



ORIGINAL RESEARCH PAPER

General Surgery

CLINICAL RESEARCH IN CARCINOMA BREAST.

KEY WORDS:

Arun Patil

Uttam Wakadkar

INTRODUCTION

Breast cancer is the most frequently diagnosed cancer in women and the second most frequent cause of cancer death in India after to cancer cervix. Over the past several decades there has been a fairly steady and large increase in incidence of the disease. 1 in 8 women have life time risk of developing breast cancer.

The management of breast cancer requires a complex multidisciplinary approach involving the surgeons radiotherapist, medical oncologist, pathologists and other professionals like counselors.

The combination of conservative surgery with adjuvant radiotherapy has now become a standard procedure for breast cancer.

In this study, the various risk factors, natural history, clinical features, mode of spread, pathology, and its management is studied.

AIMS AND OBJECTIVES

To study the patients of Early and Locally advanced stage of Ca.Breast with respect to:

- 1) Age distribution
- 2) Etiology
- 3) Risk factors
- 4) Clinical presentation
- 5) Pathological type and
- 6) Management in our setup.

MATERIALS AND METHODS

The study comprising of 50 cases diagnosed to have carcinoma breast who were admitted at premier tertiary care hospital and teaching institute in Mumbai.

Data was analyzed and various conclusions were derived from it.

Inclusion Criteria

All Patients (Both Genders) above 18 years with,

- Early breast cancers (T1 & T2, N0)
- Patients undergoing neoadjuvant chemotherapy for breast conservation and clinically uninvolved axilla.

Exclusion Criteria

- Patients with clinically involved axilla
- Pregnant and lactating women
- Multifocal/Multicentric carcinoma breast
- Previous breast surgery on same side
- Prior chemotherapy or radiotherapy.

OBSERVATIONS

Table no. 1 Presenting Features.

Presenting Feature	No of Patients	%
Lump	48	96
Nipple ulcer	5	10
Pain	4	8
Nipple Discharge	2	4
Nipple retraction	2	4
Backache	1	2
Abscess	1	2

Table no. 2 Duration of Symptoms.

Duration of Symptoms	No of Patients	%
< 1 month	3	6
1-6 months	27	54
6 months- 1 Year	12	24
1-2 years	4	8
> 2 years	2	4

Table no. 3 Local tissue Involvement.

Local tissue Invasion	No of Patients	%
Skin	20	40
Chest Wall	1	2
Nipple	12	24

Table no. 4 Site for Distant Metastasis

Site	No of Patients	%
Bone	5	10
Lungs	1	2
Liver	0	0
Brain	0	0

Table no. 5 ER and PR Receptors Status

Receptors	Premenopausal	Postmenopausal	Total	%
ER+/PR+	2	6	8	16
ER-/PR-	17	18	35	70
ER+/PR-	1	2	3	6
ER-/PR+	2	1	3	6

DISCUSSION

This study comprising of 50 cases of breast carcinoma, were undertaken at a Premier Tertiary Care Hospital in Mumbai. Confirmation of diagnosis was made on the basis of history, clinical findings FNAC/ Biopsy and other investigation for metastasis was made.

Most of the pts. (38%) were between age of 38-48 years, and this was accordance with the study of Feuer et al.

Most of the pts presented with breast lump (96%), nipple ulceration (8%), nipple discharge and nipple retraction (4%), comparable with Yorkshire Breast Group results.

Duration of history of breast lump up to 6 months was seen in 54%, whereas in 24% of pts it was found up to 1 year. This emphasizes the need of early and better screening for early diagnosis of Ca. breast.

54% and 44% of pts. were postmenopausal and premenopausal respectively. 46% presented T3 lesion and 44% had T2 lesion.

Upper outer quadrant was the most common site (72%), followed by upper inner (14%), central (8%), and lower outer quadrant (6%).

Involvement of skin was seen in 40%, nipple involvement in 24%, and chest wall involvement in 2% of pts.

92% of pts. had positive FNAC reports. 28% of pts. presented with

stage IIB disease, 24% had stage IIIA disease, 12% had stage IV disease. This was similar to the results of Chryssos and Bondi. Modified Radical Mastectomy was performed on 76% of pts. and 12% of pts. underwent Breast Conservative Surgery. Radiotherapy was given to 76% of pts. Whereas 38% of pts. received neo-adjuvant chemotherapy and 92% pts. received adjuvant chemotherapy postoperatively. Invasive ductal carcinoma was seen in 64% of pts. Whereas medullary and intra lobular carcinoma was in 18% each, in excised specimen. Minimal postoperative complications were encountered. 88% of pts. were discharged within 10 days, and rest had more days of hospital stay.

SUMMARY AND CONCLUSION

Lump in breast was the commonest presentation. An overall female preponderance over male was seen. Maximum pts. were postmenopausal. Upper outer quadrant was the commonest site. FNAC had positive reports in 92% of pts. Most common carcinoma was infiltrating ductal Carcinoma. Surgery and radiation therapy are mainstays of breast cancer treatment. Minimal postoperative complications were encountered. Maximum pts. were discharged from the hospital within 10 days.

