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Ruptured breast implant in situ for 59 years: A case presentation

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Abstract

An 87-year-old woman presented with acute chest pain and a violaceous breast lesion with serous discharge. Imaging revealed findings suspicious for Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL) and a right-sided implant rupture. Despite radiological concern, histopathology confirmed a benign inflammatory process. Bilateral total capsulectomy and mastectomy were performed, resulting in full recovery. This case highlights the diagnostic complexity of late-onset breast implant complications that can mimic malignancy, particularly in elderly patients. It underscores the need for multidisciplinary evaluation, careful radiologic-pathologic correlation, and the combined use of MRI, ultrasound, and mammography in assessing suspected extracapsular rupture.

Keywords: Breast implants; Breast implant rupture; Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL); Capsular contracture.

Abbreviations: BIA-ALCL: Breast Implant-Associated Anaplastic Large Cell Lymphoma.

Case presentation

An 87-year-old woman with a complex medical history, including extensive cardiovascular and nephrological comorbidities, presented to the emergency department with acute chest pain. Clinical examination revealed a blue-purple lesion of the left breast with skin breakthrough, accompanied by serous fluid leakage (Figure 1). The attending cardiologist suspected spontaneous hemorrhage into a pre-existing hematoma at the left breast, known to have been present for some time. The patient was discharged with a prescription for home wound care and was advised by the emergency physician to consult a plastic surgeon.

During our subsequent evaluation, the patient reported that the swelling had been present for approximately three weeks. When asked, she mentioned that the prosthetics had been there since 1965. She also disclosed a history of prosthetic displacement five years earlier. On examination, the left breast was visibly distorted, with erythema and a supra-areolar ulceration-features concerning a potential neoplastic process. Magnetic resonance imaging of the breasts was performed (Figures 2A-2C), revealing findings suspicious for Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL). Additionally, the right breast showed evidence of suspected intracapsular prosthesis rupture, a small lateral axillary lymph node, and

Figure 1: Pre-operative external view of the patient's breasts with lateral left a blue-purple swollen area. The left breast prosthesis is pushing outwards laterally at the level of the left supra-areolar area with bilateral capsular contracture grade 4.

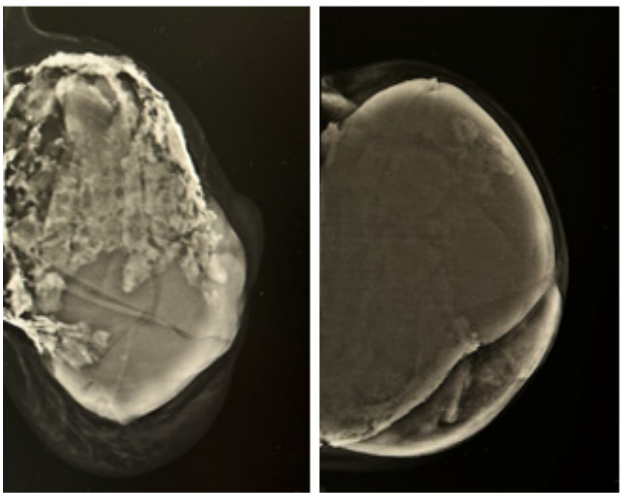

Figure 3: A (left) and **B** (right). Mammography of the left breast shows an inconclusive image. It does show extensive capsular contracture and calcification.

