CASE REPORT

Case Report: Open biopsy and drainage for breast abscess caused by cholesterol granuloma is beneficial rather than breast core biopsy [version 1; peer review: awaiting peer review]

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Abstract
Cholesterol granuloma is a rare non-infectious disease. Currently, there are no established guidelines, leaving the clinician to decide the best practice for each patient. A 43-year-old woman presented to the Surgery Clinic at Siloam General Hospital, Tangerang, Banten, Indonesia, with the primary complaint of a painful mass located in her left breast over the previous week before being admitted to the hospital. The mass was found abruptly and was accompanied by severe pain and fever. On inspection, peau d'orange, nipple retraction, tenderness, and warmth of the skin were observed. Ultrasonography suggested a malignant mass. The primary diagnosis was breast cancer, with a secondary differential diagnosis of breast abscess. An open biopsy was chosen because a breast abscess was the possible diagnosis. The biopsy results showed characteristics of cholesterol granuloma. Following the operation, the pain score was notably reduced as the operation showed a satisfactory result. The primary purpose of this case report was to illustrate a case of breast abscess caused by cholesterol granuloma, in which open excisional biopsy and drainage was superior for pain reduction and faster recovery.

Keywords
Breast Abscess, Cholesterol Granuloma, Open Excisional Biopsy
Introduction
Cholesterol granuloma is a chronic inflammatory granulomatous disease caused by cholesterol crystals that have been released into the tissue. This disease is mainly found in the middle ear cavity or mastoid process but rarely in the breast.1,3 The incidence rate of cholesterol granuloma in the ear is 0.6 cases per one million population. While the incidence rate of cholesterol granuloma in the breast has never been published, it is estimated to be far less than the incidence rate of cholesterol granuloma in the ear.4

Cholesterol granuloma of the breast is a rare and benign disease. The etiology of this disease in the breast is unclear. However, some reports mentioned the terminal stage of ductal ectasia, which is responsible for the ruptures of the terminal duct, and its lipid-rich material, such as cholesterol crystal escapes the broken luminal structure of the terminal duct. The further inflammatory process surrounds this cholesterol crystal, then forms an encapsulated lesion. The cholesterol crystal is also resistant to resorption by giant cells, creating a problematic situation for the inflammatory process to subside by itself.5,6 However, this theory is still debatable as not all ruptured ductal ectasia will lead to the leak of cholesterol crystals.5

Breast cancer is still a leading cause of newly diagnosed cancer cases in Indonesian women. As most of the patients (80%) are diagnosed in locally advanced stages, breast cancer holds a high mortality rate in Indonesia.7-9 The delay of women seeking medical attention is often the main reason for this highly advanced stage presentation. This is due to the patient’s neglect, inadequate knowledge, and other socio-economic problems.8,9 Sub-urban areas, such as our current practice location in Tangerang, are no exceptions. Clinicians can easily find new cases of locally advanced breast cancer with a classical clinical presentation, such as ulceration, peau d’orange, and multiple regional and distant metastases, with poor prognosis.10 However, in some patients with ambiguous clinical presentation, the clinician needs to consider other differential diagnoses other than breast cancer, such as a case of breast abscess caused by cholesteatoma granuloma, as depicted in this case report.

Case report
A 43-year-old Javanese housewife woman presented to the Surgery Clinic at Siloam General Hospital, Tangerang, Banten, Indonesia, with the primary complaint of a painful mass located in her left breast over the previous week before being admitted to the hospital. The mass was found abruptly in the patient, and she showed severely progressive pain (Visual Analog Score 7/10)11 and a slight fever. Initially, the patient didn’t notice any lumps on either of her breasts. A retracted nipple accompanied this complaint but without any edema and redness on the skin.

On inspection during the physical examination, peau d’orange and nipple retraction were found prominently (Figure 1). A painful mass of approximately 5 × 7cm was found on palpation. The mass had an irregular border, hard consistency, and no fluctuation. Moreover, the attending clinician noted prominent tenderness and warmth of the skin, which is unusual for such breast cancer cases.

Preliminary ultrasonography was conducted to further investigate the diagnosis, which showed a solid mass at the left breast with an irregular border and multiple enlarged lymph nodes in the left axillary region (Figure 2). These findings suggest a malignant mass at the left breast with regional metastasis to the left axillary region. The laboratory exam was unremarkable, without elevation in systemic inflammatory markers such as leucocytes and neutrophils.

Figure 1. The pre-operative clinical picture of the patient’s left breast. The red line illustrates the location of the mass. The skin of the left breast was consistent with peau d’orange, the classical sign of locally advanced breast cancer.
Clinical and differential diagnosis
Since neglected breast carcinoma is prevalent in our daily clinical practice, the primary working diagnosis was breast cancer with a secondary differential diagnosis of breast abscess. These differential diagnoses were made due to the abrupt incidence of the mass, accompanied by severe pain and warmth of the surrounding skin of the affected breast, which is unusual for patients with breast cancer. Typically, breast cancer requires a core biopsy as a further diagnostic procedure. However, the clinician felt the urge for an open biopsy because the breast abscess was the possible secondary diagnosis.

Intra-operative findings
Open biopsy and drainage were performed under general anesthesia. An abscess cavity was found within the left breast, with size and location in accordance with the mass previously palpated in pre-operative clinical examination. There was approximately 15cc purulent material found with much necrotic tissue and a hard, solid abscess wall. The surgeon decided to do a biopsy of the abscess wall, followed by debridement of the abscess cavity, and left the wound open, thus permitting secondary wound healing while awaiting the biopsy result. Culture of the purulent material was done, but no bacteria were found, further proving that this is a “sterile abscess”.

