Case of an Axillary Adenopathy Responsible for an Inflammatory Breast Appearance in a Patient Followed for Pleuropulmonary Adenocarcinoma

Houssa M., Achbak M., Benjelloun G., Ennachit M., Elkerroumi M

Corresponding Author: Mahmoud Houssa
houssamedecin@gmail.com

ABSTRACT

A large number of causes can be responsible for an "inflammatory breast", red, hot and painful. Should prioritize an infectious origin or carcinomatous mastitis. We report here the case of a patient followed for a pleuropulmonary cancer having presented an inflammatory breast table with axillary ADPs, for which the diagnosis after adenectomy objectifies lymphnode metastasis of bronchopulmonary papillary adenocarcinoma.

Keywords: inflammatory breast, pleuropulmonary adenocarcinoma, axillary adenopathy

1. INTRODUCTION

The inflammatory breast is a clinical entity that can translate a broad spectrum of etiologies ranging from infection to inflammatory cancer. We report here the case of a patient followed for pleuropulmonary cancer having presented an inflammatory breast with axillary adenopathies.

2. CLINICAL CASE

This is a 38-year-old woman, followed for pleuropulmonary cancer (papillary invasive adenocarcinoma) with pleural metastases, for which she received 6 courses of cisplatin docetaxis chemotherapy with good clinical course on the pleuropulmonary plane 6 months after her treatment, she presents herself in consultation for a progressive increase in the volume of the left breast. The clinical examination found a breast asymmetry in favor of the left breast with an aspect of orange peel without a palpable mass (fig.1) secondary a blockage of the lymphatic vessels in the axillary region by lymphadenopathies, moreover the ipsilateral upper limb was normal non-oedematous and no collateral circulation in the thorax that can eliminate vascular involvement (fig.2).

Mammography (Fig. 3) showed an asymmetry of volume and density, left cutaneous thickening and left axillary lymphadenopathy. In the ultrasound complement (Fig 4.) Had shown diffuse infiltration of left breast with cutaneous thickening, with left axillary lymphadenopathy suspected. Upper limb echodoppler was unspecific and lack of venous thrombosis. A surgical biopsy in the orange quarter was performed, achieving a discrete, non-specific chronic inflammation. Left axillary adenectomy demonstrate lymph node metastasis of bronchopulmonary papillary adenocarcinoma. The diagnosis is extensive and total breast inflammation secondary to blockage of the lymphatic vessels by metastatic lymphadenopathies of bronchopulmonary cancer that is still active despite chemotherapy previously received.

The patient had benefited from 3 additional courses of chemotherapy with good clinical and radiological progress.

**To Cite This Article:** Houssa M., Achbak M., Benjelloun G., Ennachit M., Elkerroumi M. Case of an Axillary Adenopathy Responsible for an Inflammatory Breast Appearance in a Patient Followed for Pleuropulmonary Adenocarcinoma. *International Annals of Medicine*. 2018;2(10). https://doi.org/10.24087/IAM.2018.2.10.606
3. **DISCUSSION**

The inflammatory breast is a clinical entity that can translate a wide spectrum of etiologies ranging from infection to the formidable inflammatory cancer [1]. Most often anamnesis and clinical examination allow a fast orientation. The clinical examination of a patient with an inflammatory breast, red, hot and painful, follows the classic and well-known rules [2].

The palpation of an impasto or mass is not necessarily pejorative, which may correspond to dilated pseudocystic canals or diabetic mastopathy. Conversely, in inflammatory cancer, the palpation of the underlying mass is inconsistent [3].

The diagnosis of an inflammatory breast must be established as soon as possible and is based on the classic clinical, radiological and cytoanatomopathological tripod. This is an exemplary situation of the necessary multidisciplinarity of the exercise of senology.

According to "WHO" Among the etiologies to be mentioned is carcinomatous mastitis, which must be absolutely eliminated [4].

Once this diagnosis is excluded, other causes must be mentioned: infectious mastitis, lactating or otherwise, sometimes complicated by abscess, iatrogenic (post-radiation), granulomatous mastitis, and, in an exceptional manner, venous thrombosis, which may be responsible for inflammatory breast appearance [5].

In our patient young summer in nulligest therefore we could exclude the lactating causes, also iatrogenic (no radiotherapy), and in the clinical examination had elements orienting it is homolateral axillary ADP magma.

The inflammatory aspect of the breast has been associated with an ipsilateral lymphadenopathy lymphadenopathy, whose mammography is objective in this aspect as well as ultrasound, by the presence of multiple lymphadenopathies.

4. **CONCLUSION**

In front of an inflammatory breast, the most common diagnosis is simple infectious mastitis. An ultrasound may be helpful in removing an abscess. Most infectious mastitis regress rapidly after initiation of anti-infective therapy. Non-infectious mastitis is usually clinically suspect. An assessment including mammography, ultrasound and biopsy is therefore recommended to eliminate cancer or infection before the start of corticosteroids.

**REFERENCES**

5. Céline Orliaca, Olivier Serres-Cousinéa, Sébastien Deleuzeb, Florence Di Ruggieroa, Jean-Michel Ferrua. Thrombose veineuse responsable d’un aspect de sein inflammatoire