Bilateral Giant Fibro Adenoma of Breast (Case Report)

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Abstract

Fibro-adenoma is the most common lesion of the breast, it occurs in25%of asymptomatic women [1,2]

It is usually a disease of early reproductive life, the peak incidence is between the ages15 and 35 years.[3,4] It presents as firm highly mobile, non tender mass .[5]

Less than 5% of fibro-adenomas grow rapidly and display the clinical and histologic characteristics of giant fibro-adenoma which is defined as a-tumour either having a diameter greater than 5 cm. And /or amass weighing more than 500 grams, and are conventionally a benign tumor of breast.[6]

Giant fibro-adenomas appear as well-circumscribed but not encapsulated masses on mammography and solid and the texture is homogenous and hypoechoic with low level echoes on U/S. [6, 7]

It is hormone dependent that lactates during pregnancy and involutes along with the rest of the breast in perimenopause.[5]

Excessive estrogen stimulation and /or receptor sensitivity, or lack of estrogen antagonist havebeen implicated in the etiology. [2]

Giant fibro-adenoma is often confined to one breast as a solitary mass occupying part or the whole breast and in rare cases it may be multifocal and involve both breasts. [8]

Giant fibro-adenomas are benign and do not become malignant. [9]

Histological cut surfaces have a lobulated grey-white myxoid semitransparent to dens fibrous appearance, it consist of epithelial and fibrous components, the pericanalicular fibro-adenoma maintains round and oval dilated ductal spaces whereas in the intracanalicular type the ductal lumens are compressed by polypoid fibrous stroma creating slit –like irregular spaces , the ducts are lined by two layers of cells: epithelial and myoepithelial cells and under influence of hormones the ducts become hyper plastic with papillary formation and more than two layers of cells varies from myxoid and hypo cellular to fibrous and moderately cellular . [2]

Surgical treatment of giant fibroadenoma ranges from shelling the tumour out in case it occupies part of the breast, to simple mastectomy. [10] .

Al- Kindy Col Med J 2008; Vol .4 (2): P103-105

Case Presentation

A twenty nine years old Iraqi house wife married with 4 years old boy ,presented (at Hilla Teaching Hospital in Babylon Governorate) on November 2001 with progressive bilateral breast enlargement of 5 years duration ,not painful ,no nipple discharge ,and no history of trauma .

The condition started 5 years ago as very rapid enlargement of both breasts during her first pregnancy which has decreased in size to half after delivery without any treatment.

Three years later ,the patient got pregnant and the size of the breasts started to increase rapidly ,she received anti-estrogen medications with no evident effect and developed multiple big ulcers on both breasts, and at 2 weeks gestation she suffered multiple big ulcers on both breasts , and at 32 weeks gestation she suffered from sever bleeding from breast ulcers to the extent that she was admitted to the hospital in a state of hypovolemic shock and blood transfusion was done .at 37 weeks gestation, cesarian section performed due to fetal growth retardation and embarrassment which has died few days later.

On Examination

The patient was pale anemic tiered anxious emaciated with kyphosis.

Breast examination revealed bilateral huge breasts:-

The Rt. = 45 x25x25 cm.

The Lt. = 35 x20 x20 cm .

With multiple big ulcers some of them 10x15 cm. Size ,with tense thin shiny erythematous skin with large dilated veins with solid firm mass over the whole breasts ,not tender ,with no axillary lymph nodes enlargement .

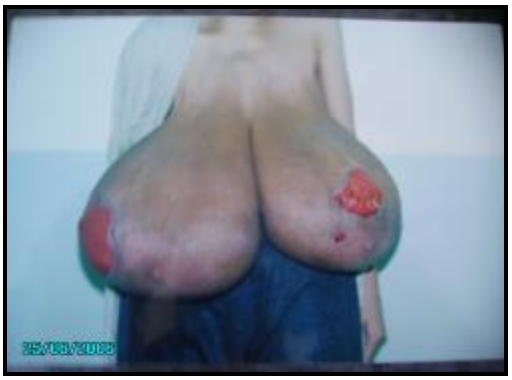
X –Ray and ultrasound study showed solid homogenous mass over whole each breast.

Hormonal study showed no significant finding.

Consultation of general surgeons was advising bilateral mastectomy, which the patient and her family refused vigorously.

