RYZYKO NIEDOSZACOWANIA RAKA W PRZYPADKU STWIERDZONYCH ATYPOWYCH ROZROSTÓW. ADH, ALH, FEA – KIEDY KONIECZNE JEST LECZENIE CHIRURGICZNE?

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BIOPSJA OTWARTA WYCINAJĄCA WSKAZANIA?

- ROZPOZNANIA HISTOPATOLOGICZNE Z GRUPY B3
  - -*BLIZNA PROMIENISTA (RS)*
  - -*BRODAWCZAK Z ATYPIĄ*
  - -*CELLULAR FA*
  - -*MUCOCELE LIKE LESION*
  - -*LOBULAR NEOPLASIA (LN)*
  - -*FLAT EPITHELIAL (FEA)*
  - -*ATYPOWA HIPERPLAZJA PRZEWODOWA (ADH)*

Pathology Reporting for Minimal Invasive Biopsies

B-Classification*

B1 = unsatisfactory or normal tissue only

B2 = benign lesion

B3 = lesion of uncertain malignant potential

B4 = suspicion of malignancy

B5 = malignant

- B5a = non-invasive
- B5b = invasive
- B5c = in situ/invasion not assessable
- B5d = non epithelial, metastatic

* National Coordinating Group for Breast Screening Pathology (NHSBSP), E.C. Working Group on Breast Screening Pathology, S3-Leitlinie Mammakarzinom der DKG

RODZAJE BIOPSJI

- Cienkoigłowa (PCI, FNB, FNAB, FNABC)
- Gruboigłowa (CB, VAB)
- Otwarta (nacinająca, wycinająca)

Zastosowana metoda biopsji	**Czułość metody w procentach (95% CI)**
Cienkoigłowa	43,8–95,0
Gruboigłowa	palpac.: 75,8–92,1 stereot.: 95,8–98,9 USG: 97,2–98,2
Aparat VAC	stereot.: 98,1–99,6 USG: 81,2–99,4
Chirurgiczna	98,0–99,0

BIO

- ROZPOZNANIA HISTOPATOLOGICZNE Z GRUPY B3

  -CZY WSZYSTKIE SĄ WSKAZANIAMI DO BIOPSJI OTWARTEJ?

Format: Abstract Send to

Breast Cancer Res Treat. 2016 Sep;159(2):203-13. doi: 10.1007/s10549-016-3935-4. Epub 2016 Aug 13.

First International Consensus Conference on lesions of uncertain malignant potential in the breast (B3 lesions).

Rageth CJ[1,2], O'Flynn EA[3], Comstock C[4], Kurtz C[5], Kubik R[6], Madjar H[7], Lepori D[8], Kampmann G[9], Mundinger A[10], Baege A[11], Decker T[12], Hosch S[11], Tausch C[11], Delaloye JF[13], Morris E[4], Varga Z[14].

Author information

Abstract

The purpose of this study is to obtain a consensus for the therapy of B3 lesions. The first International Consensus Conference on lesions of uncertain malignant potential in the breast (B3 lesions) including atypical ductal hyperplasia (ADH), flat epithelial atypia (FEA), classical lobular neoplasia (LN), papillary lesions (PL), benign phyllodes tumors (PT), and radial scars (RS) took place in January 2016 in Zurich, Switzerland organized by the International Breast Ultrasound School and the Swiss Minimally Invasive Breast Biopsy group-a subgroup of the Swiss Society of Senology. Consensus recommendations for the management and follow-up surveillance of these B3 lesions were developed and areas of research priorities were identified. The consensus recommendation for FEA, LN, PL, and RS diagnosed on core needle biopsy or vacuum-assisted biopsy (VAB) is to therapeutically excise the lesion seen on imaging by VAB and no longer by open surgery, with follow-up surveillance imaging for 5 years. The consensus recommendation for ADH and PT is, with some exceptions, therapeutic first-line open surgical excision. Minimally invasive management of selected B3 lesions with therapeutic VAB is acceptable as an alternative to first-line surgical excision.

