RSS Breast Guidelines update

Jenny Piper

Consultant Oncoplastic Breast Surgeon

Clinical Lead – Breast and Plastic Surgery

4 main areas to concentrate on:

- Nipples
- Pain
- Men
- Lumps and bumps
  - » Who needs referring (and to whom?)
  - » Who needs reassuring
  - » Who needs conservative treatment and review

So – let's talk about nipples!

- Inversion
- Retraction
- Discharge
- Skin changes

Old RSS

NHS

Referral Support Serv

B10
Nipple Rash

Definition

Persistent itchy rash around the nip

Exclude Red Flag Symptoms

Associated lump, ulceration, skin di

Management

- If itchy advise regular applic review response
- Treat any apparent associat Yorkshire antimicrobial guid
- Refer two week rule if not re referral is to exclude Pagets
- If condition is clearly part of considering

If not itchy, referral advised whethe

Referral Information

Information to include in referral

- Duration of symptoms, treatment
- Relevant past medical / surgical
- Current regular medication
- BMI/ Smoking status

NHS

Referral Support Servic

BO8
Nipple Discharge

Definition

Unilateral or bil

Exclude Red F

- Unilater
- Unilater
- Any ass

Management

- If smoke
- If age >
- Reassu
- Smoking
- Weight l
  Large ar

Referral Inform

Information to

- Outline
- Family h
- Relevant past medical / surgica
- Current regular medication
- BMI/ Smoking status

NHS
Vale of York
Clinical Commissioning Group

Referral Support Servi

Antipsychotics	Typical
	Atypical:
Antidepressants	SSRIs:
	Tricyclics
Prokinetics	metoclpram
Antihypertensives	verapamil, b
Opiates	morphine
H2 antagonists	cimetidine,
Others	digoxin, spi

NHS
Vale of York
Clinical Commissioning Group

Breast

tion/ Retraction]

ateral blood stained discharge

agnosis and monitoring

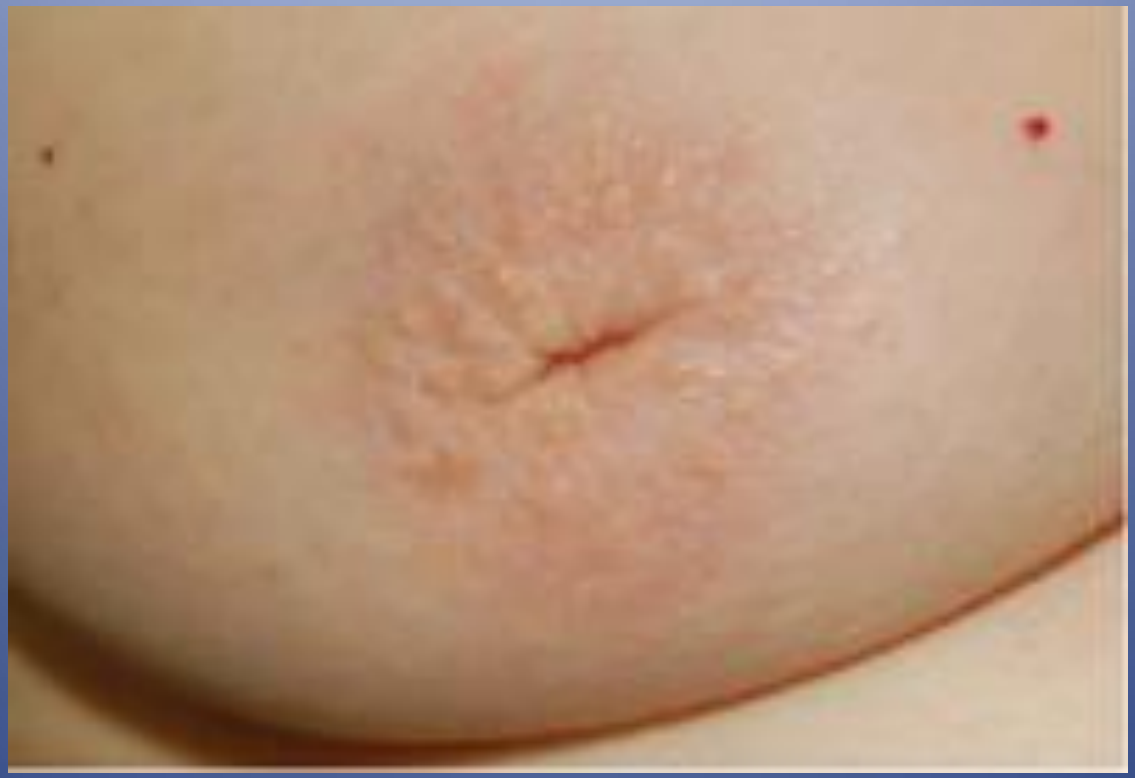
ion and distortion/retraction.

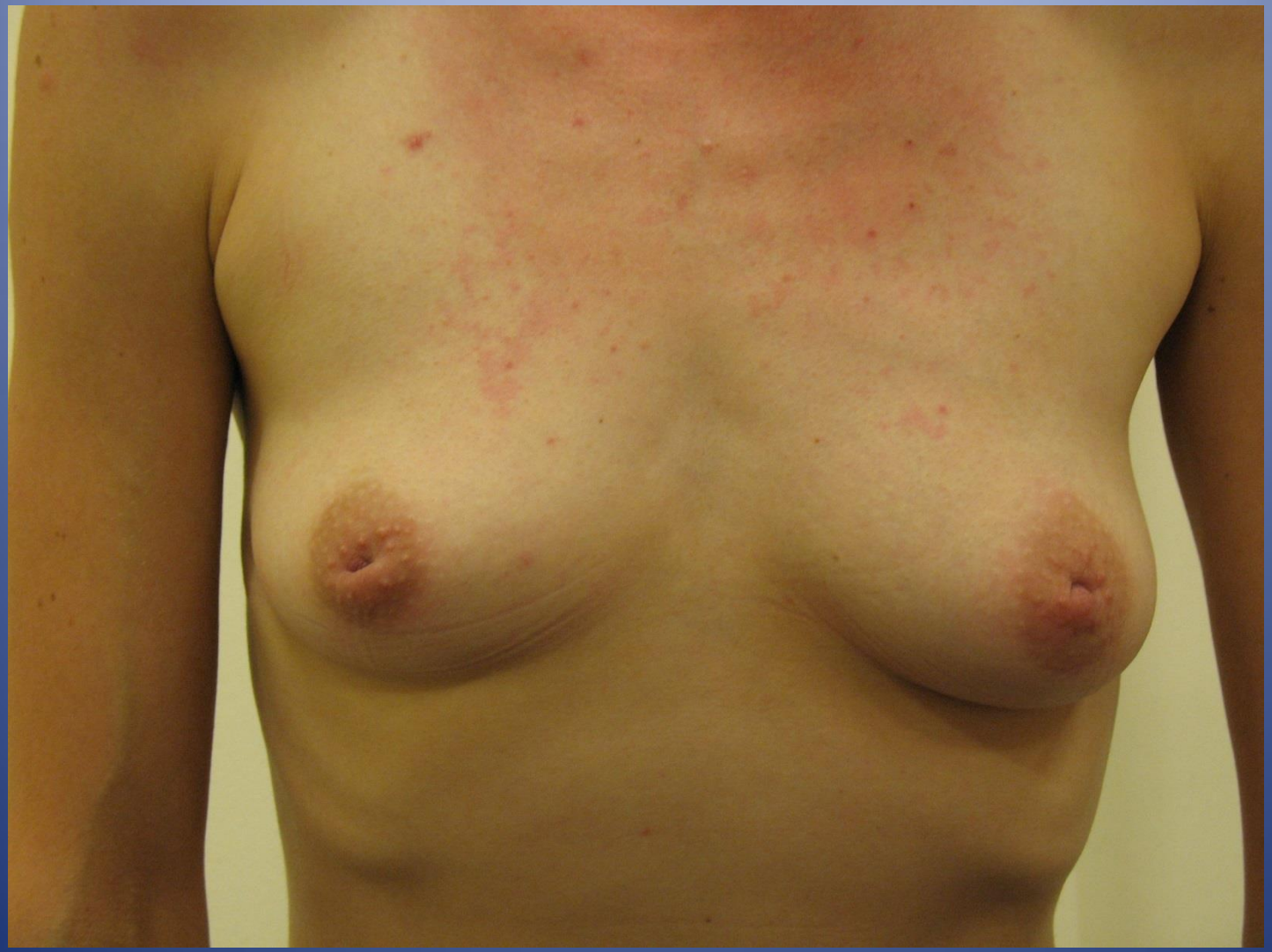
- Inversion can usually be corrected, although not necessarily permanently, and usually appears slit like. The contour of the breast is not altered.
- Distortion/retraction is usually of recent origin and progressive, cannot be corrected and will often alter the contour of the breast.
- Fast track referral if red flag symptoms present
- If long standing slit like inversion which is correctable and has no associated symptoms or signs reassure
- Smoking cessation to be encouraged
- Weight loss (if appropriate) to be encouraged

