

**BREAST HAMARTOMA ABOUT A CASE****\*Dr. F. Kamri, A. Benani, K. Tamim, Pr. M. Yousfi and Pr. S. Bargach**

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**ABSTRACT**

Breast hamartoma is an uncommon benign lesion composed of varying amounts of fatty, fibrous, and glandular elements. We report a case of mammary hamartoma discovered in a 43-year-old patient presenting a large breast nodule of the left breast and discuss the literature data. The gross aspect is a well-delimited nodule resembling a fibroadenoma, but clinical diagnosis of hamartoma is difficult. Mammography usually establishes the diagnosis. Sonography is uncontributive. The biopsy is not necessary for diagnosis and surgery is unnecessary (apart from esthetic purposes). We report illustrative pathology, radiology and clinical data observed in a case of hamartoma of the breast with a literature review.

**KEYWORDS:** Mammography usually establishes the diagnosis.**INTRODUCTION**

The Hamartoma, rare breast tumors, is a benign lesion that is described under different names (fibroadenolipoma, lipofibroadenoma, adenolipoma, breast in breast, etc.). This lesion is considered as a developmental abnormality and not as a tumor.<sup>[1]</sup>

This tumor affects women at any age from puberty onwards. The diagnosis is usually made with the help of a mammography.<sup>[2]</sup> The histological and radiological aspects are variable and depend on the adipose tissue content.<sup>[3]</sup> The identification of these lesions allows, on the one hand, to avoid systematic surgical removal and, on the other hand, to avoid the occurrence of breast cancer in these normally benign lesions.<sup>[2]</sup> In this article, we report the case of a 43 years old patient with a Hamartoma, diagnosed during a large excision of the left breast. In the light of this observation, we present in detail the data collected below.

**OBSERVATION**

She is a 43-year-old patient, without children nor notion of taking oral contraception, having as antecedent a total thyroidectomy in 2013 she was put on levothyroxine (levothyrox) 100ug/d, and no history of breast nodule nor similar case in her family. She consulted for a mastodynia of the left breast with an increase of its volume. On examination we found asymmetrical breasts with an increase in volume of the left breast, where a nodule of about 5 cm in size was located at the junction of the two upper quadrants, with regular contours,

smooth, painless and mobile in relation to both areas. The rest of the examination was without anything in particular worth mentioning.

The mammogram showed an increase of the left superior-external density of about forty millimeters. The anterior limits were clear and regular, and the posterior limits were embedded in the adjacent fibro-glandular tissue. Fig1, 2.

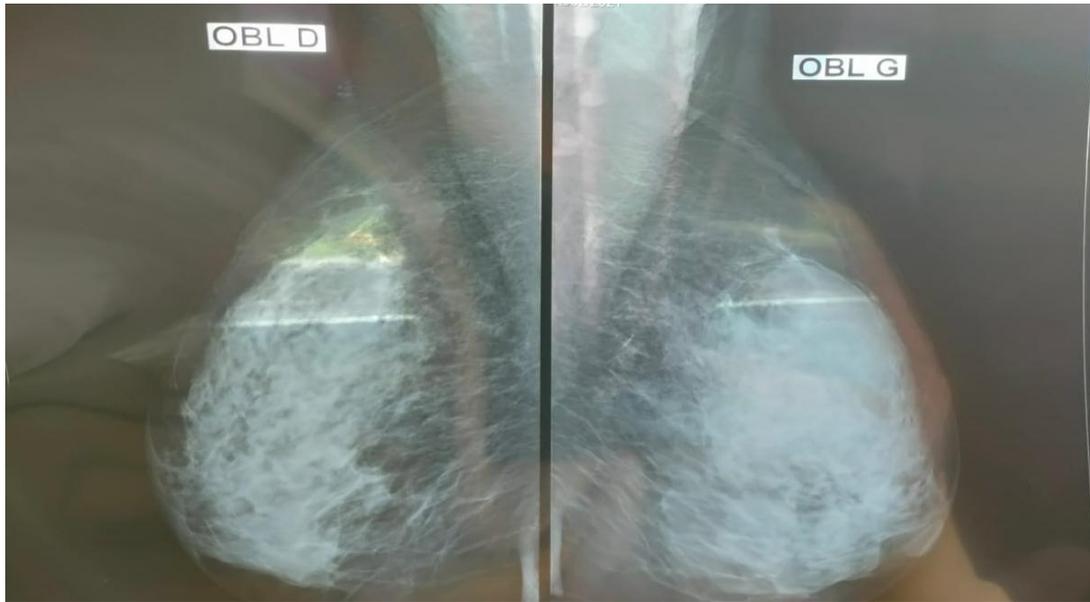


Fig 1.

