Breast Cancer

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❖Breast Cancer

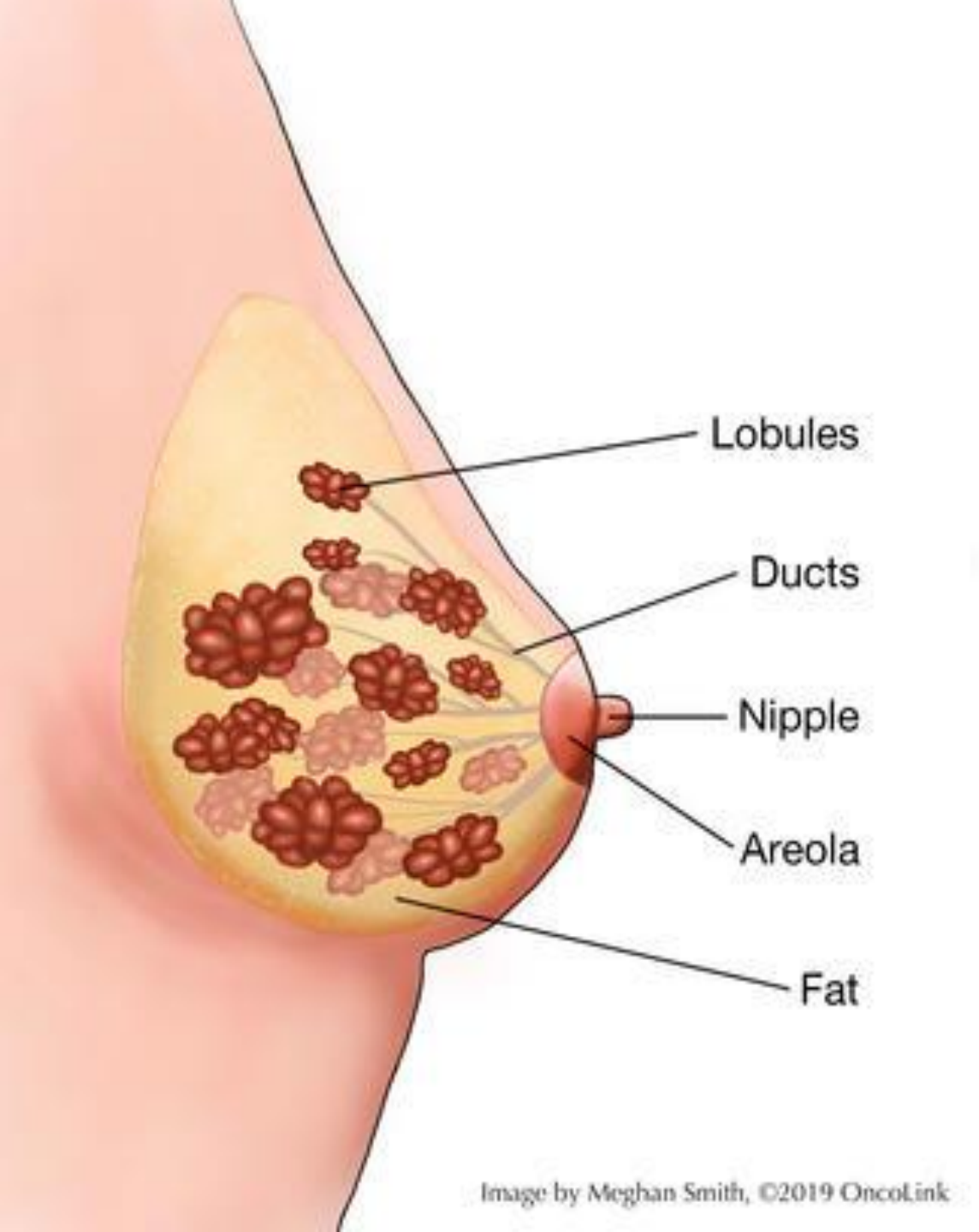
- ❖There are many types of breast cancers, and correctly identifying each one is important to determine the proper treatment.
- ❖ Breast cancers can be divided into two main overarching groups: the carcinomas and the sarcomas.
- ❖ Carcinomas are cancers that arise from the epithelial component of the breast. The epithelial component consists of the cells that line the lobules and terminal ducts; under normal conditions, these epithelial cells are responsible for making milk.
- ❖Carcinomas comprise the vast majority of all breast cancers, and will be further discussed below.

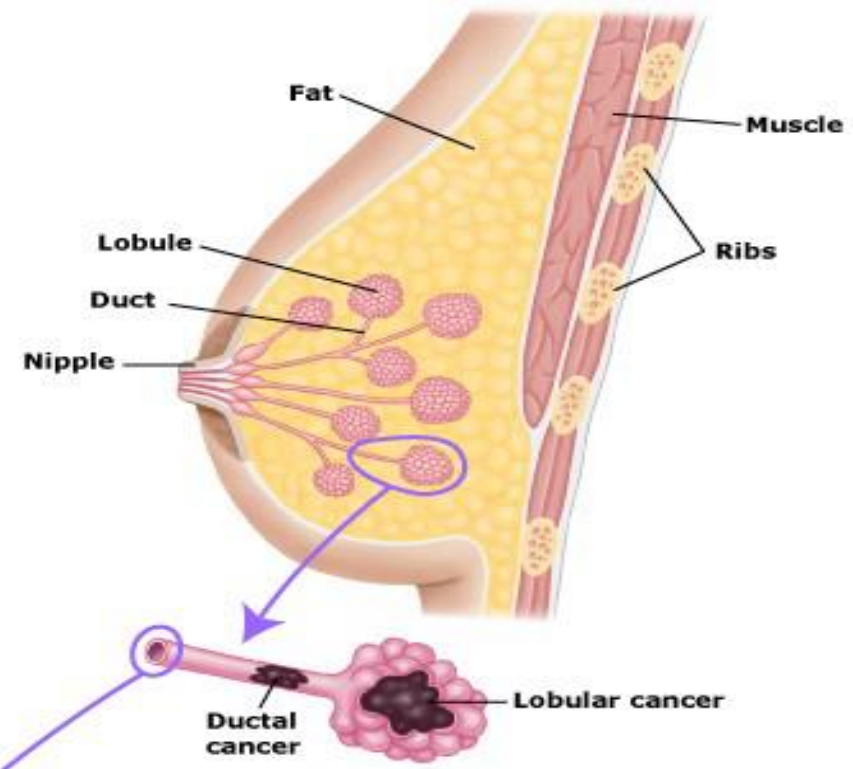
❖Breast Cancer

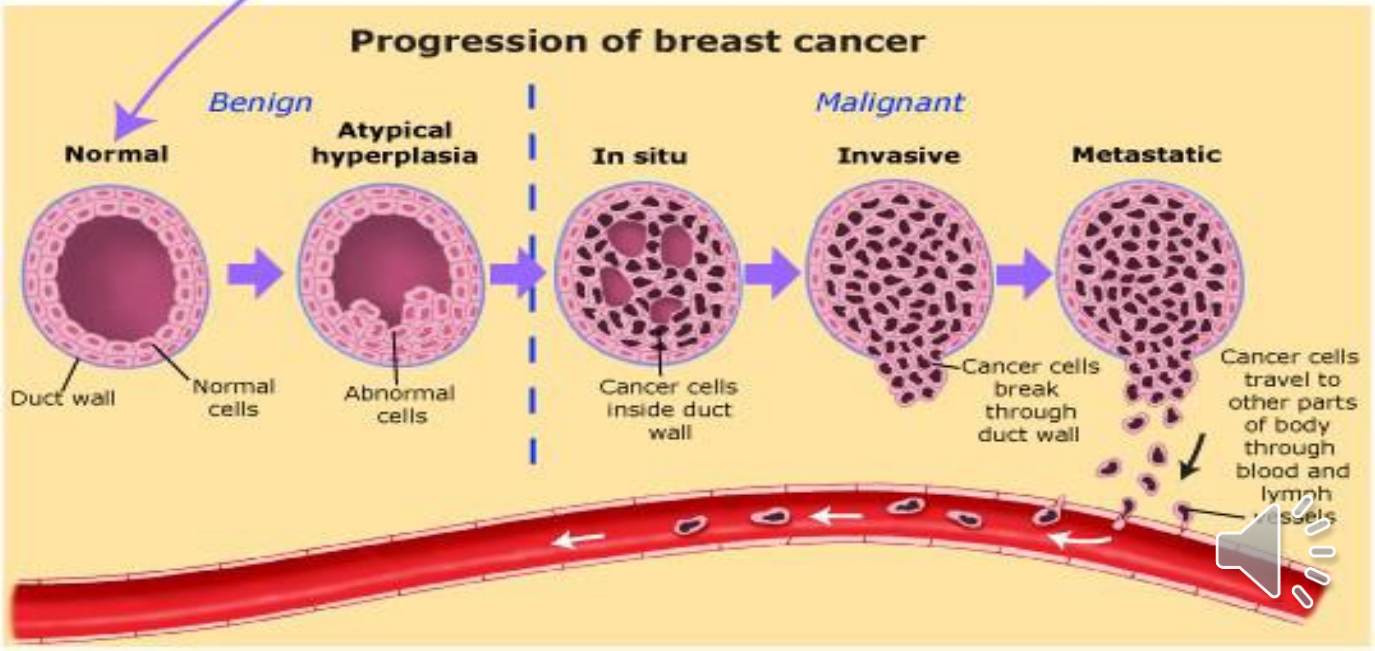
- ❖Sarcomas are rare cancers that arise from the stromal (connective tissue) components of the breast. These stromal component cells include myofibroblasts and blood vessel cells, and cancers arising from these "supportive" cells include phyllodes tumors and angiosarcoma.
- ❖Sarcomas account for less than 1% of primary breast cancers.
- ❖In the US, invasive Ca B is **2nd** to **lung cancer** as a cause of cancer death in women, & despite advances in diagnosis & treatment, **1/4 of women** who develop Ca B will die of it.
- ❖**The lifetime risk of Ca B is one in eight (1/8) for women in the US**, with 75% of cases older than age 50.

