International Surgery Journal
Shah BA et al. Int Surg J. 2017 Sep;4(9):3153-3155
http://www.ijsurgery.com
pISSN 2349-3305 | eISSN 2349-2902

DOI: http://dx.doi.org/10.18203/2349-2902.isj20173905

Case Report

A rare case report of bilateral synchronous carcinoma breast

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Received: 09 July 2017
Accepted: 04 August 2017

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ABSTRACT

Bilateral Breast Carcinoma (BBC) is a rare entity with incidence of synchronous carcinoma being 2-5% of all breast malignancies, which is much less than metachronous carcinoma. Synchronicity/metachronicity are usually associated with local and lymphatic spread and with blood-borne spread to lungs, bones and liver. Moreover, BBC are mostly lobular carcinomas but we report a rare case of Infiltrating Ductal Carcinoma (IDC), medullary type as the primary carcinoma. 56-year-old female who presented with a lump in her right breast for 6 months and lump in her left axilla. There was no e/o palpable lump in her left breast. Trucut biopsy was taken from both the lumps and was s/o infiltrating ductal carcinoma. Different histological subtypes with different grades of tumour in both breasts suggested synchronous primary tumours. Early detection of the contralateral tumour is of utmost importance emphasizing the significance of breast self-examination. Screening tools like MRI have a greater sensitivity compared to Mammography. There are no clear treatment guidelines for bilateral breast cancer. Patients are often treated with bilateral mastectomy, with breast conservative surgery having unclear importance. Meticulous diagnosis and appropriate management help to improve the longevity with an improved quality of life.

Keywords: BBC, IDC, MRI

INTRODUCTION

Bilateral Breast Carcinoma (BBC) is an uncommon presentation with an incidence of 2-5% of all breast malignancies, Chandrika et al.[1,2] Understanding the various factors contributing the development of contralateral tumour is important to ameliorate its altered clinical course, exaggerated treatment course and cost, aggravated prognosis as compared to unilateral tumour. Here is a case of a 56-year-old female with bilateral breast carcinoma with same histology and different grade on either side, who was managed adequately and recovered well.

CASE REPORT

A 56-year-old female presented with a lump in the right breast for 6 months which began as a small lump which gradually increased in size. There is no family history of breast cancer. On local examination, a 4×3cm lump in the upper inner quadrant of right breast, not fixed to underlying pectoral muscles, with mobile, firm right anterior and central group of axillary lymph nodes.

Figure 1: Lump in right breast.

Figure 2: Axillary LN on left side.

She also gives history of lump in her left axilla for 2 months which was initially small in size and increased in size. There was no e/o any palpable lump in her left breast. On examination, a 3×2 cm anterior lymph node palpated which is mobile. No other group of lymph nodes palpated.

General physical examination and systemic examination were normal. FNAC of the right breast lump and left axillary lymph node suggested positive for malignancy. Trucut biopsy of both the lumps was taken and s/o invasive duct carcinoma: Grade III.

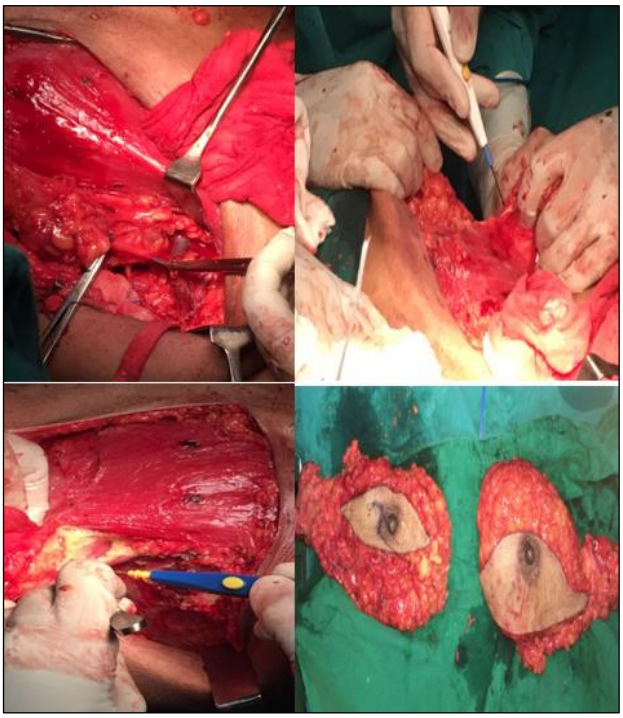

Figure 3: Intra-operative pictures of bilateral MRM.

Distant Metastasis to other organs was ruled out in view of a normal clinical examination, normal ultra-sound abdomen and normal chest X-ray. Patient was posted for bilateral Modified Radical Mastectomy with due consent.

