Revista Española de Enfermedades Digestivas
The Spanish Journal of Gastroenterology

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DOI: 10.17235/reed.2025.11378/2025
Link: PubMed (Epub ahead of print)

Please cite this article as:
Puente-Monserrat Julieta, Pérez-Santiago Leticia, Terrádez-Mas Liria, Pla-Martí Vicente, Casado-Rodrigo David, Martín-Arévalo José, Moro-Valdezate David, García-Botello Stephanie Anne. When breast cancer spreads below the belt — A case of rectal metastasis from invasive lobular carcinoma. Rev Esp Enferm Dig 2025. doi: 10.17235/reed.2025.11378/2025.

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11378 carta inglés

When breast cancer spreads below the belt — A case of rectal metastasis from invasive lobular carcinoma

Julieta Puente-Monserrat[1], Leticia Pérez-Santiago[1], Liria Terrádez-Mas[2], Vicente Pla-Martí[1,3], David Casado-Rodrigo[1], José Martín-Arévalo[1,3], David Moro-Valdezate[1,3], Stephanie García-Botello[1,2]

[1]Colorectal Surgery Unit. Department of General and Digestive Surgery. Hospital Clínico Universitario. INCLIVA Biomedical Research Institute. Valencia, Spain. [2]Department of Pathology. Hospital Clínico Universitario. Valencia, Spain. [3]Department of Surgery. Universidad de Valencia. Valencia, Spain

Corresponding author:
Leticia Pérez Santiago
Email: letperezsantiago@gmail.com

Keywords: Breast cancer. Gastrointestinal metastasis. Lobular carcinoma. Rectal metastasis.

Authors´ contribution: Resources: L. T.; writing-original draft: J. P., and L. P.; writing-review and editing: V. P., D. C., J. M., D. M., and S. A. G.

Conflict of interest: The authors declare no conflict of interest.

Artificial intelligence: The authors declare that they did not use artificial intelligence (AI) or any AI-assisted technologies in the elaboration of the article.

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Dear Editor,

We present the case of a 62-year-old female diagnosed in 2014 with invasive luminal A lobular carcinoma (ILC) of the breast (T3N0M0). She underwent a modified radical mastectomy, followed by radiotherapy and five years of endocrine therapy with letrozole. In 2021, therapy was discontinued due to musculoskeletal side effects. Seven years after diagnosis, the patient developed symptoms of partial bowel obstruction, along with a progressive rise in CA15.3 levels during oncological follow-up. Multiple diagnostic evaluations—including colonoscopies, enteric MRI, and PET scan—yielded normal results, initially suggesting inflammatory bowel disease.

In 2025, due to persistent symptoms, an abdominopelvic computed tomography (CT) was performed, which revealed concentric thickening of the rectal wall (Fig. 1A). Given the continued tumor marker elevation and imaging findings, a rigid rectoscopy was carried out, revealing a 4-centimeter circumferential stenosis and biopsies were obtained. Histopathological analysis confirmed metastatic breast carcinoma, with infiltration of the lamina propria (Fig. 1B) by cells expressing GATA3 (Fig. 1C) and TRPS1 (Fig. 1D)—breast-specific transcription factors—and loss of E-cadherin expression (Fig. 1E), consistent with ILC. Following histological confirmation of rectal metastasis, the patient initiated systemic chemotherapy with capecitabine.

Discussion

ILC is known for its potential to metastasize late and to uncommon sites, including the gastrointestinal tract. Benabdallah et al. reported a similar case of a patient presenting with chronic diarrhea 11 years after an ILC diagnosis, ultimately identified as having colonic metastases on biopsy (1). Posado-Domínguez et al. described a patient with a history of lobular breast carcinoma who presented with late gastric metastasis 12 years after the initial diagnosis (5). In our case, the patient developed symptoms of partial bowel obstruction seven years post-diagnosis, and histological examination confirmed metastatic recurrence. While some GI metastases may remain asymptomatic (4), symptomatic presentations typically include obstruction, perforation, or gastrointestinal bleeding (3-5).

Gastrointestinal metastases from ILC, although rare, carry important diagnostic implications due to their diffuse growth pattern and tendency to mimic benign or primary gastrointestinal diseases. Recognition of this metastatic pattern is essential for timely diagnosis and management (1,3).

Conclusion

In patients with a history of breast cancer presenting with gastrointestinal symptoms, late metastatic disease should always be considered as part of the differential diagnosis.

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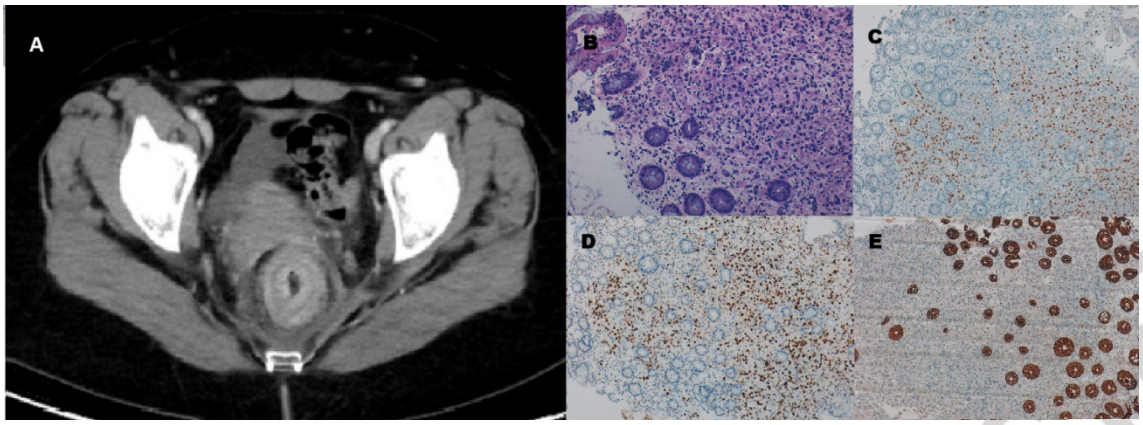

Fig. 1. A. Abdominopelvic CT scan showing concentric thickening of the rectal wall. B. Hematoxylin and eosin stain: rectal mucosa on the left with preserved crypt architecture. On the right, the lamina propria is infiltrated by cells arranged in a dispersed and infiltrative pattern. C-D. GATA3 and TRPS1: nuclear positivity for these markers, with absence of expression in colonic epithelium. E. E-cadherin: normal colonic crypts show strong positive staining (dark brown), while tumor cells completely lack expression.