Publicación Científica de la Universidad de Ciencias Médicas de Ciego de Ávila
Editorial Ciencias Médicas
REVISTA MÉDICA ELECTRÓNICA DE CIEGO DE ÁVILA
2026;32: e4335
ISSN: 1029-3035
RNPS: 1821

Letter to the Editor

The pathologist's view on a case of luminal A invasive ductal carcinoma in a male patient

La mirada del patólogo ante un caso de carcinoma ductal invasivo luminal A en un hombre

A perspectiva do patologista sobre um caso de carcinoma ductal invasivo luminal A em um homem

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Received: 2026/05/24
Accepted: 2026/06/26
Published: 2026/08/18

Dear Editor,

I am writing to comment on the article by Ramos-Lage et al., entitled "Luminal A invasive ductal carcinoma in a man. A case report", published in Mediciego Journal (Vol. 32, e4262, 2026).

I would like to highlight the timeliness and relevance of this topic. Male breast cancer is an uncommon condition, generally accounting for less than 1% of all reported cases of breast cancer. Scientific evidence

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indicates that the incidence of male breast cancer is higher in Africa, followed by Asia. Moreover, the prognosis for breast cancer in men is worse than in women.[1]

Delayed diagnosis and unfavorable outcomes are frequently reported.[2,3] The case presented—a 60-year-old male patient with a maternal family history of breast cancer—serves as an important reminder to the medical community that this disease should also be considered in men presenting with retroareolar nodules, even in the absence of pain or palpable lymphadenopathy.

As a specialist in Pathology, I particularly appreciate the clarity with which the morphologic assessment is described, including the fine-needle aspiration biopsy, the hematoxylin and eosin–stained histologic sections, and the immunohistochemical profile confirming the luminal A subtype. The photomicrographs facilitate understanding of the diagnostic reasoning process. Case reports documenting such a well-structured diagnostic sequence are uncommon, particularly when addressing a rare neoplasm in male patients.

The authors appropriately integrated clinical, ultrasonographic (including Doppler vascular assessment), cytological (fine-needle aspiration biopsy), histopathological, and immunohistochemical findings. This multidisciplinary approach, as is commonly recommended, allowed confirmation of the diagnosis of invasive ductal carcinoma and its correct classification as a luminal A subtype (ER+/PR+ in 98%, HER2-negative, Ki-67 at 10 %). These data are useful for establishing a favorable prognosis and guiding adjuvant therapy.

The authors acknowledge as a limitation of the study the absence of genetic testing for BRCA1 and BRCA2 mutations. This is particularly relevant given the patient's maternal family history of breast cancer. This type of malignancy may have a genetic basis, and BRCA1 and BRCA2 mutations are the most common and extensively studied genes associated with breast cancer predisposition. These genes play a crucial role in DNA repair and tumor suppression, and mutations in them can significantly increase the risk of developing breast cancer. BRCA2 mutations, in particular, substantially increase the risk of breast cancer in men.[4]

This report is valuable for the medical community. It serves as a reminder that male breast cancer does exist and should be suspected in the presence of a retroareolar nodule, even in the absence of pain or palpable lymphadenopathy. It also highlights the importance of a complete diagnostic workup, including fine-needle aspiration biopsy, histology, and immunohistochemistry, to accurately classify the tumor and provide a precise prognosis. Cases such as this help primary care physicians, radiologists, and

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pathologists remain more vigilant, which may translate into earlier diagnoses and improved outcomes for these patients.

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Conflict of Interest

The author declares no conflicts of interest.

Author contributions

Javier Martínez-Navarro: conceptualization, investigation, methodology, project administration, resources, software, original draft writing, writing, review, and editing.

Funding

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ISSN: 1029-3035
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