

A Rare Presentation of Aspergillosis of Breast Masquerading As Breast Carcinoma: A Case Report

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Abstract:

Introduction: We are reporting a case of 39 year old lady who presented with large lump in the breast mimicking as breast carcinoma and after surgical excision diagnosed as breast aspergilloma. Aspergillus fungal infection of the breast is a very rarely encountered phenomenon. In the literature, only countable cases has been reported which were also encountered in immunosuppressed host. Breast aspergilloma in an immunocompetent patient is an extremely rare situation. The source of breast fungal infections are considered via contamination of implants during manufacture, airborne dissemination, hematogenous dissemination or nosocomial spread from the operating room environment. The most common presumed source in most of the patients is considered as airborne infection during a surgical procedure. A team of surgeon, pathologist and microbiologist are necessary for the diagnosis and management of patients with aspergillus infection of the breast. Breast aspergilloma patients should be addressed with early and aggressive surgical and medical treatment.

Key words: aspergillosis; breast; immunocompetent; carcinoma; surgical excision

Introduction:

Aspergillus is a ubiquitous saprophytic fungus. Near about 200 species has been detected which may cause pulmonary aspergilloma, allergic bronchopulmonary aspergillosis, endocarditis, paranasal sinus infection and implant infections [1]. Aspergillus fungal infection is usually encountered in immunocompromised individuals with very are occurrence in immunocompetent host [2]. Species belonging to this group are *A. fumigates*, *A. flavus*, *A. Niger*, *A. terreus* [3]. Fungal infections of the breast have been reported in association with prosthetic breast implants

[4]. The source of breast fungal infections are considered via contamination of implants during manufacture, airborne dissemination, hematogenous dissemination or nosocomial spread from the operating room environment or instruments during surgery [5]. The most common presumed source in most of the patients is considered as airborne infection

during a surgical procedure [6]. We are reporting a case of 39 year old lady who presented with large lump in the breast mimicking as breast carcinoma and after surgical excision diagnosed as breast aspergilloma.

Case Report:

A 39 year old lady with Eastern Cooperative Oncology Group Performance Status 1 (ECOG PS – 1) with no comorbidity presented with a large right breast lump for the last 20 days. There was no positive surgical, family, past or medical history. Obstetric and menstrual history was normal. Patient had noticed right breast lump while bathing around 20 days back. She consulted a local physician who advised her to undergo mammogram and Fine Needle Aspiration Cytology (FNAC). Mammogram was suggestive of large lobulated lesion in the right breast measuring 10x 7.3cm suspicious of breast neoplastic lesion with BIRADS IV – C grading with one sub-centimetre right axillary lymph node of size 1.5x1cm with fatty hilum [Figure.1].

