pathology confirmed bilateral breast fat necrosis with no evidence of calciphylaxis (Fig. 2). Postoperatively, she experienced immediate relief of her symptoms and tapered off narcotics quickly.

In our patient, imaging included indeterminate characteristics and she remained symptomatic following conservative therapy prompting further intervention. While unable to pinpoint the exact cause of breast fat necrosis in our patient, presentation in the setting of central venous occlusion is highly suspicious. Surgical intervention for symptom management in this case was a modality of last resort.

CONFLICTS OF INTEREST

None.

Wegener’s Granulomatosis of the Breast with Peculiar Radiological Aspect Mimicking Breast Carcinoma

Rares Georgescu, MD, PhD,* Maria Daniela Podeanu, MD, PhD,† Ioana Colcer, MD,* Gabriel Grigorescu, MD,* Marius Florin Coroș, MD, PhD,* Cosmin Moldovan, MD, PhD,‡ Agota Ilyes, MD,§ Iulia Bârsan, MD,§ Denisa Moncea, MD,§ and Simona Stolnicu, MD, PhD§

*Department of Surgery, University of Medicine and Pharmacy Targu Mures, Targu Mures, Romania; †Department of Radiology, University of Medicine and Pharmacy Targu Mures, Targu Mures, Romania; ‡Department of Histology, University of Medicine and Pharmacy Targu Mures, Targu Mures, Romania; §Department of Pathology, University of Medicine and Pharmacy Targu Mures, Targu Mures, Romania

A 65-year-old patient was referred to the Radiology Department for a progressively enlarging painful palpable mass in the upper outer quadrant of the left breast without any other skin or nipple symptoms and no history of breast cancer in her family. Physical
examination through palpation revealed a movable large mass in the left breast. However, left axillary lymph nodes were not enlarged. A 7 cm dense heterogeneous mass, with predominantly obscure margins and multiple pleomorphic microcalcifications of variable density both inside the mass and in its proximity, was identified on mammographic and ultrasound examinations, which arose suspicions of breast cancer (breast imaging - reporting and data system according to the American College of Radiology [BI RADS 5]; Fig. 1a). Computed tomography confirmed the chest x-ray abnormalities and demonstrated the presence of multiple bilateral lung nodules, mostly located in the lower part of the lobes (c); Histopathological examination revealed areas of necrosis (arrow) on a background of massive inflammatory infiltrate (d); Numerous multinucleated macrophages with foamy cytoplasm and inflammatory cells (e); Inflammatory cells surrounding small vessels (f).

![Figure 1](image-url)

**Figure 1.** Mammography shows a poorly defined mass in the upper outer quadrant of the left breast, with multiple pleomorphic calcifications (arrows) inside the mass and in its proximity (a); computed tomography (CT) examination highlighted the tumor mass associated with multiple microcalcifications in the left breast (b); Chest x-ray in antero-posterior (AP) position revealed multiple bilateral masses in the lungs, mostly located in the lower part of the lobes (c); Histopathological examination revealed areas of necrosis (arrow) on a background of massive inflammatory infiltrate (d); Numerous multinucleated macrophages with foamy cytoplasam and inflammatory cells (e); Inflammatory cells surrounding small vessels (f).

Wegener’s Granulomatosis of the Breast

• 551

Necrotizing granulomatous vasculitis is a nonneoplastic inflammatory-type lesion of different tissues but breast involvement in Wegener’s granulomatosis is very unusual, with less than 30 cases published in the literature to date, most of them as scattered case
reports. The breast lesion may present as single or multiple nodules. Also, some case reports have demonstrated an association of a breast mass and lung nodules at the time of diagnosis as in the present case. The radiological appearance has been described by some authors as an ill-defined irregular mass or focal asymmetric density on a mammogram that is suspicious for carcinoma and as an irregular hypoechoic nodular mass or mass with parenchymal mixed echogenicity, consistent with mastitis or abscess on ultrasound examination. However, none of these cases was associated with a tumor mass and included pleomorphic microcalcifications. This is the first case in the published literature in which microcalcifications are present within a suspect breast mass on mammography.

Wegener’s granulomatosis of the breast needs to be reconsidered in the differential diagnosis of a single breast mass associated with microcalcifications and multiple associated lung nodules, especially in patients in which the clinical history is unknown or in patients diagnosed by using a small tissue fragment from a core biopsy, as in this case. Several inflammatory entities need to be excluded before making the diagnosis of Wegener’s granulomatosis of the breast, but especially, in cases of a breast mass associated with microcalcifications on mammography, an invasive and/or in situ carcinoma has to be excluded through microscopic examination. This emphasizes the importance of clinical features and clinic-pathologic correlations in establishing the diagnosis.

Stewart–Treves Syndrome of the Breast after Quadrantectomy for Breast Carcinoma

Benedetta Miglino, MD,* Elena Maldi, MD, † Rossana Tiberio, MD,* Paolo Boggio, MD,* Stefano Astolfi, MD,* Roberto Franchini, MD, ‡ Elisa Zavattaro, MD, PhD,* Renzo Boldorini, MD, † and Enrico Colombo, MD*

*Department of Dermatology, “Maggiore della Carità” Hospital, University of Eastern Piedmont “A. Avogadro”, Novara, Italy; †Department of Medical Sciences, “Maggiore della Carità” Hospital, University of Eastern Piedmont “A. Avogadro”, Novara, Italy; ‡Department of General Surgery, “Maggiore della Carità” Hospital, University of Eastern Piedmont “A. Avogadro”, Novara, Italy

Stewart–Treves syndrome is a rare and deadly disease. It is characterized by cutaneous lymphangiosarcoma arising on chronic lymphedema as a consequence of mastectomy and axillary lymph node dissection. Angiosarcoma of the breast after conservation surgery for carcinoma and adjuvant radiotherapy is a fairly rare occurrence. We present a rare case of lymphangiosarcoma in a 77-year-old woman. In February 2007, she had a left upper quadrantectomy and axillary lymph node dissection for a ductal carcinoma in the left breast. Histology showed a grade 2 ductal carcinoma, whereas only 30% was in situ tumor, fat tissue of left axilla was infiltrated by carcinoma and two of three nodes were positive (T1c, N3, M0). The patient received anastrozole per os and the area was treated with a fraction size of 2.25 Gy to achieve a dose of 54 Gy in 23 days. The clinical examination, total body computed tomography (CT) and hematocellular exams were negative for metastatic lesions. She was otherwise healthy.