

A retrospective study on carcinoma breast

Dr.V.Kopperundevi Ms¹, Dr.V.Pandiyan Ms², Dr.S.Kiruthiga Ms³.

¹Associate Professor, ²assistant Professor, ³post Graduate,

Department Of General Surgery, Thanjavur Medical College And Hospital, Thanjavur.

Abstract:: Breast cancer is the most common diagnosed malignancy in India, it ranks second to cervical cancer. The burden of breast cancer is increasing in both developed and developing countries; the peak occurrence of breast cancer in developed countries is above the age of 50 years whereas in India it is above the age of 40 years

Aim: To Analyse the incidence of age, stage at presentation and the modality of treatment given and hormone receptor status. It is a retrospective analysis of case sheets of women with breast cancer admitted from January 2015 to December 2015. About 76 patients were included in this study, with information of age, stage on presentation, its pathological information, treatment provided like operative management, hormonal therapy, neoadjuvant or adjuvant chemotherapy, and immunohistochemistry of biopsy specimen.

Keywords: Breast cancer, site of breast lump, immunohistochemical studies, operative management, chemotherapy.

Inclusion and exclusion criteria: Patients diagnosed with the Carcinoma Breast during the period Jan 2015 – Dec 2015 were included. Already diagnosed and on treatment for Ca Breast before 2015, and male breast cancer were excluded.

I. Introduction

Breast cancer is the most common female cancer worldwide representing nearly a quarter (23%) of all cancers in women. The global burden of breast cancer is expected to cross 2 million by the year 2030, with growing proportions from developing countries. Breast cancer incidence rates within India display a 3–4-fold variation across the country, with the highest rates observed in the Northeast and in major metropolitan cities such as Mumbai and New Delhi. Change in food style, life environment, education, obesity and genetic mutations were responsible for these variations.

Breast cancer is detectable at self breast examination and it is curable at earliest presentation. Breast cancers have good prognosis relatively when compared to other cancers. Most of the patients seek medical advice when the disease is fairly advanced. For women with symptomatic breast cancer, prolonged delay, defined arbitrarily as an interval greater than 3 months from first detection to time of diagnosis and treatment has been shown to be associated with increased tumor size and more advanced stage of disease and with poor long-term survival. Late stage of presentation can be attributed to lack of awareness regarding the nature of disease and fear about treatment. Breast cancer at a younger age has been associated with larger tumor size, higher chances of metastasis, faster tumor growth, and more frequent recurrences of the cancer. All of this decreases chances of survival.

Cancer is divided into four stages: stage I, II, III, and IV. In ductal carcinoma in situ (DCIS), the abnormal cells are just in the top layers of cells in the ducts within the breast and haven't invaded any deeper. In some women, DCIS turns into invasive breast cancer, or sometimes an area of DCIS contains invasive cancer. In some women, though, the cells just stay within the ducts and never invade deeper or spread to lymph nodes or other organs. Stage IV is the last stage of cancer where chances of survival are very low. Being diagnosed with Stage IV breast cancer usually indicates that the cancer has become invasive and has spread beyond the breast into the lymph nodes, lungs, skin, bones, or other organs of the body.

In our study we have focused on the age at presentation and its surgical management, immunohistochemical studies and the followup of patients with hormonal therapy and chemotherapy. Hormone therapy drugs used tamoxifen.

II. Results

76 patients were studied. Among them, 41 were in menopausal age group and 35 patients were in reproductive age group. In 43 patients right side breast was involved and in 33 patients left side breast was involved. About 57 patients presented at the stage of stage 3, stage 2-10 patients, stage 1-5 patients and stage 4-4 patients. Surgical procedure MRM was done as initial treatment for 44 patients. Out of 28 patients who underwent neoadjuvant chemotherapy only 15 patients returned for surgery. MRM was done for 8 patients and simple mastectomy for the remaining 7 patients. Adjuvant chemotherapy started for 44 patients. Only 40 patients

