Letter to the Editor

So-called acinic cell carcinoma of the breast arises from microgladular adenosis and is not a distinct entity

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To the Editor: I recently read the paper in *Modern Pathology*[1] titled 'Genetic analysis of microglandular adenosis and acinic cell carcinomas of the breast provides evidence for the existence of a low-grade triple-negative breast neoplasia family'. It is a fine report of a very elegant study. Unfortunately, in my opinion, the authors fail to draw the most important conclusion from the data.

I studied microglandular adenosis of the breast for nearly 40 years, beginning in 1978 with a case report for the American Society for Clinical Pathology and subsequently evidenced by reference #2 in your paper, published in 1983, in which I provided the first full description of this entity in its benign form.[2] In 1986, I published the first study to demonstrate the origin of invasive breast carcinoma from microglandular adenosis based on the case material I assembled at Memorial Sloan Kettering Cancer Center.[3] My second paper documenting invasive carcinoma arising in microglandular adenosis was published in 1993. In subsequent years, until my retirement in 2010, I continued to see examples of carcinoma arising in microglandular adenosis in clinical practice and, as a result, have probably seen more of these cases than any pathologist living today.

In the course of this experience, I observed that the cytoplasm in some examples of microglandular adenosis and carcinomas arising from it was unusually granular and had other features that I described as 'oncocytic', a characteristic now more appropriately referred to as 'acinic cell differentiation' in view of the properties that have been demonstrated in these cells. This is just one of the many amazing forms of the phenomenon of 'metaplasia', such as bone and cartilage growth, melanin, neuroendocrine differentiation, and even biologically active hormones in choriocarcinomatous differentiation, that can occur in mammary carcinoma.

Since the earliest reports that purported to discover primary acinic cell carcinoma of the breast, it has been my observation from the published material that these were examples of carcinoma arising in microglandular adenosis with acinic cell differentiation. Every case referred to me during consultation as primary acinic cell carcinoma of the breast proved to be carcinoma arising in microglandular adenosis with acinic cell differentiation. Now, your study has shown that microglandular adenosis and so-called 'acinic cell carcinoma' are, to use your words, 'part of the same spectrum of lesions'. In fact, the lesions illustrated in your paper as 'pure' and 'mixed' acinic cell carcinoma have the characteristic growth patterns of carcinoma arising in microglandular adenosis.

THE CONCLUSION I DRAW FROM YOUR STUDY IS THAT SO-CALLED MAMMARY ACINIC CELL CARCINOMA IS IN FACT INVASIVE CARCINOMA WITH ACINIC CELL DIFFERENTIATION ARISING IN MICROGLANDULAR ADENOSIS, a conclusion I have stated repeatedly for more than a decade.

Disclosure/conflict of interest

The author declares no conflict of interest.

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