



CYTO-HISTOLOGICAL DIAGNOSIS OF RARE MALE BREAST CARCINOMA

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INTRODUCTION

Male breast carcinomas are a very rare entity of carcinomas occurring in male breasts. Their incidence is very less, that is 0.5-1% only and very little is known about their etiology⁽¹⁾. Carcinomas of male breast are much more aggressive than the female breast malignancy. Elderly males present with breast nodules that are most often diagnosed with carcinomas. If the lesion is associated with nipple discharge the suspicion is strong for carcinomas. As FNAC (fine needle aspiration cytology) is well establishes in diagnosis of palpable breast masses, it also is helpful in differentiating benign from malignant lesions. Skin involvement by carcinomas is more frequent in male breast carcinomas.

CASE REPORT

A 75 year old male, farmer by occupation, presented with right breast swelling and pain since 1 year along with loss of appetite, loss of weight and breathlessness. On examination, the swelling was polypoidal measuring roughly around 5x4cm, fixed, hard, slightly tender and was seen involving the nipple areolar complex. (Figure 1) Multiple lymph node swellings in the axillary region were palpable. USG of right breast was suggestive for the possibility of neoplastic etiology. Patient was advised for CECT and FNAC and thence planned for modified radical mastectomy with axillary lymph node dissection. After mastectomy, breast malignancy was confirmed on histopathological examination.

DIAGNOSIS

On FNAC, the smears were cellular showing ductal epithelial cells in clusters and singly scattered. Individual cell showed pleomorphism, high N:C ration and prominent nucleoli raising the possibility of malignant breast lesion.(Figure 3,4) Grossly, we received right mastectomy specimen measuring 11x7x2cm along with axillary lymph node(Figure 2). On histopathological examination, malignant ductal epithelial cells were seen with nuclear atypia like that in FNAC. (Figure5) The margins were free of tumor while the nipple areolar complex was completely involved. A diagnosis of Invasive Ductal Carcinoma (Stage IIIB: T4pN2aMx), Modified Nottingham B.R. score of 6 (grade2) was made on histology and Robinson grading on cytology was concluded to be Grade1 (1+2+2+3+1+1=10)

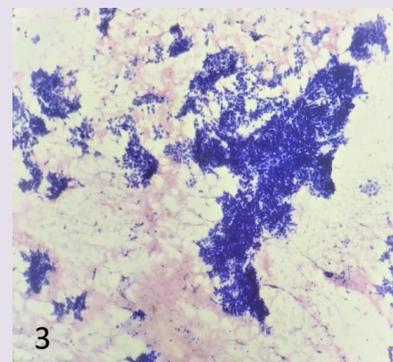
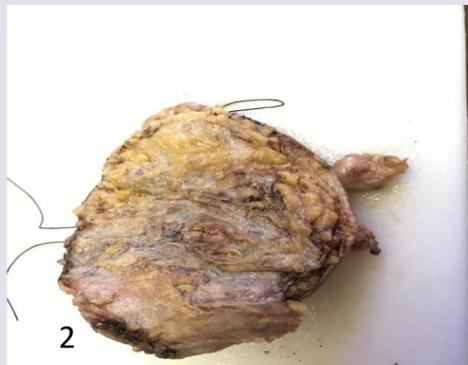


Fig.1 Swelling involving the whole of NAC.
Fig.2 Gross picture of specimen received in histopathology.
Fig.3 On FNAC, the smear malignant ductal epithelial cells in clusters as well as singly scattered.(10x)

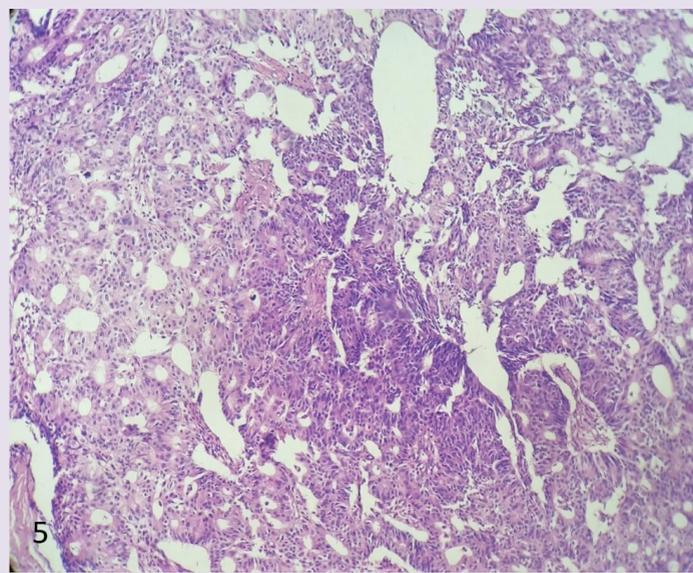
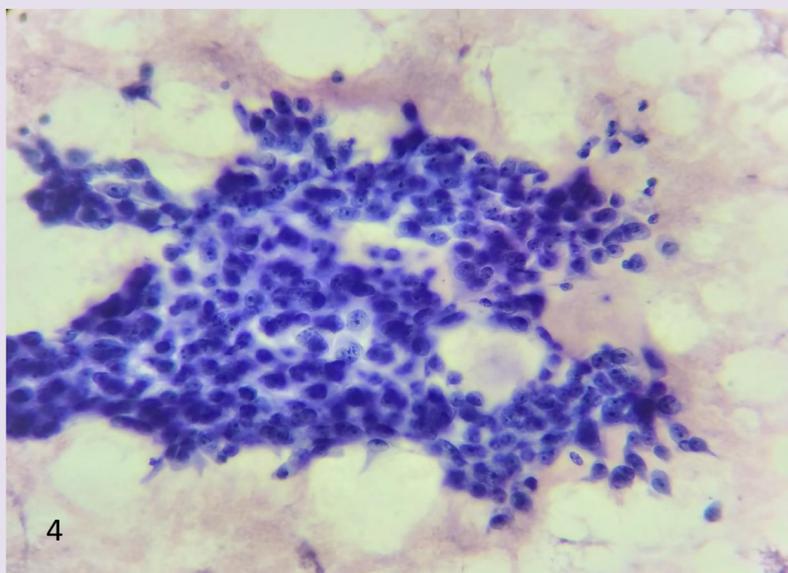


Fig.4 Tumor cells showing mild pleomorphism, prominent nucleoli and high N:C ratio in FNAC smears. (40x) Robinson Score: 10
Fig.5 Malignant ductal epithelial cells with nuclear atypia is seen with Modified BR score of 6 corresponding to grade 2.

DISCUSSION

Male breast carcinoma is a rare malignancy comprising less than 1% of all male cancers and is not completely understood because of availability of data.⁽²⁾ The diagnosis of male breast cancer can made in most cases by triple assessment: clinical assessment, radiologic assessment and tissue biopsy (fine-needle aspiration cytology), exactly as in female breast cancer. Ductal malignancy is the most common type encountered with axillary lymphadenopathy occurring more commonly in males than in females. Correct and timely diagnosis of male breast carcinomas is prudent and role of FNAC in such is eminent.

CONCLUSION

Aspiration cytology is a very accurate tool for the diagnosis of male breast lesions. It is highly sensitive and specific with good cytohistologic correlation as illustrated in our case. Careful attention and good evaluation for breast complaints, especially in high-risk patients is essential to avoid misdiagnosis.

REFERENCES

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