KEYWORDS: B3 lesions; Breast; Breast surgery; Consensus; Uncertain malignant potential; Vacuum-assisted biopsy

PMID: 27522516 PMCID: PMC5012144 DOI: 10.1007/s10549-016-3935-4

[Indexed for MEDLINE] **Free PMC Article**

Breast Cancer Res Treat. 2019 Apr;174(2):279-296. doi: 10.1007/s10549-018-05071-1. Epub 2018 Nov 30.

Second International Consensus Conference on lesions of uncertain malignant potential in the breast (B3 lesions).

Rageth CJ[1,2], O'Flynn EAM[3], Pinker K[4], Kubik-Huch RA[5], Mundinger A[6], Decker T[7], Tausch C[8], Dammann F[9], Baltzer PA[10], Fallenberg EM[11], Foschini MP[12], Dellas S[13], Knauer M[14], Malhaire C[15], Sonnenschein M[16], Boos A[17], Morris E[4], Varga Z[18].

Author information

Erratum in

Correction to: Second International Consensus Conference on lesions of uncertain malignant potential in the breast (B3 lesions). [Breast Cancer Res Treat. 2019]

Abstract

PURPOSE: The second International Consensus Conference on B3 lesions was held in Zurich, Switzerland, in March 2018, organized by the International Breast Ultrasound School to re-evaluate the consensus recommendations.

METHODS: This study (1) evaluated how management recommendations of the first Zurich Consensus Conference of 2016 on B3 lesions had influenced daily practice and (2) reviewed current literature towards recommendations to biopsy.

RESULTS: In 2018, the consensus recommendations for management of B3 lesions remained almost unchanged: For flat epithelial atypia (FEA), classical lobular neoplasia (LN), papillary lesions (PL) and radial scars (RS) diagnosed on core-needle biopsy (CNB) or vacuum-assisted biopsy (VAB), excision by VAB in preference to open surgery, and for atypical ductal hyperplasia (ADH) and phyllodes tumors (PT) diagnosed at VAB or CNB, first-line open surgical excision (OE) with follow-up surveillance imaging for 5 years. Analyzing the Database of the Swiss Minimally Invasive Breast Biopsies (MIBB) with more than 30,000 procedures recorded, there was a significant increase in recommending more frequent surveillance of LN [65% in 2018 vs. 51% in 2016 ($p = 0.004$)], FEA (72% in 2018 vs. 62% in 2016 ($p = 0.005$)), and PL [(76% in 2018 vs. 70% in 2016 ($p = 0.04$)] diagnosed on VAB. A trend to more frequent surveillance was also noted also for RS [77% in 2018 vs. 67% in 2016 ($p = 0.07$)].

CONCLUSIONS: Minimally invasive management of B3 lesions (except ADH and PT) with VAB continues to be appropriate as an alternative to first-line OE in most cases, but with more frequent surveillance, especially for LN.

KEYWORDS: B3 lesions; Breast; Breast surgery; Consensus; Uncertain malignant potential; Vacuum-assisted biopsy

Rageth CJ, O'Flynn EAM, Pinker K. **Second International Consensus Conference on lesions of uncertain malignant potential in the breast (B3 lesions). Breast Cancer Res Treat. 2019 Apr;174(2):279-296. doi: 10.1007/s10549-018-05071-1. Epub 2018 Nov 30.**

Table 1 Pure B3 lesions together with the final histology in the cases, which had a subsequent open surgical excision (OE)

Pure B3 histology	*N*	With subsequent OE	Total upgrade	Upgrade to DCIS OR pleomorphic LN	Upgrade to IC	No upgrade
ADH	943	591 (62.7%)	149 (25.2%)	119 (20.1%)	30 (5.1%)	408 (69.0%)
FEA	994	249 (25.1%)	40 (16.1%)	22 (8.8%)	18 (7.2%)	181 (72.7%)
LN	701	268 (38.2%)	68 (25.4%)	35 (13.1%)	33 (12.3%)	178 (66.4%)
PL	1251	272 (21.7%)	21 (7.7%)	16 (5.9%)	5 (1.8%)	217 (79.8%)
PT	35	4 (11.4%)	0	0	0	4 (100%)
RS	415	75 (18.1%)	6 (8%)	5 (6.7%)	1 (1.3%)	60 (80.0%)

IC invasive cancer

Main types of B3-Lesions and Prospective Predictive Value (PPV) of Malignancy in Resection Specimen (DCIS/inv. Ca.)

