reports. The breast lesion may present as single or multiple nodules. Also, some case reports have demonstrated an association of a breast mass and lung nodules at the time of diagnosis as in the present case. The radiological appearance has been described by some authors as an ill-defined irregular mass or focal asymmetric density on a mammogram that is suspicious for carcinoma and as an irregular hypoechoic nodular mass or mass with parenchymal mixed echogenicity, consistent with mastitis or abscess on ultrasound examination. However, none of these cases was associated with a tumor mass and included pleomorphic microcalcifications. This is the first case in the published literature in which microcalcifications are present within a suspect breast mass on mammography.

Wegener's granulomatosis of the breast needs to be reconsidered in the differential diagnosis of a single breast mass associated with microcalcifications and multiple associated lung nodules, especially in patients in which the clinical history is unknown or in patients diagnosed by using a small tissue fragment from a core biopsy, as in this case. Several inflammatory entities need to be excluded before making the diagnosis of Wegener's granulomatosis of the breast, but especially, in cases of a breast mass associated with microcalcifications on mammography, an invasive and/or in situ carcinoma has to be excluded through microscopic examination. This emphasizes the importance of clinical features and clinic-pathologic correlations in establishing the diagnosis.

Stewart–Treves Syndrome of the Breast after Quadrantectomy for Breast Carcinoma

Benedetta Miglino, MD,* Elena Maldi, MD,† Rossana Tiberio, MD,* Paolo Boggio, MD,* Stefano Astolfi, MD,* Roberto Franchini, MD,‡ Elisa Zavattaro, MD, PhD,* Renzo Boldorini, MD,† and Enrico Colombo, MD*

**Department of Dermatology, "Maggiore della Carità" Hospital, University of Eastern Piedmont "A. Avogadro", Novara, Italy; †Department of Medical Sciences, "Maggiore della Carità" Hospital, University of Eastern Piedmont "A. Avogadro", Novara, Italy; ‡Department of General Surgery, "Maggiore della Carità" Hospital, University of Eastern Piedmont "A. Avogadro", Novara, Italy*

Stewart–Treves syndrome is a rare and deadly disease. It is characterized by cutaneous lymphangiosarcoma arising on chronic lymphedema as a consequence of mastectomy and axillary lymph node dissection. Angiosarcoma of the breast after conservation surgery for carcinoma and adjuvant radiotherapy is a fairly rare occurrence.

Address correspondence and reprint requests to: Benedetta Miglino, MD, Department of Dermatology, "Maggiore della Carità" Hospital, University of Eastern Piedmont "A. Avogadro". Corso Mazzini 18, Novara 28100, Italy, or e-mail: bennymiglino@libero.it

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We present a rare case of lymphangiosarcoma in a 77-year-old woman. In February 2007, she had a left upper quadrantectomy and axillary lymph node dissection for a ductal carcinoma in the left breast. Histology showed a grade 2 ductal carcinoma, whereas only 30% was in situ tumor, fat tissue of left axilla was infiltrated by carcinoma and two of three nodes were positive (T1c, N3, M0). The patient received anastrozole per os and the area was treated with a fraction size of 2.25 Gy to achieve a dose of 54 Gy in 23 days. The clinical examination, total body computed tomography (CT) and hematochemical exams were negative for methastatic lesions. She was otherwise healthy.

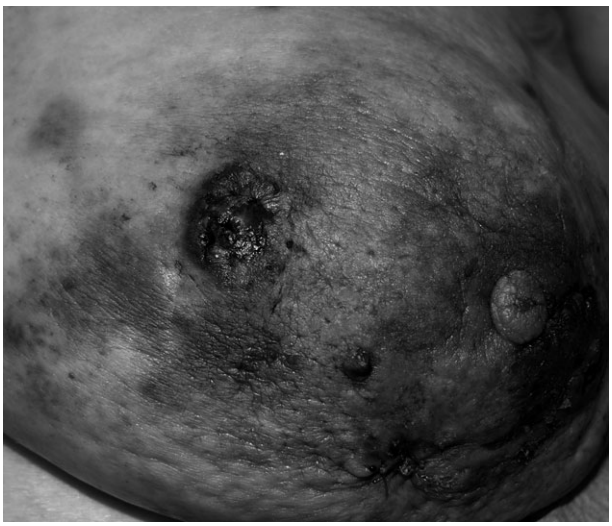

Figure 1. A cluster of red to purple bleeding nodules, measuring 2–3 cm in diameter over the left breast area.

She was followed up every 6 months with physical examination, breasts US, mammography and hematochemical investigation in oncology department. She complained of a minimum edema to left arm. She was good and all exams were negative until to July 2012, when she presented to our dermatology department for two purple bleeding nodes at the left breast. She first noticed them 3 weeks before presentation, at which time they were interpreted as ecchymosis, but they progressively became more nodular and bleeding. Physical examination at that time noted a cluster of red to purple bleeding nodules measuring 2–3 cm in diameter over the left breast area (Fig. 1). She had no pain or itching in this region. An incisional biopsy of the nodular lesion was performed and histologic examination revealed a lympho-vascular invasive pattern and diffusely infiltrative neoplastic cells. Finally after this exam, we diagnosed lymphangiosarcoma. The left mastectomy was performed in September 2012 and the histologic examination showed a diffusive proliferation of anastomosing and infiltrative vascular channels with hemorragic lacunae and lined by highly malignant and pleomorphic cells (Fig. 2a and b) they were positive for endothelial markers (CD34 and CD31; Fig. 3). The citokeratine (citokeratine 7 and 19) immunostains were negative, so the immunochemistry confirmed the diagnosis of high-grade angiosarcoma. After mastectomy, total body CT scan and ematochemical exam were negative. She is following-up to oncology department every 3 months now and she is good and negative for metastasis at this moment.

