INTRODUCTION

Accessory breast tissues are reported in 2-6% of women due to failure of regression of mammary streaks in embryogenesis. These mammary streaks extend from axilla to the groin. Accessory breast tissue may be asymptomatic or symptomatic, cause pain, restriction of arm movement, cosmetic problems or anxiety. Commonly found in the axilla, it can present on other rare sites like perineum, vulva and thigh. Differential diagnosis of a mass present along the primitive milk line may include lipoma, enlarged lymph nodes, sebaceous cyst and hidradenitis suppurativa. During the centuries of witch-hunts, supernumerary breasts and nipples were deemed as devil's marks. Men and women who had accessory breast were tortured and killed. These patients usually present during younger age group when it becomes more active or symptomatic during menarche, pregnancy and lactation as a response to fluctuating levels of sex hormones.

We are reporting a case of 30-year-old female, presented with simultaneous duct ectasia of accessory as well as ipsilateral normally located breast.

CASE REPORT

A 30-year-old young married lactating mother presented with the history of swelling in the right axilla for 10 months. This swelling increased in size slowly and gradually then burst spontaneously with the discharge of pus through multiple discharging sinuses. The complaints started just after the delivery of her last child 10 months back. One week ago, she had consulted a general practitioner who noticed a second painless lump in the right breast. She had 4 children and husband in her family. There was no family history of tuberculosis and malignancy of the breast.

On examination, a lump was found in the centre of right axilla, 3.5 x 3.5 cm in size, oval in shape and non-tender. There was a small bulging over the swelling, looking like a nipple but there was no areola. That swelling was firm in consistency and fixed to the overlying skin with scar mark of previously discharging sinuses. It was not discharging at the time of examination. Ipsilateral anterior group of axillary lymph nodes were palpable. The other swelling on the right breast present in the upper and outer quadrant was firm and mobile, approximately 1x1 cm in size and free from skin and underlying breast tissues. Contra-lateral breast and axilla were completely normal on examination.

Ultrasound examination showed hypo-echoic mass in the axilla. Fine Needle Aspiration Cytology (FNAC) reported inflammatory cell. Sinogram was not done because there was no active discharge at the time of examination. Provisional diagnosis was tuberculosis lymphadenitis, subjected to excision. Wide excision of both swellings, through separate incisions under general anesthesia, was done.

ABSTRACT

Accessory breast and duct ectasia are common clinical problems in their own right. However, their coexistence is a rare entity. Duct ectasia is a dilation in one or more of the larger lactiferous duct filled with a stagnant brown or green secretion, which may or may not discharge through the nipple. This material acts as an irritant and leads to periductal mastitis. Duct ectasia may present with subareolar mass, nipple discharge, nipple retraction, non-cyclical mastalgia or mammary fistula. Surgical options are microdochectomy or cone excision of major ducts. This case report describes the presence of duct ectasia in both accessory breast situated in the axilla and ipsilateral normal breast simultaneously.

Key words: Accessory breast. Plasma cell mastitis. Duct ectasia.

Department of Surgery, Unit V, Civil Hospital, Dow University of Health Sciences, Karachi.

Correspondence: Dr. Shahida Parveen Afridi, House No. 4/874, Shah Faisal Colony No. 4, Karachi. E-mail: drshahishakeel@yahoo.com

Received September 07, 2007; accepted October 16, 2008.

Figure 1: Figure a and b showing the axillary lump with a prominent swelling like a nipple.
Histopathology findings of the swelling present in the breast were reported as mammary duct ectasia or plasma cell mastitis and the second swelling present in the axilla was also reported as accessory breast tissues with mammary duct ectasia.

This patient was advised follow-up as the pathologic breast tissue was already excised.

**DISCUSSION**

The primitive milk streaks forms in the human embryo during the 5th week of embryonic development, the milk streaks forms the mammary ridge, which later develops into anatomically situated breast. Accessory mammary tissues result from incomplete regression of this milk streak. Polymastia, supernumerary or accessory breast tissues are terms used to describe the presence of more than two breasts in human beings. The same pathology that affects normally positioned breasts, including carcinoma, can occur in ectopic mammary tissue. A role of ultrasound, mammogram, and MRI in the diagnosis of these pathologies is equivocal and not confirmatory. Liposuction can be an option for an accessory breast in a specialized unit. The advantages of this method include a minimal incision scar from the liposuction cannula and the ability to detect residual axillary breast by ultrasound. Primary carcinoma of ectopic breast tissue has been reported only in a small number of cases. Because an overlying accessory areola or nipple is often missing and because of a general lack of awareness among physicians and patients concerning these unsuspicous nodules, clinical diagnosis is frequently delayed. Carcinoma occurring in ectopic breast tissue remains rare, but this diagnosis must be suspected when confronted with any axillary nodule. The use of lymphatic mapping and sentinel node biopsy in the case of cancer of an accessory breast allows more accurate determination of lymph node status.

The presently reported patient was a young lady developing the manifestations of duct ectasia following lactation, which is a logical sequence. The excision, intended primarily for suspected lymphadenopathy and breast mass was curative. It also helped to allay the patient’s anxiety about the nature of the breast and axillary mass.

**REFERENCES**