

unremarkable. Patient was planned for pre-operative Albendazole therapy followed by Exploratory Laparotomy. During the operation, there was large cystic lesion approx. 9 x 8 cms involving the segment 4 of liver filled with mucinous contents (fig2). No other lesion in liver or any evidence of ascites were noted. Complete excision of cyst with peripheral rim of normal liver tissue done and specimen was sent for histopathological examination. Histopathological Examination shows variable sized cysts lined by low cuboidal to tall columnar epithelium suggestive of biliary Cystadenoma, liver. Post operatively, patient recovered well and was discharged on eighth post operative day. She is doing well during regular follow up.

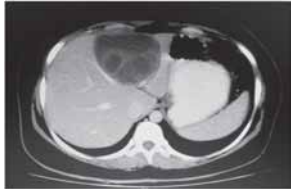


Fig.1



Fig.2

DISCUSSION

Biliary cystadenoma and cystadenocarcinoma are rare liver lesions¹. Biliary cystadenoma constitutes less than 5% of solitary non parasitic cysts of biliary origin. They are usually (85%) intrahepatic but extrahepatic locations have been reported. Fifty percent are located in the right lobe, 29% are founded in the left lobe and 16% are bilateral². Hepatobiliary cystadenoma with mesenchymal stroma occurs exclusively in young and middle-aged women and has potential tottransform into cystadenocarcinoma. In contrast, Hepatobiliary cystadenoma without mesenchymal stroma occurs in both sexes equally, at a mean age of 50, and has no clear association with cystadenocarcinoma³. These tumors are lined with columnar epithelium and frequently have papillary infoldings. Biliary cystadenoma most often presents as an intrahepatic lesion. It may also manifest as an extension of the extrahepatic biliary tree in less than 10%⁴. The origin of these lesions is postulated to be proliferation of ectopic embryonic tissues that otherwise aid in development of adult gallbladder⁵. The gross and microscopic characteristics of biliary cystadenoma distinguish this entity from other hepatic based cystic lesions including simple cysts and malignant degeneration. Biliary cystadenomas appear as multilocular cystic lesions (rarely unilocular) that are surrounded by a smooth and thick fibrous capsule. The tumors contain numerous internal septations and intraluminal

papillary projections, which are lined by mucous-secreting cuboidal or columnar biliary epithelium. This epithelium is sometimes surrounded by a dense mesenchymal stroma containing smooth-muscle cells. Cystadenoma may display a wide range of symptoms, although it is mainly asymptomatic. The most typical symptoms are a slowly growing abdominal mass, upper abdomen pain, dyspepsia, anorexia, nausea and fever. These lesions can easily be confused with the other space occupying lesions of liver. They are usually diagnosed many years after onset of symptoms. Preoperative and intraoperative diagnosis is difficult. Laboratory results are normal in most the patients. Radiographically Cystadenomas have a septated, multilocular appearance on Ultrasound and CTscan. MRI shows typical features for a fluid-containing loculated mass with homogenous low signal intensity on T1-weighted images and homogenous high signal intensity on T2-weighted images. Variable intensities depend on the presence of solid components, hemorrhage, and protein content⁶.

Treatment must be surgical whenever possible, due to a potential malignant degeneration of these lesions. The malignant potential for cystadenoma support complete excision as appropriate treatment. In addition to the malignant potential of these lesions, there is a high likelihood of recurrence with operations other than complete excision.

CONCLUSION

In conclusion, preoperative exculsion of the diagnosis of cystic liver lesions is very important to determine the treatment of choice. Biliary cystadenoma should be suspected when radiologic imaging studies suggest a multilocular cystic hepatic lesion especially in a women. Because of recurrent risk and malignant potential, treatment of choice must be complete excision in these patient. Long-term good outcomes are expected with complete excision.

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Accessory Breast Tissue in the Axilla presenting as a Pendulous Mass: A Case Report.

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Abstract: We report a case of ectopic accessory breast presenting as a large pendulous mass in the left axilla. Surgical excision was advised but the patient did not agree.

INTRODUCTION

Polymastia means the accessory breast glandular tissue with or without nipple & areola in human beings. Accessory nipple with or without rudimentary glandular tissue is called polythelia. EBT is seen mostly along the milk line & may occur unilaterally & bilaterally & the most frequent sites are axilla, chest wall & vulva^{1,2}. Other unusual sites include knee, lateral thigh, buttock, face, ear & neck³. The incidence

is 2-6% in women⁴. Accessory breast tissue & polymastia are more common among Asians especially Japanese than Caucasians⁵. EBT has usually a nipple & areola & the duct system is separate from that of the normal breast but the response of EBT to physiological influences is the same as occurring in normal breast tissue. The variability of presentation & the possibility of other diseases make this problem clinically challenging & no established classification system exists to guide its management¹.