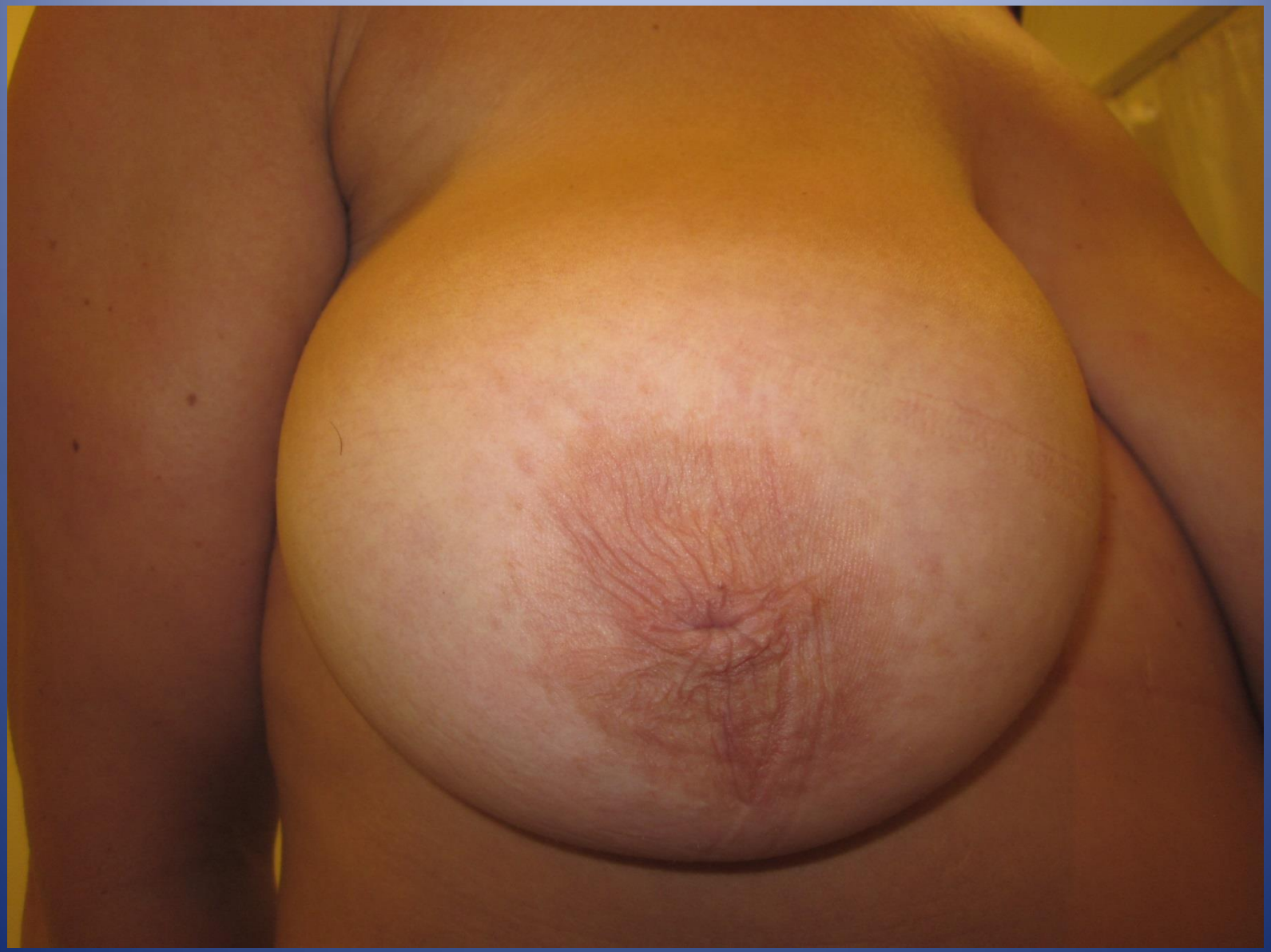
Nipple inversion

- Central, symmetrical transverse slit in the nipple
- Normal areola
- Fully evertable
- Often starts unilateral
- If long-standing and no change, no referral needed.

