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UNUSUAL PRESENTATION OF METASTATIC MALE BREAST CANCER

Surgery

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ABSTRACT

Male breast cancer usually presents late, with more than 40% of individuals having stage III or stage IV disease, when metastasis has already occurred [1].Though commonly metastasis occurs in axillary, supra-clavicular or internal mammary groups, yet occasionally metastasis to inguinal lymph nodes have also been reported [2, 3].Breast cancer metastasising to para-aortic lymph nodes and presenting as gastric outlet obstruction has not been reported so far either in male or female breast cancer.

We report a case of a male patient who presented with features of gastric outlet obstruction and was diagnosed to have invasive ductal carcinoma which metastasised to the para-aortic lymph nodes.

KEYWORDS

Male, metastasis, lymph nodes, invasive ductal carcinoma

1. INTRODUCTION

Infiltrating male breast cancer represents <1% of all male cancers [4].The entire spectrum of histological variants of breast cancer has been noted in men. Amongst the infiltrating male breast carcinoma, infiltrating ductal carcinoma is the most predominant subtype with an incidence ranging from 64-93%.The second commonest variant is papillary type seen in 2.6-5% cases [5].

Presentation is usually of a painless lump, but is often late, with more than 40% individuals having Stage III or IV disease. Nevertheless, many patients are first seen with tumours that have metastasized to the axillary lymph nodes, which markedly decrease the survival rate.

In extremely rare situations, breast carcinoma metastasising to abdominal or inguinal lymph nodes has been reported. A metastasis to para-aortic lymph node leading to gastric outlet obstruction either in male or in female breast carcinoma has not been reported in literature so far.

Here we report such a case.

2. CASE REPORT

A 61 year old male, presented with a lump in the upper abdomen, with features of gastric outlet obstruction since 1 month, associated with loss of appetite and weight loss. On examination, he appeared malnourished and dehydrated. [Figure 1] Abdominal examination revealed a 7 x 5 cm retro-peritoneal lump present with transmitted pulsation in the epigastric and umbilical region. Succussion splash was present. The patient was also noticed to have 1.5 x 1 cm lump present in the upper outer quadrant of right breast, near the nipple areola complex. Right anterior axillary lymph nodes were enlarged. Ultrasonography and CT scan of abdomen revealed enlarged para-aortic lymph node (size-6.3 x 3.1cm) compressing and obstructing the lumen of third part of duodenum. There were no focal lesion in liver. No free fluid in peritoneum. On laparotomy, a large lymph node mass was found at the root of mesentery compressing the third part of duodenum. Omental deposits were present [Figure 2]. Incisional biopsy of para-aortic lymph node and excisional biopsy omental deposits were taken. An anterior gastro-jejunostomy was done. A tru-cut needle biopsy of the breast nodule was also done. The pathologist was however not blinded, and both the HPE were carried out by the same pathologist. Histopathology examination of the breast nodule was reported as invasive ductal carcinoma with metastasis. Modified Bloom Richardson score was 3+3+2 (Grade III). The histopathology examination of para-aortic lymph node and omental nodules showed metastatic deposits from breast carcinoma. IHC of para-aortic lymph nodes was reported as triple negative ductal carcinoma with ER/PR/Her 2 neu negative and Ki 67 labelling index 70%. [Figure-3]

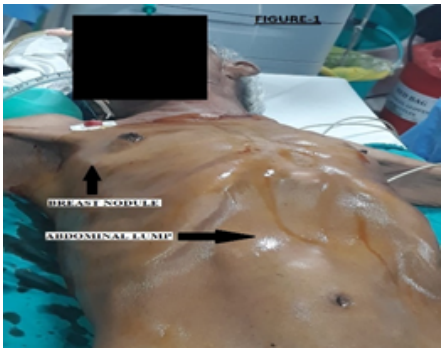

Figure 1: Showing the breast nodule and the abdominal lump.

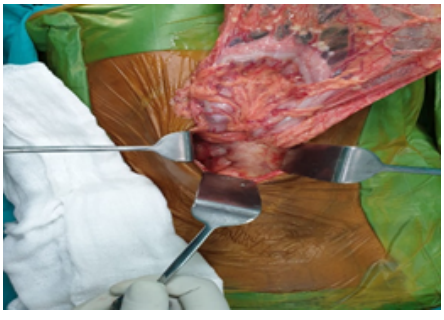

Figure 2: Showing the Intra Operative Finding of metastatic omental deposits

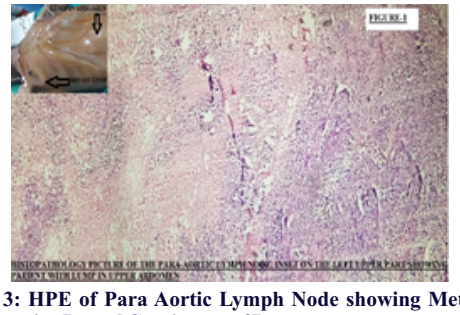

Figure 3: HPE of Para Aortic Lymph Node showing Metastasis from Invasive Ductal Carcinoma of Breast.

3. DISCUSSION

Breast cancer is a rare disease in men. Despite its infrequent prevalence, male breast cancer can cause significant morbidity and m1.ortality.Infact, it has a more aggressive clinical behaviour compared to female breast cancer.

The most common presenting symptoms in male breast cancer patients are a painless subareolar lump, nipple retraction, and bleeding from the nipple[6].But,in this case,a 61 year old male patient presented with a lump in upper abdomen,which was diagnosed as para-aortic lymph node enlargement due to metastasis of invasive ductal carcinoma of breast.

Breast cancer can spread to virtually every organ in the body. Distant spread is usually by lymphatic or haematogenous routes. Transcoelomic spread with development of ascites and pelvic seedlings has also been reported. Though very uncommon, yet a metastasis to inguinal lymph nodes of same side has been reported. With the Halstedian theory of breast cancer, spread occurs by direct permeation to regional lymph nodes. However, if as it is now believed, that spread is mainly by embolization. As Haagensen suggested, metastases via the rectus muscle most likely occur only when the internal mammary lymphatic trunk is blocked higher up in the upper intercostal spaces. When blockage occurs, the flow of lymph may be reversed and carcinomatous emboli from breast may reach unusual sites [3].

In our case, may be this was the most probable route of metastasis to the para-aortic lymph nodes.

Invasive ductal carcinoma in men presents peculiar features. About 42% of cases are diagnosed late, probably because men do not seek medical attention for breast masses as quickly as women. Most males present with advanced stage of disease due to lack of awareness.

In our case, the patient was not aware of the presence of lump in his right breast and presented with lump in abdomen along with features of gastric outlet obstruction, as the lump was compressing the duodenum. This presentation of male breast carcinoma is unusual and has not been reported in literature so far.

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