



Case Report

Male Axillary Carcinoma Breast – A rare Case Report

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ABSTRACT

The reported incidence of Carcinoma Breast in male patients is 1% compared to female population. The peak age of incidence for males is 71 years, while for females it is 52 years in documented literature. Carcinoma occurring only in accessory breast tissue with normal breasts in male patient is even more rare and easily misdiagnosed. As for adenocarcinoma in the axilla is concerned, it is difficult to identify whether the origin is the mammary tissue or the skin appendages, particularly in cases where there is a poor differentiation of cellular architecture. In this study we are reporting a case of 45 year old man who presented with an left axillary ulceroproliferative lesion of 4 months duration. FNAC revealed metastatic adenocarcinoma of unknown origin. Systemic examinations revealed no evidence of malignant or occult primary lesion in the bilateral mammary glands or in other organs. Histopathological examination of resected specimen showed adenocarcinoma of mammary tissue origin with loco-regional lymph node involvement.

KEYWORDS: Male breast cancer, Axillary breast tissue, Diagnosis

INTRODUCTION

Cases of adenocarcinoma in the axilla are uncommon and can be regarded as sebaceous or sweat gland cancer, mammary carcinoma arising in an accessory mammary gland, or metastatic lymph nodes from breast cancer or another primary cancer. Herein, we describe a rare case of a male patient with an axillary breast carcinoma arising in an accessory mammary gland. Due to the atypical location, a correct diagnosis is often reached during the later stages of cancer. The number of previous studies on male axillary ectopic breast cancer is extremely low and we have found only few relevant case reports. Written informed consent was obtained from the patient.

CASE REPORT

A 45 years old male patient presented with irregular ulceroproliferative mass in left axilla of 4 months duration. It started as smooth nodular swelling gradually increased in size to 11cms x 8 cms dimension, later ulcerated with blood and pus discharge since 1 month. The patient had occasional cough. He gives the history of occasional

smoking. No mass was palpable inside either breast. No cervical, supraclavicular or contralateral axillary swollen lymph nodes were observed. There was no history of fever, hemoptysis, upper GI or any lower GI symptoms like hematemesis, melena, jaundice, alteration of bowel habits. The patient was not diabetic or hypertensive. No history of surgeries in past.

On examination, all systems were clinically normal. There were multiple, matted, fixed group of firm to hard lymph nodes in left axilla underneath the ulceroproliferative lesion. Haematological Investigations revealed Hb% = 11.9 g/dl; RBC = $4.17 \times 10^{12}/L$; MCV = 93.3fl; MCH = 28.6pg; MCHC = 30.7 g/dl WBC = $6 \times 10^9/L$; NEUTROPHILS = $3.1 \times 10^9/L$; LYMPHOCYTES = $2.4 \times 10^9/L$; PCT = $248 \times 10^9/L$.

FNAC showed metastatic adenocarcinoma of unknown origin. Computed tomography (CT) thorax showed an exposed and lobulated soft tissue density mass in left axilla measuring about 11cms with few mediastinal hilar lymph node enlargement. The results of an upper gastrointestinal endoscopy were normal. Colonoscopy done to search for the possible primary origin of adenocarcinoma was normal.

Surgical excision biopsy of tumour was done with partial dissection of only the mobile axillary underlying lymph nodes. Few of nodes closely adherent to axillary vein and brachial plexus were left behind. HPE report confirmed the diagnosis of adenocarcinoma with nodal involvement probably arising from breast tissue. The patient was subjected to 4 courses of FEC chemotherapy (5-Fu at

500 mg/m², epirubicine at 100 mg/m², and cyclophosphamide at 500 mg/m²) every 3 weeks. There appeared to be significant regression in size of residual pathology after chemotherapy. Prognosis was explained to the patient in detail, in view of late presentation and few fixed axillary nodes detected intraoperatively.

Figure 1: Ulceroproliferative Growth seen in Left Axilla with probable extension to underlying lymph nodes.



Figure 3 :CT Thorax showing left axillary lobulated mass with mediastinal hilar adenopathy.