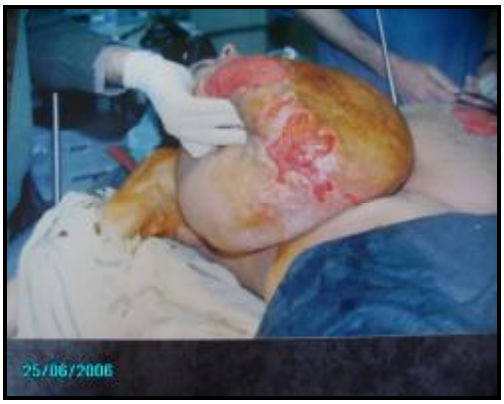
Treatment

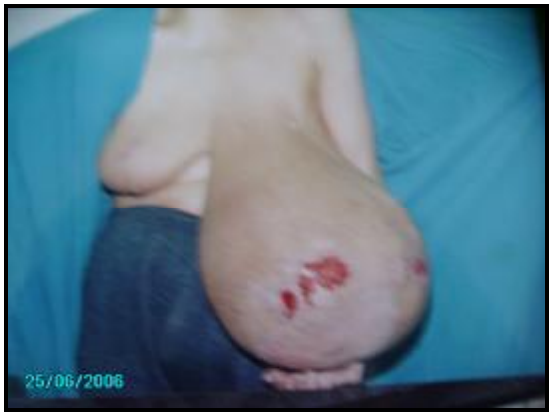
Preparation of the patient for surgery started:-
Daily cleaning with antiseptics and local application of antiseptic cream , systemic antibiotics ,correction of anemia with blood transfusion ,reassurance and psychological and emotional support .
Operation started on the Rt. Breast because it was bigger.
Under general anesthesia breast amputation with free nipple graft (Rubin meyhod) performed , 8.75 k.g. of breast tissue excised , and the remainder of the breast tissue used to create an accepted breast form .
Post operative period passed smoothly, nice wound healing, but got partial nipple- areolar complex loss, and histopathological study showed Giant Fibroadenoma with no malignant cells.
The patient has been lost for 2 months.
Two months later operation on the Lt breast performed and it was almost the same as the first in the procedure and results but the excised breast tissue was 7.5 k.g. and full take of nipple-areolar complex graft.
The patient has been followed up for one year during which no medications were given, no recurrence detected and the patient became pregnant 3 months after the second operation.

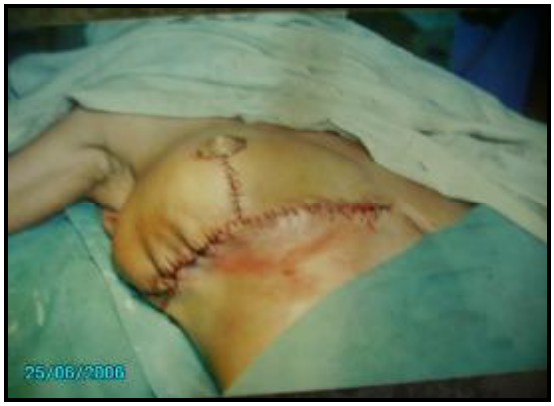


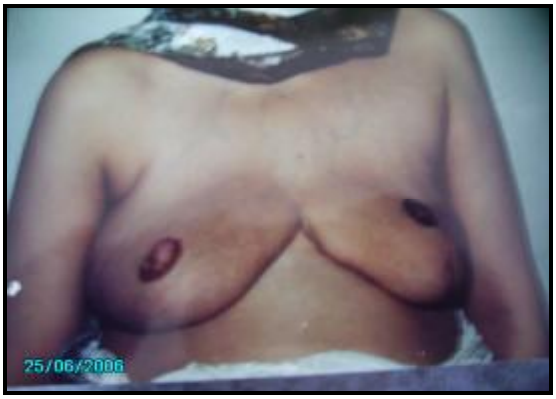
Discussion

Giant Fibroadenoma treated surgically by: excision which ranged from enucleation, wide excision, to mastectomy.
In this case in spite of huge breast and multiple big ulcers which made the planning and technique very difficult ,we treated it with breast amputation and free nipple areolar graft with good surgical result, and accepted breast form and happy patient .
From this case we agree with all surgeons who advice excision of the tumor and no need for mastectomy or mutilation of the breast. [11, 9]









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Al- Kindy Col Med J 2008; Vol .4(2) 105

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Received at 1st March 2008. Accepted at 23rd April 2008