IMMUNOHISTOCHEMICAL AND RADIOLOGICAL FINDINGS:

On immunohistochemistry, CK7 and CK20 were positive. GATA3, GCDFP15, Mammoglobin, CDX2, PAX8, WT1, SATB2, TTF1, ER, PR and HER2 were negative (Figures 4-9). Absence of myoepithelial layer was demonstrated by the negativity of p63 in the invasive component. Adjacent to the invasive component, foci of in-situ carcinoma was found as highlighted by retained p63 expression. Further whole body computed tomography and ultrasonography showed no abnormalities in the abdominal and pelvic organs which demonstrated that lung, gastrointestinal tract, pancreas, and ovary were free of any tumor.

DIAGNOSIS, MANAGEMENT AND FOLLOW-UP:

As no lesion was found in any other organ after careful evaluation, a diagnosis of primary mucinous cystadenocarcinoma was rendered. Thereafter, the patient underwent left modified radical mastectomy with axillary lymph node dissection after 1 month. No residual tumor was found and lymph nodes were free of tumor. According to AJCC/TNM the patient was pT2N0M0 with triple negative phenotype. Following this, she was planned to receive 8 cycles of Chemotherapy (Adriamycin and Cyclophosphamide). So far, she has completed two cycles of chemotherapy and is responding well. .

DISCUSSION:

The primary mucinous cystadenocarcinoma (MCA) of the breast is a rare variant of breast carcinoma. Clinically, MCA in the breast is found in postmenopausal women and present as a relatively large, firm, cystic mass with a favorable prognosis and long survival.1 It displays unique histopathologic features characterized by cystic structures lined by tall columnar cells with abundant intracellular and extracellular mucin bearing resemblance to MCAs of ovary, pancreas and appendix. To make a definite diagnosis, a metastatic mucinous cystadenocarcinoma originating from these sites must be excluded. Thus, elaborate clinical history and thorough imaging is