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B3-Lesions:	~PPV
▪ Atypical ductal hyperplasia (ADH)	20–30 %
▪ Lobular intraepithelial neoplasia (LN/LIN)	0–10 %
▪ Flat epithelial atypia (FEA)	0–10 %
▪ Radial scar / Complex sclerosing lesion	0–10 %
▪ Papilloma without atypia	0–10 %
▪ Cellular fibroepithelial tumors / phyllodes tumors	0%

Rageth CJ, O'Flynn EAM, Pinker K. **Second International Consensus Conference on lesions of uncertain malignant potential in the breast (B3 lesions). Breast Cancer Res Treat. 2019 Apr;174(2):279-296. doi: 10.1007/s10549-018-05071-1. Epub 2018 Nov 30.**

Table 4 Summary of the recent literature on FEA since 2015

Author and year	Number of patients analyzed or type of publication if no patients have been analyzed (e.g., review or comment)	Findings	Conclusions
Acott and Mancino 2016 [23]	$n=46$ Isolated FEA on CNB	Underestimation FEA on CNB 2%	May warrant close surveillance
Berry et al. 2016 [24]	$n=27$ FEA on CNBs	Underestimation FEA on CNB 11%	Only patients with a history of breast cancer or pure, prominent FEA on CNB disease should proceed to excisional biopsy
Chan et al. 2018 [25]	$n=195$ Isolated FEA on CNB		Non-operative management of biopsy-proven FEA can be considered in the absence of ADH and radiology–pathology discordance
Dialani et al. 2014 [26]	$n=37$ Isolated FEA on VAB	Upgrade FEA on VAB (6.9%)	If there are no residual microcalcifications following CNB, imaging follow-up as an alternative to surgery may be a reasonable option
Lamb et al. 2017 [27]	Pure FEA on CNB/VAB Upgrade ($n=200$) and follow-up ($n=8$)	Upgrade FEA in CNB/VAB (2.5%)	Recommend surveillance rather than surgical excision
McCroskey et al. 2018 [28]	FEA on VAB (43) FEA/ADH on VAB (18) FEA/LN on VAB (8)	No upgrade	Excision may not be necessary for pure FEA and FEA with atypical ductal hyperplasia limited to ≤2 terminal duct-lobular units, if at least 90% of calcifications have been removed on biopsy
Rudin et al. 2017 [29]	Metanalysis of 32 studies	Management change in 25%	Recommendation of OE after FEA on CNB
Samples et al. 2017 [30]	Interobserver diagnostic variability	Wide variation in the diagnosis of FEA	Diagnostic criteria may vary
Schiaffino et al. 2018 [31]	Upgrade FEA on VAB ($n=48$)	Upgrade FEA in VAB (2%)	Surgical excision may not be necessary in patients with VAB diagnosis of isolated FEA, without residual microcalcifications post-procedure and with concordant mammography
Yamashita et al. 2016 [32]	Interobserver diagnostic variability	Morphological criteria as nuclear ellipticity for columnar cell lesion	Consequent diagnostic criteria

FULL PAPER

Flat epithelial atypia: conservative management of patients without residual microcalcifications post-vacuum-assisted breast biopsy

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Advances in knowledge: Surgical excision may not be necessary in patients with VAB diagnosis of isolated FEA, without residual microcalcifications post-procedure and considered concordant with the mammographic presentation, considering the low rate of malignancy at subsequent follow-ups.

