wjpmr, 2024, 10(9), 01-03

SJIF Impact Factor: 5.922

WORLD JOURNAL OF PHARMACEUTICAL AND MEDICAL RESEARCH

www.wjpmr.com

Case Study

ISSN 2455-3301

WJPMR

CLEANLINESS MASTECTOMY: A CASE REPORT

Dr. Khalid Lghamour* and Pr. Hafid Hachi**

*Gynecology-Obstetrics and Endoscopy Department, Maternity Souissi, University Hospital Center IBN SINA, University Mohamed V, Rabat, Morocco.

**Gynecological-Mammary Pole, Sidi Mohamed Ben Abdellah National Institute Of Oncology, University Hospital Center IBN SINA, University Mohamed V, Rabat, Morocco.

***Corresponding Author: Dr. Khalid Lghamour**

Gynecology-Obstetrics and Endoscopy Department, Maternity Souissi, University Hospital Center IBN SINA, University Mohamed V, Rabat, Morocco.

Article Received on 24/06/2024 **Article Revised on 14/07/2024** **Article Accepted on 03/08/2024**

ABSTRACT

A case report of a clean-up mastectomy for a non-specific, triple-negative, ulcerated and infected infiltrating ductal carcinoma of the left breast diagnosed in a patient who presented late with severe transfused anemia and no distant metastases on thoraco-abdomino-pelvic scanner, followed by a total left mastectomy with axillary curage.

KEYWORDS: clean mastectomy; total mastectomy; non-specific ulcerated infiltrating ductal carcinoma of the breast; triple-negative breast cancer; anatomopathology; immunohistochemistry.

INTRODUCTION

Breast cancer is a malignant tumour of the mammary gland.[1] It is the leading cause of cancer-related death in women worldwide.[2] Systematic screening and enormous therapeutic advances have enabled early or even sub-clinical diagnosis and a better prognosis in the best-equipped and organized countries.[3]

Invasive ductal carcinoma of the breast is the most common malignant epithelial tumour with glandular differentiation.

In the case of late diagnosis, with locally advanced, ulcerated and infected ductal infiltrating carcinoma with contact bleeding and anaemia, a clean-up mastectomy is necessary to improve the patient's quality of life and relieve symptoms.

CASE REPORT

Patient aged 47, gravida 4, para 3, history of spontaneous miscarriage, seen in consultation for an ulcerated tumor of the left breast. Biopsy of the tumor showed a grade III infiltrating mammary carcinoma. The patient was referred to our hospital and hospitalized in medical oncology for an infected ulcerated infiltrating ductal carcinoma of the left breast.

Examination of the left breast revealed a huge ulceration bleeding on contact with the entire upper-external quadrant, extending into the axillary fossa. Orange peel appearance in the inferolateral quadrant. Fixed mass in both superficial and deep planes. No palpable adenopathy.

Pus sample isolated staphylococcus aureus. Patient started on rochephin 2g/day. Hemoglobin kinetics 8/7.1/6.3/4. Patient transfused, post-transfusion hemoglobin 9.7g/dl, CRP=22mg/l.

A thoraco-abdomino-pelvic scanner showed a large breast mass with suspicious homolateral axillary adenopathies, with no signs of secondary distant localization. A lymph node complex infiltrated the skin and deep layers in the upper left breast quadrant.

The decision to perform a total left mastectomy with axillary lymph node curage was taken at the multidisciplinary consultation meeting. The patient was given informed consent, and a clean-up mastectomy was then performed.

Pathological examination of the operative specimen showed

- non-specific infiltrating breast carcinoma measuring 12.5 cm long, infiltrating and ulcerating the skin, SBR grade III (3+3+2) modified by Ellis and Elston.
-no vascular emboli.
-deep surgical border is non-tumoral at less than 1mm.
-non-tumoral lateral surgical borders.
-axillary contouring: 02N+/23N.
-pT4b N1a Mx (TNM 2017).