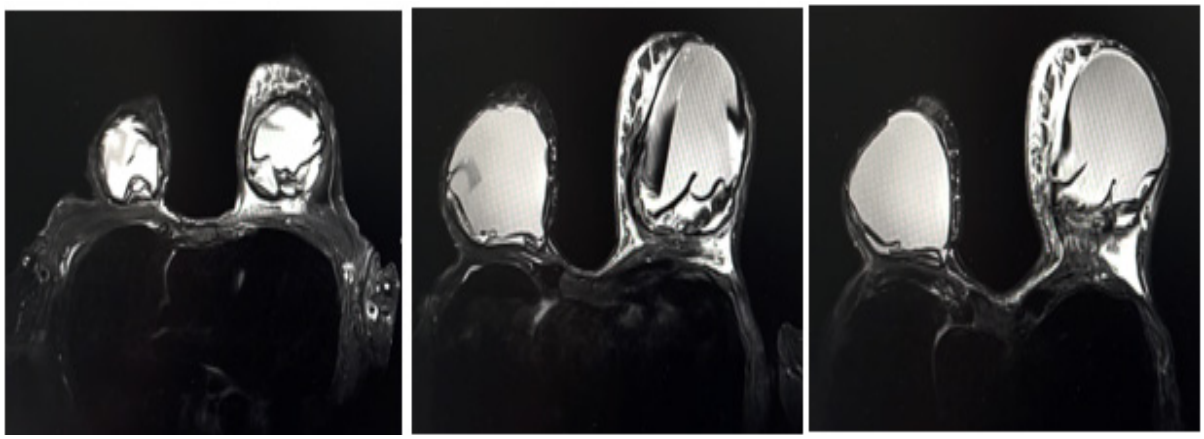

Figure 2: A (left, superior transverse slide), **2B** (middle, middle transverse slide) and **2C** (right, inferior transverse slide). MRI-Breast left shows a mass with fluid-containing components posterior to the left prosthesis and postero-central serpiginous staining zone with type three curve and calcifications around the prosthesis. The image may fit a BIA-ALCL.

several nodules along the internal mammary artery chain, all nodes demonstrating benign imaging characteristics, which was confirmed on ultrasound. The lesion was classified as BIRADS IV (Breast-Imaging Reporting and Data System). A mammogram was also performed, but gave an unclear and inconclusive image (Figure 3).

Based on radiological recommendations, Fine-Needle Aspiration Cytology (FNAC) was performed on the fluid component of the left breast mass and the suspect axillary lymph node. Core needle biopsies were obtained from the prosthetic capsule, solid components of the mass, the posterior region of the left breast, as well as the supra-areolar nodular thickening and overlying skin.

Incidentally, a dilated ascending aorta was also identified, prompting referral to a cardiothoracic surgeon.

Histopathological analysis of the collected samples was inconclusive. Due to increasing wound burden, persistent fluid leakage, and associated hygienic concerns, surgical management was advised following discussion at a Multidisciplinary Oncology Consultation (MOC). After shared decision-making with the patient and her confidant, bilateral total capsulectomy and mastectomy were performed. On the left, an elliptical incision facilitated nipple and wound resection; on the right, a nipple-sparing approach via the inframammary fold was employed. Both calcified capsules were excised en bloc with the implants. The right implant was ruptured and examined ex vivo.

Postoperative histological analysis revealed no evidence of malignancy. Findings included extensive fibrous pseudocapsule formation and an acute inflammatory response with histiocytic infiltration extending through the dermis. No lymphoid neoplasia was identified, even upon further immunohistochemical and supplementary analysis. The patient has recovered well postoperatively and remains under follow-up.

Discussion

This case highlights the diagnostic complexity of late-onset breast implant-related complications, particularly when clinical presentation mimics malignant pathology. This suspicion could be due to the extra-capsular rupture, resulting in inflammation of the skin, fluid collection and supra-areolar ulceration. The overall incidence of capsular contracture is estimated at 57.1%

[1]. Based on a review of five clinical trials, the estimated rates ranged from 2.4% to 18.9% following primary augmentation surgeries, and from 10.1% to 26.8% following reconstructive surgeries [1]. The incidence of implant rupture is estimated at 2.5% after 2 years with saline implants and 0.5% with silicone implants [1].

Despite radiological and clinical suspicion of BIA-ALCL, a thorough histopathological examination revealed a benign inflammatory process. To date (2025), the FDA has reported 1130 cases worldwide of a BIA-ALCL [1]. This type of lymphoma should be suspected in patients presenting with delayed seroma, which is typically 7 to 8 years after surgery. Symptoms are swelling, pain, or a mass within the implant capsule and an axillary lymphadenopathy may also be observed as was all observed in this case [1].

The case underscores the importance of a multidisciplinary approach, careful radiologic-pathologic correlation, and shared decision-making in managing elderly patients with implant-related breast lesions. The use of a breast MRI in combination with mammography and ultrasound for further evaluation when an extracapsular rupture is suspected is recommended by the literature [1].

Conclusion

Late-onset breast implant complications may closely mimic malignant disease, emphasising the need for thorough diagnostic evaluation. Multidisciplinary collaboration and radiologic-pathologic correlation are essential to distinguish benign inflammatory processes from malignancy and to guide appropriate management, particularly in elderly patients.

Declarations

Disclosure statement: The authors report there are no competing interests to declare.

Data availability statement: The data that support the findings of this study are available from the corresponding author upon reasonable request. Restrictions apply to the availability of these data due to privacy of the patient.

Ethical statement: The authors adhered to ethical standards by obtaining the patient's informed consent, which permits the use of clinical images and authorizes the publication of this manuscript in a scientific journal.

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