Benign Breast Conditions

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Breast Expert, CBCP
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- U of A Family Medicine 1996
- 2011 Special Interest in Breast Medicine designation, CP&S
- 2012 – 15, Breast Expert, Comprehensive Breast Care Program

Faculty/Presenter Disclosure

- **Faculty: Kimberley Kelly**

- **Relationships with commercial interests:**
  - **Grants/Research Support:** Not applicable
  - **Speakers Bureau/Honoraria:** Not applicable
  - **Consulting Fees:** Not applicable
  - **Other:** Not applicable

Comprehensive Breast Care Program

- Referral program for family docs
- Collaborative program of AHS and Covenant Health
- Edmonton program initiated in Oct. 2007

Stats Oct./14

- Patients seen in program since Oct. 2007

  13 597

- Patients with Breast Cancer

  6 060 (45%)

- Patients with Benign

  7 537 (55%)

Alberta Health Services | Covenant Health

Comprehensive Breast Care Program (CBCP) Referral Form

Please print clearly and use dd-mon-yyyy for all dates.

Referral Source (Who is referring this patient?)

- ☐ Patient's Family Physician
- ☐ Other Family Physician (locum, etc)
- ☐ Radiologist / DI
- ☐ Surgeon
- ☐ Cancer Centre
- ☐ _____

Alternate Contact

☐ Yes ☐ No

Relationship to patient: _____

Phone: _____

Patient Info (cover with patient label if label provides all info)

PHN / ULI: _____

Birth Date: ____ - ____ - _____ (dd - mon - yyyy) Gender: ☐ F ☐ M

Name: _____ (last / first / middle)

Address: _____

City: _____ Postal Code: _____

Phone: (h)_____ (alt)_____

Information about Referral Source

Name: _____

Phone _____ Fax _____

Address: _____

Postal Code: _____ Prac ID: _____

Information about Family Physician

Name: _____

Phone _____ Fax _____

Address: _____

Postal Code: _____ Prac ID: _____

Service(s) Requested

☐ DI Workup

In the event DI results are normal, would you like a referral to a medical breast expert?

☐ Yes ☐ No

☐ Surgical Consult Referral ☐ Patient Education/Info

☐ Patient Psychosocial support ☐ Medical Breast Expert (Specialist)

Criteria for Diagnostic Imaging and Triage

☐ Lump or thickening ☐ Localized, significant pain

☐ Nipple discharge ☐ Dimpling

☐ Bloody ☐ Skin changes

☐ Non-bloody ☐ _____

Referral Source's Estimate of Cancer Risk:

☐ Low ☐ Medium ☐ High

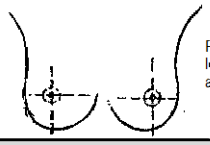
☐ Known cancer diagnosis } If ☑, **is patient aware of cancer diagnosis?** ☐ Yes ☐ No

Most Recent Breast Study (if known)

Date: *(dd-mon-yyyy)*	Location/Site

Location of Abnormality

Right Breast	Left Breast
☐ Axilla	☐ Axilla
☐ Nipple	☐ Nipple
☐ ____ o'clock	☐ ____ o'clock
☐ Other _____	☐ Other _____



Please mark location(s) of abnormality.

Special Issues and Requirements (please specify)

Breast implants ☐ Yes ☐ No ☐ Unknown

Family history of: ☐ breast cancer ☐ ovarian cancer

- ☐ Patient has been diagnosed with cancer previously.
- ☐ Allergies: _____
- ☐ Anticoagulant(s): _____
- ☐ Oxygen-dependent
- ☐ Visual impairment
- ☐ Hearing impairment
- ☐ Cognitive impairment
- ☐ Interpreter required (language: _____)
- ☐ Mobility limitations: _____
- ☐ Other: _____

Other Comments (if known)

- ☐ Patient's family physician cannot access Netcare and requests fax of results to (____) _____
- ☐ Return results via _____ PCN
- ☐ _____

Thank you for referring your patient to this program.

