

AXILLARY SUPERNUMERARY BREAST: CASE REPORT**Amina. Etber^{1*}, Otman Elharmouchi², Youssef Essebbagh¹, Amina Lakhdar and Aziz Baydada¹**¹Gynaecology-Obstetrics and Endoscopy Department, Maternity Souissi, University Hospital Center IBN SINA, University Mohammed V, Rabat, Morocco.²Gynaecology-Obstetrics and Endocrinology Department, Maternity Souissi, University Hospital Center IBN SINA, University Mohammed V, Rabat, Morocco.***Corresponding Author: Amina. Etber**

Gynaecology-Obstetrics and Endoscopy Department, Maternity Souissi, University Hospital Center IBN SINA, University Mohammed V, Rabat, Morocco.

Article Received on 21/08/2022

Article Revised on 11/09/2022

Article Accepted on 01/10/2022

SUMMARY

We report on a case of polymastia in a 17-year-old girl in whom surgical exploration of an axillary mass histologically documented a supernumerary breast. Through this observation and review of the literature, the authors describe the pathological and management aspects of polymastia.

INTRODUCTION

During its embryological development, the mammary tissue may be supernumerary, particularly in the axillary position.^[1] If the diagnosis is easy in the presence of a nipple and a milky discharge, it is more difficult in their absence or predominance of fatty tissue. His clinical and sonographic diagnosis can be difficult and can be confused with other causes of mass axillary.

OBSERVATION

It was a 17-year-old girl with no particular pathological history. Menarche for four years, she had presented in consultation for a right axillary mass appeared for three year and which gradually increased from volume especially in the middle of the menstrual cycle. The exam physical noted the presence of a right axillary

mass, although limited, measuring 5 cm in diameter, of soft consistency, painless on palpation, adherent to the skin but mobile by relation to the deep plane, (fig. 1-2) thus evoking the diagnosis of axillary lipoma. The rest of the somatic examination was unremarkable and the lymph node areas were free.

An ultrasound, indicated to support the diagnosis, revealed an image evoking an ectopic glandular tissue at the level of the right axillary hollow surrounded by fatty tissue without detectable nodular or cystic lesion. An excision surgery was decided and the anatomopathologic study confirmed the diagnosis of a supernumerary breast with absence of tumor cells. The postoperative course was simple. The evolution was favorable with regular clinical follow-up and ultrasound.



Figure 1-2: Well-limited rounded axillary mass without cutaneous modification in view.



Figure 3: Post operative result.

DISCUSSION

Any anomaly in the involution of the mammary ridge leads to persistence of glandular tissue anywhere along the milky line, from the armpit to the inguinal region, which can lead to the appearance of other buds whose persistence leads to accessory or supernumerary breasts or polymastia.^[1] About 67% of the accessory mammary glands are located in the thorax or abdomen, along the milky line, and 20% in the armpit.^[2] Cases families have been reported^[3-5] and there is a hypothesis of autosomal dominant genetic transmission.^[6]

In our observation, no family history had been found. Polymastia is present from birth but is rarely described in children. Generally, it is discovered during pregnancy or lactation due to hormonal impregnation which leads to an increase in its volume as well as the appearance of sensitivity or even pain.^[1,5,6] Indeed, the absence of areola and the absence of engorgement during gestation and lactation explains why these tumors do not immediately point to a supernumerary breast; clinically, lipoma or adenopathy are often evoked.^[6] According to Abita *et al.*^[1], the bilateral and symmetrical character of the axillary location, mobility relative to the deep plane and not the superficial plane and a transient increase in volume during pregnancy and lactation are the main clinical characteristics indicating accessory axillary breasts. In our teenager, the tumor was unilateral with neither areola nor nipple, suggesting the clinical diagnosis of axillary lipoma. Concerning imaging, the breast is composed of two-glandular connective tissue which appears hyperechoic on ultrasound, and adipose tissue which is hypoechoic.^[1] The predominance of fatty tissue in supernumerary breasts can often suggest a lipoma on ultrasound. Supernumerary breasts can be complicated. Cases of mastitis, fibro-cystic changes, fibroadenoma^[9], phyllodes tumors have been reported. The complication to consider

is the possibility of malignant transformation even if the incidence of this cancerization seems low.^[10]

The supernumerary breast can be associated and even be the revealing phenomenon of other embryological abnormalities. Cases of associated urinary malformations have been described.^[4,11] Some authors advocate systematic research of these urinary malformations by performing an ultrasound of the urinary tree^[2,12], whereas others do not research only when they are symptomatic.^[6,13] Our patient was not evaluated on the urinary level. Controversy persists regarding the therapeutic attitude; if some authors recommend abstention apart from complications, others opt for a systematic excision not only for the aesthetic handicap that it causes, but also to prevent complications such as malignant degeneration.^[1,2,6]

CONCLUSION

Polymastia is a rare malformation, the location of which axillary may be confused with other causes of axillary masses including lipomas. its clinical and sonographic diagnosis can be difficult. This fabric supernumerary breast is likely to be the site of same diseases as the physiological breast tissue, which imposes its surgical excision to prevent complications.

REFERENCES

1. Abita T, Lachachi F, Durand-Fontanier S, *et al.* A propos d'un cas de seins surnuméraires axillaires bilatéraux. *Morphologie*, 2004; 88(280): 39–40.
2. Nayak S, Acharjya B, Devi B. Polymastia of axillae. *Indian J Dermatol*, 2007; 52: 118–20.
3. Weinberg SK, Motulsky AG. Aberrant axillary breast tissue: a report of family with six affected women in two generations. *Clin Genet*, 1976; 10: 325–8.
4. Brown J, Schwartz RA. Supernumerary nipples and renal malformations: a family study. *J Cutan Med Surg*, 2004; 8: 170–2.
5. Galli-Tsinopoulou A, Krohn C, Schmidt H. Familial polythelia over three generations with polymastia in the youngest girl. *Eur J Pediatr*, 2001; 160: 375–7.
6. Anthony LT, Viera J. Breast-feeding with ectopic axillary breast tissue. *Mayo Clin Proc*, 1999; 74: 1021–2.
7. Velanovich V. Fine needle aspiration cytology in the diagnosis and management of ectopic breast tissue. *Am Surg*, 1995; 61: 277–8.
8. Bhambhani S, Rajwanshi A, Pant L, *et al.* Fine needle aspiration cytology of supernumerary breasts. Report of three cases. *Acta Cytol*, 1987; 31: 311–2.
9. Conde DM, Torresan RZ, Kashimoto E, *et al.* Fibroadenoma in axillary supernumerary breast: case report. *Sao Paulo Med J*, 2005; 123: 253–5.
10. Giron GL, Friedman I, Feldman S. Lobular carcinoma in ectopic axillary breast tissue. *Am Surg*, 2004; 70: 312–5.

11. Urbani CE, Betti R. Accessory mammary tissue associated with congenital and hereditary nephroureteral malformations. *Int J Dermatol*, 1996; 35: 349–52.
12. Ferrara P, Giorgio V, Vitelli O, et al. Polythelia: still a marker of urinary tract anomalies in children? *Scand J Urol Nephrol*, 2009; 43: 47–50.
13. Grotto I, Browner-Elhanan K, Mimouni D, et al. Occurrence of supernumerary nipples in children with kidney and urinary tract malformations. *Pediatr Dermatol*, 2001; 18: 291–4.