Breast Health Update
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Significance
- 1 in 8 women who live to be 80 years of age will develop breast cancer in their lifetime (NCI)
- Breast cancer is the second-leading cause of cancer death among women in the United States (USPSTF)

Disclosures
- Nothing to disclose

Taking a Breast Health History
- Breast health history should be completed with a WWE
- Include family and personal Hx of breast and ovarian cancer
- Hx of lobular carcinoma in situ and/or atypical hyperplasia
- Hx of radiation to the thoracic cavity

Breast Health Update
- Identify evidence based routine screening guidelines for women of all ages.
- Identify the elements of a relevant breast health history for women during a routine WWE and counseling women on risk and genetic counseling.
- Demonstrate comprehensive clinical self breast exam (CBE) and appropriate documentation, referral and follow up actions.
- Interpreting mammogram results and developing appropriate follow up plans.

Breast Health History
- There are many risk assessment tables available.
  - www.cancer.gov/bcrisktool/
  - PPFA has Breast Cancer Risk screening Questionnaire
You should consider incorporating it into your EHR.
For example if you answer yes to specific questions it would prompt further questions or recommend genetic counseling
Average Risk Screening

- Annual Mammogram starting at age 40 (ACS)
- Clinical Breast Exam (CBE) every 1-3 years from the age of 21-29 then annually at age 40 and beyond
- If it is established that the patient is above average risk the CBE may be more frequent and/or imaging started at an earlier age.
- Controversy in screening and BSE

CBE

- Length of exam varies based on size of breast and clinician technique
- All CBE should include inspection and palpation in different positions.

Clinical Breast Exam

- Discover suspicious/ non suspicious breast changes
- Evaluate changes discovered by the patient

CBE

- Women in their 20s and 30s should have a clinical breast exam (CBE) as part of a periodic (regular) health exam by a health professional preferably every 3 years. Starting at age 40, women should have a CBE by a health professional every year. (ACS)
- When a patient has physical symptoms or concerns
- As follow up from previous clinical

CBE

- As follow up from previous clinical

Inspection

- Looking at breast in a seated position
- Symmetry
- Skin changes
- Nipple changes
- Dimpling

Positions

- Arms above the Head to check for contour.
- Symmetry
Position

- Hands on hips
- Check for dimpling or retractions

Supraclavicular and Axillary Nodes

Examine Breast Tissue

- Patient should be in supine position with arm over head.
- Knees may be bent and fall to opposite side for larger breasted women
- Pillow or towel under hip for comfort

Examine Breast Tissue

- Breast exam should include:
  - Blouse seam
  - Below bra-line
  - Breast Bone
  - Collar Bone
  - Mid Axillary line
  - Using a vertical strip pattern starting at axilla

Things to remember

- Mastectomy get the same exam perimeters including palpating scar tissue
- The vertical strip method is like a lawn mower pattern. Using overlapping strips
- Pressure should be applied at 3 levels
  - Light
  - Medium
  - Deep
Breast Documentation

- Normal findings should include
  - Symmetry
  - Tenderness
  - Presence of a mass
  - Skin changes
  - Nipple changes
  - Lymph nodes

  Most common reads as: bilateral breasts are symmetrical, non-tender, no suspicious masses, skin or nipple changes or lymphadenopathy are noted on exam.

Documenting Breast Mass

- Location and Size are essential
- Shape, Tenderness, Margins, Consistency, and Mobility are additional components to note.
- The Location description should include both a narrative and a drawing.
- It should note the side where the mass was found, its location as a clock face description, and the distance from the areolar edge (in cm). Note the size of the mass in 2 dimensions as 2 measurements (in mm).

Documenting Breast Mass

- If there are abnormal findings they typically fall into 4 categories
- Inspection include: symmetry, retraction, dimpling, color
- Nipple discharge: color, consistency, number of ducts involved, location and unilateral of bilateral
- Lymphadenopathy
- Breast Mass

Documentation

- Referral and follow up
  - All patients with abnormal findings should be informed of the plan to further evaluate the findings.
  - Chart completeness is essential for both quality and continuity of care but also for liability
  - Routine screening and breast self-awareness

Referral and follow up

- Managing results
  - Understanding the BI-RADS system
  - Utilize both the imaging results and the CBE information
  - Understand the latest evidence-based recommendations for further testing and referring to breast specialist.
**BI RADS Categories**

- BiRads 1 - negative
- BiRads 2 - Benign findings
- BiRads 3 - Probably benign findings
- BiRads 4 - Suspicious abnormality
- BiRads 5 - Highly suggestive of Malignancy
- BiRads 6 - Known Cancer
- BiRads 0 - Additional evaluation needed

**Category 4 – Suspicious**

- Abnormality – Biopsy Should be Considered: Findings that do not have the classic appearance of malignancy but have a wide range of probability of malignancy. Can be subdivided into 4A – low suspicion, 4B – intermediate suspicion, 4C – moderate suspicion.

**BI RADS 1 and 2**

- Category 1 – Negative: Nothing to comment on.
- Category 2 – Benign Findings: Normal but the radiologist may include a benign finding such as calcifications, fat-containing lesions, lymph nodes, etc.

**BI RADS 5 and 6**

- Category 5 – Highly Suggestive of Malignancy – Appropriate Action Should be Taken: These lesions have a high probability (greater than 95 percent) of being cancer.
- Category 6 – Proven Malignancy: Not often used, usually in cases of biopsy-proven cancer prior to definitive therapy

**Category 3 – Probably Benign**

- Finding – Initial short-Interval Follow-up Suggested: Used for a lesion that is not definitely benign & can be safely followed with short-term imaging surveillance rather than biopsy. These lesions carry a less than 2 percent likelihood of malignancy

**Category 0 – Need Additional**

- Imaging Evaluation and/or Prior Mammograms for Comparison: This recommendation may include spot compression, magnification views, special mammographic views and/or ultrasound. If available, a mammogram should be compared to previous studies for stability.
MRI vs Ultrasound

US used to evaluate a palpable mass with neg mammo, density of breast is distorting the image of the mass
MRI is used to evaluate extent of the lesion
determine metastasis, response to treatment
Patients in whom prior studies or clinical findings are inconclusive

References


American Cancer Society

AHRQ

The American College of Radiology BI-RADS® ATLAS, 5th ed (Updated 6/24/14)

Breast Cancer Screening and Diagnosis Algorithms
http://qap.sdsu.edu/