

Delayed Recurrent and Bilateral Breast Cancer in Patients With Partial Poland's Anomaly: Report of 2 Rare Cases and Review of the Literature

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Clinical Practice Points

- Patients with Poland's anomaly are at risk for developing cancer in the ipsilateral hypoplastic/normal, contralateral, and reconstructed breasts. To date, however, only 16 cases of concurrent breast cancer in patients with Poland's anomaly have been described.
- We report the first cases of (1) recurrent ipsilateral and (2) bilateral breast cancer in 2 patients with mild variants of partial Poland's sequence. In both cases, localized, hormone-sensitive, ductal-based carcinoma was identified and effectively treated with mastectomy, direct lymph node assessment, and autologous reconstruction with regional pedicled flaps. No adjuvant therapies were administered in either case, and both patients remained disease-free at long-term follow-up.
- Recommendations regarding diagnostic screening for breast cancer in patients with Poland's anomaly should follow those of the general population. Underlying anatomical abnormalities in these patients require special consideration, as skeletal and/or soft tissue derangements may influence decisions regarding appropriate diagnostic imaging, surgical treatment planning, adjunct oncologic therapies, and strategies for breast/chest wall reconstruction.

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Introduction

Originally described by Alfred Poland in 1841, Poland's anomaly is a sporadic, congenital malformation characterized by aplasia of the sternocostal head of the pectoralis major muscle.¹ Although not requisite for diagnosis, other associated musculoskeletal abnormalities may be present, including absence or underdevelopment of the breast (> 33%), nipple-areola complex (49%), thoracic skeleton (11%-25%), chest wall musculature, and/or ipsilateral upper extremity (13.5%-56%).² Although the association between Poland's and various malignancies is well-documented, few cases of concurrent breast cancer have been reported. Herein, we describe the rare occurrences of (1) recurrent invasive carcinoma involving

the ipsilateral breast and (2) bilateral breast cancer in 2 patients with previously unrecognized Poland's anomaly and investigate the clinical characteristics of breast cancer in this setting.

Case Reports

Case 1

A 69-year-old female with a remote history of left breast ductal carcinoma in situ (DCIS), treated with breast conservation therapy (ie, partial mastectomy and whole breast irradiation) 12 years prior, presented with 2 months of left breast pain radiating to her axilla. Physical examination revealed a well-healed lumpectomy scar within the lower inner quadrant of the left breast, localized glandular volume deficiency, and mild postradiation skin changes (Figure 1A). Breast and nipple development were normal, bilaterally. There were no secondary signs of malignancy (ie, skin ulceration, edema, nipple retraction) on visual inspection, masses, or axillary/supraclavicular lymphadenopathy; however, tenderness to palpation was elicited along the 2 o'clock radian of the left breast. The remainder of the exam was notable for a mild pectus excavatum deformity, scoliosis, and absence of the anterior and posterior axillary folds on the left (Figure 1B). No other thoracic or limb abnormalities were identified.