❖Breast Cancer

- ❖ Only 5% are younger than the age of 40.
- ❖ For unknown reasons (possibly related in some part to earlier detection via mammography) there has been worldwide increase in the incidence of Ca B.
- ❖ **Is The most common non-skin malignancy of women.**
- ❖ **2nd most common cause of cancer deaths in women, following carcinoma of the lung.**
- ❖ The worldwide incidence and mortality are increasing at an alarming rate. This trend is due to social changes especially in the developing countries.
- ❖ Those social changes Include delayed childbearing, fewer pregnancies, and reduced breastfeeding and with lack of access to optimal health care.


Lobules
Ducts
Nipple
Areola
Fat
Image by Meghan Smith, ©2019 OncoLink


Fat
Muscle
Lobule
Ribs
Duct
Nipple
Ductal cancer
Lobular cancer


Progression of breast cancer
Benign
Malignant
Normal
Atypical hyperplasia
In situ
Invasive
Metastatic
Duct wall
Normal cells
Abnormal cells
Cancer cells inside duct wall
Cancer cells break through duct wall
Cancer cells travel to other parts of body through blood and lymph

Breast Cancer

- Since 1980s the mortality rate has dropped from 30% to <20% due to improvement in detecting cancers before they metastasize through screening (mammographic screening) and more effective systemic treatment.

- Almost all breast malignancies are adenocarcinomas (>95%).

❖Classification system

- The most clinically used classification system for breast cancer depends on the expression of hormone receptors

❖ hormone receptors are:

❖ Estrogen receptor (ER), progesterone receptor (PR) & human epidermal growth factor receptor 2 (HER2, or ERBB2)

❖ Can be classified according to expression of hormone receptors into three major groups:

- ER positive (HER2 negative; 50%–65% of cancers)
- HER2 positive (ER positive or negative; 10%–20% of cancers)
- Triple negative (ER, PR, and HER2 negative; 10%–20% of cancers)

❑ Risk Factors

❖Age:

It is considered rare in women younger than 25 and incidence increase after the age of 30. more than two thirds of women with breast cancer are older than the age of 50 and only 5% are younger than the age of 40.

❖Gender:

- The incidence in men is only 1% of that in women.

❖Family History of Breast Cancer:

- The greatest risk is for individuals with multiple affected first-degree relatives with early onset breast cancer mostly related to various combinations of low penetrance or weak cancer genes.
- However, in about 5 to 10% of cases a highly penetrance germlinemutations in the tumor suppressor genes is associated with lifetime risk greater than 90%

❖The three groups show striking differences in patient characteristics, pathologic features, treatment response, metastatic patterns, time to relapse, and outcome

❖ Within each group are additional histologic subtypes, some of which also have clinical importance.

An alternative classification system relies on gene expression profiling.

❖used mainly in clinical research

❖divides breast cancers into four major types:

• **Luminal A**. majority of cases are lower grade, ER-positive & HER2 negative cancers

- **Luminal B**.majority of cases are higher grade ER-positive +/-HER2 positive cancers .

- **HER2-enriched**. overexpress HER2 and ER-negative.

- **Basal-like**. gene expression profiling resemble basally located myoepithelial cells and are ER-negative, HER2-negative

❖Geographic Factors:

- higher in the Americas and Europe than in Asia and Africa

❖ The mortality rates of breast cancer in America is 5 times greater than japan .

Immigration studies showed that migrance from low incidence to high incidence areas tends to acquire the rates of their new home countries.

❖ In this context, diet, reproductive patterns, and breast feeding practices are thought to be involved .

❖ Breast cancer rates appear to be raising in parts of the world that are adapting the western habits.

❖Race/Ethnicity:

- highest rate in women of European descent because of higher incidence of ER-positive cancers.
- Hispanic and African American →develop cancer at a younger age and develop aggressive tumors.
  - ❖ This is thought to result from combination of differences in genetic social factors and access to health care.

❖ Reproductive History.

- Including Early age of menarche, nulliparity, absence of breastfeeding, with older age at first pregnancy are all associated with increased risk due to increased the exposure of the epithelial cells of the breast to estrogenic stimulation

❖Ionizing Radiation.

- Chest Radiation especially if the breast is developing.

❖Other Risk Factors.

- Postmenopausal obesity
- postmenopausal hormone replacement therapy
- mammographic density
- alcohol consumption

Pathogenesis

Factors that contribute directly to the development of breast cancer can be grouped into:

- Genetic
- Hormonal
- Environmental

❑ Genetic Factors

BRCA1 and BRCA2:Are classic tumor suppressor genes and the cancer only occur if both alleles are defected

- encode proteins that are required for repair of DNA damage.
- most carriers develop breast cancer by the age of 70 years

❖For unclear reasons, *BRCA2* mutations are primarily associated with ER-positive tumors, whereas *BRCA1* mutations are associated with triple-negative cancers

❖Other mutated genes: *TP53*and *PTEN* P53 AKA guardian of the genome

- The pathways in which familial breast cancer genes function also are often disturbed in sporadic cancers

❖**HER2 gene amplification :**

❑Cancers that overexpress HER2 are highly proliferative.

❑In the past they had a poor prognosis; Nowadays, the availability of therapeutic agents targeting HER2 has improved the prognosis.

It is a receptor tyrosine kinase that promotes the cell proliferation and suppress apoptosis

❑Hormonal factors

Estrogens are considered an important hormonal factors since they stimulate the production of growth factors promoting the tumor development.

⦿Estrogen receptors regulate other genes in an estrogen dependent fashion. Some of those genes are important for the tumor development or growth.

⦿Estrogens also drives the proliferation from precursor regions to a fully
malignant and metastatic carcinoma.

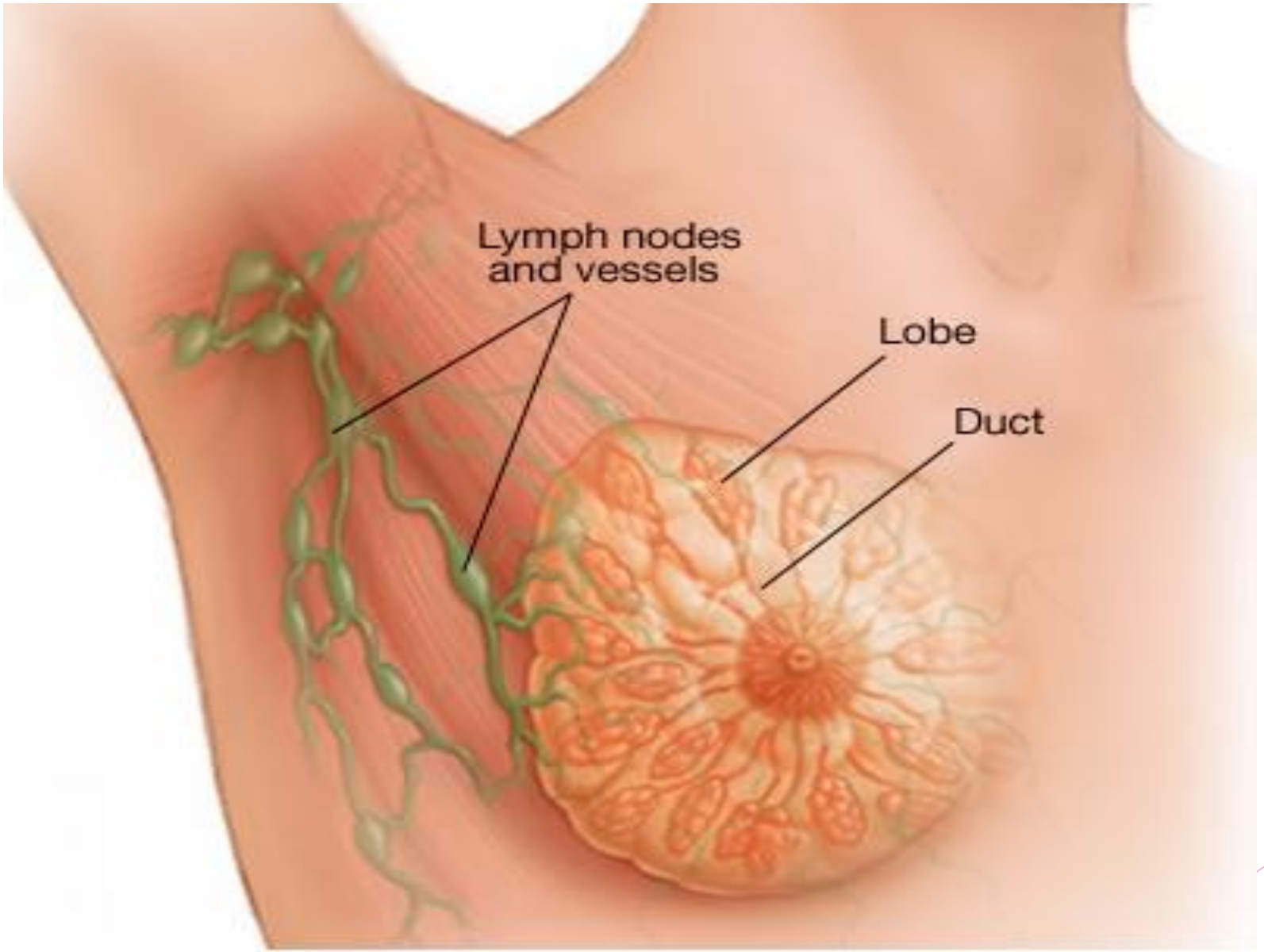
⦿**Estrogen antagonists**: reduce the development of ER-positive cancers in women at high risk and are mainstays in the treatment of established ER-positive tumors.

