



FIBROADENOMA IN BILATERAL AXILLARY ACCESSORY BREAST TISSUE: RARE CASE REPORT

Pathology

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ABSTRACT

Accessory breast tissue define as residual breast tissue that persist for normal embryologic development. Ectopic breast tissue usually occur as an accessory breast tissue without and areola and nipple. There diagnosis and differential diagnosis confirmed by USG . AAB with fibroidenoma must be confirmed after excision and histopathological examination.

KEYWORDS

Bilateral ectopic breast, Fibroadenoma , Apocrine metaplasia, Axillary Accessory breast.

INTRODUCTION

Accessory breast tissue is defined as residual (breast) tissue that persists from normal embryologic development. It has also known as ectopic breast tissue which found in upto 6% of the population.¹ The term "accessory breast", it is breast tissue which has located near the proximity of the breast and its accessory fragments of the breast tissue outside the periphery of the gland.²

Ectopic breast tissue usually occurs as an accessory breast tissue without an areola and nipple it is usually asymptomatic and can be silent or manifest itself with menarche in adolescence or with symptoms during menstruation, pregnancy and lactation because the presence of glandular epithelium which shows positive reaction for estrogen and progesterone receptors³.

Therefore USG is usually the first choice in imaging modality for evaluation of any palpable soft tissue mass outside the breast and also help to differentiate a mass of accessory breast tissue particularly located in axilla from lipomas, lymphadenopathy and other pathological entities.⁴

Kajava (1915) published a classification systems for ectopic breast tissue that still remain used now a day.⁵ According to this system present case belonged to class IV. (Table 1)

Table 1 : Kajava classification system

Class I	Complete breast with nipple areola and glandular tissue
Class II	Consist of nipple and glandular tissue but no areola
Class III	Consist of 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
Class VI	Consist of nipple only (polythelia)
Class VII	Consist of an areola only (polythelia areolaris)
Class VIII	Consist of patch of hair only (polythelia pilosa)

Case report

18 years old young unmarried girl noticed a persistent enlargement of bilateral axillary swelling which was painful during menstruation but on clinical examination she was present bilateral axillary swelling without well defined palpable lump in both axilla and both breast. She attained age of menarche at 15 years. Hence we made clinical diagnosis as axillary accessory breast. Her ultrasonography of both axillary region revealed accessory breast tissue in axillary showing extension of bilateral accessory breast tissue noted in both breast while FNAC shows benign ductal epithelial cell and also other relevant investigation were performed then we plan for excision biopsy

through elliptical incision including 1-2 cm of redundant skin with excise complete accessory mammary glands and specimen sent for histological examination and histopathology was done. Microscopic histological finding suggestive of apocrine metaplasia with proliferation of glandular tissue in pericanalicular glandular growth pattern hence histopathological finding suggesting for axillary accessory breast tissue which shows features of fibroadenoma with apocrine metaplasia were compatible for fibroadenoma. (Figure 1 & 2)

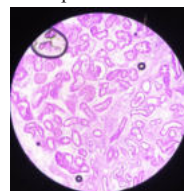


Figure 1 : Showing proliferation of glandular tissue in pericanalicular pattern (100 X)

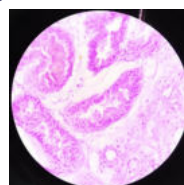


Figure 2 : Showing apocrine metaplasia

DISCUSSION

As per literature we assumed there are 2 hypothesis for developing accessory breast tissue in axilla. First, one occurred in during fifth week of embryogenesis a mammary ridge develop by thickening of ectoderm, that runs from axilla to groin. Except for two segments in pectoral region that develops into normal breast, rest involutes, hence failure of involution leads to formation of accessory breast.⁶

Second hypothesis is that accessory breast develops from modified apocrine sweat glands.⁷ Hence both this hypothesis are similar to our case report because microscopic picture shows proliferation of glandular and pericanalicular glandular growth pattern with apocrine metaplasia which are commonly found in benign lesion of the breast. So axilla is the most common site for accessory breast which occurring of female it is twice as common in female than males.⁸ It has also reported in perineum back of neck, vulva, flank, back, upper arm, midline of the shoulder.⁹ There are similar case report Trisha et al¹⁰ also found intercanalicular glandular growth pattern which were compatible feature for fibroadenoma in microscopic picture.

Sung Ryul Lee et al,¹¹ they analyzed retrospective data of patient and they found all diagnosis was confirmed as AAB with fibroadenoma after post excision at final histopathological examination with an AAB and fibroadenoma and their surgical excision. Just like same in our case report we have also conformed AAB with fibroadenoma after post excision of final histopathological examination. However in our case periodic enlargement and cyclical pain are the primary reason for surgical excision.

CONCLUSION:

As the AAB with fibroadenoma is very rare entities and it is associated with engorgement and discomfort during menses and pregnancy because of hormonal stimulation.

AAB also found, there are two types of hypothesis for its origin. Hence we concluded that AAB must be excised with complete glandular excision of AAB tissue and final diagnosis confirmed after post excision.

REFERENCES:

1. Laor T, Collins MH, Emery KH, Donnelly LF, Bove KE, Ballard ET. MRI appearance of accessory breast tissue: a diagnostic consideration for an axillary mass in a peripubertal or pubertal girl. *AJR* 2004; 183:1779–1781.
2. Goyal S, Puri T, Gupta R, Julka P, Rath G. Accessory breast tissue in axilla masquerading as breast cancer recurrence. *J Cancer Res Ther* 2008; 4:95–96.
3. Kim Ys (2004) Correction of Axillary breast tissue without visible scar. *Aesthet surg J* 24: 535 Link <http://bit.ly/2xwwdzv>.
4. Kim EY, Ko EY, Han BK, et al. Sonography of axillary masses: what should be considered other than the lymph nodes? *J Ultrasound Med* 2009; 28:923–939.
5. Kajava Y. The proportions of supernumerary nipples in the Finnish population. *Duodecim* 1995; 1:143–170.
6. Yaghoobi R, Bagherani N, Mohammadpour F. Bilateral aberrant axillary breast tissue. *Indian J Dermatol Venereol Leprol* 2009; 75:639.
7. Craigmyle M. The Apocrine Glands and the Breast. 1984; 49-55
8. Coras B, Landthaler M, Hofstaedter F, Meisel C et al. Fibroadenoma of the axilla. *Dermatol Surg* 2005; 31:1152-4.
9. Lilaia C, Capela E, Cadilla J. Ectopic Breast Fibroadenoma. *Internet J Gynecol Obstet*. 2007; 6:2.
10. Trisal M, Hasasn MJ, Rana S, Mohroo RN, Jetley S. Fibroadenoma arising in accessory breast tissue of the axilla: A rare case report. *IP Achieves of Cytology and Histopathology Research* 2018; 3(2):105-106.
11. Sung Ryul Lee. Surgery for fibroadenoma arising from axillary accessory breast. *BMC Women's Health* 2021; 21:139.