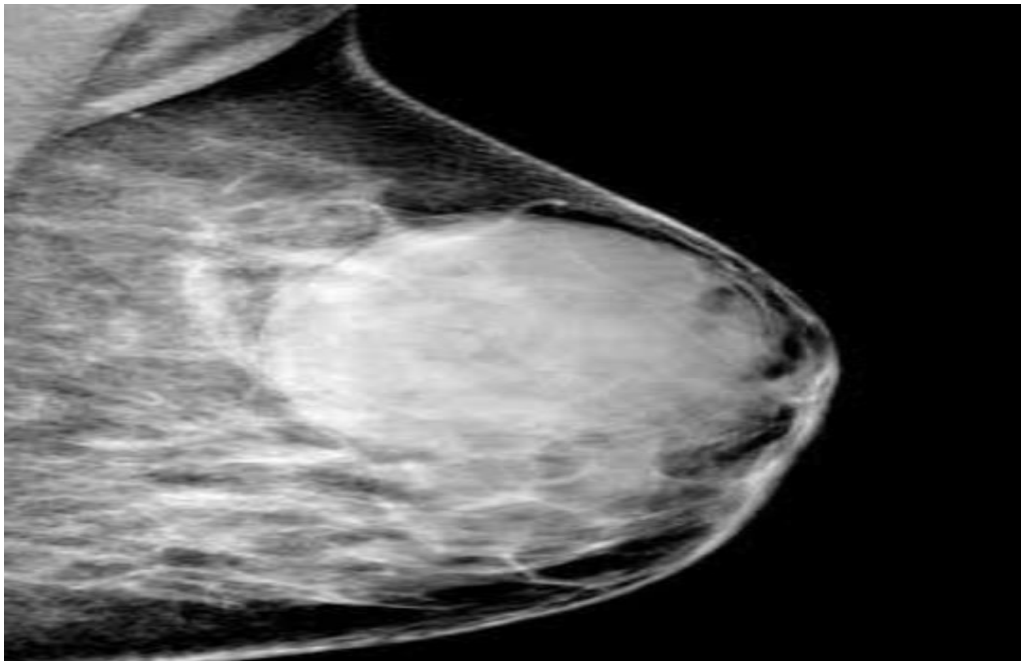


Figure. 1: *mammography image of the breast lesion*

FNAC was inconclusive. She was referred to our clinic with these reports. On clinical examination, a single, hard, well defined lump was palpable in the right breast in central quadrant with normal nipple-areola complex. A single, mobile lymph node of size 2x1cm was palpable in the right axilla. Left breast and axilla were normal. Rest of the systemic examination was unremarkable. Clinically, the impression of findings was in favor of breast carcinoma. Hence, we advised her to undergo core needle biopsy and it was suggestive of a purulent aspirate with no evidence of atypical or malignancy. Case was discussed in our institutional multidisciplinary tumor board. Our board decided to plan for wide excision of the breast lesion with frozen section control after metastatic work up. Thus, we advised her chest x ray and ultrasound of

abdomen with pelvis. Metastatic work up was normal. As per board's decision, patient underwent wide excision of the breast lesion with adequate margins and specimen was sent for frozen section control. Frozen reported it as pus containing cystic to firm lesion with no evidence of malignancy. Hence, we abandoned the further procedure. Patient was started on oral diet 6 hours post extubation and she was discharged in the evening on the same day. Final histopathology report described presence of multiple whitish, cystic to firm pus containing lesions with presence of dense inflammatory infiltrate with scanty granulomatous inflammation and multinucleate giant cells with no evidence of malignancy. Gene expert and culture was negative for mycobacterium tuberculosis and positive for aspergillus flavum [Figure 2, 3].