Morphology

Location:

- Upper outer quadrant (50%)
- Central portion(20%).
- Lower outer quadrant 10%
- Upper inner quadrant 10%
- Lower inner quadrant 10%

❖ 4% have **bilateral** primary tumors or **sequential** lesions in the same breast.



❖Breast carcinoma

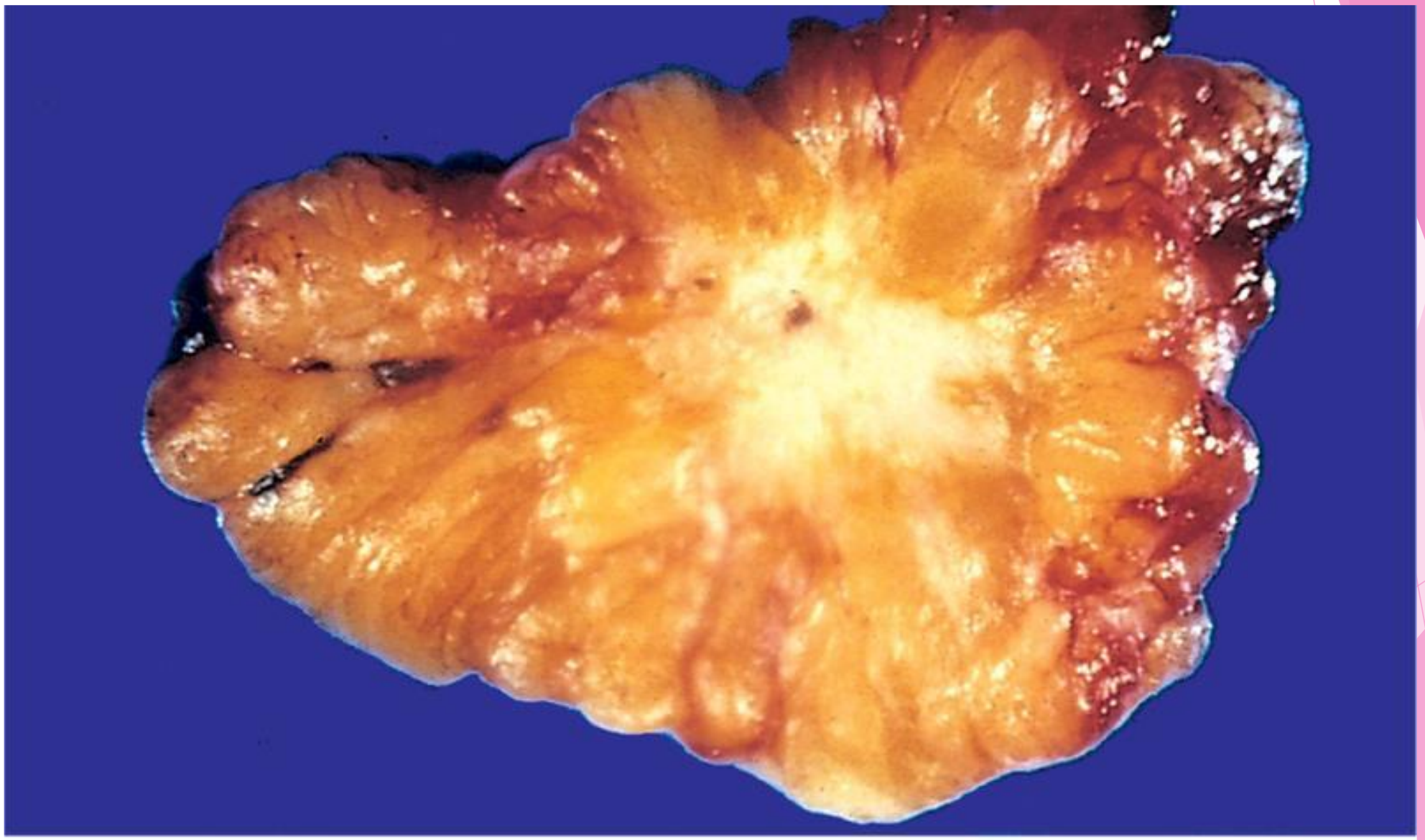
❖ **Noninvasive:(confined by a basement membrane and do not invade into stroma or lympho-vascular channels), include:**

1. Ductal carcinoma in situ
2. Lobular carcinoma in situ

❖ **Invasive (infiltrating):**

1. Invasive ductal carcinoma (includes all carcinomas that are not of a special type)→70% to 80%
2. Invasive lobular carcinoma →10% to 15%
3. Carcinoma with medullary features→5%
4. Mucinous carcinoma (colloid carcinoma) →5%
5. Tubular carcinoma→5%
6. Other types

Breast carcinoma, not well circumscribed ,Irregular ,C/S showing gritty sensation , hard ,white because of desmoplasia



❑ Invasive ductal carcinoma

- ❖ 70-80%
- ❖ Also called **Carcinomas "not otherwise specified"**
- ❖ **Precancerous lesion**: usually DCIS
- ❖ **Clinical presentation:**

❑ a mammographic density; a hard, palpable irregular mass.

❑ Nipple retraction, or fixation to the chest wallcan be seen in advanced cancers

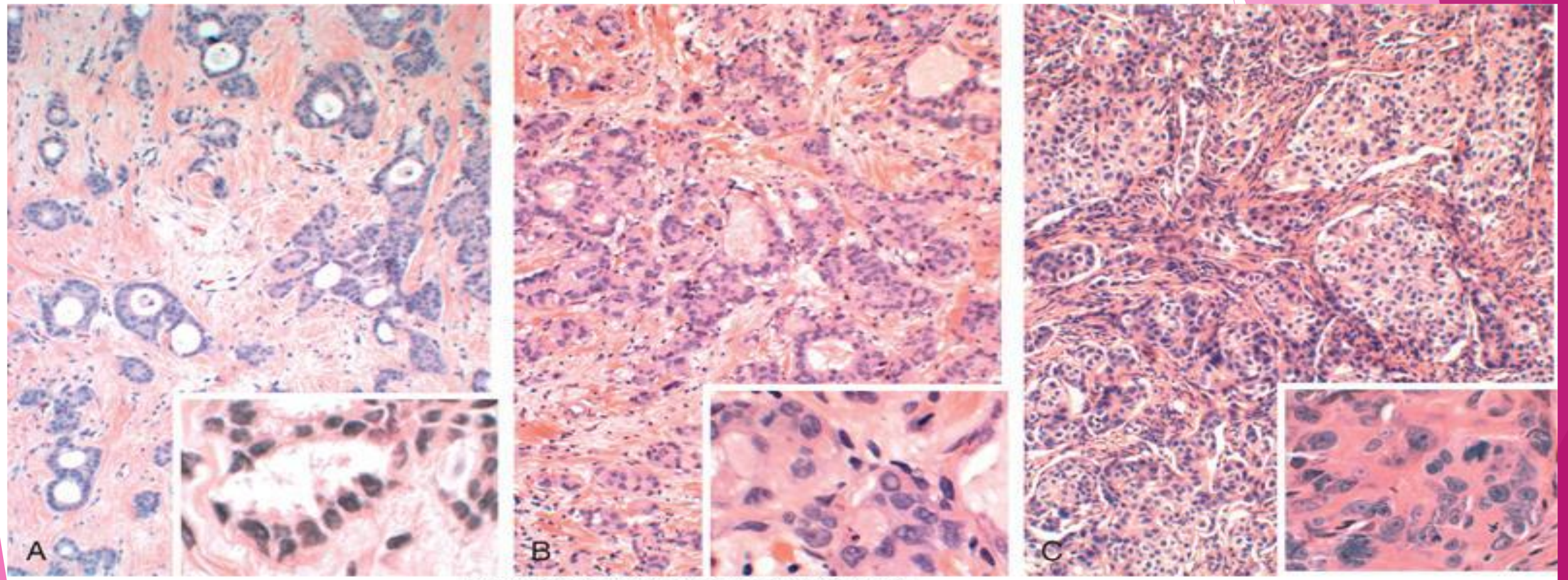
- ❖ **Receptor profile**:

- ER (+vein 50-60%)
- HER2 (+vein 20%)
- 15% are negative for both

- usually associated with DCIS.

