

CLINICAL PRESENTATION AND HISTOPATHOLOGICAL CO-RELATION IN THE MANAGEMENT OF BREAST TUMOUR

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ABSTRACT: AIM: To plan the line of management for carcinoma breast as per the clinical and histopathological findings. **OBJECTIVES:** To study various clinical presentations of breast cancer and its co-relation with histopathological pattern. **METHOD AND MATERIALS:** All the patients coming to the OPD and admitted to IPD of the surgery dept. with a mass in the breast will be screened and the data will be collected in a pre-structured and pre-formed Performa. A detail history about all vital information and other parameters will be collected in the Performa along with information regarding diagnosis, lab and histopathological examination. Then after taking consent from the patient standard histopathological examination will be done. The clinical information will be correlated with histopathological report and plan of management of the patient will be drawn accordingly. **CONCLUSION:** Our result shows that the size of the primary tumour directly corresponds to the axillary metastasis. All pathological types of breast cancer can occur in all quadrants of breast. Axillary dissection with removal of lymph nodes up to level II is a must for accurate staging and treatment. If the histopathological evaluation of lymph node has tumor tissue it should be taken as systemic disease and adjuvant chemotherapy is warranted. Irrespective of the tumor size or the stage at which they presented all patients in our study underwent modified radical mastectomy and our follow up over a period of 0- 18 months showed no recurrence. But some of the patients who presented with early breast tumor were over treated because of inability to rule out axillary metastasis. This problem can be avoided with newer methods like sentinel lymph node biopsy and cryotyping. Awareness must be raised and regular screening for breast cancer must be under taken to direct the cases in its early stage.

KEYWORDS: Breast lump, Breast carcinoma, Fibroadenoma.

INTRODUCTION: Breast is a glandular organ and possesses a dynamic structure that undergoes changes throughout the women's reproductive life. These changes involve disturbances in the breast physiology extending from an extreme of normality to well defined disease process including lesions and lumps.^{1,2} The most common presentation of breast disease is a palpable lump. Virtually every woman with a breast lump, breast pain or discharge from nipple fears that she has breast-cancer. Early diagnosis is the key to increase survival. However social, religious factors, unawareness of fatality of the disease, false vanity and fear of infertility hinder early diagnosis and treatment.^{3,4} Breast cancer is the second leading cause of cancer deaths in women today (After lung cancer) and is the most common cancer among women, excluding nonmelanoma skin cancers. Breast cancer comprises carcinoma and sarcoma but

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incidence of sarcoma in breast is less than 1%.¹ According to the American Cancer Society, about 1.3 million women are diagnosed with breast cancer annually worldwide and about 465,000 will die from this disease. According to the Society, breast cancer death rates have been dropping steadily since 1990 because of earlier detection and better treatments but about 40,910 breast cancer deaths are expected in 2007.³ Urban life style and stress may contribute breast lesions as common problem especially in adults.⁵ Breast cancer rates are rising in many western countries but deaths from the disease have decreased in some countries as a result of improved screening and treatment.^{6,7} In western world breast cancer accounts for 27% of all females' cancer and the incidence of breast cancer is particularly low in developing countries and Japan.^{8,9,10} This variation may be due to social, dietary, early marriage and related other factors.¹¹ As breast cancer is a devastating disease so, it is important for the surgeon to rule out carcinoma with minimal invasive investigation and thereby prevent the patient to undergoing surgery.¹² Breast cancer results from uncontrolled proliferation of malignant cells resulting appearance of lump or mass in the breast. Benign lesions such as fibroadenoma are managed effectively with superb result. However, malignancy imparts importance of accurate diagnosis and treatment. Malignant neoplasm is frequent like other cancer conditions in many parts of the world.¹³ Mayun et. al., in 2008 reported that delay in diagnosis and presentation causes excruciating phenomena such distant metastasis which leads to complicated management of disease.¹⁴ Patient over 30 years of old should be tested for cancer and consult with the physician cancer.¹⁵ Mammography could be a useful technique to investigative breast cancer.¹⁶

AIMS AND OBJECTIVES: Women with breast carcinoma do not benefit from removal of non-involved axillary lymph nodes. As clinical examination of axilla is a relatively poor indicator of nodal involvement, axillary dissection has been an integral part of treatment selection for adjuvant therapy. Axillary dissection, therefore, is over treatment for many women and contributes substantially to the long term morbidity. Management strategies that avoid axillary dissection are needed for women with invasive breast carcinoma.