November 2010

Please FAX completed form to (780) 643-4488 or Phone: (780) 638-CBCP (2227)

Purpose

- To offer timely, consistent, accessible care to individuals with abnormal breast changes (including suspected Breast Cancer)

Objectives:

- How to diagnose and manage:
  - breast pain
  - nipple discharge
  - fibroadenoma/fibroadenomata
- What to do if a new nodule is found with negative imaging?
- Discussion:
  - management of women w/ dense breasts

Breast Pain - types

- Cyclical
- Chest wall
- Surgical – uncommon

- Prevalence: 70% of women at some time in their life
- **RARELY** a symptom of breast cancer

Breast Pain - Dx

- Examine patient on their side – anterior axillary line
  - Indicates if chest wall pain
- Examine breast tissue also while on side
  - Opportunity to educate on origin of pain

Breast Pain - Tx

- Education and reassurance
- Heat, bra +/- (chest wall pain)
- Voltaren Emulgel ("**off-label**")
- oral acetaminophen or ibuprofen
- Flaxseed 25 grams daily in muffin
  - Small study

Breast Pain - Tx

- Oral contraceptives
  - May relieve or cause cyclic pain
- Amitriptyline 10 mg qhs (3rd or 4th line)
- Lifestyle factors
  - Physical activity, healthy diet, stress relief

Breast Pain - Tx

- Placebo response **40%!!** (cyclical pain)
  - Vitamin B6
  - Evening of Primrose Oil
  - Decreased caffeine

Breast Pain – clinical pearls

- These patients are “repeat customers”
- First thought women have is BREAST CANCER
- Often years between bouts
- All ages

Nipple Discharge

- Prevalence approximately 10%
- 95% benign cause:
  - Duct ectasia (dilated, walls thicken, duct fills with fluid)
    - Often noted on U/S report

Nipple Discharge – benign causes

- Intraductal papilloma (may resolve on own)
- Galactorrhea *see next slide
- Fibrocystic breasts
- Hormone imbalance
- Medications

Galactorrhea

- Persistent milky discharge from 1 or both
- Causes: LOTS!
  - medications (antihypertensives, antidepressants, antipsychotics, BCP)
  - cocaine, herbs
  - prolactinoma, hypothyroidism
  - nipple stimulation, chronic kidney disease
  - IDIOPATHIC

Nipple Discharge – When to REFER?

- Worrisome findings:
  - Unilateral breast
  - 1 duct
  - Spontaneous
  - Persistent
  - Bloody
  - Associated mass

Nipple Discharge – clinical pearls

- Reassurance
- Stop squeezing!!
- Refer if worrisome signs
- Consider b/w and imaging but hx alone is often sufficient
- Rechecking patient in 3 to 4 months is usually the only management necessary

Nipple Discharge – clinical pearls

- Path slide/guaiac NOT helpful
- If due for mammogram, do
- If any worrisome signs, also get U/S

Patient Scenario – new nodule

- Ms. PS, 45 year old woman
- Presents to you with a new lump RLOQ of 6 weeks duration, possible growth, mild tenderness, glandular breasts
- Periods irregular x 6 months, unsure if hot flushes
- Family history: mother had breast cancer diagnosed at 55 years, 2 sisters OK

Ms. PS

- Risk factor assessment:

Ms. PS – risk factor assessment

- AGE: 45
- Lump for 6 weeks, possibly growing
- Family history: 1 first-degree relative with post-menopausal Breast Cancer
- Tenderness?
- Irregular periods?
- HRT?
- RLOQ?
- Breast Density? (glandular breasts)

Ms. PS

- Physical exam:

Ms. PS – physical exam

- Physical:
  - Firm nodular area R 7 o'clock, approximately 2 cm, not fixed, not distinct borders but also not irregular borders
  - Plaques of nodular tissue UOQs
  - No axillary or H+N nodes
  - Skin: no dimpling, no masses
  - Symmetrical breasts
  - Nipples and areolar complexes normal
  - Left breast no findings

Ms. PS

- Imaging?

