

Détection et prise en charge des lésions frontières

IRM mammaire : Ange ou Démon ?

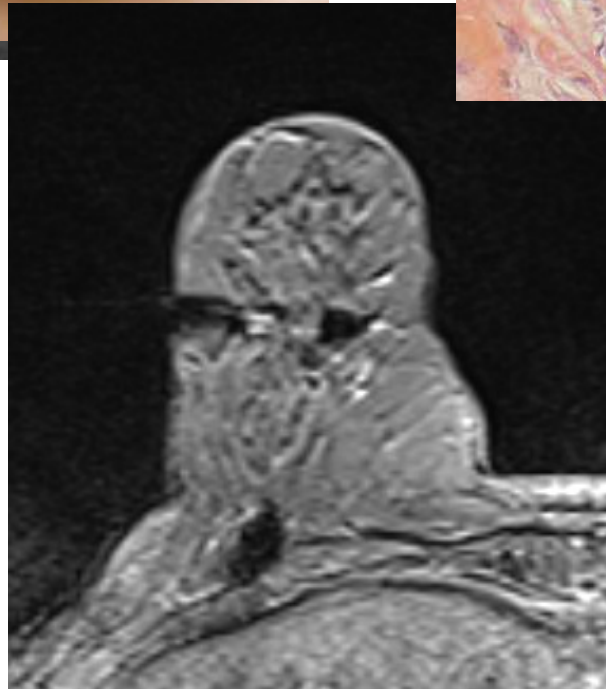
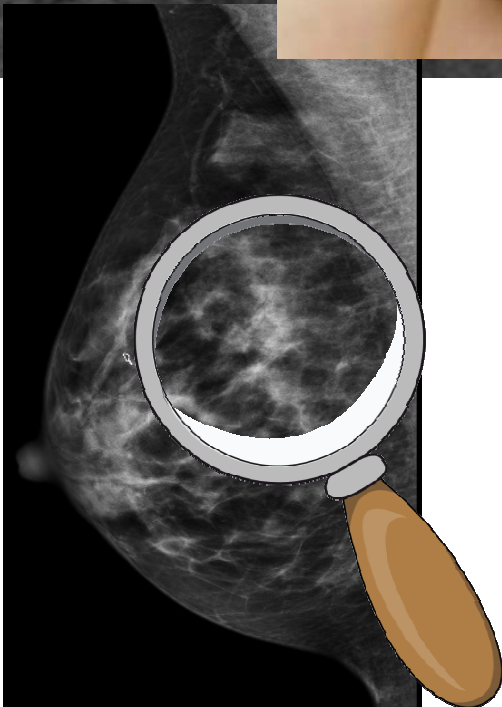
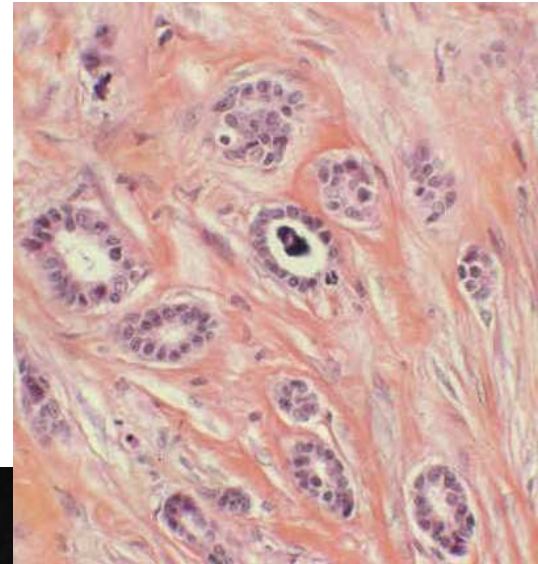
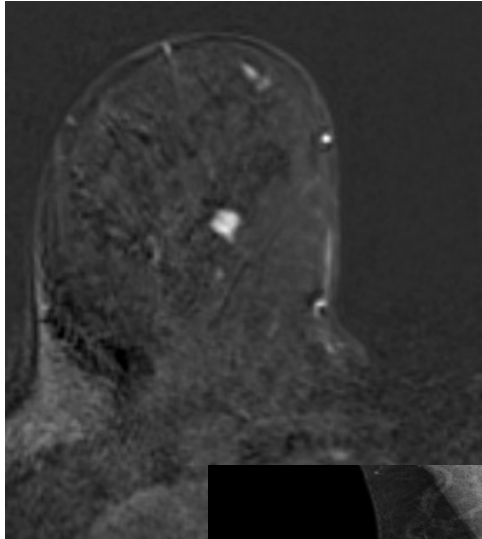


