

(英汉对照)

乳腺疾病

编译 宁连胜

乳腺疾病

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临床基础

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陕西科学技术出版社



乳腺疾病临床基础

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内 容 简 介

本书是乳腺疾病的英汉对照临床参考用书,英文原文系收集英国著名学者、临床家发表的特邀讲座。

全书共 16 章,内容包括乳腺正常发育、退化、畸型和各类疾病的临床表现;乳腺癌的普查;乳腺癌的流行病;乳腺癌早期、晚期的治疗,预后等。可供各科医师、乳腺科青年医师和进修医师阅读。

全书主要特点:①内容丰富、新颖、全面;②图文并茂,易读,易懂,易掌握;③学术上严谨,既不刻求时髦,又不落后,反映 90 年代中期西欧乳腺学科基础和临床研究状况;④了解乳腺疾病的英语专业词汇;⑤提高阅读英语乳腺疾病文献的能力;⑥最适合临床应用。

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序

乳腺疾病是广大妇女常见的一类疾病,特别是乳腺癌,其发病率近年来在我国呈明显上升趋势,增长速度已经高于发达国家。乳腺癌在女性肿瘤的死因顺位,在我国个别城市已经上升到第一位,严重危害妇女生命健康,应当引起政府有关部门和医务工作者的高度重视。

针对乳腺疾病的防治工作,多年来我国肿瘤防治专业组织和专科医生做出了很大的努力。自70年代初,著名肿瘤专家李树玲教授在天津市肿瘤医院率先创建乳腺科以来,全国各地相继出现乳腺组、乳腺科及乳腺疾病医院,培养了一批乳腺疾病专业技术人员,在乳腺疾病、特别是乳腺癌的防治研究工作中取得了令人瞩目的成绩。但是应该看到,我国在乳腺疾病防治领域还存在着专业知识不足、临床诊治不规范以及基础研究方法缺乏等诸多问题。

关于乳腺疾病及乳腺癌的研究,欧美等西方发达国家开展得较早且深入。尽管亚洲乳腺疾病及乳腺癌同西方国家在很多方面有所不同,但是在病因、诊断、治疗和康复等方面,很大程度上是一致的,有许多值得借鉴之处,“他山之石,可以攻错”。介绍西方国家在乳腺疾病临床基础方面的经验,对于规范诊治方案以及进一步开展乳腺癌的研究,都是十分必要的。

在我国,有关乳腺疾病的书籍不是很多,很需要多出一些这方面的著作。天津市肿瘤医院乳腺科主任宁连胜主任医师,曾在澳大利亚从事乳腺癌基础研究,30年来悉心竭虑于乳腺疾病防治研究。他根据当前实际需要,主持并带领该科医师翻译了《British Medicine Journal》(BMJ)的讲座文章,采用英汉对照方式,编写了《乳腺疾病临床基础》一书,这在国内尚属首次,是出版专业书籍的一种新的尝试。

《乳腺疾病临床基础》一书反映了90年代国外,特别是西欧乳腺疾病临床与基础现状。收集的文章作者多为英国知名学者和临床专家,他们经验丰富,语言标准,且各具有独特的写作风格和表达方式。编译者均系乳腺科专科医生,对于专业研究比较深入,使用标准专业术语,读者可领略不同的翻译风格。该书的出版不仅为国内从事乳腺癌防治研究工作的医生献上一本难得的参考书,而且为同行学习和交流英语、提高阅读和翻译水平提供了极大的方便。

我衷心地希望这本书的出版能够对培养乳腺疾病防治专业人员、提高队伍专业素质和促进对外学术交流起到铺路的作用,为早日攻克乳腺癌、造福人类做出应有的贡献。

天津医科大学校长

郝希山

写在翻译前

1995 ~ 1996 年间,我作为 Visiting Surgical Fellow 在澳大利亚新南威尔士州纽卡斯尔市马特医院进修。该院图书馆有很多关于乳腺疾病的最新书籍和杂志,其中最令我感兴趣的是 BMJ 杂志中每期的专题讲座。1994 ~ 1995 年的题目是乳腺疾病问题,我得到了这些文章的复印件,我在阅读中发现这些文章深入浅出,尽管论及一些专题不十分精、细、透,但面很广。乳腺疾病,尤其是乳腺癌的很多方面几乎都涉及了,非常适合初学者、乳腺科进修医生及非专科医生阅读和临床实践中应用。

