Case Report

Inframammary breast with nipple: a rare case report

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Abstract

Accessory breasts, also known as polymastia, supernumerary breasts, multiple breast syndrome, or mammae erraticae, is the condition of having an additional breast .Extra breasts may appear with or without nipple or areolae. It is a condition often goes untreated as it is mostly harmless but cases of benign breast disease and even carcinoma has been recently reported. A related condition, in which extra nipples form, is called "supernumerary nipple" or "polythelia.
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INTRODUCTION

About 2% to 6% of females and 1% to 3% of males are affected by this condition, a third of whom have more than one area of supernumerary tissue growth. Occurrence rates vary widely on the basis of ethnicity and gender, ranging from as low as 0.6% in Caucasians to as high as 5% in Japanese females.[1,2] In some cases, the accessory breast may not be visible at the surface. At 5 weeks of development, ectodermal mammary streaks extend bilaterally from axilla to groin[3], two weeks later a mammary ridge develops in thoracic portion of primitive streak and ultimately develops into mammary glands. The remainder of the mammary streak usually regresses however incomplete regression of the streak can result in foci of the accessory breast tissue anywhere along the milk line. Breast tissue may develop with or without nipple. Accessory nipple is then most common form of accessory breast structure[4], accounting for 60 -70 % of these cases. The presence of polythelia has also been associated with mal-formations and tumors in the urogenital tract[5,6]. Accessory breast may be present since childhood but generally they present during pregnancy when increase in hormones causes it to increase in size or become painful. Usually it presents as clinical fullness, its size may wax and wane with menstrual cycle or manifest during pregnancy and lactation .Carcinoma and benign breast lesion have been reported in accessory breast so evaluation is mandatory.[7] The incidence of malignancies in accessory breasts has been reported as higher than that in pectoral breasts and accounts for 0.2–0.6 per cent of all breast cancers.[8] Authors have suggested this increased incidence may be due to 'stagnation' in the ducts. Ductal cancer is the most common type of accessory breast cancer, with infiltrating ductal cancer representing 79 per cent of accessory breast malignancies. Medullary cancer, lobular cancer and Paget's Disease also occur. The axilla is the most common site for accessory breast malignancies, accounting for 55–91 per cent of presentations.[9] Women with accessory breasts should have them screened for malignancies, along with their normal breasts.[10] While mammography does not usually pick up axillary accessory breast tissue, oblique and 'exaggerated craniocaudal' views may achieve satisfactory images. On mammogram, accessory breasts have the same appearance as normal breast tissue, but are separate from the pectoral breasts. Similarly, accessory breast tissue appears the same as normal breast tissue on ultrasound.[11] As recently as 15 years ago, management of

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axillary accessory breast tissue was largely by gross surgical excision. One study (of operations between 1993 and 2000) found a complication rate of 39 per cent, with unsightly scarring and residual tissue being the most common complaints. The more recent developments in surgical management include the use of liposuction (whether alone or after surgical tissue removal), utilising elliptical incisions along tension lines to reduce scar visibility and employing minimally invasive incisions[12,13].

CASE REPORT

A 18 yrs old female presented with lump in right inframammary region since 3 years and recent single episode of blood discharge from a inframammary "spot" on the lump on in surgical OPD of Dr. Samppurnanand Medical college and Associated Hospitals, Jodhpur (India). Patient had no family history of similar complain .Patient has normal menstrual cycle but was associated with the inframammary pain .Patient visited a physician and was advised ECG, later patient was referred to the surgeon for evaluation of lump and bloody discharge .Patient ECG was normal. No drug history.

Examination

Vitals of the patients were normal. Patient had single lump of 2 cms horizontally and 2 cms vertically in Right inframammary region, which was better felt than seen, with a dark "nipple like" structure over the the lump. Lump was non tender, freely mobile and not fixed to skin or any underlying structure. Secondary sexual characteristics of the patient were normal.

Figure 1

Investigation: Patient initial laboratory investigation revealed normal reports of hemogram, renal function test, serology, ECG and chest X ray. No other investigation done.

Management and follow up: Patient was planned for excision of the lump. Under general anaesthesia, the lump with the "nipple" was excised out and a mini negative suction drain put and fixed externally, total drain output of 20 ml was noted and drain was removed on second post operative day. Her post operative period was uneventful. Tissue was sent for HPE.

Histopathology Report: Study revealed accessory breast tissue without any associated neoplasm.

CONCLUSION

In the present case, the patient had never been pregnant or breastfed and the histopathologic study revealed accessory breast tissue without any associated neoplasm. Unlike most of the cases reported in the literature, growth of the lesion was progressive with no apparent relationship to neoplastic changes or the oral contraceptive treatment started some years earlier. This is therefore a rare case of a inframammary accessory breast that presented in a 18-year-old woman as a subcutaneous mass of unknown origin in which there was no clear hormonal trigger or tumour implicated in the sudden growth. Differential diagnosis of inframammary lesions should include this entity. The lesion itself should be excised due to the risk of malignant conversion of the ectopic tissue. Although there was no malignant potential in the excised lump, it is essential that every accessory breast lump should be viewed with suspicion and managed appropriately and undergo histopathological examination and rule out the malignant possibility.

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