Evaluation of Pathology Results of Excisional Biopsies in Patients with Pre-Diagnosis of Intraductal Papilloma

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INTRODUCTION

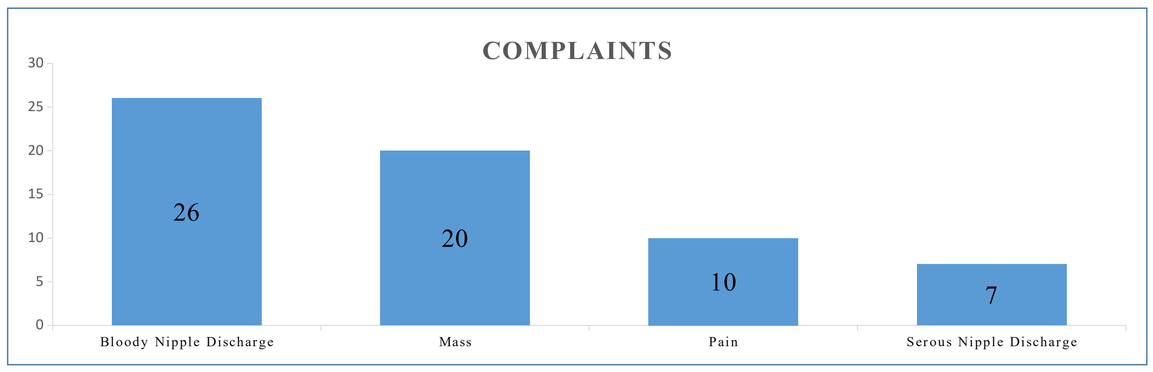
Intraductal papilloma is found in the breast ducts and is the most common cause of pathological nipple discharge, with a rate of nearly 50 percent (1). Risk factors for IDP include contraceptive use, hormone replacement therapy, lifelong estrogen exposure and family history (2). While preliminary diagnosis can be made with mammography, ultrasound and MRI, tissue sampling is also required in addition to imaging if necessary (3). Intraductal papilloma is classified as a high-risk precursor lesion. This classification stems from its association with atypia, DCIS, and carcinoma (3). Definitive diagnosis of intraductal papillomas is often made by tru-cut biopsy, and excisional biopsy is recommended if an atypical papilloma is seen in the tru-cut biopsy (4). Papillary lesions with atypia cause an increase in the patient's risk of developing breast cancer by 7.5-fold (5).