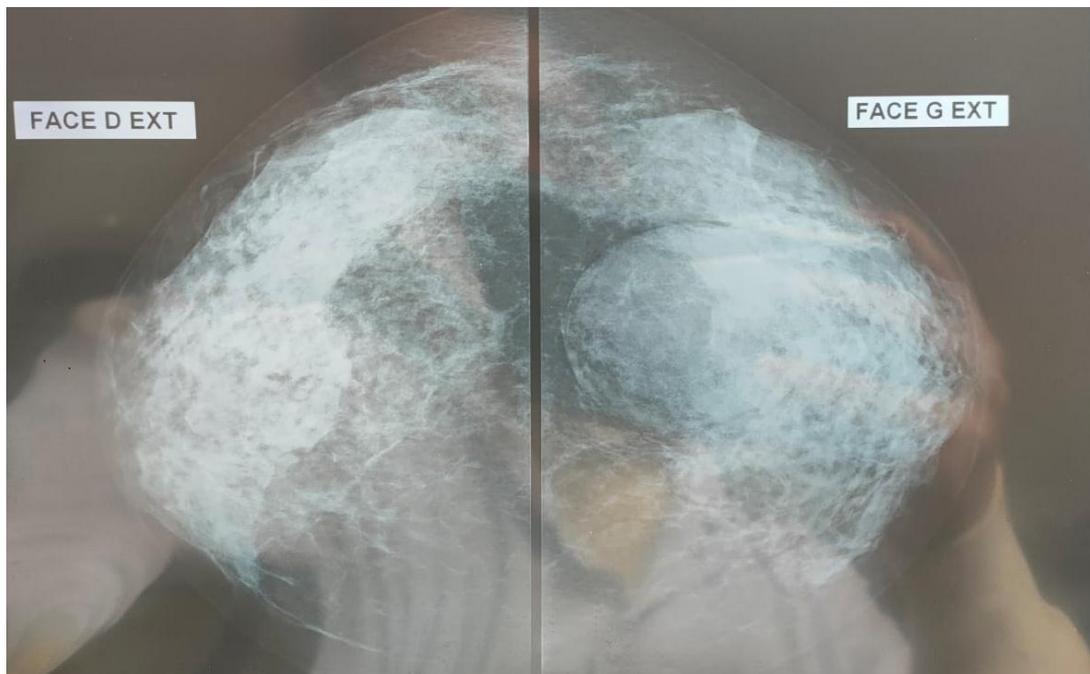


Fig 2.

The ultrasound examination of the left breast revealed an oval formation measuring 42 mm x 41 mm x 20 mm, with a long axis parallel to the cutaneous plane, with clear boundaries and regular contours, with an iso echogenic periphery and a hyper echogenic center slightly vascularized on color Doppler, suggesting a giant adenofibroma: ACR4.

A complete removal of the tumor was performed. The macroscopic examination showed a well limited lesion with smooth contours. The postoperative course was simple. The histology showed a benign tumor proliferation, of lobular architecture, of a mixture of breast, adipose and fibrous tissues confirming the diagnosis of the hamartoma.

## DISCUSSION

The breast hamartoma, or adenofibrolipoma, is a benign anomaly whose frequency is underestimated due to its misdiagnosis. It is often confused with a dystrophic lesion. It is an encapsulated lesion that associates all the components of the breast, galactophores and ductulo-lobular terminal units, supporting connective tissue and adipose tissue, as opposed to lipoma which contains only adipose elements.<sup>[4]</sup>

This tumor was first described by Arrigoni et al. in 1971.<sup>[5]</sup>

It is a scarce lesion that affects the breast at any age from puberty onwards. The reported occurrence of this anomaly according to the literature varies between 0.1 and 0.7% of all benign breast cancers.<sup>[6-7]</sup> As Feder *et al*<sup>[8]</sup> mentioned, the majority of these lesions are seen in women over 35 years of age like in our case. Rare cases of ectopic hamartoma at inguinal level or on supernumerary breast have been reported.<sup>[9]</sup> However, only one case of breast hamartoma in a man has been reported in the literature.<sup>[8]</sup>

Clinically, even if the hamartoma is generally asymptomatic, it can manifest itself sometimes as a tissue mass with a firm and mobile consistency.<sup>[8-10]</sup>, matching our patient case. The diagnosis of hamartoma is made by mammography which shows a well limited mass with partially fatty content, and sometimes with calcifications describing "breast in the breast" or "sausage slice" appearance. The hamartoma with intermediate fat content has a characteristic mammographic appearance consisting of a well-limited round or oval mass, sometimes surrounded by a hyperdense border corresponding to a pseudocapsule. In our example, the dense component predominates. When the lesion is not typical, an ultrasound and a cytopuncture can be used nonetheless the latter is not specific.<sup>[4]</sup>

