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RESEARCH ARTICLE

ULCEROFUNGATING BREAST CARCINOMA IN A MALE: A RARE PRESENTATION OF INVASIVE DUCTAL CARCINOMA CASE REPORT

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Male breast cancer; invasive ductal carcinoma; carcinoma of no special type; ulcerofungating lesion; nipple–areolar complex; mastectomy; case report.

Abstract

Background: Male breast carcinoma is rare, accounting for less than 1% of breast cancer diagnoses. It is often recognized late because awareness is limited and routine population screening is not recommended for average-risk men. Ulcerofungating disease may represent locally advanced tumor involvement.

Case presentation: A 75-year-old man presented with a gradually enlarging right breast mass of three months' duration and ulceration of the nipple–areolar complex. Examination showed a firm, mobile 5 × 5 cm breast mass and a 2 × 2 cm ulcerofungating lesion. Contrast-enhanced CT described a lobulated, enhancing right breast lesion involving the nipple–areolar complex with skin thickening and ulceration. Cytology was consistent with ductal adenocarcinoma. Following right mastectomy, histopathology showed invasive carcinoma of no special type (ductal), Grade II, with skin invasion and ulceration; margins were clear and 3 of 23 lymph nodes were metastatic (pT4b N1a, as reported). Immunohistochemistry was ER-positive, PR-positive, androgen-receptor-positive, with weak-to-moderate HER2/neu staining and Ki-67 of approximately 70–75%; FISH testing was recommended.

Conclusion: A persistent male breast mass, nipple change, or skin ulceration warrants prompt assessment. This case highlights the clinical,imaging,cytological,and pathological features of ulcerofungating male breast carcinoma.

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Introduction:-

Male breast carcinoma is an uncommon malignancy, representing less than 1% of all breast cancer diagnoses. It is most often diagnosed in older men, commonly around the sixth to seventh decades of life. Men possess a small amount of breast tissue, so malignancy is uncommon but possible. Invasive ductal carcinoma (IDC), also termed invasive carcinoma of no special type when appropriate on histology, is the predominant histological type in men;

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lobular carcinoma is uncommon because the male breast generally lacks well-developed lobules.Risk factors include increasing age, pathogenic inherited variants (particularly BRCA2), Klinefelter syndrome, hormonal imbalance, obesity, prior chest irradiation, and chronic liver disease. Typical presentation is a painless subareolar lump; nipple retraction, discharge, skin involvement, or ulceration may occur in more advanced disease. Routine screening is not generally recommended for average-risk men, and symptoms may therefore be evaluated only after a noticeable change develops. Prognosis is strongly related to stage at diagnosis; when stage and tumor biology are comparable, outcomes are broadly similar between men and women. IDC arises from ductal epithelial cells and becomes invasive when it extends beyond the duct boundary into surrounding tissue, with potential for lymphatic or hematogenous spread.Fungating or ulcerofungating tumors breach the skin and form an open ulcer with an elevated, irregular, sometimes mushroom- or cauliflower-like surface. Although IDC is the commonest breast cancer type, uncommon presentations may involve ectopic breast tissue or unusual metastatic sites. The present report describes an ulcerofungating lesion involving the nipple–areolar complex in an older man.

Case Presentation:-

A 75-year-old man presented to the surgical outpatient department with right breast swelling for three months. The lump had gradually increased in size and was initially painless; he sought care after ulceration and changes developed over the nipple and surrounding areola. He reported no history of breast trauma, nipple discharge, fever, weight loss, or similar swelling elsewhere. No known family history of breast or other cancers was reported.Examination showed fullness in the upper outer right breast and a firm, non-tender, mobile mass measuring approximately 5 × 5 cm, extending across the upper outer and upper inner regions and partly involving the nipple–areolar area. An ulcerofungating lesion measuring approximately 2 × 2 cm covered the nipple–areolar complex. The left breast was normal. No palpable axillary lymph nodes were documented on clinical examination.

Investigations:-

Contrast-enhanced CT (CECT) demonstrated a lobulated soft-tissue lesion in the right breast with homogeneous post-contrast enhancement, involvement of the nipple–areolar complex, and mild skin thickening and ulceration, suspicious for neoplasia. Cytology was consistent with ductal adenocarcinoma of the right breast.

Treatment and Histopathology:-

The patient underwent right-sided radical mastectomy. Histopathological examination showed invasive carcinoma of no special type (ductal), Grade II, with skin invasion and ulceration. Other surgical margins were free of tumor. Metastasis was identified in 3 of 23 examined lymph nodes. Pathological stage was reported as pT4b N1a according to the AJCC 8th edition.Immunohistochemistry showed estrogen receptor (ER) positivity, progesterone receptor (PR) positivity, weak-to-moderate HER2/neu membranous staining, androgen receptor positivity, and a Ki-67 proliferation index of approximately 70–75%. Further HER2 assessment by fluorescence in situ hybridization (FISH) was recommended.Following surgery, the patient received adjuvant chemotherapy with an AC-T regimen, consisting of doxorubicin and cyclophosphamide followed by paclitaxel. Considering the positive estrogen and progesterone receptor status of the tumor, adjuvant endocrine therapy with tamoxifen was initiated following completion of chemotherapy. The treatment approach was directed toward reducing the risk of disease recurrence and improving long-term disease control.