Strategy after Diagnosis of FEA

	Oxford LoE	Oxford GR	AGO
FEA in core biopsy/vacuum-assisted biopsy:			
→ Open excisional biopsy may be omitted under the following circumstances: a) a small lesion (≤ 2 TDLU* in vacuum biopsy) **and** b) Complete or near complete removal of imaging abnormality	3b	C	+
→ Representative open excisional biopsy in radiologically extensive microcalcifications or discordance to the radiological result	5	C	+
FEA at margins in resection specimen:	3b	C	++
→ No further surgery, unless calcifications have not been completely removed			

* Terminal ductal-lobular unit

- LOBULAR NEOPLASIA
  - *CZĘSTO BRAK KORELACJI RADIOLOGICZNO-PATOLOGICZNEJ PO BIOPSJI*

Risk of Breast Cancer after Atypical Hyperplasy (ADH, ALH)

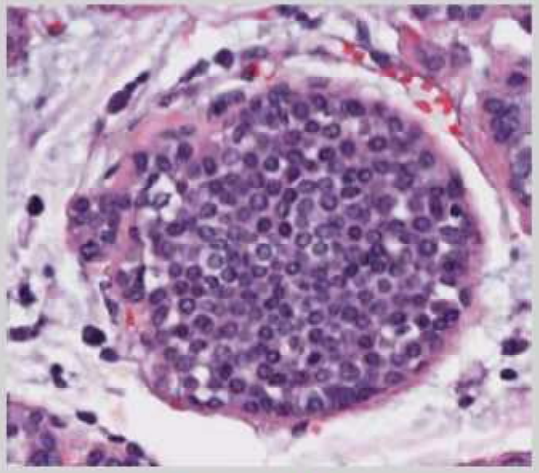
Stratification of breast cancer risk*

▪ Number of Foci:	1 2 ≥ 3	RR = 2.65 (2.06–3.41) RR = 5.19 (3.59–7.52) RR = 8.94 (5.48–14.59)
▪ Microcalcifications	present not present	RR = 3,21 RR = 4,21
▪ Type	ductal lobular both	RR = 3,83 RR = 3,67 RR = 7,10
▪ Age	< 45 45–55 > 55	RR = 6,76 RR = 5,10 RR = 2,67

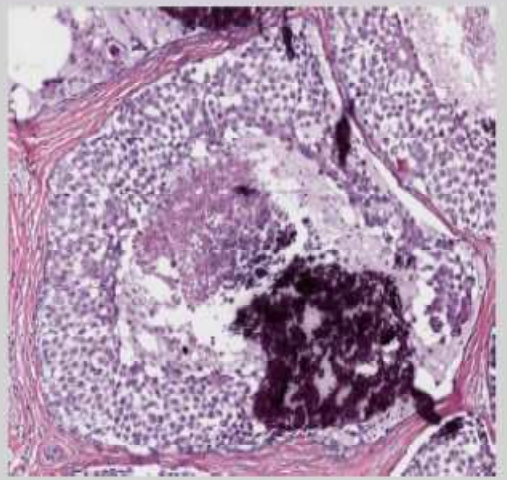
Lobular Intraepithelial Neoplasia (LIN)

- Includes: Atypical lobular hyperplasia, lobular carcinoma in situ, LCIS/CLIS
- LIN 1–3 classification is not sufficiently validated prognostically
- Pleomorphic LIN and LIN with comedo-type necrosis are classified as premalignant → **B5a**
- Indicator/Precursor lesion:
  Ipsi- and contralaterally increased breast cancer risk:
  7 x after 10 years