MATERIALS AND METHODS: It is a prospective study of patients admitted in in Krishna Institute of Medical Sciences and Hospital with breast tumor. All the patients coming to the OPD and admitted to IPD of the surgery dept. with a mass in the breast will be screened and the data will be collected in a pre-structured and pre-formed proforma. A detail history about all the vital information and other parameters will be collected in the proforma along with information regarding diagnosis, lab and histopathological examination. Then after obtaining consent from the patient standard histopathological examination will be done. The clinical information will be correlated with histopathological report and plan of management of the patient will be drawn accordingly. Patients who come for simple mastitis and other non-tumor conditions are not included in this study.

PROCEDURE: All patients presenting to surgical OPD with complaints of breast lumps were subject to a thorough clinical examination and patients in whom a clinical diagnosis of a breast carcinoma was made, underwent an FNAC examination. Patients who were confirmed to have a

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carcinoma of the breast were admitted to the hospital and all clinical details as mentioned in the proforma (Annexure II) were recorded. The original three dimensional macroscopic tumor size of the clinically palpable tumor was recorded and the number of clinically palpable Axillary lymph nodes was noted. After all the required routine investigations were performed and the patient was declared fit for the proposed surgery, the patient underwent a modified radical mastectomy and Axillary clearance.

The technique of dissection was as normally followed, with the axillary dissection up to level I and level II. The technique was not uniform as a number of surgeons working at the surgical units of the institution performed this procedure.

All the lymph nodes that were excised along with the breast tumor mass were marked with silk sutures to aid the pathologist in identifying the lymph nodes. The gross specimen and the tumor size was measured and recorded. The specimen was sent to the Department of Pathology at Krishna Institute of Medical Sciences and Hospital, Karad for histopathological examination. Data from the histopathological report collected included the size of tumor as recorded by the pathologist, which was compared with our measurements and verified. The report also contained histologic type of the tumor and grading.

OBSERVATIONS AND RESULTS: The following are the observations of the study conducted. A total of 50 cases of breast cancer who underwent treatment at our hospital were enrolled in this study.

Age	<30	31-40	41-50	51-60	61-70	71-80
No. of Pts	04	10	23	14	08	01
Percentage	6.6%	16%	38.3%	23.3%	13.3%	1.6%

Table 1: Age Distribution

The youngest patient in our study was 26 yrs old and the oldest patient was of 76 yrs.

Mean age in our study was 48.63 yrs.

Maximum numbers of patients were in the 41-50 yr age group (38.3%).

SIDE INVOLVEMENT:

- Right side 26 patients (43.3%).
- Left side 34 patients (56.6%).
- Tumors of the left side marginally exceeded those on the right side.

Complaint	No. of Patients	Percentage
Lump	59	98.33%
Pain	19	31.66%
Nipple Retraction	03	05%
Others	04	6.6%

Table 2: Presenting complaint

Most common presentation was lump in the breast, seen in 59 patients (98.33%).

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Location	No. of patients	Percentage
Upper outer	30	50%
Upper inner	10	16%
Lower outer	10	16%
Lower inner	02	3.3%
Central	08	13.3%

Table 3: Location

Most common location was upper quadrant in our study (50%).

Size	< 2cms	2-5 cms	>5cms
No. of patients	02	40	18
Percentage	3.33%	66.67%	30%

Table 4: Clinical size of the tumor

The size of the largest palpable tumor was 10x4 cms and the smallest tumor measured 2x2 cms.

Mean size of palpable lump in our study was 5.03 cms.

