Annals of Clinical and Medical Case Reports

Property Mastectomy About Two Cases On Non-Metastatic Breast

Louba Ngouomo, France Nayam , Milène Tshibola Nkashama,Younes Bencherifi, EL Kerroumi M ,Benhassou M, Ennachit M

Mohamed VI Center for Oncology-Casablanca, CHU IBN ROCHD, Morocco.
Hassan II Faculty of Medicine and Pharmacy, Casablanca, Morocco

*Corresponding Author:
louba ngouomo
Mohamed VI Center for Oncology-Casablanca, CHU IBN ROCHD, Morocco.
Hassan II Faculty of Medicine and Pharmacy, Casablanca, Morocco

Received Date: 11 Jul 2025
Accepted Date: 26 Jul 2025
Published Date: 31 Jul 2025

Citation:
louba ngouomo. Property Mastectomy About Two Cases On Non-Metastatic Breast. Annals of Clinical and Medical Case Reports 2025; 14: 1-4

1. Summary
The proprietary mastectomy remains a relevant surgical solution in cases of locally advanced breast cancer without metastases, especially when conservative surgery is not an option. We report two cases of young, nulitest, patients with advanced left breast cancer. The first, suffering from luminal B infiltrating ductal carcinoma, underwent a simple mastectomy after neoadjuvant chemotherapy. The second, with triple-negative invasive carcinoma, required a mastectomy with flap covering. These two cases illustrate the diversity of clinical presentations, diagnostic barriers and therapeutic imperatives in a context of delayed consultation.

2. Keywords: breast cancer, cleanliness mastectomy, neoadjuvant chemotherapy, clinical cases.

3. Introduction
In our daily practice of breast oncological surgery, we still face advanced forms of breast cancer in young women who consult late. Breast cancer remains the most common cancer in women in Morocco and in the world. When diagnosed at a locally advanced stage, management is based on a combined strategy involving neoadjuvant chemotherapy and radical surgery.

The proprietary mastectomy is an effective therapeutic alternative to obtain loco-regional control, especially in the presence of large, ulcerated or inflammatory tumors. This surgical option is particularly relevant when local conditions preclude conservative surgery.
We report two observations illustrating the need for such an approach in the context of locally advanced non-metastatic breast cancers.

4. Observation 1
We report the case of a 37-year-old patient, nulligeste, residing in Casablanca, admitted to our department for the continuation of the management of locally advanced left breast cancer.
The story goes back about a year, marked by the appearance of a nodule in the left breast, which gradually increased in size. This evolution was accompanied by local inflammatory signs, followed by a progressive deterioration of the condition
general, characterized by marked asthenia, anorexia, and unquantified weight loss. No family or personal history of cancer has been reported.

Ultrasound: left breast classified as density D according to the BI-RADS, with an increase in density in the superior-external quadrant (QSE), and a notable thickening of the integuments in front of it.
Breast ultrasound: hypoechoic, heterogeneous, irregularly contoured mass, localized at the QSE, measuring 60 mm × 30 mm, responsible for skin retraction. Presence of left axillary lymph nodes with thickened cortex, the largest measuring 9 mm. Right breast without abnormality.

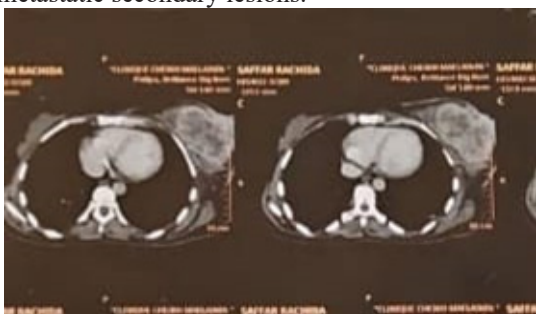
Skin biopsy : Scarff-Bloom-Richardson grade II invasive ductal carcinoma (ICC) with an in situ component.
Immunohistochemistry : luminal B molecular profile, hormone receptor positive, HER2 negative.
Genetic analysis : not carried out due to lack of immediate indication and resources.
The patient received 4 courses of neoadjuvant anthracycline-based chemotherapy, with a partial tumor response. The general condition improved slightly under treatment.

