

Sir,

A 25-year-old, multipara woman presented with asymptomatic bilateral axillary masses. She noticed them five years ago, during pregnancy [Figure 1]. During the periods of lactation and subsequent pregnancies, they increased in size, showing some variation in their diameters during menstrual cycles. There was a family history of such swellings in her mother and sister.

Examination revealed bilateral, solitary, lobular, soft, nontender, single masses, with size 9×11 cm and 6×9 cm diameters in the right and left axillae, respectively [Figures 1 and 2]. They were freely mobile and overlying skin was normal.

Routine hematologic and biochemical parameters were within normal limits. Ultrasonography of these masses showed ectopic breast tissue. An ultrasound of the abdomen and pelvis revealed normal findings. A biopsy of the axillary mass showed fatty tissue with presence of small foci of ductal structures and a fragment of the skin with hyperkeratosis of the epidermis, consistent with accessory breast [Figure 3]. After confirmation of the diagnosis, we recommended surgical excision.

Polymastia means the accessory breast glandular tissue with or without nipple and areola.^[1] The presence of an extra nipple (polythelia) and breast (polymastia) is not uncommon.^[2] Between 1 and 5% of men and women have polythelia or, less frequently, polymastia. Most cases are sporadic, but approximately 6% are familial and are believed to represent an autosomal dominant trait with variable penetrance.^[3]



Figure 2: The lateral aspects of the same patient's right axillary mass



Figure 1: Accessory breast presented with bilateral axillary masses in a 25-year old lady (anterior aspect)

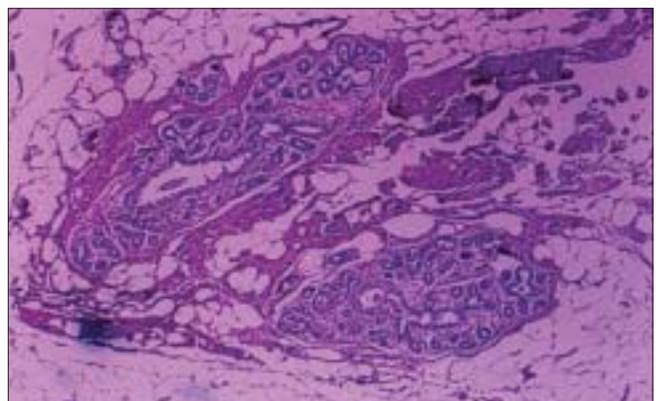


Figure 3: Histopathological examination revealed fatty tissue with the presence of small focus of ductal structures (H and E, $\times 40$)

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Approximately one-third of the affected individuals have more than one site of supernumerary breast tissue development.^[3] Although they are often found within the milk line, running from the axilla to the groin or pubic region, there are rare unusual locations, usually referred to as “mammas erraticas” including in the buttock, back of neck, face, flank, upper arm, hip, shoulders, midline of the back, chest, and vulva.^[2] Approximately 67% of accessory breast tissue occurs in the thoracic or abdominal portions of the milk line and more often on the left side of the body; another 20% occurs in the axillae.^[3]

Polymastia without nipple and areola occurs due to regression of the ectodermal element in the skin, but a normal proliferation in the mesenchyma anywhere along the milk line ⁽¹⁾. Most of this accessory breast tissue has no physiological significance.^[3] In females, it usually manifests during pregnancy or lactation. Rarely, polymastia during puberty been reported.^[4] They can undergo the same pathological changes as normally positioned breasts, such as fibroadenomas and carcinomas.^[2] In addition, some studies have suggested that aberrant breast tissue may be at a higher risk of malignant degeneration.^[5]

A subset of ectopic mammary tissue may constitute a diagnostic challenge and is often misdiagnosed as lipoma, hidradenitis, follicular cyst, or lymphadenopathy.^[5]

Polythelia or supernumerary nipple is the most common form of accessory breast tissue malformation that has been reported to be associated with nephro-urological anomalies, but no such reports are there in relation to polymastia. However, as polythelia and polymastia may coexist, all cases of polymastia should

be subjected to a thorough physical examination, urine analysis, and renal ultrasound, to exclude renal pathology.^[3] The association of supernumerary breast tissue and increased fertility mentioned in the nineteenth century medical literature has been proven false.^[2]

Proper timing of surgical intervention is necessary to optimize the functional, psychological, and aesthetic outcomes. Excision is usually recommended prior to puberty or at any age when the condition is recognized.^[3] Some authors believe that the ectopic tissue can be surgically excised if symptomatic or if it represents a cosmetic problem.^[2]

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