

GIANT INVASIVE MUCINOUS CARCINOMA OF THE BREAST - CASE REPORT¹

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1. Work carried out at the Gynecology and Obstetrics Service of the Hospital Santa Casa de Misericórdia de Vitória (HSCMV)

Abstract: Goal: to report the case of a patient with a late diagnosis of an Invasive Giant Mucinous Carcinoma of the Breast who underwent resection of the tumor weighing 4,990 grams. **Method:** this is a Case Report whose data were obtained by reviewing the medical records, photographic records and images of complementary exams to which the patient was submitted. Discussion and final remarks: the early breast cancer screening aims to reduce mortality from the disease, greater survival of affected patients, greater possibility of intervention in earlier stages of the disease with a consequent reduction in more radical interventions (generally necessary in more advanced stages) and several other advantages to this public health problem. Measures that help early diagnosis directly contribute to more favorable outcomes and considerably reduce the chances of breast cancer progressing to stages such as the one presented in this article and for these reasons, early and early screening must be increasingly disseminated and encouraged. efficient treatment of breast cancer.

Keywords: Breast neoplasms, Ductal Carcinoma of the Breast, Mastectomy.

INTRODUCTION

Breast cancer is the second most prevalent type of tumor in women, second only to non-melanoma skin cancer. The latest data from the National Cancer Institute (INCA) revealed that approximately 66,280 new cases of breast cancer in women would be reported in 2021. This data represents 29.7% of all neoplasms, except non-melanoma skin (INCA, 2021). It is worth mentioning that at a global level, cancer occupies the category of main public health problem mainly due to population aging, prevalence of risk factors for the development of such pathology and other multifactorial causes that favor the development of this disease (INCA, 2020). Mucinous breast

carcinoma represents about 1% to 7% of all invasive breast carcinomas and, therefore, is classified as uncommon among carcinomas (LAM et al., 2004; MEMIS et al., 2000).

Histologically, mucinous carcinoma is described as well-differentiated carcinoma cells distributed in small groups surrounded by mucus (GALLAGER, 1984). Depending on the mucinous content, it is divided into pure and/or mixed mucinous carcinoma and through this classification it is known that the former has a better prognosis with lower rates of metastases in axillary lymph nodes (CARDENOSA; DOUDNA; EKLUND, 1994; LAM et al., 2004).

This histological type has an indolent course and a relatively good prognosis when compared to other types. However, there may be overlap with invasive ductal carcinoma, which will result in a more reserved prognosis (FATTANEH et al., 2009; MEMIS et al., 2000; WILSON et al., 1995).

GOAL

To report the case of a patient with a late diagnosis of Nottingham Grade I Invasive Mucinous Breast Carcinoma who underwent resection of the tumor weighing 4,990 grams.

METHOD

This is a Case Report whose data contained in the present work were obtained through the review of the medical records, photographic records performed and images of complementary exams and their respective reports, to which the patient was submitted.

The patient in question was consulted in order to authorize the use of the aforementioned data through the Free and Informed Consent Term (FICT) (ANNEX 01), informed about the purpose of this study and assured all ethical and legal rights to the patient.

CASE REPORT

ANAMNESIS

Patient, E.A., female, white, 65 years old, nulliparous, menarche at 15 years old, hysterectomized at 23 years old (patient does not know how to report the reason for performing such a procedure). She denies further surgeries. She denies previous use of hormonal contraceptives and/or hormone replacement therapy. Carrier of Systemic Arterial Hypertension, in need of drugs for control, but difficulty in reporting drugs for home use. He denies smoking and reports social alcoholism.

This patient sought the Emergency Department of the Gynecology Service of the Hospital Santa Casa de Misericórdia de Vitória (HSCMV) with an extensive and hardened lesion in the right breast that caused significant anatomical deformity and retraction. She referred to the rapid growth of the lesion, despite not being able to define, even by approximation, the period of evolution of the lesion in question.

PHYSICAL EXAM

On physical examination, there was nothing noteworthy except for the right breast, which had an increased size, clear asymmetry in relation to the contralateral breast, an immobile, hardened mass, with several nodules causing deformity and occupying the entire breast, making it impossible to palpate breast tissue (Figures 1 and 2). In relation to the left breast: breast of medium volume, pendulous, without bulges or palpable nodules. Bilaterally negative axillary research.