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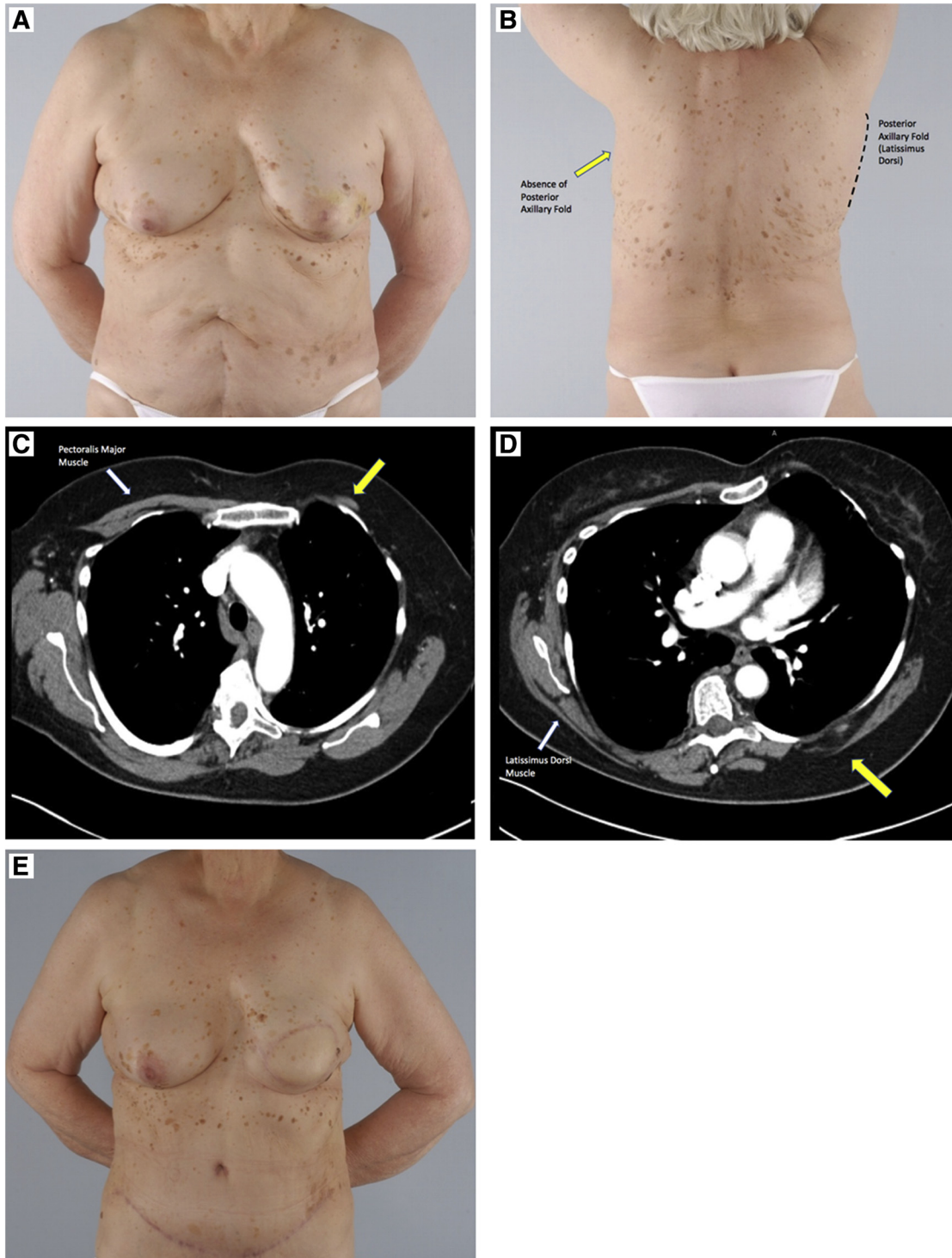
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Breast Cancer in Patients With Poland's Anomaly

Figure 1 Case 1. A 69-Year-Old Female With Previously Undiagnosed Partial Poland's Sequence on the Left Presented With Recurrent Invasive Carcinoma Involving the Ipsilateral breast. Her Presenting Physical Examination on was Notable for Mild Postsurgical Changes Involving the Lower Inner Quadrant of the Left Breast (A) and Deficiency of the Left Posterior Axillary Fold, Consistent With Absence of the Corresponding Latissimus Dorsi Muscle (B). Axial Multislice Computed Tomography of the Chest Wall Confirmed Absence of the Pectoralis Major (arrow) (C) and Latissimus Dorsi Muscles (arrow) (D) on the Left. E, Evaluation of the Patient 3 Years after Left Skin-Sparing Mastectomy and Immediate Reconstruction With a Pedicled Transverse Rectus Abdominis Myocutaneous Flap. The Patient Demonstrates Good Symmetry With Respect to Breast Size, Shape, and Position on the Chest Wall



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