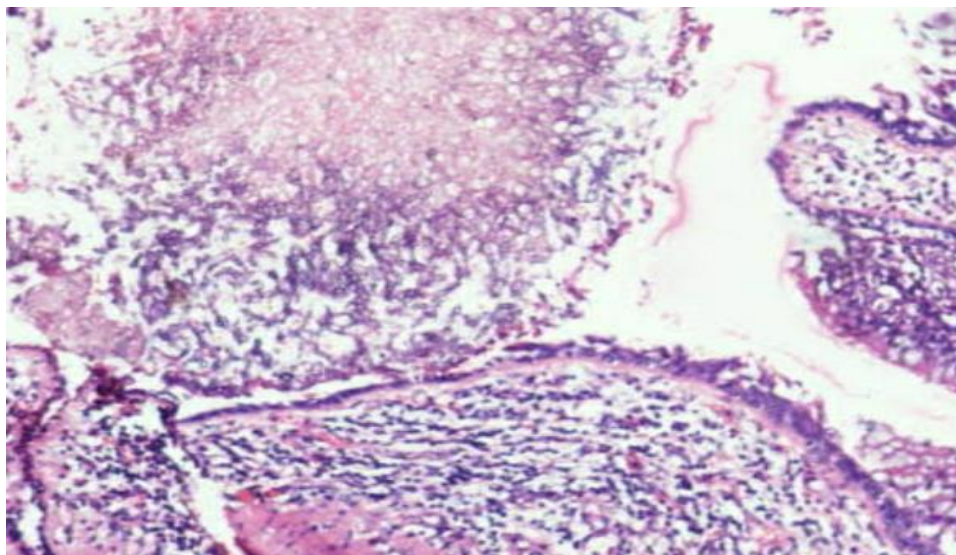


Figure. 2: *Aspergillus fungal hyphae (Low magnification)*

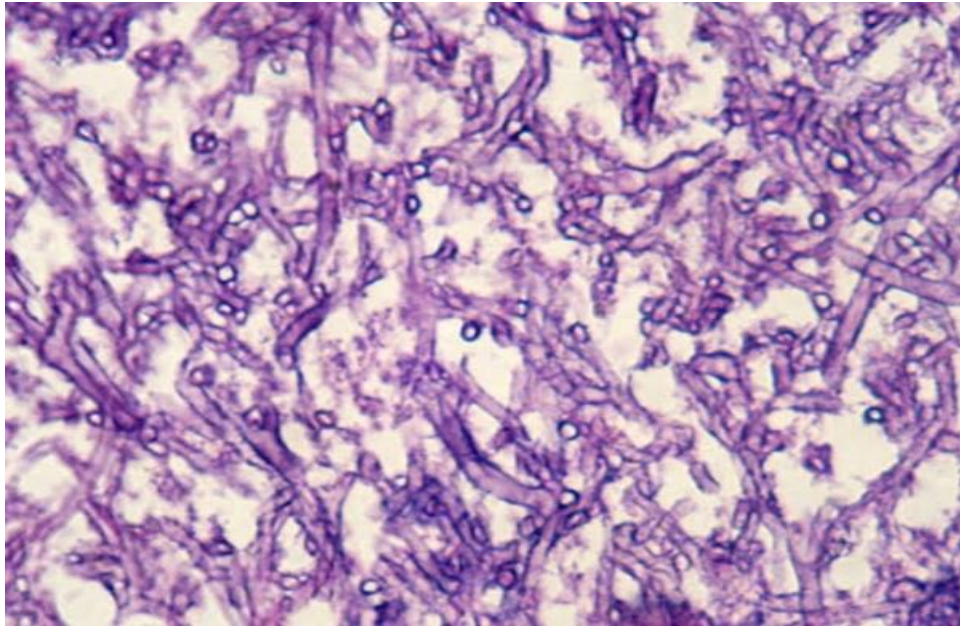


Figure. 3: *Aspergillus fungal hyphae (High magnification)*

Wound dehiscence occurred on 6th postoperative day. It was managed conservatively with alternate day dressing and after 1 month of dressing wound healed by secondary intention. Palpable axillary lymph node was disappeared after one month. She was in periodic follow up with us according to our institutional follow up protocol and after one year of completion of her treatment, she is disease free.

Discussion:

Aspergillus is an opportunistic fungus. The growth and invasion depends on the biological features of the fungus and the immune status of the host [2]. They produce conidia which defines and characterizes its infectious life cycle [7]. These conidia are responsible for spread of infection onwards. They have a special characteristic of dispersion into the air when they come in contact with compassionate environment like lungs of an immunocompromised host where they germinate and become hyphae. The hyphae is the invasive form of *Aspergillus* fungus. The hyphal growth has the tendency to invade blood vessels which results in infarction, hemorrhagic necrosis and dissemination to other organ [8]. The most commonly affected organs are the lungs and paranasal sinuses followed by with less frequencies in the skin, heart, kidney, gastrointestinal tract and brain. They manifest with extra-pulmonary signs and symptoms [9]. However, in the index case, there was absence of such positive history.

Aspergillus fungal infection is found in over 90% patients who are immunosuppressed due to bone marrow transplantation, solid organ transplantation, cytotoxic chemotherapy, corticosteroid therapy and AIDS [10]. *Aspergillus* infection is diagnosed by biopsy with demonstration of septate, acute branching hyphae in the breast tissue [11]. Histopathology helps in detecting *Aspergillus* fungal hyphae in necrotic material with distorted giant cells and final result will be possible after positive fungal culture [11]. The diagnosis is only possible with fungal culture. In immunocompetent patient, it's difficult to detect *Aspergillus* infection in the breast as radiology will be non-specific. In the index case, only after gene expert and fungal culture, we were able to diagnose *Aspergillus* infection. It's treating clinician and pathologist's thinking and implementation which directs and helps in detecting fungal infection.

The treatment of breast aspergilloma needs a combination of surgical and medical treatment to avoid unnecessary complications. The surgical procedure is complete excision of the breast aspergilloma and

recommended medical treatment for cutaneous aspergillosis is voriconazole, itraconazole, and amphotericin B. Voriconazole has been shown to be statistically superior to amphotericin B [12]. We did complete surgical excision and she had been given voriconazole in the postoperative period however, wound dehiscence occurred on 6th postoperative day which was managed conservatively with alternate day dressing. *Aspergillus* fungal infection of the breast is one of the causative factor for non-healing breast wound [13].

Surgeon, pathologist, microbiologist should have an idea of organism specific diagnosis when there is *Aspergillus* infection in the breast and especially surgeon should have a high index of suspicion [14]. The aim of presenting this case is to project the fungal infections as one of the rare cause of breast aspergilloma other than mycobacterium [15]. Until now, less than 10 case of breast aspergilloma has been reported in the literature.

Conclusion:

Aspergillus fungal infection can involve breast even in immunocompetent host, hence slow growing and long standing breast lump should be investigated with high index of suspicion of *Aspergillus* infection. Breast aspergilloma patients should receive early and aggressive medical and surgical treatment.

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