Bilateral primary breast carcinoma in a man

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Published in:
The Netherlands Journal of Surgery

Publication date:
1990

Bilateral primary breast carcinoma in a man

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The case history is presented of a 56-year-old man, who had a second primary carcinoma in the contralateral breast after 13 years. Both times, he underwent a modified radical mastectomy. The axillary lymph nodes were free from tumour. The incidence in men is about 1 per cent being bilateral in 14 out of 1,000 of these cases. The therapy for men is the same as for women. Because of the smaller breast volume, tumours in men are earlier discovered and show infiltration. If metastases cannot be detected, the first choice of treatment is surgical. Radiotherapy is indicated in case surgical intervention has not been radical.

Introduction

Carcinoma of the breast is the most frequent malignant disease in women.[1] In a population of 100,000 women, 75 are annually confronted with this diagnosis. One per cent of malignant brest tumours occurs in men[2] and of these 1.4 per cent is bilateral.[3,4] The case history is presented of a male with a second primary breast carcinoma on the contralateral side after an interval of 13 years.

Case report

A 56-year-old man visited the outpatient clinic with pain and a little swelling behind the left nipple since several weeks. There was no discharge from the nipple. Physical examination showed no nipple deformity. A small mobile solid tumour could be palpated behind the nipple of the left breast. No pathological lymph nodes could be palpated in the axilla. Local excision of the lump was performed under general anaesthesia. Microscopical examination showed an in-situ intralobular carcinoma (Fig. 1). The margins showed

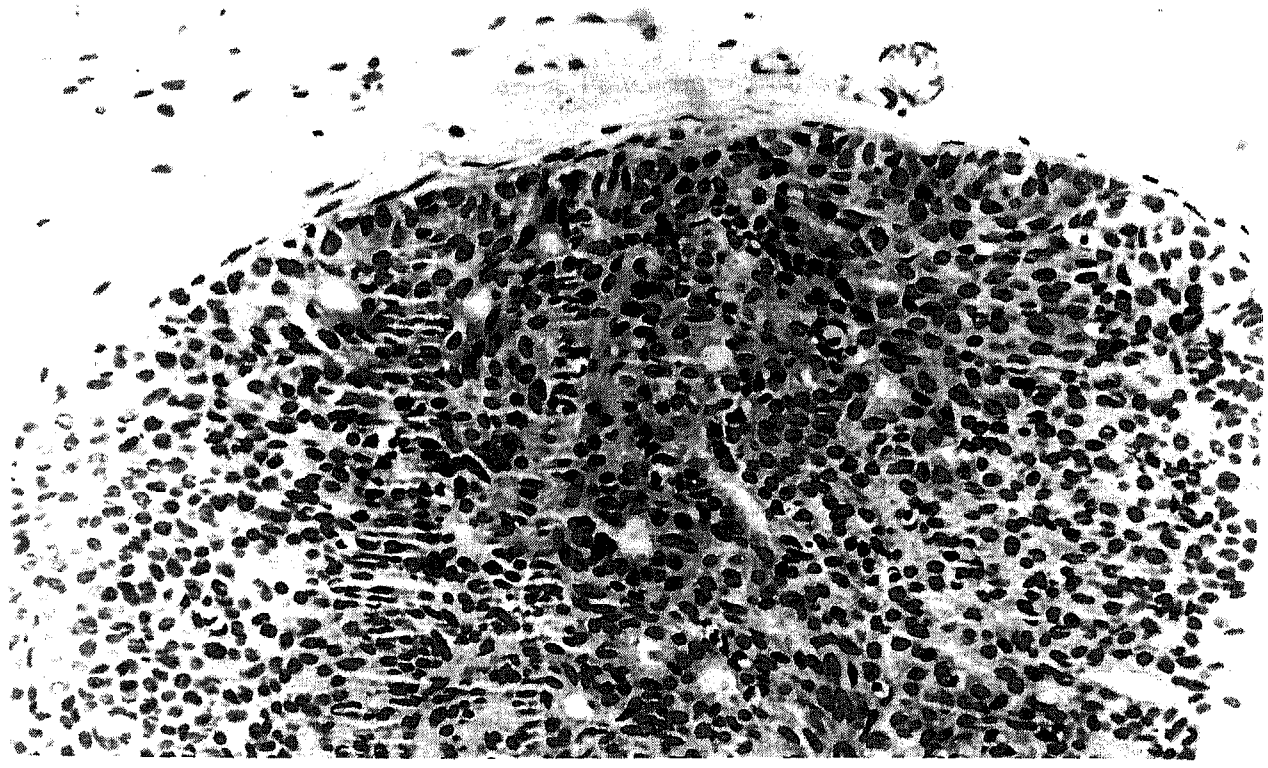

FIG. 1.

