RADY 401 Case Presentation

Rafael Alonso Saldana
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Edited by John Lilly MD
57 y.o. F w/ PMH of left breast DCIS, L. mastectomy, mammaplasty and bilateral implant surgery in 2016.

Presented to the ED on Sep. 2018 w/ L. breast redness, pain and significant swelling. She first noticed swelling ~one year ago, but it dramatically worsened over the last week. Within the last week she developed a small breast ulcer. Denies trauma, fever, and vomiting.
Imaging studies

- Left breast US
- Lateral and PA chest X-ray
- Body CT
- US guided fluid aspiration
Left Breast US

Subcutaneous fat

Implant capsule

Implant capsule
Marked enlargement of reconstructed left breast
Body CT

Axial

Left implant with peri-implant fluid

Sagittal

Left implant with Peri-implant fluid
US Guided Aspiration

LT BREAST 7 O’CLOCK  2CM FROM NIPPLE

LT BREAST 7 O’CLOCK  2CM FROM NIPPLE
Procedures

- US guided aspiration resulted in 600 ml. of brownish/red fluid. Pt. was very relieved.

- Underwent periprostatic capsulectomy and implant exchange. An additional 625 ml. of seroma was extracted.
Work-up

- Fluid was sent to microbiology for bacterial cultures and gram stain analysis.

- Due to the suspicion of breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) seroma was sent to the hemopathology lab for cytologic and immunohistochemical analysis.
Recognized by the WHO as an official entity in 2016.
Etiology unclear but likely results from chronic inflammation from breast implants. ¹⁻³
National Comprehensive Cancer Network (NCCN), recommends work up in pts. who develop seroma a year or more after breast implant placement.
Diagnosis is made by CD30 immunohistochemistry, followed by the presence of anaplastic large cells on cytology and a clonal T-cell population on cytometry. ⁴
Current literature report various estimates that BIA-ALCL may develop in 1 in between 3,817 to 30,000 women with textured breast implants.\textsuperscript{5}

As of September 30, 2017, the FDA had received a total of 414 medical device reports of BIA-ALCL, including the death of nine patients.\textsuperscript{5}

FDA offers specific recommendations for providers (see next slide)
Provide all patients with the breast implant manufacturer’s labeling as well as other educational material prior to implantation, and make sure they are aware of the benefits and risks of the different types of implants (texture vs smooth).5

Consider the possibility of BIA-ALCL when you have a patient with late onset, persistent peri-implant seroma. If you have a patient with suspected BIA-ALCL, refer the individual’s case to a MDC tumor board for evaluation.5

When testing for BIA-ALCL, collect fresh seroma fluid and representative portions of the capsule and send for pathology tests to rule out BIA-ALCL.5

Diagnostic evaluation should include cytological evaluation of seroma fluid with Wright Giemsa stained smears and cell block immunohistochemistry testing for cluster of differentiation (CD) and Anaplastic Lymphoma Kinase (ALK) markers.5
Atypical lymphoid cells (examples arrowed) with embryo shaped nuclei.

CD30 immunohistochemical stain. The brown stained atypical lymphoid cells (examples arrowed) are CD30 positive, suggestive of BIA-ALCL.

Note: Images from journal of surgery Science PG, not from the patient!
Laboratory Results

- Anaerobic and aerobic cultures demonstrated no growth and gram stain was negative.
- Cytologic studies found abundant macrophages, scattered neutrophils and lymphocytes.
- CD 30 Immunohistochemical staining showed faint staining of histocytes (negative).
- Light microscopy showed no morphological or immunohistochemical evidence of BIA-ALCL.
Patient was discharged with a diagnosis of seroma and cellulitis.

Advised to come back for follow up.
Suspect BIA-ALCL in patients who present with late-onset seroma after breast implant surgery, typically textured silicone implants. Usually develops 7-8 years after surgery.

Collect fluid and representative section of the breast capsule to pathology for analysis. Refer the case to a MDC tumor board.

Follow recommended FDA diagnostic criteria.