- Cases with invasive ductal carcinoma produces desmoplastic response which replaces the normal fat and result in mammographic densities

Invasive ductal carcinoma



Kumar et al: Robbins Basic Pathology, 9e.

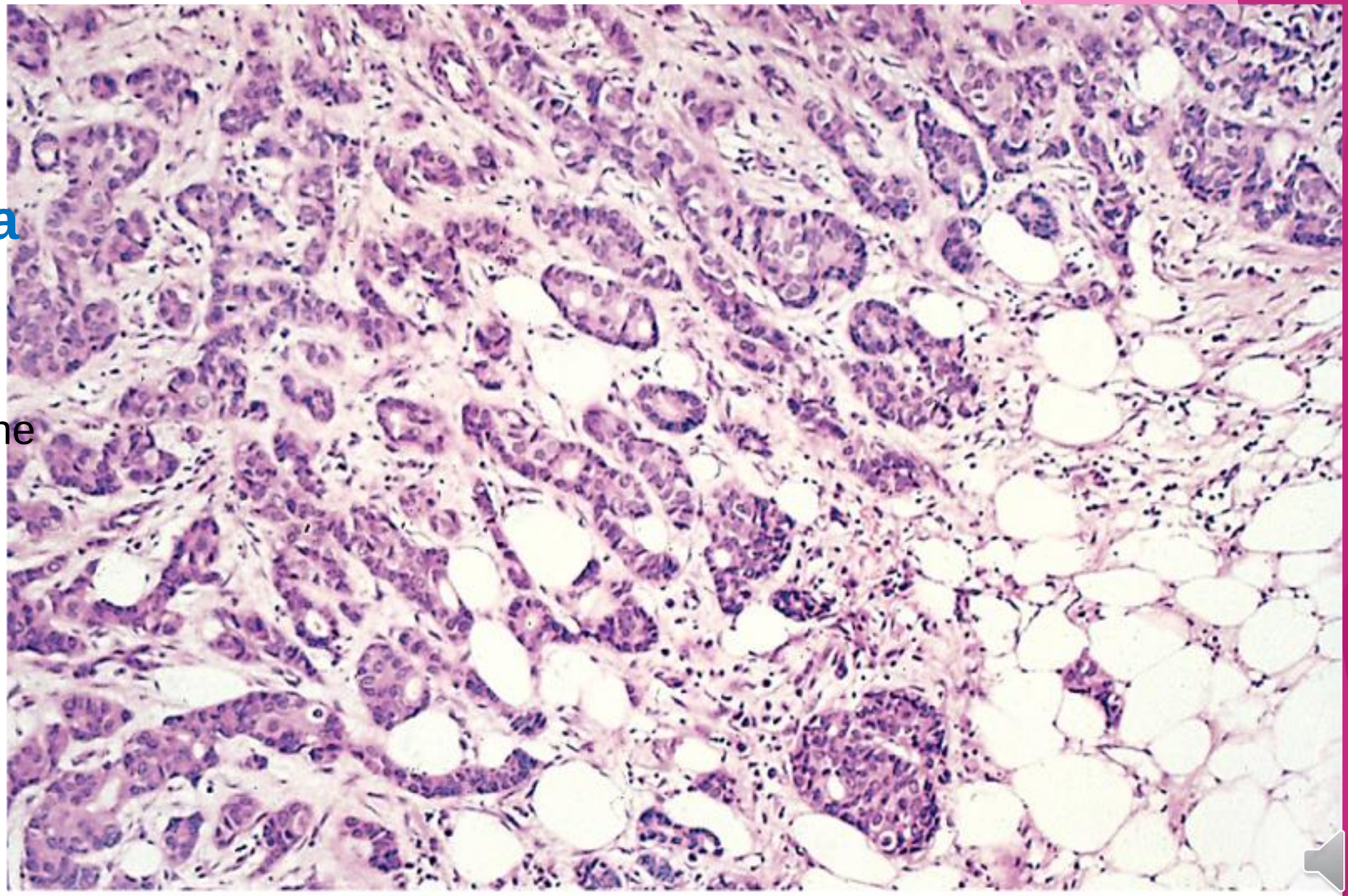
A-Well differentiated carcinoma consisting of tubules with small monomorphic nuclei

B-Moderate differentiation carcinoma with less tubular formation more solidness of cells and monomorphic nuclei

C-Poorly differentiated carcinoma with sheets of pleomorphic cells containing numerous mitotic figures and central areas of tumor necrosis

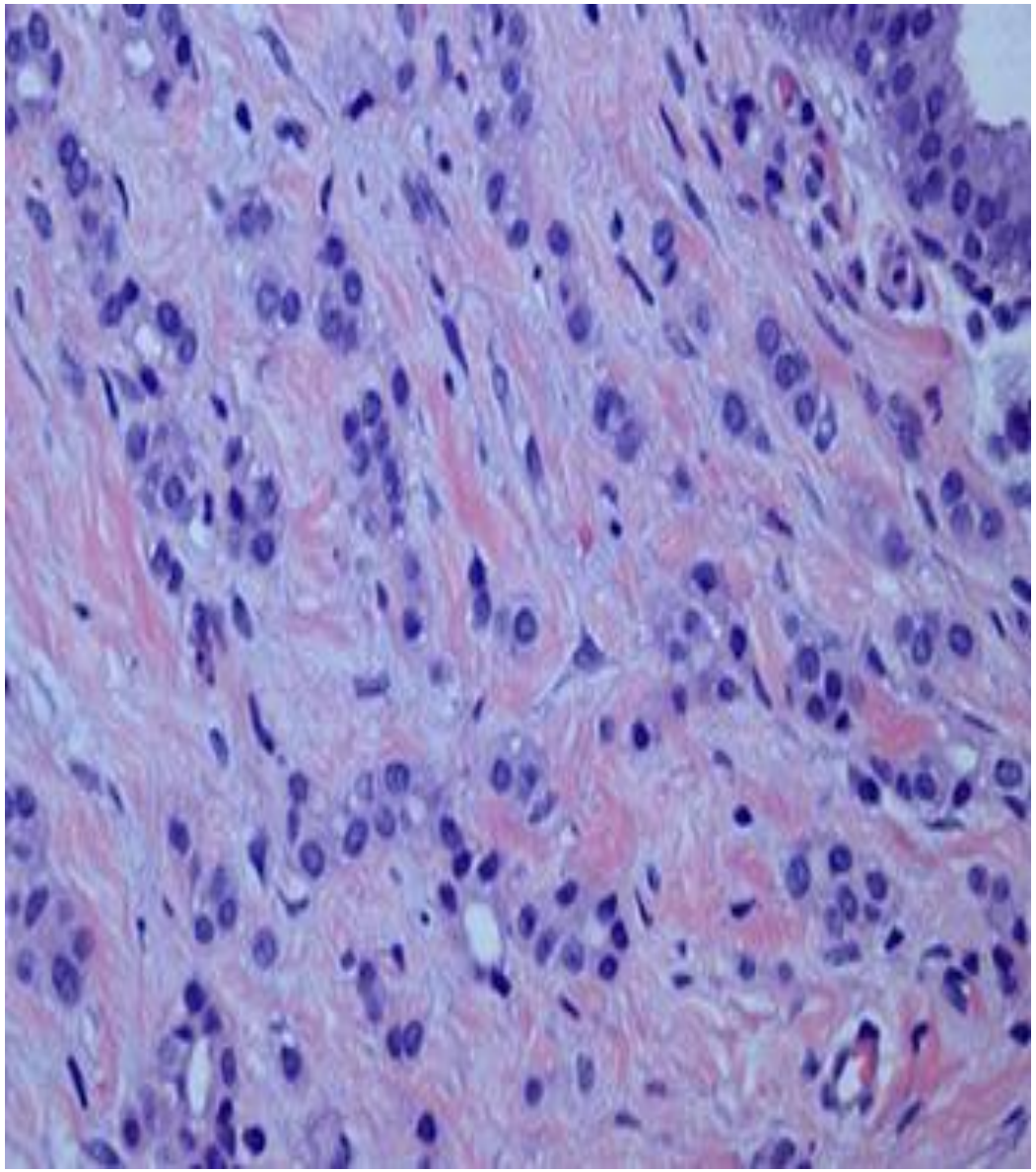
Breast carcinoma

margin, showing invasion & infiltration of the adjacent fatty tissue (on the right).

