Breast Questions with Answers

ma'am, if the indications for breast biopsy are fulfilled, do you still have to go through the mammography and/or ultrasound? or can you go straight to the biopsy?
It is GENERALLY advised to do your imaging prior to doing the biopsy. for several reasons. For example, the mass can turn out to be a complex mass cystic and solid lesion. Knowing the imaging may help guide you which part of the lesion should be best biopsied. The imaging may also identify other lesions that may require biopsy so you can do it same setting. Doing the imaging after the biopsy may also confuse also the findings on the imaging. But there are occasions where you can do the biopsy outright. Like if the mass is very big and very suggestive of cancer and you know that the eventual management of that breast will be mastectomy (so finding other lesions in that breast is irrelevant.) However, in that scenario, you still need to image/screen the contralateral breast. So mas ideal talaga getting your imaging first before doing the biopsy. That can also change your decision re: need for biopsy. E.g. you palpated firm mass but on ultrasound, turns out to be cystic. Then you can just do aspiration.

When should we perform an incision biopsy versus an excision biopsy?
Excision biopsy should not be the preferred biopsy technique if you are highly considering a malignancy and especially if it's large (say >3 cm) because that can cause tumor spillage. Also that can complicate surgery later. For example, if the patient is a potential candidate for breast conservation surgery, and the initial biopsy done was an excision biopsy, it will be difficult to determine the appropriate margin during the definitive surgery and the tendency would be to get greater margin than would have been necessary (compromising cosmesis) Incision biopsy would be preferable for larger tumors over excision biopsy, esp. where CA is being considered (assuming that core needle biopsy is not possible or non-diagnostics). There are however lesions that require the entire specimen to get a diagnosis (e.g. papillary neoplasm of the breast, atypical ductal hyperplasia if they were initially diagnosed on core needle biopsy)…

Good morning po. Maam, sorry, im confused. In cases of Breast abscesses, do we discontinue breastfeeding? Schwartz stated to do discontinue. But OB told us not to discontinue. What is your stand on this po?
It is advised to continue breastfeeding. Because if not, the breast will congest with milk leading to more problems. Breastfeeding can always be continued in the contralateral breast. With the breast affected, it may be difficulty due to pain especially if the abscess is very near the nipple. But manual milk decompression of the affected breast can be done with breast pump. It's important to choose an antibiotic that is not eliminated in the breast milk.

Maam, if a 20 year old female presents with a benign mass that is most likely a fibroadenoma. Do we do routine biopsy? or it depends in the size?
If your clinical diagnosis for a fibroadenoma is very high (like in this scenario where it's a very young patient and clinically very typical of fibroadenoma, and no risk factors for cancers), biopsy will not be routine in this case.

Is mastectomy done for patients with Stage 0?
For ductal carcinoma in situ (stage 0), total mastectomy is one of the surgical options especially if the patient has a large lesion, multicentric lesions, diffuse calcifications, or if patient does not wish to undergo radiotherapy. Treatment options for DCIS include wide excision (pathologic margin requirement of 2 mm at least), wide excision + RT, or total mastectomy. RT is generally added to wide excision to reduce risk of recurrence. In some cases like very old >70 patients, ER+ DCIS, you may forego RT.

Hi maam, in what instances is FNAB preferred over CNB? thanks
Well, if you do not have access to core needle biopsy (special device) then you can do FNA. Sensitivity and specificity is also good for FNA. The dilemma lang is it cannot diagnose invasive from in-site disease. Since cells lang. Results will say ductal carcinoma cells lang. IF clinically mukha naman syang invasive cancer talaga (say super laki na ng bukol, may skin changes na, may lymph nodes na), then obviously invasive disease yun. Problem mo n lang is how you can get the ER/PR/Her2. You can do that naman with the surgical specimen later but sometimes you need the info on ER/PR/her2 before surgery (if patient will receive neoadjuvant therapy). OR if metastatic sya and the patient will not have surgery of the breast, wala kang magiging source ng ER/PR/Her2 info that will guide your choice of systemic therapy if FNA lang ginawa

Good morning po! For younger patients (<30 y/o) who want to do screening is it better to ask them to have a breast UTZ done or still mammography as the initial screening test? Thank you!
Screening mammogram is generally not advised for patients <30 y.o.

