

Right Accessory breast: Case Report

Abid Rashid¹, Sultan Ayaz^{2*}, Muhmmad Akram², Syed Muhammad Ali shah², Asmat Ullah Khan³, Abdul Hamid³, Itikhar Ahmad Khan³

Abstract: Accessory breast tissue is a rare disorder that occurs in 0.4–6% of females commonly found in the axilla where it can result in diagnostic difficulty, specifically when it occurs unilaterally and holding large size. Usually it occurs bilaterally and display as a mass without any symptoms during lactation or pregnancy. The evaluation of accessory breast tissue is significant as it may go through the same pathological processes that take place in tissues of normal breast, like carcinoma, mastitis and fibrocystic disease. We present a case of a right-sided large accessory breast in a 21-year-old female that was diagnosed clinically as pedunculated lipoma. Subsequent histopathological examination confirmed it as an accessory breast tissue with lactational changes.

Keywords: Accessory breast, lymphadenitis, lipoma fine needle aspiration, cytology (FNAC), mastectomy

1 Directorate of Medical Sciences, Government College University Faisalabad

2 Department of Eastern Medicine, Directorate of Medical Sciences, Government College University Faisalabad

3 Department of Eastern Medicine and Surgery, Faculty of Health and Medical Sciences, University of Poonch, Rawalakot Hajira Road Shamshad Abad, Rawalakot 12350, Azad Jammu and Kashmir, Pakistan

Corresponding author email: ayaz_libra@hotmail.com

INTRODUCTION

Accessory breast tissue is an uncommon entity mostly located in the axilla. It undergoes all the cyclical changes and can develop any kind of the complications of the normal breast. Sometimes it poses a diagnostic challenge, especially when it is unilateral and large (1).

CASE REPORT

A 21 year old female patient presented with a large pendulous mass of one years' duration in her right axilla. Initially it was a small swelling of 2×2 cm. It gradually grew larger in size. It was occasionally painful and restricted arm movement. The Physical evaluation showed a 15×12×11 cm pedunculated tissue growth in the right axilla which was mobile, non-tender and soft in consistency. Skin over the swelling was hyperpigmented and free from underlying structures. There was no nipple or areola over the mass. The bilateral breasts were normal without any palpable axillary lymphadenopathy (Fig. 1).

A clinical diagnosis of the pedunculated lipoma was made and the patient was scheduled for

excisional biopsy. All routine investigations were within normal limits. No radiological investigations were carried out. Fine-needle aspiration cytology (FNAC) was carried out and revealed a greasy material on aspiration. Smears were paucicellular, consisting of only a few scattered adipocytes. A differential diagnosis of accessory axillary breast or pedunculated lipoma was made. An excisional biopsy was performed under general anesthesia and the tissue was sent for histopathology.

Grossly on sectioning, a milky white fluid oozed out. Microscopic examination showed mostly mature adipose tissue interspersed with breast tissue having lobular architecture. Numerous ducts and acini were seen lined by ductular epithelial cells showing secretory activity. Sheets of foamy cells and a large area filled with pale eosinophilic secretion were also seen. Thus, histopathological features were consistent with the accessory breast tissue showing lactational changes. The right accessory mastectomy was carried out under anesthesia.

The postoperative period remained uneventful and the patient was discharged from the hospital on the second day after surgery. The stitches

were removed on the tenth day after surgery in the outpatient department of the hospital. The patient is doing fine with no recurrence or complications (Fig 2, 3, 4).

DISCUSSION

Ectopic breast tissue happens due to failure of resolution of the embryonic mammary ridge (milk line), which is an ectodermal thickening from axilla to groin bilaterally (2). It is the term used for both supernumerary and aberrant breast tissue, which are two distinct entities. Supernumerary breasts have nipples, areolae or both with varied composition of glandular tissue (1). They mostly present along the mammary ridge but may also occur on the cheek, neck, shoulder, thigh or buttock. Pathological findings in a supernumerary breast usually comprise of a highly developed ductal system connected with the overlying skin tissues, and usually respond to all the physiological responses of the reproductive cycle (3).

An accessory breast tissue is a diverticular form of the breast tissues during the fetal stage which later on loses all communications with the ipsilateral breast. Unlike supernumerary breasts, it has no significantly developed secretory ducts system and does not communicate with the overlying skin (4). The usual site for the occurrence of accessory breast tissue is the right or left axilla while other uncommon sites are infraclavicular, subscapular, epigastric and vulva (5). Aberrant breast tissue becomes symptomatic during lactation, pregnancy and at the time of menarche and fully responds to fluctuating hormonal levels during these physiological activities in

female body (6). Our case fits in the category of accessory or aberrant breast tissue as it was without any nipple areola complex and its size increased during lactation.

Mass-like density, the same as that of the normal breast parenchyma, is seen both on ultrasound and mammography. FNAC is a useful tool to distinguish it from other masses like lipoma or lymph nodes (7). In the present case FNAC was inconclusive. The patient was planned for excisional biopsy for cosmetic reasons. The management of ectopic breast is mainly surgical, though small size asymptomatic ectopic breasts may be managed conservatively. Excision is recommended in large size tissue for cosmetic reasons and to avoid any future complications (8).

CONCLUSION

Accessory breast occurs very rarely. It leads to developmental functional, cosmetic and physiological changes in affected female breast. Its presence and diagnosis need its differentiation from any malignant development. The conservative treatment of accessory breast does not carry any successful result. The ultimate and effective treatment includes surgical removal of the ectopic breast which carries good prognostic results. The current case after final diagnosis of right accessory breast tissues was subjected to successful surgical treatment and after the surgery the young patient recovered fastly and no postoperative complications were reported. So it is recommended such kind of cases may be referred confidently for the surgical treatment.

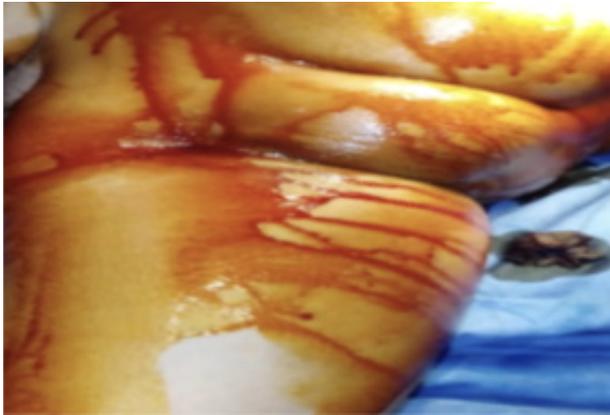


Fig. 1



Fig. 2

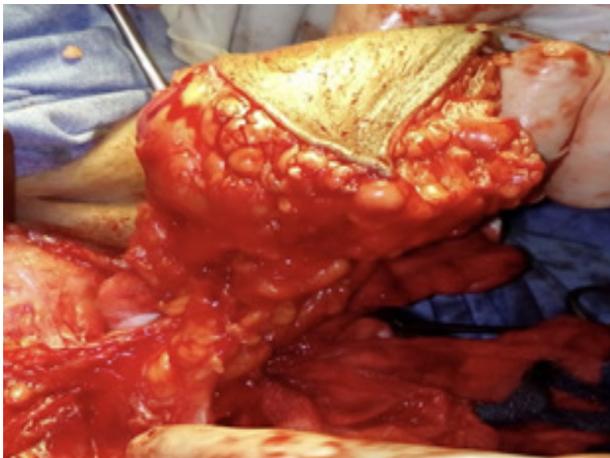


Fig. 3



Fig. 4

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