



Figure 2 Survival after development of distant metastases.

tastases was significantly longer ($P = 0.021$) in patients with lobular carcinoma compared to ductal types (Figure 2).

Discussion

Although many reports (Viandana *et al.*, 1973; Cifuentes & Pickren, 1979; Amer (1982)) have addressed themselves to the metastatic pattern of carcinoma of the breast, few have considered potential differences between the histological subtypes. The clinical and post-mortem study of (Harris *et al.*, 1984) showed that there was significant differences between the metastatic sites of invasive lobular and ductal carcinomas.

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omas. Lobular carcinoma demonstrated a tendency to produce clinically apparent diffuse meningeal involvement and both peritoneal and retroperitoneal spread. The peritoneal and retroperitoneal findings were said to be distinctive with tiny nodules, tending to become confluent in lobular cases comparing with large masses or nodules in ductal metastases; lobular metastases rarely produced clinical manifestations. Pulmonary parenchymal metastases were more frequently detected in ductal types.

We confirm that lobular carcinoma has a different clinical pattern of metastatic spread than that seen in ductal tumours; clinically detectable peritoneal and hepatic metastases are more frequent in lobular carcinoma. Unlike previous studies (Harris *et al.*, 1984) we were unable to demonstrate a significant difference in pulmonary and meningeal metastases. There was no difference in the metastatic free interval for the two pathological types. Survival after metastatic appearance was significantly longer in the group of patients with lobular carcinoma.

Previous suggestions (Ashikari *et al.*, 1973; Wheeler & Enterline, 1976; Nielson *et al.*, 1986) that bilateral cancers are more frequently seen with lobular carcinomas are confirmed. A possible explanation arises from the finding of lobular carcinoma *in situ* (LCIS) in 66% of ipsilateral (Dixon *et al.*, 1982) and 35% of contralateral breasts (Urban, 1967) in patients with invasive lobular carcinoma; LCIS lesions can also progress to invasive carcinoma (Haagensen *et al.*, 1978; Rosen *et al.*, 1978). These findings have important implications for the follow-up of patients with lobular carcinomas.