

Nodular Metastatic Carcinoma from Invasive Lobular Breast Cancer

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Among breast cancers, the incidence of invasive lobular carcinoma is rather low, varying in the literature 0.7% to 20% and there have been no reports concerning the frequency of cutaneous metastases from invasive lobular carcinoma.

Herein, we describe an interesting case of nodular metastatic lesions from invasive lobular carcinoma. (*Ann Dermatol* 13(3) 187~189, 2001).

Key Words : Breast cancer, Invasive lobular carcinoma, Cutaneous metastasis

Among breast cancers, seventy to eighty percent of all breast carcinoma are infiltrating ductal carcinoma. The incidence of invasive lobular carcinoma is rather low, varying in the literature 0.7% to 20%¹ and there have been no reports concerning the frequency of cutaneous metastases from invasive lobular carcinoma.

Cutaneous metastasis of breast carcinoma cause a number of different clinical features; inflammatory carcinoma, carcinoma *en cuirasse*, telangiectatic carcinoma and nodular carcinoma^{2,3}. Nodular carcinoma is the most common clinical type of the cutaneous metastases from the internal malignant neoplasm, but rare from the breast cancer.

Herein, we describe an interesting case of nodular metastatic lesions from invasive lobular carcinoma of the breast.

CASE REPORT

A 54-year-old female noted multiple, asympto-

matic firm nodules on her left chest of 1 month duration. She had undergone a right modified radical mastectomy for breast cancer 3 years prior to this visit. Histologic examination of the primary lesions revealed invasive lobular carcinoma. She had been in palliative radio - and chemotherapy. When she visited our clinic, multiple pea sized, skin or reddish-colored, firm nodules were disseminated over her left chest, opposite side of the primary breast cancer(Fig. 1).

Biopsy was performed under a diagnosis of metastatic carcinoma from breast cancer. The histologic study showed similarity to the primary lesions, a dense infiltration of dissociated tumor cells beneath partially atrophic epidermis intermingled with the connective tissue and extending into the fat tissue(Fig. 2).

DISCUSSION

Carcinoma of the breast includes a number of histological subtypes of which the two most common are infiltrating duct carcinoma and infiltrating lobular carcinoma¹. Seventy to eighty percent of all breast carcinomas are infiltrating ductal carcinomas¹. The incidence of invasive lobular carcinoma is rather low, varying in the literature 0.7 to 20 %¹.

Cutaneous metastases of breast carcinoma cause a number of different clinical and histopathological features; inflammatory carcinoma, carcinoma *en*

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Fig. 1. Multiple firm nodules disseminated over the left chest.

cuirasse, telangiectatic carcinoma and nodular carcinoma^{2,3}.

Inflammatory skin metastases, sometimes mimicking cellulitis are the most frequent type caused by breast cancer, and histologically show superficial lymphatic vessels that are dilated and plugged with metastatic cells^{4,5,6}. Carcinoma en cuirasse or scirrhous carcinoma presents with diffuse morphea-like induration of the skin. Histologically tumor cells lie singly, but in some areas form small groups or single rows between fibrotic and thickened collagen bundles^{2,3,7}. Telangiectatic carcinoma is characterized by violaceous papulovesicles resembling lymphangioma circumscriptum^{2,3,8}. Nodular carcinoma appears as asymptomatic multiple nodules and histologically shows a variably-sized groups of tumor cells in the dermis and these nodular area are surrounded by fibrosis^{2,3}. Nodular carcinoma is the most common clinical type of the cutaneous metastases from the internal neoplasm, but rare from the breast cancer.

Lymphatic dissemination of breast carcinoma can lead to inflammatory carcinoma, telangiectatic carcinoma, nodular carcinoma, and carcinoma en cuirasse¹.

In addition to cutaneous tumor nodules, hematogenous dissemination may produce characteristic clinical presentation^{1,9}. Alopecia necro-plastica occurs as oval plaques or patches of the scalp and may be confused clinically with alopecia areata or a scarring alopecia¹⁰. Metastatic mammary carcinoma involving the eyelid has been described in 13 patients¹¹. Several types may occur in the same pa-

Fig. 2. The metastatic lesion. Numerous tumor cells intermingle with the connective tissue(H&E, $\times 200$).

tient¹.

The histology of the metastatic lesions of our case, at a glance, looked like the common scirrhous type, however clinically showed not a diffuse morphea-like induration, but asymptomatic multiple firm nodules. Careful observation of the histology showed their peculiarities, which were exactly those noted in the primary lesions, particularly with regard to the characteristic arrangement of tumor cells and their cellular cytology. The finding that capillary invasions of tumor cells were not observed seems to suggest lymphatic metastases in our case.

Harumi et al¹². have reported two cases of cutaneous metastases of invasive lobular carcinoma of the breast, and our case showed very similar clinical and histopathological features to the reported cases by them.

We report herein an interesting case of nodular metastatic lesions from invasive lobular carcinoma.

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