BREAST LYMPHOMA

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Problem statement

Breast lymphoma supposes the 0,04-1,1% of the breast malignant tumors and the 0,3-2,2% of extranodal lymphomas. Its clinical and radiological non-specificity makes extremely difficult the differential diagnosis with other breast carcinomas. Histopathological study is essential to achieve a diagnosis. Its treatment is based on chemotherapy and radiotherapy and occasionally surgical approach.

Methods

A case of a patient with breast lymphoma is exposed. 72 years old woman with antecedents of hypercholesterolemia, arterial hypertension, arthrosis and depression, 2 deliveries, menopause at 55, mother with postmenopausal breast carcinoma. She came to the consultancy for a 1 month evolution right breast tumor, with moderate peritumoral inflammation. Her general practitioner had started treatment with ciprofloxacin and had asked for a mammography. Simultaneously, she had a light postmenopausal vaginal bleeding and a right inguinal adenopathy.

The physical exploration showed a normal left breast and a 6x7cm suspicious, retroareolar tumor in the right breast. Gynecological examination showed a firm and stenotic vaginal area in Douglas, with no other genital anomaly. No axillary or inguinal adenopathies were touched.

Mammography showed a right breast retroareolar 8cm tumor, poorly delimited, and an axillary adenopathy with increased cortical thickness (Image 1). Left breast was normal.

Because of a high malignant disease suspicion, a biopsy was made, with the result of non-Hodgkin high grade B lymphoma. Axillary puncture was negative for malignant process.

Thoracic and abdominal computerized tomography (TC) informed about the suspicious right breast tumor previously described, axillary bilateral adenopathies (hypercaptating in right axilla), and undetermined mediastinal, paratracheal, pretracheal-retrocaval and subcarinal adenopathies. Uterus inferior part and cervix had a size increase, with an increase of volume and density of vaginal area. Urinary bladder posterior wall was thickened, without separation plane with anterior uterine wall, affecting ureteral meatus and causing light ureterohydronephrosis. Multiple pathological adenopathies were seen in iliac territory, inguinal regions, inferior mesenteric area and perirectal space (Image 2).

With the diagnosis of non-Hodgkin high grad B lymphoma, medullar biopsy was taken. It did not show lymphoma infiltration. 8 cycles R-CHOP chemotherapy treatment were administrated, followed by local radiotherapy. Then, a PET/TC (positron emission tomography/computerized tomography) showed a residual right breast lesion, metabolically inactive, without nodal disease, in complete metabolic remission.

Results

A suspicious breast tumor was finally diagnosed of non-Hodgkin B lymphoma in stage 4 with breast and vaginal affectation. Response to chemotherapy treatment was complete.

Conclusion

A malignant breast tumor not always is a ductal or lobulillar carcinoma. Complete clinical interview and exploration are essential for a correct diagnostic orientation.

Image 1. Right breast mammography: Retroareolar 8cm tumor, poorly delimited, and an axillary adenopathy with increased cortical thickness.

Image 2. Abdominal tomography (TC): Cervix size increase, increase of volume and density of vaginal area. Urinary bladder posterior wall thickened, without separation plane with anterior uterine wall. Multiple pathological adenopathies.