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528 - A CASE REPORT: BREAST MYIASIS — AN UNCOMMON DISEASE

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Myiasis is a dermatosis resulting from flies' larvae infestation in animal and human tissues. More prevalent in subtropical and tropical countries, it is related to lower social and economic levels. The fly species that can cause this pathology are *Cordylobia anthropophaga*, *Cochliomyia hominivorax*, and *Dermatobia hominis*. The infestation happens after eggs are deposited in a disrupted tissue or by an orifice caused by a fly sting and attacks cutaneous and mucous membranes in many body regions, including the breast. There is no person-to-person transmission. The larvae feed on the injured tissue, leading to pain and tissue destruction. The abscesses, tuberculosis, and inflammatory sebaceous cysts are clinical conditions to be ruled out in differential diagnosis. An abscess is the most common inflammatory breast condition, presenting with pain, erythema, and local heating. A cold abscess may lead to the suspicion of mycobacteria infection, mostly in lactating women. Otherwise, sebaceous cysts when inflamed may look like an abscess, but will not have fluctuation signs, and an ultrasound (US) image will help the diagnosis. The diagnosis is clinical and done by observing moving larvae or by US showing a well-defined lesion, with high echogenicity, and the presence of larvae. The best treatment option is manual larvae extraction, associated or not with paste vaseline or mineral oil covering the affected area, which causes larvae immobilization and asphyxia. The ideal treatment is to remove the larvae intact, because maceration leads to the release of irritating substances into the surrounding tissue. Surgery is not a good option. It is useful to prescribe an antibiotic regimen to treat or prevent infections. This case report allows the conclusion that myiasis is an uncommon breast pathology and sometimes may be ignored in the clinical setting. For this reason, its presence must always be taken into consideration in the differential diagnosis of breast diseases in certain groups of patients coming from at-risk areas. A 56-year-old white female, obese, with low social and economic conditions, came to a public health outpatient clinic complaining of increasing volume, hardening, and skin alterations in the right breast (hyperemia and skin thickening) in the past 10 years. No investigation was done during this long period, but the symptoms worsened in the past 6 months and severe pain was reported by the patient. She was referred to a specialized center and a bilateral mammogram revealed an extensive asymmetry in the upper outer quadrant of the right breast with architectural distortion associated with uncountable atypical calcifications and diffuse dermal thickening, classified as BIRADS 5. Physical examination revealed the presence of bilateral, enlarged, suspected axillary lymph nodes. The patient underwent breast core biopsy that resulted in invasive breast cancer of nonspecial histologic type, Nottingham grade 3, molecular type luminal B (RE 20%, RP 30%, negative HER-2, and KI-67 60%/cells). After being staged with radiologic examinations, she was found with multiple bone metastases in the thoracic and lumbar bodies, as well as a lytic lesion in the left iliac wing. She started treatment with the oncology team using hormone therapy plus Zoledronic Acid plus chemotherapy. One month after beginning therapy, she went to an emergency unit presenting cavitations and dimpling in the right breast, associated with bullous lesions, necrosis, and bad smell. Physical examination demonstrated live moving larvae over the necrotic tissue, confirming the diagnosis of breast myiasis associated with a stage IV breast carcinoma.