BEHAVIOR

Hospital admission was carried out to perform an ultrasound-guided core biopsy and send the collected material for anatomopathological examination.

SUBSIDIARY EXAMS

During the performance of the indicated exam, core biopsy, there was a need to interrupt the procedure due to increased bleeding, in jet. The patient was promptly referred to the operating room for completion of the biopsy followed by hemostasis and suture. During the procedure, a skin incision was made to remove fragments of the lesion, with a mucinous and bleeding characteristic. Compressive dressing left, local ice, optimized analgesia, requested laboratory tests, imaging tests, rigorous hemodynamic and clinical surveillance and sending the collected material for anatomopathological examination.

Imaging exams were performed: (1) Chest tomography revealing a voluminous expansive, heterogeneous formation, with a solid-cystic aspect, which takes up the contrast medium, located in the right breast, bulging the local myoadipose planes, measuring 21 cm in its largest transverse diameter, containing internal microcalcification and apparent lobulated/septate appearance, and/or with other nodules around it. Bilateral, infracentimetric axillary and pectoral lymph nodes (Figure 3). Left breast with aspect within the limits of normality for the method. Assessment findings limited to the method, at clinical criteria, complementary to a specific study. Small bilateral pleural effusion, determining compressive opacities over the pulmonary parenchyma in association, being slightly larger on the right, where extension to the great fissure is observed. Nodular, infracentimetric and non-calcified opacities, bilaterally sparse, the largest of which can be seen in the lateral region of the posterior basal segment of the lower lobe of the left lung, measuring about 7.1 mm in its largest transverse diameter, with a nonspecific aspect due to its small dimensions, however highly suspicious of implants; (2) Tomography of the abdomen: liver with normal shape, contours



Figure 1 - Patient's breasts. Clear asymmetry between the breasts.



Figure 2 – Right breast (affected breast) of the patient. Enlarged breast, clear asymmetry in relation to the contralateral breast, immobile, indurated mass, with several nodules causing deformity

and dimensions, slightly heterogeneous and slightly reduced parenchymal density, suggesting incipient steatosis, without evidence of focal lesions. Topical kidneys, with normal shape, contours and dimensions, concentrating and eliminating the contrast medium in physiological time and under good density. Tiny cortical cysts (BOSNIAK I), smaller than 6.0 mm, predominating on the left. Aorta and inferior vena cava with usual shape and dimensions for age, with parietal calcifications of the aorta, iliac and femoral arteries. Uterus not properly visualized. There is no evidence of solid or cystic expansile lesions in adnexal topographies. Small amount of free fluid in the pelvis. Sparse colonic diverticula, without evident inflammatory signs. No other noteworthy changes.

It is valid to say that due to the dimensions of the patient's right breast, there was a limitation for performing mammography. Performed through images of computed tomography, three-dimensional reconstruction (Figure 4).

EVOLUTION

Armed with the results of a core biopsy with histopathology of a Grade I Nottingham Invasive Mucinous Breast Carcinoma and with the preoperative exams already carried out, the surgical risk was requested urgently and the Radical Mastectomy schedule was carried out.

SURGICAL PROCEDURE

Although the initial program was to perform a mastectomy in the right breast without manipulation of the muscles, which in preoperative exams showed no deformities and/or involvement, during the surgical procedure it was necessary to proceed with the removal of the Pectoralis Greater muscle that was adhered to the tumor. Right breast with a weight of 4,990g was removed and sent for anatomopathological study (Figure

5). Procedure performed under general anesthesia and concluded without any complications (Figure 6).

In the analysis carried out by the Pathology team, a proliferation of cells similar to ductal cells was described as a description of the ductal cells, with moderate anaplasia, forming blocks and cords in the midst of abundant mucinous material, as can be seen in Figures 7 and 8. Such description is in accordance with what the medical literature brings about this type of tumor.

FOLLOW-UP AND FOLLOW-UP AFTER SURGERY

Due to the significant manipulation of the region, moderate bleeding, resection of a large tumor and significant vascularization, associated with the patient's clinical condition tending to hypotension (mean arterial pressure of 45 mmHg), it was decided to refer her to the postoperative period. bed in the Intensive Care Unit (ICU).

