

Primary Carcinoma of Ectopic Breast Tissue in Axilla

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ABSTRACT

A 30 years old married lady presented with 4 x 5 cm, firm, non-tender, mobile swelling on anterior wall of left axilla. FNAC revealed carcinoma. The examination of breast including axillary tail, arm, chest and abdomen did not reveal any abnormality. Mammogram and MRI of both breasts did not reveal any lesion in the breast including axillary tail. Local wide excision along with axillary clearance was carried out. Final histopathology revealed invasive ductal carcinoma (Grade II) of axillary breast tissue and one, out of the recovered lymph nodes, was involved by the tumour. The immunohistochemistry also confirmed the findings.

Key words: Ectopic breast. Axillary mass. Ductal carcinoma.

INTRODUCTION

Ectopic breast tissue is an uncommon finding and can occur anywhere along the milk line running from the axilla to the groin, most common site being the axilla.¹ Rarely can they occur on unusual sites like buttock, back of neck, face, flank, upper arm, hip, shoulders, and in the midline of the back and chest.² The incidence of ectopic breast tissue has been reported upto 6% in various ethnic sub-populations.³ Ectopic breast tissue is subject to the same physiological changes that occur in normal breasts, including lactation, if there is a fully matured nipple areolar complex. Benign and malignant tumours such as carcinoma, intraductal papilloma, fibroadenoma, and fibrocystic disease have all been described.⁴ Although tumours of ectopic breast tissue are very rare, carcinoma occurs more frequently than benign tumours.⁵ They may prove to be a diagnostic challenge till they are biopsied.

We report here a case of infiltrating ductal carcinoma arising from ectopic breast tissue in axilla and presented as mass. It remained a diagnostic challenge till the patient was operated.

CASE REPORT

A 30 years old lady noticed a small lump in her left axilla 1 year back. The swelling gradually increased in size without any associated problems. Two months before admission, the swelling rapidly increased in size associated with mild discomfort. She consulted a local doctor who gave her broad spectrum antibiotics initially and later on antituberculosis treatment was given which she took for 2 months without any response. There was

no history of cough, bowel or urinary complaints. The swelling had no relation with the menstrual cycle. She was married with 2 children, both breast fed. There was no history of breast, ovarian or uterine carcinoma in the family. The examination revealed 4 x 5 cm size non-tender swelling on anterior wall of left axilla. It was firm in consistency, mobile on underlying muscles and fixed to skin at one place. There were few palpable lymph nodes in left axilla. The examination of breast, chest, abdomen and left arm did not reveal any abnormality.

She underwent ultrasound examination which revealed axillary lymphadenopathy. She was referred to our department where FNAC was done which revealed metastatic carcinoma. Mammograms, MRI of breast and CT scans of chest and abdomen did not reveal any abnormality. Local wide excision along with axillary clearance was carried out. Final histopathology and immune histochemistry revealed invasive ductal carcinoma (Grade II) and one out of the recovered lymph nodes was involved by the tumour. At present, the patient is undergoing chemotherapy and advised to follow-up regularly (Figure 1).

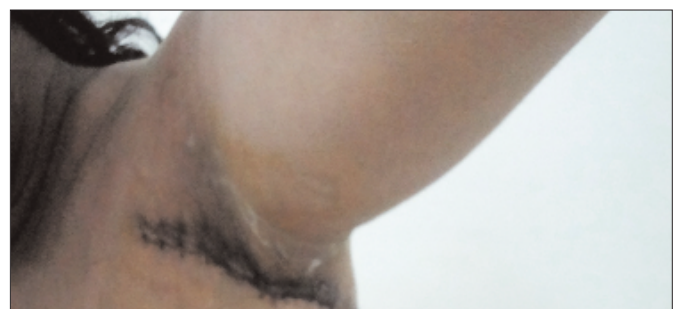


Figure 1: Postoperative photograph

DISCUSSION

The exact incidence of accessory breast tissue is not known but it is more common in females as compared to males. These ectopic breast tissues undergo same

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hormonal changes as the normal breast. Although rare, both benign and malignant tumours have been described. The most common pathology arising from accessory breast tissue in axilla is invasive ductal carcinoma,⁵ as with the normal breasts. The usual presentation is asymptomatic axillary mass. The nipple / areola are often absent and possibility of ectopic breast tissue pathology is not considered. These tumours are usually diagnosed on histological examination.² The role of MRI in identifying the carcinoma arising in axillary breast tissue is well established.^{6,7} In this case, the MRI enabled us to exclude primary carcinoma of anatomical breasts. Some authors have recommended radical mastectomy of the ipsilateral breast if regional lymph nodes are involved by the tumour.⁸ Majority, however, consider that local wide excision and axillary lymphadenectomy is the treatment of choice.⁹ If mastectomy is not performed, regular follow-up is necessary to exclude any later manifestation of occult primary neoplasm in the breast.

The principles of postoperative treatment are the same as for anatomical breast carcinoma.¹⁰ The prognosis of accessory breast carcinoma is difficult to establish due to limited follow-up data and small sample size. Some consider the same prognostic indices as for the anatomical located breast.⁹ Others consider worst prognosis of axillary breast carcinoma because of earlier spread to axillary lymph nodes. It is important to keep in mind this possibility in evaluation of such masses so as to provide earlier diagnosis and rapid definitive treatment.

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