SOCIÉTÉ FRANÇAISE DE SÉNOLOGIE
ET DE PATHOLOGIE MAMMAIRE

37^{ES} JOURNÉES
DE LA SOCIÉTÉ
FRANÇAISE DE
SÉNOLOGIE
ET DE
PATHOLOGIE
MAMMAIRE

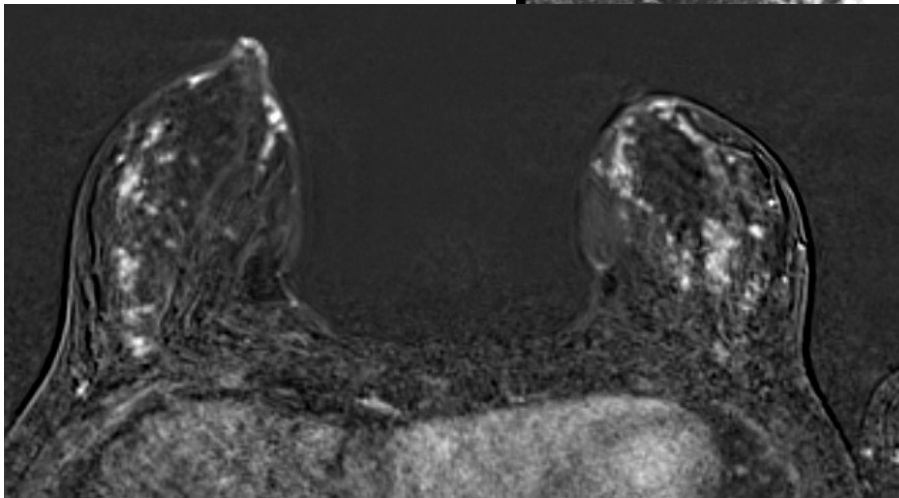
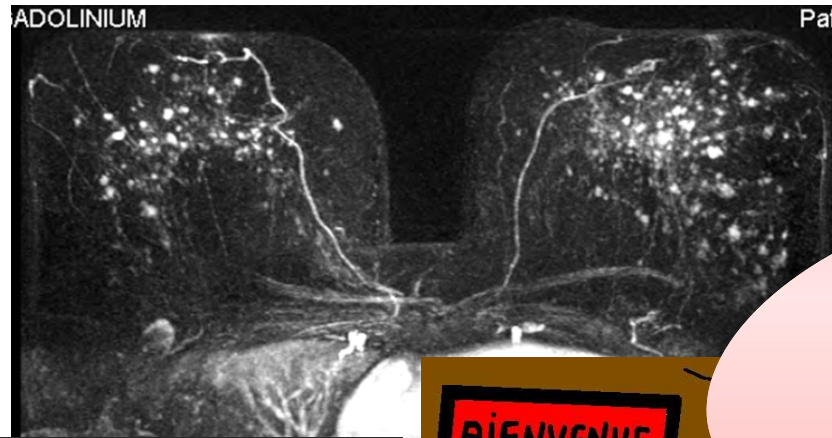
Dr Isabelle Doutriaux-Dumoulin
ICO Nantes

IRM mammaire : Ange ??





IRM mammaire : Démon ?



Voilà où vous
mène l'IRM à
toute les sauces !



Indications IRM mammaire : EUSOMA et HAS 2010

Quelle place pour l'IRM dans la prise en charge
des lésions Frontières ?



