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499 - BREAST IMPLANT-ASSOCIATED ANAPLASTIC LARGE CELL LYMPHOMA: A LITERATURE REVIEW

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Objective: This review aims to bring updates about the relationship between the silicone implant and the breast implant-associated anaplastic large cell lymphoma (BIA-LCL), in order to have a better knowledge about this disease. Despite the low risk of its development, a better understanding of BIA-ALCL is of interest to women, oncologists, breast specialists, plastic surgeons, regulatory agencies, and the general public, as the number of women with breast implants is increasing worldwide. ***Methods:*** This article is based on a review of publications on the topic. A search for articles was carried out through the SciELO databases, at the interface of the U.S. National Library of Medicine and National Center for Biotechnology Information (PubMed) and Latin American and Caribbean Literature on Health Sciences (LILACS). ***Results:*** BIA-ALCL is a very rare disease (1 case per 1–3 million women with implants), accounting for 2–3% of these lymphomas in adults and 0.5% of breast cancers and occurs between 8 and 10 years after breast cancer and implantation of a breast prosthesis. Textured implants are the most associated because they have a greater contact surface, so more biofilm is formed, causing bacterial adhesion. Most patients have peri-implant effusion and less often have a mass. Other described symptoms included breast enlargement, skin rash, capsular contracture, and lymphadenopathy. Lymphoma may be located in the seroma cavity or may involve pericapsular fibrous tissue. To make the diagnosis, imaging tests and cytological analysis must be performed. The fluid must be aspirated and is usually cloudy and thick, with large pleomorphic epithelioid lymphocytes, abundant cytoplasm, eccentric reniform nucleus and prominent nucleolus, and anaplastic lymphoma (ALK). Morphological and immunophenotypic features are indistinguishable from those of ALK-negative ALCL. ***Conclusion:*** The treatment of BIA-LCL includes implant removal, complete capsulectomy, excision of suspected adenopathy, and excision of lymphoma margins. Surgeons may consider removal of the contralateral implant as approximately 4.6% of cases have demonstrated incidental lymphoma in the contralateral breast. There are no data to recommend a mastectomy, sentinel lymph node biopsy, axillary lymphadenectomy, or breast reconstruction. The best prognosis is with complete capsule elimination surgery. Follow-up is done every 3–6 months for 2 years, in addition to imaging tests and the segment will depend on the patient's clinical manifestations.