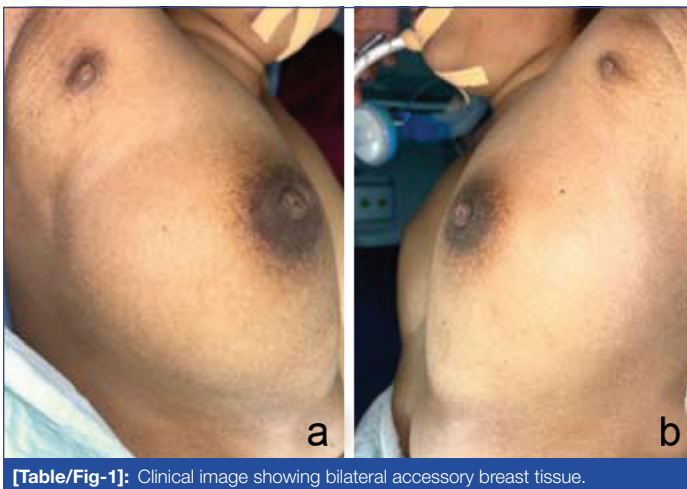


Polymastia: Bilateral Accessory Breast in a Young Female

YASHASVI TRIVEDI¹, RAJESH GATTANI², SHRADDHA GAJBHIYE³, NITISH REDDY⁴, SAURABH GAWAND⁵**Keywords:** Axillary breast, Breast cancer, Granulomatous mastitis Line of Schultz, Milk line

A 28-year-old female presented at the outpatient department with complaints of swelling in the bilateral axilla associated with pain. She reported being alright 12 years back, when this swelling was first noted. It was initially small and has gradually increased in size, reaching its current dimensions of 6×6 cm on the right and 5×4 cm on the left [Table/Fig-1].



[Table/Fig-1]: Clinical image showing bilateral accessory breast tissue.

Swelling over the left axilla was associated with non-radiating pain, which was on and off in nature. The swelling over the right axilla was not associated with any aggravating or relieving factors. There was no history of restriction of movement, trauma, nipple discharge, skin changes, fever, chronic cough or cold, difficulty in breathing, nausea or vomiting, or bowel and bladder complaints. There was no history of any associated comorbidity. Family history was positive on the maternal side, with her mother having similar complaints. The patient underwent a screening mammogram at another hospital, which showed normal parenchyma and no abnormalities.

Hormonal blood profile reported FSH- 9.63 mIU/mL, Prolactin- 24.7 ng/mL, and LH- 57.3 mIU/mL. Blood Vitamin D3 levels were also low (10.5 ng/mL). The patient was advised to undergo FNAC to confirm the diagnosis, which was suggestive of granulomatous changes in the left accessory breast tissue.

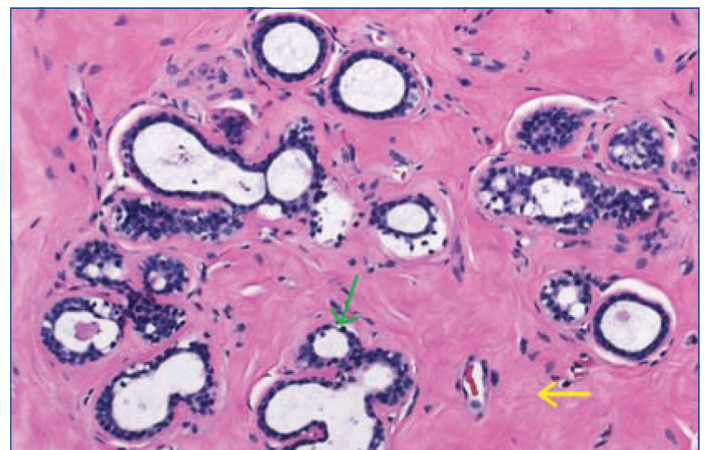
The patient was induced under general anaesthesia. Excision of the bilateral accessory tissues with nipple areola complex was performed by an elliptical incision followed by drain placement [Table/Fig-2]. Histopathology of the breast was suggestive of inflammatory fibrocystic changes of bilateral accessory breast tissue [Table/Fig-3].

The patient had no abnormal discharge from the suture site and was discharged on postoperative day seven with advice to follow-up from one month to six months, followed by 1-year follow-ups. The patient was followed up regularly, and no abnormalities were detected until the 6-monthly follow-up.

Bilateral accessory breast tissue is commonly observed in the axillary region. It consists of 0.3%-0.6% of all types of breast cancers, with the majority being reported in the axilla region [1].



[Table/Fig-2]: Postoperative image.



[Table/Fig-3]: Haematoxylin and eosin-stained slide showing bilobed ducts embedded in fibrous stroma (40x magnification); Green arrow- ducts; Yellow arrow- fibrous stroma.

Genetic linkage of FANCC gene variants has been found in certain sub-saharan families with an autosomal-dominant pattern of linkage, raising questions about the development of accessory breast tissue with familial linkage [2].

This female also presented to the outpatient department when there were a few episodes of pain in the left breast associated with growth, though the axillary masses had been present for 12 years. This was confirmed as mastitis in the left accessory breast mass, and a decision was made to remove the bilateral accessory tissues. A similar case was reported by Nakumara J et al., in a 24-year-old pregnant female, who was also managed by surgical excision [3].

A 25-year-old multiparous female had asymptomatic bilateral axillary masses, which were first noted five years back and increased during lactation and subsequent pregnancies. She also had similar complaints in her first-degree family members (mother and sister) [4].

Accessory breast tissue is a rare clinical presentation with female preponderance. It does not pose a significant health risk, but caution is required as it is susceptible to the diseases that affect normal breast tissues, with mastitis being one of them.

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