STATUS OF LYMPH NODES:

- Axillary lymph nodes were palpable in 46 patients (76.6%) whereas 14 patients had no palpable lymph nodes (23.3%).
- 43 patients had 1-5 palpable lymph nodes.
- 3 patients had > 5 palpable lymph nodes.
- Mean number of palpable lymph nodes in our study – 2.18 (1-8 nodes in 46 pt).

Group	No. of patients	Percentage
Central	27	45%
Apical	23	38.33%
Pectoral	15	25%
Brachial	03	05%

Table 5: Status of lymph nodes

- Supraclavicular lymph nodes were palpable in 2 patients (3.3%).
- Lymph nodes of the opposite axilla were palpable in 2 patients (3.3%).

STAGE OF PRESENTATION: Most of the patients presenting to us were in stage II disease.

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Type	No. of patients	Percentage
Intraductal	51	85%
Medullary	04	6.67%
Atypical Medullary	02	3.33%
Cribriform	02	3.33%
Comedo	01	1.6%

Table 6: Histopathological Type

Most common histopathological type was Infiltrating Ductal Carcinoma of the Not Otherwise Specified group 85%.

Group	No. of patients	Percentage
I	09	15%
II	36	60%
III	11	18%
None	04	6.67%

Table 7: Grade of the Tumor

36 patients in our study were moderately differentiated (60%).

HISTOPATHOLOGY OF LYMPH NODES: Total number of lymph nodes removed surgically by axillary dissection in our study was 497.

Total number of positive lymph nodes were 151.

Positive	None	1-5	6-10	>10
No. of patients	24	26	08	02
Percentage	40%	43.33%	13.33%	3.33%

Table 8

- 14 patients had clinically palpable Axillary nodes but were negative histologically (23.3%).
- 5 patients whose axilla was clinically negative had positive histological nodes.
- Statistical analysis of the comparison between the tumor size and the number of histologically positive nodes was performed.

No. of patients	F.N.A.C	Histopathology
Intraductal carcinoma	51	51
Medullary	04	04
Atypical Medullary	02	02
Cribriform	02	02
Comedo	01	01

Table 9: Comparison of Pre-Operative F.N.A.C. With Post-Operative Histopathology of the Primary Tumor

All cases of our study showed histopathology report same as the F.N.A.C. report.

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Table 10: Out-come of treatment on follow up:

12 patients lost follow up after surgery

48 patients came for at least a minimum of one time for follow up.

14 patients did not have positive lymph nodes histopathology, 5 patients lost follow up.

Remaining patients were followed up for a period of 2-18 months developed no recurrence.

46 patients underwent modified radical mastectomy with adjuvant chemotherapy [CMF] regimen.

Tumor size	No. of patients	No. of patients with histologically positive nodes	Percentage of patients with histologically positive nodes
<5cms	28	13	46.4%
5-6cms	24	15	62.5%
>6cms	08	08	100%

Table 11: Relationship of size of the tumor and the number of patients with histologically positive lymph nodes

DISCUSSION: Breast cancer has been increasing because of increase of life span; changes in life style, etc. despite increase in incidence, mortality in breast cancer continue to fall in the western countries because of early detection and knowledge about breast cancer among the public and improvements in therapy. Current therapy is guided by recent insights in breast cancer biology and ability to define in individual patients. As the improvement in treatment occurs the more of conservative treatment for breast cancer is on place. The disease free survival benefit attained by radical mastectomy can be achieved by modified radical mastectomy and breast conservative surgery. The morbidity associated with more radical procedure is taken into consideration and newer improvements in treatment modalities question the need of radical surgeries. In this scenario the role of Axillary dissection has come into scrutiny because of the morbidity associated with it, from complications such as paraesthesia, pain, weakness, lymph edema, stiffness and occasionally wound infection.^{17,18} A full Axillary dissection is still the gold standard. since it provides quantitatively the accurate information required for staging. There is as yet no evidence that Axillary treatment improves survival, but currently the issue remains controversial.⁹ Treatment of axilla with either surgery or radiotherapy remains an integral part of management of patients with invasive breast cancer. It is also an effective staging procedure¹⁹ and is essential for local control of the disease in the axilla.¹¹ Studies are underway evaluating the alternatives of Axillary dissection, like sentinel lymph node biopsy.