The development of angiosarcoma in a chronically lymphedematous extremity was described by Stewart and Treves in 1948 after observation of this syndrome in a women with breast cancer treated with radical mastectomy. The incidence of this disease is between 0.07% and 0.45% in patients who survive at least 5 years after radical mastectomy.

Of lymphangiosarcomas, 90% develop in the upper limb. Lymphoedematous changes are necessary for the development of Stewart–Treves syndrome. Because of the popularity of breast conservation therapy, improvement of operative and radiation therapy techniques, and development of novel

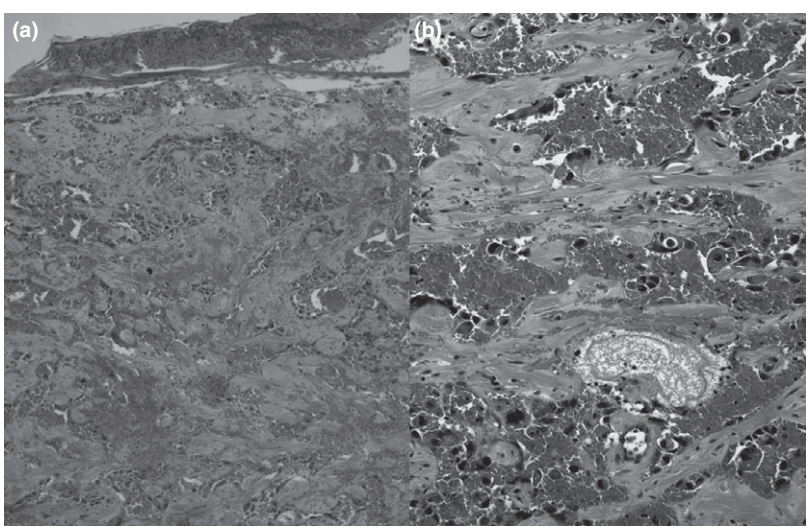

Figure 2. (a and b) Diffusive proliferation of anastomosing and infiltrative vascular channels with hemorragic lacunae and lined by highly malignant and pleomorphic cells (a: H&E, original magnification 10×, b: H&E, original magnification 40×).

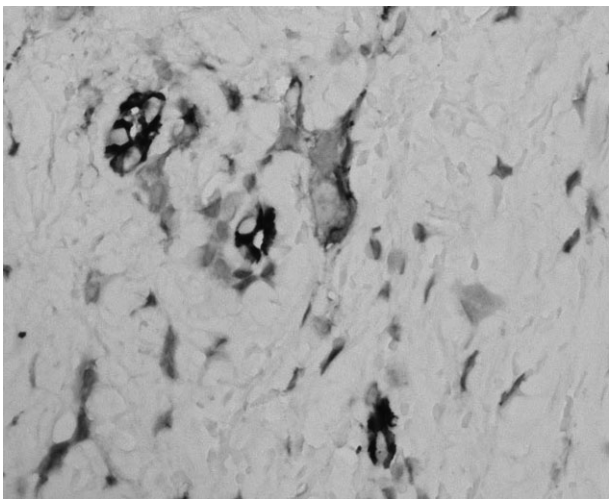

Figure 3. The highly malignant and pleomorphic cells were positive for endothelial markers. (CD34, original magnification 20×).

chemotherapeutic agents, the incidence of Stewart–Treves syndrome has significantly decreased. This case should not be considered as metastatic or recurrent angiosarcoma, but as angiosarcoma secondary to irradiation, or secondary angiosarcoma. A Dutch population-based study found that the absolute risk of developing angiosarcoma after breast-conserving therapy for breast cancer was 0.16% at 5 years. Reporting this case, we want to remember that the angiosarcoma should be considered in any postradiation patient with persistent or worsening skin thickening and the occurrence of skin nodules. Early diagnosis is crucial in fact it allows the patient to quickly obtain aggressive surgical treatment, which is the only chance for definitive treatment and survival.

Spontaneous Milk Fistula from an Accessory Breast: An Extremely Rare Case

Deniz Firat, MD,* Oguz Idiz, MD,* Arda Isik, MD,* Kemal Peker, MD,* Nilgun Atar, MD,† and Eylem Gul, MD‡

**General Surgery, Erzincan University, Erzincan, Turkey; †Radiology, Erzincan University, Erzincan, Turkey; ‡Dermatology, Erzincan Uunversity, Erzincan, Turkey*

A 19-year-old patient referred to us by complaint of efflux from the right axilla. When patient history was investigated, it was learned that she has been breast feeding since 5 months ago. Her efflux complaint from her right axilla has started spontaneously without any trauma, abscess or surgery 2 months ago. Furthermore, she specified that a slowly growing swelling occurred on the right axilla in parallel with her delivery of her child. In her physical examination, there was a soft mass with a size of 3 × 3 cm, which excretes milk by squeezing on the right axilla (Figs 1 and 2). Other axilla was normal. In the ultrasonography performed, a 3.5 × 2 cm breast tissue including ducts was observed in the right axilla (Fig. 3).

Address correspondence and reprint requests to: Deniz Firat, General Surgery, Erzincan University, Erzincan, Turkey, or e-mail: drydf@yahoo.com

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Figure 1. Milk efflux from the axilla by squeezing.