For LCIS do we need to always do management such as lobectomy?
Lobectomy? We don't do lobectomy in the breast. Do you mean lumpectomy? If you diagnose LCIS on core needle biopsy, you usually need to do an excision biopsy to get the entire specimen to make sure that it really is just LCIS and there's no invasive component. Unlike with DCIS, clear, wide margin is not required for LCIS.

Hi ma'am! If you decide to do a sentinal LN biopsy, which turns out to be positive, can you do the axillary LN dissection during the same surgery or would that be done on another time?
It depends on the institutional protocol in place for the SLNB. In some institutions (like what we do in PGH), when we do the SLNB, we send the sentinel lymph nodes for frozen section, while we do surgery for the primary in the breast. We wait for the result of the frozen section of the lymph nodes, if positive then we proceed with ALND same setting. IN some institutions where they do not believe in frozen section of the lymph node, they await the final routine histopath. If it's positive, they do the ALND at another time. This is what we try to avoid in PGH due to the financial limits ng patients (costly to go for another surgery) that's why we incorporate frozen section. Meron din situations where even if sentinel node biopsy positive ang 1-2 lymph nodes pedeng hindi mag-ALND but I think that's a bit high level na for interns. Marami kasing nuances ang breast cancer management. I don't want to confuse you further and just wanted to give you the basics from which you can understand all other variations in management

In MRM, is RT not recommended?
I mentioned earlier that following MRM, radiotherapy of the chest wall and lymph node basins may still be needed usually if tumor is >5 cm, there are 4 or more positive axillary lymph nodes, or there are positive margins. IN SOME cases where there are 1-3 lymph nodes, it MAY BE considered if there are other high risk features like lymphovascular space invasion, triple negative disease, grade 3.

Is there also neoadjuvant radiotherapy done for inoperable breast CA? Or just chemo? Thank you!
Apart from neoadjuvant chemotherapy, we can also give neoadjuvant targeted therapy (Herceptin +/- pertuzumab) along with the chemo for Her2 positive disease. Neoadjuvant hormonal therapy can also be done actually (but the problem here is that medyo slow yung response compared to chemotherapy) and has particular application for older patients with advanced tumors and who are not good candidates for chemo. IN some cases neoadjuvant radiotherapy may be done especially if following neoadjuvant chemotherapy+/-targeted therapy tumor remains unresectable (though an option will be second line

neoadjuvant chemo). However it is not commonly performed because it makes wound healing a problem later when definitive surgery is done. So it is not standard as say neoadjuvant chemo/targeted therapy.

Is it possible to have non-palpable breast mass for patients with small breasts?
Yes. Because not everyone has same proficiency when doing clinical breast exam. Also, a patient who has a very posteriorly-based tumor especially retroareolar or in the upper outer quadrant (where breast is generally denser), pwedeng difficult to palpate

Hello, Maam. I encountered before a patient who had a history of a benign breast mass from taking contraceptives pills in her teenage years for PCOS, which resolved spontaneously without surgery (through discontinuation of pills). What might this be, fibrocystic change or fibroadenoma? Would this patient also be safe to take contraceptive pills in the future? Thank you.
Fiboradenomas don't generally regress significantly unless they were very small to begin with or maybe if postmenopausal na yun gpatient, pwedeng lumiit yun. Most likely fibrocystic disease of the breast yun if nawala. If mag take ulit sa ng OCP in hte future, pwede ulit magkaroon ng same symptoms. But of course it has to be reevaluated. HIndi pedeng iassume right away n FCC lang ulit yun.

Good morning, Maam. Can fibroadenoma resolve spontaneously? Also, what is the probability of it turning into a malignant mass?
It does not degenerate into a malignant mass. It's not a pre-malignant condition. Small fibroadenomas (subcentimeter) may regress especially as patient reaches menopause. But for large lesions, you cannot expect it to resolve spontaneously.