Nipple inversion



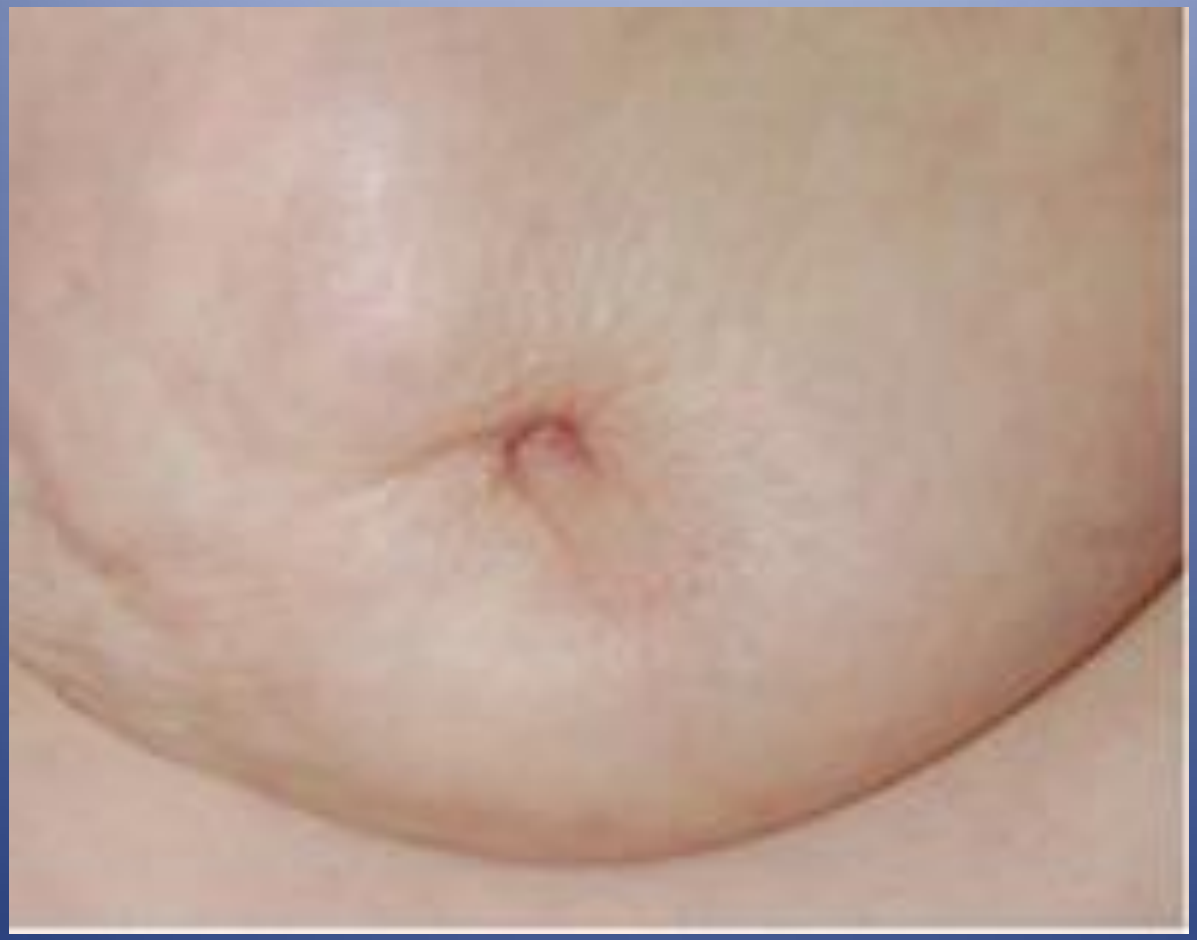


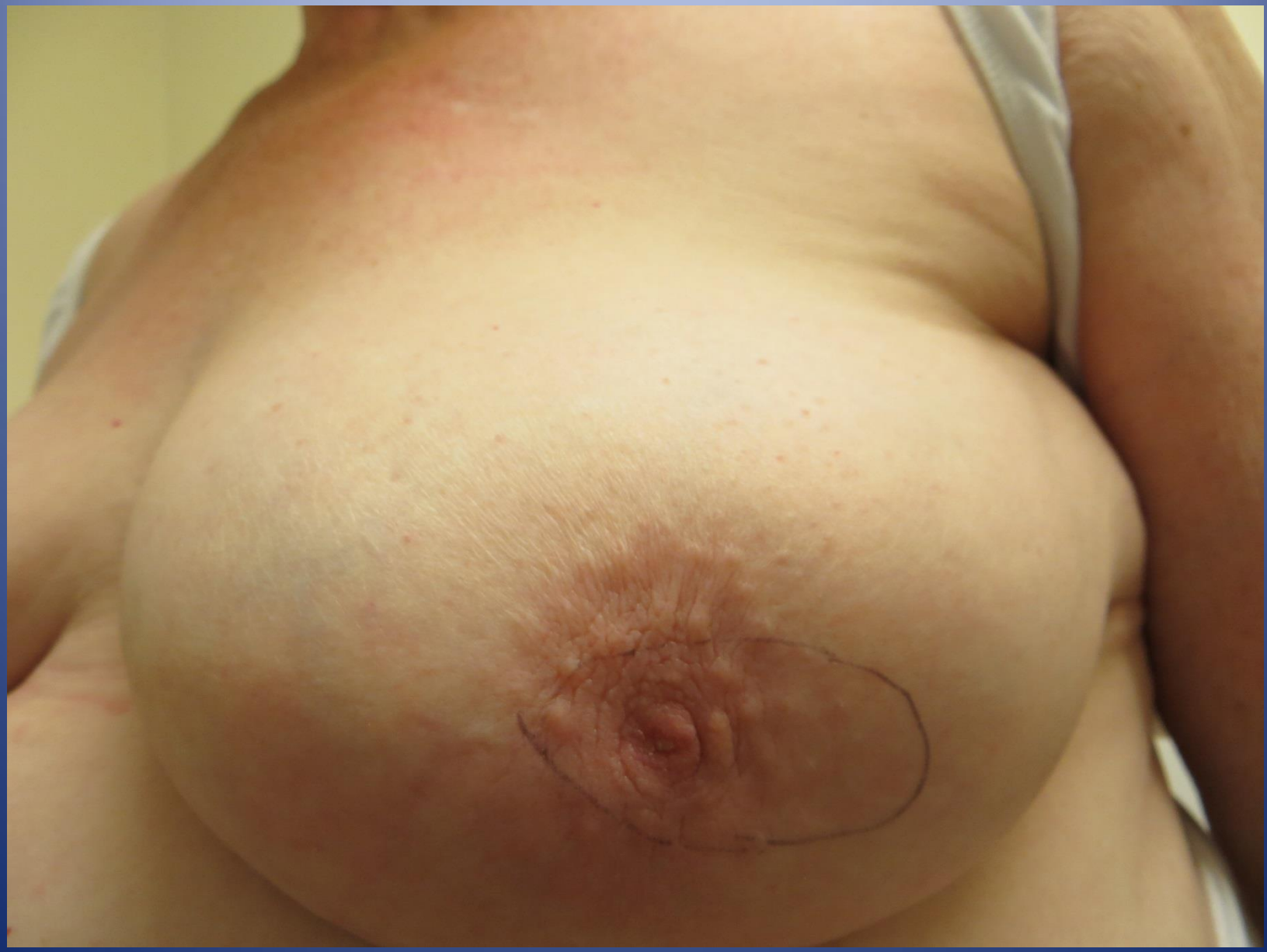


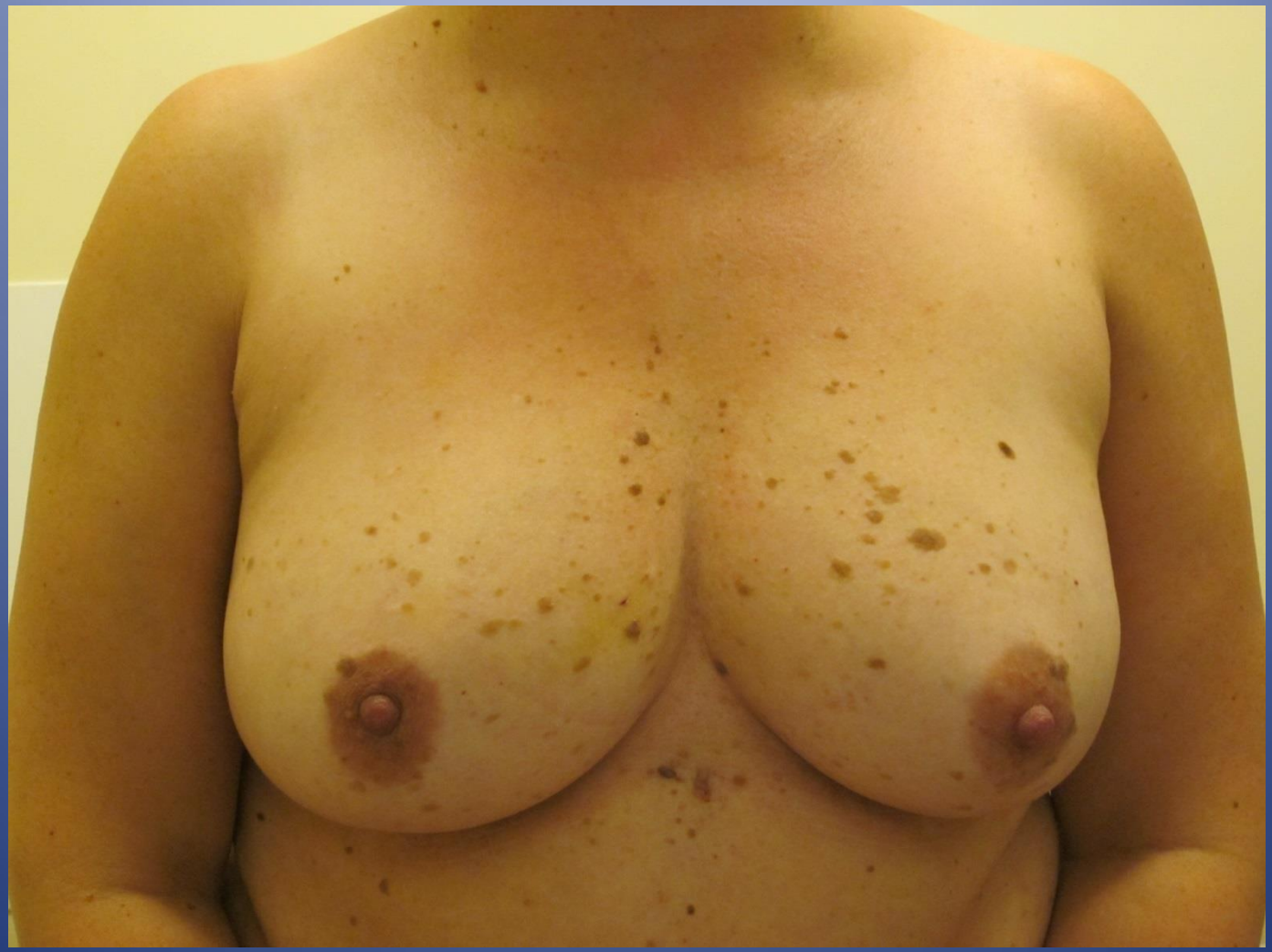
Nipple retraction

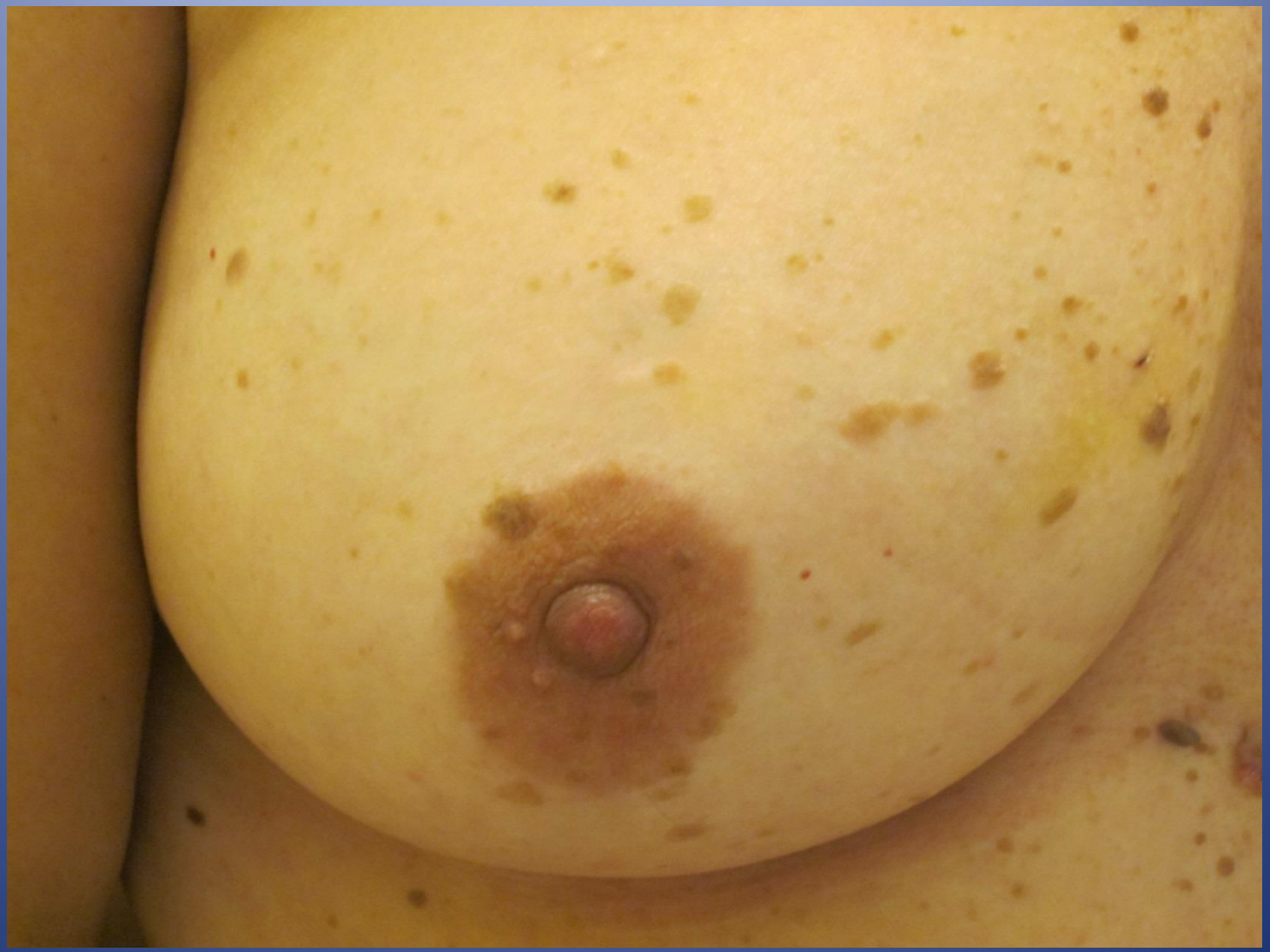
- Whole nipple pulled inwards
- Fixed, not evertable
- Often changes in areola
- May be more pronounced on lifting arms
- Not always cancer (can be associated with inflammatory conditions) but does need investigating

