



HIGH GRADE EXTENSIVE DCIS WITH INVASIVE COMPONENT WITHOUT CLINICALLY PALPABLE MASS –SURGEON PERSPECTIVE

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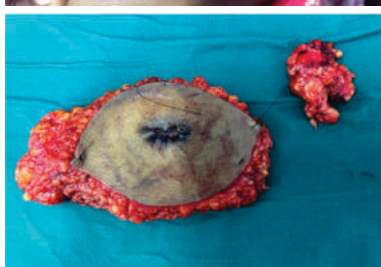
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ABSTRACT Ductal carcinoma insitu or intraductal carcinoma is considered as pre invasive or stage 0 of carcinoma breast is a neoplastic proliferation of ductal epithelial cells confined to the mammary ducto lobular system. DCIS considered as marker for development of invasive breast carcinoma. Occurrence of concurrent invasive component (11 to 25 %) especially with high grade DCIS. They may or may not associated with paget's disease. clinical presentation varies from palpable or non palpable lump, nipple changes etc. prognosis of the DCIS depends on time of diagnosis, grade of DCIS, hormonal and HER2 neu receptor status. In this single case report, clinical presentation, radiological diagnosis pathological perspective, treatment, prognosis and recurrence of post menopausal women with high grade extensive intraductal DCIS with invasive component presented with non palpable lump with only nipple changes which was diagnosed by microcalcification on diagnostic mammogram under gone MRM. Tumour biology shows they are ER, PR negative with HER 2 Neu positive.

KEYWORDS : Invasiveductal Carcinoma –Nipple Areolar Complex – High Grade DCIS- Extensive Intraductal Component – ER, PR- Negative, HER 2 Neu –Positive- p53, BRCA

CASE STUDY

A 52 year old post menopausal women, presented with complaints of nipple changes over her left breast for past 1 year. she was apparently normal a year back then she initially developed retraction of the nipple, then it progressed to a complete shrinking and resorption. she had no palpable lump over her left breast. No nipple discharge. she has no other co morbid illness. She states no similar illness or history of GI or ovarian malignancy in her siblings and cousins parents and aunts. she has attained menarche at age of 12 menopause at age of 45, she has one living child. Her age at pregnancy was 28. No history of HRT intake. upon examination her ECOG score was 0. Examination of left breast – complete disappearance of the nipple, no clinically palpable mass in all quadrants of the left breast, ipsilateral clinically negative axilla. Contralateral breast, nipple areolar complex, axilla clinically normal. Diagnostic mammography shows retraction of the nipple with microcalcification –BIRADS-IV. since patient has no palpable lump, punch biopsy taken from the central quadrant –Atypical ductal hyperplasia with foci of ductal carcinoma insitu. For metastatic workup CT chest with abdomen with spine screening done – Found to be normal. Proceeded with Modified radical mastectomy done. pathological staging of the disease- pT1cN0Mx- Invasive breast carcinoma of No special types with Histological grading III (Elston –Ellies modification of scarf bloom Richardson grading). Tumour dimension was >1cm but <2cm, margins found to be negative. DCIS found more than 30 %, with higher grade with comedo necrosis. There is an extensive intraductal component present. Regarding nodal status, total regional nodes examined was 14, all nodes found to be negative. Immuno histochemistry of the cancer cells shows estrogen and progesterone receptors –Negative, positive for HER 2 neu. By nottingham prognostic index- NPI score –4.2.



DISCUSSION

Clinical Presentation

As of in the above discussed case more than 90 percent of the DCIS will have Non palpable lump, hence it is generally missed during self breast examination by the patient. It may delay the early diagnosis and treatment. By the time when patient comes to clinician carcinoma might progress to invasive forms. If DCIS arising from the terminal ducts around the nipple areolar complex as like in the above case, it may present with nipple discharge, retraction of the nipple or distorted nipple.

MAMMOGRAM

The incidence of DCIS is increasing due to screening mammogram. The highly sensitive diagnostic method for diagnosing microcalcification is the mammogram. High grade DCIS will show pleomorphic calcification, while low grade DCIS shows fine or granular calcification. In our patient since there was nipple changes –diagnostic mammogram done –showed pleomorphic microcalcification with retraction of the nipple.

Pathological Perspective Of DCIS

DCIS is the precursor of the invasive cancer, they are genetically similar to the invasive cancer cells but remain confined to the ducts and lobules. Extensive DCIS is defined as type of Non invasive breast cancer that are associated with invasive component, can involve multiple ducts. DCIS is graded according to the nature of the cells and rapidity of the cellular division. In the above discussed case, pathologically since it was high grade DCIS with ki67 index – 47, it turned to be invasive form of cancer breast ie- cancer cells spread beyond the ductal lumen, crossed the basement membrane. Comedo type of DCIS characterized by large atypical cells that fill and expand the breast ducts, have higher risk of developing in to invasive breast cancer than non comedo type, hence it is called comedocarcinoma. since our patient has comedo type of DCIS, she might have progressed in to invasive cancer.

Genetics

Breast cancer progression of low grade DCIS, starts with precursor lesion of epithelial atypia, progressing to atypical ductal hyperplasia then to Ductal carcinoma insitu. These cancer cells express estrogen receptor take a decades to form invasive breast cancer. Germline mutation of BRCA2 expresses ER associated with low grade DCIS. In contrast germline Tp53 leads to Her 2 amplification forms high grade DCIS without any precursor lesions. Germline BRCA1, inactivation also causes high grade DCIS without precursor lesion lead to Triple negative invasive cancer.

Treatment

The pathological staging of the above discussed case – is pT1c N0 MX- histological grading –III, with high grade DCIS- with ER negative Her 2 neu positive. Since we have done Modified radical mastectomy – with pathologically node negative axilla –patient does not need of adjuvant Radiotherapy. we have given adjuvant chemotherapeutic agents including Docetaxel, carboplatin combined with Herceptin and pertuzumab.

Prognosis and Recurrence

The prognosis for DCIS is generally considered as excellent with good survival rate.

Factors that may cause recurrence of the tumour includes-(i) younger onset of age (ii)positive surgical margins after lumpectomy (iii)high grade DCIS with higher nuclear grading (iv)DCIS with comedo necrosis