Results:-

Component	Details to include
Age / sex	75-year-old male
Clinical presentation	Right breast swelling for 3 months
Tumor characteristics	5 × 5 cm breast mass with 2 × 2 cm ulcerofungating lesion
Radiological findings	CECT: lobulated enhancing lesion with nipple–areolar involvement, skin thickening and ulceration
Cytological findings	Ductal adenocarcinoma
Histopathology	Invasive carcinoma of no special type (ductal), Grade II
Surgical findings	Clear margins; skin invasion and ulceration
Lymph node status	3 out of 23 lymph nodes positive

Component	Details to include
Pathological stage	pT4b N1a, as reported
Immunohistochemistry	ER-positive, PR-positive, HER2 weak-to-moderate staining, AR-positive, Ki-67 70–75%
Chemotherapy	AC-T regimen
Endocrine therapy	Tamoxifen

Clinical Images:-



Figure 1. Clinical / diagnostic image



Figure 2. Clinical / diagnostic image

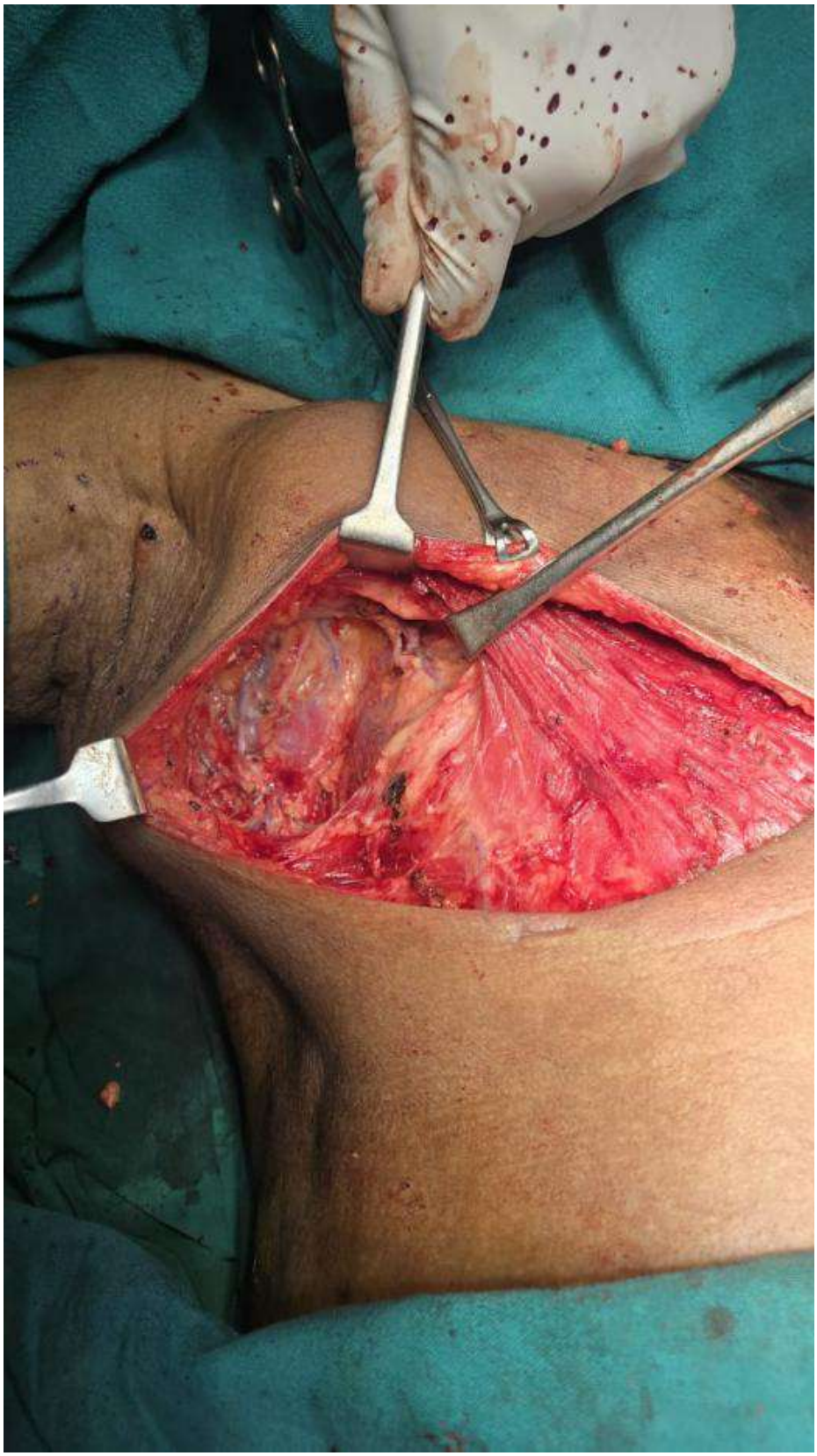


Figure 3. intra operative image after specimen and lymph node dissection

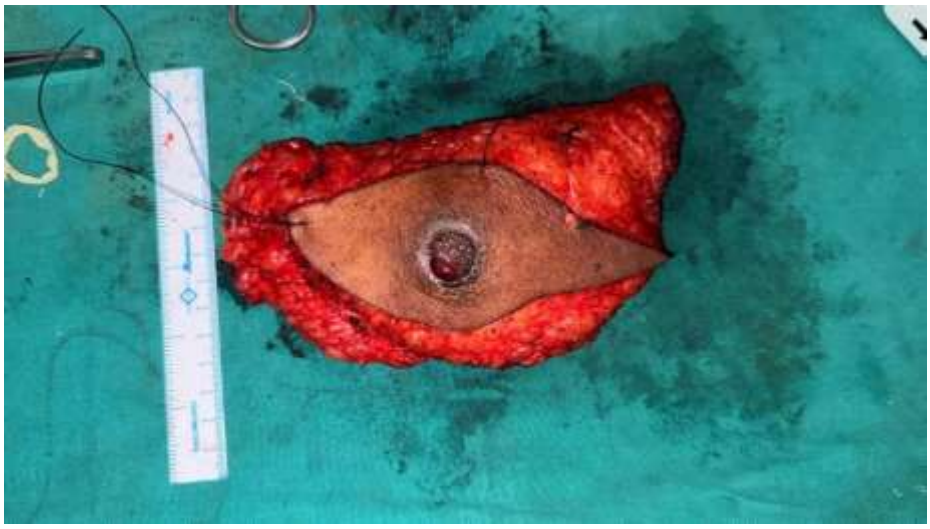


Figure 4. specimen with tumor

Discussion:-

Male breast cancer is rare and may be diagnosed later than female breast cancer because of low clinical suspicion, limited awareness, and the absence of routine screening for average-risk men. The usual symptom is a painless subareolar lump, but nipple retraction, discharge, skin involvement, and ulceration can occur. The present patient delayed evaluation while the mass was painless and presented with an ulcerofungating nipple–areolar lesion.IDC is the most frequent histological type of male breast carcinoma. In general breast cancer literature, IDC accounts for approximately 75–80% of diagnoses; published series of male breast cancer report an even higher proportion, often around 85–90%. These figures refer to different populations and should not be conflated. IDC develops from ductal epithelial cells and is considered invasive when malignant cells extend beyond the duct into adjacent tissue. Invasive disease may spread through lymphatic channels or the bloodstream.

An ulcerofungating appearance describes tumor growth through the skin, producing an open, non-healing ulcer with an elevated, irregular or cauliflower-like surface. In men, the limited volume of breast tissue and the proximity of the ducts to the nipple–areolar complex may contribute to early involvement of this region. Although IDC is the commonest subtype, rare clinical scenarios described in the