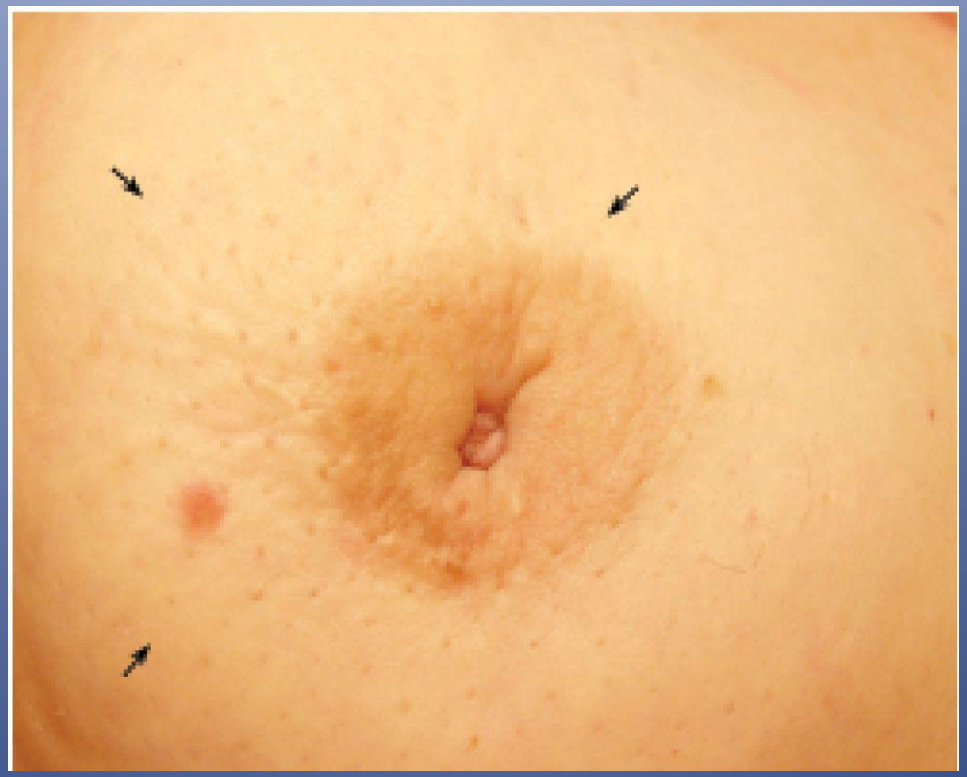
Nipple retraction











Nipple discharge

- Most discharge is of no significance.
- Nipple discharge can be expressed by pressure in up to 85% of women and in this case is normal.
- Spontaneous discharge may be more significant. Even so, nipple discharge is rarely a sign of anything serious provided there are no other symptoms such as blood staining, a lump, or new inversion of the nipple.
- Intermittent discharge which is clear, yellow, creamy, greenish or brown is considered normal. **Only if the discharge is red blood coloured or clear do you need further investigation by your doctor**.
- Note - The best way of distinguishing red from brown discharge is to dab a little onto a white tissue and look at it under a good light.

Causes of nipple discharge

- Physiological
- Duct ectasia
- Mild inflammation
- Post-partum
- Papilloma
- DCIS/Cancer
- Abscess
- Endocrine causes, joggers nipple……

Nipple discharge

Physiological

- Not spontaneous
- Bilateral
- Multi-duct
- Multicoloured – green, brown, white, yellow, grey
- Sticky

Pathological

- Spontaneous
- Unilateral
- Single duct
- Persistent
- Clear
- Blood stained

Nipple Discharge

- Reassure – bilateral, multiduct, multicoloured
- DON'T SQUEEZE NIPPLES!
- Reassure and discharge diary
- Refer – single duct, spontaneous and clear or blood-stained, concerned

Itchy nipples/rash

- Usually eczema/dermatitis, nipple sparing, settles with conservative treatment
- Paget's – involves nipple first, then areolar, doesn't settle with conservative management

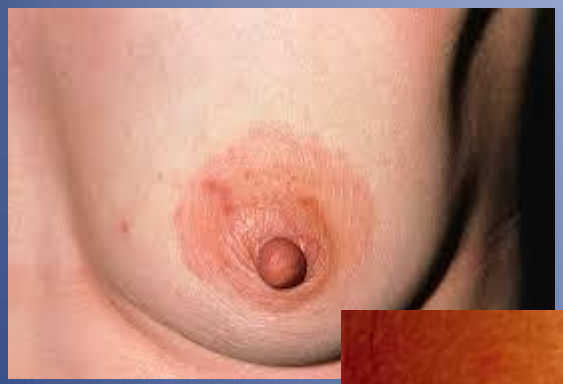
- Trial of topical steroids (?anti-fungal or Timodine)

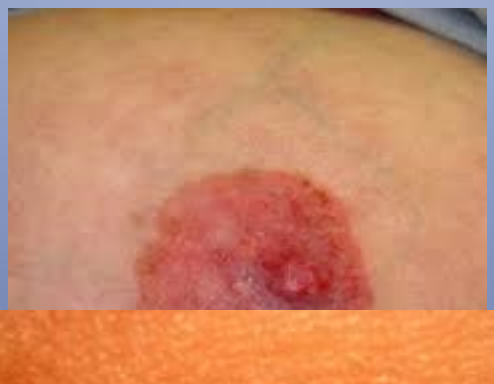
Itchy nipples/rash

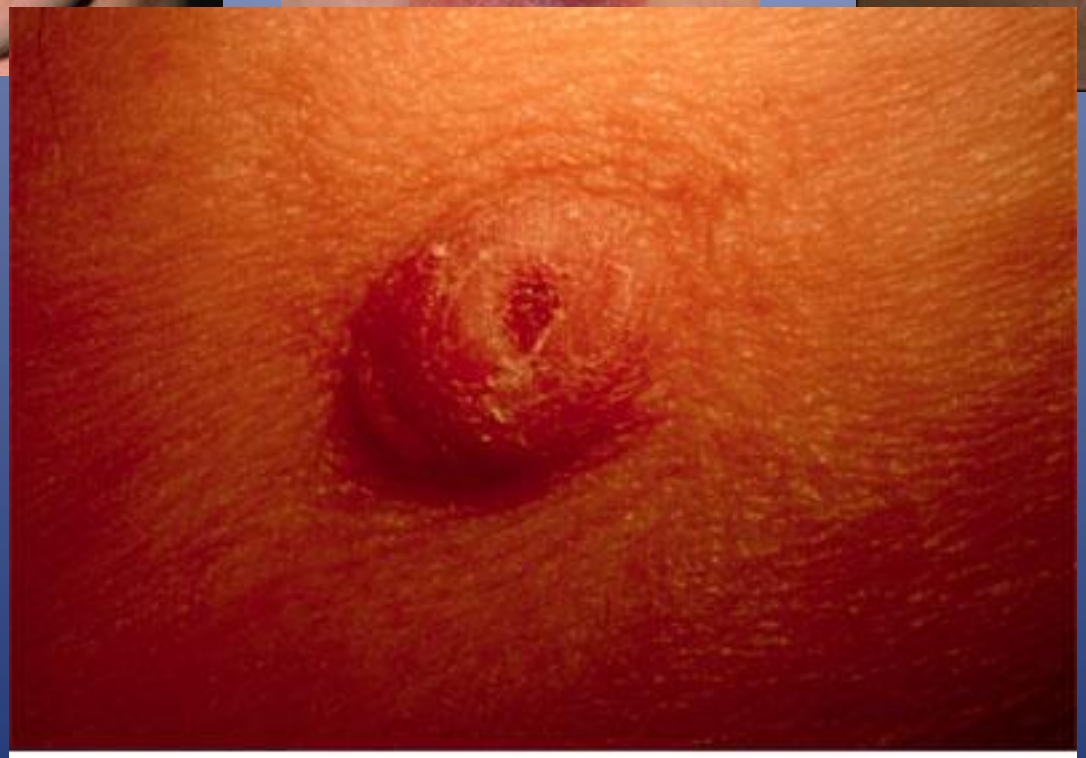
Paget's disease of the nipple

- Rare form of breast cancer on the nipple, extending to the areolar
- Often associated with an underlying invasive or in situ carcinoma
- Approx 1-4% of women with breast cancer have Paget's disease

Nipple rash







Early Paget's disease

RSS guidelines

- **<u>Red Flag Symptoms (=fast track referral)</u>**

- Associated lump or skin distortion,
- Unilateral single duct spontaneous nipple discharge that is blood-stained, clear or serous
- Unilateral nipple retraction (not inversion) age >50 and less than 3 (?6) months duration.