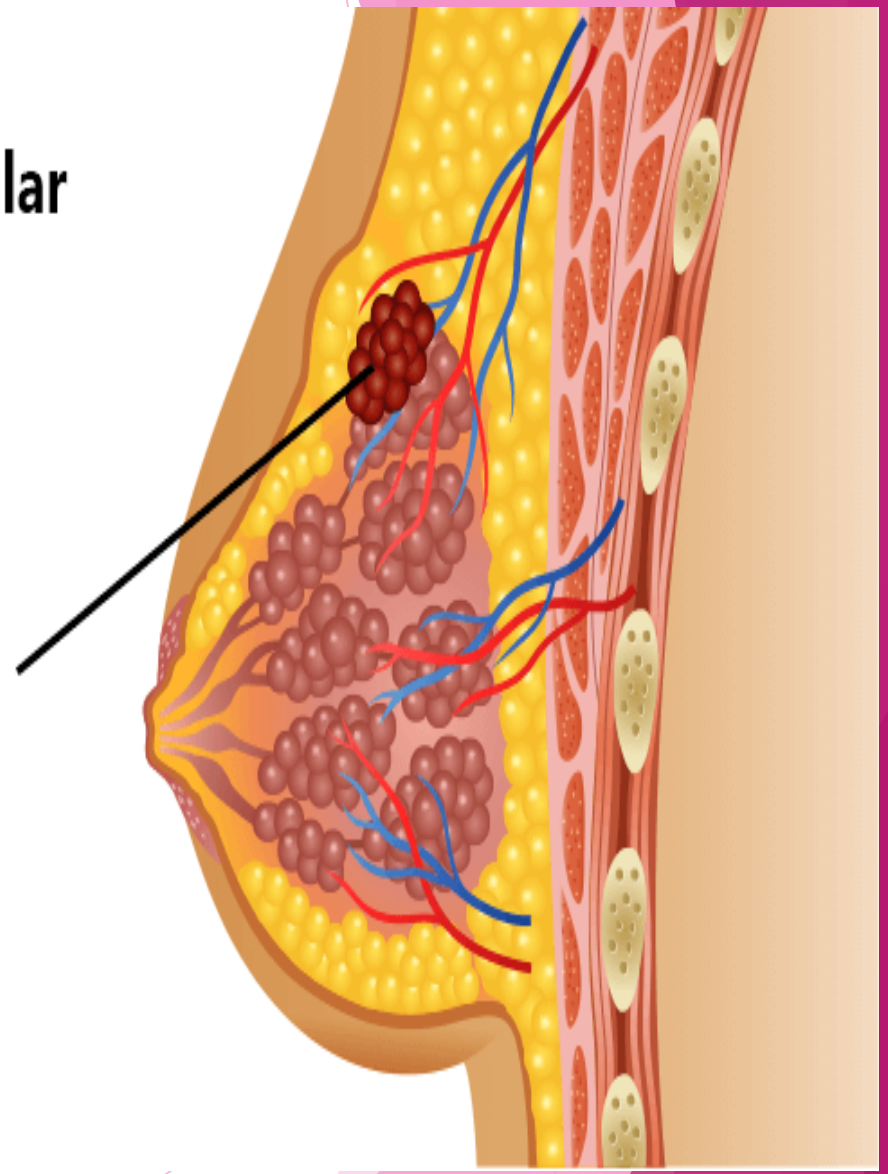


❑ Invasive lobular carcinoma

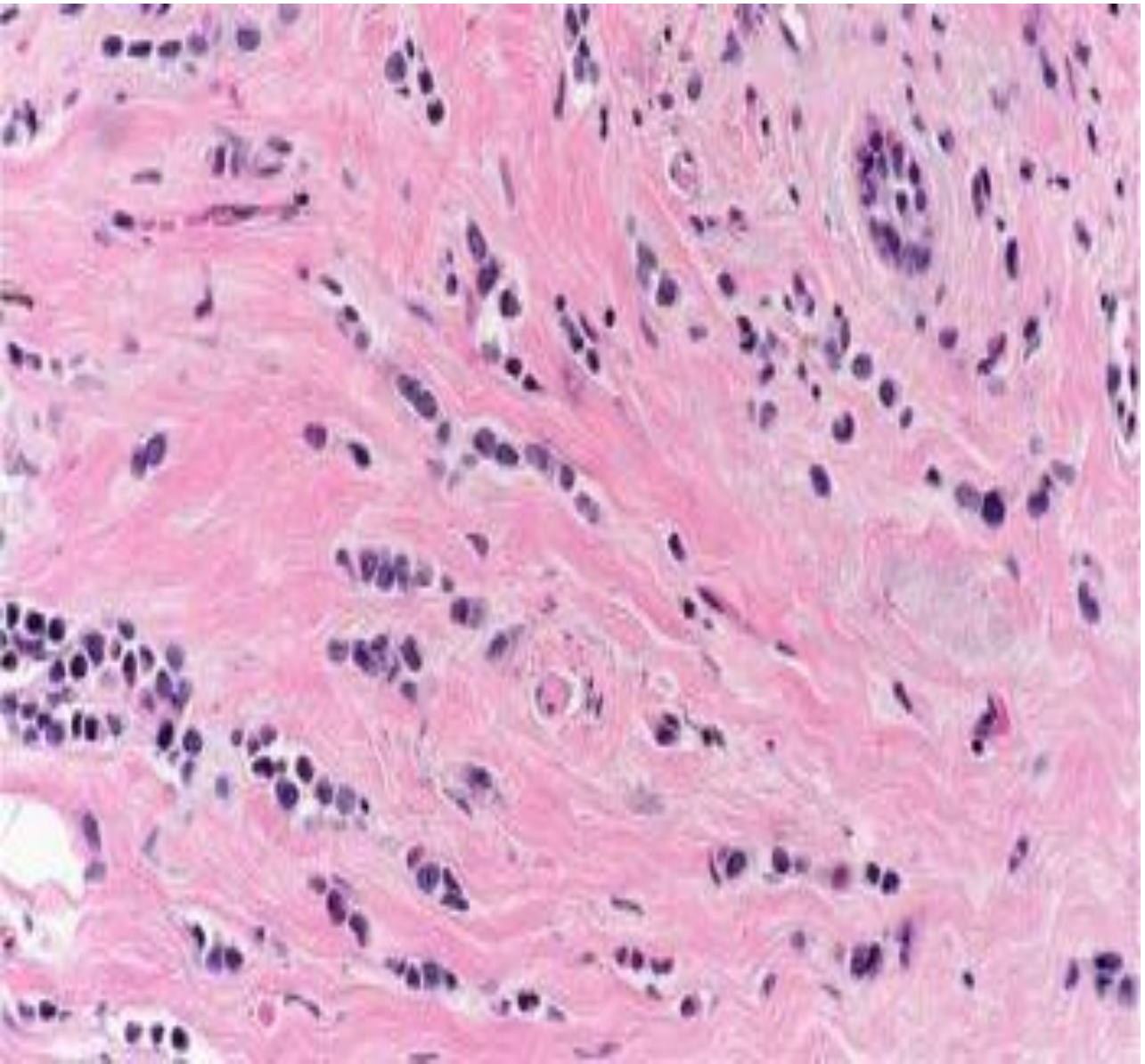
- 10-15%
- **Precancerous lesion**. associated with LCIS.
- 10% to 20% are multicentricand bilateral
- **Clinical presentation**. Most present as palpable masses or mammographic densities
- cells invade stroma i**ndividually** and often are aligned in **“single-file”**
- Almost all of these carcinomas express hormone receptors, but HER2 overexpression is very rare or absent.
- Metastasis of lobular carcinoma is unique since it frequently reaches the CSF, serosal surfaces, bone marrow , ovary, and uterus

