

BREAST DISEASE

I. INTRODUCTION

Fear of breast cancer motivates women with breast symptoms and concerns to consult their medical provider. It has been estimated 1 in 4 women in the United States will require medical attention for breast problems, most of which are benign – such as symptomatic fibrocystic changes, mastodynia, nipple discharge and fibroadenoma. The National Cancer Institute of the National Institute of Health currently estimates 12.2% as the lifetime risk of developing breast cancer.

Fibrocystic disease, the most common benign condition of the breast, occurs in 10% of women under age 21 and becomes more common in the premenopausal period. Common symptoms are bilateral pain and tenderness especially in the upper outer quadrants of the breasts, which increase during the premenstrual phase of the cycle. Examination reveals a generalized lumpiness or granular feeling especially in the upper outer quadrants and beneath the nipple-areola complex. Oral contraceptives and depot medroxyprogesterone acetate have been shown to be helpful in suppressing symptoms of fibrocystic changes.

Nipple discharge may be spontaneous or provoked. Milky discharge in a non-lactating breast may be associated with hypothyroidism, a prolactin-secreting tumor or the administration of certain medications including hormonal contraceptives and chlorpromazine type drugs. Unilateral, spontaneous serous or serosanguinous discharge from a single duct is usually caused by intraductal papilloma, rarely cancer. In premenopausal women, spontaneous multiple duct discharge, unilateral or bilateral, is often due to fibrocystic change and may be green or brownish in color.

An American woman now has a 1 in 8 chance of developing breast cancer before she reaches age 85. A woman with a family history of a mother or sister having breast cancer is more likely to develop the disease. The risk is increased when the breast cancer occurred before menopause, was bilateral, or was present in 2 or more first degree relatives. However, in over 90% of the women with the disease there is no history of breast cancer among female relatives. The association between an increased risk of breast cancer and hormonal contraception is unclear.

II. SCREENING

While mammography is the most effective screening method for detecting non-palpable breast cancers, clinical breast exam (CBE) is also important. The long standing recommendation that all adult women practice monthly breast self examination (BSE) is now being questioned. Recent studies have shown breast cancer survival is no greater in women who practice BSE than those who do not. Despite the recent controversy, approximately 90% of breast masses are discovered by the woman and therefore BSE is still recommended by the majority of practitioners. ACOG recommends OB-GYNS should continue to

counsel women that BSE has the potential to detect palpable breast cancer and should not discourage women from performing BSE.

In 2009, the US Preventative Task Force (USPTF) issued revised mammogram guidelines. Those guidelines stated screening mammograms should be done every 2 years beginning at age 50 for women at average risk of breast cancer and screening mammograms before age 50 should not be done routinely and decision for mammogram at this age be based on a woman's values regarding the risks and benefits of mammography. The USPTF also stated doctors should not teach women to do breast self-exams.

The American Cancer Society (ACS) and current ACOG guidelines differ from the USPTF's recommendations. ACOG continues to recommend women age 40 - 49 have mammography every 1 - 2 years and yearly beginning at age 50. Women ages 35 and older with a strong family history of breast cancer (in a first-degree relative diagnosed prior to menopause), should have an annual mammogram. ACOG continues to recommend that all women, along with their physicians, should individually assess the benefits as well as the risks of mammography screening.

