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# Fibromatosis, a benign breast disease mimicking carcinoma.

## A case report

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## ABSTRACT

**INTRODUCTION:** Fibromatosis is an uncommon breast lesion that can mimic breast carcinoma in its clinical presentation.**CASE SUMMARY:** We present a clinical case in which a diagnosis and treatment dilemma existed, in terms of ultrasound findings that were not clear and suspicious, as well as results of Fine needle aspiration cytology. Our findings are compared with previous published cases. Also, literature review regarding fibromatosis presentation and diagnosis has been discussed, as well as treatment options.**CONCLUSION:** Management of breast fibromatosis remains controversial because of the low incidence and further efforts needed to establish evidence-based treatment guidelines.© 2017 The Author(s). Published by Elsevier Ltd on behalf of IJS Publishing Group Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

## 1. Introduction

Fibromatosis, a locally aggressive but non metastasizing neoplastic proliferation of fibroblastic cells. It is commonly encountered in the abdominal wall and extra-abdominal sites but it rarely occurs in the breast [1]. They are distinctive lesions best defined as a group of non metastasizing fibrous tumors which tend to invade locally and recur after surgical excision. Fb (fibromatosis) arising from the breast, also referred to as desmoid tumor, is a rare benign entity, accounting for only 0.2% of all breast tumors, and 0.3% of all solid tumors [2].

Our case of recurrent fibromatosis in a young lady presented at the European institute of oncology in Milan, a well know reference center of breast cancer in Europe.

This work has been reported in line with the SCARE criteria [21].

## 2. Case summary

31 years old lady presented to the breast surgery clinic with dimpling in the left breast, with no history of nipple discharge. The patient had regular menses, she denied any genetic familial history or family history of breast cancer or any other breast conditions, any previous breast procedures; including Aesthetic ones. No drug his-

tory including hormonal therapy. The patient's psychological status was optimum with no past history. No smoking history

On physical examination, a nodular density around 2 cm in the LOQ (lower outer quadrant) of the Lt (left) breast was noted, which was firm on palpation with irregular borders, no other lesions were noted in the same breast or in the other side. Bilateral axillary examination was unremarkable.

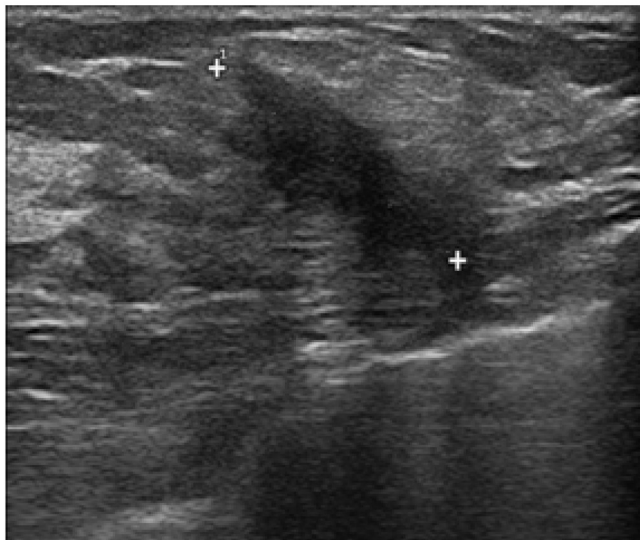
Ultrasound examination of the Lt breast showed a solid hypoechoic irregular vascularized nodule around 20 mm in size at the LOQ, with suspicious characteristic. Axillary examination of the same side documented the presence of ovular 9 mm lymph node with central hypercogenicity and minimal cortical thickening. The report was staged as BIRADS 4C with a high suspicion of malignancy. MRI was done and showed background enhancement already evident in early phases that limits the diagnostic sensitivity. In the Lt breast at the UOQ (upper outer quadrant), a coarse distortion is noted about 23 × 10 mm which was suspicious. Noted as well at the OCQ (outer central quadrant) of the same breast a distortion of 15 mm with a doubt significance. At the Rt (right) breast, in the LOQ (lower outer quadrant), another suspicious area of distortion is documented, which was difficult to measure [Fig. 1].

FNA aspiration was done for the lesions noted at the Lt breast which shows negativity for malignant cells in the LOQ, staged C2 according to the European Guidelines – 1997. The same results were noted also at the LOQ lesion of the Rt breast (the lesion was also suspected in MRI). The FNA for the lesion in the OCQ of the Lt breast was inadequate for diagnosis, as well as those at the Lt axilla.