Immunohistochemistry shows

-estrogenic and progesterone hormone receptors negative.
-herceptest negative (score 0).

The patient's case was discussed again at a multidisciplinary consultation meeting. The patient was referred to the medical oncology department for further management.

Figure 1: total left mastectomy with axillary curage.

Figure 2: skin-edge approximation.

Figure 3: skin closure.

DISCUSSION

Invasive ductal carcinoma is a type of breast cancer that develops in the glandular cells of the breast's milk ducts. It is the most common type, accounting for 75% of all breast cancers. Unlike ductal carcinoma in situ, this cancer spreads outside the breast duct to neighbouring breast tissue or other body organs.

It can take on several forms, depending on the characteristics of the tumour cells present: papillary, mucinous, medullary, tubular, infiltrating with no other indication or of a non-specific, squirrel-like type. It is said to be triple-negative when the tumor expresses neither estrogen nor progesterone hormone receptors, nor HER2/neu.

Invasive ductal carcinoma is often diagnosed during mammography or breast ultrasound scheduled as part of a screening strategy, or performed as part of a consultation prompted by visible symptoms or the patient's own self-examination.

When breast cancer is suspected, but mammography or breast ultrasound cannot locate a lesion, other types of medical imaging examinations may be considered (scanner, MRI). If an abnormality is detected on medical imaging, a breast biopsy is performed.

Treatment of invasive ductal carcinoma is always tailored to each patient's profile, wishes and tumour characteristics. It is therefore normal for treatment protocols to vary widely from one patient to another.

In most cases, oncological surgery remains the first-line treatment when feasible.

This involves surgical removal of the cancerous tumour, and a margin of healthy tissue around it.[4]

Depending on a number of parameters, including the aggressiveness of the cancer, the patient's profile, the level of risk of recurrence and the likely response of the disease to adjuvant treatment, this healthy tissue margin may be more or less extensive, up to and including total mastectomy,[5] sometimes combined with axillary curage.[6]

Radiotherapy, chemotherapy and hormone therapy are among the treatments most frequently associated with surgical removal of invasive ductal carcinoma. Other types of treatment, such as targeted therapies or immunotherapy, may also be indicated.[7]

In the case of locally advanced infiltrating ductal carcinoma with ulceration, and above all without distant metastasis, as in the case of our patient who was very anaemic due to bleeding on contact, clean mastectomy with axillary curage improves quality of life for the patient, who will then benefit from adjuvant treatment.

CONCLUSION

Invasive ductal carcinoma is the most common type of breast cancer. In the case of locally advanced, ulcerated and infected tumors that bleed on contact and have no distant metastases, a clean mastectomy can improve the patient's quality of life. After surgery, the patient is referred for adjuvant treatment.

REFERENCES

1. World Health Organization (WHO) Cancer. http://www.who.int/cancer/fr/.
2. World Health Organization (WHO) Women's health. Media Centre, fact sheet N°334. 2013 September; http://www.who.int/mediacentre/factsheets/fs334/fr/.

3. Bosetti C, Bertuccio P, Levi F, Chatenoud L, et al. The decline in breast cancer mortality in Europe : an update (to 2009) Breast., 2012 Feb; 21(1): 77–82.
4. Breast cancers - Recommendations and practice aids. [cited 2019 Feb 15]; Available from: https://www.e-cancer.fr/Healthcare professionals/Recommendations and practice aids/breast cancer/#specialized management recommendations.
5. Garrido. Conservative surgery and oncoplastic surgery. In: Breast plastic surgery. Elsevier Masson., 2012; 108-20.
6. Patey DH, Dyson WH. The Prognosis of Carcinoma of the Breast in Relation to the Type of Operation Performed. Br J Cancer. Juin, 1948; 2(1): 7-13.
7. Madden JL, Kandalaft S, Bourque R-A. Modified Radical Mastectomy: Ann Surg. Mai, 1972; 175(5): 624-34.