Mediterranean BioMedical Journals
International Journal of Medicine and Surgery
Volume 3, Issue 2, 2016
DOI: 10.15342/ijms.v3i2.71

IMAGES IN CLINICAL MEDICINE

Erosive Adenomatosis Of The Nipple

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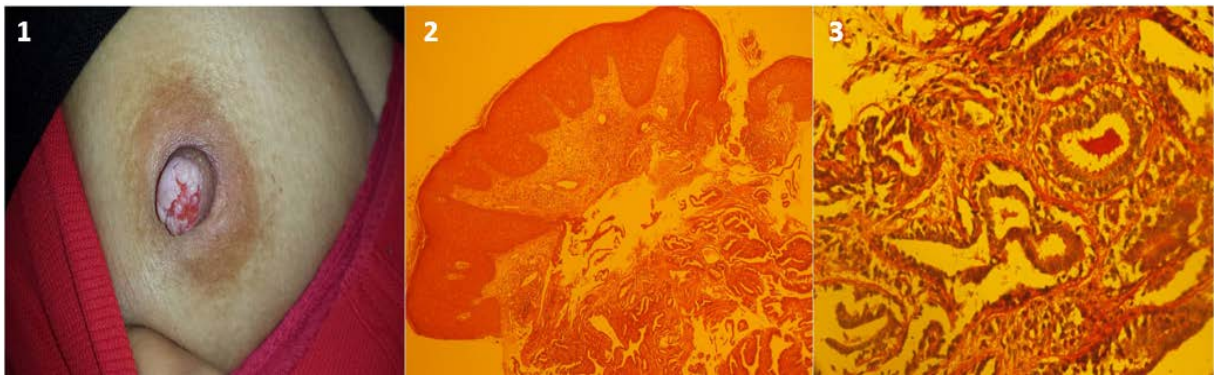
Received 19 December 2015; Revised 22 Mars 2016; Accepted 09 Avril 2016.

KEY WORDS: Adenoma; Nipple ; Breast



A 46-year-old female patient was referred to the Dermatology Service with a 3-year history of erosions over the right nipple. There was no family history of breast disease. She reported that she had been a steady increase in the size of this nipple, accompanied by itching, superficial ulceration and a serosanguineous discharge. Physical examination revealed an irregular ulcer on right nipple with slight serous exudates (Panel 1). Breast palpation failed to reveal any masses, and clinical axillary lymph node examination was negative. Reports of ultrasound scanning and bilateral mammography were negative. Histopathological examination revealed a skin formed by acanthotic regular epithelial cells without dysplasia or exocytosis. The dermis is home to many fomations with ductal acini whose light is dilated with luminal epithelial invaginations. Their bilaminate wall is formed by epithelial and myoepithelial cells without atypia or mitosis. The stroma is fibrous, somewhat inflammatory and without granulomatous lesions (Panel 2 and 3). A diagnosis of erosive adenomatosis of the nipple was made. The lesion was excised and no relapse was noted after 2 years of follow up. This is a rare benign neoplasm caused by a complex proliferation of the lactiferous ducts. There are many differential diagnoses, including inflammatory, infectious and neoplastic diseases. Clinically, the most important differential diagnosis is with Paget's disease. though we should always eliminate the diagnosis of a malignant tumor. Histological examination is fundamental for a diagnosis. Treatment is usually surgical. The prognosis is excellent, and there are reports of recurrence when the excision is incomplete.

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