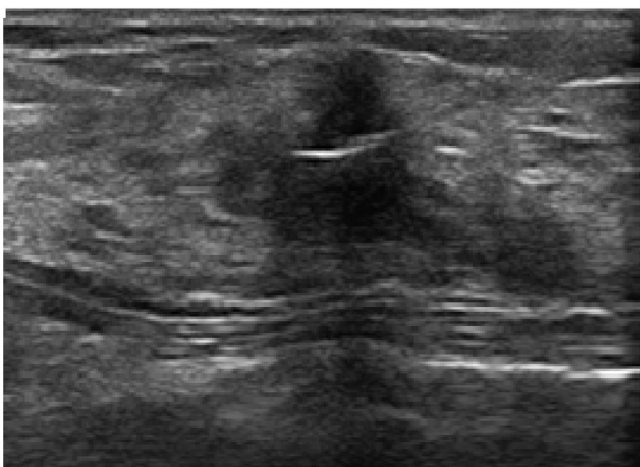
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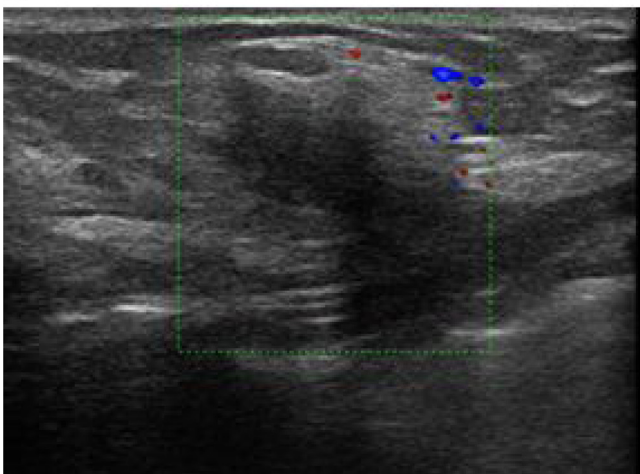
A.



B.



C.



**Fig. 1.** Left breast ultrasound shown (A) a hypoechoic coarse distortion with irregular margins and “more tall than wide”-like aspect. (B) noted the presence of the needle biopsy, represented by the hyperechoic central line inside the lesion. (C) Only a small peripheral signal was highlighted at the color-doppler exam.

Giving the discrepancy between the suspicious findings in the US for the lesion noted in the LOQ of the Lt breast and the result of the FNA which was C2, a Core biopsy was performed, which revealed a proliferation of spindle cells of a fibroblastic type with slight atypia in a background of dense connective tissue. Embedded mammary ducts in apocrine metaplasia without atypia and microcalcifications. The lesion tended to be a mesenchymal one with an uncertain potential of malignancy, suggesting the need for surgical excision.

The patient after that underwent a surgical excision by a senior breast surgeon of the suspicious lesion which in the LOQ of the left breast. Intraoperative frozen section (Macroscopic Examination) for the lesion revealed a 2 cm nodule without signs of malignancy, compatible with a benign mesenchymal lesion. A radioguided excision of the other non palpable lesion in COQ of the same breast was done and sent for definitive histological exam. The patient tolerated the procedure well in day surgery and was discharged home in good condition with No post operative events.

The final histopathology for the LOQ lesion revealed; Proliferation of Spindle cells with a slight focal atypia in a background of dense connective tissue, [Fig. 2], immunophenotyping was positive for ACTIN of the smooth muscles, and focally for B-CATENIN, negative for CYTOKERATIN, DESMIN, CD34, CD99 & BCL-2.

Fibrocystic disease with non proliferative type with stromal fibrosis and apocrine metaplasia were the findings for the COQ lesion. So, the final diagnosis was Fibromatosis, which is a benign condition.

Then, the patient was reassured of the benignity of the lesion and was scheduled for close follow up.

After 3 months of follow up the patient presented for the reappearance of dimpling in the lower part of her Lt breast at the position of the previously excised lesion. And the patient reported episodes of pain as well at the same site.

Physical Examination showed a hard nodule, moderately mobile, with an overlying dimpling of the skin [Figs. 3 and 4]. Repeated follow up ultrasound of the breast showed a hypoechogenic area with dyschaemogenic structure with a maximum diameter of 23 mm, the same characteristics of the previous lesion in the LOQ which was excised for a Fibromatosis [Fig. 5]. At the site of the excised lesion, there was another hypoechogenic area, with an irregular margin with the same characteristics of the previous lesion and a maximum diameter of 14 mm. A third lesion morphologically identical of that at the LOQ of the Rt Breast (previously documented in the MRI) about 17 mm which resulted previously to be C2 in the FNA. Bilateral Fibrocystic lesions. Axillary regions were clear. The stage of the US was BIRADS 3, a probably benign finding.

The patient was referred after that to a Sarcoma specialist for further evaluation, and repeated MRI was done, which showed in comparison with the previous one, that at the Rt breast two newly developed lesions about 5 mm & 5,5 mm in size respectively, with irregular margins and early and progressive enhancement which was suspicious (considering at that time the menstrual cycle of the patient). The same findings were found in a 5 mm lesion noted at the Lt UOQ of the other breast.

Again in the Rt breast at the LOQ, a distorted lesion around 20 mm with efigarly and persistent enhancement with the same characteristics of the previously excised fibromatosis. Meanwhile, a less distortion was evident at the site of the excised lesion at the Lt COQ of the left breast, while persisted particularly at the late signaling at a 24 mm lesion noted at the Lt LOQ adjacent to the surgical wound. The report of MRI was staged as BIRADS 3 with a benign probability.

Comparing the characteristics of the lesions in MRI with the previous histological exam and literature review, the diagnosis was made that of a recurrent Fibromatosis.

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