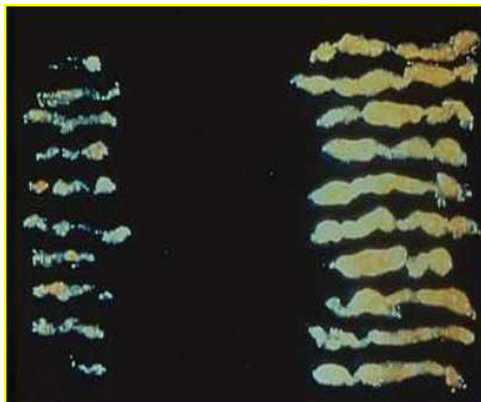
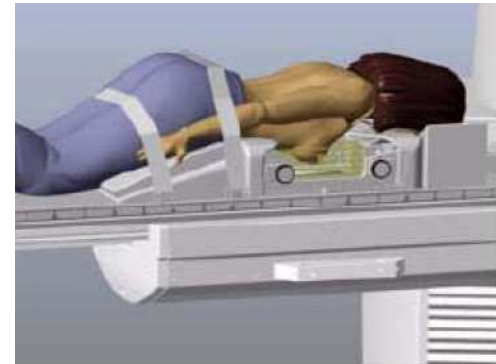
Aucune !

IRM et Lésions Frontières (à risque)



- Peut-elle éviter une prise en charge chirurgicale après diagnostic sur prélèvements percutanés ?
- A t-elle une place dans la surveillance après exérèse chirurgicale ?
- Prise en charge des atypies découvertes sur biopsies guidées sous IRM ?

L'IRM peut-elle éviter une prise en charge chirurgicale après diagnostic sur prélèvements percutanés ?



Sous estimation histologique
sur
prélèvements percutanés ?

Lésions à risque : groupe hétérogène de lésions



Diagnosis and Management of Benign, Atypical, and Indeterminate Breast Lesions Detected on Core Needle Biopsy

Lonzetta Neal, MD; Nicole P. Sandhu, MD, PhD; Tina J. Hieken, MD;

TABLE 1. Summary of Benign Breast Disease Lesions by Histology, Relative Breast Cancer Risk, and Mammographic Abnormality

