

Occult Metastasis of Inflammatory Carcinoma: Case Report



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Abstract

An interesting topic is lymph node metastasis of unknown origin. Therefore, this paper reports axillary lymph node enlargement, which simulated tuberculous adenitis but turned out to be due to classical inflammatory carcinoma. At the time of presentation, the breast had exhibited no palpable lump. Accordingly, it merits documentation as regards hidden breast primary.

Keywords: Lymph node; Axillary; Inflammatory carcinoma; Occult primary; Breast

Introduction

A subject of subsiding interest is metastasis of unknown origin [1]. Usually, presentation in a known lymph node is the problem because the primary site is unknown [2]. A good example of the possible choice is finding follicular metastasis, seeing that this is suggestive of thyroid origin [3,4]. Therefore, a case is reported from Nigeria where inflammatory carcinoma has been reviewed in the breast in this journal [5]. The probability was that the breast was the hidden source, seeing that the nearby axillary lymph nodes were found to contain typical inflammatory carcinoma.

Case Report

OG, a 45-year-old Igbo para 6, gravida 6, presented to the co-author (ABUA) with the history of axillary carbuncle of 3 months duration. There was some fever with poor healing. Tuberculous adenitis was queried and biopsy undertaken. The co-author (WIBO) received several crumbly, small, brownish pieces of tissue. On section, there were whitish pale areas. On microscopy, lymphoid tissue was being replaced by a tumor with poor glandular nature and striking inflammatory infiltrates. Accordingly, the diagnosis was "Inflammatory carcinoma," while the commentary was "the chances are that this is secondary to occult mammary primary." Unfortunately, the undertaking of follow-up was not reported.

Discussion

This case became available from a Reference Pathology Laboratory in the Capital City, Enugu, in Eastern Nigeria. It

confirms the opinion of a Birmingham (UK) group which recommended the use of a histopathology data pool in undertaking epidemiological analysis [6]. Moreover, there was not long ago in the UK the debate on whether a distant hospital could make use of a central laboratory [7]. As a colleague and myself actually showed, this does not apply to our developing community, [8] which is domiciled by the Igbo ethnic group [9]. The subsiding subject of "Metastasis of Unknown Origin" was massively dealt with in the journal, Current Problems in Cancer [10]. Incidentally, among their 146 references, none expressly cited inflammatory carcinoma. Therefore, the present case is worthy of documentation.

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