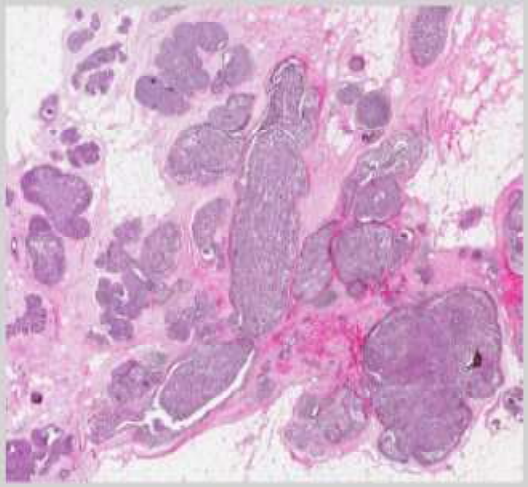
Classical LIN and Variants of LIN with increased risk



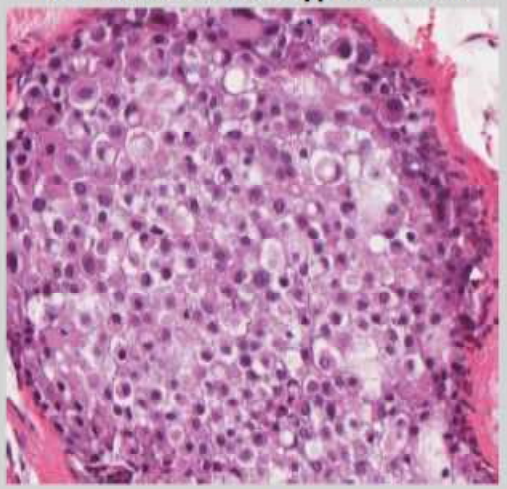
Classical LIN



LIN with comedo type necrosis



Florid LIN



Pleomorphic LIN

Rageth CJ, O'Flynn EAM, Pinker K. **Second International Consensus Conference on lesions of uncertain malignant potential in the breast (B3 lesions). Breast Cancer Res Treat. 2019 Apr;174(2):279-296. doi: 10.1007/s10549-018-05071-1. Epub 2018 Nov 30.**

Table 5 Summary of the recent literature on LN since 2015

Author and year	Number of patients analyzed or type of publication if no patients have been analyzed (e.g., review or comment)	Findings	Conclusions
Calhoun et al. 2016 [50]	$n=76$ on CNB Upgrade after 15 years follow-up	10 cases (13%) with upgrade	The extent of LN in CNB may be an indicator of the likelihood of upgrade to carcinoma
Donaldson et al. 2018 [15]	$n=393$ on CNB with ADH/LN Upgrade rate and follow-up (87 months)	Upgrade in $n=181$ (46%) The 7-year cumulative breast cancer incidence was 9.9%	Multiple foci do not influence BC development Close clinical and radiologic follow-up for more than 5 years in this patient population
Fives et al. 2016 [51]	$n=25$ LN on CNB accompanying fibroadenomas	Upgrade in 1 case (5%)	Rare upgrade
King et al. 2015 [40]	$n=1004$ with /wo chemoprevention Median follow-up 81 months	10-Year cumulative risk 7% With chemoprevention 21% (3.2% per year) with no chemoprevention	Chemoprevention reduced BC risk Volume of disease, (ratio of slides with LCIS to total number of slides) was associated with breast cancer development ($p=0.008$)
Mao et al. 2017 [52]	BC risk in LN -Hormone receptor status -Skin color		LN was higher in HR positive and in black patients
Maxwell et al. 2016 [53]	$n=392$ pure LN 326 with OE	Upgrade to pleomorphic LN In 23/326 cases (7%)	Screen detected LN -In younger women -Unilateral -Non-pleomorphic
Nakhlis et al. 2016 [54]	$n=77$ on CNB	Upgrade in 2 of 77 cases (2%)	Routine excision is not indicated for patients with pure LN on CB and concordant imaging findings
Renshaw and Gould, 2016 [4]	$n=69$ CNB with LN Upgrade Follow-up	Upgrade in 17 of 69 cases (25.8%)	Immediate BC risk is higher for ADH than LN Long-term BC risk is higher for LN than ADH
Schmidt et al. 2018 [55]	$n=178$ on CNB 115 OE 54 Surveillance (55 months follow-up)	Upgrade in 13/115 cases (11%) 1/54 Cases developed BC after follow-up (2%)	Low-upgrade rate and low BC risk
Sen et al. 2016 [56]	$n=447$ (ALH and LCIS)	Upgrade ALH 2.4% Upgrade LCIS 8.4%	Excision is recommended for LCIS on CNB and for ALH surveillance at 6, 12, and 24 months
Susnik et al. 2016 [47]	$n=302$ of 370 Upgrade after OE	Upgrade In 3.5% (8/228) pure LN lesions In 26.7% in "LCIS variants" (4/15) in 28.3% in LN with ductal atypia (15/53)	LN with non-classic morphology or with associated ductal atypia requires surgical excision, this can be avoided in pure LN