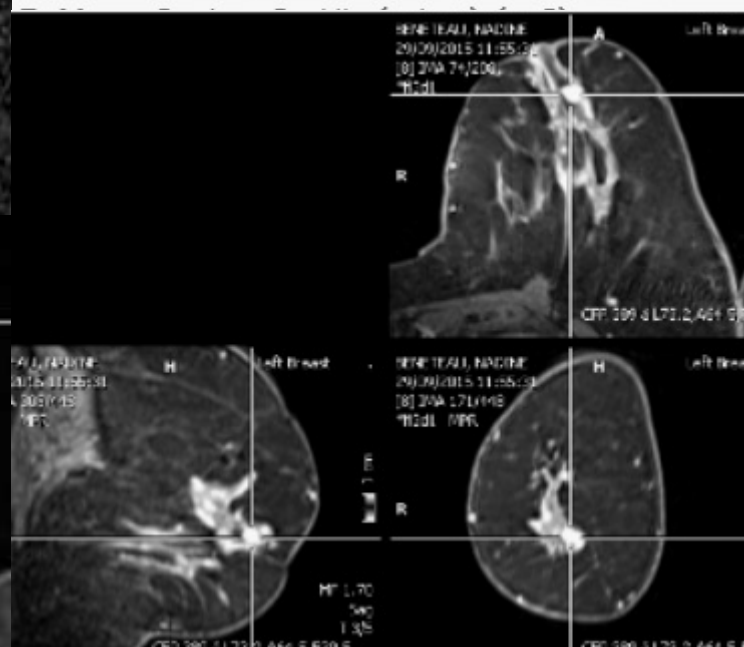
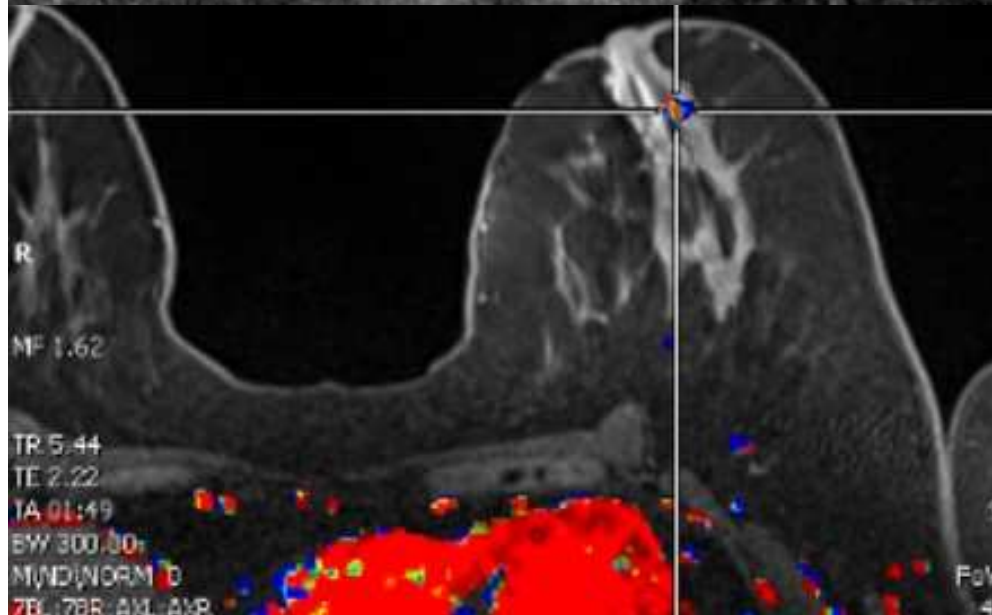
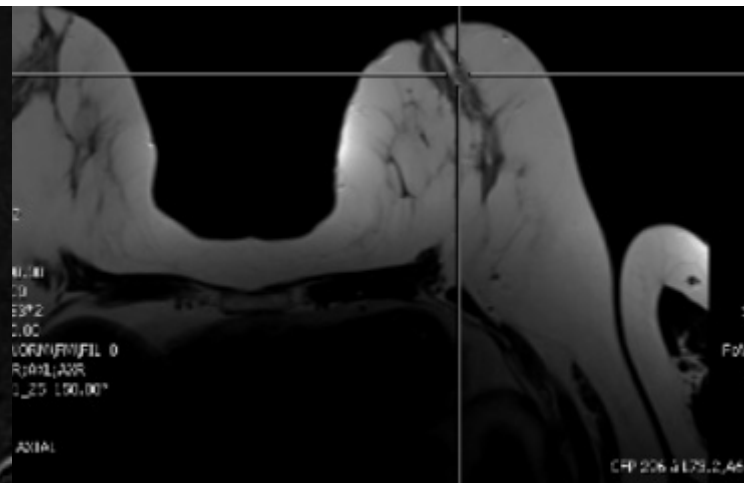
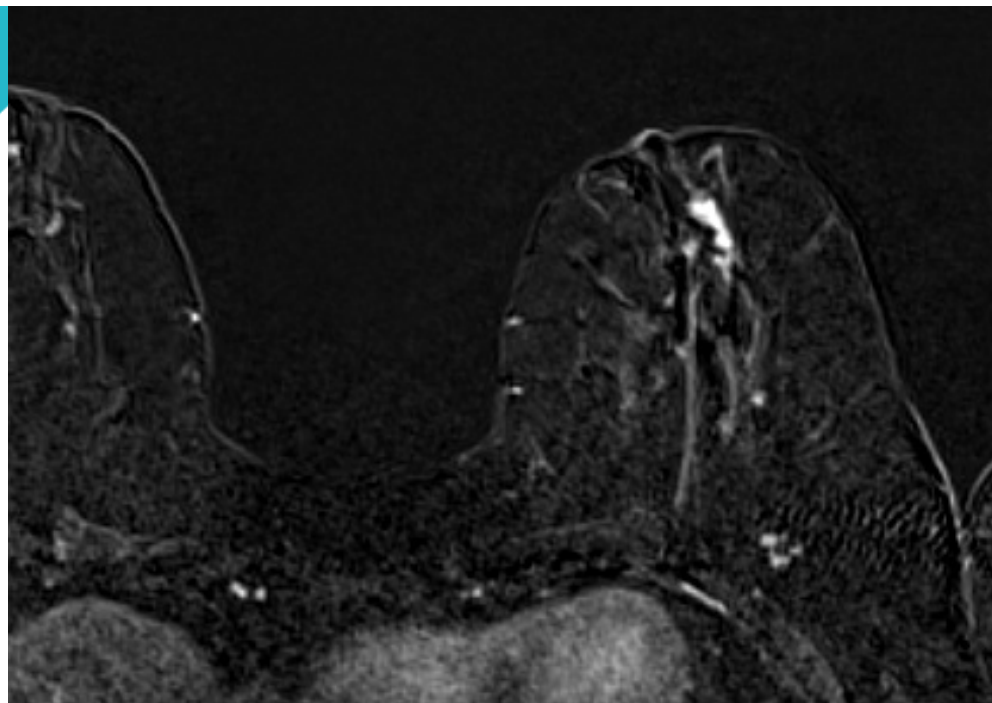
Category (relative cancer risk)	Mammographic findings
Nonproliferative (RR, 1.2-1.4×)	
Simple cyst	Circumscribed mass
Fibrosis	Mass, focal asymmetry
Fibroadenoma (simple)	Circumscribed mass
Columnar alteration (simple)	Calcifications
Apocrine metaplasia (simple)	Mass, focal asymmetry
Mild ductal hyperplasia	Calcifications
Proliferative disease (RR, 1.7-2.1×)	
Usual ductal hyperplasia	Calcifications
Sclerosing adenosis	Calcifications, focal asymmetry, architectural distortion
Columnar hyperplasia	Calcifications
Papilloma	Mass, calcifications
Radial scar	Architectural distortion
Proliferative disease with atypia (RR, ≥4×)	
Atypical lobular hyperplasia	None, calcifications
Lobular carcinoma in situ	None, calcifications
Atypical ductal hyperplasia	Calcifications
Unclear risk	
Mucocele-like tumor	Calcifications, mass
Apocrine atypia	Calcifications, mass
Secretory atypia	Calcifications
RR = relative risk.	