5. Breast Examination
Left breast: large hard mass, measuring about 15 cm, adherent to the cutaneous plane without ulceration or discharge.
Right breast: without abnormality.
Lymph node areas: mobile left axillary lymphadenopathy,

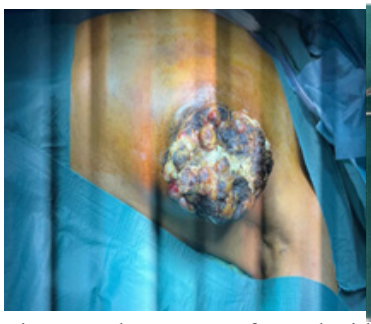
Annals of Clinical and Medical Case Reports

measuring 1 cm, without inflammatory signs.

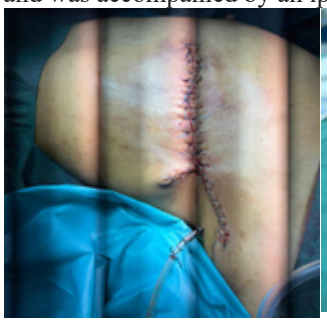
Extension workup: Thoraco-abdominopelvic CT revealed no metastatic secondary lesions.

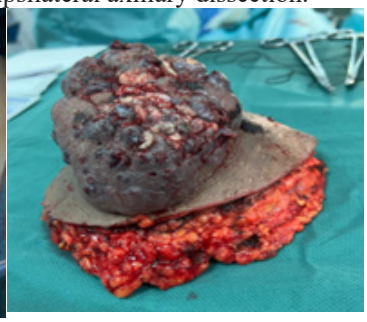


A cleanliness mastectomy was indicated, given the persistence of a locally large mass, the partial response to chemotherapy, and the absence of metastases.



The procedure was performed without immediate reconstruction, and was accompanied by an ipsilateral axillary dissection.





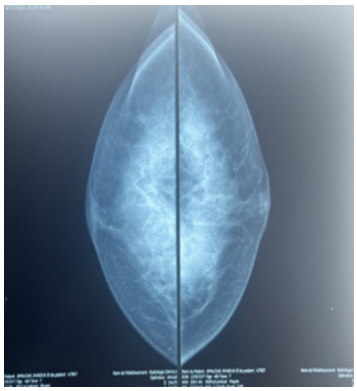
Postoperative follow-up : patient spent 6 days in hospital and received a transfusion of two red blood cells.

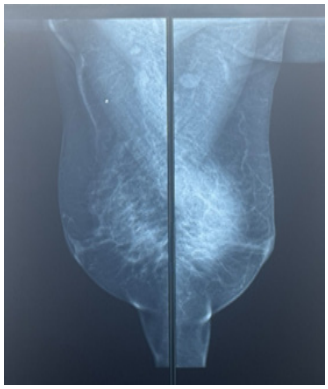
Final histopathological results shown: Scarff-Bloom-Richardson grade III infiltrator (CCI), with an in situ component.

6. Observtion 2

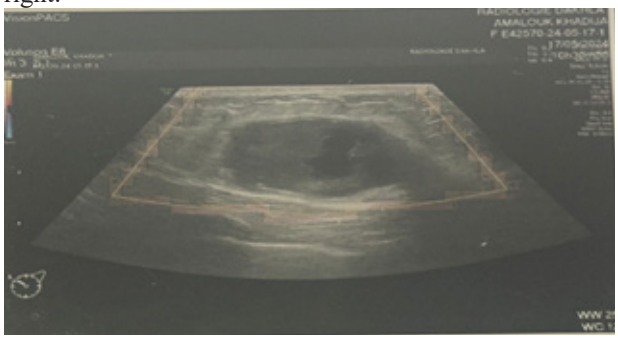
Patient, 47 years old, nulligeste, in chemo-induced menopause, residing in Casablanca, who consults for a neoplasm of the left breast evolving for 13 months.

