Tubular adenoma of the breast is a rare benign epithelial tumor of the breast that has not been widely studied; the World Health Organization (WHO) classifies it as a rare entity. It is usually diagnosed in patients who present with a palpable nodule in the breast. The lesion is typically characterized by a well-circumscribed mass with ill-defined borders, soft-tissue density, and contrast enhancement, together with fluid collections and fistulas. The differential diagnosis includes fungal ulcers, carcinoma, idiopathic midline granuloma, and osteomyelitis of the maxilla caused by other germs. In the histopathological analysis, hematoxylin and eosin staining reveals chronic abscess with polymorphonuclear leukocytes, granulation tissue and fibrosis. Grocott’s staining revealing colonies of bacilli forming “sulfur granules”, which represent tangled filaments of Actinomyces, present in abscesses, exudates of the sinus tract, or tissues infiltrated by the lesion.

Penicillin G is the drug of choice for the treatment of actinomycosis, requiring long courses of antibiotic therapy. Surgical management is reserved for the drainage of bulky abscesses, marsupialization of chronically infected sinus tracts, excision of fibrotic lesions, and debridement of necrotic bone tissue.

Therefore, despite its rarity, it is important to bear actinomycosis of the maxilla in mind as a differential diagnosis, mainly in cases of aggressive lesions of the mouth related to the above-mentioned predisposing factors.

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The Health Organization defines it as a “benign, usually round, nodules formed by a compact proliferation of tubular structures composed of typical epithelial and myoepithelial cell layers”\(^{(1,2)}\).

Although four cases of malignant transformation of tubular adenoma have been reported in the literature, studies indicate that there is no high risk for carcinoma\(^{(3)}\). Tubular adenoma accounts for 0.13–1.7% of all benign neoplasms of the breast\(^{(3)}\). Although the size of the tumor ranges from 1 cm to 7.5 cm, it rarely exceeds 5 cm\(^{(4)}\). The vast majority of cases are in young women, and the disease is much more rare in postmenopausal women, 90% of the patients being under 40 years of age (mean, 31 years). Nevertheless, there have been reports of its occurrence in males. It has not been found to be associated with oral contraceptive use or pregnancy\(^{(4,5)}\). It is considered a variant of fibroadenoma, appearing in the same clinical context and with overlapping imaging characteristics\(^{(6)}\). It can be difficult to make the histological differentiation between tubular adenoma and fibroadenoma if the tubular adenoma has a relatively abundant stromal component or the fibroadenoma shows significant proliferation of small ducts\(^{(1)}\).

Clinically, tubular adenomas of the breast can be asymptomatic, occasionally being detected on mammography or physical examination as a palpable nodule that gradually increases in size\(^{(4)}\). On mammography and ultrasound, these tumors have the appearance of noncalcified fibroadenomas\(^{(7)}\). On mammography, the lesions typically appear as well-circumscribed nodules, with no evidence of calcifications. However, in older patients, punctate or irregular calcifications can be observed, findings that justify a biopsy to exclude malignant neoplasm of the breast. Occasionally, mammography shows lesions with ill-defined margins. On ultrasound, the tumors are generally described as hypoechoic, well-circumscribed nodules. Noncalcified tubular adenomas generally have a relatively homogeneous internal texture and may have posterior acoustic reinforcement\(^{(4)}\). Other differential diagnoses that should be included are ductal adenomas, lactating adenoma, gestational hyperplasia, and ductal carcinoma\(^{(8)}\).

Sengupta et al.\(^{(3)}\), analyzing 32 confirmed cases of tubular adenoma, concluded that, although radiological and cytological studies can distinguish between benign and malignant lesions, the final diagnosis depends on the histopathology\(^{(3)}\).

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