

Occult Pleomorphic Invasive Lobular Carcinoma with Extensive Lymph Node Metastases

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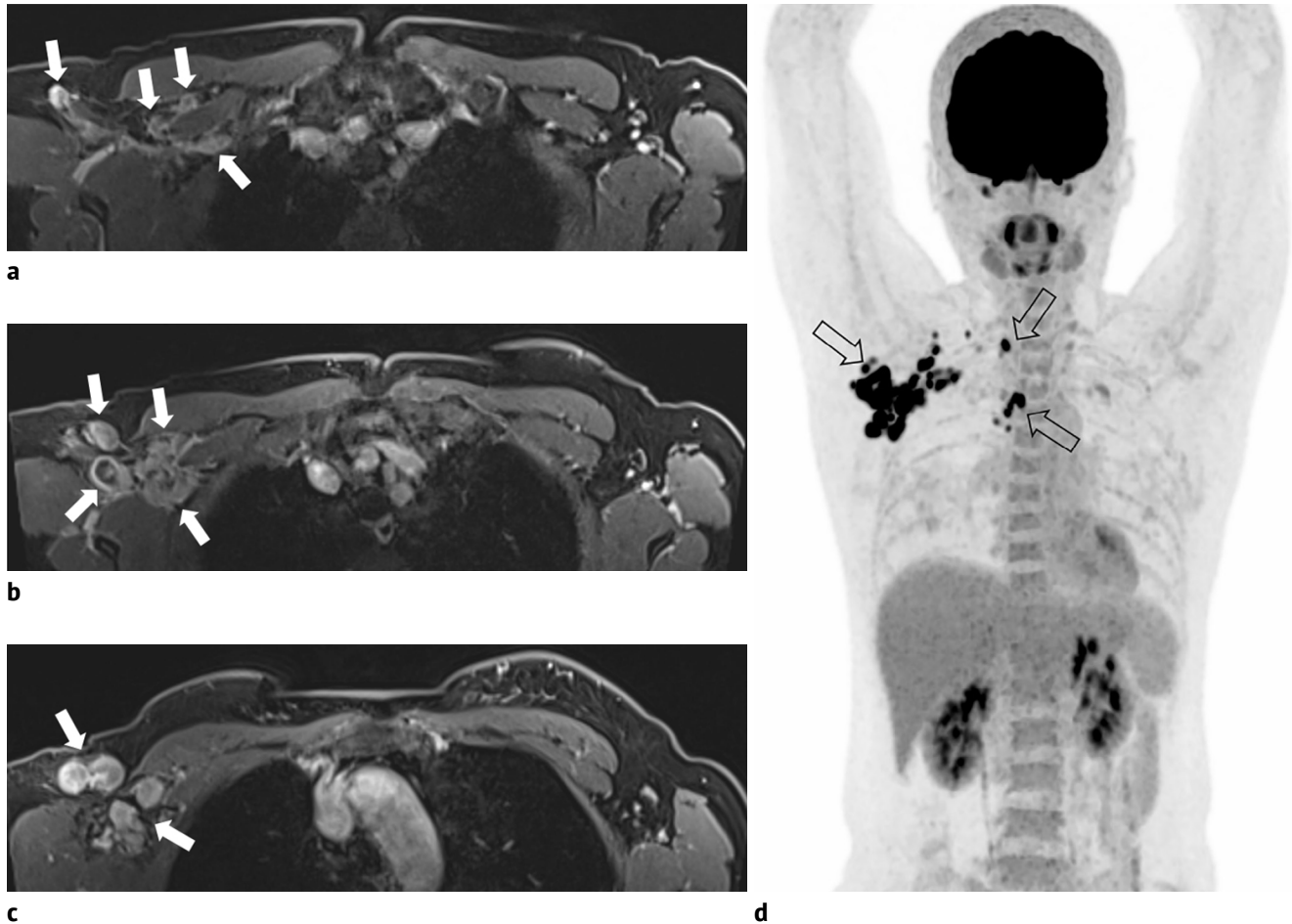


Fig. 1. A 48-year-old woman presenting with a palpable mass in the right axilla. **a-c.** Breast MRI reveals multiple enlarged lymph nodes with marked cortical thickening at right axilla level I, II, and interpectoral region (arrows). **d.** PET-CT demonstrates multiple FDG uptake at right axilla level I, II, and interpectoral region, right supraclavicular fossa, right side of mediastinum, and right internal mammary chain (arrows). There is no significant FDG uptake in both breasts.

A 48-year-old woman presented with an incidentally discovered right axillary mass one month ago. Ultrasound revealed multiple enlarged

lymph nodes in the right axilla, leading to an ultrasound-guided core needle biopsy. The biopsy confirmed poorly differentiated metastatic

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carcinoma with discohesive feature. Subsequent immunohistochemical staining indicated ER/PR negative, HER2 negative, Ki-67 80%, focally positive for GATA3 and E-cadherin loss. The final diagnosis was pleomorphic invasive lobular carcinoma (ILC) of breast origin.

Breast MRI revealed multiple enlarged lymph nodes with marked cortical thickening in right axilla level I, II, and interpectoral region (Fig. 1a-c). PET-CT demonstrated multiple FDG uptake in the right supraclavicular fossa, right side of mediastinum, and right internal mammary chain, in addition to the right axillary region (Fig. 1d). As there were no suspicious lesions in both breasts, we diagnosed occult breast cancer, and the patient is currently undergoing systemic chemotherapy.

Occult breast cancer is defined as the clinical presentation of metastatic carcinoma mostly to the axillary lymph node, originating from a malignant primary breast cancer undetectable by clinical examination and radiological findings. Immunohistochemical markers play a crucial role in differentiating metastatic breast cancer from other cancers (1).

ILC is the second most common histology

type of invasive breast cancer, accounting for 5-15% of cases. E-cadherin, which is involved in cell adhesion, is usually lost, resulting in the proliferation of discohesive cells. Various histologic variants of ILC exist, encompassing classic, solid, alveolar, mixed, tubulo-lobular, and pleomorphic subtypes. The pleomorphic subtype, representing 10% of ILC, commonly manifests with aggressive characteristics, including a larger size, higher-grade cytologic features such as ER/PR negative, triple positive, or HER2+, and a propensity for metastasis to the axillary lymph nodes. Consequently, this subtype is considered to be at higher risk for recurrence or metastasis (2).

References

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