and possible etiological factors are diabetes, hereditary predilection, local trauma and drugs including inhaled medications.[1,2]

Ipratropium bromide (Atrovent) is a commonly and widely used antimuscarinic bronchodilator with very few side-effects.[3] Although buccal ulceration[4] and haemorrhagic bullae affecting the palate[5] have been reported with ipratropium bromide (IB) they do not appear in the British National Formulary[6] and are not mentioned in the manufacturer’s (Atrovent) product information either. Therefore, we believe not many physicians would be aware of these rare adverse effects of IB.

Our patient developed haemorrhagic bullae affecting his palate after being commenced on nebulised IB; he had developed similar lesions in the past after receiving treatment with IB; the lesions healed completely after withdrawing IB; and there was no alternative cause for such reaction in our patient. On Naranjo adverse drug reaction (ADR) algorithm, [6] this scored 6, classifying it as a probable ADR.

Appearance of any blistering lesions can be alarming due to various differential diagnoses, including serious systemic diseases. However, adverse drug reaction and ABH should be considered in patients developing haemorrhagic bullae affecting palate while receiving treatment with ipratropium bromide and other inhaled drugs.

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Lobular adenocarcinoma of the breast metastatic to the mandible

Sir,
A 39-year-old woman presented with one-year history of progressive trismus. Patient did not give history of tobacco or related product addiction. Two years ago, she had undergone a modified radical mastectomy for a lump in the left breast and was started on tamoxifen which was discontinued a year later by herself. No details of the histopathology could be retrieved. Physical examination revealed right cheek swelling, trismus and multiple ipsilateral cervical lymph nodes. The right breast and the left chest wall showed no evidence of disease. No axillary or supraclavicular lymphadenopathy was noted.

Deep biopsies revealed a poorly differentiated carcinoma involving the mandible. An orthopantomogram showed lytic lesion and pathological fracture in the right hemi-mandible. A chest radiograph and liver ultrasound were normal. Isotope Bone scan revealed isolated increased uptake in the right hemimandible. Computed tomogram showed erosion of the right hemi-mandible and a soft tissue mass in the right retromolar area involving the buccal space, submandibular salivary gland and posterolateral portion of the tongue. Due to the extensive nature of the disease, two cycles of cisplatin and ifosfamide were administered following which the trismus resolved and the patient was symptomatically better. The patient underwent a retromolar trigone composite resection with a posterior tongue flap and had an uneventful recovery.

Histology revealed scanty residual carcinoma infiltrating marrow spaces with chemotherapy related changes. The cells were small and resembled pleomorphic lobular carcinoma with a trabecular and Indian file growth pattern [Figure 1]. The nodes were negative for metastasis and cut margins of excision were free of tumour. Immunohistochemistry (IHC) was required in this unusual clinical setting to rule out other small round cell tumours, mainly lymphoma, primitive neuroectodermal tumour, and rhabdomyosarcoma and confirm diagnosis of a carcinoma. The hormone receptors (ER/PR), showed strong positivity for PR and moderate ER positivity. On IHC, cells were positive for cytokeratin and LCA, Desmin, Myoglobin, Vimentin, S-100 and Mic2 were negative. Though the slides from the primary tumour could not be reviewed, the morphology of the carcinoma and ER/PR positivity indicated a diagnosis of metastases from breast carcinoma. At three years

Figure 1: Photomicrograph of mandible showing marrow spaces infiltrated by uniform appearing cells arranged in nests and Indian File pattern. (H/E, 10x)
follow-up, the patient is in good general condition without evidence of local or regional recurrence in the breast and the jaw, or disseminated disease.

Malignant oral tumors constitute five percent of all malignant neoplasms in the body, of which one percent is considered metastatic. Because of the scarcity of bone marrow in the maxilla and mandible, lesions in these areas account for less than one percent of the overall incidence of bone metastases. The most common location of metastatic tumors is the mandible, with the molar area the most frequent site involved.

Awareness of this unusual presentation that is solitary bone metastasis in the absence of loco regional recurrence is required. This report stresses that solitary mandibular bone metastases can occur in the absence of locoregional recurrence and clinicians evaluating non-squamous oral lesions in patients with breast cancer should be aware of the same.

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