https://doi.org/10.29289/259453942022V32S1007

474 - AXILLARY ACCESSORY BREAST SARCOMA IN A YOUNG PATIENT

Camila Vitola Pasetto[1], Diego Wallace Nascimento[1], Gabriela Bezerra Nóbrega[1], José Roberto Filassi[1]

[1]Universidade de São Paulo – São Paulo (SP), Brazil.

The accessory breast tissue in the axillary region is rare, but as there is breast tissue, there is the possibility of pathological degeneration. With an even greater rarity, breast sarcoma is a diverse group of malignancies derived from mesenchymal tissues. The aim of this report was to describe a case of a young patient with sarcomatous neoplasia in the axillary accessory breast topography. Patient LPMS, 19 years old, female, admitted to the mastology service of the Hospital das Clínicas of the Universidade de São Paulo with a nodule realized in the left axillary region with progressive growth during pregnancy. The patient was healthy with a family history of a maternal aunt with breast cancer at 50 years old. At the clinical examination, she had an extensive tumor affecting the left axillary region measuring 10 cm with clinically negative axilla. Contralateral breast and axilla and supra-/infraclavicular fossas without abnormalities. In the initial mammogram, a hyperdense, oval, and indistinct nodule was found in the left axillary extension, measuring 10.8 cm. In breast magnetic resonance imaging, a heterogeneous mass in the left axillary extension is observed with irregular, lobulated margins, measuring 10.3×10×10.1 cm, heterogeneously and concentric by the contrast. Core biopsy was performed with the result of spindle cell mesenchymal neoplasm. In the systemic staging examinations, there was no evidence of a lesion suspected of distant metastasis. Vincristine 1.5 mg/m^2 + Actinomycin D 0.45 mg/kg/day + Cyclophosphamide were prescribed to the patient. After six cycles with no clinical response, it was decided to switch the neoadjuvant chemotherapy to doxorubicin 25 mg/m^2 and Ifosfamide 3,000 mg/m^2. After three cycles, the patient remains without a clinical response to neoadjuvant chemotherapy. It was decided to refer the patient to radiotherapy for axillary irradiation on the right, with a subsequent surgical approach. The patient underwent surgery with wide resection of the tumor and axillary lymph nodes. The anatomopathological examination showed sarcoma with immunohistochemistry suggestive of rhabdomyosarcoma measuring 19.3×14.8×14.7 mm with free margins and with sarcoma metastasis in one of the 21 dissected lymph nodes. The patient progresses well postoperatively. Accessory breast tissue has a very rare incidence in the population, with incidence rates of 1–2%. With regard to breast sarcoma, it is a very rare condition. It consists of a heterogeneous group of nonepithelial tumors originating from the mesenchymal tissues of the breast. They account for <1% of all breast malignancies and <5% of all sarcomas. Due to its rarity, current knowledge about breast sarcoma is limited and is mainly based on small retrospectives, case series, or case reports. Angiosarcoma, including secondary angiosarcoma from before breast radiation, is the most frequent type of breast sarcoma. As with other soft-tissue sarcomas, the primary breast sarcoma is associated with genetic conditions such as Li-Fraumeni syndrome, familial adenomatous polyposis, and type 1 neurofibromatosis. Therefore, breast sarcoma treatment generally follows the algorithms derived from trials of soft-tissue sarcomas in the chest wall, as has been done with the reported patient. Surgical treatment is the standard and most accepted treatment for breast sarcoma. The role of chemotherapy for breast sarcoma is also uncertain. There are no prospective studies that specifically assess the benefit of chemotherapy in adjuvant or neoadjuvant settings. Likewise, the benefit of radiotherapy in breast sarcoma is also very doubtful with evidence of benefit in large tumors and with positive margins after surgical resection.