INTRODUCTION: Breast cancer is the most common malignancy in women all over the world. Distant metastasis is by far the most common cause of death. It is common for breast cancers to metastasize to bone, liver and lung. Metastasis to the GI tract especially colon is very rare and can mimic primary colon cancer vs colitis with variable colonoscopy findings.

CASE DESCRIPTION/METHODS: A 72 years old female was diagnosed with estrogen receptor-positive, well-differentiated, invasive mammary cancer in 2013. She underwent a localized lumpectomy with sentinel lymph node dissection. Her disease was stage IIA(pT1c pN0(+) pMX). She received adjuvant radiation, tamoxifen and an aromatase inhibitor. Five years later, she was diagnosed with widespread metastatic disease to the axial and appendicular skeleton. She got palliative radiation and 10 cycles of Fulvestrant chemotherapy. A restaging CT scan 6 months later showed colonic wall thickening at the hepatic flexure. A colonoscopy showed normal colon with a subtle decrease in the mucosal vascular pattern at the hepatic flexure, biopsies were taken and pathology revealed expansion of the lamina propria by metastatic adenocarcinoma. The specimen was reviewed alongside the previous biopsy of the T9 vertebral lesion and showed similar histologic features, compatible with metastases from the patient’s known breast cancer. In addition, CK7 was positive and CK20 was negative. In the subsequent 8 months, she received 8 cycles of chemotherapy but developed worsening abdominal pain, inability to tolerate diet and an interval CT scan showed progression of colonic wall thickening in ascending colon and proximal transverse colon. Shortly after, she passed away from her widespread metastatic disease.

DISCUSSION: The incidence of breast cancer metastasizing to GI tract is 3-4.5%, according to one study, 92% of it involves stomach. Metastasis from primary breast cancer to the colon is extremely rare. Usually liver, bone and lungs are the most common sites of metastasis. Presentation is variable and symptoms include abdominal pain, weight loss, bowel obstruction, anemia and GI bleed. Certain markers such as CK7 can be used to differentiate between primary GI cancers and metastasis from breast cancer. Diagnosis can be challenging as these colon lesions can mimic other diseases such as IBD, radiation colitis and primary GI cancers. Colonoscopy findings can be variable and as in this case, even minimal changes in background of known malignancy warrants a biopsy for early diagnosis.

The Three Headed Monster: Bowen’s Disease
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INTRODUCTION: Squamous Cell Carcinoma in Situ (SCC IS), also known as Bowen’s Disease, is an early form of SCC involving the epidermis without invasion to deeper layers. The perianal region and anorectal area are the least common locations of disease. This is a case of a patient with vulvar, perianal, and anorectal Bowen’s Disease.

CASE DESCRIPTION/METHODS: A 56-year-old female with (w/) past medical history (hx) of AML s/p chemotherapy and allogeneic stem cell transplant on immunosuppression and C. Diff Colitis s/p total colectomy and ileostomy presented w/ 1-year hx of rectal and vaginal bleeding. Hgb 11.5. HIV antigen and antibody neg. On gynecological exam, there was a right vulvar lesion. Wide local excision was completed and pathology revealed SCC IS. Anoscopy demonstrated nodularity 2 cm from the anal verge. Biopsies from the anal verge and anal canal demonstrated SCC IS. CT chest, abdomen, and pelvis (CAP) and MRI pelvis showed no evidence of metastasis or fistula. She was treated with perineal resection and proctectomy. Proctectomy path revealed anorectal SCC IS without further rectum involvement. P16 immunostaining was positive suggesting HPV associated neoplasia.

DISCUSSION: Anal Bowen’s disease is associated w/ human papillomavirus (HPV) types 16 and 18. Additional risk factors include hx of receptive anal intercourse, HIV, hx of other anogenital cancers and an immunosuppressed state. Diagnosis is made via anoscopy or lower endoscopy with full thickness bx specimens. Histologically it demonstrates epithelial hyperkeratosis, atypical epithelial cells w/ mitotic figures and full-thickness epidermal involvement. If there is worry the lesions are invasive, local staging w/ pelvic MRI and systemic staging with CT CAP and PET can be completed. If there is rectal involvement, rectal endoscopic ultrasound can be used to determine the depth of invasion and local nodal involvement. The gold standard treatment is surgical excision. To our knowledge, there are few cases of a patient having vulvar, perianal, and anorectal Bowen’s disease. Sahai A, Kodner IJ. Premalignant neoplasms and squamous cell carcinoma of the anal margin. May 2006. 88-93. Troicki F, Pappas A, Noone R, et al. Radiation therapy of recurrent anal squamous cell carcinoma in-situ: a case report. 24 Feb 2010. 67.

Primary Follicular Lymphoma of the Colon: A Rare Case in a Rare Place
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INTRODUCTION: Primary lymphomas of the colon are rare, accounting for < 1% of all GI malignances. Studies describing the disease suggest that it most commonly involves the cecum and presents symptomatically in patients with abdominal pain and weight loss. However, given the rarity of the cancer, literature on the clinical and pathologic features of the disease are still evolving. Here,