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Case Report

Primary lymphoma of the breast: A case series

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ABSTRACT

Primary breast lymphoma has been defined as localized involvement of one or both breasts with or without ipsilateral axillary nodal involvement, usually as a rare manifestation of extranodal non-Hodgkin's lymphoma. We describe three cases of this uncommon disease seen at our institution. Two of these cases presented as palpable breast lumps and one was screening detected. None of the patients had a prior history of lymphoma; only one reported B symptoms night sweats and weight loss. Diagnosis was established on ultrasound-guided core biopsy and no evidence of metastatic disease was identified. Even though the imaging features are not specific to this diagnosis, the radiologists should be aware of the clinical and imaging presentation of this rare malignancy to recommend appropriate management and establish radiologic–pathologic concordance.

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1. Introduction

Primary breast lymphoma (PBL) is a rare presentation of non-Hodgkin's lymphoma (NHL), with mostly case reports and small case series reported in the literature. It usually presents as a clinically palpable mass and is rarely screening detected. Although the imaging characteristics are not specific, they may sometimes mimic benign masses. Diagnosis can usually be established with a percutaneous needle biopsy. Unlike primary breast carcinoma, surgery is not the key treatment for PBL. Treatment is mainly confined to combination of chemotherapy and radiation therapy. We present three cases of PBL from our institution with discussion about their imaging features and management.

1.1. Case 1

A 63-year-old female with past medical history of ovarian cancer in 1986 and history of low-grade B-cell NHL involving the right breast 4 years ago treated with excision and radiation therapy. Patient presented with a rapidly growing palpable left breast mass and also reported recent night sweats and weight loss. Mammogram was performed and demonstrated increased asymmetric density within the left subareolar region (Fig. 1). Targeted ultrasound (US) was performed demonstrating a 5 × 4 × 3 cm solid oval mass with mixed echogenicity in the left breast at 2 o'clock corresponding to the palpable finding (Fig. 2A). Increased vascularity was identified (Fig. 2B). No abnormal or enlarged left axillary nodes were seen on US. US-guided left breast biopsy was performed and demonstrated large B-cell lymphoma. Positron emission tomography (PET)–computed tomography (CT) done few weeks later showed that the mass had increased to 7 cm size and showed intense increased metabolic activity, with maximum

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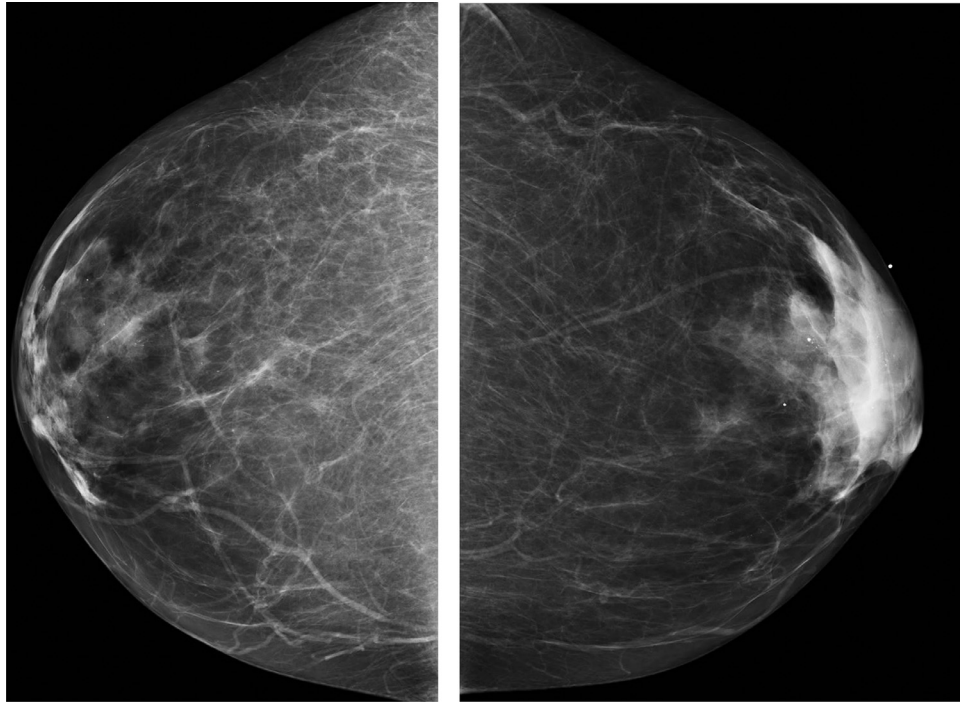


Fig. 1 – (Case 1) Mammogram with bilateral craniocaudal views. Palpable area in the left lateral breast marked with a radiopaque marker. There is underlying dense asymmetry seen in the palpable area in the left breast. Also bilateral subareolar round calcifications are present, which were unchanged from prior mammograms.

standardized uptake value (SUV) of 38 (Fig. 3). Mild activity was seen in left subpectoral and axillary nodes. No other evidence of metastatic disease was seen on PET-CT and other staging workup.

Patient subsequently underwent chemotherapy (R-CHOP $\times 2$). Additionally, consolidative radiation therapy to the left breast to 50 Gy in 25 fractions as well as the regional lymphatics to 46 Gy in 23 fractions was given. Follow-up PET-CT after treatment showed complete resolution of left breast and axillary mass and uptake (Fig. 4). The patient has since been in remission about 4 years postcompletion of her treatment.

1.2. Case 2

A 56-year-old female with past medical history of diabetes mellitus, hypertension, and hypercholesterolemia presented with a palpable right-sided breast mass and fatigue. No history of fever, night sweats, or chills. Mammogram was performed and identified a 3.0 cm mass in the right breast at 10 o'clock, corresponding to the palpable finding (Fig. 5). Targeted US confirmed a 4.3 \times 2.0 \times 0.9 cm solid hypoechoic mass (Fig. 6). Patient underwent an US-guided needle biopsy, which revealed diffuse large B-cell lymphoma (DLBCL). PET-CT demonstrated a 1.7 cm right breast mass with mild uptake and maximum SUV of 2.0, without uptake in the axillary nodes or elsewhere to suggest metastatic disease (Fig. 7). Bone marrow biopsy was negative.

Patient underwent chemotherapy (R-CHOP \times six cycles) and consolidative radiation therapy to the right breast to a total dose of 48 Gy delivered in 24 fractions and 46 Gy in 23 fractions to the regional lymph nodes. Follow-up PET showed no evidence of malignancy. The patient is now 5 years out from treatment completion, without any clinical or mammographic evidence of disease recurrence.

1.3. Case 3

A 79-year-old female was found to have increasing focal asymmetries in the upper outer right breast on her screening mammogram (Fig. 8). Patient had a benign biopsy in this area 3 years ago which showed "Benign intramammary node." No corresponding sonographic abnormality was seen and breast magnetic resonance (MR) was recommended. The breast magnetic resonance was interpreted as normal with no corresponding abnormal enhancement in the upper outer right breast (Fig. 9). The right breast findings were followed for another year, when a diagnostic mammogram revealed further increase in the size and number of these focal asymmetries (Fig. 10). Repeat US evaluation demonstrated multiple small hypoechoic superficial masses in the upper outer right breast (Fig. 11). US-guided biopsy showed "Extranodal marginal zone lymphoma." PET-CT showed no evidence of lymphadenopathy or lymphoma in the right axilla or elsewhere in the body.

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