

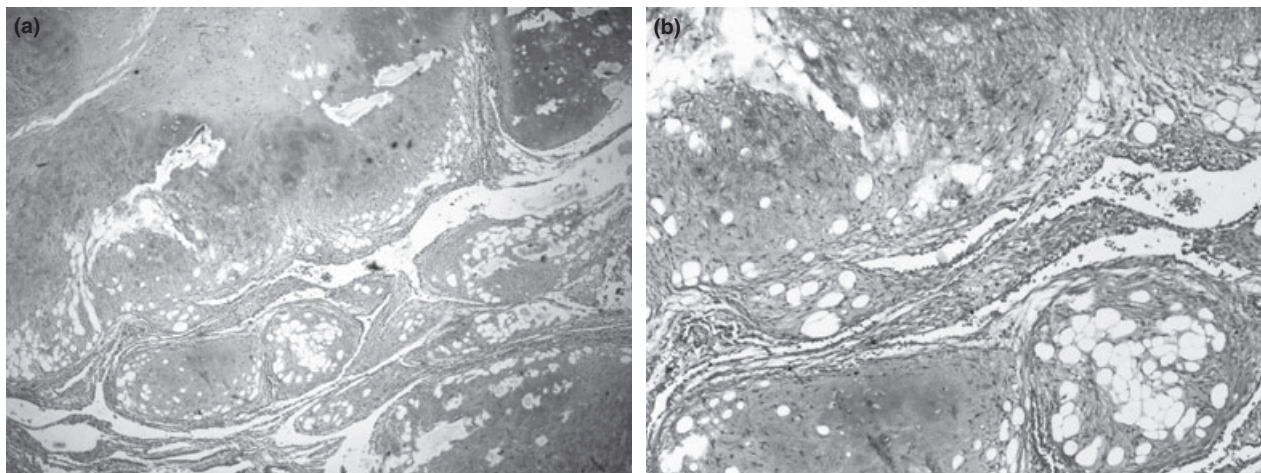


Figure 4. (a) Histologic section showing hyaline cartilage, adipose tissue, and well-differentiated bronchial structures (Hematoxylin and Eosin stain; original magnification 40 $\times$). (b) Higher magnification microphotograph demonstrating the microscopic pattern of pulmonary hamartoma (Hematoxylin and Eosin stain; original magnification 100 $\times$).

thin islets of well-differentiated bronchial structures, consistent with pulmonary hamartoma (Fig. 4a,b). The breast histologic findings confirmed the initial biopsy diagnosis, whereas cut sections documented the presence of 12 axillary lymph nodes, with no metastatic deposits within. Postoperative follow-up is satisfactory to date and 32 months later she remains well, without any signs of tumor recurrence.

Although the pulmonary nodule in the current case showed no remarkable growth during the 6 months from detection to surgical resection, the possibility of metastasis could not be excluded, because the lesion did not demonstrate typical findings of a benign lesion on imaging and because the primary advanced breast cancer had associated

axillary lymphadenopathy. These features were consistent with a high risk of distant metastatic spread. Thus, we eventually performed video-assisted thoracic surgery, prior to breast surgery and the pathologic examination revealed hamartoma.

In conclusion, a solitary pulmonary lesion most often represents malignancy (primary lung tumor or metastatic lesion) and rarer corresponds to a benign condition. When a solitary pulmonary lesion is more than 2.5 cm or the possibility of malignancy cannot be excluded, as in our case, surgery shall be performed. In addition, breast cancer patients with one or more isolated pulmonary nodules are in increased risk of distant metastatic disease and these patients consequently stand to benefit from a confirmed tissue diagnosis.

Chyle Fistula after Simple Mastectomy and Sentinel Lymph Node Biopsy: A Rare Occurrence

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A 79-year-old woman presented with a recent diagnosis on core needle biopsy of a left breast poorly differentiated, triple negative, infiltrating ductal carcinoma. Clinical breast examination revealed a 4.5-cm solid mass in the upper outer quadrant of the left



Figure 1. Engorged left mastectomy site.



Figure 2. Drainage of chylous fluid from left mastectomy site.

breast with a palpable axillary lymph node that was not biopsied. The patient had no family history of breast cancer and past medical history was only significant for gastroesophageal reflux disease, osteoporosis, and anemia for which she was taking a proton pump inhibitor, raloxifene, and iron supplementation. Due to the size of the tumor, the patient underwent neo-adjuvant chemotherapy. After four cycles of doxorubicin/cyclophosphamide, the mass decreased to 1.5 cm and the axillary lymph node was no longer clinically evident.

She underwent a left simple mastectomy with sentinel lymph node biopsy and two closed suction drains were left in the breast cavity. Pathology demonstrated a 0.5-cm tumor and no lymph node metastases for a T1a N0 pathologic stage. The drains initially



Figure 3. Chylous fluid evacuated.

demonstrated serosanguinous fluid that turned slightly milky in color and consistency. The output decreased, the drains were removed on postoperative Day (POD) 2 at which time the output from the JP drains was 20 and 30 mL over the previous 24 hours, and the patient was discharged home.

