FLAME LECTURE: 184

BURNS/BOTELHO 8.13.15

Learning Objectives

- Describe the symptoms and physical examination findings of benign or malignant conditions of the breast
- Demonstrate the performance of a clinical breast exam
- Discuss the steps in the evaluation of common breast complaints
- Discuss initial management options for benign and malignant conditions of the breast
- Prerequisites:
  - NONE
- See also – for closely related topics
  - FLAME LECTURE 185 – Evaluation of Nipple Discharge
  - FLAME LECTURE 186 – Evaluation of Mastalgia
  - FLAME LECTURE 187 – Breast Cancer

This is your patient's biggest concern.

Risk Factors[2]

SLIGHTLY ELEVATED RISK

- Nulliparity or late age of first pregnancy
- Early age of menarche (<12 yrs)
- Late age of menopause (> 55 yrs)
- No breast feeding
- Post-menopausal obesity

MEDIUM RISK

- One 1st degree relative with premenopausal, bilateral or male breast cancer
- High dose radiation to the chest

HIGH RISK

- Age (>65 yrs)
- Cancer syndromes (BRCA1/BRCA2)
- ≥ 2 1st degree relatives with premenopausal, bilateral, or male breast cancer
- High breast tissue density
- Biopsy-confirmed atypical hyperplasia

What else can it be?

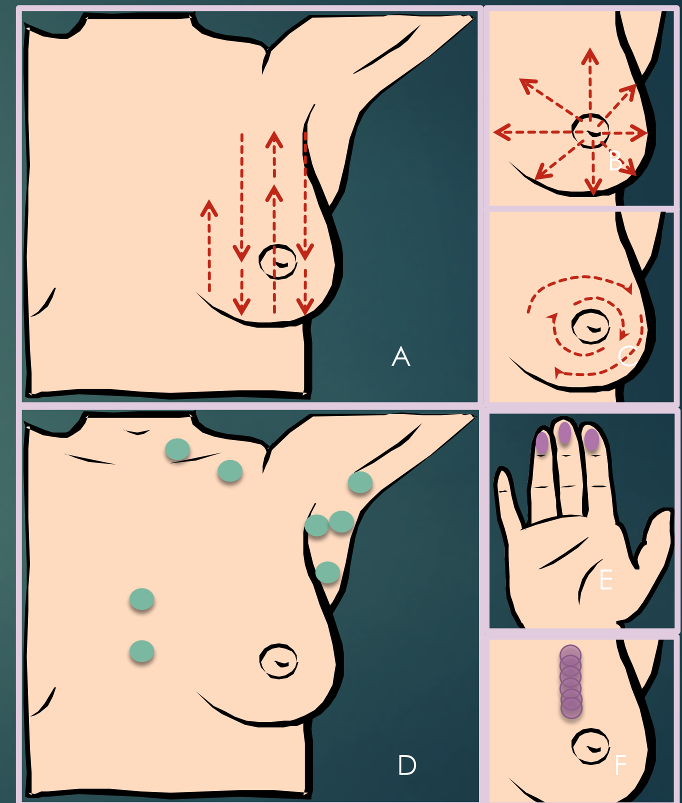
- Dense breast tissue
- Fibrocystic change
- Fibroadenoma
- Obstructed duct/ Lactocele /Galactocele
- Fat necrosis
- Mastitis

How to differentiate and diagnose

- HISTORY
  - Breast lump history:
    - Change over time or relative to menses?
    - Pain, swelling, redness, discharge, warmth?
  - Is the patient taking hormonal medications?
  - Is the patient breastfeeding?
  - History of prior masses, biopsies, abnormal imaging
  - Family history of breast disease
- PHYSICAL EXAM – Clinical Breast Exam
  - See FLAME LECTURE 7- The basic OBGYN Exam: Breast
  - Reassuring signs: Well circumscribed, small, mobile, tender
  - Concerning findings: Fixed, hard, irregular borders, erythematous, dimpling/ retraction

