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LETTERS TO THE EDITOR

Mammary hamartoma in a male

Hamartoma mamario en el varón

To the Editor:

Mammary hamartoma was first described by Arrigoni et al.[1] in 1971 and is a rare benign tumor, although presumably underdiagnosed.[2] Usually present as painless, well-circumscribed and mobile breast lump. Histologically consist of various amounts of glandular tissue, fat, fibrous tissue, and occasionally muscle, hyaline cartilage and a thin capsule.[2,3] We present a case of breast hamartoma in male.

A thirty-two year old male was observed in our consultation for a slowly growing and painless right breast lump. The patient denied nipple discharge or other symptoms. Examination revealed a well-defined, soft and mobile lump in the external upper quadrant of the right breast. There were no inflammatory signals or palpable lymph nodes.

Ultrasound study showed no specific alterations, with a nonspecific and ill-defined area of increased density in the right breast. By the persistence of this pseudonodular area on palpation and discomfort mentioned by patient, and according to the patient's will, surgical treatment was proposed, with excision of small densification of breast tissue from the right breast.

Histological examination of the nodular fragment of 3.2 cm × 2.5 cm showed a disorganized overgrowth of mammary tissues with variable amounts of fatty tissue, fibrotic stroma and epithelial elements with mild epithelial hyperplasia. Without a typical capsule, the nodule was well demarcated from the adjacent breast tissue by fibrous tissue (Fig. 1).

Mammary hamartoma has an incidence of 0.1–0.7% in the literature,[2,3] and only 4 cases described in males, 2 in adults[4,5] and another 2 in pediatric age.[6,7] Hamartomas presents at any age group but are more common in premenopausal and perimenopausal women. It is a benign lesion, although it has already been described in association with carcinoma in situ and lobular carcinoma.[8] The diagnosis is difficult and relies on the correlation between the clinical and typical radiological findings (oval-shaped masses with heterogeneous density, ill-defined limits and occasionally a radiolucent halo).[3,9] The ultrasound has no utility in the diagnosis of this entity as descriptions show variable and non-specific sonographic appearance.[10]

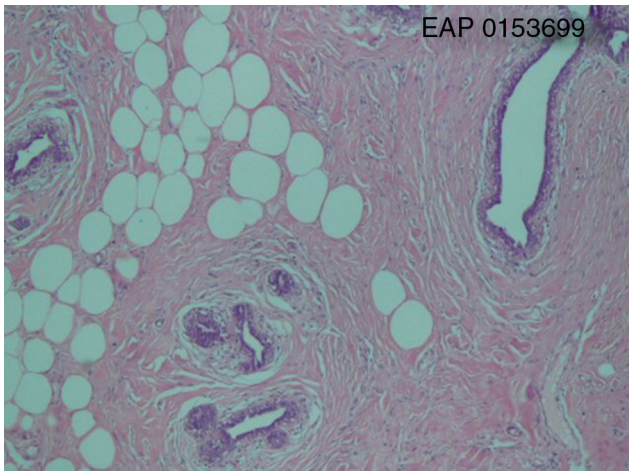

Figure 1 Histological examination of the excised breast tissue (hematoxylin–eosin, 100×), showing disorganized overgrowth of mammary tissues with variable amounts of fatty tissue, fibrotic stroma and epithelial elements.

Previous reports have shown variable cytological and histological characteristics of breast hamartoma and some attempts have been made to subclassify hamartomas, although none of them has been widely accepted. Jones et al. suggested a four category classification of encapsulated fibrocystic changes, fibroadenoma with fibrous stroma, fibroadenoma-like and circunscribed adenolipoma based on hystological parameters.[11] The main interest of fine-needle aspiration cytology was the exclusion of malignancy, regarded the similarities of other benign lesions as fibroadenoma.[12] Although both represent a benign fibroepitelial growth of breast tissues, some studies have been pointing out differences in cytological aspects. Herbert et al. showed that the finding of intact lobular units and various amounts of adipose tissue favored a diagnosis of breast hamartoma over fibroadenoma. The most common histological pattern, as seen in this case, is that of a lesion with well demarcation from adjacent breast tissue, intact lobules and interlobular adipose tissue and fibrotic stroma. Other frequent characteristics are epithelial hyperplasia and pseudo-angiomatous stroma hyperplasia.[13]

As the differential diagnosis it is important to consider not only frequent benign lesions such as fibroadenoma or fibrocystic disease but also diseases as the breast adenomyoepithelioma, diabetic mastopathy, intramammary lipoma or breast lesions associated with Cowden's disease, usually with multiple hamartomas and pathognomonic mucocutaneous lesions.[12]

The breast hamartoma does not require surgical treatment when the diagnosis is previously established, the lesion is small and the patient is young. In this case it is only indicated a radiological surveillance.

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Plasmocitoma de mama, a propósito de un caso

Breast plasmacytoma, apropos of a case

Sr. Director:

Presentamos el caso de una mujer de 73 años que desde hace 6 meses se encuentra en tratamiento con quimioterapia y radioterapia por mieloma múltiple (MM). Acude a su médico de atención primaria al palparse un nódulo doloroso en la mama derecha. En la mamografía se identifica una masa de 4 cm en intercuadrantes externos, con contornos bien definidos. Se completa el estudio con ecografía, en la que se observa un nódulo hipoecoico de $36 \times 25 \times 20$ mm, de ecoestructura heterogénea, contornos algo lobulados y sin sombra acústica posterior. En el estudio doppler se demuestra una amplia vascularización en su interior. Ante los hallazgos, se sospecha lesión mamaria maligna, sin poder descartar una extensión de su MM. Se realiza biopsia ecodirigida mediante aguja gruesa de 14 G. La anatomía patológica muestra una proliferación linfoide maligna compatible con plasmocitoma, diagnóstico que se confirma tras el análisis inmunohistoquímico (receptores CD79a+, CD138+, Kappa− y Lambda+). Posteriormente se realiza RM (fig. 1a), identificando un realce nodular precoz e intenso (fig. 1b) con curvas funcionales sospechosas de malignidad (fig. 1c y d). El estudio de difusión presenta valores de ADC de 0,00102 mm^2/seg, con un porcentaje de restricción a la difusión del 41%. Se descarta multifocalidad y multicentricidad. La paciente recibió tratamiento radioterápico local, y en la ecografía de control realizada 3 meses después, la lesión había desaparecido por completo.

Las gammapatías monoclonales malignas constituyen un grupo de trastornos caracterizados por la proliferación clonal y progresiva de células plasmáticas malignas, que producen una proteína de carácter monoclonal[1]. Se distinguen varios subtipos, de los cuales el más común es el MM, y el menos frecuente (4%) y agresivo, el plasmocitoma extramedular (PEM)[2]. Los PEM pueden presentarse en cualquier parte del cuerpo, pero aproximadamente el 90% de los casos aparecen en la cabeza y el cuello. La afectación de la mama es extremadamente rara[3–6], pudiendo aparecer como un tumor solitario o, más frecuentemente, en el contexto de un MM diseminado[4,5,7,8].

La mayoría de los plasmocitomas mamarios registrados en la bibliografía corresponden a pacientes con MM con afectación secundaria de la mama[1,2]. Son más frecuentes en mujeres, con una edad media de 53 años y un tamaño que oscila entre 1 y 7,5 cm[3]. Más de dos tercios son unilaterales[1,4–6] y pueden aparecer de forma sincrónica a otros tumores primarios de mama, como el carcinoma ductal invasivo[5].