近年来,国内关于乳腺疾病和乳腺癌的书籍出版有所增加,似乎仍不能满足日益发展的乳腺学科临床实际需要。全国各地,尤其是那些新建立乳腺科的单位,迫切需要一本普及、入门性质的英汉对照的专业书,既可了解乳腺专科的专业英语词汇、句型,又可学习有关乳腺科的专门知识和国外动态。于是我开始酝酿搞这样一本“特殊”的乳腺专业书。

本书收集,编译 BMJ 杂志发表的文章,共 16 篇,13 名作者。这些作者多数是英国从事乳腺专业的学者和临床家。无论写作文章偏于普及还是专业,都是标准的英式英语。因为不是出自一人之手,读者可领会不同的写作风格和表达方式、手法。为尊重原作者的版权以及使国人习惯英国人写作方法,我们完整地保留了原来版式。

为了便于英汉阅读,多数译者加了生词解释、个别还加了背景注释和疑难句子分析。本着“信、达、雅”原则,多数采用直译,对一些直译结果令人费解之处,亦使意译。因为翻译不是出自一人之手,读者又可领会到不同的翻译风格,相信对读者提高英语阅读水平会有很大帮助和启发。

经过与英国有关作者、出版部门多次信件、传真、E-mail 联系终于得到理解,给予免税的翻译权。

在编译过程中,受到天津医科大学校长、肿瘤医院院长郝希山教授,原中国抗癌协会乳腺癌专业委员会秘书长、天津肿瘤医院乳腺科主任郎义芳以及牛荣琥、金永准、艾励生、王宇等领导、专家学者的热情关怀和大力帮助,在此表示衷心感谢!

我和我的同事都是临床工作者,我们的翻译仅仅是参考译文,谬误肯定不可避免,恳请同道给予谅解和指正。

宁连胜 2001.2.8

于天津

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Chapter 1 SYMPTOMS ASSESSMENT AND GUIDELINES FOR REFERRAL

J M Dixon, R E Mansel



"Bathsheba bathing" by Rembrandt. The model was Rembrandt's mistress, and much discussion has surrounded the shadowing in her left breast and whether this represents an underlying malignancy.

A breast lump, which may be painful, and breast pain constitute over 80% of the breast problems that require hospital referral, and breast problems constitute up to a quarter of the general surgical workload.

Prevalence of presenting symptoms in patients attending a breast clinic

Breast lump	36%
Painful lump or lumpiness	33%
Pain alone	17.5%
Nipple discharge	5%
Nipple retraction	3%
Strong family history of breast cancer	3%
Breast distortion	1%
Swelling or inflammation	1%
Scaling nipple(eczema)	0.5%

Guidelines for referral to hospital

When a patient presents with a breast problem the basic question for the general practitioner is, "Is there a chance that cancer is present, and, if not, can I manage these symptoms myself?"

Conditions that require hospital referral

- All patients with a discrete mass (aspiration of masses by general practitioners is not encouraged because bruising can follow aspiration of a solid mass making subsequent assessment difficult)
- Nipple discharge in patients aged over 50, and bloodstained, persistent, or troublesome nipple discharge in younger patients
- Mastalgia that interferes with patient's lifestyle or sleep and which has failed to respond to reassurance, simple measures such as wearing a well supporting bra, and common drugs
- Nipple retraction or distortion, change in skin contour, or nipple eczema
- Request for assessment by a patient with a strong family history of breast cancer
- Asymmetrical nodularity that persists at review after menstruation

For patients presenting with a breast lump, the general practitioner should determine whether the lump is discrete or is an area of lumpiness or nodularity. A discrete lump stands out from the adjoining breast tissue, has definable borders, and is measurable. Nodularity is ill defined, often bilateral, and tends to fluctuate with the menstrual cycle.

