Case reports

Metastatic accessory breast carcinoma in a thoracic subcutaneous nodule

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Each year 14 000 women die from carcinoma of the breast in the United Kingdom[1]. Carcinoma arising in accessory breast tissue is rare and few cases have been reported. However, since such tissue is under the same multifactorial influences as normal breast tissue, carcinoma should be anticipated. A case of carcinoma in a previously unrecognized thoracic accessory breast is reported.

Case report

A 43-year-old Caucasian woman presented with a left-sided, thoracic, subcutaneous lump. It had been present for 4 months and had become hard and tender over a period of 2 months. Her menstrual history was unremarkable, she had never taken the oral contraceptive pill and had breast-fed her three children without complication.

Examination revealed a firm, mobile, non-tender mass measuring 2×1 cm overlying the left eighth rib in the mid-clavicular line. A clinically normal accessory nipple was noted 3 cm lateral to it with no obvious attachment.

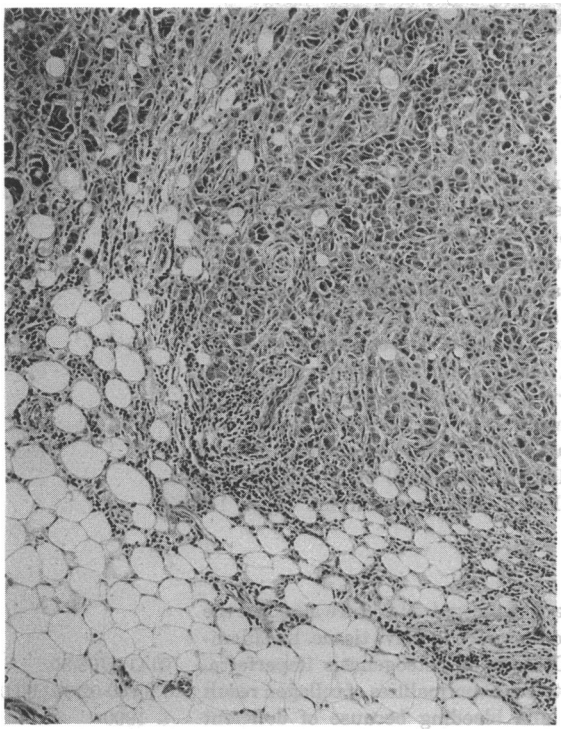

Figure 1. Poorly differentiated carcinoma of the breast infiltrating adipose tissue (H&E ×17)

The accessory nipple and mass were excised. Histological examination of the nipple demonstrated normal accessory breast and nipple tissue with no evidence of malignancy. The subcutaneous lump contained poorly differentiated carcinoma of the breast infiltrating adipose tissue (Figure 1).

The full blood count, erythrocyte sedimentation rate, urea and electrolytes, liver function tests, serum calcium and phosphate were normal, as were the chest X-ray, bilateral mammogram, abdominal ultrasound and technetium bone scans.

Computerized tomography of the chest, abdomen and pelvis demonstrated small soft tissue nodules in the left anterior chest wall in the region of the excision.

Wide excision of the operative area was performed. Histology confirmed residual in situ and infiltrating ductal carcinoma within breast tissue, with clear margins of excision.

Tamoxifen 20 mg orally twice a day was commenced. A course of radiotherapy was given to the left breast, axilla, supraclavicular fossa and internal mammary chain with an inferior extension to include the operation site.

Six months later a large recurrence was excised from the left supraclavicular fossa. Histology demonstrated lymph nodes virtually replaced by metastatic tumour. Further staging showed stage IV disease with pulmonary lymphangitis carcinomatosa, hilar enlargement and liver and bone metastases.

Discussion

Mammary tissue develops in utero at five weeks when bilateral ectodermal mammary streaks appear running from the axillae to the groins. Mammary ridges form in the thoracic region by the 7th week and downgrowth into the mesoderm produces the rudiments of the mammary glands. Concurrently, the remainder of the mammary streak involutes. Incomplete involution or excessive dispersion can result in the development of accessory breast tissue along this line or elsewhere[2,3]. Camisa reported the presence of a mass resembling a normal female breast on a man's thigh[4].

Accessory breast tissue can consist of any or all components of the breast[3] and be functional or non-functional[5,6]. Accessory breast tissue is present in the axilla in 2-6% of women[2] and may be a mammographic finding[6]. In the absence of a nipple or lactation the diagnosis is rarely made and the findings are commonly attributed to a lipoma[7].

Accessory breast tissue is subject to the same pathological influences as normal breast tissue. Fibroadenomata, fibrocystic disease and primary carcinoma have all been reported[8-10]. Guerry and Pratt-Thomas reported a patient with a primary breast carcinoma in both breasts and in accessory breast tissue in the vulva. They suggested a common carcinogen was acting in multicentric loci[11].

