ED STAY

ED Triage Note:

[redacted]
Registered Nurse
Specialty: Emergency Medicine

ED Triage Notes
Addendum

Date of Service: [redacted]

Addendum

Patient c/o pain to left breast with lumps for last year did not tell anyone. Also c/o area being itchy - told sister a few days ago so they are here wanting investigations and surgery. Difficult to assess due to language barrier.

ED Provider Note:

CC

Redness / Tenderness, Breast

HPI

Patient's triage note and vital signs were reviewed see additional notes for details.

Presents with sister because of lesion left breast present times a year. Has become worse over time. Became itchy today and finally told sister. Minimal tenderness. No fever. No nausea or vomiting.

PMHX

No past medical history on file.

MEDS

No current facility-administered medications for this encounter.
No current outpatient medications on file.

No

ALLERGIES

No Known Allergies

Physical Exam with understanding normal. Abnormal heart with regular abnormal heartbeat yesterday

ED Triage Vital[redacted]

Temperature	Heart Rate	Resp	BP
37.6 °C	**(!) 120**	**18**	**(!) 113/48**

SpO2	Peak Flow	Heart Rate Source	Patient Position
100 %	--	--	**Sitting**

BP Location	FiO2 (%)
Left arm	--

The patient was examined with verbal consent obtained.

General - patient is alert and in no acute distress. Mildly tachycardic.

ED Provider Note Continued:

Cardio - normal S1/S2, with no murmurs or extra heart sounds heard. No significant peripheral edema

Respiratory - clear, with good air entry to both bases with no crackles or wheezes heard. No increased work of breathing

Left breast plus mass present less necrotic. Picture taken. Plus lymph nodes axillary. Minimal tenderness on palpation.

Investigations

Labs Reviewed - No data to display

No orders to display

INITIAL SUMMARY

[redacted]female presenting with Redness / Tenderness, Breast
X 1 year. Concerning for neoplasm. Will get ultrasound plus mammogram plus referral to surgery.

Patient was made aware to follow-up with family physician for ongoing management and should their symptoms persist or change significantly they should seek medical attention urgently.

Note generated using voice recognition software. Errors may exist despite proofreading.

Nursing Notes in ED:

[redacted] ED Notes Date of Service [redacted]
Registered Practical Nurse Signed
Specialty: Emergency Medicine

Signed
PATIENT LEFT BREAST VERY LARGE SWOLLEN, OPEN WOUNDS, BLACK IN COLOUR NECROSIS NOTED WITH PUNGENT ODOUR. PHOTOS TAKEN FOR CHART.

[redacted]

Consult note from Surgery:

[redacted]
Resident
General Surgery

Consults
Attested Addendum

[redacted]

Attested Addendum

Attestation signed [redacted]

Patient reviewed [redacted] with left sided fungating and necrotic breast mass that is most certainly a malignancy. She is tachycardic and anemic likely from the chronic nature of her disease. I will admit her and resuscitate her with blood.

She will need staging done with bone scan, CT chest abdomen pelvis. I will consult oncology in the morning. I have also spoken to [redacted] who has kindly offered to facilitate breast biopsy for tissue diagnosis and receptor status.

GENERAL SURGERY CONSULTATION

Primary Care Provider [redacted]

DATE [redacted]

Reason for Consultation: ?Necrotic breast mass

HPI

1. Patient describes having mammogram 3 years ago which was normal.
2. Over the past year she has noted more bloody discharge and increasing mass size. The mass is not particularly painful but is very itchy.
3. 1 week ago the patient felt to be smelling more by sister and the discharge was more yellowish and bloody.

ROS: no fevers or chills, no night sweats, eating well, no significant weight loss, normal stools, non bloody and no black stools, walking without sob.

Past medical history: none
Past surgical history: none
Meds: vitamin D

Allergies: nkda
Social hx: no smoking, [redacted]ndependent and walks without walker, no rec drugs, no alcohol.
Risk factors for breast cancer:
Famhx: no history of breast cancer

Last Recorded Vitals
Blood pressure **(!) 113/48**, pulse **(!) 120**, temperature 37.6 °C, temperature source Tympanic, resp. rate 18, SpO2 100%.