Imaging Features and Management of High-Risk Lesions on Contrast-Enhanced Dynamic Breast MRI

Heller S L. AJR 2012

- Revue littérature
- Pas de signe morphologique ou cinétique spécifique des lésions à Risque (Atypies ++, C R, papillome)
- Pas de signe prédictif de malignité (sous estimation)
- Papillome : aspect IRM évocateur
 - PdC intragalactophorique
 - Ne préjuge pas du caractère malin ou non





MB 16 G sous écho : papillome. Pas d'atypie
Exérèse par macrobiopsie échoguidée
Absence d'atypie. Surveillance

Absence de signe prédictif de malignité

50 ans. DO

Distorsion architecture UQINT gauche ACR5

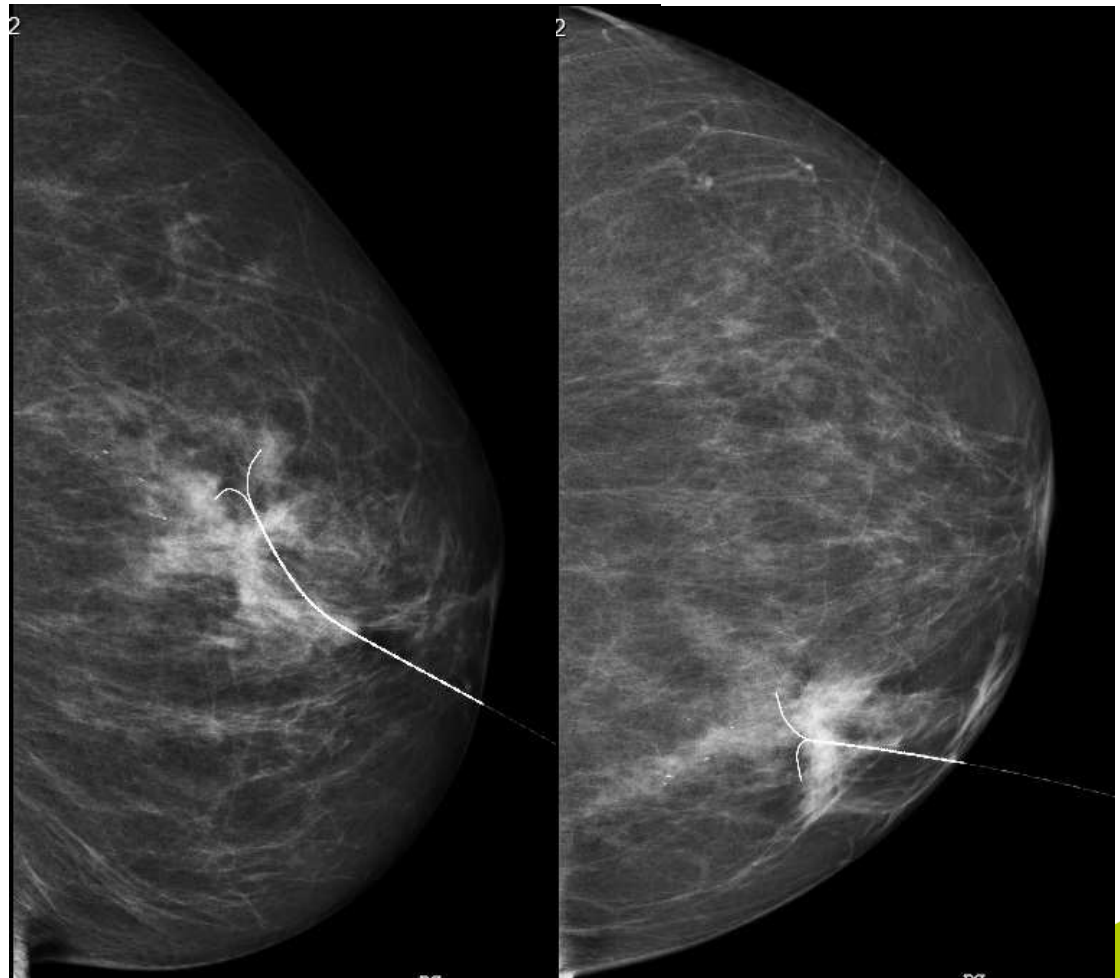
Ex clin et échographie : RAS.