In the evolution of the ICU, after anesthetic recovery, the patient reported to the doctor in charge that since the day the biopsy was performed, she kept bleeding and a foul odor in the place, in addition to an unmeasured, practically daily fever. After requesting laboratory tests at the Unit, moderate anemia was found, worsening of renal function compared to the values of tests prior to admission to the service, sufficient for the diagnosis of acute renal dysfunction, and due to clinical status, oliguria and laboratory alterations suggesting a process. infectious, the diagnosis of cutaneous focus sepsis was concluded and measures were promptly initiated to reverse the condition.

During hospitalization in the ICU, the management and complete resolution of the new injuries presented were carried out and after 04 days he was discharged to the ward where he could complete the antibiotic therapy

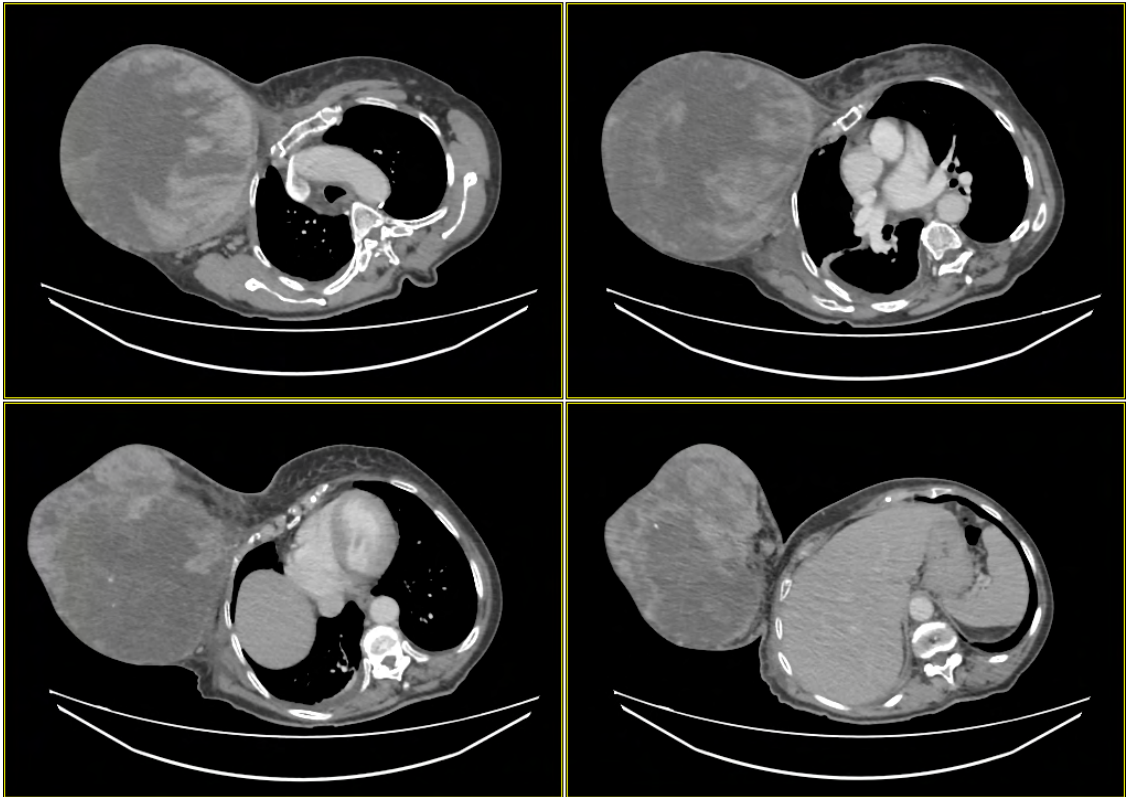


Figure 3 – Serial computed tomography images of the patient in different follow-ups.