Physical Exam
Right breast no palpable masses, no discharge, no axillary nodes palpable
Left breast 15cm mass with purulent discharge and nipple displacement, foul smelling. Not easily palpable node (identified on ultrasound)

Investigation [redacted]ammography shown at BIRADS 1 or 2
Ultrasound in ER: left breast BIRADS 5 and enlarged 2.5cm axillary node highly suggestive of malignancy.

Assessment [redacted]with very likely malignant breast cancer with spread to left axillary node. The mass is highly progressed and likely infected, will need staging and operative intervention.

1. Will request patient be seen by breast surgery staff tomorrow to expedite workup. Will place patient on IV antibiotics in interim and will transfuse 1 unit now (patient very anemic with hb 57).

Progress Note General Surgery:

[redacted]
Resident
General Surgery

Progress Notes
Signed

Date of Service: [redacted]

Signed

Discussed with medial oncology today who agreed with our plan for biopsy, CT, bone scan.

They have recommended urgent outpatient referral, as it is difficult for them to weigh in on best systemic therapy without the biopsy results. This referral has been sent off.

Hb this morning in the 60s, repeat transfusion given.

Diagnostic Imaging (Under ED Time)

Breast U/S:

PROCEDURE: US BREAST LEFT

INDICATION: mass

Compared to Previous: Bilateral breast mammography July 2019.

FINDINGS:

There is a large solid mass in the left breast encompassing multiple quadrants measuring 16.8 x 10.6 x 15.3 cm with internal vascularity and areas of cystic/necrotic change
Sonographer note indicates the solid mass protrudes through the skin with open soft tissue wound and leakage.

Enlarged abnormally shaped left axillary lymph node measuring up to 2.5 cm.
Impression:
Sonographic findings are concerning for multicentric locally advanced left breast malignancy with skin involvement. Enlarged likely metastatic left axillary lymph node.
Breast oncology and surgical referral recommended. Further evaluation with bilateral breast mammography and breast MRI suggested. Ultrasound-guided percutaneous sampling advised.

RECOMMENDATION: As above.

BI-RADS CATEGORY: 5 Highly suggestive of malignancy

ED STAY ENDED, NOW INPATIENT:

Nursing Note:

[redacted]
Registered Nurse
Specialty: Emergency Medicine

ED Notes
Signed

Date of Servic[redacted]

Signed

Pt transferred to Mammogram in a wheelchair

[redacted]

[redacted]
Registered Nurse
Specialty: Emergency Medicine

ED Notes
Signed

[redacted]

Signed

Pt to be transferred to OPD for a breast biospy

[redacted]

Consult General Surgery:

GENERAL SURGERY CONSULTATION

Consult order not associated with note.

Primary Care Provider: [redacted]

DATE [redacted]

[redacted] is a [redacted] female seen in consultation today. She is admitted to the acute care service with a fungating left breast mass. [redacted] asked if I would see her to help facilitate a tissue diagnosis. She was admitted from the emergency room where she still resides on a stretcher in the hallway. She was feeling weak and short of breath and went to her family doctor who encouraged her to go to the emergency room. She was found to have a hemoglobin of 57. A fungating, weeping foul-smelling left breast mass was identified. An ultrasound was performed yesterday showing a large mass measuring up to 16 cm with abnormal left axillary node. This was highly suspicious for malignancy. She underwent a right breast mammogram this morning which was unchanged. She is not able to undergo a left breast mammogram due to the nature of the mass.

She has been aware of this breast mass for several years. She did last have a screening mammogram [redacted] At that time she was having some brown nipple discharge with compression of the breast. She reports that last week the breast started leaking. She has had some intermittent bleeding from the skin. She began to feel short of breath with any exertion last week. She has received blood transfusions and feels today much better than yesterday. She has also been started on Ancef.

Past Medical History
She has no past surgical history on file.

Allergies
Patient has no known allergies.

Last Recorded Vitals
Blood pressure 104/68, pulse 70, temperature 37.2 °C, resp. rate 18, height 1.65 m, weight 59.4 kg, SpO2 98%.

Physical Exam
She is alert and oriented and able to converse quite well in English. She is in no obvious distress. She is quite slender. The right breast is unremarkable. The left breast is grossly abnormal. The medial aspect of the left breast appears normal but does feel somewhat indurated. She still has the nipple in place. The lateral aspect of the breast is replaced with a large mass. Most of it is subcutaneous but there are multiple areas of open skin with fungating tumour like tissue protruding. This extends to almost the posterior axillary line. There is areas that have yellow slough. It is very foul-smelling. She does have an enlarged palpable axillary lymph node. She has a visible and palpable enlarged supraclavicular node on the left. There is edema of the lateral chest wall below the breast.

