Abstract:
Primary Non-hodgkins lymphoma of breast is a rare one with incidence of 0.12–0.5. It mimics invasive ductal carcinoma in its presentation but it has very aggressive clinical course than invasive ductal adeno carcinoma. Even though it is aggressive in nature, they are potentially curable neoplasms by early diagnosis. So, early diagnosis is mandatory in suspicious cases by immunohistochemistry and histopathological examination.

Keyword: PRIMARY NON-HODGKINS LYMPHOMA (PNHL), BREAST, IMMUNOHISTOCHEMISTRY.

INTRODUCTION: Primary tumours of breast arises from the ductal epithelium. But PNHL arises from connective tissue of the breast. It is a rare malignancy with incidence of 0.12–0.5%. The clinical features and radiological features of PNHL is almost similar to that of invasive ductal carcinoma. So, diagnosis must be arrived by histological examination and immunohistochemistry. But sometimes (like our case) histological examination doesn’t reveal the correct diagnosis.

CASE REPORT: 20 years old female came with swelling of right breast with 4 months duration. H/o ulcers in right breast since 15 days. H/o pain and loss of weight was present. There was no history of trauma, fever, nipple discharge, chest pain, breathlessness, jaundice, bone pain and back ache. Patient had taken treatment in a private hospital before coming to our hospital where FNAC and trucut biopsy were taken. FNAC report was benign phylloides and trucut report diagnosed as NHL. Then the patient was referred here for further management. On examination, no pallor, no jaundice, no generalized lymphadenopathy. Per abdomen- no hepatosplenomegaly and no other mass was palpable. In local examination, swelling of whole right breast with ulcer of size 2*1 cm in upper outer quadrant and another ulcer of size 1*0.5 cm in the circumareolar region. (figure 1 and 2). Nipple areola complex – normal. Warm, tender with irregular surface and
DISCUSSION:
PNHL is a rare malignancy with incidence of 0.12 – 0.5%. Mean age of presentation is 60 years (in our case – 20 years). Most common type is diffuse intermediate B cell NHL (in our case – T cell type) and usually unilateral. PNHL should fulfill the following criteria: 1) Adequate pathological evaluation 2) close association of breast tissue and lymphomatous infiltrate 3) Exclusion of previous extra-mammary lymphoma and systemic lymphoma. No specific sonological or mammographic pattern have been reported. Core needle biopsy is needed to establish the diagnosis. IHC is the investigation of choice to confirm the diagnosis. Other investigations to rule out systemic involvement of NHL are USG abdomen and pelvis, CT abdomen, CT chest and bone marrow biopsy. There has been no uniform approach to the treatment of these tumors. Generally, low grade tumors are treated with 30-50 Gy field irradiation. Intermediate and high grade tumors are treated with 3-10 cycles of R-CHOP (Rituximab, cyclophosphamide, hydroxyl daunorubicin, oncovin, prednisolone) with field irradiation. Many patients will not require any form of surgery if diagnosed and treated earlier.

REFERENCES:
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