Post-operatively patient recovered well with no complications. Histopathology of both the specimen proved to be infiltrating ductal carcinoma, medullary type (Stage III A).

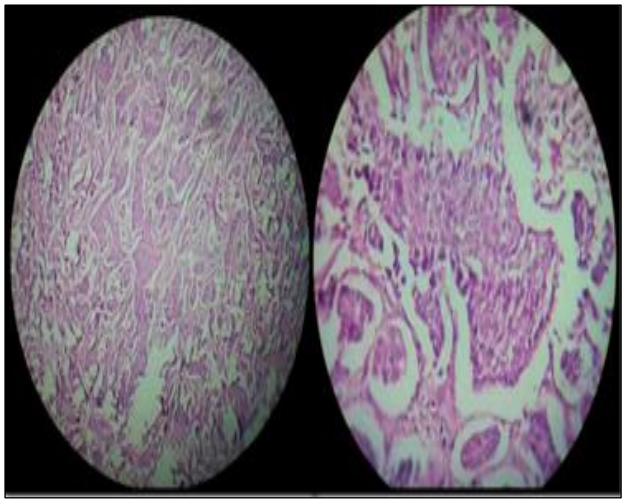

Figure 4: Infiltrating ductal carcinoma.

Specimens were tested positive for estrogen and progesterone receptors and but negative for Her2neu receptor.

Final diagnosis was B/L infiltrating ductal carcinoma-medullary type (stage IIIA). Patient received 6 cycles of adjuvant chemotherapy with Cyclo-phosphamide, 5FU and Adriamycin.

Postoperatively patient has recovered well. On follow-up, clinical examination and PET scan shows no signs of recurrence after 7 months.

DISCUSSION

Bilateral breast carcinoma (BBC) is an uncommon presentation with an incidence of 2-5% of all breast malignancies. The second tumour in the contralateral breast can be either synchronous (within 6 months of the primary tumour) or metachronous (after 6 months of the primary).[2]

In the present case, the second lump in the left axilla developed 4 months after the right breast lump. The exact etiology is not clearly defined (Chen et al) but among the various hypothesis suggesting risk factors for bilaterality of breast carcinomas; lobular carcinoma as the primary carcinoma is considered as an important factor.[4] Women previously diagnosed with breast cancer, are at increased risk of developing contralateral breast tumour with a two to six times greater relative risk than developing a first breast cancer in general population (Kheirelseid et al and Chaudary et al).[3-5] Other factors include a positive family history of breast cancer, genetic predisposition, a younger age at the diagnosis of the first primary breast cancer,

inadequate treatment received for the first tumour and nulliparity (Chen et al; Kheirelseid et al).[4-5]

A tumor in contralateral breast may represent either a second primary tumor or metastasis from first tumor. Various studies (Chandrika et al; Tuttle and Douglas 2004; Leis) proposed guidelines, including Chaudary et al, who proposed a criterion to differentiate between a separate second primary and metastasis to the other breast; comprising of: demonstration of in situ disease on either side, both carcinomas with different histological types and different grades of cancer with no evidence of local, regional or distant metastasis. Generally, in the absence of widespread systemic metastases, there is more likelihood of contralateral breast tumors being separate primary tumors.

In the present case, same histological subtypes with grade of tumour suggested synchronous primary tumours.

Early detection of the contralateral tumour is of utmost importance emphasizing the significance of breast self-examination. Screening tools like MRI have a greater sensitivity compared to Mammography (Kheirelseid et al.[5]

Unlike unilateral breast cancer, there are no clear treatment guidelines for bilateral breast cancer. Patients are often treated with bilateral mastectomy, with breast conservative surgery having unclear importance. In view of preventing bilaterality of tumours and with various recent breast reconstruction options, there has been dramatic increase in preference for prophylactic contralateral mastectomy for unilateral tumors (Kheirelseid et al).[5]

Our management plan was based upon the grade of the individual tumours. According to clinical examination and histological diagnosis patient was posted for B/L MRM.[7]

There is no clear relationship between ER and PR positivity and bilaterality of the tumour. But bilaterality is more commonly seen in cases with Her-2/neu overexpression (Kheirelseid et al).

Studies suggest that there was no significant difference in survival for patients with bilateral compared to unilateral tumour (Branica et al), but synchronous tumours was associated with poorer survival in comparison to metachronous tumours (Kheirelseid et al).[6-7]

CONCLUSION

Meticulous diagnosis and appropriate management help to improve the longevity with an improved quality of life.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

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Cite this article as: Shah BA, Yadav N, Akhil K, Alam F. A rare case report of bilateral synchronous carcinoma breast. Int Surg J 2017;4:xxx-xx.