

Bilateral Accessory Breast: A Case Report from Nepal

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Introduction

Accessory or ectopic breast tissue is residual breast tissue that persists after normal embryonic mammary development. It can occur anywhere along the embryonic mammary streak, but is most commonly located in the axilla. Accessory breast tissue can consist of any component of the breast and may be functional or non-functional and its development is hormone dependent like normal breasts. Overall, the prevalence of accessory breast tissue in women ranges from 0.4% to 6%, and in men, from 1% to 3% [1]. Usually they are asymptomatic and do not need any intervention unless they start causing discomfort. Diagnosis of accessory breast tissue is important because they are subject to all diseases of the breast including carcinomas [2]. Here we report a case of asymptomatic accessory breast tissue in bilateral chest wall of a 32-year Nepalese multi Para female patient.

Case Description

A 32-year-old multi Para woman presented with swelling over bilateral lower chest. Physical examination revealed two 5 X 5cm each sized lobular, soft, non-tender, diffuse masses in bilateral lower chest wall over 8th costal cartilage in the mid clavicular line. The overlying skin had a 1cm pigmented center each which was the nipple-areola complex. The mass was not adherent to the underlying structures and was separate from both breasts. There was no discharge from the masses or the breasts. Both breasts were clinically normal and there was no enlargement of axillary, cervical, supraclavicular lymph nodes (Figure 1). She had no other medical problems, no past history or family history of cancer. Routine blood examinations were within normal limits. Ultrasonography of these masses showed ectopic breast tissue with normal ultrasound of the abdomen, breast and axilla.



Figure 1

On questioning she does not recall any problems or symptoms arising from these masses during the pubertal or pregnancy period. This is a case of asymptomatic bilateral accessory or ectopic breast tissue.

Discussion

Accessory breast tissue, ectopic breast tissue, supernumerary breasts, aberrant breast, polymastia are the different terms used interchangeably. Higher incidence of accessory breast tissue is recorded in Asian population, especially in the Japanese, and twice as common in females than in males [3]. Various forms of accessory breast tissue was first described by Kajava [4] in 1915 into eight groups, but this classification has been further simplified as polymastia, polythelia and aberrant breast tissue.

Class I: complete breast including glandular tissue, nipple, and areola.

Class II: glandular tissue and nipple, without areola.

Class III: glandular tissue and areola, without nipple.

Class IV: glandular tissue only.

Class V (pseudomamma): nipple and areola, without glandular tissue.

Class VI (polythelia): the nipple only.

Class VII (polythelia areolaris): the areola only.

Class VIII (polythelia pilosa): hair only.

Polymastia is breast tissue containing glands and duct system communicating with overlying skin. Polythelia is presence of accessory nipples or areole or represented by tuft of hair. Aberrant breast tissue is presence of disorganized secretory glandular tissue not related to skin [5]. Accessory breast tissue is usually misdiagnosed and the women are at times unaware until examined thoroughly by an expert. The differential diagnosis includes lipoma, lymphadenopathy, sebaceous cyst, abscess, hidradenitis suppurativa, follicular cyst among others. Accessory breast tissue is usually asymptomatic and presents with a further diagnostic dilemma in the absence of nipple and areola.

Standard mammograms do not usually show accessory breast tissue, because of its location. Ultrasonography can be of help in the diagnosis of this condition. Fine-needle aspiration is a sensitive in evaluating these masses [6]. Tissue diagnosis obviously is gold standard for confirmation of accessory breast tissue. The typical lobules, stroma and duct may be poorly organized in ectopic breast tissue.

The main complaints at presentation are cyclical enlargement, tenderness, discomfort, pain, milk secretion, and local skin irritation, while psychological embarrassment seems to be the main cause for surgical removal [7]. Accessory breast tissue can develop all disease components of ANDI (aberrations of normal development and involution) that affect the normal breast like abscess, mastitis, milk fistula, cyclical mastalgia, cysts, fibroadenoma, fibroadenosis, hamartomas, phylloides tumors and carcinoma [8]. The incidence of carcinoma in axillary breast is 0.2% to 6% which is higher than in normal breasts. The increased incidence of carcinoma in accessory axillary breast is attributed to stagnation in the ducts hence infiltrating duct carcinoma is the commonest variant [9].

In asymptomatic patients the management is conservative in most cases of accessory breast tissue through regular follow-

up [10]. In symptomatic patients accessory breast tissue can be removed by excision, liposuction, or both with satisfactory outcomes [11]. The commonly reported complications after removal of accessory axillary breast are incomplete removal of the ectopic breast, poor scar, intercostobrachial nerve injury and lymph edema of arm [7].

Conclusion

Accessory breast tissue is a not an uncommon condition and should be considered as a differential diagnosis by a clinician when appropriate. It can persist as a cause of anxiety among women for fear of a malignant change in it. Such patients should be evaluated completely along with their presenting complaints, past history and family history, general physical examination including breast and axilla and the swelling(s), and this entity must be investigated by radiological and fine needle aspiration cytology and biopsy when required.

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