Ms. PS - imaging

- Diagnostic Bilateral Mammogram
  - Baseline – no evidence of malignancy
- Bilateral U/S
  - Subcentimeter cysts scattered t/o bilaterally, nothing seen on imaging that corresponds to R 7 o'clock

Ms. PS

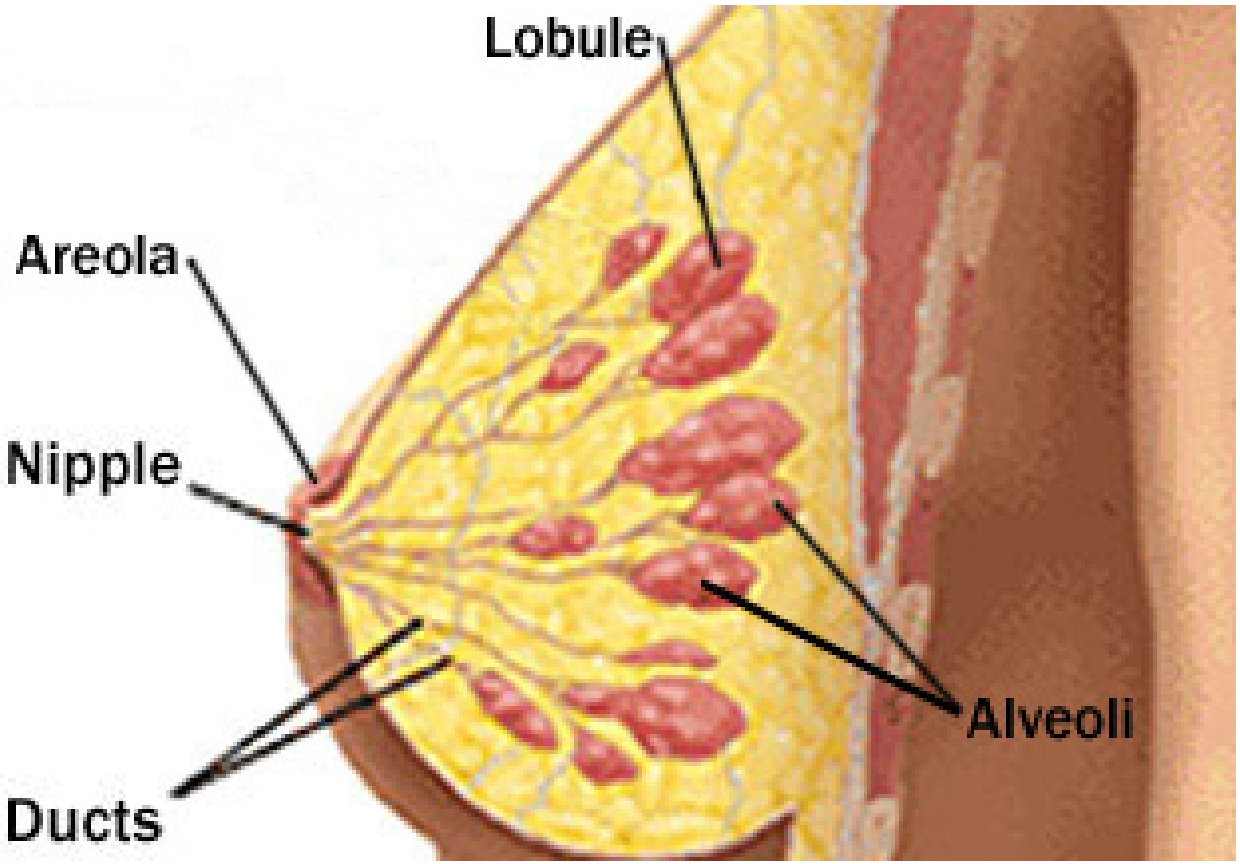
- Management?

