

Treatment of

BREAST TUMORS

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Adrenalectomy

Pathologic Classification of Breast Tumors
Medical Treatment of Chronic Cystic Mastitis

Hypophysectomy

Trans-sphenoidal Hypophysectomy

Oral and Parenteral Hormones

Radiotherapy of Breast Cancer

Results of Surgery and Effect of Special Factors on Results
Extended Radical Mastectomy

PREFACE

It is hoped that this book will bring together many loose ends regarding the diagnosis and treatment of breast cancer. For such a large topic brevity and conciseness, which have been major aims, were hard to maintain, yet have been accomplished. The practicing physician today is faced with a plethora of information regarding breast cancer. He may even feel that despite his most conscientious efforts his program of therapy lacks something, is old fashioned or unnecessary*.

The general nature of breast cancer itself tends to enhance this feeling. Certainly it is a disease which occupies a keystone position in the hormone dependent group of cancers. It also is responsive to irradiation therapy. Its method of operative treatment represents a major tenet of cancer surgery. In addition to all this, newer concepts of hormone physiology, radiation therapy and surgical techniques have added to the complexity of treatment.

It is the purpose of this book to broaden our knowledge of breast cancer first by presenting a brief classification of breast tumors, and then discussing the diagnosis, treatment and complications of both benign and malignant breast tumors in the light of histology and newer concepts of therapy. Special sections on radiotherapy, results of treatment, the extended radical mastectomy, and treatment by hormone alteration follow to complete the picture without omission of the main theme, to renew, yet reaffirm the practicing physician's basic knowledge and methods.

To my close friends and colleagues, who have added so much to this book by their collaboration, I offer my thanks. I wish also to express my gratitude to the members of the Tumor Boards of the Stanford University Hospital, San Francisco, California and of the Veterans' Administration Hospital and the U.S. Naval Hospital, Oakland, California, whose constant presentation of cases and discus-

*Crile, G., Jr.: Cancer of the Breast: The Surgeon's Dilemma, Cleveland Clinic Quarterly, 23, 179, 1956.

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sions added so much to my own knowledge and experience; and to Grant Levin, M.D., neurosurgeon, for his suggestions regarding the chapter on hypophysectomy.

Indeed, I would be greatly remiss if I were not to thank Miss Kay Hyde whose painstaking drawings have added inestimable value and interest to this book; my secretary, Mrs. Ernestine Stotler, for her cheerful labors in expertly typing and retyping the manuscript; and finally, the publishers, Lea & Febiger, for their help and cooperation.

ROBERT S. POLLACK, M.D.

SAN FRANCISCO, CALIFORNIA

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Chapter 1

INTRODUCTION

WITHOUT resorting to published statistics it is apparent that tumors of the breast occur frequently enough to occupy a significant place in the practicing physician's daily work be he internist, surgeon or general practitioner. Adding to deep, psychological fears any breast lump will cause in the mind of the average woman, current lay educational trends create concern and anxiety. Because of this the patient rushes to her doctor, expecting not only reassurance, but also action on the part of her physician which will restore her to health. Unfortunately, the perplexities of breast tumors, and especially cancer, often preclude a wholly confident approach on the part of the physician. Yet there are procedures and methods which through years of experience have proved generally to be reliable, and are recommended as the measures to take.

No treatment can begin without a specific diagnosis and since a lump in the breast may be one of many types, the primary step is biopsy. Although statistically, the chances of such a lump, in the average middle-aged woman, being malignant are less than its being benign, histologic verification must be obtained. On the other hand, indiscriminate biopsy of every lump should be avoided. The art and science of physical diagnosis is still to be pursued.

Once diagnosis is established methodology becomes all important, as a successful outcome may very well depend on the techniques applied. Following the initial definitive surgery there will be other considerations, such as x-ray therapy, oophorectomy, pregnancy, and management of the opposite breast, all of which must then be weighed in the light of the circumstances and conditions at hand. In breast cancer there are many factors which influence the ultimate result. One, therefore, considers the patient as a whole in addition to the specific organ involved.

During the life cycle or natural history of a patient with breast cancer it may become apparent that despite initial therapy the patient is doomed and the result, from the standpoint of cure, a failure. Even then there are steps to take which will increase longevity in comfort and reduce pain and morbidity. This later stage of breast cancer may be called the "physiologically therapeutic," in contradistinction to the initial or early stage which is called the "anatomically therapeutic." Since the overall purpose of the practicing physician is to cure and alleviate, each of these stages is considered of equal importance.

Chapter 2

PATHOLOGIC CLASSIFICATION OF BREAST TUMORS

THE following classification of tumors of the breast includes the great majority encountered in daily practice.

I. Breast Tumors

A. Benign

1. Encapsulated

a) Solid

1) Fibroadenoma

2) Periductal fibroma

b) Cystic (pseudo-encapsulated)

1) Simple cyst—single or multiple

2) Benign papillomatous cyst

2. Non-encapsulated

a) Intraductal papilloma

b) Cystadenoma

c) Granular cell myoblastoma

B. Malignant

1. Ductal origin

a) Malignant intraductal papillary carcinoma

b) Malignant intracystic papillary carcinoma

c) Carcinoma—ductal type including comedo-carcinoma

1) Malignant extension to nipple—Paget's disease

2. Glandular origin

a) Lobular carcinoma *in situ*

b) Carcinoma—scirrhous, papillary, medullary, colloid or mucoid

3. Mesenchymal tumors

a) Lobular carcinoma *in situ*

1) Benign form

2) Malignant form—sarcoma or carcinoma

b) Lymphosarcoma

c) Sarcoma

II. Hypertrophies and related conditions

A. Focal interstitial fibrosis

1. With glandular hyperplasia

2. With ductal ectasia (comedo-mastitis)

B. Focal glandular hyperplasia

C. Gynecomastia

III. Inflammations

A. Acute

1. Diffuse

2. Focal

B. Chronic

C. Fat necrosis

IV. Anomalies