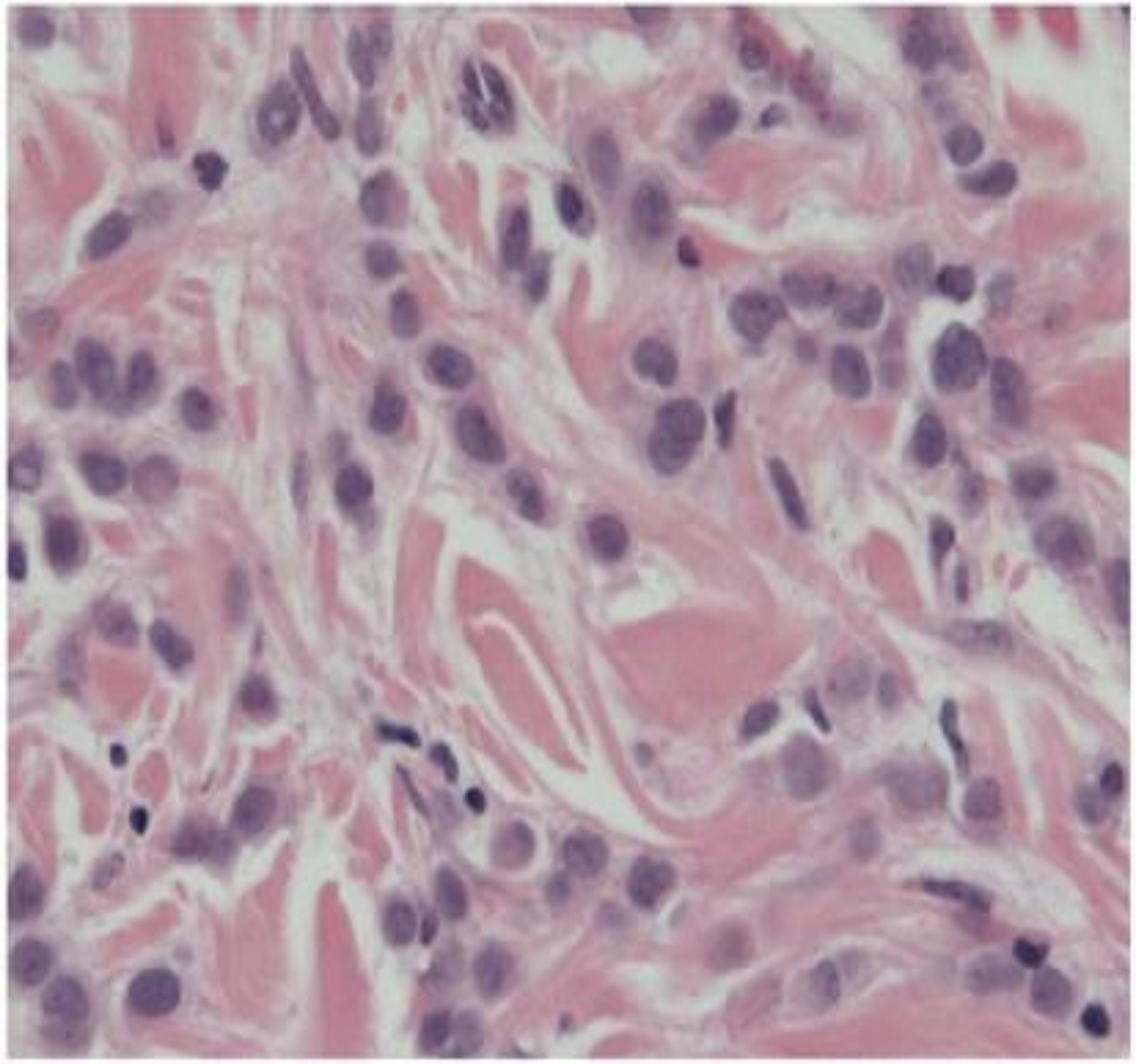


Invasive lobular carcinoma



Lobular breast carcinoma





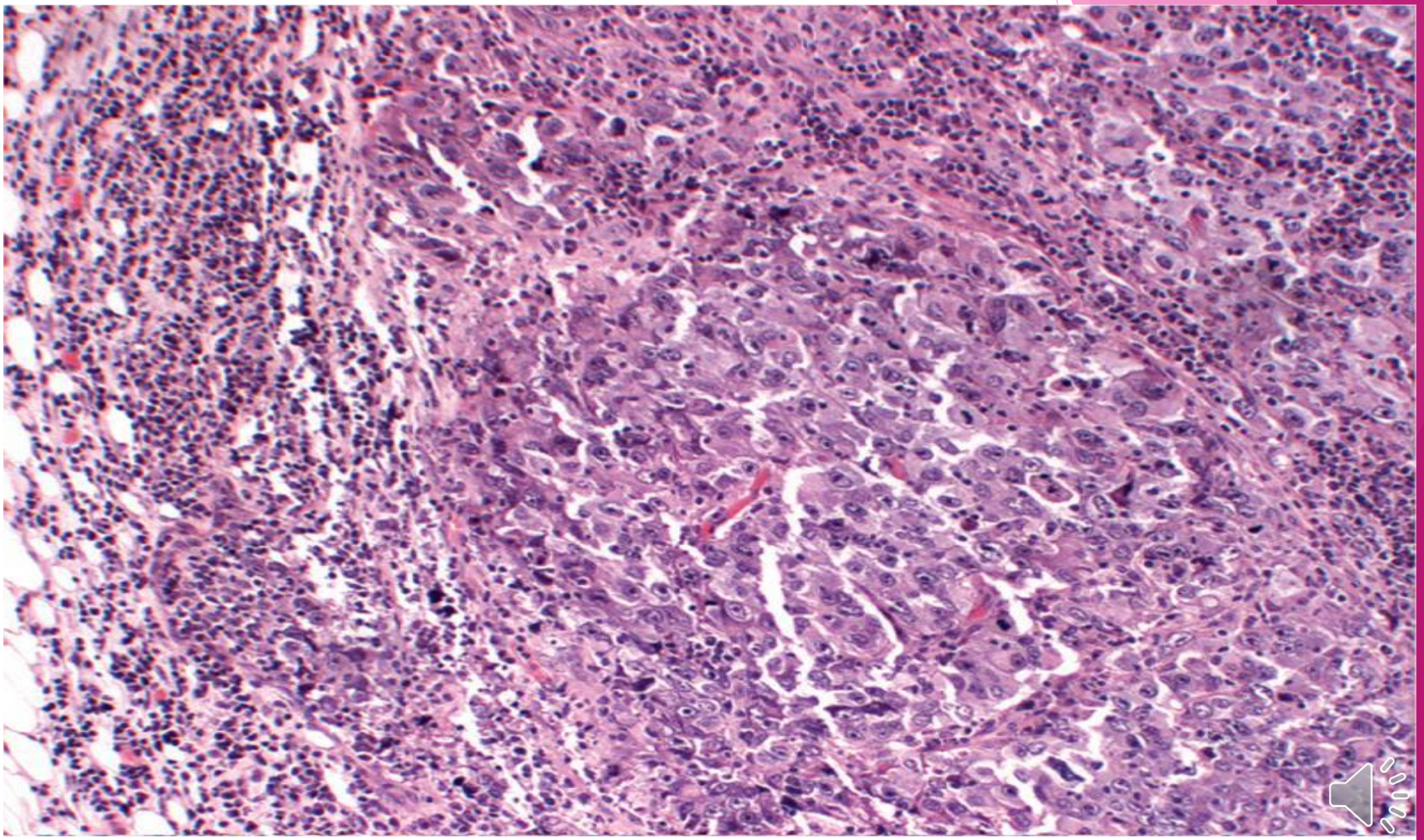
❑ Carcinoma with Medullary features

- 5%
- Triple negative
- **Microscopically:** large anaplastic cells with pushing, well-circumscribed borders with a pronounced lymphocytic infiltrate.
- **Precancerous lesions**. usually absent
- increased frequency in women with ***BRCA1*mutations**,.
- **Receptor profile**. lack hormone receptors and do not overexpressHER2/NEU.
- Those carcinoma typically grow as rounded masses that can be difficult to distinguish from benign tumors on imaging

Histology with Carcinoma with medullary features

the tumor in the middle consist of tightly adhesive clusters of cells

At he periphery there is a dense lymphocytic infiltrate around the island of tumor cells

