

A Rare Case of Fibroadenoma in an Accessory Breast over Anterior Chest Wall

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Abstract: Accessory breast tissue is an uncommon condition which occurs in 0.4–6% of women. It is mostly located in the axilla where it can cause diagnostic difficulty, especially if it is unilateral and large. Usually it is bilateral and presents as an asymptomatic mass during pregnancy or lactation. The diagnosis of ectopic breast tissue is important as it can undergo the same pathological changes that occur in a normal breast, such as mastitis, fibrocystic disease and carcinoma. We present a case of unilateral accessory breast without nipple and areola over anterior chest wall with a fibroadenoma inside it in a 20 year old lady.

Keywords: Accessory breast, ectopic breast tissue, fibroadenoma.

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INTRODUCTION

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

CASE PRESENTATION

A 20 year old lady presented with gradually increasing lump over anterior chest wall underneath left breast for last 2 years. There was no positive family history of any gynaecological or breast cancer. Her menstrual history was normal. On examination, a soft globular swelling around 8cm*10cm in size is seen over the left infra-mammary region. It was separate from the left breast. The skin over the lump was essentially normal except few venous prominences. Both breast and axilla were normal.



Fig-1: Clinical photograph showing lump over left infra-mammary region



Fig-2: Lump seen from lateral side

An ultrasound was performed in the breasts and soft tissue swelling below left breast, which showed a well-defined iso to hypoechoic mass measuring approx (66x 62x93)mm (Bi-Rads® 3) with internal vascularity seen in left hypochondriac region in subcutaneous plane involving lower chest wall and upper abdominal wall. Mammography suggestive of a large well defined mixed density mass seen in left upper quadrants. No areas of internal calcification seen and no enlarged axillary lymphnode noted. The findings above mentioned discarded the hypothesis of a possible malignancy. The patient was, then, submitted to a fine-needle aspiration biopsy (FNAB). The material obtained and sent for analysis was suggestive of fibroadenoma possibility in accessory breast tissue.



Fig-3: Ultrasonography of the swelling

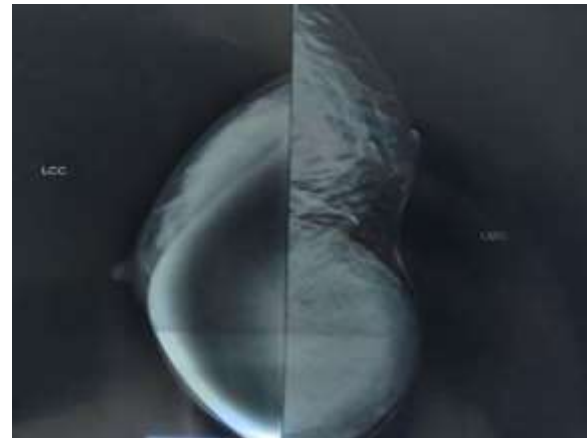


Fig-4: Mammography



Fig-5: Operative photograph

All routine investigations were essentially normal. Patient posted for surgery. Complete excision of the accessory breast with fibroadenoma in situ was done and sent for histopathology. Histopathology report corroborated with our pre-operative diagnosis. The specimen was suggestive of fibroadenoma with fibrocystic changes in accessory breast.



Fig-6: Histopathological section showing breast tissue

Post operative recovery was uneventful. Patient was discharged in healthy condition with advice for regular follow up.

DISCUSSION

Ectopic breast tissue occurs due to failure of resolution of the embryonic mammary ridge (milk line), which an ectodermal is thickening from axilla to groin bilaterally. It is the term used for both supernumerary and aberrant breast tissue, which are two distinct entities [1].

Supernumerary breasts have nipples, areolae or both with varied composition of glandular tissue [2]. They mostly present along the mammary ridge but may also occur on the cheek, neck, shoulder, thigh or buttock [3]. Pathological findings in a supernumerary breast usually comprise of an organised ductal system communicating with the overlying skin, and usually respond to all the physiological changes of the reproductive cycle [4, 5].

An aberrant or accessory breast tissue is a diverticular form of the breast during the fetal period which subsequently loses all connection with the ipsilateral breast. Unlike supernumerary breasts, it has no organised secretory system and does not communicate.

With the overlying skin. The most common location for the aberrant breast tissue is the axilla while other uncommon sites are infraclavicular, subscapular, epigastric and vulva [5].

Aberrant breast tissue becomes symptomatic during menarche, pregnancy and lactation and responds to fluctuating hormonal levels [6].

In 1915, Kajava published a classification system for supernumerary breast tissue that remains in use today.

Class I consist of a complete breast with nipple areola glandular tissue.

Class II consists of nipple and glandular tissue but no areola.

Class III areola and glandular tissue but no nipple

Class IV consist of glandular tissue only.

Class V consist of nipple and areola but no glandular tissue (pseudomamma).

Class VI consist of nipple only (polythelia).

Class VII consist of areola only (polythelia areolaris).

Class VIII consist of a patch of hair only (polythelia pilosa) [7]

Our patient belong to class IV.

The incidence of the accessory breast ranges from 0.4% to 6% [8]. Mostly it is bilateral and presents as an asymptomatic mass during pregnancy or lactation. It may also present with pain, restriction of arm movements and cosmetic problems [8]. Diagnosis of ectopic breast tissue is important as it can undergo the same pathological events that occur in the normal breast such as mastitis, fibrocystic disease and carcinoma [8, 9]. Like in the present case, there was a fibroadenoma inside the accessory breast which was not clinically palpable but visible in sonography. Mass-like density, the same as that of the normal breast parenchyma, is seen both on ultrasound and mammography [10]. FNAC is a useful tool to distinguish it from other masses like lipoma or lymph nodes.

The management of ectopic breast is mainly surgical, though small size asymptomatic ectopic breasts may be managed conservatively [8]. Excision is recommended in large size tissue for cosmetic reasons and to avoid any future complications [11].

CONCLUSION

Accessory breast is a rare disorder. It can pose diagnostic difficulty particularly when nipple or areola is absent. Therefore high degree of suspicion is needed because as it contains breast tissue, all the breast pathologies like fibroadenoma, fibrocystic disease, and carcinoma can arise in it. Ultrasonography is an useful diagnostic tool. FNAB can be used for tissue diagnosis but if inconclusive, excision biopsy is required. The management is surgical with complete excision is the usual procedure.

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