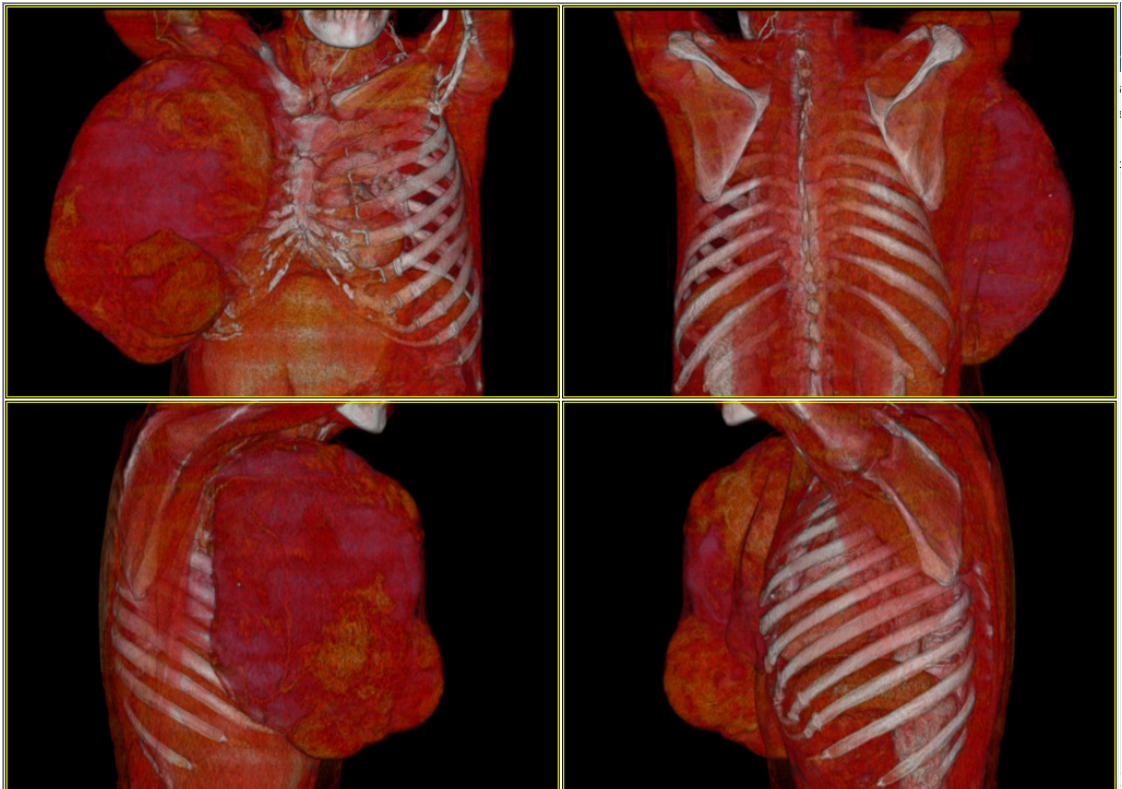


Figure 4 – Serial images of three-dimensional projection through computed tomography performed.

