

Altering Drifts in the Treatment of Granulomatous Mastitis in a Surgeon's Point of View

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Granulomatous mastitis (GM) is an erratic chronic inflammatory breast ailment that was first described in 1972. Granulomatous changes arise around lobules and ducts of the breast in the absence of precise infection, trauma, or sign of sarcoidosis. As the etiology of GM is not clear, and the diagnosis is made by exclusion, GM can be an assorted disease with capricious clinical demonstrations [1]. The most common clinical presentation is a firm, unilateral, and discrete breast mass that is often related with an abscess or inflammation of the overlying skin and fistulae [2].

The clinical and imaging symptoms of GM are somewhat close to those of breast carcinoma, with the result that many patients are misdiagnosed prior to the final pathological diagnosis. This disease has been rare in the past, but many GM cases have been reported in the 30 years since the first study, mostly in Asian countries such as India, Iran and Turkey. In recent years, the incidence of GM has risen significantly [3].

Treatment options for GM include corticosteroids, antibiotics, abscess drainage, thorough surgical resection, and even mastectomy. Several studies have identified the efficacy of corticosteroid administration and/or broad excision [4]. Even then, the appropriate treatment of GM patients is unclear. The management of GM cases needs to be adapted to clinical presentations. In addition, a differential diagnosis must be made in parallel with the procedure. While GM is a benign disease, it may have local symptoms that resemble carcinoma [5]. Most studies to date have focused on the

diagnosis of GM; however, little is reported on the management of GM cases with well-defined causes. As a surgeon, I describe management of GM solely by surgery in this editorial message. I hope that the information presented herein will provide further insights into the surgical approach for the treatment of idiopathic granulomatous mastitis and help to improve the clinical management of similar cases.

Surgical approach for the treatment of idiopathic granulomatous mastitis

Surgical excision and systemic immunosuppressive agents are the primary methods of treatment. The extent of the lesion was carefully measured by mammography and ultrasound, and magnetic resonance imaging (MRI) was used in patients with several or extensive lesions [1]. Extended excision was performed to remove the entire lesion, including the infected skin, breast abscess, fistula, and inflammatory or necrotic tissues, with a clear margin of the breast defect based on histological analysis. Based on the position and nature of the lesion, the patients were grouped into four separate groups and a particular surgical procedure was used for each group. Since the size of the breast differs in one individual to another, the trends for large lesions are dependent on the size of the lesion compared to the size of the breast [6].

- **Pattern 1: Crescent-shaped incision:** This template was appropriate for small lesions (≤ 3 cm) below or anterior to the areola.

- **Pattern 2: T-shaped incision:** This pattern was ideal for medium-sized lesions for which the crescent-shaped incision could not close the defect, but the width of the lesion was not greater than one-third of the total breast size. In these cases, two assistive periareolar incisions were made to release the mammary tissue around the defect and to force it inside the defect to heal the wound.
- **Pattern 3: Pear-shaped incision:** This trend was ideal for lesions greater than one third of the total breast size, but did not extend to the other side of the areola. In these cases, the breast defect was wider than that of Pattern 2 and could not be covered by a T-shaped incision. An adjacent oblique incision was made on the skin of the rich mammary tissue region. In this way, new breast tissue flaps could be produced to repair the large defect [7].

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