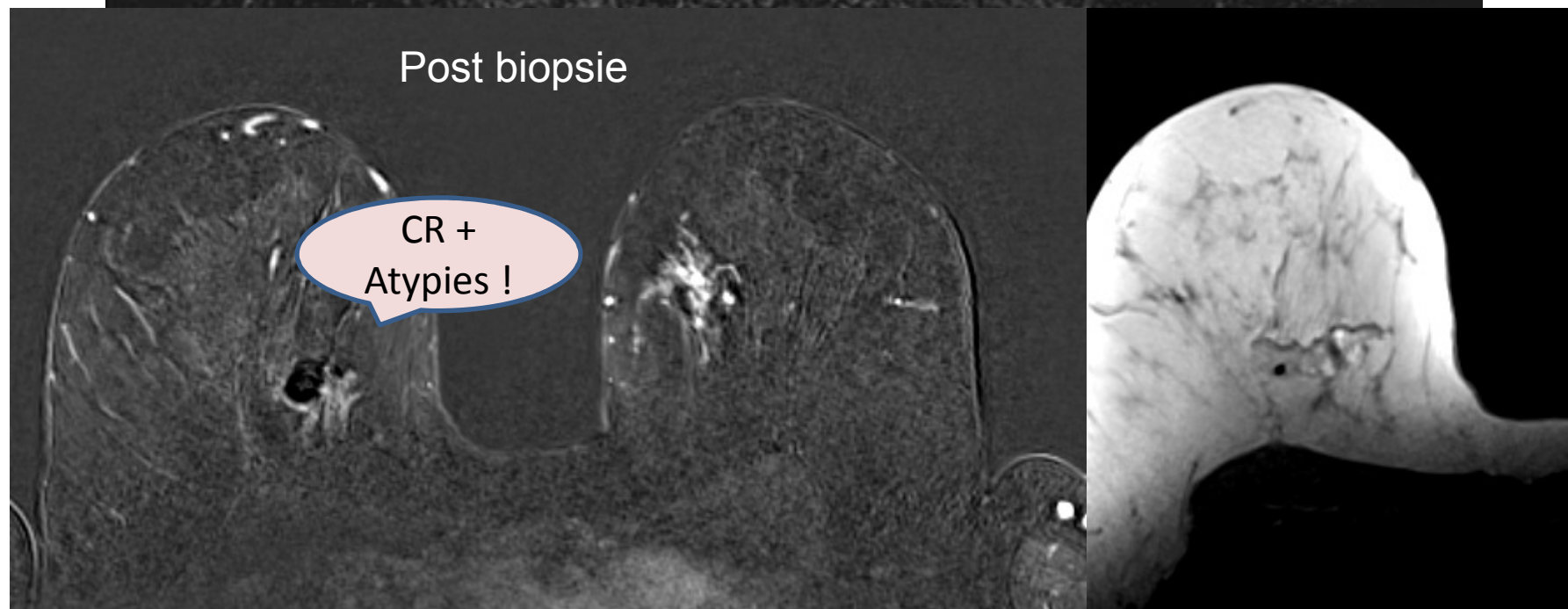
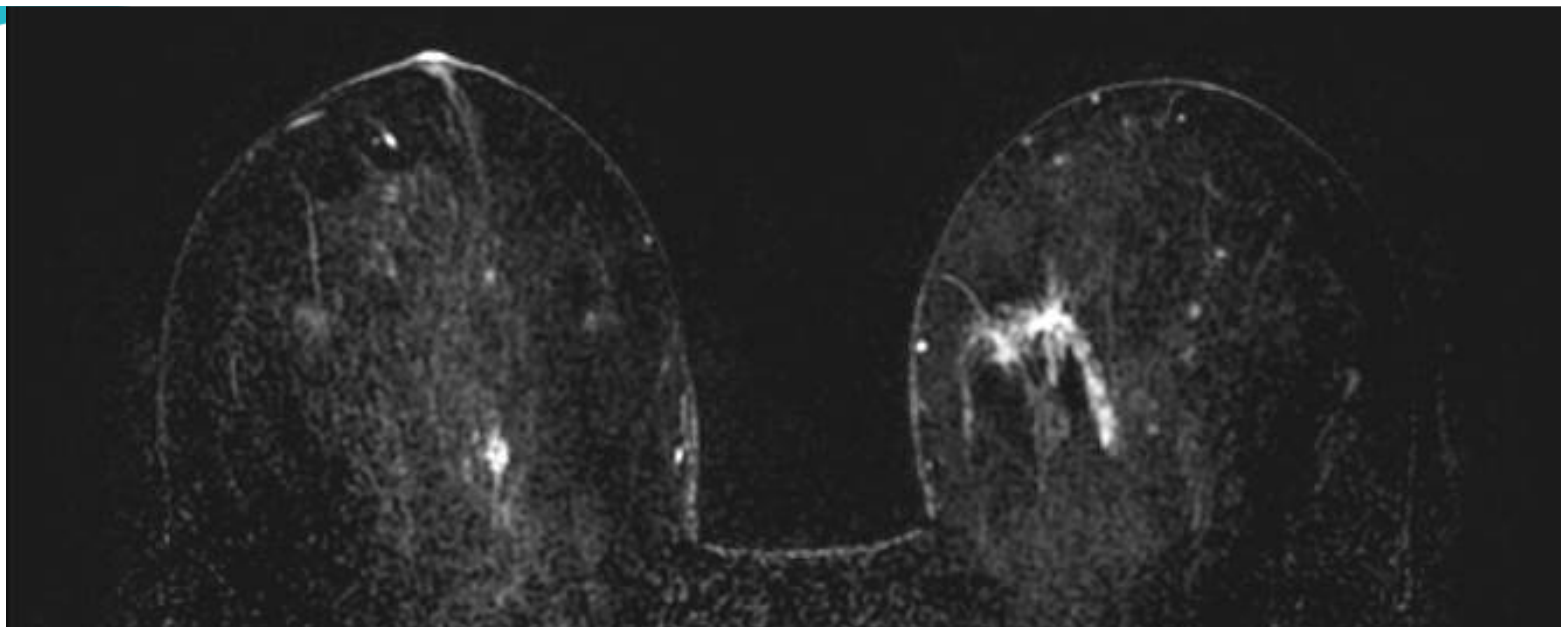
Microbiopsie/steréotaxie

Cicatrice radiaire

=

Prise en charge
chirurgicale
recommandée





Chirurgie bilatérale : Dt : bénin, Gauche : lésion sclérosante complexe



Nonsurgical Management of High-Risk Lesions Diagnosed at Core Needle Biopsy: Can Malignancy Be Ruled Out Safely With Breast MRI?