REFERENCES

- 1) Feuer EJ, Wun LM et al: The lifetime risk of developing breast cancer. *J Natl Cancer Inst.* 1993;85:892-7.
- 2) Yourkshire Breast Group: Symptoms and signs of operable breast cancer. *1976-1981 Br J Surg* 1983;70:350-1.
- 3) Bartow SA, Pathak DR, et al.: Prevalence of benign, atypical and malignant breast lesions in populations at different risk for breast cancer. *Cancer* 60:2751, 1987.
- 4) Beahrs OH, Henson DE, Hutter RVP, Kennedy BJ, Handbook for staging of cancer. American joint Committee on Cancer, 4th ed. Philadelphia JB Lipincott, 1933.
- 5) Berg J.W. et al.: 20 years follow up of breast cancer, *Acte Un Int. Cancer*, 19:1575-7, 1963.
- 6) Black MM: Opler S.R.: Speer F.D.: Survival in breast cancer cases in relation to the structure of the primary tumour and regional lymph nodes. *Surg. Gynaec. Obst.* 100: 543-551, 1955.
- 7) Bland KI: Inflammatory, Infections & Metabolic disorders of breasts, in Bland KI, Copeland EM III (eds.): *The Breast: Comprehensive management of Benign and Malignant Diseases.* Philadelphia, WB Saunders, 1991, Chap. 5.
- 8) Bland KI, Frykberg ER: In situ carcinoma of the breast: Ductal and lobular cell origin, in Cameron JL (ed): *Current surgical Therapy*, 4th ed. St. Louis, Mosby-Year Book, 1992, pp. 612-621.
- 9) Bland KI, Page DL: Gynaecomastia in Bland KI, Copeland EM III (eds): *The Breast comprehensive Management of Benign and Malignant Diseases*, Philadelphia, WB Saunders, 1991, Chap.7.
- 10) Bloom HJG, Richardson WW et al.: Natural history of untreated breast cancer (1805-1933): Comparison of untreated and treated cases according to histological grade of malignancy. *Br. Med. J* 5299:213:1962.
- 11) Bloom H and Richardson TG: Prognosis in carcinoma breast. *Briti. J. Cancer*; 4:259-68, 1060.
- 12) Boova RS, Roseann B et al: Patterns of axillary nodal involvement in breast cancer: Predictability of level one dissection. *Ann. Surg.* 196:642, 1982.
- 13) Boring CC, Squires TS, Ton T, Montgomery S. *Cancer statistics 1994* *Cancer J. Clin. Ca* 1994; 44:7-26.
- 14) Bright RA, Morrison AS et al.: Histologic and mammographic specificity of risk factors for benign breast disease, *Cancer* 64: 653, 1989.
- 15) Brinton LA, Hoover R et al.: Epidemiology of minimal breast cancer. *JAMA* 249: 483, 1983.
- 16) Melinda L Telli MD, Kathleen C Horst, J, *Natl Compr Canc Netw 2007, Phylloides Tumours of the Breast: Natural History, Dignosis and Treatment.*
- 17) Clemmesen J, "Statistical studies in the aetiology of malignant neoplasms I, Review and Results" Munksgaard, Kobehavn, 1965.
- 18) Clemmesen J, "Carcinoma of the breast, symposium, Results from statistical research" *Brit. J. Radiology*, 21:583-590, 1958.
- 19) Cooke TG: Ductal carcinoma in situ: A new clinical problem. *Brit. J. Surg.* 660, 1989.
- 20) Culture JP, Gordon HH, Shenck RR, Zollinger RM, Brumberg DJ, Shuck JM, Age does not predict breast cancer outcome, *Arch. Surg.* 1994: 129: 483-8.
- 21) Culture S.J., Black M.M. and Goldberger, L.S: Prognostic factors in cancer of female breast. An investigation of some inter-relations. *Cancer*, 16:1589-1597
- 22) De Waard F.: "The epidemiology of breast cancer: Review and prospects" *Int. J. Cancer*, 4; 577-586 (1969).
- 23) Dela Rochefordiere Am Asselain B. Campana F. School SM, Fenton J., Vilcoq JR et al. Age as prognostic factor in premenopausal breast carcinoma, *Lancet* 1993; 341:1039-43.
- 24) Dent DM, Cant PJ, Fibroadenoma, *World J. Surg.* 1989; 13:706-10
- 25) Dixon JM, Dobie V, Lamb J, Walsh JS, Chetty U.: Assessment of the acceptability of conservative management of fibroadenoma of the breast. *Br. J. Surg.* 1996: 83:264-5.
- 26) Dupont WD, Page DL: Risk factors for breast cancer in women with proliferative breast disease. *N. Engl. J. Med.* 312:416, 1985.
- 27) Dupont WD, Page DL et al.: Long term risk of breast cancer in women with fibroadenoma. *N. Engl. J Med.* 331: 10, 1994.
- 28) Randimbison L. et al.: Incidence of breast cancer in women with fibroadenoma. *Int. J. Cancer* 57: 681, 1994.
- 29) Fechner RE: Fibroadenoma and related lesions in Page DL, Anderson TJ: *Diagnostic Histopathology of the Breast*, Edinburgh Churchill Livingstone, 1987, pp 72-88.
- 30) Garfinkel L, Boring CC, et al.: Changing trends: An overview of cancer incidence and mortality. *Cancer* 74:222, 1994.
- 31) Glass AR: Gynaecomastia *Endocrinol Metab Clin North Am* 23: 825, 1994.
- 32) Gloeckler Ries L, Pollack ES, Young L. *Cancer patient survival: surveillance,*

epidemiology and end results program, 1973-79, *J. Natl Cancer Inst.* 1983; 70: 693-707.

- 33) Haagensen CD, Adenofibroma In: Haagensen CD, editor, *Diseases of the Breast*, 3rd ed. Philadelphia: WB Saunders, 1986; 267-83.