There have been a number of studies to compare and correlate the relationship between breast tumor size and Axillary lymph node status and evaluate if a certain group of patients may be excluded from Axillary dissection based on tumor size. Such studies though many in number, there are very few Indian literature available about the same.^{2,13,20, 21, 22, 23, 24, 25, 26}

Sixty patients admitted with diagnosis of breast cancer in Krishna Institute of Medical Sciences and Hospital, Karad, satisfied the inclusion criteria and was enrolled in this study over a period of two years. The age of the patient varied from twenty six to seventy six years with

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maximum number of patients seen in the 40-50 yrs age group, similar to the study conducted in India.^{27, 28} In western literature, the incidence is shown to be higher in the older age group, mean age more than sixty years.²⁹

The higher incidence in the left breast (56%) correlated with literature. The most common presentation in our study was breast lump (98%). Other literatures mention similar presentation, though Tyagi et al.,²⁷ reported 100% of the cases presenting as lumps. 40 patients (66%) in our study presented with breast lump of size 2-5 cms range. 18 patients (30%) had lump of more than 5 cms and only 2 patients had a lump of 2 cms. This is in contrast to the studies published in the western literature^{2,20,22} where most of the patients has a lump size of less than 2 cms probably due to the better screening facilities available, with an increased emphasis on mammographic examination and early detection, along with patient education regarding the disease and self-examination.¹⁴ The most common quadrant involved in our study was the upper outer quadrant (50%) followed by the lower outer and inner quadrant (16% each) this is probably due to the fact that there is an increased amount of breast tissue in the upper outer quadrant. However it was observed in our study that 21 patients (70%) having a tumor in the upper outer quadrant had positive Axillary nodes but it was not significant statistically and did not correlate with literature.³⁰ 46 cases had involvement of the axilla clinically. It was also noticed that clinically palpable nodes were less than the number of nodes in the specimen. This is in agreement with most studies, as the surgical procedure (modified radical mastectomy) gives almost a complete dissection of the axilla and yields the greatest number of nodes.^{30, 31} In our study, most of the lymph nodes involved were in the central group (45%) followed by the apical group (38%) of nodes that correlated with standard literature.¹⁶ The most common histological type in our study was Infiltrating Ductal carcinoma of the Not Otherwise Specified group (85%) that correlated with other standard texts. 4 cases of medullary carcinoma were studied in our study that also correlated with the incidence rate mentioned in standard texts. Available literature reveals that the number of metastasis is related to the aggressiveness of the tumor.²² In the National Surgical Adjuvant Protocol B-04 (NSABP) Fisher³⁰ reported the above facts. This correlates with our study, but as the number of cases is few and most of the cases being of the infiltrating ductal variety not much significance can be attached.

It was also observed in our study that postmenopausal patients had increased axillary nodal involvement as compared to premenopausal patients. On univariate analysis it was not significant ($p = 0.07$). The main part of our study was the correlation between tumor size and the status of the lymph nodes. Though there have been numerous studies done regarding this subject, most of these studies involve early T1 N1 M0 tumors with emphasis on the requirement of an Axillary dissection.^{32,13,23,24,2,33,26} There have been a few studies correlating the tumor size and the status of the lymph nodes.^{20,21,22,26} These studies have had more than 60% of the patients with tumor <2cms. Our study had only 2 patients with a tumor <2cms. These patients did not have any positive lymph node that is in agreement with the literature published, but since it comprises a small percentage of the study population, it is difficult either to attach any significance to the finding or use this data for the purpose of any change in treatment.