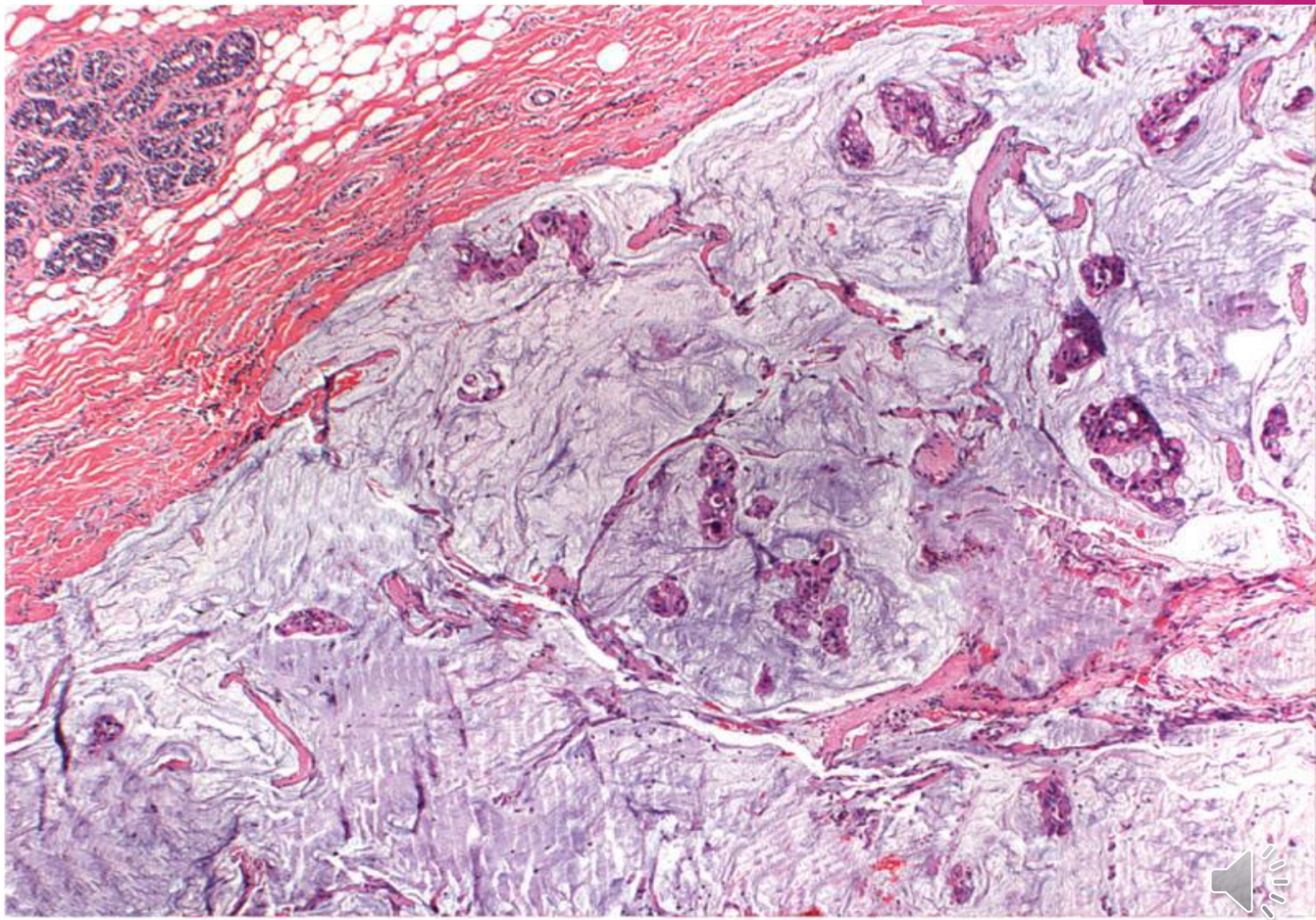


❑ Colloid mucinous Carcinoma

- a rare subtype
- **Microscopic picture**. The tumor cells produce abundant quantities of extracellular **mucin**that dissects into the surrounding stroma. Grossly the tumors are usually soft and gelatinous.

- ER-positive/HER2-negative cancer

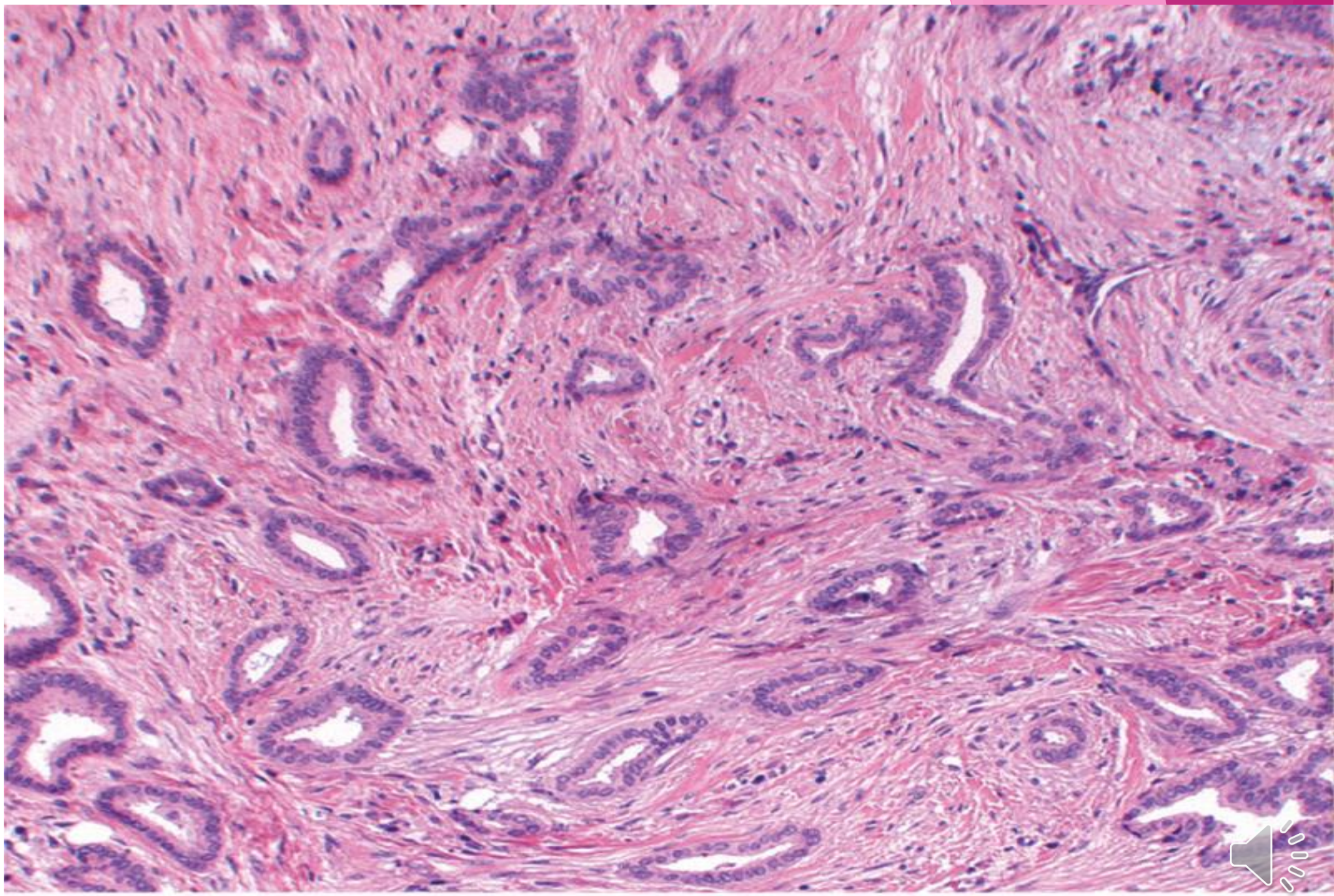
- Shows abundant blue mucin and the carcinoma cells appears to be floating in those lakes of mucin
- This mucin matrix gives the tumor the grossly soft blue to gray appearance



❑ Tubular carcinoma

- **10%** of invasive carcinomas
- **Clinical presentation**. irregular mammographic densities.
- **Microscopically**, well-formed tubules with low-grade nuclei.
- **Lymph node metastases are rare, and prognosis is excellent.**
- ER-positive/HER2-negative cancer
- Sometimes mistaken for benign sclerosing lesions. Calcification may present in the tumor lumen

- well-differentiated neoplastic cells form a single cuboidal layer in small,round to tear drop shaped ductules widely spaced in a fibrous stroma.



❖ Spread of breast cancer

- ❖ through **lymphatic** and **hematogenous** channels.
- ❖ Favored metastasis are the **bone**, **lungs**, **skeleton**, **liver**, and **adrenals** and (less commonly) the brain, spleen, and pituitary.
- ❖ **Metastases may appear many years after apparent therapeutic control of the primary lesion that's why we use screening program**

❖ SCREENING:

- ❑ **mammographic screening**
- ❑ **Magnetic resonance imaging, MRI**

❑ Spread of Breast Cancer

- ❖ Spread eventually occurs through lymphatic & hematogenous channels. LN metastases are present in about 50% of ca presenting as palpable masses, but… in fewer than 15% of cases found by mammography.
- ❖ **Outer quadrants & centrally located ca**typically spread first to the axillary LN.
- ❑ **Ca B** in the **inner quadrants**often involve the LN along the internal mammary arteries.
- ❑ The supraclavicular LNare usually become involved only after the axillary & internal mammary LN are affected, but… sometimes are the primary site of spread (Skipped).