literature include carcinoma arising in ectopic breast tissue and metastasis to atypical organs; such unusual patterns are not demonstrated in this case and are mentioned here only as context.Imaging and tissue diagnosis are central to evaluation. The submitted case records CECT findings and cytology consistent with ductal adenocarcinoma. Definitive histopathology documented Grade II invasive carcinoma, skin ulceration, clear margins, and nodal metastasis in 3 of 23 nodes. ER and PR positivity is common in male breast cancer and has therapeutic relevance. HER2 status remained unresolved in the supplied report, for which FISH was recommended. The high Ki-67 index suggests a high proliferative fraction; treatment decisions, however, require complete staging and multidisciplinary assessment.Surgery is commonly used for localized male breast cancer because the volume of breast tissue is limited. Adjuvant endocrine therapy, chemotherapy, radiotherapy, or HER2-directed treatment may be considered according to stage, receptor profile, final HER2 status, and patient factors. Early recognition of a male breast lump or nipple/skin change is important. When men and women are compared at the same stage, prognosis is broadly comparable, underscoring the importance of stage at presentation rather than sex alone.

Summary Points:-

Male breast carcinoma accounts for less than 1% of breast cancer diagnoses and most often affects older men.

An enlarging painless breast lump with nipple–areolar ulceration should prompt urgent evaluation. IDC / invasive carcinoma of no special type is the predominant histological type in male breast cancer.Histopathology in this case showed Grade II invasive carcinoma with skin ulceration and metastasis in 3 of 23 lymph nodes.ER and PR were positive; HER2 requires completion of testing, and Ki-67 was approximately 70–75%.Clinical suspicion, timely imaging, tissue diagnosis, and multidisciplinary care are essential.

Conclusion:-

Male breast carcinoma is uncommon but should be considered in older men presenting with a breast mass, nipple abnormality, or skin breakdown. This case demonstrates an ulcerofungating invasive ductal carcinoma involving the nipple–areolar complex, with skin invasion and regional nodal metastasis. Prompt assessment and complete pathological characterization are necessary to guide treatment and improve the opportunity for stage-appropriate care.

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