Mammography objectifies a breast with density B, with an additional opacity localized to the left upper-internal quadrant (QSI), without associated architectural distortion. Left axillary adenomexly is also noted. The right breast is without abnormality.





Breast ultrasound revealed a solidocystic formation with thickened walls on the left breast, measuring 38 mm × 19 mm, without posterior attenuation or rupture of the fibrous tracts. A breast cyst of 14 mm × 8 mm is visualized in the left upper-outer quadrant (QSE), as well as several ipsilateral infracentimetric axillary lymphadenopathy. The right breast has a small breast cyst of 7.6 mm on QSE. The BI-RADS rating is 4A on the left and 2 on the right.



7. Histological exploration

The first skin biopsy reveals a cell infiltrate without malignancy, with a histiocytic profile benign to immunohistochemistry. A second biopsy performed two months later showed polymorphic, reactive and non-specific exulcerated dermatitis.

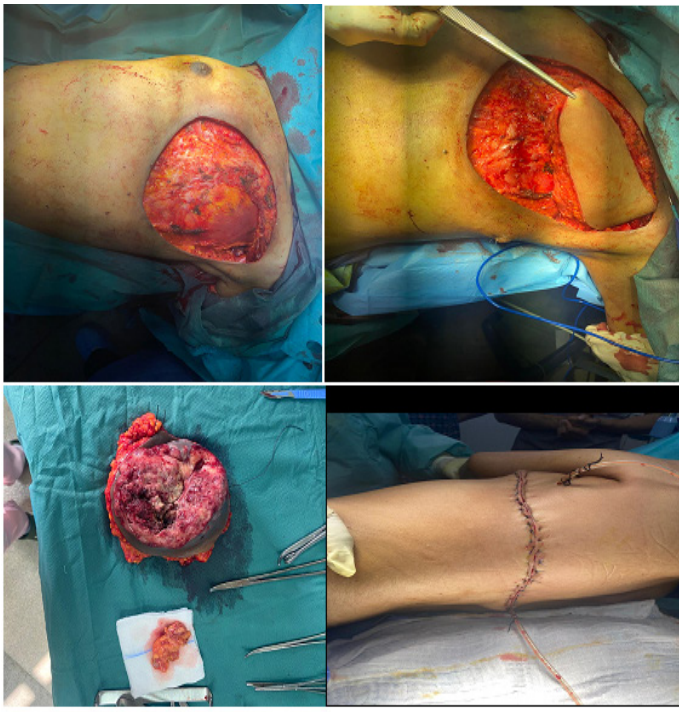
In view of the persistence of the lesions and the clinical discordance, a third biopsy, performed two weeks later, confirmed the presence of poorly differentiated invasive carcinomatous proliferation, compatible with a non-specific infiltrating breast carcinoma of grade SBR III, with a triple-negative profile (absence of hormone receptors and HER2).

Extension assessment by thoraco-abdominopelvic CT revealed no metastatic location

The patient underwent neoadjuvant treatment with eight courses of chemotherapy in a specialized center.

At the end of the medical treatment, the decision was made for a cleanliness mastectomy.

Annals of Clinical and Medical Case Reports



\The reconstruction was carried out immediately using a musculocutaneous flap taken from the latissimus dorsi muscle, allowing a better functional and aesthetic result.

Dressing on day 2 of the postoperative period

8. Discussion

The proprietary mastectomy, although old in its conception, remains a relevant surgical technique in some cases of locally advanced but not metastatic breast cancers. The two cases reported in this study illustrate a common reality in our clinical contexts: patients consulting at a late stage, often with inflammatory, ulcerated or bulky lesions, rendering conservative strategies ineffective.

