



Non-lactational inflammatory disorders of the breast, from benign to malignant

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INTRODUCTION/BACKGROUND

A breast is inflammatory if it is red, warm and possibly painful. The incidence of both benign and malignant inflammatory breast diseases has been rising since 1990. This pathology is highly varied, and treatment depends on the aetiology.

OBJECTIVES

to study the features of inflammatory mastitis clinically, radiologically and histologically.

METHODS

it was a retrospective, monocentric, longitudinal observational study that included patients followed for inflammatory breast disorder who had undergone radiological and histological investigations over a 5-year period. Puerperal mastitis, known secondary inflammatory cancers and cysts were excluded.

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RESULTS

We identified 55 cases of inflammatory mastitis, representing an incidence of 6.36%, including two male patients. The median age was 42, with the majority between 30 and 45. Four patients were smokers. The mean gestational age was 3.6 and the mean parity 2.5, 72% of whom had breastfed. The majority (69.8%) were in their reproductive Years, one patient was pregnant and oestroprogestogenic contraception was noted in 42% of cases. The medical history included: an immunosuppression-associated pathology in 12 patients, breast pathology in 12 patients, including 6 cases of breast abscess, 5 cases of benign breast nodule and 1 case of inflammatory galactophoritis, and a family history of cancer in 13 cases, including 6 cases of breast cancer. The primary reason for consultation was inflammatory signs (81.8%), followed by mastodynia (70.9%). Examination revealed a nodule in only 43.6% of cases, and lymphadenopathy in 20%. Skin signs were present in 21 cases, including 4 with fistulas. Inflammatory involvement was widespread throughout the breast in 40% of cases, and in the retro-nipple area in 23.6% of cases. There was only one case of bilateral involvement. The mean size of the lesion was 3.7 cm [1.5-10cm]. Breast ultrasound classification was as follows: 2 cases of ACR1, 10 cases of ACR2, 22 cases of ACR 3, 11 cases of ACR 4a, 3 cases of ACR 4b, 3 cases of ACR 4c and ACR 5 in 3 cases. The histological findings were: 9 cases of infectious mastitis, 4 cases of granulomatous mastitis, 1 case of purulent galactophoritis, 1 case of cytosteatonecrosis and 6 cases of carcinomatous mastitis. Antibiotic therapy combined with an anti-inflammatory agent was systematically prescribed, except for 3 patients who were started on corticosteroids. Surgery was performed in 27.2% of cases and ultrasound-guided percutaneous-drainage in one case. On follow up, three patients had recurred as abscesses within 3 years of treatment.

DISCUSSION

In epidemiological terms, although the central clinical form of nonpuerperal breast abscess is the most common (90% of nonpuerperal abscesses), it remains rare, accounting for 1 to 2% of symptomatic breast diseases [1]. They occur mainly in women (95% of cases) during their reproductive period, but can also be observed in the post-menopause [1]. Smoking is thought to be a risk factor (NP3). According to the recommendations of E Laas et al, there is no link between periareolar abscesses and hormonal contraception. Clinically, global or localized inflammatory involvement of the breast is characteristic of IM [1]. Lesions vary in size from 0.5 to 10 cm [3]. Retraction and sagging of the nipple are rarely reported in the literature, which is an additional argument in favour of a malignant process [3]. Axillary adenopathy is reactive. They have been observed in 40-60% of cases in several series [2]. IM is often unilateral. Exceptional cases of bilateral involvement have been reported [1]. Infectious mastitis is the most commonly identified histological pathology. Peripheral abscesses are less common and often occur in immunocompromised patients or following trauma or breast surgery [1,3]. Chronic or recurrent abscesses can be secondary to an inadequately treated abscess or due to special germs. For non-infectious inflammatory mastitis, a distinction is made between plasma cell mastitis and idiopathic granulomatous mastitis (IGM), depending on the topography of the initial involvement. These two entities are very similar and have in common the formation of a granuloma, but the topography of the initial involvement is different on histology. It is always important to bear in mind the possibility of cancer, in particular CIS, the cardinal clinical signs of which combine an inflammatory reaction with a very rapid increase in the volume of the affected breast. [4]. Histological evidence by breast or skin biopsy is often necessary to distinguish between these two entities [4].

CONCLUSIONS

The Inflammatory mastitis is a polymorphous pathology, both clinically and radiologically, but also in terms of management. The two main challenges are to detect cancer and long term recurrence.