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533 - NIPPLE MINIMUM PAGET DISEASE: A CASE REPORT

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Paget's disease (PD) of the nipple is a rare cancer that affects the nipple and areola and accounts for between 0.4% and 5% of breast cancers. It was first described in 1877 by the English physician Sir James Paget. It affects women between 60 and 70 years of age and very rarely affects men. In PD, the skin on the nipple and areola becomes thicker. Clinical presentations are usually erythema, desquamation, or eczematous changes in the nipple, features that can progressively progress to erosion, overt destruction, and ulceration of the papilla. Bloody papillary discharge, itching, nipple retraction, and/or a palpable mass may be associated. Cancer cells, called Paget cells, are malignant, large, with clear, abundant cytoplasm and nuclei with prominent nucleoli. Like glandular cells, they appear either as isolated cell in the epidermal tissue or as groups of cells. Most women diagnosed with PD also have ductal adenocarcinoma, either in situ or invasive. The prevalence is 67–100% of cases, which gives a worse prognosis to the patient. Patients with Paget-associated invasive breast disease have lower hormone receptor expression, greater lymph node involvement, and higher human epidermal growth factor receptor type 2 (HER2) expression. An 82-year-old woman sought the mastology outpatient clinic for a follow-up of carcinoma in situ in the right breast 2 years ago, having been submitted to quadrantectomy and hormone therapy with tamoxifen, with no signs of recurrence. She complained of an exudative pruritic lesion on the left nipple that had started 6 months ago. She reported that the lesion started with itching and burning, associated with a spontaneous discharge of serous secretion from the itchy surface of the breast, which improved with the use of "talcum powder." On physical examination, the presence of a discrete reddened area with a diameter of 3 mm, eczematous, with bloody areas interspersed with serous secretion was observed on the left nipple. Areola lesions and palpable nodules in the left breast were absent. She underwent mammography, which showed symmetrical breasts with fat-replaced parenchyma, absence of nodules, presence of isolated calcifications, and grouping in the superior lateral region of the left breast, categorized as BIRADS II. On ultrasound, a nodule with angled edges, measuring 5×4 mm in the superomedial quadrant of the left breast, which showed nodular enhancement and persistent kinetic curve on magnetic resonance imaging of the breasts. The histopathological study diagnosed moderately differentiated left breast ductal carcinoma, associated with a high-grade solid intraductal carcinoma and PD of the nipple, without the involvement of the areola. Immunohistochemistry revealed the absence of estrogen and progesterone hormone receptors and HER-2 overexpression in both histological types. She underwent mastectomy with sentinel lymph node biopsy that was free of neoplasia. Oncological follow-up with no signs of recurrence. PD, if left untreated, extends to the areola and other regions of the breast. Therefore, clinical suspicion from the first physical examination allows an early diagnosis of extreme importance, which improves the prognosis and allows less aggressive treatments.