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Case Report

# Neglected Breast Cancer: A Cauliflower-Like Tumor: Case Report

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## Abstract

Breast cancer is the first cancer of women. Its locally advanced form is becoming less and less frequent in Western countries and is still observed in developing countries.

Presenting the case of a patient treated at the Hedi Cheker University Hospital in Sfax, Tunisia. A 25 year old woman from Ivory Coast admitted to our department for the management of metastatic stage breast cancer.

**Keywords:** Breast Cancer; Cauliflower-Like Tumor; Neglected; Metastatic

## Introduction

Breast cancer is the first cancer of women. When diagnosed early, it is eligible for curative treatment. It is generally associated with a good prognosis. Its locally advanced form is becoming less and less frequent in Western countries and is still observed in developing countries [1,2]. Recent studies report that breast cancer is the leading cause of death in women under 45 years of age [3].

### Clinical Case

We report the case of a historical breast cancer observed in the department of obstetrics gynecology of the CHU hedi cheker of Sfax.

The patient was a 25 year old woman from Ivory Coast with a family history of uterine and breast cancer in her mother and without any particular pathological history, nulligravida and nulliparous. The patient was admitted to our department for the management of metastatic stage breast cancer diagnosed in 2018 and initially managed in Libya. The patient received a single course of chemotherapy and then discontinued follow-up due to war and socioeconomic conditions.

On admission, she was found to have a huge cauliflower-like tumor with areas of necrosis and surinfection in the left breast with a foul odor. There was also a huge left axillary adenopathy of 5 cm (Figure 1).

Bacteriological samples of the tumor were taken showing the presence of *Pseudomonas aeruginosa* and *Acinetobacter baumannii*. The patient was put on antibiotic therapy.

**Figure 1:** Cauliflower-like left breast cancer.

**Figure 2:** Surgical site after mastectomy.

Biopsies were taken and the anatomopathological examination concluded the presence of an infiltrating ductal carcinoma classified as SBR II with negative hormone receptors, a negative her2 nu score and Ki67 at 80%.

An extension workup was done which showed the presence of bilateral axillary and retro pectoral adenopathies and of the 2 internal mammary chains and of hepatic and bone metastases. A right latero-uterine mass of secondary appearance was also found. A pleural effusion was present, which was punctured and found to be a pleural metastasis.

A clean mastectomy was indicated with a definitive anatomopathological examination showing poorly differentiated squamous cell carcinoma grade III SBR of 23 cm long axis occupying almost the entire left breast and exophytic through the skin. We also note the presence of numerous images of carcinomatous lymphangitis in the peri-tumor and in the dermis and the presence of 6N+/6N lymph node metastases. Hormone receptors were negative, the Her2 neu score was negative and Ki67 was 70%.

After stabilization of her condition, the patient was discharged with a chemotherapy appointment and a schedule for placement of a skin flap at the surgical site after the chemotherapy courses (Figure 2).

The patient was lost to follow-up for 2 months and then reconsulted after her condition worsened.

Tumor regrowth was observed with the presence of multiple nodules of carcinosis (Figure 3).

**Figure 3:** Tumor regrowth after mastectomy.

A thoraco-abdominal CT scan was indicated and showed tumor tissue on the anterior aspect of the left hemithorax extending superiorly and medially to the left supraclavicular fossa reaching the contacts of the confluence of the internal jugular vein and the supraclavicular vein and invading the distal third of the clavicle, upwards and externally towards the axillary fossa with invasion and thrombosis of the axillary vein and invasion of the axillary artery, laterally it invades the round muscle and the anterior serratus, medially it gives buds at the level of the anterior face of the sternum, in depth it exceeds the pectoral muscles and arrives at the level of the intercostal spaces arriving by place at the level of the pleura. Also, multiple distant subcutaneous nodules were noted, a pleural effusion of medium abundance with pleural nodules, a retro sternal nodule and secondary hepatic nodules and necrotic right axillary and mediastinal adenomegaly.

Palliative care measures were taken and the patient died one week later with a multivisceral failure.

## Conclusion

Several factors are linked to the delay in diagnosis of breast cancer in developing countries, including ignorance, poverty and socio-cultural habits. These factors are now complicated by the misinterpretation of online medical information. To improve early diagnosis, it is necessary to encourage education, generalize social medical coverage, fight against poverty and traditional treatments, and develop a critical mind towards medical information found on the Internet.

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