With increase in tumor size, it was observed that the number of patients with positive lymph nodes also increased. All the patients having tumor of size more than six cms had positive

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Axillary lymph nodes. The percentage of positive lymph nodes also increased as the tumor size increased which is in agreement to the published literature.^{20,21,12,22,13,23,24,2,26} Our study had a maximum number of patients with tumor 2-5 cms. This is probably due to the poor screening facilities available and also lack of awareness among the general population regarding self-examination and the disease.

The mean number of lymph nodes removed by Axillary dissection was 8(3-17), which is in agreement to the available literature.^{31, 34} On statistical analysis, it was decided to divide the cases based on tumor size in three groups i.e., tumor size up to 5 cms. 5-6 cms and 6 cms. There was significant difference between these groups of patients with histologically positive lymph nodes. On statistical analysis, it was found to be significant ($\chi^2 = 7.54$; $p < 0.05$) and those tumors 6 cms in size had 100% involvement of Axillary lymph nodes. In another study¹⁸ NSABP06 a total of 1851 patients with tumors up to 4 cm and clinically negative axillary lymph nodes were taken randomly into three groups, some undergone MRM, lumpectomy, Lumpectomy with radiation. Post-operative histopathological assessment of lymph nodes were done and those had positive lymph nodes were given adjuvant chemotherapy. At 25 years follow up disease free survival were same in all three treatment arms. This study provided valuable information about rates of ipsilateral breast cancer recurrence. At 20 years 14.3% of women had recurrence in lumpectomy and radiation arm and 39.2% had recurrence in lumpectomy alone arm. For patients who received chemotherapy local recurrence occurred in 44.2% in lumpectomy alone arm and 8.8% in lumpectomy with radiation.

This study proved once again the direct relationship between the tumor size and metastasis. This study also disproves the risk associated with developing breast cancer in opposite breast because of radiation. Concluding from this study, we have found that the tumor size and axillary metastasis have a direct relationship. The result of our study are of particular importance because histologic involvement of lymph nodes has a high correlation with prognosis which depends on- the number of nodes involved, the level of nodes involved and the extent of disease in individual nodes.¹⁸ Our study results point out to the fact that most of the patients presenting to us have a quite large tumor size and the examination of the excised specimens have shown that most of these patients had positive lymph nodes.

So it can be concluded that axillary dissection of level I and II is must for tumor of larger size. It will help stage the disease accurately, obtain regional disease control and may benefit survival, yet nearly 50% of tumors up to 5 cms have involvement of axillary nodes.¹² Another novel method of staging the axilla is Axillary nodal sampling. Picking out at least four individual lymph nodes from the lower axillary fat stages the axilla, but is not a form of treatment. However for small cancers (<2 cms) that are axillary sample negative it may prevent a full axillary clearance. A positive node sample needs axillary irradiation or clearance. Histological examination of nodes obtained by sampling has been shown to stage the axilla accurately.³⁵

The ideal would be to have an acceptable, non-invasive method of determining the status of axilla preoperatively like the Sentinel node biopsy. A tumor negative sentinel node virtually excludes lymphatic involvement of the entire lymphatic basin. It results in fewer complications, shorter hospital stay, cost reduction and a more accurate indication for treatment with adjuvant

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therapy. The clinical assessment of axillary nodes in our study nearly correlated with that of standard literature, as 23% of clinically palpable nodes were histologically negative.

The proper planning of surgery for breast cancer is established by biopsy of a palpable or image guided lesion. Image guided core biopsy is the approach of choice for diagnosis, with open biopsy being reserved for lesion not amenable to core biopsy or when core biopsy being non-diagnostic. F.N.A.C. biopsy is also diagnostic in diagnosing breast lesions but false negative rate is high. Examination of biopsy material gives results about ER/PR/HER 2 receptors and the presence of lymphatic vessel invasion. The patient should undergo preoperative staging to assess the current extent of disease. Common site of metastases from breast cancer- the liver, lung, bones are assessed in all patients by chest radiograph, USG abdomen, and bone scans. Other investigations are reserved for patients with large or clinically positive lymph nodes. Through imaging of the contra lateral breast is performed to look for additional areas of concern, and breast MRI is performed in selective cases. In the absence of metastases the first intervention is surgery to excise the tumor and surgically stage the axilla when appropriate. Pathology results from the tumor and the axillary nodes define the pathology stage and provide an estimate of prognosis to inform systemic therapy decisions. Selection of surgical procedures takes into account patient characteristics, as well as the properties of tumor and its stage.

