvis was unremarkable for any
  significant GI pathology
• Outpatient EGD demonstrated a normal esophagus, normal duodenal bulb and
  second portion of the duodenum along with non bleeding gastric ulcers with no
  stigmata of bleeding in the fundus of the stomach (Figure 1 and 2)
• Biopsies of these gastric ulcers were consistent with metastatic breast carcinoma
  via immunostaining (CK7 and GATA 3) and she was initiated on Sacituzumab and
  Gavitencan

DISCUSSION
• The rate of gastric metastasis in lobular breast carcinoma is higher than in ductal
  carcinoma (4.5% vs 0.2%)2
• Gastric metastasis usually presents anywhere from 4-10 years from the initial
  diagnosis of the primary breast carcinoma1

Figure 1: Gastric metastatic lesion secondary to breast carcinoma in the fundus of stomach (yellow arrow).

Figure 2: Multiple gastric metastatic lesions secondary to breast carcinoma in the fundus of stomach

• Patients suffering from gastric metastasis from breast carcinoma often present with non-specific upper GI symptoms: epigastric discomfort, pain, dyspepsia, loss of appetite, nausea/vomiting, delayed gastric emptying1,3
• Taal et al. demonstrated amongst 51 patients with gastric metastasis from
  breast carcinoma, anorexia, epigastric pain and vomiting were the
  predominant clinical presentation3
• Esophagogastroduodenoscopy (EGD) evaluation along with
  histopathological examination and immunohistochemistry are important in the
  diagnosis of gastric metastasis
• EGD findings with patients with gastric metastasis from invasive lobular
  breast carcinoma include localized lesions, diffuse infiltration and external
  compression at the cardia or pylorus4
• Treatment often includes chemotherapy/hormonal agents targeting the
  lesions vs surgery when GI obstruction is a result4

CONCLUSIONS
• This is the first reported case where gastric metastasis from invasive lobular cancer was
  found fifteen years after the diagnosis of the primary breast cancer
• This is the first case in the literature where the predominant clinical symptoms included
  odynophagia and dysphagia to both solid and liquid foods and epigastric pain (instead of
  vague upper GI symptoms)
• Our case reiterates the importance of considering gastric metastasis in patients with
  a history of breast carcinoma (regardless of onset) and who present with upper GI
  symptoms

REFERENCES
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3. Taal BG, Peterse H, Bost J. Clinical presentation, endoscopic features, and treatment of gastric metastases from breast