Arch Pathol Lab Med. 2018 Mar;142(3):391-395. doi: 10.5858/arpa.2017-0155-OA. Epub 2017 Nov 21.

Isolated Atypical Lobular Hyperplasia Diagnosed on Breast Biopsy: Low Upgrade Rate on Subsequent Excision With Long-Term Follow-up.

Muller KE, Roberts E, Zhao L, Jorns JM[1].

Author information

1 From the Departments of Pathology (Drs Muller and Jorns) and Biostatistics (Ms Roberts and Dr Zhao), Michigan Medicine, Ann Arbor.

Abstract

CONTEXT: - The upgrade rate to carcinoma on excision for atypical lobular hyperplasia diagnosed on breast biopsy is controversial.

OBJECTIVE: - To review cases with isolated atypical lobular hyperplasia on biopsy to establish the rate of upgrade on excision and correlate with long-term follow-up.

DESIGN: - A database search was performed for 191 months to identify breast core biopsies with isolated atypical lobular hyperplasia. Cases with other atypical lesions in the biopsy or discordant radiologic-pathologic findings were excluded. Invasive carcinoma and ductal carcinoma in situ were considered upgraded pathology on excision. Patients without and with a history of, or concurrent diagnosis of, breast carcinoma were compared.

RESULTS: - Eighty-seven cases of isolated atypical lobular hyperplasia on biopsy underwent subsequent excision, which resulted in 3 upgraded cases (3.4%). All 3 cases with immediate upgrades revealed ductal carcinoma in situ. Upgrade was higher in patients with a concurrent diagnosis of breast carcinoma (2 of 26 and 1 of 61; 7.7% versus 1.6%, respectively). Follow-up information was available for 63 patients (57.8 ± 43.9 months; range, 6-183 months). Overall, 13% of patients without a history of breast carcinoma had a future breast cancer event, with the majority (83%) presenting in the contralateral breast.

CONCLUSIONS: - With careful radiologic-pathologic correlation, the upgrade rate for isolated atypical lobular hyperplasia on biopsy is low, and a more conservative approach may be appropriate.

PMID: 29160721 DOI: 10.5858/arpa.2017-0155-OA

Strategy after Diagnosis of LIN

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	Oxford LoE	GR	AGO
LIN in core- / vacuum-assisted biopsy:			
→ No further studies when LIN (classical variant) represents an incidental or isolated finding in core or vacuum biopsy and concordance in imaging	2b	C	++
→ Open excisional biopsy, with pleomorphic LIN, florid LIN, or LIN with comedo type necrosis or when not concordant with imaging findings	2b	C	++
LIN at margins of resection specimen (BCT):			
→ No further surgery	2a	C	++
Exceptions:			
a) Pleomorphic LIN, florid LIN, or LIN with necrosis			
b) Imaging abnormality is not removed			

- ADH
  - -Jedna z częstszych przyczyn przekierowania z CB do biopsji otwartej
  - -Niedoszacowanie dla CB 10-50%, Dla VAB do 25%
  - -McGhan (2012) 20% ryzyko niedoszacowania, jednak 17% do DCIS a 3% do NST

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Atypical ductal Hyperplasia (ADH)