CASE REPORT

A 32 year old Indian female was admitted in the hospital with a large pendulous swelling in the left axilla (Fig 1) since 6 ½ years duration 2 weeks after

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delivering a still born baby at her first pregnancy. The swelling appeared during the first trimester of first pregnancy but increased in size with history of pain in the second pregnancy. There was no history of change in the size of the swelling during the premenstrual period. Examination revealed a large pendulous swelling in the left axilla with nipple & areola, 16×12 cm in size, which was firm, nonadherent to underlying tissue & was completely isolated from the left breast (Fig 1). This caused much embarrassment to the patient. Both breasts were clinically normal & there was no enlargement of axillary, cervical & supraclavicular lymph nodes. The patient had no significant medical problems, no past history or family history of cancer. In the history of drug intake, she was taking calcium, oral iron & folic acid supplementation. Her routine investigations were within normal limits. Fine needle aspiration of the mass on cytological examination revealed singly scattered apocrine cells with vacuolations among red blood cells. The cytological features were consistent with accessory breast tissue. Mammography & U/S of EBT did not reveal any abnormality. The patient was started on analgesics along with hot fomentation to relieve pain. The patient was advised for excision of the mass to prevent further complications but the patient did not allow. As the symptoms subsided, the patient was discharged & is now asymptomatic with regular follow up.



Fig 1: A large pendulous swelling in the left axilla

DISCUSSION

Accessory breasts occur in 2-6% of women⁴. They may present as asymptomatic masses or cause pain, restriction of arm movement, cosmetic problems & lot of anxiety⁶. Accessory breasts are uncommon below the pectoral region. Our patient noticed painful swelling in the left axilla at her first pregnancy. During second pregnancy, this swelling increased in size & became tender & painful probably through hormonal influence⁶. This pointed strongly in favour of polymastia. During the early weeks of embryonic development, the mammary milk lines, which represent two ectodermal thickenings along the sides of embryo, extend from axillary region to groin. Normally most of the embryonic mammary ridges resolve except for two segments in the pectoral region, which later on become the breast. A failure of any portion of the mammary ridge to involute may lead to ectopic breast tissue with (polythelia) or without (polymastia) a nipple/ areolar complex⁷. However ectopic breast tissue has also been reported in unusual sites including perineum, face & vulva². The occurrence of ectopic breast is believed to be due to failure of regression & development of milkline after normal development of the breast in the pectoral area^{8,9}. Kajava¹⁰ has classified accessory breast into 8 types: Class I consists of a complete breast with nipple, areola, glandular tissue.

Class II consists of nipple & glandular tissue but no areola. Class III consists of areola & glandular tissue but no nipple. Class IV consists of glandular tissue only. Class V consists of nipple & areola but no glandular tissue (Pseudo-mamma). Class VI consists of a nipple only (polythelia). Class VII consists of an areola only (Polythelia areolaris) . Class VIII consists of a patch of hair only (polythelia pilosa). In the present case swelling had areola, nipple & glandular tissue and was accordingly classified as Class I type of EBT. Although EBT is present at birth, it remains dormant until puberty, pregnancy & lactation & the presence of EBT is often noticed only during pregnancy or lactation due to hormonal stimulation^{6,10}. As compared to pectoral breast tissue, EBT shows same hormonal effects is prone to develop breast diseases like abscesses, mastitis, milk fistula, cyclical mastalgia, fibroadenomas, fibrocystic disease, phyllodes tumor, Paget's disease & all types of breast cancer¹⁰.

The clinical differential diagnosis for a solitary axillary mass is very broad & may also be a diagnostic challenge as other benign & malignant lesions occur in the area¹¹. Mammography & sonographic findings include mass like density which is identical to that of the normal breast parenchyma in the axilla. Fine needle aspiration is a useful tool¹². The management of EBT is essentially conservative especially for asymptomatic cases^{1,10}. But the complications after removal of EBT may occur in the form of incomplete removal, poor scar & injury to intercosto- brachial nerve & lymph edema of the arm¹. Liposuction may be indicated in selected cases¹⁰.

CONCLUSION

Accessory or ectopic breast tissue (EBT) is an uncommon entity that persists from normal embryonic development, found in 2-6% of the female population. It may occur anywhere along the embryonic mammary streak/ line extending from axilla to pubic region. The development of this tissue is hormone dependent similar to normal breast tissue. EBT presents as asymptomatic mass & may prove to be a diagnostic dilemma in the absence of areola & nipple.

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