In another study Milan trial²⁹ patients with smaller tumors were enrolled and used more extensive surgery and radiation than the NSABP 06 trial did. The Milan trial²⁹ randomised 701 patient's up to 2 cms tumor size and clinically node negative patients to receive radical mastectomy versus quadrantectomy, axillary dissection and post-operative irradiation. Pathologically node positive patients received chemotherapy. Overall survival results were no difference in both groups. The local failure rate was 2.3% in radical mastectomy group versus 8.8% in lumpectomy and radiation group. From this study we can conclude that even for lesser size tumor there is benefit from doing radical surgery [lesser local recurrence] than lumpectomy and radiation. The other benefit from this study is their observation of developing breast cancer in the contra lateral breast. It was 0.66% per year for all women.

In our study most patients presented with a tumor size of more than two cms and all were subjected to undergo modified radical mastectomy and depending on their pathological nodal status were given chemotherapy. 14 patients had no lymph node metastasis even after histopathological evaluation. 5 patients did not turn up for follow up even after sending reminder letters, the remaining 9 cases were followed for 6 months to 18 months, and they did not develop any local recurrence in the ipsilateral or contralateral breast or any evidence of metastasis. As all patients could not afford the financial burden for evaluating for ER/PR/Her 2 receptors and these facilities are not available in our institution they were not done. The ideal suggestion at this point would be to have a center in each region run by government of India to evaluate these receptor statuses at a lesser cost as that will help in making the protocol for further proper management of poor patients. The patients whose histopathological evaluation shows metastasis in lymph nodes received 6 cycles of adjuvant chemotherapy. CMF regimen were given. These patients were followed for a period of 2- 18 months and no patients developed local recurrence or metastasis.

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Though most of the patients in our study had LABC (locally advanced breast carcinoma), 2 patients came with 2cm tumor without metastases also underwent MRM since we could not rule out multicentricity. It is unfortunate that most Indian women present with a greater tumor size and an advanced stage. There is a need for awareness regarding the disease among the public and high risk women should be screened.

The three tests that are used for screening of breast cancer are breast self-examination, physical examination by a trained examiner and low dose mammography.¹ This can be coordinated by establishing a breast clinic that is present in most of the referral hospitals having facilities for multi-disciplinary treatment of breast cancer. This requires a team effort with the surgeon, radiotherapist, medical oncologist and the pathologist. The limitation of this study is probably the small number of patients as the study was conducted at one hospital over a small time frame and follow up could not be done for a longer time period.

Another deficiency has been the inability to correlate axillary metastasis to the type of the tumor as most of the tumors were of the infiltrating ductal variety. In spite of the above mentioned limitations, this study is definitely representative of the patients in Indian set-up and therefore we suggest that all patients coming with larger tumors should undergo a thorough axillary dissection with removal of all lymph nodes up to level II for accurate staging of the disease and a better prognosis based on treatment after staging. If the histopathology of the lymph nodes is positive for tumor then adjuvant chemotherapy has to be added.

The natural history of breast cancer has not been fully elucidated, but surgeons are making progress in the treatment of patients with this disease. Randomized control trials indicate that screening, adjuvant systemic therapy and adjuvant radiotherapy can reduce morbidity. There is scope for further study incorporating more number of patients over a longer time period with longer periods of follow up to assess the relationship of this study to long term prognosis with a wider and broader outlook. Thus the results of these trials should serve as a basis for additional investigation. Ultimately, a better understanding of the natural history of breast cancer may translate into improved treatments and better outcomes in future.