Ms. PS - management

- SURGEON for excisional biopsy
  - Need tissue diagnosis
- Prior to imaging, could attempt office FNA

New Nodule

- What could it be?
  - Fibroglandular Tissue
  - Cyst
  - Fibroadenoma
  - Cancer



Risk Assessment – risk factors

- **Not modifiable**
  - AGE
  - Breast Density
  - Gene mutation
    - Of women with Breast Ca, 1 -2 % have BrCa1 or BrCa2
  - Lifetime estrogen & progesterone exposure

Risk Assessment – risk factors

- **Modifiable**
  - Healthy lifestyle
    - Weight
    - Physical activity
    - Nonsmoker
    - Low alcohol
  - Hormone replacement therapy
    - Combo E/P
    - +15% after 5 years, baseline after 2 years D/C

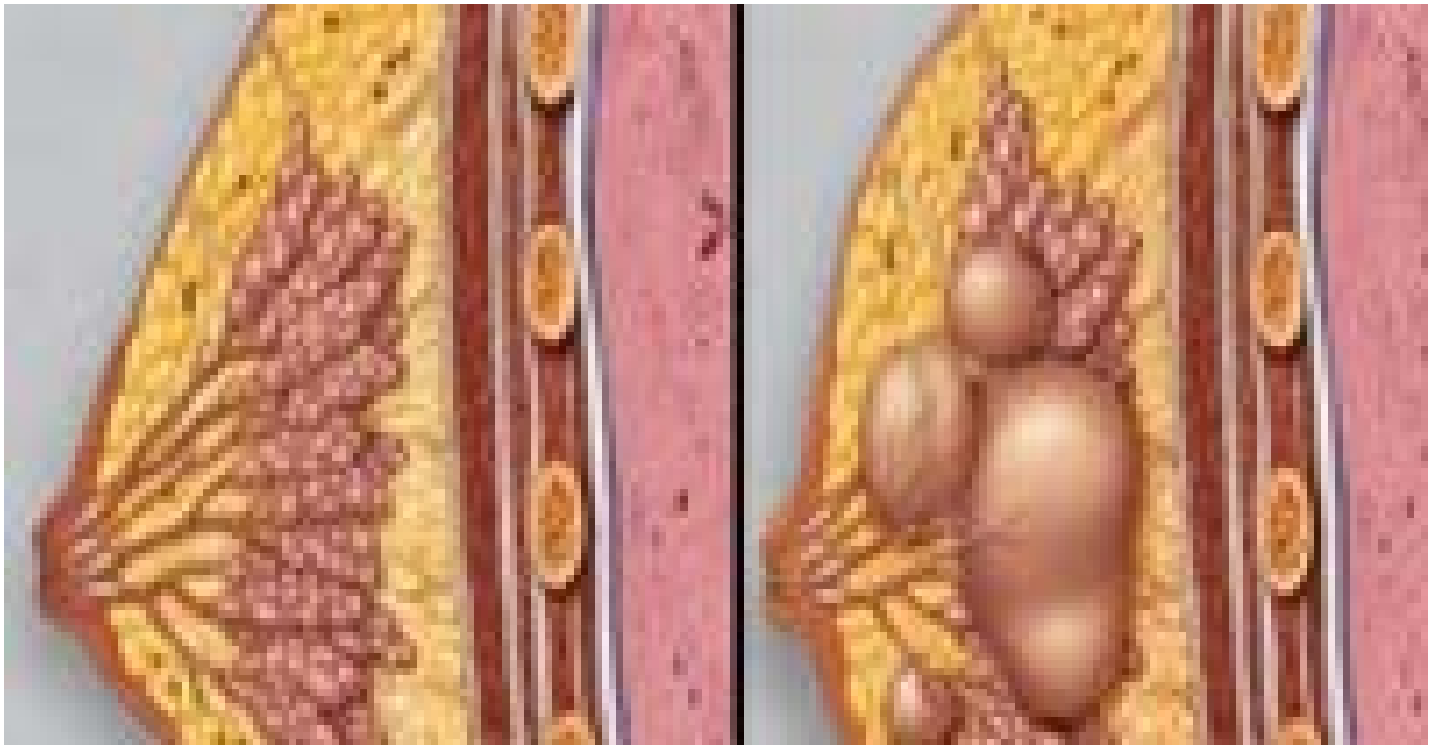
New Nodule – normal breast architecture

- Fibroglandular tissue
  - Waxes and wanes
  - Younger women
  - May be tender
  - Often similar feel in contralateral breast
  - Recheck 4 – 6/52
    - Theoretically, day 7 to 10

