

Management of Common Breast Problems

The evaluation of breast disease is based on risk factors and age and is determined by history, physical examination, imaging studies, cytologic examination, and biopsy. The clinician should be able to:

- Obtain a history related to breast disorders including:
 - Duration, onset, and cyclicity of signs and symptoms
 - Menstrual and reproductive history
 - Hormone use
 - Dietary habits
 - Breast implants
- Perform a thorough physical examination of the breasts
- Educate patients on technique of breast self-examination
- Counsel patients on the appropriate screening and diagnostic modalities for life-threatening breast disease, such as mammography and sonography, including timing and follow-up
- Diagnose and manage (consistent with training and experience) or refer for management, patients with:
 - A solid or cystic breast mass
 - A mammographic abnormality
 - Breast pain
 - Physiologic and pathologic nipple discharge
 - Mastitis
 - Fibrocystic conditions
- Counsel patients on familial risk and behavioral factors related to breast disease

Taken from the Guidelines for Women's Health Care, Second Edition, The American College of Obstetrics and Gynecologist,s, p. 270, 2002

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Adapted from the Society of Surgical Oncology and the Commission on Cancer of the American College of Surgeons

- **Thorough communication with patients about all management options, their risks, and all test results, as well as written documentation of these discussions, is of the utmost importance to the provision of quality care.**

Palpable Mass

Cyst

- Ultrasound or cyst aspiration useful to differentiate between solid and cystic mass.
- With aspiration, if mass does not disappear or fluid is bloody, send for cytology and refer to surgeon. Fluid can otherwise be discarded. Re-examine breast in six weeks for recurrence. If cyst recurs refer to surgeon. Otherwise, follow routinely.

Solid

- Refer patient to surgeon for solid, dominant, persistent mass as biopsy is almost always indicated.
- **A normal mammogram does not eliminate need for further evaluation of a clinically suspicious mass.** However, if mass is clinically benign on breast exam, and this is confirmed by cytologic exam and mammography, patient may be followed by a surgeon every three months until biopsy or resolution of problem.
- Women <30 most likely have cyst or fibroadenoma. Ultrasound or needle aspiration may be used to confirm. Refer to surgeon for solid, dominant, persistent mass as biopsy is almost always indicated.

Vague Nodularity

- If significant doubt exists about nature of mass, consider mammogram or ultrasound. If mass appears benign – slightly lobulated breast tissue, or poorly defined thickening not matched in opposite breast – recheck bi-monthly or quarterly. If mass persists after 3 months and can be distinguished from remainder of breast tissue, refer to surgeon.

Abnormality of mammography – nonpalpable

- For American College of Radiology (ACR) categories **four** (*suspicious abnormality – biopsy should be considered*) and **five** (*highly suggestive of malignancy*), refer to surgeon.
- For ACR category **three** (*probably benign – short term followup suggested*), patient may be followed with sequential imaging at an interval suggested by the radiologist. Clearly communicate to woman need for clinical and imaging followup.
- If further mammographic/ultrasound evaluation advised (*assessment is incomplete*), obtain recommended imaging studies to better characterize the abnormality.
- Non palpable simple cysts confirmed by ultrasound do not need aspiration except for pain relief. Cysts having suspicious characteristics need to be biopsied.

Breast Pain

- Perform clinical breast examination (CBE) and mammography, if age-appropriate.
- If exam and mammography negative, fibrocystic change is most likely. Reassure patient, offer a trial of non-narcotic analgesic, and recommend use of a well-supporting brassiere.
- If conservative measures do not relieve pain symptoms, referral to surgeon is indicated.

Skin/Nipple Change and Nipple Discharge

- Women with skin breakdown on the nipple or areola should be referred to a surgeon.
- Patient with palpable mass and any nipple discharge should be referred to a surgeon.
- If discharge suspicious for neoplasm (*spontaneous; unilateral; confined to single duct; occurring in older patient; clear, bloody, serous, or serosanguinous*) send patient for mammography and surgical consult.
- Nipple discharge (particularly if bilateral or mult ductal, or milky) is not suspicious for cancer and needs no referral. If milky discharge is profuse, medical workup for galactorrhea may be indicated.

The Worried Patient with a Negative Workup

- Refer patient to a surgeon for a second opinion.

Difficult Breast Examinations

- May refer woman to surgeon if she has had reduction or augmentation mammoplasty; if breasts very large or multinodular; if multiple biopsies severely scar breasts.
- All women who are pregnant or lactating and have a breast mass or area of patient concern should be referred to a surgeon.

High Risk Patients

- Consult breast cancer specialist for a woman with prior history of breast cancer, strong first-degree family history, or previous history of atypia or multiple biopsies. Such a woman may need a special followup regimen.