III. PLAN OF ACTION

- A. Routine breast screening
 1. CBE should be performed at each annual exam.
 2. During the CBE, the client can be instructed in performing a BSE a few days after the cessation of each menstruation or on a monthly calendar day for women who are not menstruating.
 3. Screening mammography should be ordered according to current ACOG guidelines as described under "Screening".
- B. Evaluation of breast disease is based on risk factors, age history, and physical examination. History should include: the duration and onset of signs and symptoms, menstrual and reproductive history, hormone use and dietary habits. Factors that increase the risk of breast cancer should be considered (Appendix A).
- C. Management of fibrocystic disease may include:
 1. Restriction of caffeine
 2. Avoidance of vigorous exercise during the times of most discomfort.
 3. Wearing a bra with good support.
 4. Taking Vitamin E, 400 IU p.o. bid.
 5. Using the lowest amount of estrogen in oral contraceptives.
 6. Using diuretic therapy or analgesics as necessary.
- D. Diagnostic evaluation for nipple discharge includes:
 1. Cytology of the discharge and referral to a surgeon if abnormal.
 2. A prolactin level done 24 or more hours after the breast examination and instruction not to manipulate the breast until blood is drawn. If the result is abnormal, refer the client to an endocrinologist.
 3. A thyroid profile, and if abnormal, referral for medical evaluation.
 4. A pregnancy test.
- E. Patient presents with palpable breast mass:

1. A client who presents with palpable breast should be referred immediately for evaluation by a breast specialist. Diagnostic imaging and/or biopsy may be ordered as needed to facilitate the referral and expedite care.
 2. The only exception to the requirement for immediate referral is for low-risk women under age 30 with a single palpable mass. In these women, clinicians may consider evaluation following next menses. If mass(es) persist after next menses, referral for further examination with fine-needle aspiration, ultrasound and/or biopsy is indicated. Mammography may be necessary, but is often of limited usefulness in this age group.
- F. Be familiar with the indicators for breast disease requiring referral (Appendix B).
- G. For breast cancer prevention, all women should be encouraged to follow a healthy diet, control weight, exercise regularly and avoid overindulgence in alcoholic beverages.

IV. FOLLOW-UP

- A. Follow-up should be scheduled as appropriate to review client status, laboratory test results and treatment responses.
- B. If a client expresses concern regarding nipple discharge and the diagnostic evaluation is negative, consider discontinuing hormonal contraception and offering alternative methods of birth control.
- C. The referring clinic should follow up on all surgical consultations to insure they have been carried out (Appendix C).

REFERENCES

1. ACOG. *Precis: Primary and Preventive Care*. 3rd Ed., 2004
2. ACOG. *Precis: Gynecology*. 2nd Ed., 2001
3. Hatcher RA et al. *Contraceptive Technology*. 19th Revised Edition. Ardent Media, Inc., New York, 2007
4. Tierney LM Jr. et al. *Current Medical Diagnosis and Treatment*. 44rd Ed., McGraw-Hill, New York, 2005

APPENDIX A

FACTORS THAT INCREASE THE RISK OF BREAST CANCER

1. Increased age
2. Previous history of breast cancer
3. Nulliparity
4. Delayed childbearing (after age 30)
5. Early menarche (before age 12)
6. Late menopause (after age 53)
7. Family history of breast cancer (first degree relative)
8. Biopsy-proven ductal or lobular hyperplasia, particularly atypia
9. Higher socioeconomic status
10. Obesity
11. Moderate to high alcohol intake (2 to 5 drinks per day)
12. Genetics: BRCA1 or BRCA2 mutation

APPENDIX B

INDICATIONS FOR REFERRAL

1. Dominant mass
2. Marked increase in size or firmness of one breast
3. Retraction of the nipple or the skin
4. Redness and edema over at least a third of the breast with underlying induration
5. Bloody nipple discharge
6. Changes in nipple epithelium, such as erosion
7. Mammographic evidence of breast disease
8. Genetic counseling/ testing may be considered for clients with a strong family history

APPENDIX C

RECOMMENDED STEPS WHEN REFERRING FOR POSSIBLE BREAST LESION

1. Advise the client of the need for a surgical consultation and give her the name(s) of a surgeon. Provide the full name, address, and telephone number of the surgeon.
2. Complete a clinic referral form for the client and attach a duplicate copy for the client's record.
3. Give the client the referral to take to the surgeon, and request that the form be returned to the clinic after the surgeon has completed the evaluation and provided a note for the clinic record.
4. Give the client an appointment for a family planning visit within 6 weeks of referral.