With her consent I did perform a punch biopsy of some of the fungating tissue in the upper outer quadrant. The area was insensate and I did not have to inject local anaesthetic. The tumour was very friable. I took 2 large pieces at the edge of the skin. It bled quite robustly. I placed a 3-0 Vicryl stitch but it did not really hold. I held pressure and placed Surgicel and it did dry up completely. I covered the breast with Bactigras, silvercel and ABD pads.

MAMMO Diagnostic Right

Result Date [redacted]
PROCEDURE: MAMMO DIAGNOSTIC RIGHT INDICATION: mass Compared to Previous: [redacted] BI-RADS Breast Density: CATEGORY D - Extremely dense, which lowers the sensitivity of mammography. FINDINGS: Stable well-circumscribed nodular density in the upper-outer quadrant of the right breast. The left breast could not be imaged due to the fungating mass.

Stable benign nodular density in the right breast sinc[redacted] The left breast could not be imaged

US Breast Left

Result Date [redacted]
PROCEDURE: US BREAST LEFT INDICATION: mass Compared to Previous: Bilateral breast mammography [redacted] FINDINGS: There is a large solid mass in the left breast encompassing multiple quadrants measuring 16.8 x 10.6 x 15.3 cm with internal vascularity and areas of cystic/necrotic change. Sonographer note indicates the solid mass protrudes through the skin with open soft tissue wound and leakage. Enlarged abnormally shaped left axillary lymph node measuring up to 2.5 cm.

Sonographic findings are concerning for multicentric locally advanced left breast malignancy with skin involvement. Enlarged likely metastatic left axillary lymph node. Breast oncology and surgical referral recommended. Further evaluation with bilateral breast mammography and breast MRI suggested. Ultrasound-guided percutaneous sampling advised. RECOMMENDATION: As above. BI-RADS CATEGORY: 5 Highly suggestive of malignancy

Assessment:

[redacted] old female with a fungating left breast mass. This is likely an invasive carcinoma. Less likely it could represent a malignant phyllodes. Given the axillary and supraclavicular adenopathy I do think it is likely a carcinoma. The smell is most likely from necrotic tumour. There may be some superinfected tissue so I think treating with Ancef is reasonable. This could be stepdown to Keflex. She may be anemic from bleeding from the tumour but I would be suspicious for metastatic disease given her presentation and the length of time that she has had this mass. A bone scan and CT scan of the chest abdomen and pelvis have been ordered. Medical oncology has been consulted. Apparently they will see her as an outpatient. I have consulted wound care. Radiologist suggested yesterday she be considered for an MRI breast. I do not think this will add anything. Hopefully this tissue biopsy will provide a diagnosis. If it does not then she should undergo a bedside core biopsy to get deeper tissue.

At this point this is an unresectable tumour. If she does not have metastatic disease and is able to respond to medical management then she may become a surgical candidate in the future.

Thank-you for involving me in the patient's care.

Biopsy Note:

Procedure: Punch biopsy left breast

Anesthesia: local

Operative note:
Patient placed supine on the operating table. The left breast was prepped with Benadene and draped. It appeared entirely insensate so I did not inject local anaesthetic. I used a 5 mm punch biopsy to take large pieces of tissue from an open area in the upper outer quadrant. This bled briskly but slowed with pressure. I did place a figure-of-eight 3-0 Vicryl suture but the tissue was too friable to really hold the suture. I applied Surgicel and held more pressure in the area stop bleeding.

To help deal with the drainage and smell I applied Bactigras, Surgicel, ABD pads and tape to the left breast.

The patient tolerated the procedure well and was given instructions for postoperative care and follow-up.