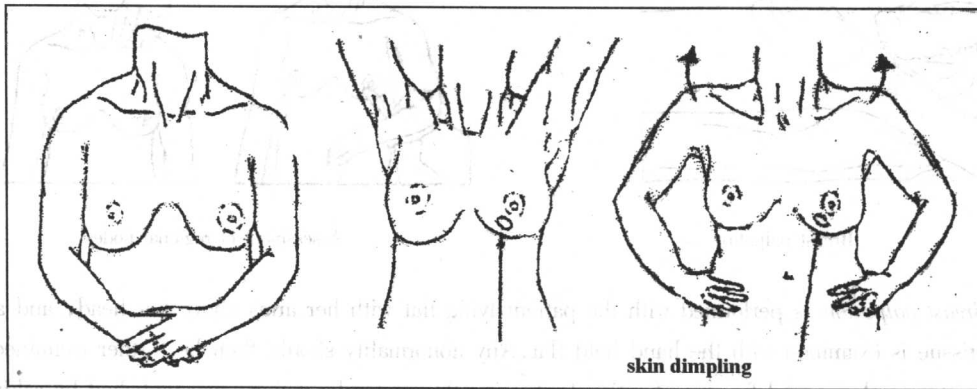
Patients who can be managed, at least initially, by their general practitioner

- Young patients with tender, lumpy breasts and older patients with symmetrical nodularity, provided that they have no localised abnormality
- Patients with minor and moderate degrees of breast pain who do not have a discrete palpable lesion
- Patients aged under 50 who have nipple discharge that is from more than one duct or is intermittent and is neither bloodstained nor troublesome

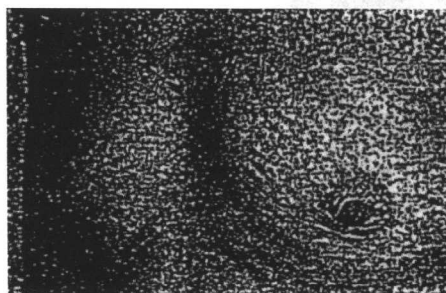
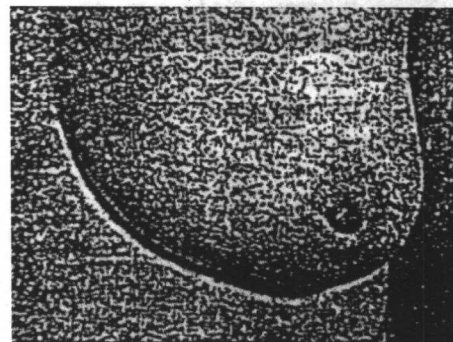
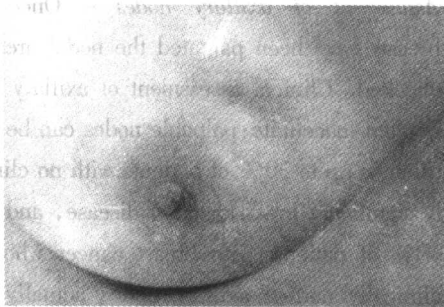
Assessment of symptoms

Patient's history

Details of risk factors, including family history and current medication, and be obtained with a simple questionnaire to be completed by a patient while waiting to be seen in the outpatient clinic. The duration of any symptom is important – breast cancers usually grow slowly, but cysts may appear overnight.



Positions in which breast should be inspected. Skin dimpling in lower part of breast only evident when arms are elevated or pectoral muscles contracted.



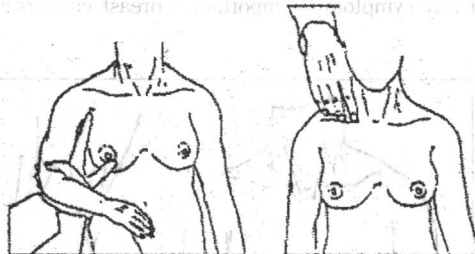
Skin dimpling (left) and change in breast contour (right) associated with underlying breast carcinoma; skin dimpling in both breasts (centre) due to breast involution.

