



“SYNCHRONOUS BILATERAL CARCINOMA BREAST WITH DIFFERENT HISTOLOGICAL SUBTYPES IN A NULLIPAROUS WOMAN - A RARE CASE REPORT”

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ABSTRACT Bilateral Breast Carcinoma (BBC) is a rare entity with incidence of synchronous carcinoma being 2-5% of all breast malignancies, which is much less than metachronous carcinoma. Synchronicity/ metachronicity are usually associated with local and lymphatic spread and with blood-borne spread to lungs, bones and liver. Moreover BBC are mostly lobular carcinomas but we report a rare case of two different histological subtypes, phyllodes tumor in right breast along with invasive mucinous carcinoma in left breast

KEYWORDS : Bilateral breast carcinoma; Synchronous breast carcinoma; mucinous carcinoma; phyllodes; Simple mastectomy

INTRODUCTION

Bilateral Breast Carcinoma (BBC) is an uncommon presentation with an incidence of 2-5% of all breast malignancies Understanding the various factors contributing the development of contralateral tumour is important to ameliorate its altered clinical course, exaggerated treatment course and cost, aggravated prognosis as compared to unilateral tumour. Here is a case of a 50 year old female with synchronous bilateral breast carcinoma with different histology and different grade on either side, who was managed adequately and recovered well.

CASE REPORT

A 50 year old postmenopausal lady, labourer by occupation presented with complaints of lump in the right breast for the past 5 months which began as small lump that gradually increased in size, associated with mild discomfort for the past 1 month, she is a nulliparaous woman with no history of breast cancer running in the family. General physical examination and systemic examination were essentially normal.

LOCAL EXAMINATION OF THE BOTH BREAST EXAMINATION OF RIGHT BREAST

On inspection breast lump of size 15X 9cm involving all quadrants of right breast, Nipple Areolar Complex normal, dilated veins present, no peau de orange change, on palpation lump mobile along with breast tissue not fixed. Right axilla was clinically negative for nodes.

EXAMINATION OF LEFT BREAST

On inspection left breast appeared normal, but on palpation a hard lump of size 3*2 cm in upper outer quadrant, which is non tender, and mobile along with breast tissue skin pinchable. Left axilla was clinically normal.

A clinical diagnosis of synchronous bilateral breast cancer was made and worked up further based on our institutional protocol.



Figure 1. Clinical picture of the patient

INVESTIGATIONS:

The routine blood investigations were normal. Proceeded with imaging and histopathological studies.

- **SONOMAMMOGRAPHY :**
- Right Breast BIRADS – 3 , Left breast BIRADS – 4
- Right Axilla – Normal , Left Axilla- Few sub centimetric lymph nodes.

- **CORE NEEDLE BIOPSY –** Right breast lump revealed phyllodes, on left breast lump revealed invasive ductal mucinous carcinoma.
- **CECT CHEST –**
- Right breast – large necrotic soft tissue mass lesion , possibility of phyllodes tumour.
- Left breast - heterogenous enhancing soft tissue mass lesion most likely malignancy
- USG ABDOMEN – normal study
- ECG – normal
- X ray chest – normal

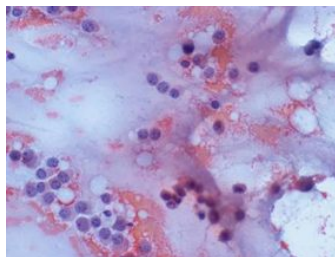


Figure 2: Tru-cut of left breast lump showing mucinous carcinoma

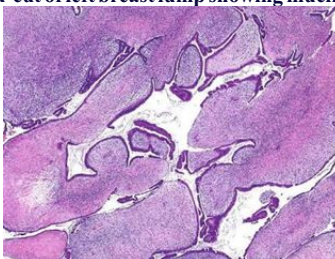


Figure 3: Tru-cut of right breast lump shows phyllodes

MANAGEMENT

The following surgery was done in the same sitting. For RIGHT BREAST - Simple Mastectomy was performed and for LEFT BREAST – Modified Radical Mastectomy with level II nodal clearance done and sent for histopathological examination. Delayed reconstruction was planned.



Fig 4: Postoperative scar in the patient

Histopathological examination of the specimen revealed

RIGHT BREAST – Phyllodes tumour of intermediate grade with all resected margins free.

LEFT BREAST – Mucinous carcinoma of Bloom Richardson grade 1, nuclear score 2, all margins free from tumour, lymphovascular invasion absent, axillary dissection 9/9 nodes free from tumour, lymphovascular invasion absent. Adjoining breast parenchyma shows IDC 5% of tumour.

The post operative period was uneventful. Patient received adjuvant chemotherapy (doxorubicin and cyclophosphamide) and hormonal therapy. Follow up was uneventful.

DISCUSSION

Bilateral Breast Carcinoma (BBC) is an uncommon presentation with an incidence of 2-5% of all breast malignancies. The second tumour in the contralateral breast can be either synchronous (within 6 months of the primary tumour) or metachronous (after 6 months of the primary).

In our case the second lump in the left breast developed 3 months after the right breast lump and was completely ignored by the patient. The exact etiology is not clearly defined but among the various hypotheses suggesting risk factors for bilaterality of breast carcinomas; lobular carcinoma as the primary carcinoma is considered as an important factor. Women previously diagnosed with breast cancer, are at increased risk of developing contralateral breast tumour with a two to six times greater relative risk than developing a first breast cancer in general population.

Other factors include a positive family history of breast cancer, genetic predisposition, a younger age at the diagnosis of the first primary breast cancer, inadequate treatment received for the first tumour and nulliparity. A tumour in contralateral breast may represent either a second primary tumour or metastasis from first tumour. Various studies show differentiation between a separate second primary and metastasis to the other breast; comprising demonstration of In Situ Disease on either side, both carcinomas with different histological types and different grades of cancer with no evidence of local, regional or distant metastasis. Generally in the absence of widespread systemic metastases, there is more likelihood of contralateral breast tumours being separate primary tumours. In our case different histological subtypes with different grades of tumour suggested two different synchronous primary tumours. Early detection of the contralateral tumour is of utmost importance emphasising the significance of breast self-examination.

Unlike unilateral breast cancer, there are no clear treatment guidelines for bilateral breast cancer. Patients are often treated with bilateral mastectomy, with breast conservative surgery having unclear importance. In view of preventing bilaterality of tumours and with various recent breast reconstruction options, there has been a dramatic increase in preference for prophylactic contralateral mastectomy for unilateral tumours. Our management plan was based upon the grade of the individual tumours. Even though mucinous carcinoma is an invasive breast cancer, it tends to be a less aggressive type that responds well to treatment. Mucinous carcinoma is less likely to spread to the lymph nodes than other types of breast cancer. There is no clear relationship between ER and PR positivity and bilaterality of the tumour. But bilaterality is more commonly seen in cases with Her-2/neu overexpression. Studies suggest that there was no significant difference in survival for patients with bilateral compared to unilateral tumour but synchronous tumours were associated with poorer survival in comparison to metachronous tumours.

CONCLUSION

In a case of bilateral synchronous breast carcinoma with different grades and histology; meticulous diagnosis and appropriate management helped to improve the longevity with an improved quality of life.

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