Screening Tools

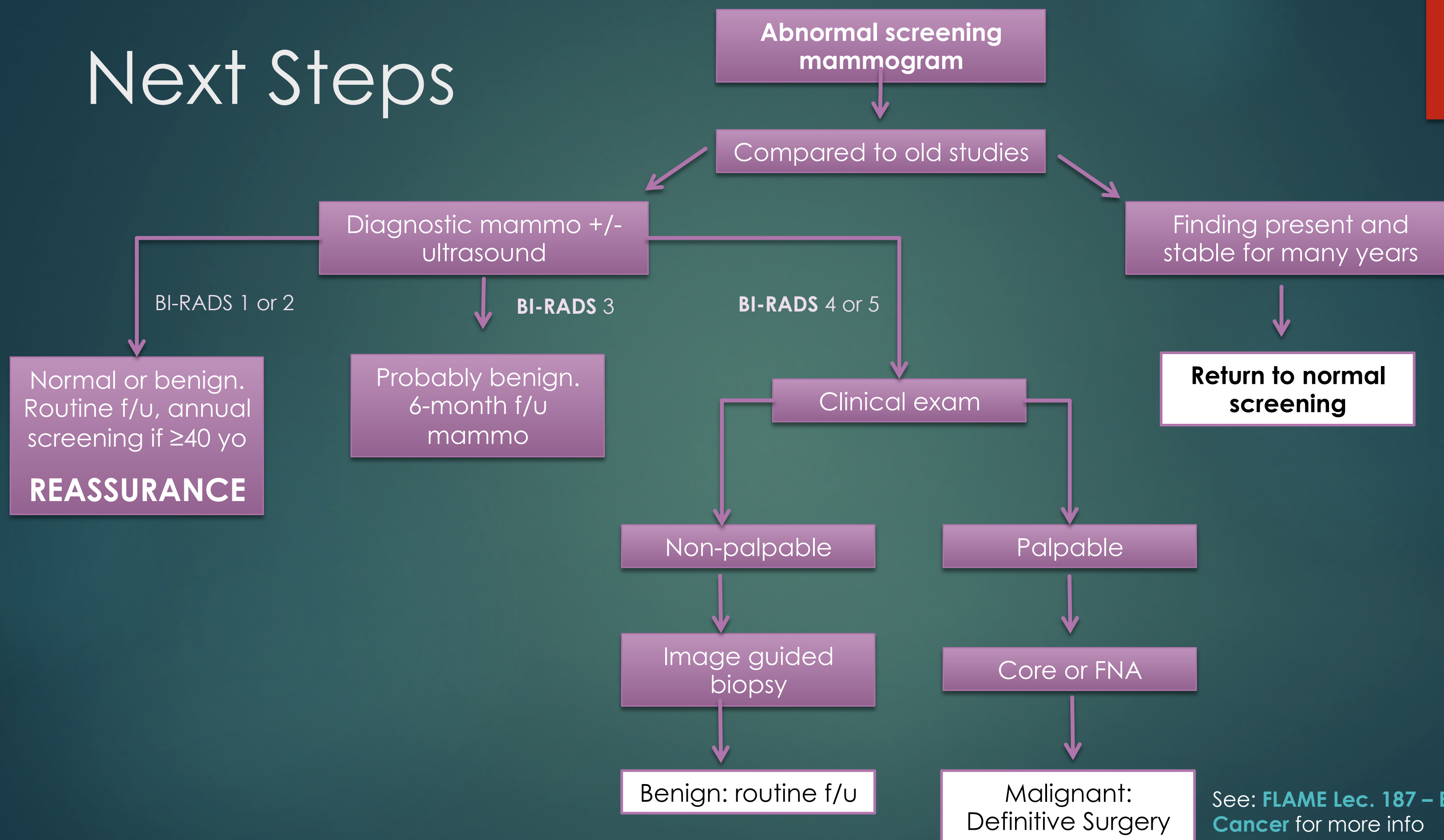
- Clinical Breast Exam (CBE)
  - CBE alone in women >40 yo has cancer detection rate of 59%[3]
- Mammogram
  - DIAGNOSTIC (not screening)
    - Cancer detection rate: Digital 59% vs Films 38%[4]
- Breast Ultrasound
  - Used in younger patients <30 yo
  - Useful in patients with dense breast tissue
  - May help distinguish cystic vs solid masses
  - Inconclusive mammogram findings
- MRI for high risk pts only
  - >20% risk on risk calculator