Who may not need referring?

- Itchy skin around the nipple with no other changes, rash around the nipple that resolves with topical steroids/treatment
- Bilateral nipple discharge that is **not** blood stained.
- Milky nipple discharge with normal prolactin.
- Long standing nipple inversion that has not significantly changed, no associated symptoms.

Management – nipple rash

- If itchy advise regular application of moderately potent topical steroid for at least 2 weeks and review response. Treat any apparent associated infection with **flucloxacillin** or **clarithromycin** – as per North Yorkshire antimicrobial guidance (cellulitis and wound infection).
- Refer two week rule if not resolved within 2 weeks of good compliance with treatment (purpose of referral is to exclude Pagets Disease of the Nipple.)
- If condition is clearly part of a more generalized eczema dermatology referral may be worth considering.

Management -

- **Nipple discharge (if age >40 years, routine referral unless meets fast track criteria)**
- If bilateral, multiple duct discharge under the age of 40 – no referral needed, just reassurance
- If milky discharge – check prolactin
  - Normal prolactin – no referral needed, just reassurance.
  - Raised prolactin – refer Endocrinology
- Check serum prolactin, U+E, LFTs, and TFT.

Referral Support Service

Breast

B10
Nipple Problems (discharge, rash, inversion)

Red Flag Symptoms (=fast track referral)

Associated lump or skin distortion, unilateral single duct spontaneous nipple discharge that is blood-stained, clear or serous and unilateral nipple retraction (not inversion) age >50 and less than 3 months duration.

What may not need referring?

Itchy skin around the nipple with no other changes, rash around the nipple that resolves with topical steroids
Bilateral nipple discharge that is **not** blood stained.
Milky nipple discharge with normal prolactin.
Long standing nipple inversion that has not significantly changed, no associated symptoms.

Management

- **Nipple rash**
  If itchy advise regular application of moderately potent topical steroid for at least 2 weeks and review response. Treat any apparent associated infection with **flucloxacillin** or **clarithromycin** – as per North Yorkshire antimicrobial guidance (cellulitis and wound infection). Refer two week rule if not resolved within 2 weeks of good compliance with treatment (purpose of referral is to exclude Pagets Disease of the Nipple.). If condition is clearly part of a more generalized eczema dermatology referral may be worth considering.

- **Nipple inversion**
  Need to distinguish between inversion and distortion/retraction. Inversion can usually be corrected, although not necessarily permanently, and usually appears slit like. The contour of the breast is not altered.
  Distortion/retraction is usually of recent origin and progressive, cannot be corrected and will often alter the contour of the breast.
  If long standing slit like inversion which is correctable and has no associated symptoms or signs reassure

- **Nipple discharge (if age >40 years, routine referral unless meets fast track criteria)**
  If bilateral, multiple duct discharge under the age of 40 – no referral needed, just reassurance
  If milky discharge – check prolactin Normal prolactin – no referral needed, just reassurance
  Raised prolactin – refer Endocrinology
  If Large amount of milky discharge from multiple ducts consider visual field assessment. Common causes include physiological, drugs* (see below), thyroid disorder, pituitary tumor (visual field

defects/ new headaches), prolactinoma (menstrual disturbance/ acne).
Check serum prolactin, U+E, LFTs, and TFT.

***Drugs which demonstrate ability to induce hyperprolactinaemia above the normal range:**
This list is not exhaustive; please refer to the SPC for individual drugs.

Antipsychotics	haloperidol, chlorpromazine, risperidone, amisulpiride
Antidepressants	SSRIs: sertraline, fluoxitine, paroxetine
	Tricyclics amitriptyline, clomipramine
Prokinetics	metoclpramide, domperidone
Antihypertensives	verapamil, betablockers
Opiates	morphine
H2 antagonists	cimetidine, ranitidine
Others	digoxin, spironolactone, sumatriptan, valproate
Illicit drug use	cannabis, amphetamines
Herbal remedies	fennel, anise, fenugreek seed

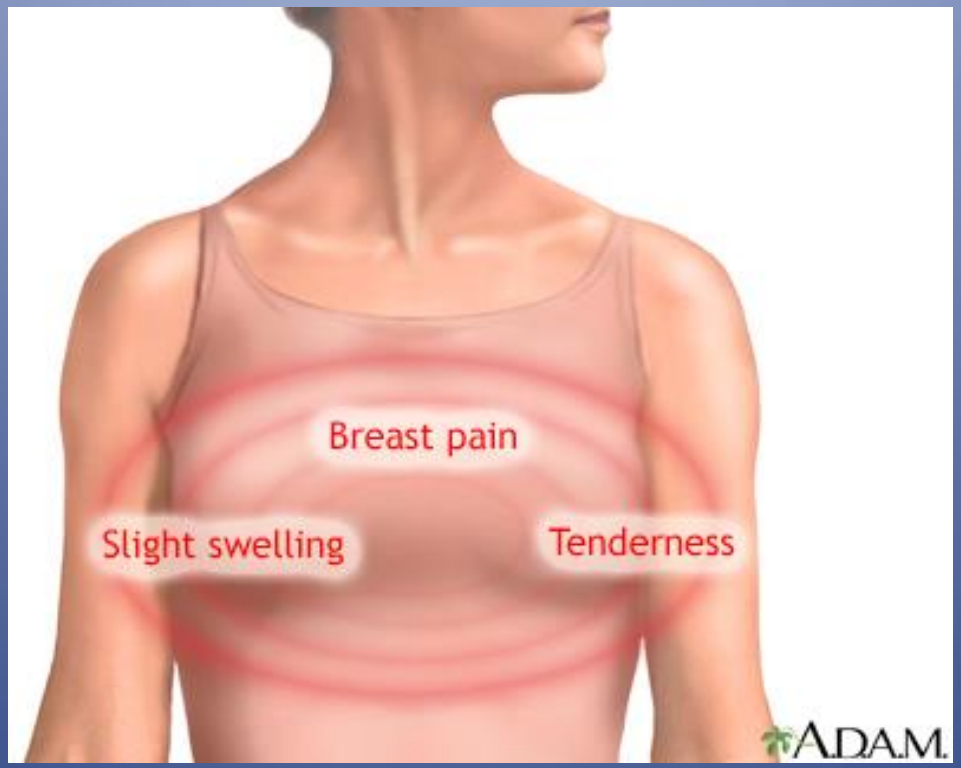
Information to include in referral letter

- Duration of symptoms, treatments tried and response to this.
- Recent pregnancy or breast feeding
- Relevant past medical / surgical history
- Current regular medication
- BMI/ Smoking status
- Family history if breast cancer

References

www.patient.co.uk/doctor/pagets-disease-of-breast

Breast pain



Breast pain

Mastalgia alone or in combination with lumpiness is the commonest reason for referral to a breast clinic, accounting for over half of all referrals

Almost never associated with a malignancy if examination is normal

Best practice guidelines for referral and investigation

Very few patients with breast pain need treatment with drugs

Breast pain

- Cyclical
- Non-cyclical
- Non-breast – primary care studies indicate this is the most common type of mastalgia
  - muscular, Tietz's syndrome, cervical rib, angina, pleuritic, pneumonia, gall stones
  - More likely if very lateral or medial, unilateral and can be reproduced by pressure on a specific area of the chest wall
  - Especially post-menopausal women not on HRT

Cyclical breast pain

- Related to menstrual cycle
- Described as dull, heavy or aching
- Often associated with swelling and lumpiness
- May radiate into axilla
- Can build up almost for the whole of the cycle before period, so appear almost constant, but changes in intensity

Non-cyclical breast pain

- Unrelated to menstrual cycle
- Tight, burning, sore
- Constant or intermittent
- Usually affects one breast, in a localised area, but can be more diffuse
- Usually affect post-menopausal women

Breast pain history

- Previous breast problems (cysts, pain, biopsies, cancer, surgery)
- Previous breast imaging – what, why, when?
- LMP
- Use of OCP, mirena, depot, POP and if recently started/changed
- Assess pain – pain chart if not straightforward

Breast pain chart

Pain chart

Record the amount of breast pain you experience each day by shading in each box as illustrated.

Severe pain

Mild pain

No pain

For example:- If you get severe breast pain on the fifth of the month then shade in completely the square under 5. Please note the day your period starts each month with the letter 'P'.

Please bring this card with you on each visit.