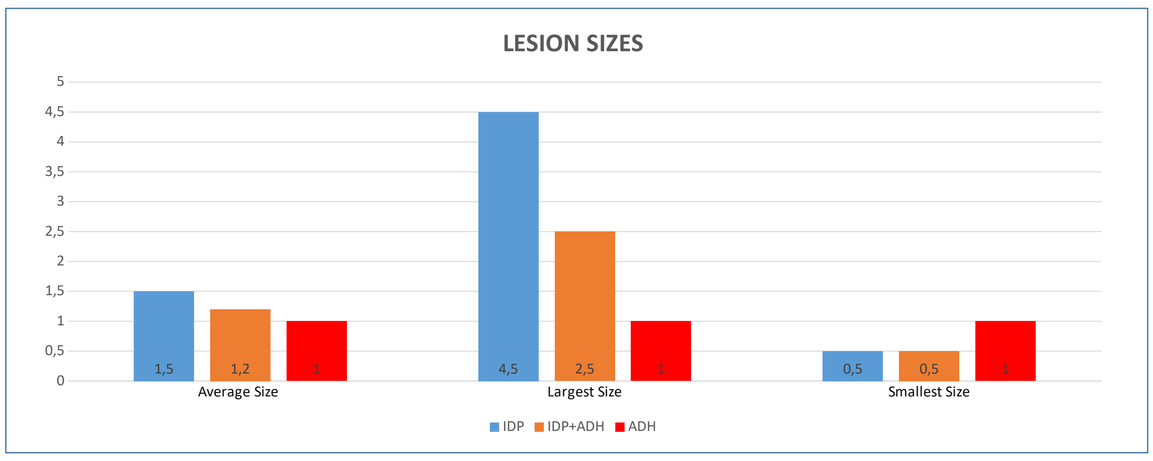
METHOD

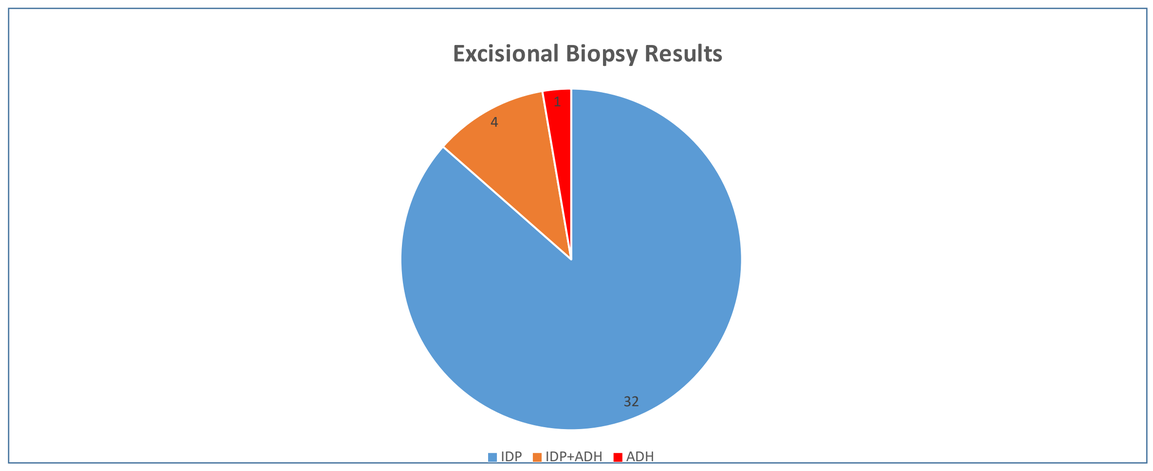
In our retrospective study, patients who were admitted to Bezmialem Vakif University Hospital General Surgery Outpatient Clinic between October 2010-February 2023 and were undergone excisional biopsy after diagnosing with IDP by core biopsy were investigated. Nucleus Database of the hospital were used to retrospectively analyze the data of patients regarding demographic features, complaints, radiology reports, trucut biopsy and surgical excision results.

RESULTS

63 patients, with mean age of 43.7 (range:13–79), had complaints of bloody nipple discharge (n: 26), mass (n: 20), pain (n: 10) and serous nipple discharge (n: 7). 37 patients underwent excisional biopsy, while 26 were followed up. Among patients who underwent excisional biopsy, 9 had IDP-compatible findings only in ultrasound (USG), 8 in both USG and mammography (MMG), 5 in both USG and magnetic resonance imaging (MRI), and 8 in USG, MMG, and MRI. The pathology of the excised lesions resulted as IDP in 32 cases (86.5%), IDP+ADH (atypical ductal hyperplasia) in 4 cases (10.8%), and ADH in 1 case (2.7%). Almost 13,5% of the lesions that were reported as IDP in core biopsy, showed additional ADH after excision (mean age 47,6). When we examined the lesion sizes, the smallest size in the lesions resulted IDP was 0.5 cm, the largest size was 4.5 cm, and the average size was 1.5 cm. For IDP+ADH lesions, the smallest size was 0.5 cm, the largest was 2.5 cm, and the average size was 1.2 cm. For the ADH lesion, it was 1 cm. While 15 of the lesions were marked with a wire for excision before surgery, 22 were marked with a skin marker.







CONCLUSION

Since ADH increases the risk of breast cancer, IDPs especially showing ADH in core biopsy, palpable and detectable as a mass on a mammogram, >1 cm in size and ones in the patients of 45-50 years of age should be evaluated carefully and considered for excisional biopsy.

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