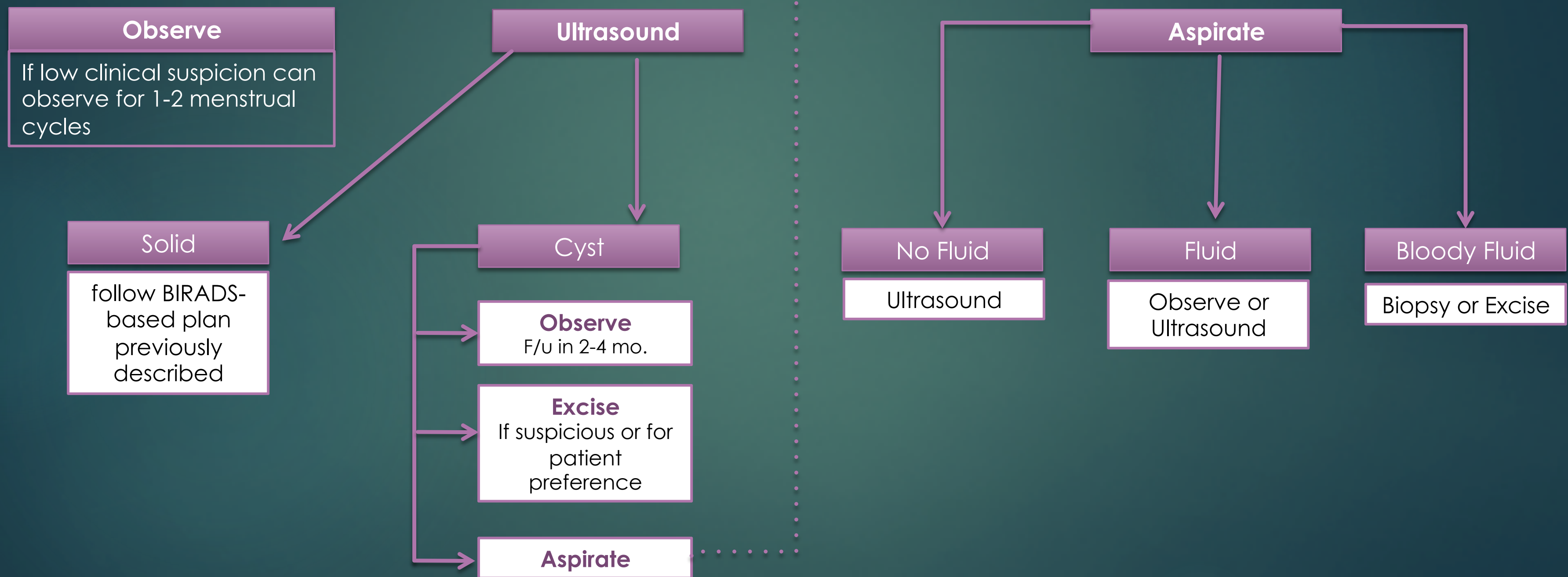
BIRADS Assessment System

Numerical interpretation of screening imaging results (mammo, US, MRI)

- **BIRADS 0** – Incomplete exam
  - Not enough information from views available; Repeat imaging is required
- **BIRADS 1** – Negative
- **BIRADS 2** – Benign Findings
  - Routine follow up
- **BIRADS 3** – Probably Benign
  - Likelihood of malignancy <2%
  - Followed at shorter intervals for stability
    - usually q6m x 1-2 years unless category is changed to more definitive finding
- **BIRADS 4** - Suspicious
  - Likelihood of malignancy 2-94%
    - 4A (2-9%)
    - 4B (10-49%)
    - 4C (50-94%)
- **BIRADS 5** – Highly Suggestive
  - Classic malignancy with 95-100% likelihood
- **BIRADS 6** – Biopsy Proven Malignancy


Next Steps
Abnormal screening mammogram
Compared to old studies
Diagnostic mammo +/- ultrasound
Finding present and stable for many years
BI-RADS 1 or 2
BI-RADS 3
BI-RADS 4 or 5
Return to normal screening
Normal or benign. Routine f/u, annual screening if ≥40 yo
REASSURANCE
Probably benign. 6-month f/u mammo
Clinical exam
Non-palpable
Palpable
Image guided biopsy
Core or FNA
Benign: routine f/u
Malignant: Definitive Surgery
See: FLAME Lec. 187 – Breast Cancer for more info

Options in Younger Women (<30yo)



Follow up and Management

- Follow up screening per recommendations based off BIRADS findings
- Consider biopsy or excision
- Consider referral to Breast Oncology
  - NCCP Referral Guidelines on next slide
- Symptom management for benign condition as appropriate (warm compresses, NSAIDs)

REFERRALS FOR SUSPECTED BREAST DISEASE

Patient presents with

URGENT REFERRALS	EARLY REFERRALS	ROUTINE REFERRALS
• Discrete breast or axillary lump (unilateral, distinct, separate mass in patients over 35 years) • Ulceration • Skin distortion • Nipple eczema • Recent nipple retraction or distortion (less than 3 months) • Blood-stained nipple discharge • Patients with an acute abscess should be referred immediately to the next available breast clinic	• Inflammation that persists after antibiotics • Persistently refilling or recurrent cyst • Unilateral discharge (not blood-stained) • Intractable pain that does not respond to reassurance or to measures such as wearing a well-fitting bra, or a 3 month course of evening primrose oil or common analgesic drugs • Discrete lump in women under 35 years • Asymmetrical nodularity that persists at review after menstruation	A patient whom the referring doctor considers to require a specialist opinion or investigation at the specialist breast centre but where there is no clinical concern about breast cancer e.g. • Minor or moderate degrees of persistent breast pain • Persistent bilateral nipple discharge (not blood-stained) *While 12 weeks is the standard, we aim to see patients sooner.*
URGENT REFERRALS *(to be seen within 2 weeks)*	**EARLY REFERRALS** *(to be seen within 6 weeks)*	**ROUTINE REFERRALS** *(to be seen within 12 weeks)*

IMPORTANT LINKS / REFERENCES

1. ACOG Practice Bulletin 122 – Breast Cancer Screening
2. UpToDate
3. National Breast and Cervical Cancer Early Detection Program
4. Oslo II Study
5. NCCP Referral Guidelines

Risk Calculators:

1. Gail/NCI Model (>35yo only): http://www.cancer.gov/bcrisktool/
2. Patient Friendly/Educational Calculators:
   - http://www.brightpink.org/knowledge-is-power/assess-your-risk/
   - http://canceraustralia.gov.au/affected-cancer/cancer-types/breast-cancer/your-risk/calculate