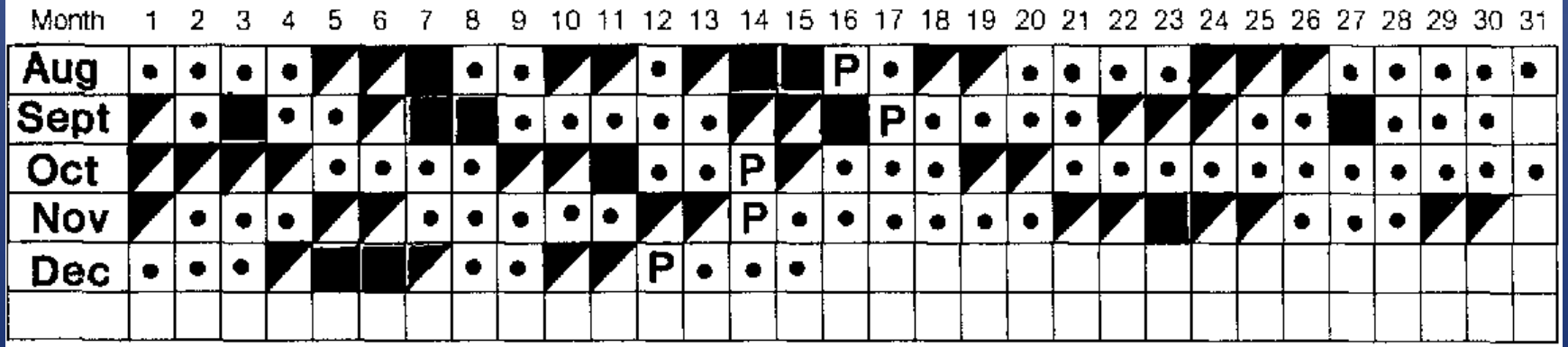
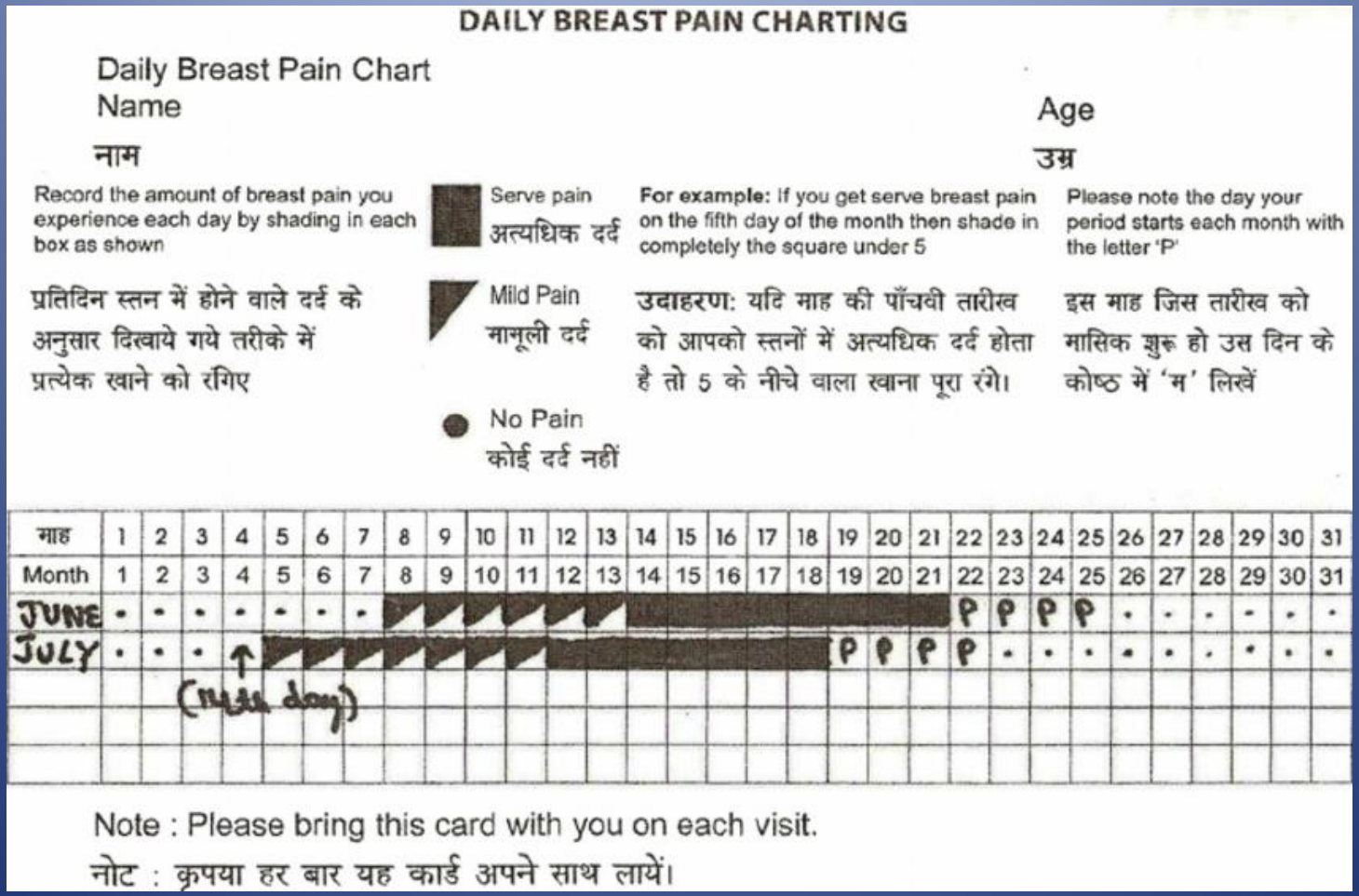


Fig. 3. Daily breast pain chart: Noncyclical mastalgia

Pain chart



DAILY BREAST PAIN CHARTING

Daily Breast Pain Chart

Name

Age

नाम

उम्र

Record the amount of breast pain you experience each day by shading in each box as shown

Serve pain
अत्यधिक दर्द

Mild Pain
मामूली दर्द

No Pain
कोई दर्द नहीं

For example: If you get serve breast pain on the fifth day of the month then shade in completely the square under 5

Please note the day your period starts each month with the letter 'P'

प्रतिदिन स्तन में होने वाले दर्द के अनुसार दिखाये गये तरीके में प्रत्येक खाने को रंगिए

उदाहरण: यदि माह की पाँचवी तारीख को आपको स्तनों में अत्यधिक दर्द होता है तो 5 के नीचे वाला खाना पूरा रंगे।

इस माह जिस तारीख को मासिक शुरू हो उस दिन के कोष्ठ में 'म' लिखें

माह	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JUNE	•	•	•	•	•	•	•	■	■	■	■	■	■	■	■	■	■	■	■	■	■	P	P	P	P	•	•	•	•	•	•
JULY	•	•	•	↑	■	■	■	■	■	■	■	■	■	■	■	■	■	■	P	P	P	P	•	•	•	•	•	•	•	•	•
			(1st day)																												

Note : Please bring this card with you on each visit.

नोट : कृपया हर बार यह कार्ड अपने साथ लायें।

Best practice guidelines

- Breast pain alone is not an indication for imaging
- Breast pain is a common symptom and if of short duration with no other clinical concern may be managed initially in a primary care setting.

NICE guidance

- **For women with moderate-to-severe pain, consider the use of a breast pain diary to aid diagnosis.** Advise the woman to use this for at least 2 months to assess the severity and timing of breast pain.
- **Exclude breast cancer.**
  - Refer using a suspected cancer pathway (for an appointment within 2 weeks) if the woman is:
    - 30 years of age or older and has an unexplained breast lump with or without pain, *or*
    - 50 years of age or older and has discharge, retraction, or other concerning changes in one nipple only.
  - Consider referral using a suspected cancer pathway (for an appointment within 2 weeks) if the woman:
    - Has skin changes suggestive of breast cancer.
    - Is 30 years of age or older with an unexplained lump in the axilla.
  - Consider non-urgent referral if the woman is younger than 30 years of age and has an unexplained breast lump with or without pain.
  - Seek specialist advice if there is doubt about whether a referral is needed.

Who to refer?

- Previous breast cancer
- Focal, discrete lump or clinical signs
- Persisting unexplained pain for >3 months??

Who not to refer?

- The vast majority of women with breast pain **have no underlying pathology** (even in focal or unilateral cases) and **do not need investigating**, just simple reassurance (effective in 70% of women?)
- All women with breast pain and no other symptoms should have a trial of conservative treatment, consider the use of a breast pain diary for at least 2 months, and **re-evaluation prior to referral**.

