Our Dermatology Online

Case Letter

A giant male breast tumor

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Sir,

Male breast cancer (MBC) is a rare disease, with an incidence of 0.5–1% of all breast cancers, representing less than 1% of all malignancies in males [1,2]. Although rare, its incidence has an increasing trend similar to that of its female counterpart [2]. A late diagnosis makes the prognosis unfortunate.

Herein, we report the case of a 77-year-old patient with no pathological history presenting for cachexia with a giant, rounded, ulcero-budding tumor in the thorax evolving for two years, which had gradually increased in size, becoming bleeding and painful.

A physical examination revealed an ulcero-budding tumor fixed to the deep plane with raised borders and an infiltrated base, measuring 10 cm on the long axis, taking the entire left breast region with the total disappearance of the nipple, with an erythematous nodule measuring 4 cm above the tumor. The tumor bled on contact (Fig. 1a). Dermoscopy revealed hemorrhagic suffusions, a rainbow appearance, polymorphic vascularization, and ulceration (Fig. 1b). The examination of the lymph node areas revealed centimetric adenopathies fixed at the deep level, painless at the bilateral axillary level. The diagnosis of a breast carcinoma, sarcoma, and T or B lymphoma was evoked and a biopsy was performed showing an infiltrating breast carcinoma type NOS guard III of SBR with positive hormone receptors, for which the decision was to perform urgent neoadjuvant chemotherapy after an extension assessment. However, the evolution was fatal within fifteen days of performing the biopsy.

Breast carcinoma in men is a rare entity, most often occurring after the age of sixty. Although its etiology remains unknown, several risk factors have been reported, such as the patient's age, genetic predisposition, anatomical factors, and hormone metabolism abnormalities related to elevated estrogen or prolactin levels [3]. The diagnosis most often occurs late in the advanced stages with lymph node involvement, positive hormone receptors, and distant metastases, making the prognosis worse, as was in the case of our patient.

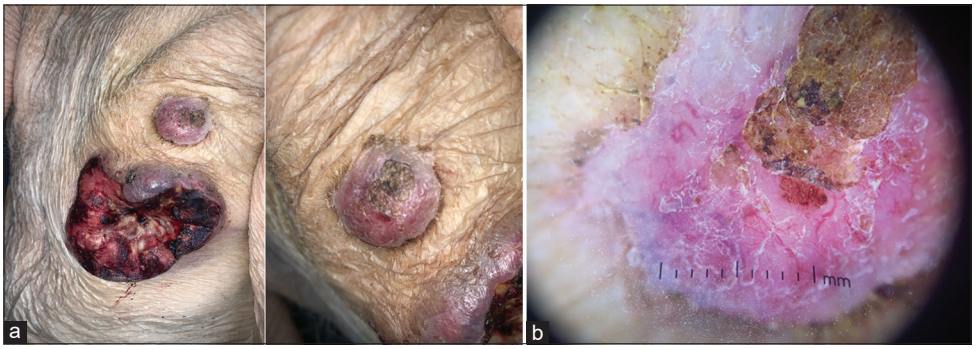

Figure 1: (a) Clinical appearance of the tumor and nodule. (b) Dermoscopic appearance showing hemorrhagic suffusions, a rainbow appearance, polymorphic vascularization, and ulceration.

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Clinically, it presents with varying aspects: a painless palpable mass under the areolar, changes in the nipple (retraction, ulceration), and damage to the areolar and peri-areolar skin [4].

The diagnosis is based on clinical examination, mammography, ultrasound, and histology.

Cutaneous tumor invasion is more frequent and earlier in men than in women due to the small volume of the mammary gland.

Early diagnosis and the advancement of treatment modalities have led to a significant improvement in survival in female breast cancer, yet no such data exist for male breast cancer [5].

Consent

The examination of the patient was conducted according to the principles of the Declaration of Helsinki.

The authors certify that they have obtained all appropriate patient consent forms, in which the patients gave their consent for images and other clinical information to be included in the journal. The patients understand that their names and initials will not be published and due effort will be made to conceal their identity, but that anonymity cannot be guaranteed.

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