Clinical examination

Inspection should take place in a good light with the patient with her arms by her side, above her head, and pressing on her hips. Skin dimpling or a change in contour is present in a high percentage of patients with breast cancer. Although usually associated with an underlying malignancy, skin dimpling can follow surgery or trauma, be associated with benign conditions, or occur as part of breast involution.

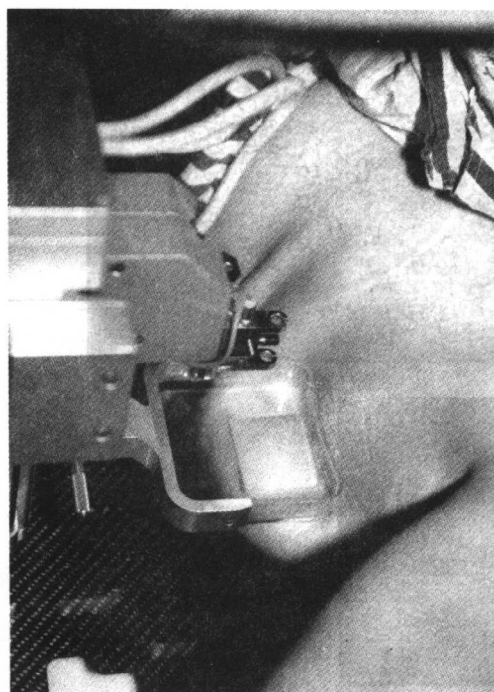


Breast palpation



Assessment of regional nodes

Breast palpation is performed with the patient lying flat with her arms above her head, and all the breast tissue is examined with the hand held flat. Any abnormality should then be further examined with the fingertips and assessed for deep fixation by tensing the pectoralis major – accomplished by asking the patient to press on her hips. All palpable lesions should be measured with callipers.

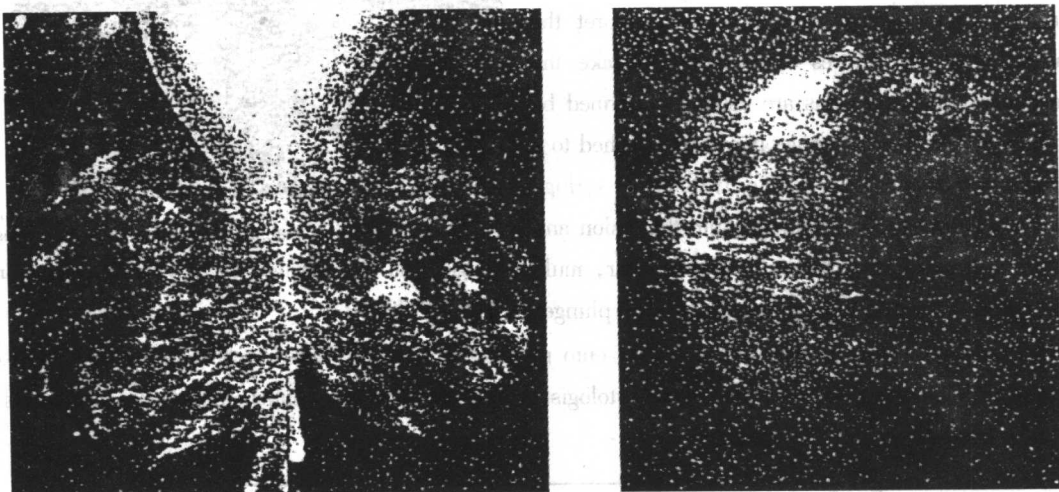


Assessment of axillary nodes – Once both breasts have been palpated the nodal areas are checked. Clinical assessment of axillary nodes is often inaccurate: palpable nodes can be identified in up to 30% of patients with no clinically significant breast or other disease, and up to 40% of patients with breast cancer who have clinically normal axillary nodes actually have axillary nodal metastases.