Treatment

- Educate and reassure
- Bra fitting if appropriate
- Topical NSAID gel
- Avoid caffeine?
- Evening primrose or starflower oil – minimum of 3 months for effect
- If on HRT - ?reduce
- If recently started or changed OCP/mirena – reassure and re-assess

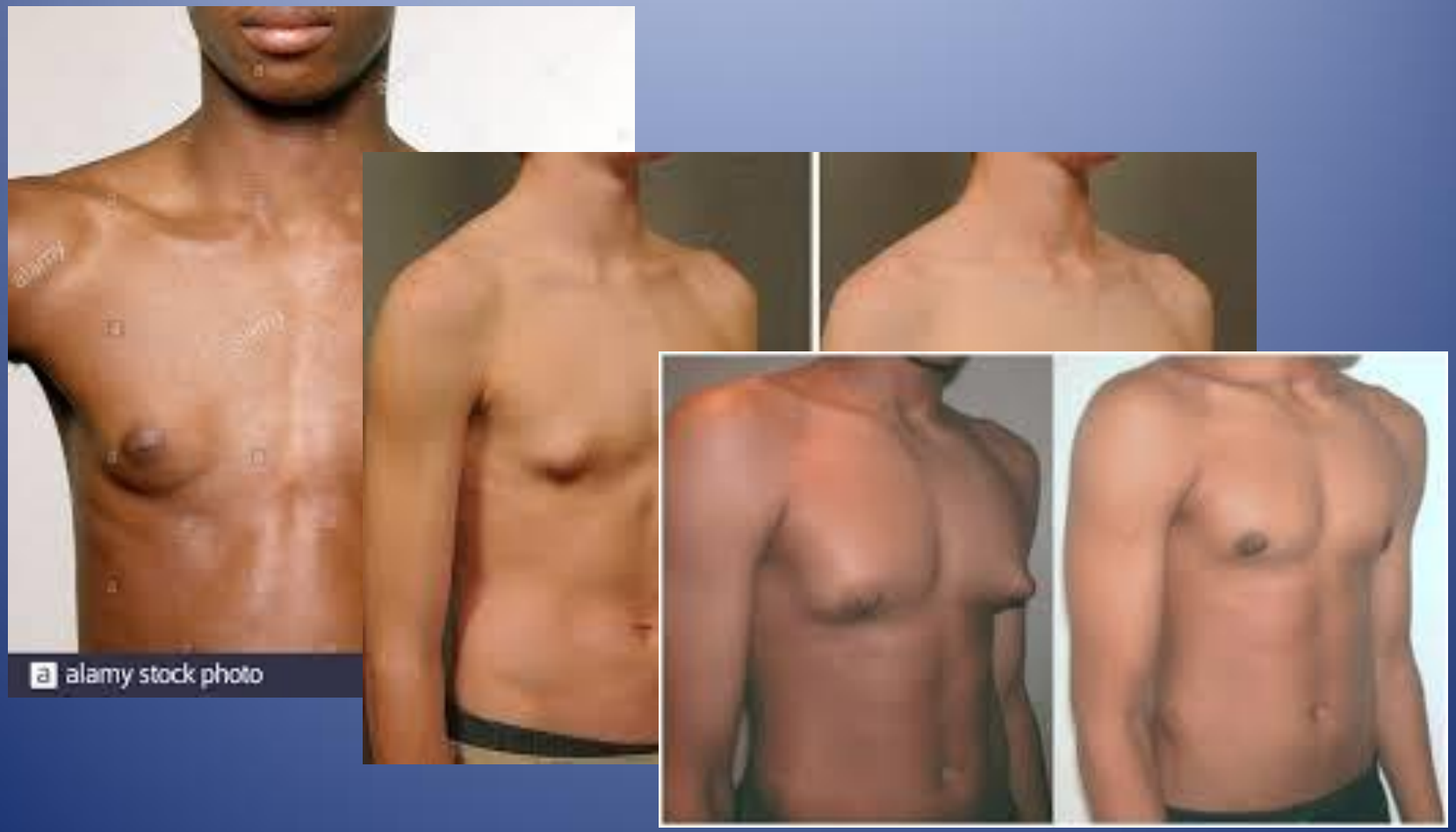
Men!

- >400 referrals of male patients were made to the York One-stop breast clinic in 2 years (2013-2014)
- In these referrals only 3 male breast cancers were diagnosed
- <20% required further investigation other than routine bloods

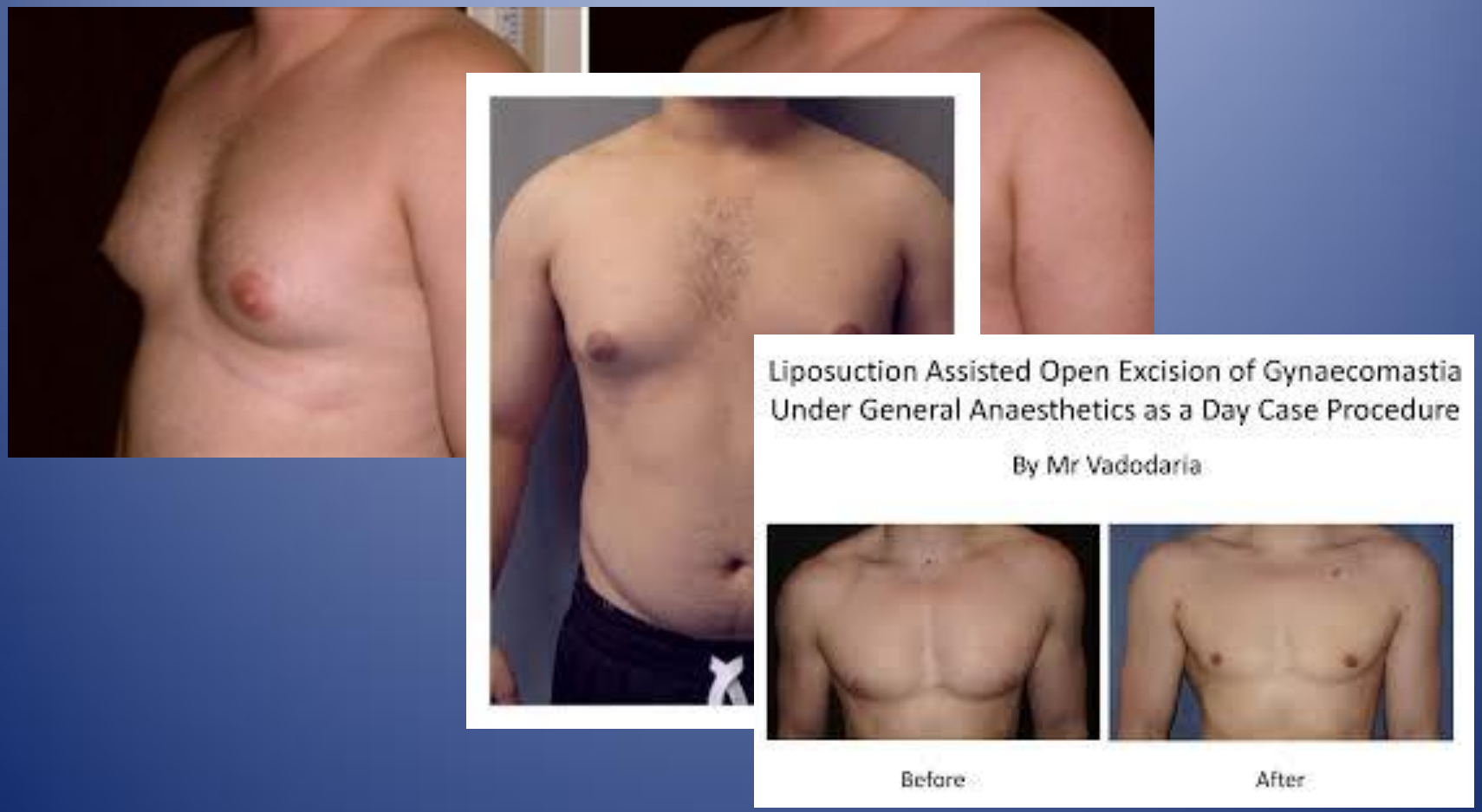
Gynaecomastia

- Any age, especially young and elderly
- Pain and swelling
  - Unilateral or bilateral
  - Concentric, rubbery
- No nipple changes or discharge
- 25% taking recreational drugs
- 50% on medication known to cause
- 10% high alcohol intake