Accepted for publication May 1990.

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tumour cells. Therefore, a modified radical mastectomy was performed. In the resection specimen no tumour rests were found, all examined lymph nodes were free from tumour. Adjuvant therapy was not applied. Follow-up for about nine years showed no signs of local or regional recurrence. The right breast remained normal and the patient did not need further follow-up.

Thirteen years after the first carcinoma, the patient came again to the outpatient clinic with a deformity of the nipple of the right breast. Physical examination showed no further pathology. A tumour could not be palpated and the axillary lymph nodes were not enlarged. Mammography showed a suspect deformity behind the right nipple. Cytological examination confirmed malignancy. There were no signs of distant metastases. A modified radical mastectomy was performed. Pathological examination of the tumour revealed an invasive mammary duct carcinoma with a diameter of 1.5 cm (Fig. 2). There were no signs of multifocal or in-situ tumour growth. All 15 examined axillary lymph-nodes were free from tumour. There were no signs of tumour invasion in the surrounding tissue. Therefore, adjuvant therapy was not indicated.

Discussion

Cancer of the male breast was first described by John of Aderne, an English surgeon in the 14th century.[4] Larger groups of patients were first reported around the turn of the century. Most reports originate from the United States.[5,10] Van Geel[4] and Broekhuizen et al.[11] reported on cancer in the male breast in The Netherlands.

Bilateral cancer of the breast in a male is even more rare and has, as far as we know, not yet been reported in The Netherlands. In collective studies male patients are only described incidentally with a synchronous or anachronous carcinoma of the contralateral breast.[6,12-14] Van Geel, in his thesis, reported an incidence of bilateral breast carcinomas of 1.4% in all male breast cancer cases,[4] the same figure as reported by Crichlow.[3]

It is almost impossible to distinguish a second primary carcinoma from a metastasis if the microscopical picture is similar. A metastasis at the contralateral side is extremely rare and must be interpreted as a sign of wide-spread dissemination. Generally, a contralateral tumour has to be considered as a second primary carcinoma, especially if there are pathological differences as in our patient.

Essentially, the treatment of breast carcinoma in men does not differ from that in women. Often the carcinoma is discovered in an earlier stage due to the smaller breast volume. Nevertheless, the prognosis is worse, because tumour infiltration in a small breast occurs sooner.[6,12,13] The initial treatment in patients without proven metastases has to be surgical and sometimes a skin graft is necessary to close the skin defect. Postoperative treatment depends on the mi-

