Langar’s axillary arch; a misleading finding to the physicians and unexpected barrier to the surgeons

Sardar Hassan Arif, Ayad Ahmad Mohammed, Abdulwahid M. Salih, Fahmi Hussein Kakamad

ABSTRACT

Introduction: Variation in the axillary anatomy is of tremendous practical relevance along almost all operations executed in this area. The aim of this study is to report and discuss a case with the axillary arch of Langer. Case Report: A 48-year-old lady presented to the clinic with a right breast mass sized about 3×2.5 cm in the upper outer quadrant for a 6-month duration. The mass was proved to be malignant. During mastectomy and axillary lymph node dissection, an abnormal muscle was encountered that crossed the axilla in front of the axillary vessels and extended from the pectoralis major muscle to the latissimus dorsi muscle. Conclusion: Axillary arch of Langer is a rare but crucial anatomical variation of the axillary region required to be known by every physician and surgeon dealing with pathologies in this region to promote their assessment and dissection skill.

Keywords: Axillary arch, Axillary lymph node dissection, Langer’s muscle, Latissimus dorsi muscle

INTRODUCTION

Variation in the axillary anatomy is of tremendous practical relevance along almost all operations executed in this area. These range from the major procedures like vascular bypass surgeries, axillary dissection and reconstructive procedures to the minimal axillary operations like sentinel lymph node biopsy (SLNB), where accuracy in perceiving anatomical landmarks is crucial [1]. Various small muscles like dorso-epitrochlearis, chondro-epitrochlearis, costo-corocoideus which collectively called axillary arches or Langar’s axillary arch are seldom encountered in the axillary region, and they are regarded as the principle axillary anatomy variation [2]. Although the size of the muscle is not constant, it measures about 0.5-1.5 cm in breath and 7–10 cm in length. It could be singular or multiple fibers [2]. It extends from the coracobrachialis, pectoralis major, or the fascia covering the biceps brachii to the edge of latissimus dorsi crossing the neurovascular bundle of the upper arm [3, 4]. The aim of this study is to report and discuss a case with the axillary arch of Langer.

CASE REPORT

A 48-year-old lady presented to the clinic with a right breast mass sized about 3×2.5 cm in the upper outer...
quadrant for a 6-month duration. The axilla was free of lymph node by examination. The mass assessed by the triple assessment (mammography, ultrasound, and biopsy) and proved to be malignant. There was no evidence of metastatic disease (as proven by PET scan). During the mastectomy, and axillary lymph node dissection, we encountered an abnormal muscle that crossed the axilla in front of the axillary vessels and extended from the pectoralis major muscle to the latissimus dorsi (Figure 1). We excised the slip to gain access to the axilla and proceed to axillary lymph node dissection. The surgery was uneventful, and the patient had no postoperative complications. The pathological assessment revealed invasive ductal carcinoma Grade 3, one out of 11 lymph nodes was involved by the tumor. The tumor was positive for estrogen and progesterone receptors and negative for Her2/neu, and the ki67 were expressed in 10% of the cells.

**DISCUSSION**

The muscular arch of the axilla (axillopectoral muscle, Langer’s axillary arch) can be described as an anomalous muscular slip of the latissimus dorsi muscle. It generally joins the pectoralis major muscle to insert onto the lateral border of the intertubercular sulcus of the humerus, passing medially and anteriorly to the biceps brachii, and coracobrachialis muscles, the axillary artery, and comitant veins, the median, ulnar, and radial nerves and the medial cutaneous nerve of the forearm.

This anatomical variation although certified by Langer in 1864, it was first chronicled by Ramsay in 1795. Despite the fact that contrasting prevalence has been recorded by the anatomists and surgeons, its precise picture has never been confirmed [4–6]. However, the popularity range depends on the population. Numbers can be found in the literature between 1.7% in the Turkish population, and 43.8% in the Chinese population [7, 8]. The frequency of this anatomical variation has never been reported in our country (Iraq) and its prevalence in this region is not known. Jelev summarized the three main characteristics of a typical axillary arch in his literature review; (1) the axillary arch has a constant origin from the latissimus dorsi muscle, (2) the structures surrounding the posteroanterior part of the upper axillary neurovascular bundle from the ventrolateral to the dorsomedial region [9].

Preoperative awareness of this variation is achievable by a history of periodic axillary vein thrombosis, loss of the normal concavity of the axilla, a marked disparity between axillary fullness, the great difficulty encountered in the axillary examination, phlebography and operation [3, 9]. Magnetic resonance imaging (MRI) is a helpful tool to diagnose the axillary arch. It can positively correlate its presence with neurovascular entrapment symptoms. Also, it can assess its anatomic relations [10, 11]. Knowledge about anatomical alterations of the axillary region is very influential for both the surgeon and the physician who want to perform axillary operation or examination. Ligature mistakenly might be applied to the axillary arch of Langer, which if present passes over the axillary vessels and cause an unexpected problem [12].

The axillary arch may be confused for the true lateral margin of the latissimus dorsi muscle. This may guide the operators to go into an area superior to the axillary vein escalating the peril of injury to the brachial plexus and axillary artery.

During sentinel node biopsy, the axillary arch can pose difficulty as it stretches in the hyper extension shifting the nodes into a higher region. Lymphoedema might be precipitated when breast reconstructed using latissimus dorsi myocutaneous flap. For this reason, a division of the axillary arch is necessary if the requirement for this flap is anticipated [14].

**CONCLUSION**

Axillary arch of Langer is a rare but crucial anatomical variation of the axillary region required to be known bay
every physician and surgeon dealing with the pathologies of this region to promote their assessment and dissection skill.

REFERENCES


Submit your manuscripts at www.edoriumjournals.com