SUMMARY: There have been innumerable controversies regarding the natural history of breast cancer, raised for the past few centuries as mentioned in the reference literature. Opposing views on breast cancer being a systemic disease or a loco-regional disease at inception have been put forth. Consequently, the use of loco-regional therapy and systemic therapy in breast cancer patients has been a contentious issue. A better understanding of the natural history is needed. This may provide information on the evaluation of therapy and prognosis, which will lead to new forms of therapy.

It has been found that there is significant correlation between the axillary lymph node status, the number of positive lymph nodes and the tumor size. As the tumor size increases, there is a significant increase in the number of positive lymph nodes detected histologically and all large tumors are invariably associated with histologically positive axillary lymph nodes. These results indicate that axillary dissection is absolutely necessary in patients with larger tumor size. Most of the patients presented with upper outer quadrant tumor and our study showed no

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correlation between the tumour site, size and histopathology, all pathological variation have occurred in all quadrants.

Effective screening and awareness regarding the disease can bring more patients with early breast cancers. Recent studies have demonstrated that sentinel node biopsy is as accurate for the assessment of axilla in patients with T2 tumors as it is for those with T1 tumors. Because histological examination of sentinel node biopsy still has its limitations, it is unlikely that false negative cases can be eliminated. Until we find new method for detecting or to rule out axillary metastasis with 100% specificity and sensitivity, axillary dissection upto level II should be done. Studies proved that positive predictive value and survival benefit are same for level II and level III axillary dissection with more morbidity associated with level III dissection.

As we move to avoid axillary dissection in the disease free axilla using sentinel node biopsy, the crux of its clinical application lies in the accuracy of confirming the absence of involvement of the axilla intraoperatively. Recent advance in the field of touch imprint cytology can provide a quick intraoperative assessment of the nodal status.

The F.N.A.C. from the primary tumor is almost conclusive of final histopathology report but since the study is small and does not include all pathological variants of breast tumor it is inconclusive. In our study all 60 patients had same type of tumor in both F.N.A.C. and histopathology. F.N.A.C. has high false negative rate. Negative F.N.A.C. needs more work up. In our study all patients underwent modified radical mastectomy regardless of their stage of presentation. Depending on their histopathology of lymph nodes adjuvant chemotherapy were given. Our follow up over a period of 2-18 months showed no local recurrence. But the ideal mode of management is to give the option of breast conservative surgery or MRM to patient themselves because both the management modalities show equal percentage of disease free survival. Provided they do not fall in to the category of contraindication to these surgeries.

Most of the patients presented to us had larger tumor sizes, which probably was due to lack of awareness among the general population regarding the disease. These patients had ignored small breast lumps and presented quite late, and prognosis was poor in most of these cases. To prevent this and detect more number of patients in the early stages of the disease, education regarding the disease must be imparted with an effective screening programmed. The real impacts on control of breast cancer will however, come with an improvement in the socio economic conditions of the country. It is expected that the health of the individual's along with the level of education and awareness about breast cancer will improve with the improvement in socio economic conditions of the country. It is expected that the health of the individuals along with the level of education and awareness about breast cancer will improve with the improvement in socio economic status. The irony, however, is that with rapid industrialization, economic growth and change in life style, the incidence of breast cancer is in fact on a rise. The fight against breast cancer therefore promises to be a long and challenging one.

CONCLUSION:

1. Our result shows that the size of the primary tumor directly corresponds to the axillary metastases.

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2. All pathological types of breast cancer can occur in all quadrants of breast. Axillary dissection with removal of lymph nodes up to level 11 is a must for accurate staging and treatment.
3. If the histopathological evaluation of lymph node has tumor tissue it should be taken as systemic disease and chemotherapy is warranted. Awareness must be raised and regular screening for breast cancer must be under taken to detect the cases in its early stage.

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Fig. 1: Ulceroproliferative growth in Left Breast with involvement of skin & left axillary lymph nodes



Fig 2: Right breast swelling



Fig. 2b: Skin involvement in right lower outer quadrant

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