Gynaecomastia

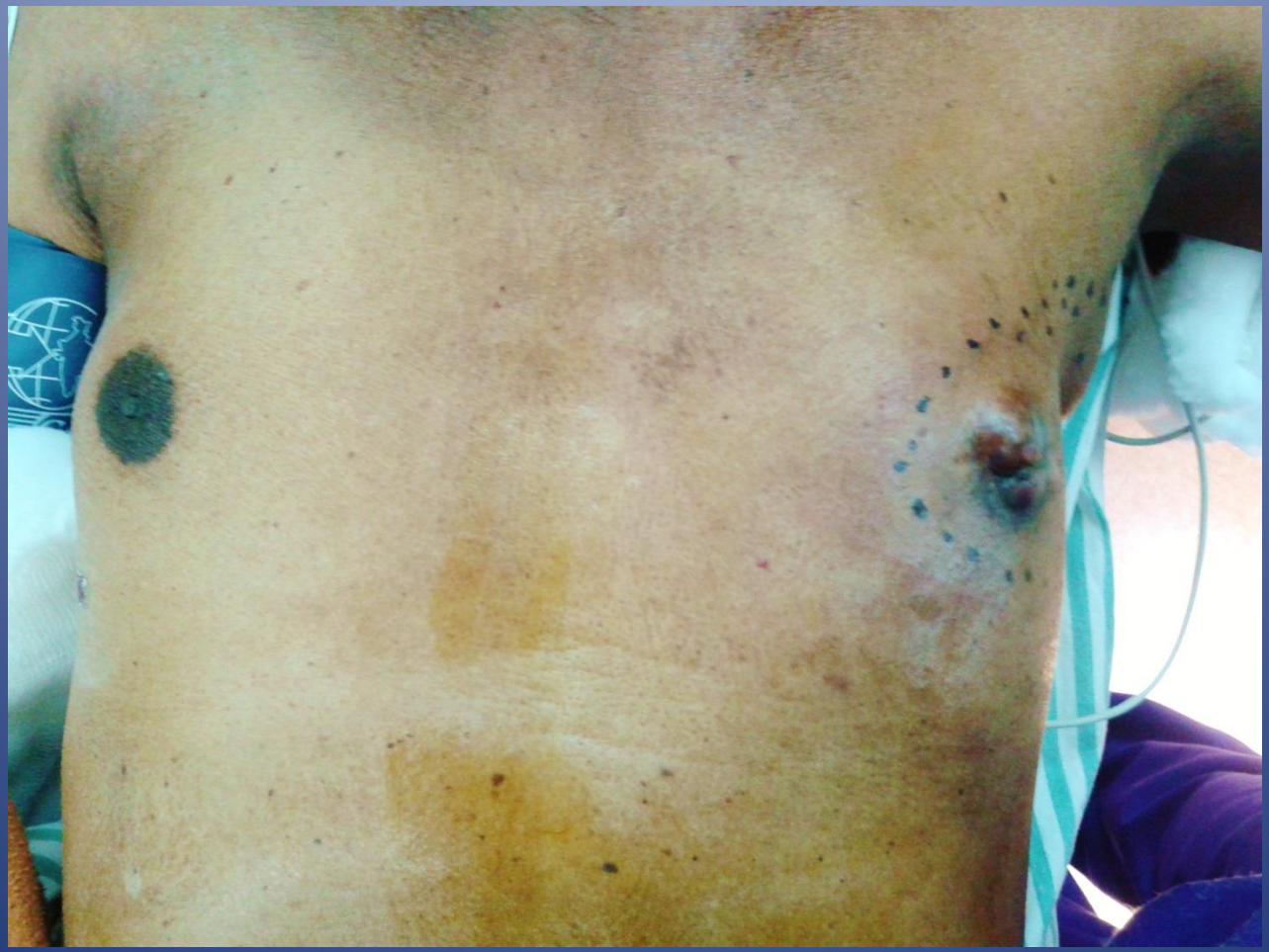


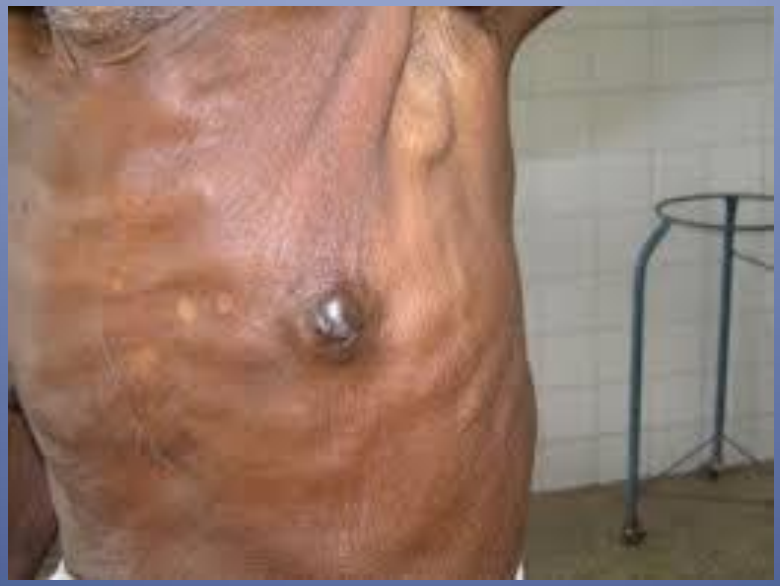
Pseudo gynaecomastia

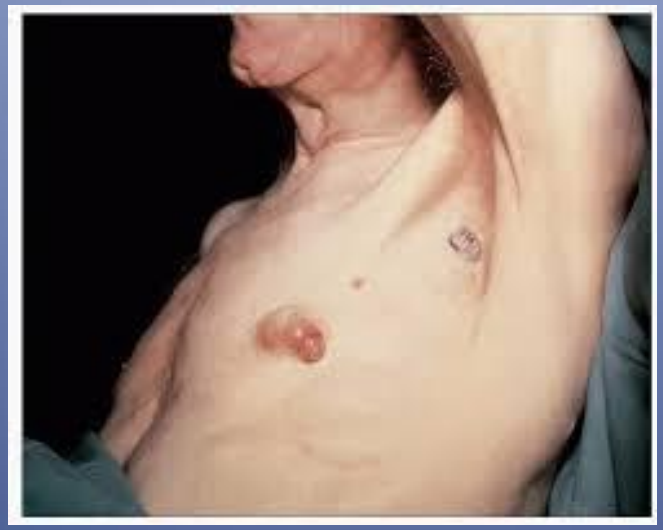


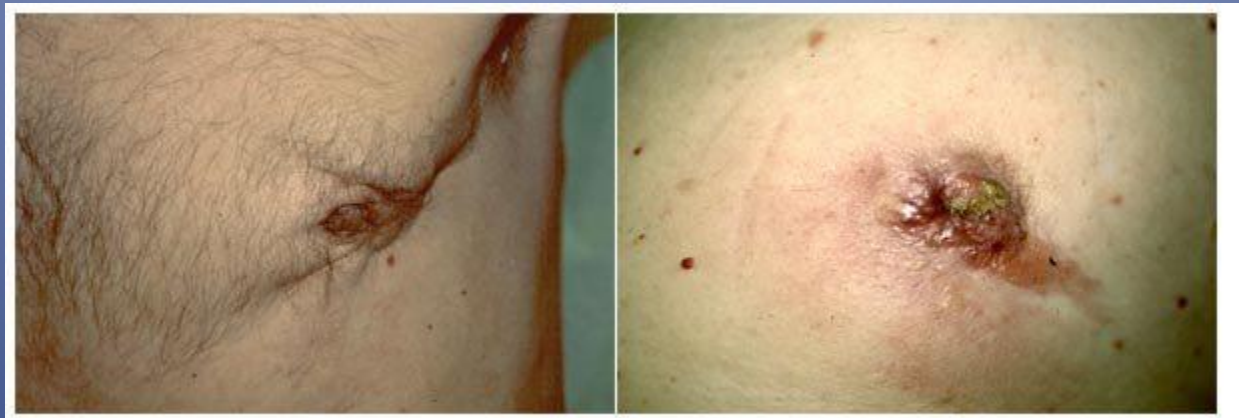
Male breast cancer

- >50 years (mean age 65 years)
- Positive family history in 50%
- Referred with an irregular mass, nipple changes and nipple discharge
- None of them presented with swelling or pain









Male Breast Cancer

RSS referral guidelines

Exclude Red Flag Symptoms (If present – 2WW referral)

- Unilateral eccentric mass (i.e. not uniformly behind the nipple) **in age >50 years**
- Mass is usually hard or firm, often fixed, or with skin dimpling
- Nipple discharge, retraction, inversion or ulceration
- High risk family history

Do Not Investigate:

- Adolescents with physiological pubertal gynaecomastia
- Elderly men with senile gynaecomastia
- Men with a drug related cause (prescribed medication or recreational drug use)
- Men with obvious breast cancer (2WW referral)
- Men with fatty pseudogynaecomastia

Management

- **Age <50 :** no referral needed unless special circumstances (please ask for advice and guidance)
-
- **Bilateral:** no referral needed unless special circumstances (please ask for advice and guidance)
-
- **Unilateral, age>50:** rule out and discontinue medication known to cause gynaecomastia (see below) and physiological causes (investigate as necessary).
-
- If above all normal, arrange blood tests and hormone screen to include U+E's, LFTs, TSH, LH, FSH, SHBG, testosterone, prolactin, oestradiol and, if short history, HCG
-
- All bloods normal – reassure, no further investigation required
- Abnormal hormone screen – refer to endocrinology
- Abnormal TFT's/LFT's/U&E's – treat/refer as appropriate
- Abnormal βHCG or αFP blood results or abnormal finding on testicular examination/USS – refer to Urology clinic urgently

Patients to refer

- Clinical suspicion of malignancy – see red flag symptoms above
- Unilateral lump >50 years with no obvious physiological or drug cause, increased risk due to family history or genetic conditions e.g. Klinefelter's Syndrome

Looking to the future……

- Further PTL session Scarborough
- GP VTS training?
- Advice and guidance
- Open up non-OSC slots?
- Anything else we/I can do for you…..?


ARE YOUR KNEES SWOLLEN OR ARE YOU GOING BRALESS AGAIN?


THANK YOU!
ANY QUESTIONS?