Gestational hypertrophy of the breast

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DESCRIPTION

A 22-year-old woman, parity 1, 24 weeks pregnant, presented with massive diffuse enlargement of both breasts, since, second trimester. Her earlier pregnancy was uneventful. Multiple ulcerations as a result of pressure necrosis were also present for the last 3–4 months (figure 1). Her breasts were normal on ultrasonography with no evidence of cancer. Fine-needle aspiration revealed hyperplasia of the mammary glands with foci of increased fat and connective tissue. The patient was managed conservatively with antibiotics and dressings and she improved. The ulcerations and the huge size were affecting the morbidity of the patient. The patient was advised to have an abortion followed by reduction mammoplasty but she refused and has not since returned for follow up.

Benign breast hypertrophy is a rare disorder; 1:28 000–1:100 000¹ seems to occur only in adolescence and pregnancy. The aetiology remains unknown, but various theories have been put forward ranging from endocrine imbalance including hyperprolactinemia to target organ hypersensitivity.¹ Histology of affected breast ranges from increase in the periductal interlobular connective tissue progressing to moderate lymphocytic infiltration of the hyaline connective tissue with significant lobular hypertrophy, ductal proliferation and periductal fibrosis consistent with changes found in normal breast. The enlargement may be associated with ulceration of the skin or sepsis or bleeding from the grossly engorged veins.

Figure 1 A 22-year-old woman presented with massive diffuse enlargement of both breasts, since, second trimester with multiple ulcerations as a result of pressure necrosis.

Some degree of regression occurs after delivery. Conservative management includes tamoxifen, testosterone, dihydrogestrone, hydrocortisone, diuretics and medroxy progesterone acetate, some patient may respond to bromocriptine therapy but this might not necessarily lead to regression of size. Suppression of lactation in the puerperium is mandatory, as further engorgement may precipitate infection and necrosis. Surgical treatments include reduction mammoplasty, subcutaneous mastectomy or total mastectomy with reconstruction of nipple areola complex forms the mainstay of treatment.² Termination of pregnancy in first trimester may be needed if the skin overlying the enlarged breast gets severely ulcerated and necrosed. Less often bilateral mastectomies may also be needed.³

Learning points

- ▶ Cause of gigantomastia is unknown.
- ▶ The patient may have varied response to bromocriptine therapy or any other medical therapy ultimately necessitating surgical intervention.
- ▶ Giant fibroadenoma, phylloides tumour of the breast, non-Hodgkin lymphoma and lymphoblastic lymphoma may form differential diagnosis.

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