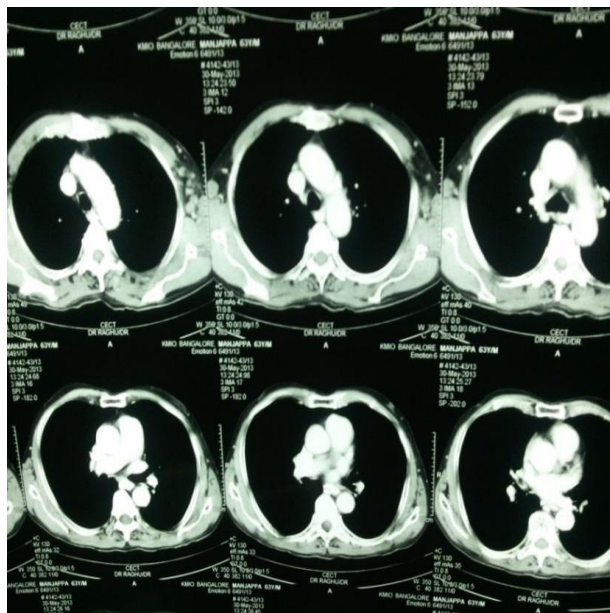
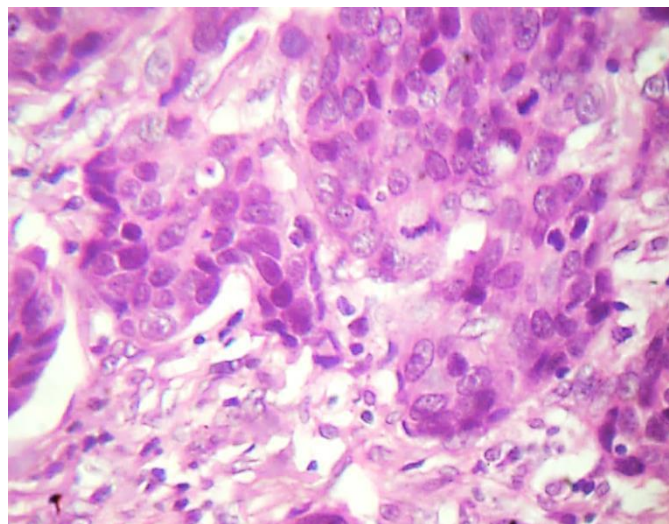


Figure 2: Post operative photograph of the left axilla of same patient.



Figure 4 :HPE X100 showing enlarged cells with irregular nuclei, and mitosis.



DISCUSSION

The occurrence of male axillary breast cancer is extremely uncommon, only few cases of male axillary breast cancer has been reported [1]. Ectopic breast tissue has been identified in a number of regions, including in the vulva [2], anal polyps [3], axilla [4,5] and axillary lymph nodes (6), affecting up to 6% of the general population and occurring more frequently in females and the axillary region [7]. The presentation of male axillary breast cancer may have a wide differential diagnosis and, in particular, metastatic carcinoma from the breast or other origins must be considered [8].

In our patient whose initial FNAC revealed metastatic adenocarcinoma of unknown origin, it was imperative to determine whether the primary tissue of origin of adenocarcinoma was from the gastrointestinal tract, the lung, colon or the prostate. Primary adenocarcinoma arising in the axilla always poses difficulty in differentiating from metastatic carcinoma of any type of origin [9]. Since the axillary region has abundant sweat and sebaceous glands, diagnoses of cutaneous adnexal malignancies must also be considered. In review of literature it has been found that accessory mammary carcinoma is very rare, occurring in only 0.3%–0.6% of all cases of breast cancers and usually appears as an axillary tumor [10].

Accessory mammary tissue develops due to incomplete embryologic regression of the mammary ridge, which is composed of a portion of the galactic band that runs from the axilla to the groin [11]. Generally, accessory breast cancer must be pathologically demonstrated to be located adjacent to normal breast ducts or lobules that are not connected with the proper mammary gland, and it is also necessary to exclude the possibility of a metastatic lesion from another primary cancer [12]. The prognosis of accessory breast cancer is found to be worse than that of breast cancer arising in proper mammary gland, although no long-term follow-up data regarding the prognosis of accessory breast cancer is available.

CONCLUSION

In this paper, we have described a very rare case of a male breast carcinoma arising in an accessory mammary gland. The treating surgeon should always think of possibility of such a disease when dealing with such cases of unusual presentation. In cases of doubt regarding tissue of origin in suspected cases, Immunohistochemistry plays an important role in establishing the diagnosis. Postoperative Chemotherapy or Neo-adjuvant Chemotherapy to downstage the tumour is also helpful. ER/PR status determination on resected tissue also helps to plan postoperative Hormonal therapy (Tamoxifen) in positive cases.

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