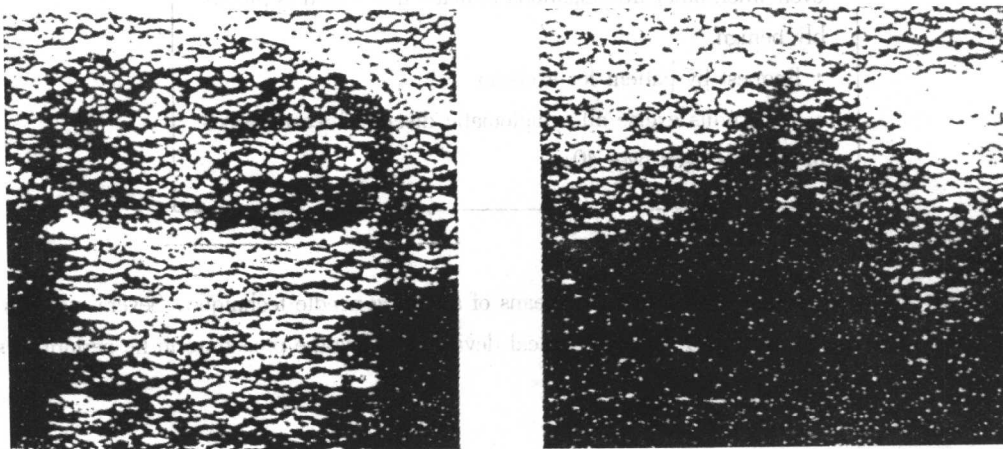
Mammography

Mammography

Mammography requires compression of the breast between two plates and is uncomfortable. Single views of each breast can be taken obliquely, or two views – oblique and craniocaudal – can be obtained. With modern film screens a dose of less than 1.5mGY is standard. Mammography allows detection of mass lesions, areas of parenchymal distortion and microcalcifications. Because breasts are relatively radiodense in women aged under 35, mammography is rarely of value in this age group.



Mammograms showing (left) two mass lesions, in left breast irregular in outline with characteristics of carcinomas, and (right) a mass lesion with the extensive, branching, impalpable microcalcification characteristic of carcinoma in situ



Ultrasound scans showing clear edges of fibroadenoma (left) and indistinct outline of carcinoma (right)

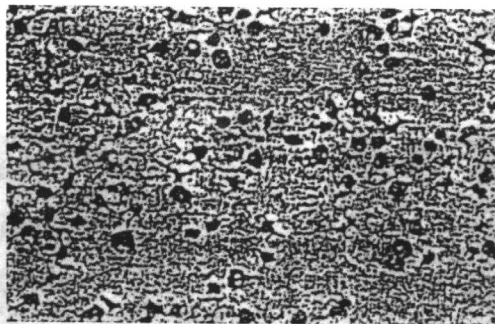
Ultrasonography

High frequency sound waves are beamed through the breast, and reflections are detected and turned into images. Cysts show up as transparent objects, and other benign lesions tend to have well demarcated edges whereas cancers usually have indistinct outlines.

Fine needle aspiration cytology

Needle aspiration can differentiate between solid and cystic lesions. Aspiration of solid lesions requires skill to obtain sufficient cells for cytological analysis, and expertise is needed to interpret the smears. In a few centres cytopathologists take the specimens, but aspirations are usually performed by a clinician. A 21 or 23 gauge needle is attached to a syringe, which is used with or without a syringe holder. The needle is introduced into the lesion and suction is applied by withdrawing the plunger, multiple passes are made through the lesion. The plunger

is then released, and the material is spread onto microscope slides. These are then either air dried or sprayed with a fixative, depending on the cytologist's preference, and are later stained. In some units a report is available within 30 minutes.



Cell smear showing malignancy-cancer cells are lying singly, and they and their nuclei vary substantially in size and shape

Indications for excision of breast lesion

- Diagnosis of malignancy on cytology that is not supported by results of other investigations when a mastectomy or axillary clearance is planned
- Suspicion of malignancy on one or more investigations even when other investigations indicate that lesion is probably benign
- Request by patient for excision
- Some units excise all symptomatic discrete breast masses in patients aged over 40

Core biopsy

A small core is removed from the mass by means of a cutting needle technique. Several needles are available, and some can be combined with mechanical devices to allow the procedure to be performed single handed.

