



A CASE REPORT- METACHRONOUS BILATERAL BREAST CARCINOMA

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ABSTRACT

Arcinoma breast is the second most common carcinoma in female. Incidence of bilateral breast carcinoma is 4.4% in asian population. Of those 2.1% were synchronous while 2.3% were metachronous bilateral tumour. Patient presenting with bilateral breast carcinoma either synchronously or metachronously could be either metastatic or new primary. It is evaluated with triple assessment with clinical, radiological and pathological assessment and staged accordingly. If the diagnosis is metastatic, treatment is palliative or if it is new primary the treatment is curative. This is the first reported case in our hospital.

Keywords: Arcinoma breast, bilateral breast carcinoma

CASE REPORT

56 year old female presented with lump in right breast for the past 6 months. History of nipple retraction x 3 months. History of bloody nipple discharge x 3 months. She was previously been treated for left breast carcinoma with modified radical mastectomy 2 years back. HPE came as Ductal carcinoma invasive not otherwise specified. IHC came as ER negative, PR negative and Her-2 negative. She did not follow up after surgery for chemotherapy and hormone therapy. Other history being nil significant.

On examination**Right breast along with NAC:**

A lump of 10x8cm involving the central quadrant extending to lower outer and lower inner quadrant. Not warmth, tenderness and patchy redness present. Irregular shape and surface. Well defined margin [1]. Hard in consistency. Moves along with breast tissue. Circumferential nipple retraction present and bloody discharge is seen. Paeu'd orange appearance is seen.

R axilla

A single mobile lymph node of size 2x2cm

of central group palpable.

Left side- MRM scar healthy.

Left axilla- Normal.

On evaluation with ultrasonography and trucut biopsy it came as carcinoma breast of ductal origin. Metastatic workup with skeletal survey, Chest X-Ray and Ultrasonography abdomen was done which did not show any metastatic changes (**Figure 1**). Patient was diagnosed to have metachronous bilateral breast carcinoma. Patient was planned for modified radical mastectomy. Breast tumour along with axillary node is sent for histopathological examination and immunohistochemistry (**Figure 2**).

Histopathology report came as: Ductal carcinoma invasive not otherwise specified. Deeper margin positive and all lymph nodes positive. Immunohistochemistry came as: ER negative, PR negative and Her-2 positive [2, 3]. Patient postoperative period was uneventful. Patient is advised radiotherapy, hormone therapy and chemotherapy and is under follow up now (**Figure 3**).



Figure 1: Right breast showing circumferential nipple retraction. Left MRM scar being healthy



Figure 2: Right breast carcinoma showing peau'd orange appearance and bloody nipple discharge



Figure 3: Postoperative right modified radical mastectomy specimen with axillary lymph nodes

DISCUSSION

Incidence of bilateral breast carcinoma is 4.4% in Asian population. Factors contributing for bilateral occurrence of breast carcinoma are familial or hereditary breast carcinoma, young age at primary breast cancer diagnosis, lobular invasive carcinoma, multicentricity and radiation

exposure [4, 5]. Patient presenting with bilateral breast carcinoma either synchronously or metachronously it could be either metastatic or new primary. The differentiation is very important that it decides the treatment as palliative or curative. Synchronous tumour occurs within 6 months and metachronoustumour occurs

beyond 6 months.

Metachronous bilateral breast carcinoma is more common than synchronous bilateral breast carcinoma. If the diagnosis is metastatic then the treatment is palliative chemo-radiotherapy whereas if the diagnosis is made as new primary then the treatment could be definitive i.e., modified radical mastectomy followed by chemo-radiotherapy and hormone therapy as required. Patient is assessed by triple assessment with clinical, radiological and pathological investigations [6].

Though several criteria have been proposed, there is no standardized protocol available for distinction between bilateral breast carcinoma as de-novo primary or metastasis. On comparing the prognosis of bilateral breast carcinoma with unilateral breast carcinoma, in no doubt bilateral breast carcinoma carries a worse prognosis [7].

CONCLUSION

Bilateral breast carcinoma is not an uncommon presentation and knowledge about it is important for early intervention to prolong the life expectancy of the patient. During Evaluation of patient with risk factors of bilateral breast carcinoma, they should always be followed up at regular

interval for early diagnosis and treatment.

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