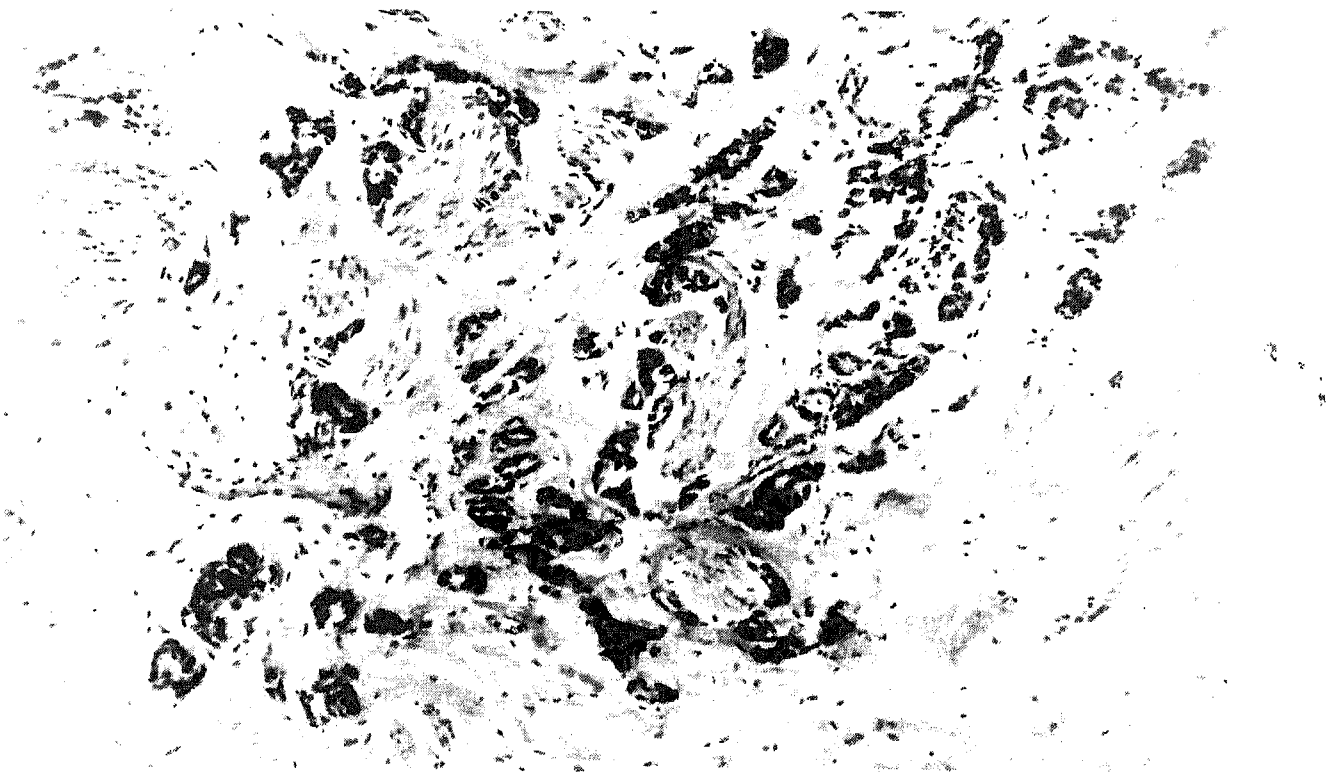

FIG. 2.

croscopical results. Radiotherapy is often indicated, because of irradical resection margins or doubtful radicality.

Key words
breast carcinoma
male breast carcinoma

References

1 HAAGENSEN CD: *Diseases of the breast*. 3rd ed., Philadelphia, W.B. Saunders Company, 1986, p. 397, table 26-1
2 HAAGENSEN CD: *Diseases of the breast*. 3rd ed. Philadelphia, W.B. Saunders Company, 1986, p. 977
3 CRICHLOW RW: Carcinoma of the male breast. *Surg Gynecol Obstet* 114: 1011-1019, 1972
4 VAN GEEL AN: *Borstkanker bij de man*. Thesis, University of Amsterdam, Amsterdam, 1984
5 WAINWRIGHT JM: Carcinoma of the male breast. *Arch Surg* 14: 836-859, 1927
6 MOSS NH: Cancer of the male breast. *Ann NY Acad Sci* 114: 937-950, 1964
7 VANDERBILT PC, WARRER SE: Fourty years experience with carcinoma of the male breast. *Surg Gynecol Obstet* 113: 629-633, 1971
8 ROBINSON R, MONTAGUE ED: Treatment results in males with breast cancer. *Cancer* 49: 403-406, 1982
9 BERNS AWC: Ein Fall von Carcinoma Mammae bei einem Mann. *Arch Klin Chir* 35: 228-230, 1887
10 DELEMARRE JFM, DE JAGER H: Pathologie van de ouderdom. *Geneesk Gids* 45: 96-102, 1967
11 BROEKHUIZEN AH, OLTHUIS GAA, HENTZEN K: Het mammacarcinoom bij de man: een retrospectief onderzoek van 43 patiënten. *Ned Tijdschr Geneeskd* 14: 694-695, 1984
12 SCHEIKE O: Male breast cancer. Clinical manifestations in 257 cases in Denmark. *Br J Cancer* 28: 552-599, 1973
13 EGE G: Carcinoma of the male breast: a reappraisal. *J Can Assoc Radiol* 29: 195-199, 1968
14 YAP HJ, TASHIMA CK, BLUMENSCHEIN GR, ECKLES NE: Male breast cancer, a natural history study. *Cancer* 44: 748-754, 1979
15 MCKAY EN, SELLERS AH: Breast cancer at the Ontario cancer clinics 1938-1956. A statistical review. *Can Med Assoc J* 92: 647-651, 1965
16 CRICHLOW RW, KAPLAN EL, KEARNEY WH: Male breast cancer. *Ann Surg* 175: 489-494, 1972