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That's Not Your Implant!

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HISTORY OF PRESENT ILLNESS

CHIEF COMPLAINT: Left breast pain/swelling

53-year-old female with PMHx of bilateral breast implants, IV drug use, and hypertension presents to the emergency department with swelling and pain to the left breast over the last 5 months after an assault with trauma to the area. She was seen at a previous hospital for these symptoms 3 months ago and reports fluid was drained from the left breast at that time. She reports subjective fevers and chills but denies other symptoms at this time including drainage or discharge from the breast/ nipple, chest pain, or shortness of breath. Her breast implants were placed over 20 years prior. She denies injecting drugs into her breast tissue.

PHYSICAL EXAM

Vitals: BP 155/85 HR 75 RR 18 T 36.6 SpO2 100%

General: Uncomfortable-appearing, cachectic female in no acute distress

Cardiovascular: Regular rate and rhythm without murmurs, rubs, or gallops

Respiratory: Clear to auscultation bilaterally

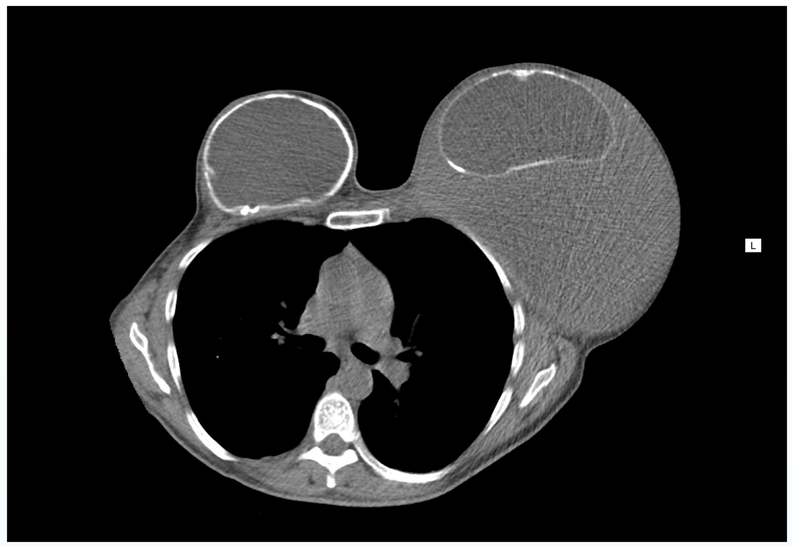
Chest wall: Massively enlarged left breast as compared to the right breast. Fluctuance to the left breast with swelling and tenderness to palpation without erythema or signs of recent injury. Bilateral breast implants palpated.

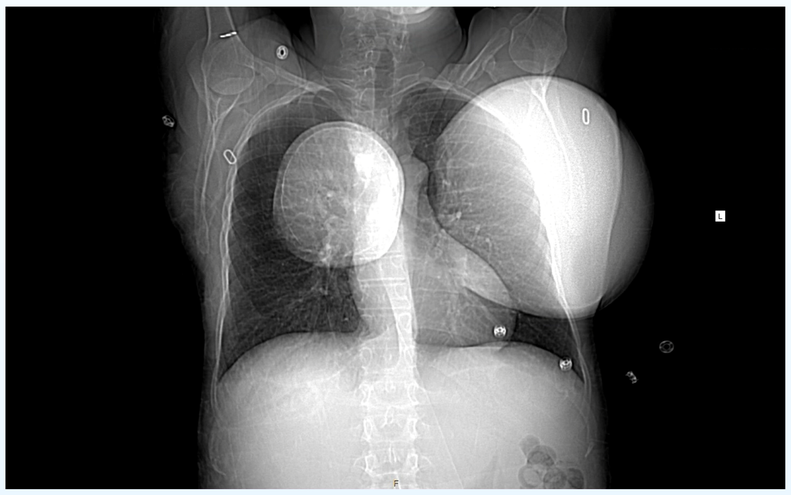
LABORATORY DATA

CBC – WBC 6.0

Fluid Studies – Turbid yellow fluid

- RBC count 136,000
- WBC count 61,072
- Differential unremarkable





CLINICAL QUESTIONS

1. What are common causes of this diagnosis?
2. What is the treatment?

Answers

1. Seromas can form with the creation of dead space in the body (i.e. mastectomy, tumor excision) or with lymphatic disruption causing a serous fluid leak.
2. Seromas are often resorbed by the body without intervention but if severe (painful, large, or infected) can be treated with aspiration, compression, or surgical intervention.

CASE DISCUSSION

The CT scan of the chest revealed a probable seroma surrounding the left breast prosthesis measuring up to 19 cm in diameter. The patient was admitted to the hospital medicine service for further management.

During the admission, Interventional Radiology (IR) performed an ultrasound-guided aspiration of the left breast which yielded 2,200 mL of cloudy yellow fluid. Fluid studies (see *Laboratory Data*) were performed which confirmed the diagnosis of a seroma. Findings from this admission were consistent with prior records from an outside hospital, where the patient was admitted three months prior and had approximately 2 liters of serous fluid drained. During that previous admission, the patient had rapid re-accumulation of fluid in the breast, and IR had planned to place a drain; however, the patient ultimately left against medical advice before drain placement.

Unfortunately, the patient eloped on day 4 of this admission. Conversation for further management of what was likely to be another re-accumulating seroma was unable to be had.

Seromas are collections of serous fluid under the skin, most often forming postoperatively (particularly after mastectomies and axillary surgeries) when dead space is created. Lymphatic system disruption contributing to serous fluid leakage also plays a role in the formation of seromas, although the exact etiology is not fully understood. Less commonly, seromas can occur after traumatic injury, as seen in this patient.

CLINICAL PEARLS

- Most seromas will spontaneously resorb, but consider aspiration if they cause pain, are large, or show signs of infection.
- Rapidly re-accumulating seromas after initial aspiration may be further managed with drain placement.