- **Synonyms:** Atypical intraductal epithelial proliferation (AIDEP), atypical epithelial proliferation of ductal type
- **Definition:** Atypical intraductal proliferations with cytological and structural features of well differentiated DCIS, such as rigid bridging or micropapillae, well demarcated cell borders and occupy less than two separate duct spaces. The extension of all involved lumens within one ductulo-lobular unit is less than 2 mm. Atypical ductal proliferations larger than 2 mm or in at least two ductules are classified as DCIS (low-grade).
- **Indicator/Precursor lesion:** Ipsi- and contralateral breast cancer risk: RR 3 - 5 x after 3 - 5 years.
- Particularly high risk for breast cancer when combined with BIRADS IV / V and high breast volume.

Rageth CJ, O'Flynn EAM, Pinker K. **Second International Consensus Conference on lesions of uncertain malignant potential in the breast (B3 lesions). Breast Cancer Res Treat. 2019 Apr;174(2):279-296. doi: 10.1007/s10549-018-05071-1. Epub 2018 Nov 30.**

Table 3 Summary of the recent literature on ADH since 2015

Author and year	Number of patients analyzed or type of publication if no patients have been analyzed (e.g., review or comment)	Findings	Conclusions
Ahn et al. 2016 [10]	$n=103$ Upgrade	Underestimation rates FEA (5.9%) FEA + ADH (44.4%) ADH 27.3%	Recommend OE especially if calcification is present
Badan et al. 2016 [11]	$n=40$ Upgrade	Underestimation rate ADH in CNB (50%) ADH in VAB (25%)	Recommend OE
Co et al. 2018 [12]	$n=104$	ADH in CNB (41%)	Suspicious mammogram correlates with upgrade
Collins et al. 2016 [13]	Association between extent of ADH/LN and BC risk	1–2 foci ADH (OR 3.5) 1–2 foci LN (OR 5.2) ≥3 foci ADH (OR 2.7) ≥3 foci LN (OR 8.0)	No influence of extent of ADH or LN on BC risk
Degnim et al. 2016 [14]	Association between extent of ADH /LN and BC risk	1–2 foci ADH (RR:2.65) 2 foci ADH (RR: 5.19) ≥3 foci ADH (RR 8.94) 1–2 foci LN (RR:2.58) 2 foci LN (RR: 3.49) ≥3 foci LN (RR 4.97)	BC risk increases with ADH/LN extension $p<0.001$

Donaldson et al. 2018 [15]	$n=393$ Upgrade	ADH/LN on CNB	No upgrade
Khoury et al. 2016 [16]	$n=100$ Upgrade	Underestimation rate ADH in VAB (15%)	Extension and nb of positive cores correlate with upgrade
Latronico et al. 2018 [17]	Upgrade ($n=45$) and long-term follow-up ($n=12$)	Upgrade after ADH 45% BC (8%)	Recommend OE
Menen et al. 2017 [18]	$n=175$ Follow-up after/wo surgery	BC 12% (after surgery) BC 5.6% (only follow-up) Contralateral BC only after surgery	Prior history of breast cancer was the only variable associated with subsequent breast cancer events (hazard ratio 12.53)
Menes et al. 2017 [19]	BC risk after ADH in CNB ($n=1727$) OE ($n=635$)	10-year cumulative BC risk 2.6% (CNB) 5.7% (OE)	BC risk after ADH diagnosis is higher
Mesurolle et al. 2014 [20]	$n=50$ Upgrade ADH in CNB	Underestimation rate ADH in CNB (56%)	OE recommended
Pena et al. 2017 [21]	$n=399$ Low BC risk after ADH in CNB	Underestimation rate ADH in CNB (16%) Low BC risk ADH in CNB (4–9%)	Low BC risk if (1) lack of necrosis and (2) 1–2 foci or ≥ 3 foci with $\geq 90\%$ removal
Renshaw and Gould, 2016 [4]	Upgrade and Long-term clinical follow-up 175 ADH on CNB	Underestimation rate ADH in CNB (30.3%) BC after surgery (11.5%)	Immediate BC risk is higher for ADH than LN Long-term BC risk is higher for LN than ADH
Yu et al. 2015 [22]	Upgrade ADH in CNB (83)	Underestimation rate ADH in CNB 9.5%	Age, associated mass, and calcification distribution are independent factors for upgrade