Pathology:

Result

Tissue Examination [454133722] Resulted: [redacted] Result status: Edited Result - FINAL

Ordering provider: [redacted] Resulting lab: [redacted]

Specimen Information

ID	Type	Source	Collected On
1	Skin, Punch Biopsy	Breast, Left	[redacted]

Comment: ? Ca / necrotic left breast

Components

Component	Value	Reference Range	Flag	Lab
Clinical Information	--	—	—	[redacted]
Result: A. ? Ca / necrotic left breast				
Addendum 1	--	—	—	[redacted]
Result: THE TUMOR IS POSITIVE FOR GATA3, NEGATIVE FOR PAX8, WT1, P16, P63, NAPSIN A PATCHY P53 FAVOR BREAST PRIMARY Addendum electronically signed by [redacted]				
Diagnosis	--	—	—	[redacted]
Result: BREAST LEFT, CORE BIOPSY: INVASIVE PAPILLARY CARCINOMA WITH NECROSIS Electronically signed b[redacted]				
Comment	--	—	—	[redacted]
Result: PRIMARY VERSUS METASTATIC OVARIAN CARCINOMA SUGGEST CLINICAL CORRELATION FURTHER IMMUNO WILL FOLLOW IF BREAST BIOMARKER REPORT WILL ALSO FOLLOW				
Synoptic Report	--	—	—	[redacted]
Result: Breast Biomarker Reporting Template (Added in Addendum) BREAST BIOMARKER REPORTING TEMPLATE - All Specimens Protocol posted: [redacted]				

Pathology Continued:

Synoptic Report	--	—	—	[redacted]

Result:
Breast Biomarker Reporting Template
(Added in Addendum) BREAST BIOMARKER REPORTING TEMPLATE - All Specimens
Protocol posted: [redacted]

Test(s) Performed:
Estrogen Receptor (ER) Status: Positive (greater than 10% of cells demonstrate nuclear positivity)
Percentage of Cells with Nuclear Positivity: 81-90%
Average Intensity of Staining: Strong
Test Type: Laboratory-developed test
Primary Antibody: SP1
Test(s) Performed:
Progesterone Receptor (PgR) Status: Negative (less than 1%)
: Internal control cells absent
Test Type: Laboratory-developed test
Primary Antibody: 16
Test(s) Performed:
HER2 by Immunohistochemistry: Positive (Score 3+)
Percentage of Cells with Uniform Intense Complete Membrane Staining: 90 %
Test Type: Laboratory-developed test
Primary Antibody: 4B5
Cold Ischemia and Fixation Times: Meet requirements specified in latest version of the ASCO / CAP Guidelines
Testing Performed on Block Number(s): A1

METHODS
Fixative: Formalin

Gross Description	--	—	—	[redacted]

Result:
A. Breast, Left.
The specimen labeled with the patient's name and as "breast L" consists of two punch biopsies of pink-tan skin, both measuring 0.5 x 0.5 x 0.8 cm received in 10% buffered formalin.
A1–A2 submitted in toto, 1 core per block

Progress Note Surgery:

GENERAL SURGERY PROGRESS NOTE
06/06/24

ID
[redacted] female
LOS 2

Diagnosis: Neoplasm of breast, female, malignant
Operation: * Surgery not found *
Days Post Op: * No surgery found *

S
- no nausea or vomiting
- tolerating regular diet
- no pain at breast site
- no fevers or chills

O
Vitals
Temperature: [36.4 °C-37.2 °C] 36.4 °C
Heart Rate: [68-101] 81
Resp: [16-18] 16
BP: (103-134)/(49-78) 103/52
SpO2: [96 %-98 %] 97 %
Height: [165 cm] 165 cm
BSA (Calculated - sq m): [0 sq meters] 0 sq meters

Exam
Left breast still purulent discharge, biopsy site no issues, foul smelling, covered with gauze.

IN & OUT
I/O last 3 completed shifts:
In: 706.7 [Blood:706.7]
Out: -

No intake/output data recorded.

A/P
1. Breast neoplasm: Pending CT and bone scan[redacted] has seen and thinks downgrade to keflex is possible. Very likely metastatic disease. Currently for medical mgt. Medical oncology will see as outpatient. Punch biopsy complete yesterday.
2. Anemia: Hb borderline yesterday received 2 units so far. Monitor. Likely from malignancy. Hb 71 today
3. Continue ancef for now, downgrade to keflex on discharge.

Significant Event Note- Surgery Resident:

[redacted]
Resident
General Surgery

Significant Event
Addendum
[redacted]

Addendum
Patient alerted of metastatic cancer diagnosis and that given that the breast cancer has invaded chest wall, patient is not surgical candidate. Patient alerted about plan for medical oncology follow up and likely need for chemotherapy.