New Nodule - cyst

- Common (50 – 90% prevalence)
- 35 – 55 years
- Tender
- Soft??
- Sudden occurrence
- Similar to past episode
- Often disappear
- FNA for dx in office – 10 cc syringe, 22 G
- Consider U/S

Breast Cysts



New Nodule - fibroadenoma

- Fibroadenoma (10% prevalence)
  - Firm, painless
  - Solid lump made of fibrous tissue and gland cells that have multiplied faster than usual
  - Family hx
  - 15 – 35 yo
  - Fast growing – remove, stable - leave
  - ULTRASOUND for dx

Fibroadenoma – clinical pearls

- 25 + get tissue diagnosis
  - core biopsy
    - Largest that's representative OR
    - Most atypical OR
    - Something on physical is odd or discordant eg. 70 yo with new FA
- If growing, do excisional bx
- Bx if > 2.5 cm

New nodule - CANCER

- MAMMOGRAM for dx
- +/- Ultrasound
- **FOLLOW-UP CLINCALLY**

Mammograms

- Gold std for breast cancer screening
- Xray of the breast, very low doses of radiation
- Up to 40% mortality reduction rate
- 45% of women 50 – 69 did not receive a screening mammogram
  - (AB stats, Jan./10 – Dec./11)

MRI

- Not for routine screening
- High false +ve rate
- Consider referral to CBCP

Tomosynthesis

- Uses x-rays to create a 3-D image of the breast, hundreds of views, slice 1mm sections
  - Pros: good for dense breasts, reduces overlapping of tissue
  - Cons: increased reading time, double the radiation dose, cost
- OVERALL: Not good for screening

Dense Breasts

- Clinically difficult dense breast is often NOT dense on mammogram
- For general population, consider U/S for clinically difficult dense breasts
- Consider tomosynthesis

Patient DI - Hx

- 37 yo
- G3 P1, 13.5 yo daughter
- FH –ve for breast and ovarian cancer
- Regular periods
- Pt noticed lump L12 adj to areola, pea-sized
- 3/12 and slightly growing, not tender

DI – Hx

- Similar nodule L breast 10 o'clock 2012 which eventually resolved
- L mammo and U/S from 2012, 8 mm superficial lesion thought to be an obstructed Montgomery's gland or sebaceous cyst
- No sx/signs of breast infection

DI - Px

- Symmetrical breast tissue
- No axillary or H+N nodes
- N+A normal
- Nontender 0.5 cm soft nodule L12 adj to areola
- In sitting position, this tissue feels quite different than contralateral left breast
- “Feels glandular” and “benign”

DI - Imaging

- BM June/14 – compared to 2012 mammo
  - Moderately dense FG tissue which limits mammo sensitivity
  - No spiculated mass, architectural distortion, or suspicious clustered microcalcifications
  - No mammo features of malignancy

DI - Imaging

- Left ultrasound
  - Compared to U/S from 2012
  - Normal Left axillary node
  - Vague hypoechoic area 9 mm adjacent to areola superiorly. Does NOT appear significantly altered from 2012 study.
  - Benign etiology is favoured.

DI - surgeon

- Open bx 2/12 later (non-urgent, pt concerned)
  - Multifocal invasive ductal Ca and DCIS
- Segmental resection 2/52 later
  - 5.5 cm tumor invasive ductal Br Ca
  - 3/13 nodes +ve
  - No lymphovascular invasion