

Early breast cancer

- What is early breast cancer?

- Is it early in size

invasion

negative nodes

Histology

- Defined as cancer that has not spread beyond the lymph nodes.
- Includes Tis,T1,T2 and N1 and early Pagets

?

- What is carcinoma in situ

- No invasion of BM
- Detected on screening mainly by microcalcification

- Are there any clinical presentation of in situ?

- Rarely
- Blood stained nipple discharge
- Can present as a mass ...5%

Types of DCIS

- Low, intermediate and high grade
- Is a pathological diagnosis
- MICROINVASION is an important finding to be looked for

Treatment of DCIS

- Mastectomy may be overkill... but is curative
- Wide local treatment and radiotherapy is the current consensus for a single focus DCIS

Lobular carcinoma in situ

- Not usually picked up by screening
- Presents as a mass
- Needs follow up as it has a predictive value for bilateral disease.



Early invasive duct carcinoma

- What is the presentation?

- Mass
- Pain... <11% (study at the Edinburgh breast clinic)
- Single duct discharge any color
- Screen detected

Triple Assessment

What is triple assessment

Which is the most powerful?

- Mammogram + Ultrasound
- FNAC
- Clinical

- What if triple assessment is inconclusive?
- Next step?????

- CORE BIOPSY

(Excision biopsy is not in favour as it compromises future surgery.)

- What are the problems of core biopsy?

- What other investigation for screening?

- Basic CXR and US scan abdomen

Treatment

- What options for the Breast.?

- Mastectomy
- Breast conservation
- SSM and immediate reconstruction
- Mastectomy and delayed reconstruction

- What is the TRIAD for breast conservation

- Wide local excision WITH NEGATIVE MARGINS
- Axillary clearance or sentinel node
- Radiotherapy to the breast



Contraindications

- Early pregnancy
- Multifocal disease
- Collagen diseases

Recurrence rate??

- <7-11%...recurrences are treated with mastectomy
- Recurrence is no threat to long term survival

Treatment of axilla

- What nodes are important in breast cancer??

- Level 1 axilla
- Level 2 axilla
- Level 3 (infraclavicular)
- Interpectoral
- Internal mammary
- supraclavicular



- What is the concept of the sentinel node?

- First node to drain the tumour
- In early breast cancer 35% negative axillary nodes after routine clearance
- Unnecessary morbidity including lymphedema

- At present Sentinel nodes only on early breast cancer patients WITH NEGATIVE NODES
- An axillary recurrence is often aggressive hence later stage cancers not allowed

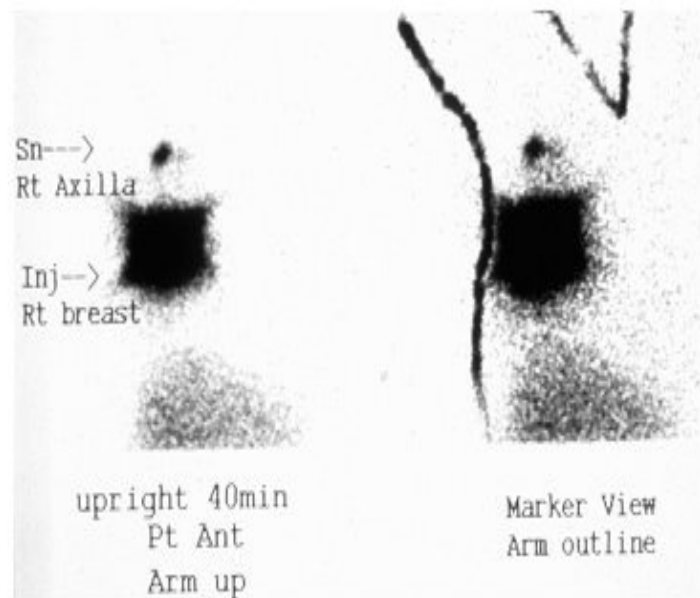
- Axillary negativity at present is clinical based....may evolve into mandatory scanning of axilla

Method

- Peri tumoral or subareolar injection of isotope at least 2 hours prior to surgery
- Blue dye (Isosulphan blue) injected in addition just prior o surgery
- Axilla scanned for isotope activity whilst in Radiology

Pre operatively,

Figure 3



Lymphoscintigram taken day of surgery. The breast is injected with a radionuclide dye and the dye travels to the sentinel lymph node.

Radioactive substance,

- . Day before/ same day
- . Serial large field gamma camera views AP/lateral in 15 mins. until initial draining nodes seen.

Colored dye

- . 5-10 mins. prior to surgery
- . Massage
- . colors streaks seen up to the sentinel node

- Patient anaesthetised and cleaned
- Navigator probe moved over axilla until high count
- Area explored and node found
- Immediate imprint cytology and decision to proceed or not
- Mastectomy completed.







- At times sentinel node as well as non sentinel nodes are found stained
- All sent for histology.

- If sentinel node not done..routine Axillary clearance to level 2
- If suspicious nodes level 2 then clear level 3
- Skip lesions < 2%
- Interpectoral sampling/clearance needed