1. Attempted to get a hold of sister to discuss diagnosis and disposition planning, unable to reach.
2. Will be sent home in AM
3. Will need home care referral for wound dressings, as specified by wound care nurse. This has been faxed.

Revision History

Discharge Summary:

Admitting Provider: No admitting provider for patient encounter.
Discharge Provider: [redacted]
Primary Care Physician at Discharge: [redacted]

Admission Date: [redacted] Discharge Date [redacted]

Primary Discharge Diagnosis
Likely metastatic left breast cancer

Secondary Discharge Diagnosis
none

Discharge Disposition
Home

Active Issues Requiring Follow-up
Metastatic breast cancer

Outpatient Follow-Up
Pending oncology medicine outpatient

Referrals and Follow-ups to Schedule

Referral to CE Hospital Medical Oncology
Please see urgently this patient with 15cm fungating and possibly infected left breast with severe anemia and positive axillary node
Priority: High
Is patient aware of referral?: Yes
Primary Site: Breast
Has biopsy been completed?: Yes
Location of biopsy: left breast
Has CT been completed?: Yes

DETAILS OF HOSPITAL STAY

Presenting Problem/History of Present Illness
Mastitis [N61]
Mastitis, left, acute [N61]
Breast pain, left [N64.4]

Hospital Course
[redacted]female that presented to [redacted]with an enlarging left breast mass that was gradually becoming more itchy and bleeding and over the past 2 weeks had been more foul smelling. The breast mass was very extensive and was felt to likely be a fungating breast malignancy. She was also found to be very anemic and was transfused several units. She was admitted to general surgery and was placed on IV antibiotics for possible necrotic/infected tissue.

She subsequently had further workup of this likely breast mass with CT chest abdomen pelvis and with bone scan and with a punch biopsy. Unfortunately the patients bone scan did reveal metastatic spread to the bones and her CT showed spread to the lymph nodes and that the tumor had invaded the chest wall making it non-resectable. She will see medical oncology urgently as an outpatient in the coming weeks for consideration of chemotherapy. At the time of discharge she was feeling well and her hemoglobin stabilized. Wound care has provided recommendations for dressing changes and we have arranged for home care for her.

Follow up with family doctor in 1-2 weeks and with medical oncology in 2-3 weeks (once biopsy results are back).

Operative Procedures Performed

Treatments: wound care
Consults: med onc (outpatient pending), wound care
Procedures: punch biopsy
Pertinent Test Results: left breast tissue biopsy

Physical Exam at Discharge
Discharge Condition: well
Heart Rate: 86
Resp: 18
BP: **(!) 111/47**
Temperature: 36.5 °C
Weight: 59.4 kg

Diagnostic Imaging (All under IP Time)

CT Chest Abdomen and Pelvis:

TECHNIQUE:
- Protocol: Volumetric image acquisition through the chest, abdomen and pelvis.
- IV contrast: Yes
- Oral contrast: Yes
- Rectal contrast: No

FINDINGS:

CHEST:

LUNGS (series 204):
Clear of airspace disease with no concerning pulmonary nodule.

PLEURA:
Trace left pleural fluid collection

LYMPH NODES, MEDIASTINUM AND HILA:
Please see below which documents left supraclavicular/left subclavian/left axillary/left chest wall adenopathy

Image 65, 12 mm anterior mediastinal lymph node.
Image 64, 14 mm left internal mammary lymph node

CHEST WALL AND SOFT TISSUES:
Huge heterogeneous mass involving the left lateral breast/left lateral chest wall with extension towards the axillary region. Polypoid projections extending beyond the skin surface which should be clinically apparent. This mass measures at least 16.7 cm in AP dimension, 10.6 cm in transverse dimension, and 12.7 cm in maximal craniocaudal dimension. This abuts and may invade into the left lateral chest wall musculature.

There is bulky adjacent lymphadenopathy, for reference purposes image 78 measuring 2.4 cm
conglomerate nodal mass in the left axilla on image 59 measuring at least 7.3 x 7.2 cm
Image 39, lymph node along the left subclavian chain measuring 2.9 cm
Left supraclavicular lymph node on image 29 measuring 3.2 cm

ABDOMEN/PELVIS:

LIVER (incl portal and hepatic veins):
The liver is unremarkable. There is no portal or hepatic vein thrombosis.

