vaccine may have been lost [4].

Rubella. Prior to rubella vaccine programmes in developed countries, the peak incidence of the disease was in children 5-14 years of age—now most cases occur in susceptible teenagers and young adults [2]. It is especially important that girls have immunity to rubella during child bearing age, either by contracting the natural disease or by active immunisation. In USA, Australia and Nordic countries, a second dose of MMR is recommended for teenagers for both genders [3]. In our country the priority should be first to protect women of childbearing age and only then to interrupt transmission of rubella by universal immunisation of children (and not the other way round as is being advocated by premature introduction of MMR in UIP). As no programme exists for teenage/adult women immunisation in our country (and not likely in the near future), MMR during infancy should be withheld lest it cause epidemiological shift towards older age group of teenage/adult women leading to increased incidence of congenital rubella syndrome.

Because of above considerations, only measles vaccination should continue during infancy. MMR is like a chess gambit, con-

cealing a lot of dangerous traps and snares [5], which we can ill afford.

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METASTATIC MALIGNANT MELANOMA BREAST-FNAC DIAGNOSIS

Dear Editor,

A 31-year-old wife of a serving soldier presented with a lump in Lt breast outer upper quadrant of 2 months duration. It measured 10 x 10 cms and was hard non-tender and freely mobile. It was rapidly increasing in size for the past two months. Past history of a surgery for a nodular lesion on planter aspect of right foot was obtained. However, no further clinical/histological details were available. USG revealed a lobulated mixed echoic large mass with irregular necrotic areas within. Multiple small rounded lesions were seen surrounding the large lesion. FNAC of lump revealed a brownish aspirate. Giemsa and H & E stained smears revealed a mixed population of epithelioid cells and spindle cells. Epithelioid cells displayed eccentric large nuclei, prominent macronucleoli and nuclear vacuoles. There was also presence of binucleated and multinucleated tumor giant cells. Intra cellular melanin pigment was noticed in most spindle cells better appreciated in Giemsa stain as a brownish-black pigment. An FNAB diagnosis of metastatic malignant melanoma breast was concluded (Fig-1).

Metastasis to breast from an extra mammary site is uncommon. In a large study they have been reported to constitute 0.4 to 2% of all breast malignancies [1]. Agarwal et al [2] reported an incidence of 7.6% for all malignancies of the breast. Malignant melanoma is the most common tumor metastasizing to the breast [3] followed by lymphoma, lung cancer, ovarian carcinoma, soft tissue sarcoma, gastrointestinal tumours and genitourinary tumours. The most common breast metastasis in men is from prostatic carcinoma [4] and in children Rhabdomyosarcoma [5]. Clinically, a breast metastasis usually presents as rapidly growing single firm mass that is usually moveable, non-tender and located more in the left breast in upper outer quadrant [6]. Skin involvement or nipple discharge is usually absent. Mammographically, metastasis to breast usually presents as a rounded well circumscribed discrete dense mass that mimics a fibro-adenoma. However, they usually show indistinct margins that help distinguish them from benign lesions. Microcalcifications and spiculations are absent.

FNAB has proven to be an excellent method for detecting metastatic tumours in the breast and of confirming clinically and radiologically suspected breast metastasis. We think that FNAB must be

Fig. 1: Mixed population of epithelioid and spindle cells with macronucleoli. Intracellular melanin pigment seen in spindle cells.

the first approach to obtain a correct diagnosis because not only it is faster, safer, cheaper and more reliable, but also at times it will be the only proof available and thus avoid unnecessary mastectomy and ensure appropriate chemotherapy and radiotherapy.

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