- More **distant dissemination** eventually follows, with metastatic involvement of **almost any organ or tissue in the body. Favored** locations are the lungs, skeleton, liver, & adrenals & (less commonly) the brain, spleen, & pituitary. However, **no site is exempt!**

- Metastases may appear many years (sometimes 15 years) after apparent therapeutic control of the primary ca!

- Clinically,Ca B is often discovered by the woman or her physician as a solitary, painless, & not movable mass(fixed , hard in consistency). At this time, the ca is typically **2 to 3 cm**in ø, with involvement of the **regional LNs**(most often axillary) in about **50% of patients.**

❑ Breast cancer Prognosis

- The outcome for women with breast cancer depends on the **biologic features of the carcinoma (molecular or histologic type)**and the extent to which the cancer has spread (**stage**) at the time of diagnosis.

Prognostic Factors

- Tumor stage
- Invasive carcinoma versus carcinoma in situ
- Distant metastases.
- Lymph node metastases.
- Tumor size.In cm
- Locally advanced disease
- Inflammatory carcinoma
- Lymphovascularinvasion
- Molecular subtype.
- Special histologic types.
- Histologic grade
- Estrogen and progesterone receptors and HER2 expression

❖ Tumor Stage

Invasive carcinoma versus carcinoma in situ.

- ❑ **Distant metastases. Once** distant metastases are present, cure is unlikely,
- ❑ **Lymph node metastases.**
- ❑ **Axillary lymph node status is the most important prognostic factor for invasive carcinoma in the absence of distant metastases.**
- ❑ biopsy is necessary for accurate assessment.

- ❑ With no lymph involvement the ten years survival is 70-80%

1 -3 lymph involvement →35-40%

If morthan 10 lymph nodes →10-15%

Tumor Stage

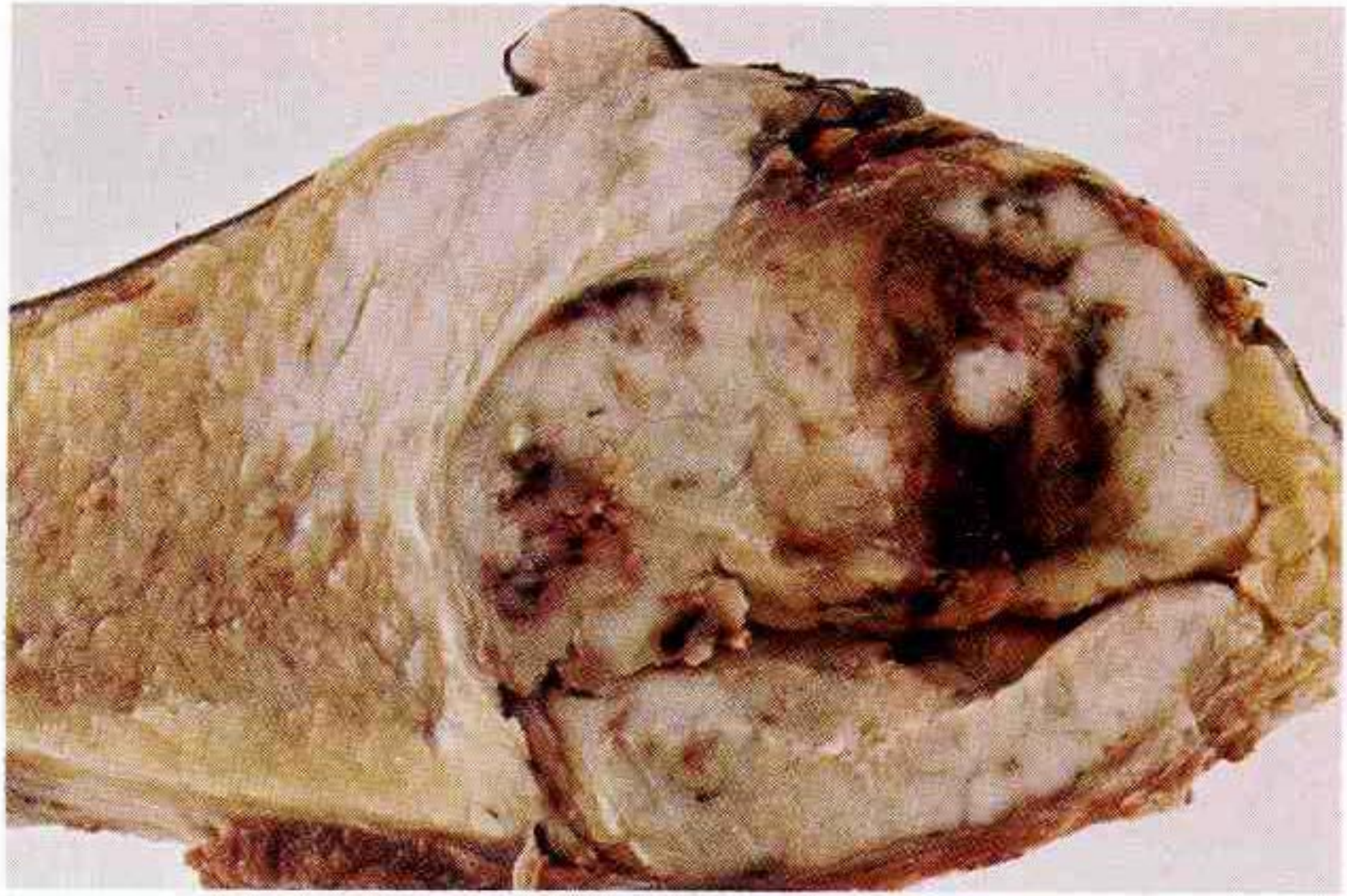
- **Tumor size. The** risk of axillary lymph node metastases increases with the size of the primary tumor, but both are independent prognostic factors.

- **Locally advanced disease. Carcinomas** invading into skin or skeletal muscle are usually large and may be difficult to treat surgically.

❑ Inflammatory Carcinoma

- clinically present as an enlarged, swollen, erythematous breast (resulting from the blockage of dermal lymphatic spaces by ca cells)usually without or, with ill-define palpable mass or presents with breast erythema and skin thickening
- The ca is generally poorly differentiated & diffusely invading the breast tissue.
- True inflammation is minimal or absent.
- Most of these T have distant metastases & the prognosis is extremely poor.
- mimics the surface of an orange peel, an appearance referred to as peaud'orange.

Lactating (Inflammatory) carcinoma: **breast.** A large greyish-white cancer with extensive central necrosis & hemorrhage. Clinically, the tumor resembles an acute inflammatory lesion & has a rapid malignant course with extremely poor prognosis.



12.18 'Lactational' carcinoma: breast

❑Lymphovascular Invasion

- ❖strongly associated with the presence of lymph node metastases.
- ❖poor prognostic factor

❑ Special Histologic Types

- The survival rate of women with **tubular, mucinous, lobular, papillary, and adenoid cystic** is greater than that of women with cancers of no special type.

- Women with **metaplastic carcinoma or micro papillary carcinoma** have a poorer prognosis.

❑ Histologic grade

- ❖ All invasive carcinomas are graded using Histologic Score composed of Nuclear grade, tubule formation, and mitotic rate
- ❖ **Proliferative rate:**
- ❑ measured by mitotic counts.
- ❑ Highly proliferative tumors have poorer prognosis but may respond better to chemotherapy

❑ ER,PR,HER2

❖ ***ER & PR:***

- ❑ Eighty percent of carcinomas that are both ER-and PR-positive respond to hormonal manipulation
- ❑ 40% of CA positive for only ER or PR respond.
- ❑ Strongly ER-positive cancers are less likely to respond to chemotherapy.
- ❑ cancers that fail to express either ER or PR have a less than 10% likelihood of responding to hormonal therapy but are more likely to respond to chemotherapy.

❖ ***HER2:***

- HER2 overexpression is associated with poorer survival
- predictor of response to agents that target this receptor.

Stages of breast ca

Stage 0: DCIS or LCIS, with 5-year survival rate (5YSR):**92%**

Stage I: Invasive ca up to **2 cm**Ø(including ca in situ with micro invasion) without LN involvement **(**5YSR:**87%).**

Stage II: Invasive ca up to **5 cm**Ø **with up to 3 involved axillary LNs** or invasive ca more than 5 cm without LN involvement **(**5YSR:**75%).**

Stage III. Invasive ca up to **5 cm**Ø **with 4 or > involved axillary LNs**; invasive ca more than 5 cmØ with LN involvement; invasive ca with 10 or more involved axillary LNs; invasive ca with involvement of the ipsilateral internal mammary LNs; or invasive ca with skin involvement (edema, ulceration, or satellite skin nodules), chest wall fixation, or clinical inflammatory ca (5YSR:**46%).**

Stage IV. Any Ca B with **distant metastases**(5YSR: **13%**).

Why some cancers **recur** following postoperative therapy whereas others do not? Remains unknown & a **mystery**.

Thanks a lot dear third year medical students
Wishing to you Good luck