An accessory nipple revealed during pregnancy

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A previously healthy 25-year-old woman, with no past personal or familial history, was referred for a troublesome naevus of the trunk that had increased in size recently during her first pregnancy. The lesion was localized on the left side of the flank, under the breast. The lesion was a dome shaped, skin coloured, well-demarcated papule with a soft rubbery texture and a discrete hyper-pigmentation around (figure 1). The overall clinical aspect was evocative at first of an intradermal naevus. The patient explained that it increased in size during the second trimester of her first pregnancy. Pregnancy and delivery were otherwise uneventful. She did not breastfeed and the lesion was otherwise stable two months after delivery. Dermoscopic examination showed a central scar-like white colored area and a fine pigment network in the periphery of the lesion (figure 2). The aspect and the localization of the lesion, the increase during pregnancy and the dermoscopic features confirmed the diagnosis of supernumerary (or accessory) nipple.

Discussion

Supernumerary (ectopic or aberrant) mammary tissue/nipple (SNN) is far from being uncommon as it is generally found in 1 to 6% of the population [1–3]. They are usually observed along the “milk lines” (or “Hughes lines”), which extend from the axillary region to the groin, even though totally ectopic locations have been reported, such as the neck, the face, the back or the vulva [1]. Typically, breast tissue is located in the axillae or under the left breast. The generic term of “accessory nipple” is rather confusing as there is a wide spectrum in the presentation according to the full development or not of mammary gland: complete SNN with a full glandular tissue with nipple–areola complex (polymastia); SNN with fat tissue, nipple and areola; SNN with a nipple with an areola of various size (polythelia areolaris); SNN with a nipple alone (polythelia); breast tissue with an areola but no nipple; breast tissue with a nipple but no areola;
breast tissue alone without areola and nipple; and a patch of hair only (*polythelia pilosa*) [2]. Even though the breast tissue is already present at birth, the diagnosis is commonly done during puberty, pregnancy or breastfeeding period as hormones induce the lesion to blossom as in our case [1,2]. Thus, the clinical aspect may range from a small, soft, brown or skin macule or papule, a patch of hair or a subcutaneous mass. Discovery can also be fortuitous during a complete physical examination or because the lesion is mistaken for a naevus or a dermatofibroma [4,5]. Dermoscopy may be of help to assess the diagnosis as in our case.

Accessory nipples are usually solitary, smaller than the normally placed nipple [1,3] and they disclose an asymmetrical distribution with a tendency to be on the left side [3]. Historical cases recount about higher numbers of accessory breasts in one patient, up to 8, and fully functional tissue leading to breastfeeding [1,2]. Ectopic breast tissue may undergo the same modifications as the normal breast tissue including development of benign or malignant lesions [1]. Accessory nipples are usually a sporadic condition but familial cases have been reported. Different modes of transmission have been reported: autosomal dominant, recessive X-linked [3,6]. In his series, Schmidt found that 40% of the patients had at least one parent who had also a supernumerary nipple [3]. The association between supernumerary nipple and malformations of the urinary tracts remain debated [7,8] because of contradictory results that may be explained by ethnic/geographic factors, by selection bias and also the possibility that not all the variant of “accessory nipple” are related to such malformations [3]. Many authors suggest an ultrasound investigation in case of discovery of a SNN in a child [8]. Accessory nipples can also be associated with various complex malformative syndromes. Except in case of diagnosis doubt, surgical removal of the tissue is usually performed for cosmetic reasons.

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**References**


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