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BREAST TUBERCULOSIS; ABOUT A CASE

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ABSTRACT

Breast tuberculosis is the contamination of the mammary gland by Mycobacterium tuberculosis, mainly affecting women during the period of reproductive activity. It is a rare condition of extra pulmonary tuberculosis even in endemic countries, it represents 0.06 to 0.1% of tuberculous localizations and 0.5 to 4.5% of breast pathology. It poses a problem of differential diagnosis with breast cancer. We presenting in this article a case in the diagnosis of breast tuberculosis was a diagnosis of elimination.

KEYWORDS: Tuberculosis, Mammary Gland, Ultrasound, Mammography, Anatomo-Pathology.

INTRODUCTION

mammary tuberculosis is described for the first time by Ashley Cooper in 1829, it is a rare condition due to contamination of the mammary gland by Mycobacterium tuberculosis (MT) or Koch's bacillus, in women in period of genital activity[1], especially in vulnerable populations (precariousness, chronic diseases, immunosuppression). Breast form accounts for just 0.025-4% of all breast conditions.[2] In addition, it accounts for 0.1% to 0.5% of all TB cases.[3,4] This form is often considered as a tumor localization from the clinical and radiological point of view.

We report the case of a patient who presented with primary breast tuberculosis.

OBSERVATION

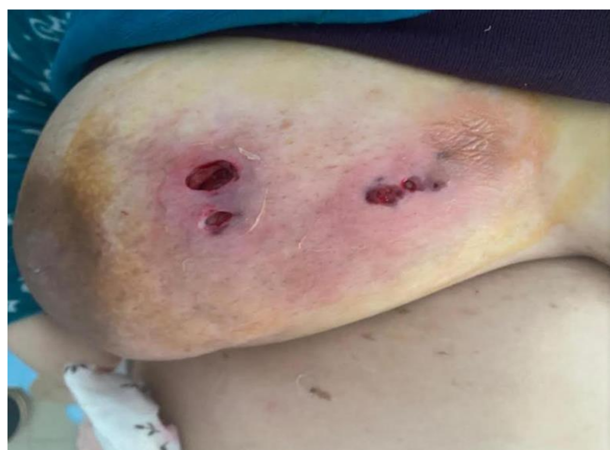
This is a 64-year-old G4P3 diabetic patient under ADO who consults for a right breast tumor that appeared 5 months previously and gradually increasing in volume without nipple discharge or associated mastodynia.

The clinical examination found a tumorous right breast with a mass taking up almost the entire mammary gland, tending to fistulization with an orange peel appearance and satellite axillary adenopathies suggesting first advanced breast cancer; the left breast was normal, as was the rest of the clinical examination (Fig. 1).

Mammography and ultrasound concluded that there was a highly suspicious tumor process in the right breast. (Fig.2).

A breast aspiration biopsy showed no suspicious cells. A breast biopsy was completed, which showed specific lesions of follicular-caseous tuberculosis. The chest X-ray was normal and no other tuberculous localization could be suspected clinically.

The diagnosis of breast tuberculosis with lymph node invasion was retained. The patient was put on anti-bacillary treatment (2ERHZ/4RH) with a favorable outcome: Rifampicin, Isoniazid and Pyrazinamide six days out of seven for two months then Rifampicin and Isoniazid six days out of seven for four months.



Fig; 1: clinical appearance of the right breast initially suggesting an advanced neoplastic breast.

Fig. 2: mammogram of the right breast showing suspected opacity (BIRADS 5),

DISCUSSION

Breast tuberculosis is a rare condition, it represents 0.025 to 4% of breast pathology and 0.06 to 0.1% of all tuberculous localizations[2] which can occur in a primitive form (the most common 60% cases) or secondary.

The clinic is non-specific and polymorphic (nodular, diffuse and sclerotic), with an onset that is almost always insidious, rarely acute, the lesions are often unilateral and mainly located in the upper outer quadrant. According to Wilson and MacGregor, bilaterality is observed in only 3% of cases.[5]

Breast tuberculosis is always a differential diagnosis, in young women, with a pyogenic abscess and, in older women, with breast carcinoma.[6]

Echo-mammography is non-specific. It may show nodular lesions with thickened skin; sclerotic type; edematous type, calcifications.

The diagnosis is bacteriological and / or histological. The cytology of a fine needle puncture can show the presence of histiocytic cells with an epithelioid appearance, bringing back caseum in the event of a collected abscess, but most often it is the histological examination of the biopsy specimens which makes the diagnosis by revealing the specific lesion: epithelio-giganto-cellular granuloma with caseous necrosis.[7]

The treatment is mainly medical based on anti bacillary, for new cases: two months are given associating Rifampicin-Isoniaside and Pyrazinamide followed by a maintenance phase associating Rifampicin and Isoniazid for four months; in the event of a recurrence, an initial phase combining Rifampicin-Isoniazid and Pyrazinamide for two months followed by a maintenance phase combining Rifampicin and Isoniazid for seven months. The evolution is often favorable under treatment.

Surgery is indicated as a second intention in the event of a poor response to medical treatment. The procedure consists of either resection of a nodule or drainage of an abscess, resecting as much as possible.

possible necrotic and infected tissue, either from a segmental (quadrantectomy) or total (mastectomy) mastectomy, if the breast is completely destroyed and riddled with fistulas.

CONCLUSION

Breast tuberculosis must be distinguished from other breast pathologies and especially from cancers given the clinical and radiological similarities, hence the interest of a histological confrontation. The medical treatment remains in first intention with a most often favorable evolution, but the surgery can reserve a place in case of failure.

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