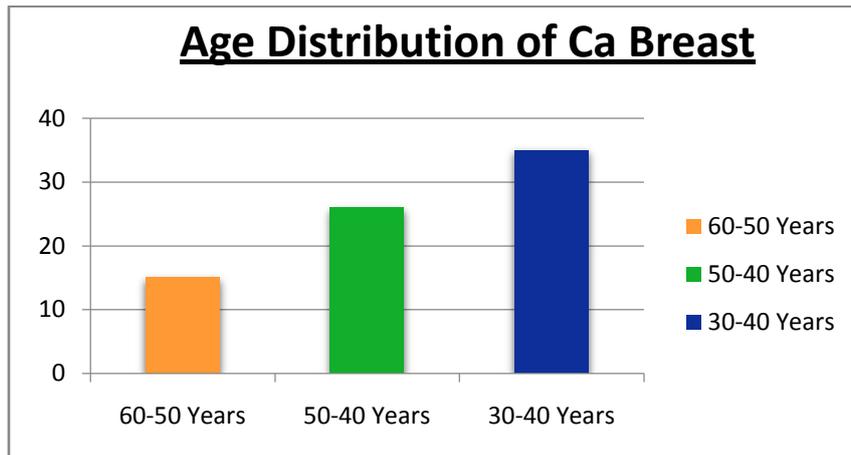
completed chemotherapy. Radiotherapy was combined for 10 patients. Hormonal therapy (T. Tamoxifen 10mg BD) started for 48 patients.

The Immunohistochemical analysis was done for 46 patients, 13 patients were shown to have triple negative, 12 patients showed ER+PR+HER2+, 15 patients showed ER- PR+HER2+, 6 patients showed ER+,PR-,HER2-. About 59 patients showed intraductal carcinoma, 6 patients showed lobular carcinoma, 11 patients had ductal carcinoma in situ. About 34 patients were on regular follow up and 42 were on irregular follow up.

Age distribution of carcinoma breast:

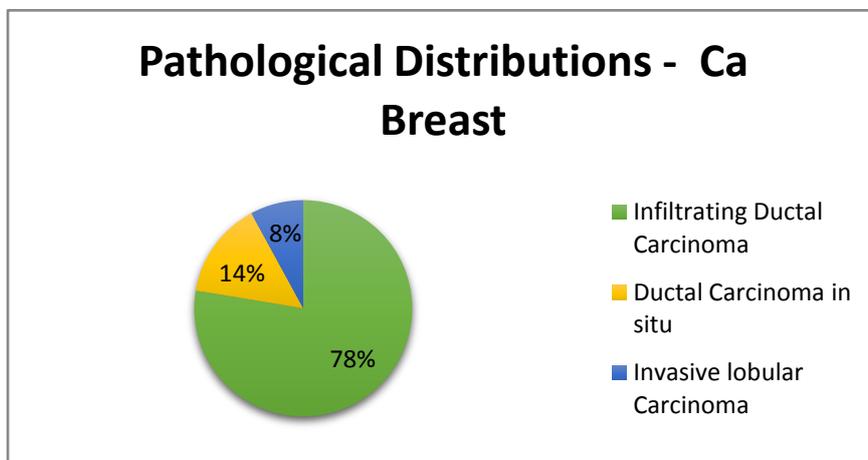
Total No. of Patients: 76

Distributions of Age	No. of Patients
50-60 years	15
40-50 years	26
30-40 years	35



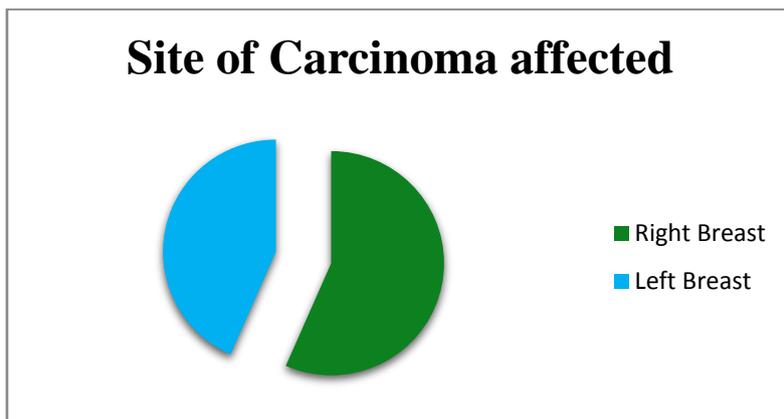
Pathological distributions:

Pathological Distributions	No. Of Patients
Infiltrating Ductal Carcinoma	59
Ductal Carcinoma In Situ	11
Invasive Lobular Carcinoma	6