Strategy after Diagnosis of ADH in Biopsy Sypecimen

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Version 2019.1

	Oxford LoE	GR	AGO
ADH in core- / vacuum-assisted biopsy:			
→ Open excisional biopsy	3a	C	++
→ Open excisional biopsy may be omitted, with:			
a) No mass-lesion radiologically, and			
b) a small lesion (≤ 2 TDLU*) in vacuum biopsy, and	5a	C	+/-
c) complete removal of imaging abnormality			
ADH at margins in open biopsy specimen:			
→ No further surgery, if incidental finding accompanies invasive or intraductal carcinoma	3a	C	++

* Terminal ductal-lobular unit

Najważniejsza jest ścisła współpraca z radiologiem i patologiem!!!

Analiza metod diagnostycznych zmian ogniskowych w gruczołach piersiowych za pomocą otwartych biopsji chirurgicznych i biopsji gruboigłowych w Polsce

Zespół do spraw opracowania mapy potrzeb zdrowotnych MZ dla nowotworów łagodnych; reprezentant: A. Lorek
Klinika Chirurgii Onkologicznej Uniwersyteckiego Centrum Klinicznego im. prof. K. Gibińskiego, Śląski Uniwersytet Medyczny, Katowice

Wstęp. Liczne badania potwierdzają korzyści wykorzystania biopsji gruboigłowej (BG) w diagnostyce chorych z podejrzeniem raka piersi. W Polsce przeprowadzono badanie w celu określenia proporcji chorych u których rozpoznano raka piersi przez otwarte zabiegi chirurgiczne (WLE) i BG wykonanych w trybie hospitalizacji według województw.

Materiał i metody. W opracowaniu została wykorzystana mapa potrzeb zdrowotnych do identyfikacji chorych w 2014 roku i częściowo w 2015 roku, którzy mieli wykonaną WLE lub BG w trybie hospitalizacji z powodu zmian łagodnych piersi, i którym w jej wyniku zmieniono rozpoznanie z łagodnego na złośliwe. Ogółem zanalizowano 13 718 tys. hospitalizacji z procedurą WLE i 7205 hospitalizacji z BG.

Analiza metod diagnostycznych zmian ogniskowych w gruczołach piersiowych za pomocą otwartych biopsji chirurgicznych i biopsji gruboigłowych w Polsce

Zespół do spraw opracowania mapy potrzeb zdrowotnych MZ dla nowotworów łagodnych; reprezentant: A. Lorek
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Wyniki. W ogólnej liczbie hospitalizacji wynoszącej 13 718 tys., w których wykonano WLE i u 1506 tys. chorych zmieniono rozpoznanie na złośliwe, co stanowiło 8,59% nowych rozpoznań raka piersi w całym kraju. Zmiana rozpoznania z łagodnego na złośliwe w wyniku tej procedury różniła się znacznie wg województw od 5,3% do 23,4%. W ogólnej liczbie hospitalizacji w 2014 roku wynoszącej 7205 tys.,w których wykonano BG różnymi metodami wykazano 1574 tys. rozpoznań złośliwych, co stanowiło 8,9% nowych rozpoznań w Polsce. Wykorzystanie BG w trybie hospitalizacji do rozpoznania raka piersi różniło się znacznie wg województw od 0,6% do 34,4%.

Wnioski. WLE są nadal zbyt często wykorzystywane w diagnostyce zmian ogniskowych w gruczołach piersiowych w Polsce. Procedura BG w niektórych regionach jest zbyt często wykonywana w trybie hospitalizacji zamiast w ambulatoryjnym. Istnieje potrzeba analizy, jakości, oraz dostępności do nowoczesnej diagnostyki gruczołów piersiowych w niektórych województwach.

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