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Original Research Article

Unilateral supernumerary axillary breast secreting milk: A case report

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ABSTRACT

Accessory breast tissue or ectopic breast tissue or supernumerary breast tissue is an aberration of normal breast development. It is known to be rare entity which occurs in 0.4 - 6% of women anywhere along the embryologic mammary streak or milk line but more common in axilla. Accessory breast cancer is a rare entity with incidence of around 0.2 - 0.6 %. Routine mammography can miss accessory breast tissue. It is generally bilateral may be unilateral occasionally. General lack of awareness of accessory breast cancer among clinicians has potentially dangerous implications.

Key Message: Knowledge about Accessory breast tissue has important implications for the patient care. If accessory breast tissue is not recognised, then a normal variant may be misdiagnosed as an abnormal lesion like lipoma, lymphadenopathy, sebaceous cyst, vascular malformation and malignancy. Also if surgical treatment is required it needs appropriate operative and post operative management.

1. Introduction

Accessory breast tissue is an uncommon condition which occurs in 0.4 - 6 % of women.[1] It is mostly located in axilla and has a high incidence of being misdiagnosed. Usually it is bilateral and presents as an asymtomatic mass during pregnancy or lactation.[2]

It is easy to diagnose when there is milk secretion during lactation. The ectopic breast tissue can undergo pathological changes that occur in a normal breast such as carcinoma, fibrocystic disease and mastitis.[3] However if it is located in the axilla and is unilateral and large it maybe difficult to diagnose and may be misdiagnosed as lipoma.[4] The incidence of malignancy is 0.2 - 0.6%. The most common pathology is invasive ductal carcinoma (50 - 70%) Most common location is axilla (60 - 70%).[5]

2. Case History

A 24-year-old woman presented with swelling and discomfort in left axilla since 1 month. The swelling was initially the size of lemon and slowly increased to present size and associated with secretion of milk. It was occassionally painful and associated with restricted movement of left upper limb.

She was Para one, delivered vaginally one month back at hospital. The baby cried immediately after birth, breast feeding and doing well. She had lactational amennorhoea. Her past medical, surgical history and family history was insignificant. Her bowel, bladder habits were normal and she took mixed diet and was not on any medication or contraception.

On general examination she was normally built and nourished and well oriented. Afebrile, normotensive with no pallor/icterus/cyanosis. The bilateral Breasts, Thyroid and Spine were normal in findings. Her cardiovascular, respiratory system were normal. The obstetrics examination

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Figure 1: Left breast and the spherical swelling in the left axilla.

Figure 2: Milk secretion in the lump in theaxilla and absence of nipple in the lump.

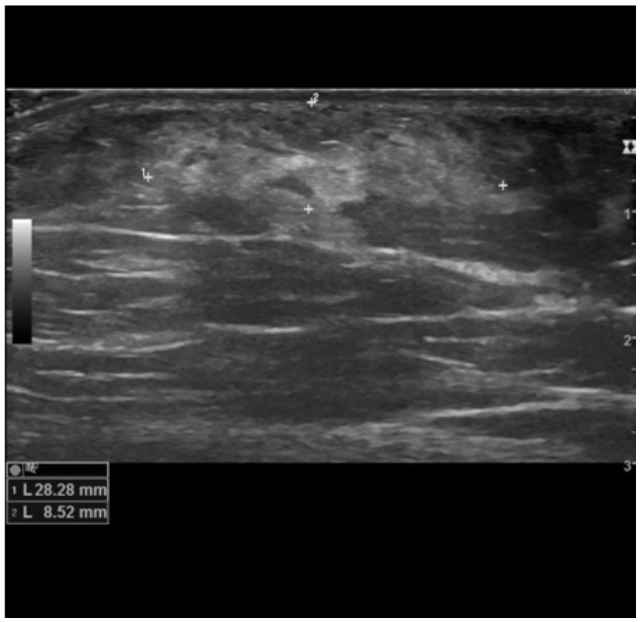

Figure 3: The ultrasound showed a heterogeneous hyperechoic area below the skin same as normal glandular tissue of breast not connected to pectoral breast in left axilla.

revealed soft abdomen. The per speculum and per vagina examination was normal and lochia was healthy.

On local examination- A swelling of 4 x 4cm^2 soft, spherical mass was felt in the left axilla. It was non tender and soft, mobile with secretion of milk at a point in the swelling which increased on pressure. Overlying skin was free and normal. No nipple was visualised on the swelling. Both breasts were normal with milk secretion. There was no swelling in right axilla.(Figures 1 and 2)

2.1. Management

As there was milk secretion and she was lactating the clinical diagnosis was unilateral accessory breast tissue in left axilla with secretion of milk. The patient was advised high resolution ultrasound of the lump and histopathology of tissue. The ultrasound of swelling in the left axilla revealed a heterogeneous hyperechoeic area below the skin similar to the normal glandular tissue of the breast tissue not connected to the pectoral breast tissue. There was no solid or cystic mass lesion in it. The axillary artery was patent. There was no axillary lymphadenopathy or epidermal inclusion cyst or lipoma.(Figure 3) As she was lactating biopsy was planned at later date and she was given Iron, calcium and Vitamin D supplmentation and asked to report after one month. After one month she reported with same condition as above with no mastitis or engorgement and was managed conservatively. She was advised exclusive breast feeding and hot fomentation if any engorgement or pain and to report if needed. She was not willing for immediate surgical

intervention and biopsy as she was lactating.

3. Discussion

Supernumerary breasts/Accessory breasts tissue are located in thorax 90%, abdomen 5% and axillary region 5% of cases. Accessory breast tissue is an uncommon condition which occurs in 0.4 - 6 % of women.[1,2] Ectopic breast tissue occurs due to failure of resolution of embryonic mammary ridge/milk line, which is an ectodemal thickening from axilla to groin bilaterally. It is usually sporadic. The accessory breasts may have nipples, areola or both with varied composition of glandular tissue. It is present at birth and is dormant until puberty, pregnancy or lactation.[3,4] The ectopic breast tissue can undergo pathological changes like carcinoma, fibrocystic disease and mastitis. The accessory breast tissue needs histopathology and imaging for confirmation.[5]

Excision is recommended in large size tissues for cosmetic reasons and to avoid any further complications[6,7] An alternative tumescent liposuction technique is also advocated.[8] However studies have shown excision of accessory axillary breast tissues was associated with significant morbidity. The 1915, classification system for supernumerary breast tissue by Kajava.[9,10]

3.1. Classified accordingly

1. Class 1: Polymastia consist of complete breast with a nipple, areola and glandular tissue.
2. Class 2: Supernumerary breast without an areola, consisting of glandular tissues and a nipple.
3. Class 3: Consist of an areola and glandular tissue.
4. Class 4: Glandular tissue only.
5. Class 5: Pseudo mamma or nipple and areola only.
6. Class 6: Just a nipple or polythelia.
7. Class 7: Just an areola / polythelia areolasis.
8. Class 8: Polythelial pilosis/ patch of hairs.

Most common presentation is Class 4/ Fibroglandular tissue in axilla.

It is important for the Oncologist, Pathologist, Gynaecologist to be aware of this entity for timely diagnosis and intervention.

4. Conclusion

Knowledge about Accessory breast tissue has important implications for patient care. If accessory breast tissue is not recognised then a normal variant may be misdiagnosed as an abnormal lesion like a lipoma, lymphadenopathy, sebaceous cyst, vascular malformation and malignancy. Also if surgical treatment is required it needs appropriate operative and post-operative management.

5. Source of Funding

None.

6. Conflict of Interest

The author declare no conflict of interest.

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