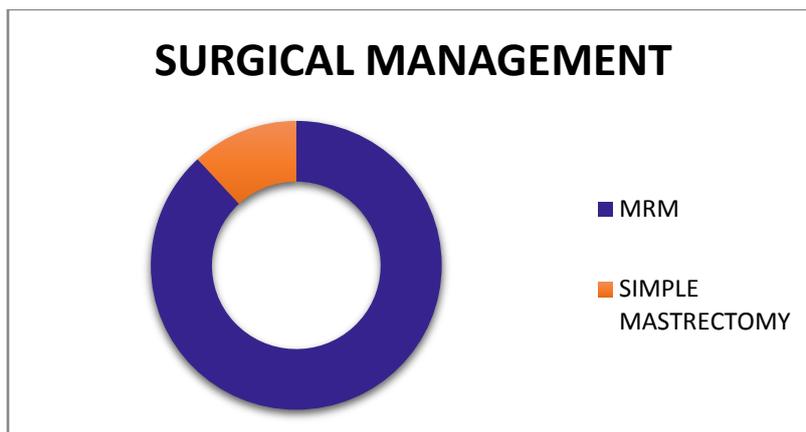
Site of carcinoma affected:

Site of Carcinoma affected	No. of Patients
Right Breast	43
Left Breast	33



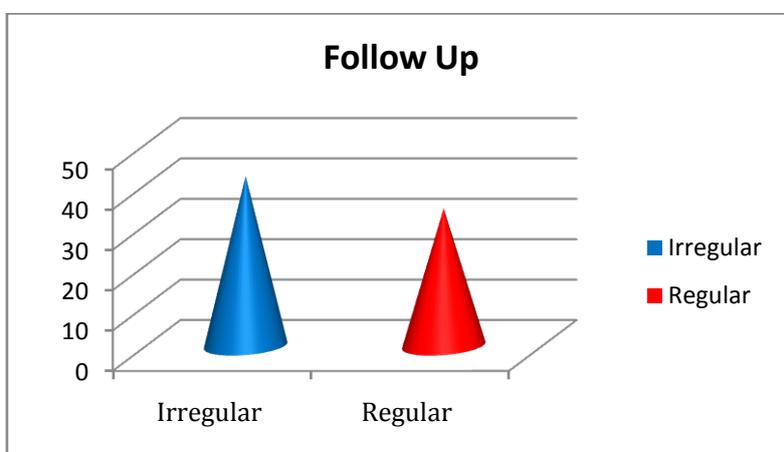
Surgical Management

MRM	-	52
Simple Mastrectomy	-	7



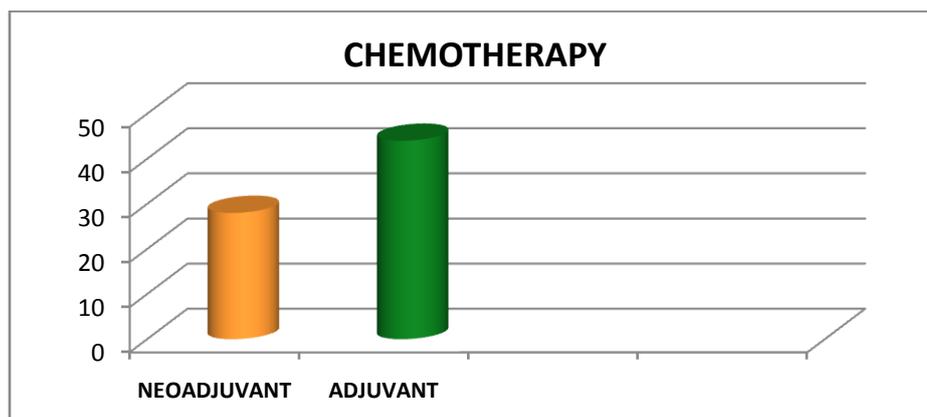
Follow up of the patients:

Irregular Follow up	: 42
Regular Follow up	: 34



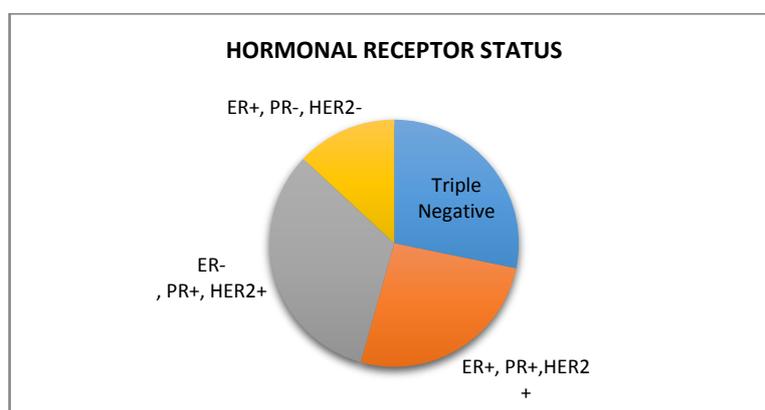
Patient received:

Neoadjuvant Chemotherapy	-	28
Adjuvant Chemotherapy	-	44



Hormonal Receptor Status

Triple Negative	-	13
ER+, PR+, HER2+	-	12
ER-, PR+, HER2+	-	15
ER-, PR-, HER2+	-	6



III. Conclusion

In this study majority of the female breast cancers were infiltrating ductal carcinoma (45%) presented in advanced stage of the disease.

This reflects the poor awareness regarding the symptoms of early cancer.

About 26% of patients were around the 30- 40 yrs. 43% of the patients presented with stage 3 diseases. In the neoadjuvant group (28patients) only 15 patients underwent surgery.The remaining patients (13) did not come for follow up after a 2-3 doses of chemotherapy.

Efforts to be made to detect breast cancer at the very early stage through periodic screening of high risk groups either by physical self examination or by self breast examination as number of affected individuals is rising and the age of onset is shifting towards younger age groups. Training of health care providers and community worker should be frequent regarding the latest evidence of breast cancer risk factor, early warning signs, significance of a painless lump and its treatment facility should be emphasized, so they can transmit this knowledge to the other sections of society. Continuing medical education programmes with enhanced emphasis on breast cancer in the curricula of nursing at institutional level and other healthcare training institutions should be a priority for women’s health in the country.

References

- [1]. Population based cancer registries consolidated report (1990-96) [Last accessed on 2010 Oct 31].
- [2]. L. Drazan, J. Vesely, P. Hyza et al., “Bilateral breast reconstruction with DIEP flaps: 4 years' experience,” Journal of Plastic, Reconstructive and Aesthetic Surgery, vol. 61, no. 11, pp. 1309–1315, 2008.
- [3]. A. E. Isern, I. Tengrup, N. Loman, H. Olsson, and A. Ringberg, “Aesthetic outcome, patient satisfaction, and health-related quality of life in women at high risk undergoing prophylactic mastectomy and immediate breast reconstruction,” Journal of Plastic, Reconstructive and Aesthetic Surgery, vol. 61, no. 10, pp. 1177–1187, 2008.
- [4]. M. H. Frost, T. L. Hoskin, L. C. Hartmann, A. C. Degnim, J. L. Johnson, and J. C. Boughey, “Contralateral prophylactic mastectomy: long-term consistency of satisfaction and adverse effects and the significance of informed decision-making, quality of life, and personality traits,” Annals of Surgical Oncology, vol. 18, no. 11, pp. 3110–3116, 2011.

- [5]. J. Gahm, M. Wickman, and Y. Brandberg, "Bilateral prophylactic mastectomy in women with inherited risk of breast cancer—prevalence of pain and discomfort, impact on sexuality, quality of life and feelings of regret two years after surgery," *Breast*, vol.19, no.6, pp 462–469,2010.
- [6]. M. denHeijer, C. Seynaeve, R. Timman et al., "Body image and psychological distress after prophylactic mastectomy and breast reconstruction in genetically predisposed women: a prospective long-term follow-up study," *European Journal of Cancer*, vol. 48, no. 9, pp. 1263–1268, 2012
- [7]. P. Hopwood, A. Lee, A. Shenton et al., "Clinical follow-up after bilateral risk reducing ('prophylactic') mastectomy: mental health and body image outcomes," *Psycho-Oncology*, vol. 9, no. 6, pp. 462–472, 2000.
- [8]. A. McGaughey, "Body image after bilateral prophylactic mastectomy: an integrative literature review," *Journal of Midwifery and Women's Health*, vol. 51, no. 6, pp. e45–e49, 2006.
- [9]. D. Unukovych, K. Sandelin, M. Wickman et al., "Breast reconstruction in patients with personal and family history of breast cancer undergoing contralateral prophylactic mastectomy, a 10-year experience," *ActaOncologica*, vol. 51, no. 7, pp. 934–941, 2012.