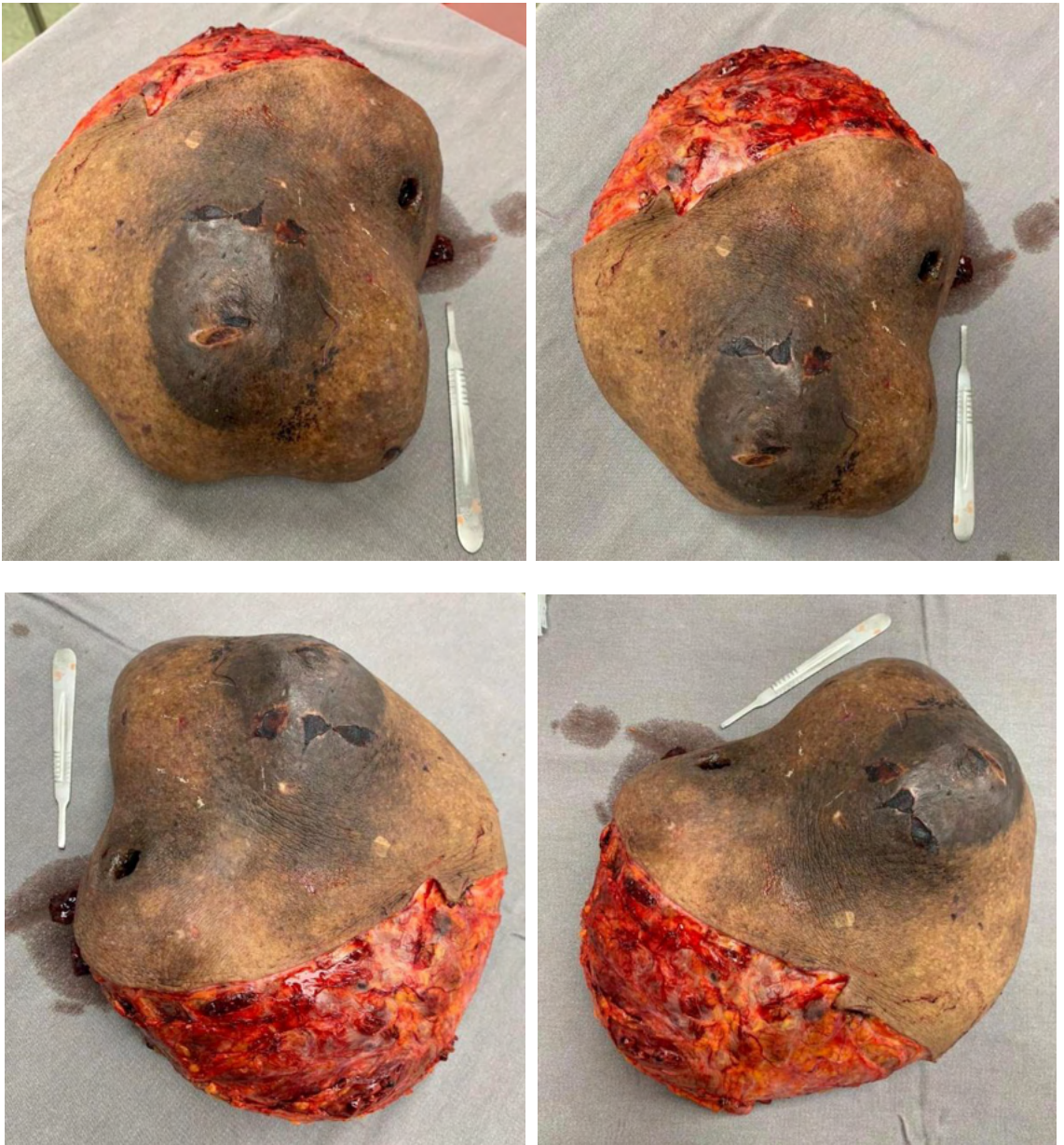


Figure 5 – Right breast at different angles after resection, weighing 4,990g..



Figure 6 – Surgical wound dressing.

