After standard inner quadrant suggestive of indeterminate carcinoma. Patient was diagnosed as a case of metastatic breast carcinoma histopathological examination. The Operative finding as shown in figure breast with multiple axillary lymph nodes. Patient was planned for Modified radical mastectomy.

Ultrasound breast and axilla reveals breast as normal and a single lymph node in axilla of around 2.5x2 cm. There was no lump in bilateral breast. There was no history of weight loss, nipple discharge and no lesion was found in breast par. Mammogram and MRI were not able to rule out primary source. FNAC reported it as metastatic carcinoma. Patient was further managed with Modified radical mastectomy and biopsy showing it as metastatic carcinoma breast. So all isolated ALN metastasis should be considered as occult primary breast cancer unless otherwise proved.

Keywords: Occult Breast Cancer, Axillary Nodal Metastasis, Mastectomy, Radiotherapy.

INTRODUCTION
Occult carcinoma breast is a rare entity which accounts for less than 1% of all patients of breast cancer (Owen et al., 1954). The secondaries from the sites like lung, thyroid, gastrointestinal tract, ovary, melanoma etc. may occasionally metastasized to axilla, however, the most common site of primary cancer in such cases is the ipsilateral breast unless otherwise proved (Feuerman et al., 1962; and Copeland and McBride, 1973).

Diagnosis and treatment in these patients remain very challenging. Due to its rare occurrence and therapeutic dilemma, we decided to report our case who presented with a lift axillary mass without any evidence of primary malignancy in bilateral breasts. An effort has been made to review the literatures for complete management in such patients.

CASE
56 year female patient presented in our outdoor with complaint of swelling in left axilla for three months. There was no history of weight loss, nipple discharge and lump in bilateral breasts. There was no family history of breast cancer. Patient was previously operated for hysterectomy 8 year back for some benign disease however documents were not available. On examination of B/L breast and right axilla were normal. In left axilla there was single, mobile, palpable swelling, hard in consistency, around 2 x 2.5 cm size present in anterior part of axilla. There was no lump in bilateral breast, no hepato-splenomegaly or any bony tenderness. Patient was diagnosed as a case of unknown primary and further evaluated.

Ultrasound breast and axilla reveals breast as normal and a single lymph node in axilla of around 2.5x2 cm. Mammogram breast was advised and suspicious area of calcification was depicted in left breast and a single rounded Lymph node in axilla. Fine needle aspirate from the left axillary swelling shows, poorly differentiated adenocarcinoma. MRI breast reported a parenchymal heterogeneity in left retro areolar area with few suboptimal enhancing lesion in lower inner quadrant suggestive of indeterminate carcinoma breast with multiple axillary lymph nodes. Patient was planned for Modified radical mastectomy. Operative finding as shown in figure 1 revealed 3 lymph node of size 2 x 2 , 2x2.5 and 1x2 cm with other small size lymph node. Level 1 and II lymph node dissection done and whole specimen sent for histopathological examination. The report of pathology shows 20 out of 21 lymph node positive for metastatic breast carcinoma and no lesion was found in breast parenchyma. Patient was doing well with radiotherapy.
no intraoperative or postoperative complication and further referred to department of radiotherapy for further chemoradiation management.

**Figure 1:** Intraoperative photo: Arrows showing metastatic lymph nodes in left axilla

**DISCUSSION**

The female patients who have adenocarcinoma in axillary lymph nodes as the sole clinical site of cancer can be a diagnostic and therapeutic challenge for surgeons. Halsted, in 1907, first described two patients with ‘extensive carcinomatous involvement of the axilla’ due to occult breast cancer. Within few months, the mammary disease manifested itself in both patients. Occult carcinoma breast presenting with axillary metastasis as a first sign is rare among breast cancers patients (Lloyd and Nash (2001). However, for all practical purpose in case of isolated axillary metastasis, occult breast cancer should be the most pertinent differential diagnoses in absence of any other primary site of malignancy after initial diagnostic workup. Feuerman in his study stated that once carcinoma reaches the axillary lymph nodes from an extramammary source, the primary lesion is no longer “occult” it will be definitely detectable by initial diagnostic workup (Feuerman et al. 1962). The actual incidence of occult breast cancer is not known but a study done by Owen et. al., (1954) in their study stated the incidence as 0.3% and Pentheroudakis et al., (2010) as 0.12 to 0.67%. A thorough clinical examination, FNAC of the axillary lymph node, Chest X-ray, ultrasound of the abdomen, screening, mammogram and /or Magnetic resonance imaging (MRI) of the breast are sufficient as the recommended investigations for locating potential sites of primary carcinoma. MRI of the breasts was highly sensitive (Pantheroudakis et al., 2010) (59%) in detecting occult primary lesion in breasts and MRI increased the rate of breast conservation surgery. Hence, MRI should be the recommended imaging for breast in such cases (Pantheroudakis et al., 2010).

Regarding management level I and II with or without level III Axillary lymph nodes dissection is a standard practice and radiotherapy must be advised accordingly. Feigenberg et.al., (1976) reported 50% recurrence rate when the axilla is treated only with radiotherapy (RT) in comparison to axillary dissection
(followed by RT to axilla also showed higher recurrence (20-50%) as well. Treatment of the ipsilateral breast in patient with occult primary and axillary lymph node metastasis remains controversial (Pantheroudakis et al., 2010). The standard approach in several series was ‘blind’ modified radical mastectomy (MRM) (Feuerman et al. 1962; Halsted (1907); Pantheroudakis et al., 2010) at the time of axillary clearance. Earlier few authors (Ellerbroek et al. 1990; Merson (1992) tried conservative management (observation only) of the breast after treating the axilla; but after analysing their results it was seen that 5 year disease free survival is significantly better in the patient treated with mastectomy along with axillary treatment (83%) than in patient with conservative management to the breast after treating axilla only (43%).

CONCLUSION
All isolated ALN metastasis should be considered as occult primary breast cancer unless proved otherwise. MRI breast, FNAC of axillary mass along with other metastatic workup should be carried out in all patients of axillary mass. Axillary dissection with mastectomy should be followed by appropriate adjuvant chemo-radiotherapy.

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