A 55 yr old female Mrs.Usha Rani, house wife from Perambur belonging to low socioeconomic status presents with the chief complaints of **lump in the Right breast** for the past 6 months.

HISTORY OF PRESENTING ILLNESS

Patient was apparently normal 6 months back,after which she noticed a lump in the outer aspect of her right breast

-insidious in onset ,

-progressive,

-initially small in size gradually increased in size and attained the current size

-not associated with pain

- No h/o nipple discharge/ retraction of nipple
- No h/o ulceration over breast
- 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

- Pt is a K/C/O Dibetes mellitus for 3 years. (On regular medication Tab. Metformin 1BD)
- No H/O HT/ Bronchial asthma/ Pulmonary tuberculosis/ Seizures
- 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
- No h/o drug/food allergy

MENSTRUAL HISTORY

Age at menarche : 13 years

Attained Menopause 5 years ago (At the age of 50)

No h/o bleeding PV

OBSTETRIC HISTORY

Obstetric score: P3 L3

Age at marriage : 17

Age at first child birth : 18

2nd child : 20

3rd child : 22

breastfeeding done for all children till 10 months

FAMILY HISTORY

No h/o

- breast/
- gynaecological/
- gastrointestinal malignancy in first degree relatives.

GENERAL EXAMINATION

On Examination,

patient is conscious

oriented

moderately built and nourished

No pallor

No icterus

No cyanosis

No clubbing

No pedal edema

No significant generalized lymphadenopathy

VITAL SIGNS

- PR-76/min,regular in rhythm,normal volume,no specific character,no radiofemoral, radioradial delay,felt in all peripheral pulses,nature of vessel wall normal
- RR-18/min, thoracoabdominal type
- BP-130/70 mm Hg in right upper limb,sitting posture
- Afebrile.

LOCAL EXAMINATION

EXAMINATION OF RIGHT BREAST

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

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

INSPECTION

[Arms by the side]-

Right breast is larger than the left breast

fullness is noted in the upper outer quadrant of breast,

skin over the lump is normal,

No peau d'orange appearnance

no ulcers, sinuses, nodules, fungation and dilated veins

No dimple/puckering seen

Nipple :

size 1*1 cm, centrally placed

same level as the contralateral nipple

no retraction of nipples

no discharge from nipples

no ulcers, cracks, fissures

Areola ;

size 4*4cm, brown in colour

circular, 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 prominence of lump

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.
- Single Lump of size 4*3 cm, hard in consistency, ovoid in shape, well defined margins, irregular surface, felt in the the upper outer quadrant.
- 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/ serratus anterior

Nipple : no palpable mass deep to the nipple

no discharge from the nipple

no retraction of nipple

- *Examination of rt axilla:* No lymph nodes palpable
- ***Rt Supraclavicular fossa***: No nodes palpable

Examination of contralateral breast :normal

Examination of contralateral axilla :normal.

Examination of contralateral supraclavicular fossa : normal

Percussion

- Resonant note felt over parasternal areas

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

EXAMINATION OF OTHER SYSTEMS

Examination of abdomen : soft, not tender, no organomegaly
no palpable mass, no free fluid
hernia orifices- free
external genitalia- 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 thyroid gland: Noraml, No swelling

DIAGNOSIS

CARCINOMA of Right BREAST – T2 N0 M0 (STAGE IIA).

MANAGEMENT

INVESTIGATIONS

- Routine:

  Blood: Complete hemogram- TC, DC, Hb%, ESR, BT, CT

  Blood urea, sugar ,creatinine

  Urine: sugar, albumin

  X ray chest , ECG

- Specific : Mammogram of Right breast
  FNAC of Right breast lump
  core needle biopsy
  Sentinel node biopsy
- Staging investigation: X-Ray Chest
  USG abdomen
  liver function test
  bone scan
  x-ray skull and pelvis
  mammogram of contralateral breast

TREATMENT

1. WIDE LOCAL EXCISION (Breast conservative surgery)+adjuvant radiotherapy of Right Breast

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