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Doenças hematopoiéticas podem ser encontradas na mama e simular uma neoplasia mamária, como leucemia e/ou linfoma. Apesar de os linfomas serem considerados tumores linfonodais, 25-40% acometem sítios extranodais, sendo um deles a mama. Os linfomas primários da mama representam 0,1-0,5% de todas as neoplasias da mama. Podem ter origem primária ou secundária. Os primários normalmente iniciam-se na mama sem acometimento de outros sítios linfonodais. O diagnóstico é feito através do exame físico e anatomopatológico. Relatamos um caso de uma paciente, idosa, de 77 anos, que compareceu em nosso serviço com uma massa progressiva envolvendo toda a mama direita, ulcerada e associada a sinais e sintomas inflamatórios com linfonodos axilares palpáveis. Os exames de imagem foram inespecíficos e não ajudaram no diagnóstico, não tendo sido recomendados para o rastreio dessa neoplasia. O exame anatomopatológico revelou um linfoma de células B difuso infiltrando a mama (linfoma não-Hodgkin’s). Devido à raridade do caso, e o desconhecimento do processo, o tratamento foi realizado com esquemas quimioterápico para linfoma segundo o consenso para linfoma de células B, sendo a base o tratamento com antraciclinas. A paciente realizou seis ciclos de CHOP (ciclofosfamida, doxorrubicina, vincristina e prednisona), com a regressão total da lesão. O uso do rituximabe, bem como a radioterapia, permanecem controversos na literatura, mas no nosso caso a radioterapia é indicada com uma dose de 30 a 45 GY. Nossa paciente realizou radioterapia da mama e da axila. Como o consenso para linfoma de células B, não tendo sido necessário tratamento complementar ou cirurgia da mama.

PALAVRAS-CHAVE: Linfoma; Neoplasias da mama; Linfoma não-Hodgkin.
INTRODUCTION
Hematopoietic diseases can be found in breast and mimic breast cancer, like leukemia and/or lymphoma. Although lymphomas are considered lymph node tumors, 25–40% involve extranodal sites. By definition, extranodal diseases refer to any lymph node involvement of the lymphatic system in other tissues, such as the central nervous system, Waldeywer ring, lungs, bones, skin and stomach1-3. We report a case of breast lymphoma presenting as a locally advanced breast cancer.

CASE DESCRIPTION
We describe a 77-year-old female patient, without comorbidities. She was referred to our hospital due to a progressive lump growth in the right breast noticed four months before. The contralateral mammography (left breast) showed a category BI-RADS 2. The patient had no family history of cancer, except for an aunt who died of intestinal cancer. Physical examination revealed a large mass involving the entire right breast. The mass was ulcerated and associated with inflammatory signs and palpable ipsilateral axillary lymph node (cT4bN2) (Figure 1). Histopathologic investigation with core biopsy was performed. The pathology findings confirmed the diagnosis as diffuse B-cell lymphoma infiltrating the breast tissue (diffuse non-Hodgkin lymphoma) (Figure 2). The patient had a Karnofsky performance status of 90 and an ECOG 1. The treatment recommended was chemotherapy with six cycles of CHOP (cyclophosphamide, hydroxy doxorubicin, vincristine, Prednisone). A complete clinical response with regression of the mammary lesion after the fifth cycle was observed. The treatment was complemented with breast radiotherapy of the right axilla. Currently, the patient is under regular monitoring, without signs of recurrence or progression of the disease as of her last visit (Figure 3).
DISCUSSION

Primary breast lymphomas are rare tumors, accounting for 0.85 to 2.20% of all extranodal lymphomas and 0.1 to 0.5% of all breast tumors. The World Health Organization (WHO) subdivides breast lymphomas into large cell lymphoma, Burkitt’s lymphoma, and mucosa-associated lymphoid tissue (MALT) follicular lymphoma. Their origin may be primary or secondary and the distinction is often very difficult. The primary tumor is first manifested in the breast, without history or evidence of lymph node disease elsewhere, except in the ipsilateral axilla and supraclavicular lymph nodes. Primary breast lymphomas are usually B-cell non-Hodgkin lymphomas, but there are reports of some forms of T-cell lymphoma, common in Asia. This pathology was first described in 1972 by Liao and Wiseman. They proposed four diagnostic criteria that are still used:

1. Presence of lymphoma and breast tissue, very close anatomically.
2. Previous diagnosis of lymphoma.
3. Absence of another disseminated disease.
4. Lack of adequate and quality histopathological sample.

Due to its rarity, the natural history of the disease and pathogenesis remains unknown. As there are few reports of men with this involvement, some hypotheses suggest the role of sex hormones. The natural history of breast lymphoma is known to be different from other extranodal lymphomas, due to its rapid progression and poor prognosis. The diagnosis is made by clinical examination and pathology, and the disease usually occurs in women in their 50s or 60s. The most common symptom is a lump or a palpable, unilateral and painless mass in the breast. Although rare, there are some reports of bilateral lymphomas. Other diagnoses are made through incidental findings in mammography screening or computed tomography (CT) scans. Less frequent symptoms are shrinking or papillary flow, thinning of the skin and swelling, simulating an inflammatory carcinoma. Their origin may be primary or secondary and the distinction is often very difficult. The primary tumor is first manifested in the breast, without history or evidence of lymph node disease elsewhere, except in the ipsilateral axilla and supraclavicular lymph nodes. Primary breast lymphomas are usually B-cell non-Hodgkin lymphomas, but there are reports of some forms of T-cell lymphoma, common in Asia. This pathology was first described in 1972 by Liao and Wiseman. They proposed four diagnostic criteria that are still used:

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REFERENCES

Primary breast lymphoma presenting as locally advanced breast cancer: a case report