Hi ma'am. Just a question on semantics, is Her2 positivity reported as "Her2+" or "Her2-positive" on histopath reports? Usually nakareport doon , 0, +1, +2, +3 doon sa body ng report. And then sa interpretation, nakalagay if POSITIVE or NEGATIVE. They usually have an accompanyin interpretation naman sa reports
This is a bit tricky to explain. Take for example, a patient who is ERpos, PRpos, Her2 -negative vs. a patient who is ERpos, PR pos, Her2postiive. The latter will generally have a poorer prognosis BUT if appropriate therapy is given (if patient is given Herceptin+/- Trastuzumab where patients is PREDICTED to have good response because of HEr2 positivity), the prognosis will actually approach ERpos, PR pos, Her2 neg. But if Her2-targeted therapy is not given, then that will have poorer prognosis than the former. I encourage you to look into the AJCC prognostic staging. Remember that the prognostic staging there assumes that the appropriate therapy has been given to approach that prognosis.

Good morning Ma'am. How do we differentiate between an infectious breast pathology vs a necrotic tumor?
If the patient has a palpable mass or imaging evidence of mass, then you have to take biopsy of the mass and do biopsy on viable tumor tissue. If you take biopsy of the necrotic tissue, pwedeng necrosis lang lumabas and may not reveal the cancer. They can also co-exist , an infection in the breast and necrotic tumor. So look for cardinal symptoms of infection, evaluate for a mass and biopsy as appropriate, assess the response of the breast to your antimicrobials…

Hi maam! Can you give us an example case where we do incisional and excisional biopsy? Thank you po!
Excisional biopsy is something you can do for small lesions if you are not highly entertaining malignancy. For example, you have a patient in her 20's in whom your clinical diagnosis is a fibroadenoma. The patient wants the mass removed. You can forego your core needle biopsy and go ahead with the excision because

your pre-test probability of it being benign is very high. You can forego a core needle biopsy in this case. But if this were in patient who is say 40 years old, I would rather go for core needle biopsy first rather than outright excisional biopsy because my consideration that this is benign might be lower because of the age. Incisional biopsy is something you do for larger tumors where you cannot exclude the possibility of cancer and your core needle biopsy may be non-diagnostic. For example, if you have a large soft tissue lesion in whom you are considering a sarcoma, but your core needle biopsy (even image guided) keeps coming up with non-diagnostic result, it's preferable to do incision than excisional biopsy

Ma'am, at the boards, which age should we answer for start of annual screening: 40, 45, or 50?
This is a bit tricky I think to answer because it depends on what recommending body the one who made the exam referred to (and obviously we have no way of predicting that). Questions that are controversial are generally avoided naman. But just in case, I suggest taking a look at the stem of the question and see the specifics in the stem (lucky if they will have statements like "In the Philippines"…)Coz if you take the same question in another country there may be a completely different recommendation…The 50 age as the recommendation for the Filipinos can be seen in the Philippine cancer Facts and Estimates (by Philippine Cancer Society and DOH disease prevention and control bureau). American cancer Society recommended 40 before but changed it to 45 (optional only for 40-44) in the past few years. NCCN in its 2020 version cites 40. So hopefully they will qualify the question. Sorry if I caused more confusion.

What's the significance po of Her2+ tumors being a good predictive factor, but a poor prognostic factor? Good response but high risk of recurrence after complete response po ba?
Very insightful question. I encourage you to look into the AJCC prognostic staging to give you an idea of the implication of her-2 positivity. By itself, while it may suggest more aggressive breast cancer (her2 promotes growth of cancer cells), because there are effective targeted therapy (and Her2 positive tumors are predicted to have good response to these), if the targeted therapy is given, they will actually have good outcomes. Also interpretation of prognostic factors should be done not in isolation but in consideration of the other prognostic factors present in the patient particularly ER/PR status. When you look at the prognostic staging, remember that this assumes that patient received the optimal/standard therapy. So kung Her2-psoitive assumed na nagtargeted therapy for that. If not, then you cannot approximate that prognosis

Good morning Ma'am. What is the role of mammography in male patients with breast symptoms po?
The use of mammography in male patients is limited by the technical feasibility of the test in that population since maliit ang breast/minimal breast tissue and may not be amenable to compression. Because of the size of the breast, most likely lesions can be evaluated clinically. Of course breast sizes vary in males so diagnostic mammogram can be done naman but I think this will be case to case.