A 47 yr old female Mrs.Revathi, house wife from Pattabiram belonging to low socioeconomic class presenting with the chief complaints of **painless lump in the left breast** for past 6 months .

HISTORY OF PRESENTING ILLNESS

Patient was apparently normal 6 months back after which she noticed a lump in the left breast

-insiduous in onset ,

- progressive,

initially small in size

gradually increased and attained the current size

not associated with pain

- No h/o nipple discharge
- No h/o recent onset of nipple retraction
- No h/o fever/trauma
- No h/o loss of weight
- No h/o loss of appetite
- No h/o bone pain
- No h/o difficulty in breathing
- No h/o cough with hemoptysis
- No h/o jaundice/abdominal pain/distension
- No h/o headache/blurring of vision/seizures
- No h/o swellings elsewhere in the body

PAST HISTORY

- No h/o DM,HT,asthma,tuberculosis, epilepsy,jaundice,IHD.
- No h/o previous hospitalization
- No h/o previous surgeries.
- No h/o previous irradiation.
- No h/o intake of OCPs

PERSONAL HISTORY

- Consumes non vegetarian diet
- Normal bowel and bladder habits
- No h/o additive habits

MENSTRUAL AND MARITAL HISTORY

Age at menarche :13 years

Age at marriage : 17 years

Age at first child birth : 19 years

2nd child : 20 years

3rd child : 22 years

breastfeeding done for all children till 10 months

Age at menopause : 44 years.

No h/o hormone replacement therapy.

FAMILY HISTORY

No h/o breast/gynaecological/ gastrointestinal malignancy in first degree relatives.

GENERAL EXAMINATION

patient is conscious
oriented
well built and nourished

No pallor
No icterus
No cyanosis
No clubbing
No pedal edema
No significant generalised lympadenopathy

VITAL SIGNS

- PR-76/min,regular in rhythm,normal volume,no specific character,no radiofemoral, radioradial delay,equally felt on both sides in all palpable peripheral vessels ,no vessel wall thickening
- RR-18/min, thoracoabdominal type
- BP-130/80 mm Hg in right upper limb,sitting posture
- Afebrile.

LOCAL EXAMINATION

After getting consent from the patient and in the presence of a female attender, the patient is stripped upto waist.

EXAMINATION OF LEFT BREAST

Examined in sitting posture with arms by the side, arms raised above the head, arms at hip, leaning forward, and supine posture under bright light

INSPECTION

[Arms by the side]-left breast is slightly higher than the right breast,fullness is noted in the upper outer quadrant of breast,

skin over the lump is normal,

No peau d'orange appearnance

no ulcers, nodules, fungation and dilated veins

No dimple/puckering seen

Nipple :

size 1*1 cm, centrally placed

Left nipple is slightly higher than right nipple

no retraction of nipples

no discharge from nipples

no ulcers, cracks, fissures

Areola ;

size 4*4cm, brown in colour

circumferential ,no cracks ,fissures and ulcerations

Arms and thorax : no edema, no visible nodes/fullness

Axilla : no visible nodes

Supraclavicular fossa : no fullness

ON RAISING ARMS ABOVE HEAD

Both breast move equally

Undersurface of the breast appears normal

No peau d'orange /dimpling/puckering

No retraction of nipple

ON LEANING FORWARDS

Breast fall equally on both sides.

ON CONTRACTING PECTORALIS MAJOR BY KEEPING HANDS AT HIP

The lump does not become prominent

PALPATION

- Not warm,not tender.
- Lump of size 7*5 cm hard in consistency, ovoid in shape, well defined margins, irregular surface, felt in the the upper outer quadrant, fixed to the breast tissue
- Skin over the lump is pinchable
- The Lump moves along with breast tissue on contracting and relaxing the pectoralis major there is no restriction of mobility along the line of muscle fibres
- No fixity to chest wall

Nipple : no palpable mass deep to the nipple
no discharge from the nipple

- Examination of axilla: A single node is palpable behind the anterior axillary fold, 1*1 cm ,which is firm in consistency ,mobile and skin is pinchable with normal skin surface

  no other lymph nodes palpable.
- Supraclavicular fossa:No nodes palpable

Examination of right breast :normal

Examination of right axilla :normal.

Examination of right supraclavicular fossa : normal

Percussion

- Resonant note felt over parasternal areas

OTHER SYSTEMS

- Examination of abdomen : soft,not tender, no palpable mass,no organomegaly,no free fluid,hernial orifices are free,external genetalia normal.
- Examination of RS : Normal vesicular breath sounds heard. No added sounds
- Examination of CVS:S1 S2 heard,no murmurs
- Examination of CNS:No focal neurological deficit
- Examination of Spine and Cranium:Normal

- Per rectal examination- to be done
- Per Vaginal examination- to be done

DIAGNOSIS

CARCINOMA of left BREAST – T3 N1 Mx (STAGE IIIA).

MANAGEMENT

INVESTIGATIONS

- Routine:
- Blood: TC, DC ,ESR,Hb%, Blood grouping/typing,urea,sugar,creatinine.
- Urine: sugar,albumin,deposits
- X ray chest
- ECG

- Specific : Mammogram
  FNAC , core needle biopsy
- Staging investigation: chest x-ray
  USG abdomen
  liver function test
  x-ray skull,pelvis,spine
  mammogram of contralateral breast
  CT chest
  CA 15-3/CEA

TREATMENT

1. Neoadjuvant chemotherapy- downstage the tumour+Modified radical mastectomy in the left breast + adjuvant chemotherapy + radiotherapy

.