Open biopsy

Open biopsy should be performed only in patients who have been appropriately investigated by imag-

ing, fine needle aspiration cytology, and, if appropriate, core biopsy. Women who are told that investigations have shown their lesion to be benign rarely request excision.

Breast biopsy is not without morbidity. A fifth of patients develop either a further lump under the scar or pain specifically related to the biopsy site.

The routine use of frozen section to diagnose breast cancer is no longer acceptable

Other techniques such as computed tomography, magnetic resonance imaging, thermography, radioisotope studies, nipple cytology, and ductography have no role in routine investigation of patients with breast problems

Frozen section

Frozen section should be used only in the following circumstances:

- Confirmation of a cytological diagnosis of malignancy before proceeding to definitive surgery (such patients should already have been told that their lesion is malignant and have been appropriately counselled, with discussion of all treatment options)
- Assessment of excision margins for a wide local excision to ensure complete excision
- Assessment of axillary nodes to identify patients who are node negative and who require only a limited dissection

Accuracy of investigations

Accuracy of investigations in diagnosis of symptomatic breast disease

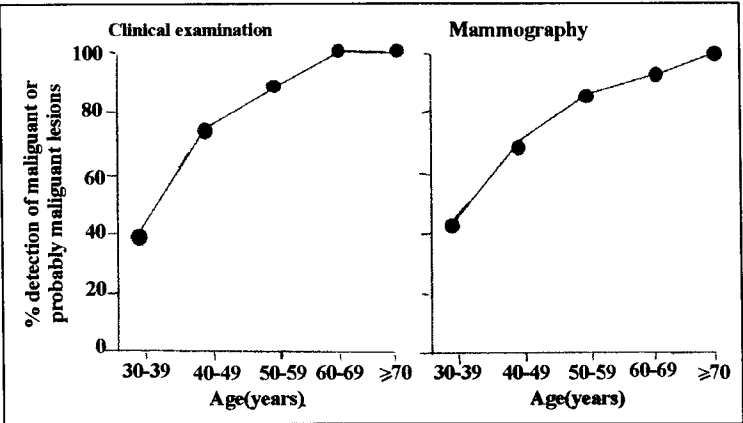
	Clinical examination	Mammography	Ultrasonography	Fine needle aspiration cytology
Sensitivity for cancers *	86%	86%	82%	95%
Specificity for benign disease * *	90%	90%	85%	95%
Positive predictive value for cancers * * *	95%	95%	90%	99.8%

* % Of cancers detected by test as malignant or probably malignant.

* * % Of benign disease detected by test as benign.

* * * % Of lesions diagnosed as malignant by test that are cancers.

False positive results occur with all diagnostic techniques. It is now routine to plan treatment on the basis of malignant cytology supported by a diagnosis of malignancy on clinical examination and imaging. Cytology has a false positive rate of about two per 1000, and the lesions most likely to be misinterpreted are fibroadenomas and areas of breast that have been irradiated. The sensitivity of clinical examination and mammography varies with age, and only two thirds of cancers in women aged under 50 are deemed suspicious or definitely malignant on clinical examination or mammography.



Sensitivity of clinical examination and mammography by age

Triple assessment

Triple assessment is the combination of clinical examination, imaging (mammography for women aged 35 or over and ultrasonography for women aged under 35), and fine needle aspiration cytology. In a recent series of 1511 patients with breast cancer having triple assessment, only six patients (0.2%) had lesions that were considered to be benign on all three investigations.

Advantages and disadvantages of techniques for assessment of breast masses		
Technique	Advantages	Disadvantages
Clinical examination	Easy to perform	Low sensitivity in women aged ≤ 50
Mammography	Useful for screening women aged ≥ 50	Requires dedicated equipment and experienced personnel. Low sensitivity in women aged ≤ 50 . Unpleasant (causes discomfort or actual pain)
Ultrasonography	Same sensitivity in all ages Useful in assessing impalpable lesions Painless	Operator dependent Less sensitive and less specific than clinical examination or mammography
Fine needle aspiration cytology	Cheap High sensitivity Provides definitive diagnosis in most instances Low incidence of false positives	Operator dependent Needs experienced cytopathologist Painful