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# A case of primary squamous carcinoma of breast

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A 52-year old woman presented with a rapidly progressive painful lump in the right breast of 5 months' duration which fungated one week before presentation. She did not have any risk factors for breast cancer.

General examination revealed no skin lesions, except for that overlying the breast lump. There were no masses

or lesions in the oral cavity. Rest of the general examination was normal. Breast examination showed a fungating, hard 4 x 3cm mass with irregular, ill-defined margins, and limited mobility involving the upper lateral quadrant of the right breast (Figure 1). The left breast was normal. There were no palpable axillary lymph nodes. Other systems were normal.

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Figure 1 Squamous carcinoma involving upper lateral quadrant at right breast.

Fine needle aspiration cytology (FNAC) revealed a moderately differentiated squamous carcinoma. An upper gastrointestinal tract endoscopy, dermatological and ENT surgical evaluation excluded a primary source of spread. Her chest xray was normal. Total mastectomy and level III axillary clearance was performed. Histology confirmed the FNAC. In addition, it excluded vascular or lymphatic invasion, and none of the harvested lymph nodes contained tumour deposits. Post-operative ultrasound scan of abdomen, contralateral mammogram and a Technetium 99 bone scan excluded metastatic disease.

Primary squamous carcinoma of breast (PSC) is rare [1–5] with a reported incidence of 0.1% [1]. A primary tumour, which could metastasise to the breast, needs exclusion, before diagnosing PSC [1, 2].

The recommended initial treatment for PSC is surgical excision [1]. Menes and colleagues reported a lower rate of lymph node metastasis, which was 22%, versus a 40–60% rate for infiltrating duct carcinoma [3]. The role of lymph node involvement, in determining the outcome in PSC, remains unresolved [3, 4]. Our patient did not have any evidence of metastatic disease during the follow up 12 months.

Although chemotherapy is recommended, its role remains unresolved for lack of data. The hormone receptor levels are very low in PSC [1, 3, 4] thus excluding the need for adjuvant hormonal therapy. However this patient was

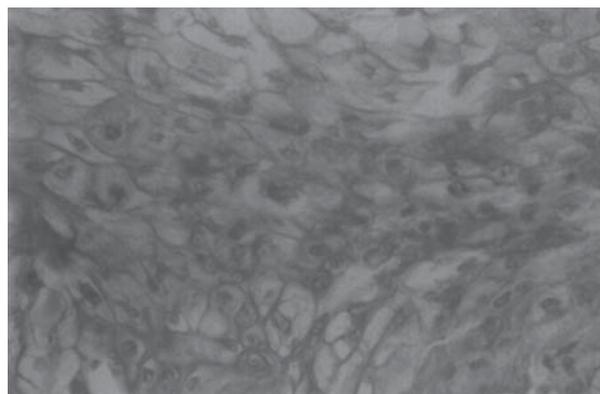


Figure 2. Islands of squamoid cells showing keratinisation and abortive keratin pearl formation (H & E x 400).

given radiotherapy, warranted because the deep margin of resection of the tumour.

The clinical behaviour of PSC of breast remains uncertain [5]. One case report indicates an indolent clinical course with good prognosis [1], while another indicates an aggressive course [3]. PSC should be treated on an individual basis, taking available evidence into consideration and with regular follow up.

## References

1. Cardoso F, Leal C, Meira A, Azevedo R, Mauricio MJ, et al. Squamous cell carcinoma of the breast. *Breast* 2000; **9**: 315–9.
2. Weigel RJ, Ikeda DM, Nowels KW. Primary squamous cell carcinoma of the breast. *Southern Medical Journal* 1996; **89**: 511–5.
3. Menes T, Schachter J, Morgenstern S, Fenig E, Lurie H, Gutman H. Primary squamous cell carcinoma (SqCC) of the breast. *American Journal of Clinical Oncology* 2003; **26**: 571–3.
4. Behranwala KA, Nasiri N, Abdullah N, Trott PA, Gui GP. Squamous cell carcinoma of the breast: clinico-pathologic implications and outcome. *European Journal of Surgical Oncology* 2003; **29**: 386–9.
5. Vidyasagar MS, Fernandes DJ, Ramanujam AS, Rao DS, Narayan R. Primary squamous cell carcinoma of the breast in a young woman—a case report and review of literature. *Indian Journal of Pathology and Microbiology* 1998; **41**: 485–8.