Matsuoka *et al.*[12] reported a case of axillary, accessory breast carcinoma and reviewed 33 cases of carcinoma of accessory breast tissue. They stressed the importance of considering the diagnosis of carcinoma in subcutaneous nodules found around the breast.

In conclusion, early diagnosis and treatment are imperative in the management of subcutaneous nodules of uncertain origin in the region of the breast and primitive mammary streak.

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Ehlers-Danlos syndrome with recurrent bruising

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Despite being a well-described 'textbook feature' of Ehlers-Danlos syndrome, there are few case reports or published series on bruising or bleeding in this condition. We report the case of a 62-year-old man with Ehlers-Danlos syndrome and recurrent, troublesome bruising. Clinical, haematological and biochemical features are described.

Case report

Our patient first developed skin problems in early childhood with frequent skin lacerations particularly over the lower legs, knees and elbows. These often required suturing and healed to leave large, unsightly splayed scars. Once healed, these scarred skin areas were a frequent site for haematoma formation which occurred following even trivial trauma and often took weeks to disperse. At the age of 10 years he was admitted to hospital for excision of the scarred skin overlying the knees. The wounds failed to heal satisfactorily and the scars remain widely splayed.

At 17 years he entered the army but was soon discharged because his delicate skin could not withstand the stresses applied to it during training. He was noted to suffer from severe bruising of knees and elbows for which no underlying cause could be identified at that time.

The diagnosis of Ehlers-Danlos syndrome was established in 1952 when he was first seen by a dermatologist. The following year he ruptured the left tendo-achilles which was repaired surgically, but with great difficulty. Bruising and poor wound healing were again prominent in 1967 when he underwent ligation and stripping of varicose veins from the right leg.

The past five years have seen a deterioration in his bruising tendency. He has been troubled by frequent painful bruises at pressure points on the feet which have necessitated the wearing of well cushioned shoes and walking at a gentle pace to minimize pressure and shearing forces. He has also been prone to uncomfortable bruising of the hands and fingers which have often taken weeks to disperse (Figure 1). He has recently avoided eating abrasive foods, as this has tended to induce oral blood blisters.

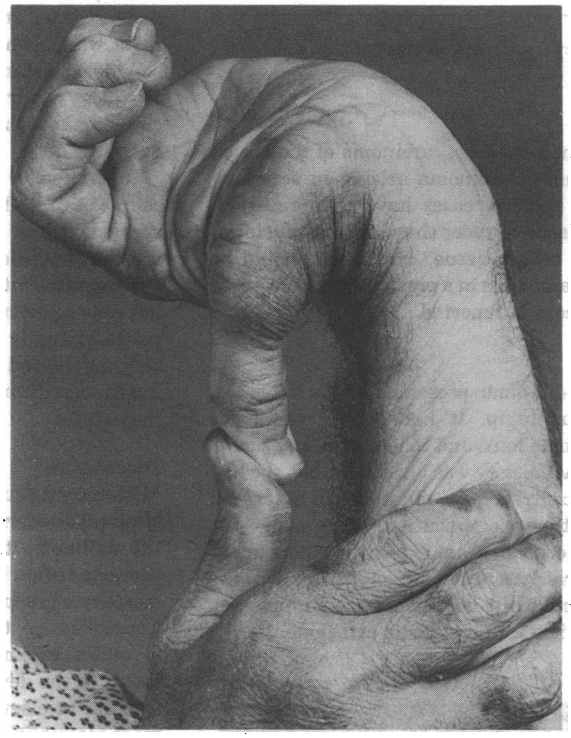

Figure 1. Hypermobile left wrist and numerous small bruises on the fingers of the right hand

Skin biopsy showed normal epidermis with some increase in dermal elastic fibres relative to a decreased amount of collagen. Full blood count was normal with a platelet count of 235×10^9/l. The prothrombin and partial thromboplatin times were both normal and no clotting factor abnormality was detected. Platelet aggregation studies showed a normal aggregation pattern to a range of concentrations of ADP, adrenaline, collagen, arachidonic acid and ristocetin. Bleeding time was normal, at 7 min, and the Hess capillary fragility test was negative. The separation of radiolabelled collagens from fibroblast culture showed no abnormalities of pro collagens nor collagen α1(I), α2(I) or α1(III) chains, therefore excluding Ehlers-Danlos syndrome types IV and VII.

Discussion

Abnormal bleeding is a well recognized feature amongst the various hereditary disorders of connective tissue. In Ehlers-Danlos syndrome (EDS) and in osteogenesis imperfecta, qualitative and quantitative abnormalities of collagen result in vascular fragility and bleeding because of deficient extravascular and perivascular support. There are, at present, 11 types recognized, of which types I, IV and X may all exhibit prominent bruising. Haematological investigation

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