On POD 9, she was seen in the office and the left mastectomy site appeared to be engorged (Fig. 1). A 2 L of chylous fluid was drained (Figs 2 and 3). Fluid analysis demonstrated an elevated triglyceride level of 486 mg/dL and a low cholesterol level of 14 mg/dL, consistent with a chyle leak. She was placed on a low-fat diet. Over the following 3 weeks, she returned to the office every few days and had 2 L of chylous fluid drained a total of five times. The decision was made to re-explore the patient after 4 weeks of unsuccessful conservative management.

An incision was made through the previous mastectomy scar and approximately 750 mL of chylous fluid was evacuated. After exploration, there was no visible source of drainage. Methylene blue dye mixed with heavy cream was given via a nasogastric tube, but no clear site was identified. The lateral chest wall near the serratus muscle was still noted to be accumulating chylous fluid. The soft tissue in the infero-lateral side of the chest wall was suture ligated and the latissimus dorsi muscle was sutured to the pectoralis major muscle to close the suspected area of drainage. A closed suction drain was placed laterally in the surgical

cavity. The subsequent postoperative course was uneventful and the volume of chylous drainage decreased. POD 8 no fluid was noted to be draining and the closed suction drain was removed. Follow-up visits showed no recurrence of the chylous fistula.

A chylous fistula from a sentinel lymph node biopsy has never been reported in the English literature, and its description after mastectomy with axillary lymph node dissection is very rare. In general, treatment is

divided into two groups: local and systemic. The patient should be placed on bed rest with a pressure dressing, closed suction drainage should be continued, and a low-fat diet and total parenteral nutrition should be initiated. In those patients whose drainage continues, surgical exploration with the goal to promote fibrosis of the tissue overlying the area of the leak is beneficial. Although rare, it is important to be aware of the complication of a chyle leak after breast surgery.

Foreign Body Reaction Mimicking Breast Carcinoma in Patient with Stage IV Ovarian Cancer

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A 65-year-old Caucasian female presented with increasing shortness of breath over a 4-month period. Her past medical history was significant for hypertension, osteoarthritis, and glaucoma, with no significant surgical history. The patient underwent menarche at age 13, natural menopause at age 50, and was nulliparous. She had never taken oral contraceptive pills or hormone replacement therapy. She had not had any previous abnormal mammograms or breast biopsies. The patient's family history was significant for prostate cancer in her father, but there was no history of breast or gynecologic malignancies. Her last screening mammogram completed 2 months prior to her presentation with shortness of breath was unremarkable.

She was seen in the Emergency Department of a local hospital, and a full workup for her shortness of breath was initiated. She was diagnosed with a large right pleural effusion. A chest tube was placed, and cytology from the fluid indicated malignant cells, positive on immunohistochemistry for cytokeratin-7, WT1, estrogen, and CA-125. The patient's serum CA-125 was 5458 $\mu\text{g/mL}$ (normal 0–35 $\mu\text{g/mL}$). This was

consistent with ovarian or primary peritoneal origin. The patient had a talc pleurodesis, and underwent further workup by the Gynecology Oncology service.

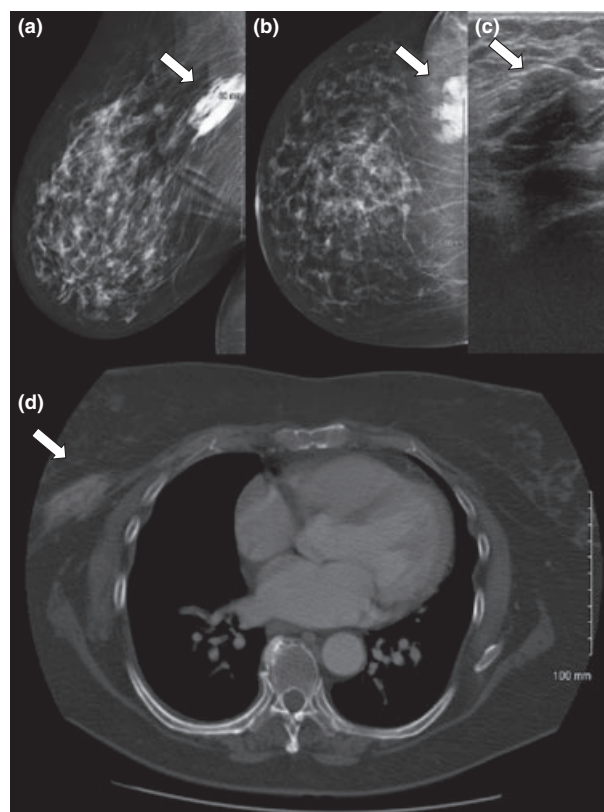


Figure 1 (a) Mammogram MLO, (b) CC views, (c) ultrasound and (d) CT scan showed a suspicious, solid, irregular mass.

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