GALLBLADDER AND BILIARY TREE:
Unremarkable

SPLEEN:
Unremarkable

PANCREAS:
Unremarkable

KIDNEYS, URETERS AND BLADDER:
Left renal cyst

ADRENALS:
Unremarkable

STOMACH AND BOWEL:
The stomach and opacified bowel loops are normal in distribution and configuration.

LYMPH NODES:
There is no significant adenopathy by CT measurement criteria within the abdomen, pelvis and inguinal regions.

PERITONEUM/MESENTERY/OMENTUM
There is no omental or mesenteric nodularity or caking. There is no free fluid.

PELVIS:
Unremarkable

AORTA AND MAJOR ARTERIES:
Unremarkable

IVC AND OPACIFIED MAJOR VEINS:
Grossly unremarkable

ABDOMINAL WALL AND SOFT TISSUES:
Unremarkable

BONES:
There are a few scattered nonspecific sclerotic osseous foci. For reference purposes, left pubis on image 291, left ilium on image 245, left ilium on image 235, left anterior third rib on image 74, and the lateral right 10th rib image 170. Also sclerosis T1 vertebra

---
INTERPRETATION:
Huge heterogeneous mass involving the left lateral breast/lateral chest wall. Abutment of and possible invasion into the left lateral chest wall musculature. This mass measures at least 16.7 x 10.6 x 12.7 cm

Extensive regional lymphadenopathy as documented above. This adenopathy is seen left chest wall, left axilla, left subclavian region, left supraclavicular region.

The mediastinum, enlarged lymph nodes are noted along the left internal mammary chain and in the anterior mediastinum

Scattered sclerotic osseous foci which may represent metastatic disease and bone scan correlation recommended

Bone Scan:

Narrative:
CLINICAL HISTORY : Fungating left breast cancer for staging.

Whole body delayed planar images with tomograms of the shoulder girdle, thorax, spine and pelvis were obtained.
Mild mid thoracic scoliosis and moderate thoracolumbar scoliosis were observed with concavity directed to the left and right respectively.

Asymmetric prominently increased size of the left breast was observed with diffusely increased tracer uptake throughout it.

Extensive irregular features of increased tracer uptake were present throughout the spine.
Focal sites of prominence include the right sides of about C3-C4, distal anterior cervicothoracic junction, left sides of T10, T11, right sides of T12, L1, L2 and left sides of L4-L5.
The bodies of T11 and L2 exhibit relative photopenic features

Asymmetric mild prominence of tracer uptake was associated with the inferior right sacroiliac joint.

Nonarticular foci of increased tracer uptake were present in the proximal left 12th rib and mid clavicular line of the left 4th rib, head of the left clavicle, lateral aspects of both humeral heads, anterior border of the right ilium, lateral cortex of the left femoral diaphysis at the junction of its middle and distal thirds, right side of the maxillary alveolar ridge and right mandibular body.

Variable degrees of increased articular tracer uptake were associated with the 1st carpometacarpal joints, sternoclavicular joints, acromioclavicular joints, right hip and knees.

No prior bone scan examination has been performed at LHO for comparative review.

INTERPRETATION :

1. Several focal lesions are visualized and considered suspect for possible underlying metastatic bone disease including the left anterior 4th rib, left proximal 12th rib, head of the left clavicle, bodies of T11 and T12 and possibly anterior border of the right ilium.
2. Extensive multilevel degenerative-type features of the spine in distribution as described above and right sacroiliac joint. Coincident presence of metastatic disease involvement cannot be excluded.
3. Minor bilateral features of supraspinatus tendinitis.
4. Nonspecific minor focal cortical lesion of the distal left femoral diaphysis. Radiographic correlation may assist in diagnostic clarification if clinically indicated.
5. Degenerative articular changes involving the 1st carpometacarpal joints, sternoclavicular joints, acromioclavicular joints, right hip and knees.
6. Dental changes of the maxillary alveolar ridge and mandible.

Mammogram:

PROCEDURE: MAMMO DIAGNOSTIC RIGHT

INDICATION: mass

Compared to Previou[redacted]

BI-RADS Breast Density: CATEGORY D - Extremely dense, which lowers the sensitivity of mammography.

FINDINGS:
Stable well-circumscribed nodular density in the upper-outer quadrant of the right breast.

The left breast could not be imaged due to the fungating mass.
Impression:
Stable benign nodular density in the right breast[redacted] The left breast could not be imaged