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 pathologycal control.

We have to take in account

- Circumstantes witch have permitted to discover the lesion a lump, a cyst - microcalcifications, an abnormal pattern in a mammogram and/or ultra sound.

- 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 <u>selection</u>

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 ultra sound

No treatment
(follow up)
If clinic and ultra sound
show no suspicious lesion

Punction and cytology

No recurence
= the cyst is cured

Usual follow up

Voluminous and/or painful

Punction
and emply the liquid in the
cyst

cytology
Chemical hormonal analysis
are not
necessary

if

- **the cyst occurs again quickly**

Or

- **bloody liquid**

Or

- **a remaning mass is present**

Or

- **cyto/mammogram/U.S abnormal**

Surgery

UNCERTAIN DYSTROPHY

Clinical findings =

mammogram
ultra sound
with doppler
analysis of vascularization
MRI (last but not least)

localized imaging with compession,
magnification, numerisation

no perceptible mass

Punction and/or microbiopsy

with mammo or ultra sound
guide

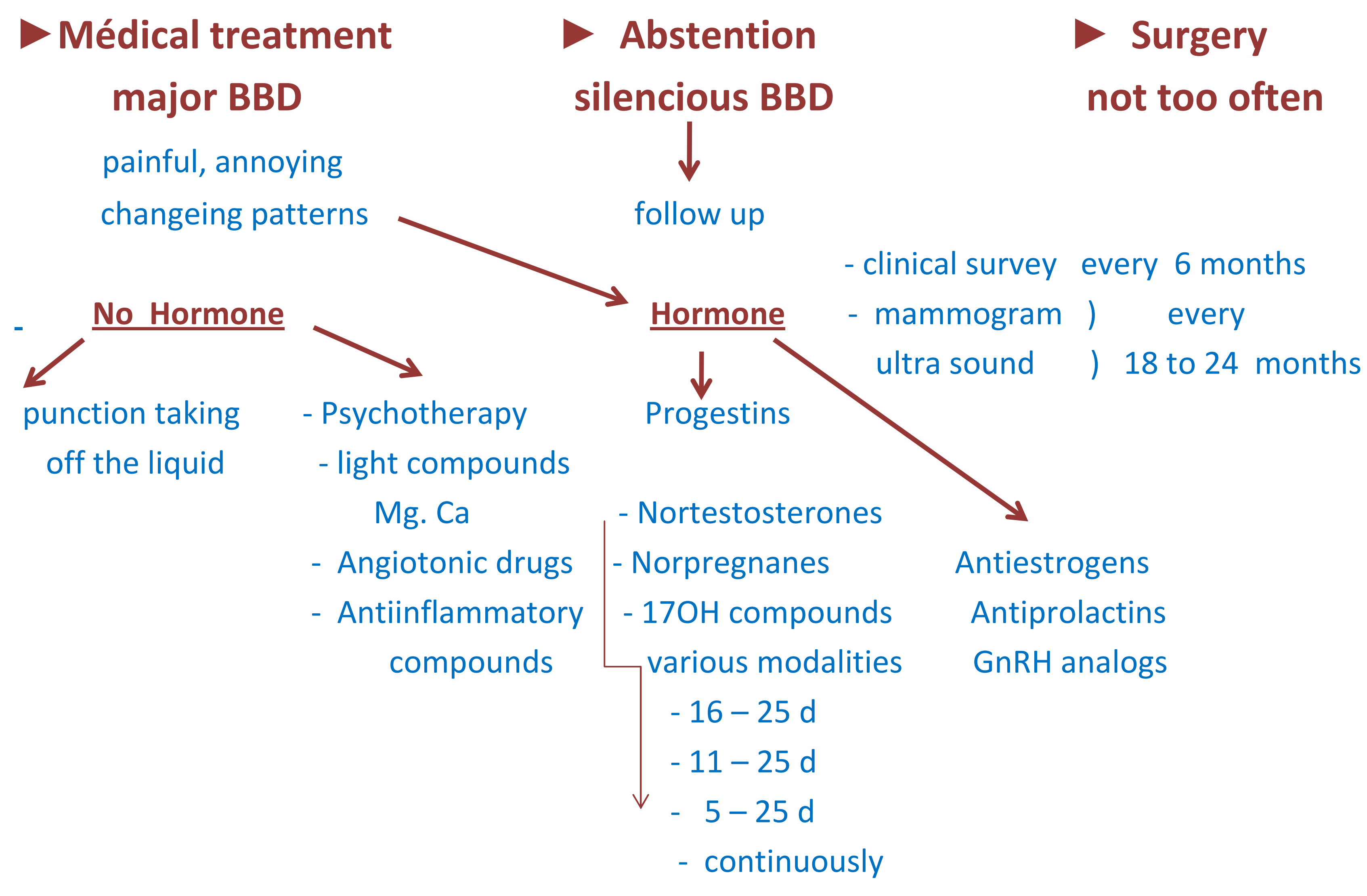
**surgery is readily indicated
with spotting of the lesion
if needed**

a perceptible mass

cytopunction
microbiopsy
macrobiopsy

surgery or not according to results

TREATMENT OF BENIGN BREAST DISEASE (a) (BBD)



TREATMENT OF BENIGN BREAST DISEASE (b) (BBD)

SURGERY

- **Prophylactic**

↓

it is rare indication
for
Hight risk women
- family
- genetic BRCA1
BRCA2

Whit 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)

} helped by image (mammogram, Ultra Sound, MRI)

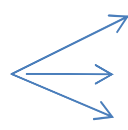
1. **BBD**

- Without proliferation
- With proliferation without atypia

} follow up

2. <u>BBD</u> with proliferation with atypia

A. <u>DUCTAL</u>

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

- Idem. Distinguishing
  - atypical hyperplasia (AH)
  - in situ lobular carcinomas
  - micro-invasive carconomas

Your attention !

The lesions are frequently bilateral

(so follow up carefully the opposite breast)

If,
- AH → follow up
- Intra-lobular carcinomas

2 diametrally 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 atypial 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, Raloxifen) 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 cautions 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**

  ≤ 20µg / 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 ↗ 1,2 to 1,6

  (for a treatment duration ≥ 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 circonstances, **but that it is very important to explain women that the basal risk is increased and that it is no more increased by HTM**

Conflict of interest disclosures

the Author

made no disclosure