Outcome and follow-up
Following the operation, the patient’s pain scores were notably reduced to only 3/10. This low pain level was easily managed by oral analgesics such as paracetamol (500 mg per oral solution). The patient was discharged on the first day after the operation. A follow-up meeting was scheduled two weeks, four weeks, and six months after the surgery. The patient did not complain of any pain. The scar healed entirely within four weeks and was observed for six months with satisfactory results (Figure 3).

Figure 2. Ultrasonography of patient’s left breast. A solid mass with an irregular border is shown in the left picture. The right image shows multiple enlarged lymph nodes in the left axillary region.

Figure 3. The clinical picture of the left breast at the 2nd week post-surgery. Peau d’orange and necrotic tissue or purulent material were absent. The scar was partially healed.
At one-month post-surgery, a follow-up with the patient was scheduled. At this follow-up, the patient reported no complaints at her surgical site. The pain score was reduced to zero points, and the wound showed an improvement without any secondary infection (Figure 4).

**Figure 4.** The clinical picture of the left breast at one-month post-surgery. The scar was nearly healed without any infection.

**Figure 5.** Biopsy result of the abscess wall. A dilated duct lumen contains needle-like cholesterol crystals, with surrounding chronic inflammatory infiltrate and foreign body type multinucleated giant cells (H&E, magnification ×10). H&E, hematoxylin and eosin.
**Biopsy result**

Biopsy of the abscess wall showed dilated duct lumen containing needle-like cholesterol crystal, with surrounding chronic inflammatory infiltrate and foreign body type multinucleated giant cells (Figure 5). Some areas showed cholesterol crystals being engulfed by multinucleated giant cells (Figure 6). Thus, the biopsy confirmed cholesterol granuloma of the breast as the diagnosis, and a malignant lesion of the breast was not found.

**Discussion**

The management of breast carcinoma and breast abscess are entirely different. Typically, the difference is prominent in clinical pictures and imaging, so clinicians will not consider these two entities as differential diagnoses.12

The primary diagnostic assessments for breast cancer are clinical examination, radiology, and core biopsy of the mass.9,13 However, the experience of both the clinician and radiologist is also a dominant factor in determining whether a mass is benign or malignant.13 A report of two cases of cholesterol granuloma on the breast showed that both mammography and ultrasonography were suggestive of carcinoma of the breast, but open biopsy showed cholesterol granuloma.14 While some reports find this is an accurate tool to get a definitive diagnosis for invasive breast cancer with sensitivity reported 90-99%, reports in Indonesia show its sensitivity is only 78% in early breast cancer.15–17 The last fact, combined with the plausibility of breast abscess as the diagnosis in this case report, led the surgeon to choose open biopsy instead of core biopsy for the patient.

Due to its rarity and similarity to breast cancer signs and symptoms, treatment guidelines for breast abscess due to cholesterol granuloma have not yet been established. A report by Jeong et al., 2016 indicated that core biopsy was sufficient to diagnose breast abscess, and afterward, the follow-up showed a decrease in size.18 But serial cases from Nam et al., 2019 of 12 cases of cholesterol granuloma of the breast showed that the more suitable treatment for breast abscess was an excisional biopsy.5 Reports from Osada & Kitayama, 2002 and Fujii et al., 2013 stated that open and excisional biopsies provided satisfying results and no recurrence.6,19 In most cases, diagnosis based on microscopy is precise, but some conditions may mimic malignancy in fragmented core biopsy samples. Conversely, some malignancies can also simulate benign inflammatory or reactive conditions.20

Due to its consideration as a breast abscess, open biopsy and drainage were preferable, which acted as diagnostic and curative procedures. On the other hand, core biopsy simply is less suitable in many cases because of cholesterol...
granuloma present in other body regions, such as the ovary, middle ear cavity, brain, and testis, which also require resection of the affected tissue and removal of the inflammatory tissue.1,2,4,5

This case report has many strengths; the physical, laboratory, and radiography examinations were done thoroughly, which support the diagnosis, and definitive treatment of surgery was performed with a satisfactory result with no complications and complete scar healing. Moreover, the complete patient follow-up during the hospitalization and post-hospitalization were comprehensively collected. In addition, most previously reported cases didn’t report or evaluate post-procedure pain scores. However, in this case report, the pain score was dramatically reduced.

Conclusions
Although it could be very similar in presentation, an experienced clinician should be wary and consider some entities that could mimic carcinoma of the breast, such as cholesterol granuloma. An excisional biopsy is essentially required to eradicate inflammatory tissue to ensure the healing process.

Data availability
Underlying data
All data underlying the results are available as part of the article, and no additional source data are required.

Consent
Written informed consent for publication of their clinical details and clinical images was obtained from the patient.

Author contributions
FH worked on the Conceptualization, Data Curation, Formal Analysis, Funding Acquisition, Investigation, Methodology, Resources, Software, Visualization, Writing – Original Draft Preparation. RVH was involved in Conceptualization, Formal Analysis, Methodology, Software, Visualization, Writing-Review & Editing. EJW was involved in Project Administration, Supervision, Writing – Review & Editing. FH wrote the draft of the article, RVH and EJW helped with the final manuscript preparation. All figures are original to this manuscript and permission from the patient to publish such an image is obtained. All authors read and approved the final manuscript.

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References


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