MANAGEMENT OF BENIGN BREAST DISEASE
The gynecologist’s point of view

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How difficult this topic is!

- Choosing therapeutics is really specific for everybody.
- Are the same guidelines for the surgeon, the gynecologist and the oncologist?
- There is no absolute rule, except when there is a doubt: It is mandatory to perform a surgical and pathological control.
We have to take in account

- Circumstances that have permitted to discover the lesion: a lump, a cyst, microcalcifications, an abnormal pattern in a mammogram and/or ultrasound.

- Age

- Background
  - Family: a breast cancer of mother, sister etc...
  - Personal: previous breast disease (pathology?)
  - a breast cancer in the past
• MRI is very useful

  It allows selection
  sensitivity ++ >> specificity

  Howser it lacks sensitivity for:
  . Micro-calcifications
  . Very small lesions ≤ 5 mm

• Type of lesion to be found and by what means
  a hierarchy of security is useful, without obligation (eclectic choice)

  SO:

  cytological punction < microbiopsy < macrobiopsy (mammotom)
  < surgery with clip (helped by ultra sound or mammogram)
MANAGEMENT

A Cyst

Asymptomatic (Discovered by palpation) and/or ultrasound

Voluminous and/or painful

Punction and empty the liquid in the cyst

Chemical hormonal analysis are not necessary

Punction and cytology

No recurrence = the cyst is cured

Usual follow up

If clinic and ultrasound show no suspicious lesion

No treatment (follow up)

Surgery

▪ the cyst occurs again quickly
▪ bloody liquid
▪ a remaining mass is present
▪ cyto/mammogram/U.S abnormal

▪ Punction
▪ cytology

▪ Chemical hormonal analysis are not necessary

▪ Usual follow up
UNCERTAIN DYSTROPHY

Clinical findings =
- mammogram
- ultrasound
- with Doppler
- analysis of vascularization
- MRI (last but not least)

Localized imaging with compression, magnification, numerisation

No perceptible mass
- Punction and/or microbiopsy
  - with mammogram or ultrasound guide

Surgery is readily indicated with spotting of the lesion if needed

A perceptible mass
- Cytopunction
- Microbiopsy
- Macrobiopsy

Surgery or not according to results
TREATMENT OF BENIGN BREAST DISEASE (BBD)

► Médical treatment
  major BBD
  painful, annoying
  changeing patterns
  - No Hormone
  - Punction taking off the liquid
  - Psychotherapy
  - light compounds
    Mg. Ca
  - Angiotonic drugs
  - Antiinflammatory compounds

► Abstention
  silencious BBD
  follow up
  - Hormone
  - Progestins
    - Nortestosterones
    - Norpregnanes
    - 17OH compounds
    - various modalities
      - 16 – 25 d
      - 11 – 25 d
      - 5 – 25 d
      - continuously

► Surgery
  not too often
  - clinical survey every 6 months
  - mammogram every 18 to 24 months
  - ultra sound
TREATMENT OF BENIGN BREAST DISEASE (b) (BBD)

**SURGERY**

- **Prophylactic**
  - it is rare indication for
  - **High risk women**
    - family
    - genetic BRCA1
    - BRCA2
  - white high and/or heterogenous density in breasts
    - Mastectomy
      + Plastic reconstruction

- **Necessary**
  - for suspicious lesions
    - Nevertheless
      - one must avoid repeated operations
        - useful for pathological finding according to
          - W. Dupont & D. Page criteria
But nowadays

Of paramount importance

- microbiopsy
- macrobiopsy (mammotom)

\[
\begin{cases}
\text{helped by image} \\
\text{(mammogram,} \\
\text{Ultra Sound, MRI)}
\end{cases}
\]

1. BBD

- Without proliferation
- With proliferation without atypia
2. **BBD** with proliferation with atypia

**A. DUCTAL**

- We have to recognize in situ carcinomas
  
  - atypical hyperplasia (AH)
  
  - micro invasive carcinomas

- So, if micro or macrobiopsy = AH
  
  - A surgical procedure is mandatory
    
    (helped by the clip)
  
  - to confirm or not AH

- If AH is confirmed
  
  - with complete ablation (see margins)
  
  ↓

  - follow up (clinic, mammogram, U.S, MRI)
B. LOBULAR

atypical hyperplasia (AH)

- Idem. Distinguishing in situ lobular carcinomas
  micro-invasive carcinomas

Your attention!
The lesions are frequently bilateral
(so follow up carefully the opposite breast)
If,
  - AH → follow up
  - Intra-lobular carcinomas
    2 diametrically opposite managements
    for precancerous lesions

taking in account what
the patient wishes

follow up or bilateral
mastectomy (+ reconstruction)
Important reminder

- Relative risk (RR) of AH for Breast Cancer (BC)
  - X 4,5
  - X 9 if there are BC in the family (especially mother, sister)
    Dupont & Page NEJM 1985

- The RR persists will duration of time > 10 years
  Dupont & Page → Hartmann ⇔ NEJM 2005

- Presently: the entity of atypical cylindric hyperplasia
  → a surgical control is needed
At last, genetic risk for breast cancer, ovarian cancer

**BRCA1, BRCA2**

one must be very cautious

**a proposal for prophylactic bilateral mastectomy**

(to discuss with the patient and her family and to obtain an informed consent)

Medical prevention (Tamoxifen, Raloxifene) not authorized in France.
Is there a real medical treatment of BBD
May be ........ But ........

- In the majority of cases: NOTHING - reassure
  - follow up
- Psychotherapy
- Punction of voluminous and/or painful cysts
- No hormonal prescriptions (see above)
- Hormonotherapy
  - be cautious with Progestins: heads and tails

Fabre A and Al : B.J.C 2007
2 paramount problems

- Hormonal contraception (HC)
- Hormonal treatment for menopause (HTM)
HORMONAL CONTRACEPTION

Yes, ....however

It has been ascertained that pills will a progestagen climate are preferable

- **Micro pills** - No
  - induce iatrogenic luteal deficiency in half cases

- **Pills will a dominant progestagen climate**
  - In fact, sometimes → mastodynia (Norsteroïds activate ER)

- **Choosing pills of 3rd generation** small doses of EO
  - $\leq 20\mu g / pill$

- **Epidemiological studies concerning HC and BC**
  - (cohort, case control)
  - pill = guiltless

  M. Le  Reproduction et Hormones 1999
HORMONAL TREATMENT FOR MENOPAUSE (HTM)

Yes, ....... however

- **Estrogen + Progestins**
  
  RR of BC slightly increased \(\uparrow\) 1.2 to 1.6
  
  (for a treatment duration \(\geq\) 5 years)

- **But, W Dupont and D. Page 1999**
  
  No significant increase of RR (9,903 women) followed during a mean of 20 years) in BBD (A.H included)
  
  but it was premarin alone 0.625 mg / day

- **Studies WHI & One Million Study** → nothing concerning BBD

- **No study about E2 + natural progesterone** concerning BBD
  
  Nevertheless, the study of F. Clavel is reassuring
So, HTM

My opinion: Yes, but caution!

I believe that HTM may be prescribed in this circumstances, but that it is very important to explain women that the basal risk is increased and that it is no more increased by HTM
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