

POSITION PAPER ON BREAST CANCER DIAGNOSIS

BACKGROUND

Breast cancer is the second leading cause of cancer deaths in women in the United States. Almost two million women will be diagnosed with the disease in the next decade and approximately 450,000 will lose their lives to the disease within the same time frame. Although the incidence of the disease has consistently risen over the past 40 years, mortality is unchanged.

Although reduction of the morbidity and mortality of breast cancer depends upon early detection and appropriate management once the condition is diagnosed, the greatest gains will ultimately come from effective preventive measures. The American Medical Women's Association has identified multiple areas for improvement in breast cancer control. Our positions on the issues of diagnosis follow.

Diagnosis of Breast Cancer

1. Breast cancer diagnosis is a multi-specialty effort that includes nurses, primary care physicians, diagnostic radiologists, surgeons, pathologists, social workers and psychologists. The interpretation of clinical examination of the breast is an art rather than an exact science; this is also true of mammography. Women may become "lost between the cracks" when close follow-up of an equivocal result is recommended. This is most likely to occur in a setting where roles among and between the woman's health care providers is undefined.
2. Definitive breast cancer diagnosis has traditionally required open biopsy. With the increasing use of screening mammography, many equivocal results have resulted. It is unnecessary and not cost-effective to biopsy every non-palpable mammographic abnormality given that, even in the best settings, only 25% of mammographic abnormalities which are biopsied represent cancer. An alternative to open biopsy recently available to women with mammographic abnormalities is sampling of the abnormality using stereotaxic techniques. Since little data is available regarding effectiveness of this technique, follow-up of the mammographic abnormality is warranted to ensure its stability.
3. Just as with any diagnostic test, mammography is not 100% sensitive. Any woman with a palpable abnormality of the breast needs diagnostic work up, regardless of the results of the mammogram.
4. Breast lumps, or asymmetrical breast thickenings, are the most common presentation of breast cancer. However, most breast lumps (80%) are benign. If a lump or asymmetrical thickening is not removed, close follow-up of it is required,

just as in the case of the non-palpable mammographic abnormality. Diagnostic accuracy in this setting is often enhanced by fine needle aspiration biopsy. These principles are true regardless of the results of the mammogram.

5. Women with a breast lump are sometimes told that it is "just a cyst". It is impossible to reliably distinguish a cyst from a solid mass by physical examination. Further diagnostic work-up with needle aspiration (which is also therapeutic in the case of a cyst) or ultrasound is required.
6. Spontaneous nipple discharge is an uncommon, but often ignored, symptom. Persistent spontaneous nipple discharge requires surgical consultation, and in some cases, evaluation with galactography.
7. Failure to diagnose breast cancer is the second most common reason for malpractice action against physicians, and results in the highest indemnity payments of any single condition. Risk management principles exist to address the most common pitfalls in breast cancer diagnosis.

Given the above considerations, the American Medical Women's Association advocates for the following:

1. Promotion of a multi-specialty approach to the diagnosis of breast cancer with clearly defined roles and expectations among providers regarding any needed follow-up.
2. In cases of equivocal findings on mammography, close follow-up must be done. In general, this consists of a 6 month follow up for one year, followed by a minimum of yearly follow up for the following two years. This results in documentation of three years of stability. An alternative approach is evaluation via core or fine needle biopsy. In this case, a minimum of yearly mammography for three years is helpful to ensure stability.
3. All breast symptoms should be pursued to resolution, as indicated by spontaneous symptom regression, ensuring abnormality stability through repeated exams at regular intervals, cyst aspiration, or through surgical removal.
4. Professional education addressing risk management principles specific to breast cancer diagnosis must be vigorously pursued. Collaboration with outside organizations may be helpful in this regard.

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