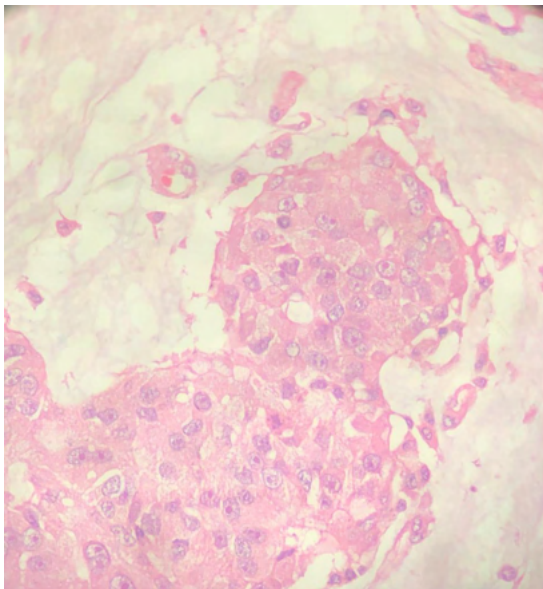


Figure 7 - Blade HEx 20

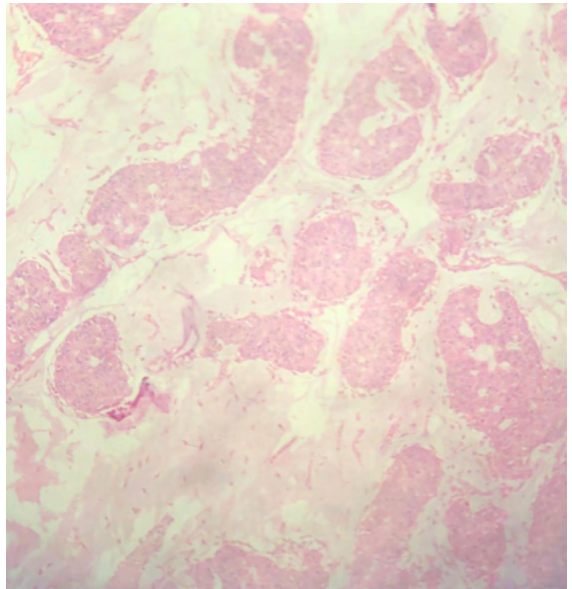


Figure 8 - Blade HEx 40

regimens proposed during hospitalization, clinical stabilization, stabilization of laboratory tests, strict surveillance of hemodynamics and operative wound remaining for a total of 23 days in this last post-surgical hospitalization. It is worth mentioning that she presented a picture of plateletosis, reaching values of 1,147,000 which was promptly discussed with the hematology team and advised that in the patient's context, such laboratory alteration would probably be related to an inflammatory/infectious process and most likely associated with iron deficiency. Also guided by the same team that the resolution would be self-limiting, perform prophylaxis with Acetylsalicylic Acid (ASA) and if values above 1,500,000, pay attention to Von Willebrand disease acquired by excess platelets.

On the 18th postoperative day, the patient was discharged with general guidelines, was referred to return to the Mastology outpatient clinic for postoperative follow-up. Immediate return to the HSCMV emergency room was offered in case of complications.

DISCUSSION AND FINAL CONSIDERATIONS

In a review of the literature on mucinous carcinoma, this entity is a subtype of invasive ductal carcinoma, with a higher relationship in older age groups, corresponding to 7% of all breast cancers in women aged 75 years or older (YOO et al., 2010). The age range of the patient in the case presented is in line with data in the scientific literature.

Although studies indicate that mucinous carcinoma has a generally slow growth rate, in the case reported here, the patient states that the tumor growth occurred quickly. However, as she is unable to define a period for such an evolution, it is believed that this statement made by the patient may be biased and not reliable to the real evolution of the neoplasm under analysis (MEMIS et al., 2000; WILSON

et al., 1995).

The articles point out that mucinous carcinoma has a relatively good prognosis if not associated with invasive ductal carcinoma. In the case of the patient presented, because it is an Invasive Mucinous Carcinoma, classified after ultrasound-guided core needle biopsy, which has high sensitivity and predictive value for the diagnosis of mucinous neoplasia, it is believed that the patient's prognosis was affected once that it was not possible to rule out the possibility of pulmonary metastases because they presented highly suspicious nodular images of implants in exams performed prior to surgery (ZANETTI; RIBEIRO-SILVA, 2010; GALLAGER, 1984; MEMIS et al., 2000; TAVASSOLI; DEVILEE, 2003; WILSON et al., 1995).

Regarding the presentation in complementary imaging exams, in general, mucinous carcinoma presents as a rounded, lobular or oval mass with well-delimited limitations and occasionally reveals a microlobulated appearance (MEMIS et al., 2000). It is commonly possible to visualize mixed cystic and solid components and posterior acoustic enhancement on ultrasound (LAM et al., 2004).

Due to the importance that breast cancer occupies in the world scenario due to its high incidence, its high capacity to limit the affected patients and the significant consequences of non-identification and early intervention, it is of paramount importance that there is a greater incentive in investigation and early detection of breast cancer. Early screening aims to reduce mortality from the disease, greater survival, the possibility of intervention in the early stages of the disease with consequent reduction of more radical interventions (generally more necessary in more advanced stages) and other advantages for this public health problem (SOCIEDADE BRASILEIRA OF MASTOLOGY, 2017).

Follow-up with subject matter experts, periodic examinations and access to quality information are extremely useful in this process. In Brazil, the Brazilian Society of Mastology (SBM) recommends performing screening mammography annually from the age of 40 for women who are at risk equal to the rest of society. However, it is valid to say that mammography and other complementary exams can and must be requested, regardless of age, whenever necessary (CRISTINA et al., 2016). Measures that help early diagnosis directly contribute to more favorable outcomes and considerably reduce the chances of breast

cancer progressing to stages such as the one presented in this article and for these reasons, early and early screening must be increasingly disseminated and encouraged. efficient treatment of breast cancer.

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