

Letter to the Editor

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Bilateral axillary lymphadenopathy in an elderly female

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Dear Editor,

A 50-year-old female patient presented with the complaint of bilateral axillary swelling for the past two months. The general physical examination was unremarkable. The patient had been married for 29 years and her last child birth was 24 years ago. The local examination revealed bilateral non tender axillary lymph nodes each measured 2x2 cm in size. The overlying skin was unremarkable and no breast lump was identified on examination. There was no other lymphadenopathy. Her chest X-ray was normal. Fine needle aspiration cytology (FNAC) was performed from the bilateral axillary lymph nodes. Smears were stained with May-Grünwald-Giemsa and Papanicolaou stains. The cytology smears were moderately cellular and comprised of reactive lymphoid cells with many loose histiocytic aggregates and foamy macrophages showing intracellular and extracellular globules of refractile colourless material consistent with silicone (Figure 1a and b). Few foreign body giant cells and focal granulomatous reaction were also seen (Figure 1c and d). The patient was contacted for further history.

The patient gave a history of bilateral silicone breast implants 22 years ago. The course was uneventful, until two years ago when she suddenly developed pain, redness and swelling in bilateral breasts and then the implants were removed, due to a high clinical suspicion of implant rupture. Correlating with the clinical history and pathological findings, a diagnosis of silicone lymphadenopathy of the bilateral axillary lymph nodes was made. The patient refused any surgical excision. She was advised to have regular follow-up.

The breast reconstruction after mastectomy and augmentation with the help of silicone-gel implants have been in use for decades. Silicone migration can occur after

implant rupture or gel bleed in an intact implant by various mechanisms like migration into lymphatic channels or the bloodstream through macrophages, release from dying macrophages to lymphocyte by cytoplasmic bridging and movement along fascial planes via gravity and muscle action.¹

Although the cytology and histopathology of silicone particles have been described in breast and lymph node, there is no special stains or immunohistochemical markers that can confirm silicone.^{2,3} However, electron microprobe analysis using transmission or scanning electron microscopy can give definitive identification of silicone in lymph nodes and other tissues.³

The differential diagnosis in a case of bilateral axillary lymphadenopathy in an elderly female includes metastases from breast carcinoma, granulomatous lymphadenopathy due to tuberculosis and axillary lipogranuloma secondary to lipid metabolism disorder.⁴ Therefore a thorough clinical history followed by FNAC is necessary to arrive at a definitive diagnosis. While FNAC is diagnostic in appropriate clinical settings, the role of excision biopsy is to exclude malignancy.²

This case demonstrates the need to retain an open mind when dealing with lumps in the breast and axilla especially in India where silicone implantation is not prevalent and patients are hesitant to give such a history.

Sincerely,

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Conflict of Interest

None to declare

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FNAC smears showed predominantly reactive background with many loose histiocytic aggregates (Figure 1a) with foamy macrophages showing intracellular and extracellular globules of refractile colourless material (silicone) (Figure 1b). Also seen were a few giant cells (Figure 1c) and a focal granulomatous reaction (Figure 1d).

