Cavernous Hemangioma in the Breast

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ABSTRACT

Although the observation of breast vascular tumors is rare, the most common tumor is hemangioma in the benign group, and these tumors are observed incidentally in lumpectomy or mastectomy specimens during histological examinations. They are classified into capillary, cavernous, and venous hemangiomas. Cavernous hemangioma is the most common subtype. Cavernous hemangiomas are benign vascular tumors, which malformation from mature blood vessels. Hemangiomas in the benign group may show a suspicion of ductal carcinoma in situ (DCIS) in mammographic analysis. Ultrasonography (US) and magnetic resonance imaging (MRI) are the most useful imaging methods for analyzing the structure of breast vessels. In this case, a 54-year-old female who have any complaint. Scanning mammography (MG) detected the tumor, but physical examination and US could not identify the mass. According to the MG analysis, the lesion was evaluated as BIRADS 4b, and the patient underwent excisional biopsy after wire localization. Pathological analysis revealed cavernous hemangioma.

Keywords: Cavernous hemangioma, breast, ultrasonography

Introduction

Benign or malignant mesenchymal tumors of the breast are rare (1). Vascular tumors in the breast are usually classified as angiosarcoma or hemangioma (2-4). These lesions may present as a palpable mass or might be detected incidentally (5). Hemangiomas are benign vascular lesions of the breast. Cavernous hemangiomas are the most common type of breast hemangiomas (6). In this case report, a non-palpable cavernous hemangioma that was detected by screening mammography is discussed.

Case Presentation

The screening mammography of a 54-year-old female patient who did not have any complaints revealed a 14 x 13 mm lesion with microlobulated borders in the upper quadrant of the left breast, in another health center. This lesion was not detected on ultrasonography (USG), and the patient was referred to our center. Physical examination of her breast and axilla were normal. The patient was radiologically re-evaluated due to a lack of any significant risk factors for breast cancer, and discordance between imaging results. The lesion was not identified on repeat USG, and a single exposure digital MG (single mediolateral-oblique, MLO) was obtained. The lesion was interpreted as BIRADS 4b within a lipomatous breast tissue (Figure 1). The lesion was localized by a guide-wire on mammography, and excisional biopsy was performed since the lesion was non-palpable. The wire was observed to progress easily through the lesion. The operation was uneventful. It was noticed that achieving hemostasis within the lipomatous breast tissue took relatively long for a biopsy procedure. Histopathological examination of the excisional biopsy specimen revealed a cavernous hemangioma (Figure 2).

Discussion and Conclusion

Hemangiomas are benign vascular tumors that arise from malformation of mature blood vessels, and are usually incidental findings on histologic examination of a lumpectomy or mastectomy specimen (7). Although hemangiomas are benign, Shi et al. (8) have stated that they may lead to suspicion of ductal carcinoma in situ (DCIS) due to calcifications on mammography as a result of phlebolith formation.
phy findings, along with magnetic resonance imaging (MRI), it is usu-

Although the diagnosis can be made by ultrasound and mammogra-

however, the lesion was not palpable in our case.

study, it was stated that even small lesions can be clinically palpable,

mm in diameter, in patients between 10 and 67 years (14-16). In this

mens (13). Rosen and colleagues reported 15 hemangiomas, 7 to 50

are detected in 10% of autopsy series, and 1% of mastectomy speci-

mas reaching up to 6 cm have been reported. Perilobular hemangiomas

spongios, well circumscribed lesions (2). Macroscopically hemangio-

breast parenchyma or fat tissue. Grossly, they are dark red or brown,

oma or malignant lesions of the breast. It may be localized within the

excised with wire guidance. Breast hemangiomas may rarely present as

Clin Q 1984; 51:471-474. (PMID: 6088123) [CrossRef]


References

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