The first patient, young (37 years old), presented with luminal B infiltrating ductal carcinoma, which did not respond to neoadjuvant chemotherapy. The tumor remained localized without major skin invasion or alteration of tissue coverage, which allowed a simple mastectomy, without the use of a flap. In contrast, the second patient presented with a triple-negative, high-grade tumor (SBR 3) with aggressive biological behavior and an ulcerated clinical presentation. The need for a flap in this case illustrates the importance of surgical adaptation to local conditions, but also to the tumor phenotype [1].

In resource-limited countries, proprietary mastectomy remains a much-needed approach, due to diagnostic delays, reduced availability of immediate reconstruction techniques, and the prevalence of neglected forms of breast cancer [2]. This surgery allows for effective loco-regional control, especially when it is preceded by well-conducted neoadjuvant chemotherapy, as was the case in our two patients. Studies show that neoadjuvant chemotherapy not only allows a reduction in tumor volume, but also an in vivo evaluation of tumor sensitivity to treatment [3].

Whether or not reconstruction is required depends closely on the quality of the surgical bed, the skin condition, the patient's general condition and the technical platform. In the first patient, the good cutaneous trophicity made it possible to avoid the use of a flap, thus reducing operative morbidity. Conversely, the second case, marked by tumor necrosis, exulcerated dermatitis and an inflammatory component, imperatively required tissue supply by flap to allow adequate coverage and optimal healing [4].

In addition, the triple-negative molecular subtype of the second patient underlines the poor prognosis often associated with these tumors, due to their aggressiveness, the absence of specific therapeutic targets and their poor response to hormonal or targeted treatments. These patients require close follow-up and often a reinforced adjuvant strategy [5].

Finally, this study recalls the importance of strengthening breast cancer screening campaigns in developing countries and improving the training of health professionals on early warning signs. Radical surgery should not be the norm in a pathology that is increasingly treatable early, but it is still necessary in neglected or advanced inflammatory forms [6].

9. Conclusion

Proprietary mastectomy remains a life-saving intervention in some locally advanced non-metastatic breast cancers, particularly in clinical settings where technical limitations and delay in diagnosis

persist. Adapting the surgical procedure to the local terrain, the response to chemotherapy and the tumor profile is essential to ensure optimal management.

Authors' contributions

All authors have read and validated the final version of the manuscript. The lead author wrote the observations and coordinated the formatting. Co-authors contributed to the literature review and discussion.

References

1. Cardoso F, Kyriakides S, Ohno S, Penault-Llorca F, Poortmans P, Rubio IT, ... & Senkus, E. Early breast cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Annals of Oncology. 2019; 30(8): 1194-1220. https://doi.org/10.1093/annonc/mdz173
2. Fadwa H & El Fatemi H. Breast cancer in Morocco: A literature review. Pan African Medical Journal. 2019; 32: 123. https://doi.org/10.11604/pamj.2019.32.123.18349
3. Untch M & von Minckwitz G. Neoadjuvant chemotherapy: Early response as a guide for further treatment. Journal of Clinical Oncology. 2014; 32(30); 3445-3451. https://doi.org/10.1200/JCO.2014.56.1175
4. Clough KB, Kaufman GJ, Nos C, Buccimazza I & Sarfati IM. Improving breast cancer surgery: A classification and quadrant per quadrant atlas for oncoplastic surgery. Annals of Surgical Oncology. 2010; 17(5): 1375-1391. https://doi.org/10.1245/s10434-009-0792-y
5. Ministry of Health of Morocco. Greater Casablanca Cancer Registry 2012–2017. 2020
6. World Health Organization (WHO). Breast cancer: Fact sheet. https://www.who.int/news-room/fact-sheets/detail/breast-cancer.7. Cardoso, F., et al. (2019). Early breast cancer: ESMO Clinical Practice Guidelines. Annals of Oncology, 2021; 30(8): 1194-1220. https://doi.org/10.1093/annonc/mdz1738. NCCN. (2024). NCCN Guidelines: Breast Cancer. Version 3.2024. https://www.nccn.org/professionals/physician_gls/pdf/breast.pdf