The MRI is not classically recommended but may be requested in case of a lesion of indeterminate appearance on the mammography and the ultrasound. In the typical form, the diagnosis of the hamartoma is made by mammography. Therefore, neither ultrasound nor surgical biopsy is useful.<sup>[3,8,10]</sup> On the other hand, in case of discomfort or deformation of the breast by the mass, as in the case of our patient, surgical removal is advised. This latter procedure, even for large hamartomas, does not require breast reconstruction; in fact, the breast tissue, initially displaced by the hamartoma, returns to its usual position and no aesthetic deformation is observed.<sup>[3,2]</sup> This was the case in our patient.

Hamartomas usually have a similar course to the adjacent breast and usually remain stable over many years. The hamartoma of the breast does not degenerate, but due to the presence of normal breast tissue, the development of cancer within the hamartoma is possible. The elements of suspicion for cancer are the same as those in the breast. Eight cases of typical hamartomas have been published in the literature.<sup>[6,11-13]</sup> Exceptionally, the hamartoma is part of the multiple hamartoma disease, or Cowden's disease (associating periorificial verrucous papules and mammary, thyroid and digestive dysplasias).<sup>[14,15]</sup>

## CONCLUSION

The diagnosis of breast hamartoma is relatively easy in its typical form. Mammography alone is sufficient to establish this diagnosis, avoiding the need for biopsy or systematic surgical removal. This removal is only

conceivable in case of discomfort or breast deformation. On the other hand, the diagnosis is more difficult in forms with a predominantly fibrous and glandular or fatty component, in large hamartomas, where recourse to surgery may be necessary to confirm the benignity of this lesion.

## REFERENCES

1. Feder JM, de Paredes ES, Hogge JP, Wilken JJ. Unusual breast lesions: radiologic-pathologic correlation. *Radiographics*, 1999 Oct; 19 Spec No: S11-26; quiz S260.
2. Boyer B, Graef C. Hamartome du sein: une tumeur bénigne rare de diagnostic mammographique. *Presse Med*, 2007; 36: 1999–2000.
3. Oueslati S, Salem A, Chebbi A, Mhiri S, Kribi L, Ben Romdhane K, *et al.* Hamartome du sein. *Imagerie de la femme*. 2007; 17: 19–25.
4. Gomez-Aracil V, Mayayo E, Azua J *et al.* Fine needle aspiration cytology of mammary hamartoma: a review of nine cases with histological correlation. *Cytopathology*, 2003; 14(4): 195–200.
5. Arrigoni MG, Dockerty MB, Judd ES. The identification and treatment of mammary hamartoma. *Surg Gynecol Obstet*, 1971; 133: 577–82.
6. Lee EH, Wylie EJ, Bourke AG, Bastraan De Boer W. Invasive ductal carcinoma arising in a breast hamartoma: two case reports and review of the literature. *Clin Radiol*, 2003; 58: 80–3.
7. Ravakhah K, Javadi N, Simms R. Hamartoma of the breast in a man. *Breast*, 2001; 7: 266–8.
8. Feder JM, de Paredes ES, Hogge JP, Wilken JJ. Unusual breast lesions: radiologic-pathologic correlation. *Radiographics*, 1999; 19: S11–26.
9. Reck T, Dworak O, Thaler KH, Kockerling F. Hamartoma of aberrant breast tissue in inguinal region. *Chirurg*, 1995; 66: 923–6.
10. Daya D, Trus T, D'Souza TJ, *et al.* Hamartoma of the breast, an underrecognized breast lesion. A clinicopathologic and radiographic study of 25 cases. *Am J Clin Pathol*, 1995; 103: 685–9.
11. Anani PA, Hessler C. Breast hamartoma with invasive ductal carcinoma report of two cases and review of the literature. *Pathol Res Pract*, 1996; 192: 1187–94.
12. Mester J, Simmons RM, Vazquez MF, Rosenblatt R. In situ infiltrating ductal carcinoma arising in a breast hamartoma. *AJR Am J Roentgenol*, 2000; 175: 64–6.
13. Gatti G, Mazzarol G, Simsek S, Viale G. Breast hamartoma: a case report. *Breast Cancer Res Treat*, 2005; 89: 145–7.
14. Herbert M, Sandbank J, Liokumovich P, *et al.* Breast hamartomas: clinicopathological and immunohistochemical studies of 24 cases. *Histopathology*, 2002; 41: 30–4.
15. Guray M, Sahin AA. Benign breast diseases: classification, diagnosis, and management. *Oncologist*, 2006; 11: 435–49.