Linda A et al. AJR 2012

- Prospective
- 3243 biopsies sous mammo (22%) ou écho (78%)
- 241 lésions à haut risque (7,4%).
- Population étude : 169 lésions à haut-risque étudiées en IRM. (Sous estimation histologique : 13%)
 - Papillomes sans atypie: 64 (38%), (sous estimation : 6%)
 - CR : 54 (21%) , (sous estimation : 3,7%)
 - NL : 35 (21%) , (sous estimation : 34%)
 - HEA : 16 (9,5%) , (sous estimation : 25%)

IRM et lésions à haut-risque

Linda A et al. AJR 2012

- Méthode : Interprétation IRM (2 lecteurs)
 - Connaissance topographie et histologie des lésions
 - IRM Bi-Rads 1 ou 2 (bénin) / Bi-rads 4 ou 5 (malin)

IRM	Papillome	Cicatrice Radiaire	LN / HEA
Sensitivité	75.0 (62-85)	50.0 (36-64)	75 / 75
Spécificité	63.3 (50-75)	78.8 (65-88)	95.7 / 75
VPP	12.0 (6-23)	8.3 (3-20)	90.0 / 50
VPN	97.4 (89-100)	97.6 (88-100)	88 / 90
Gold standard : chirurgie () 95% IC			



Suivi après diagnostic chirurgical de lésions à haut-risque



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TABLE 2. Management of Breast Lesions Identified on Core Needle Biopsy

Breast lesion	Management	Surveillance
Atypical ductal hyperplasia	Surgical consultation with excision	CBE every 6-12 mo; annual mammogram
Lobular neoplasia, ALH/LCIS	Surgical consultation	CBE every 6-12 mo; annual mammogram
Flat epithelial atypia	Surgical consultation	CBE every 6-12 mo; annual mammogram
Papillomas	Surgical consultation for lesions with atypia, size >10 mm, multiple or peripheral	CBE every 12 mo; annual mammogram
Radial scar/complex sclerosing lesion	<10 mm: observation if adequately sampled >10 mm: surgical consultation	If excised, annual CBE and mammogram
Fibroadenoma	Surgical consultation if atypical features or enlarging	Annual CBE and mammogram
Complex fibroadenoma	Observation	Annual CBE and mammogram
Sclerosing adenosis	Observation	Annual CBE and mammogram
Fat necrosis	Observation	Annual CBE and mammogram
Columnar cell hyperplasia	Observation	Annual CBE and annual mammogram
Phyllodes tumor	Surgical consultation	CBE every 12 mo Annual mammogram
Desmoid tumor/mammary fibromatosis	Surgical consultation	CBE every 12 mo Annual mammogram
PASH	Surgical consultation if large or symptomatic	Annual CBE and mammogram
Apocrine metaplasia	Surgical consultation if atypia present or discordant	Annual CBE and mammogram if excised

ALH = atypical lobular hyperplasia; CBE = clinical breast examination; LCIS = lobular carcinoma in situ; PASH = pseudoangiomatous stromal hyperplasia.



HAUTE AUTORITÉ DE SANTÉ

RECOMMANDATIONS DE SANTÉ PUBLIQUE

Dépistage du cancer du sein en France : identification des femmes à haut risque et modalités de dépistage Volet 2

Date de validation par le collège : Mars 2014

Volet 1

- Identification de FdR pour lesquels aucun dépistage spécifique n'est justifié en dehors du programme de dépistage organisé
 - Alcool, obésité, Contraception orale, diabète type 2, catégorie socioprofessionnelle élevée, densité mammaire avant la ménopause...
- Sélection de FdR justifiant de poursuivre l'évaluation à la recherche de stratégie de dépistage efficaces, sûres et efficientes
 - ATCD cancer du sein invasif, ATCD CCIS et CLIS
 - ATCD familiaux de cancer du sein invasif avec score d'indication de CS oncogénétique ≥ 3
 - ATCD irradiation thoracique à haute dose
 - ATCD de lésions mammaires avec atypies
 - Densité mammaire radiologique type 4 après la ménopause
 - TSH

Dépistage du cancer du sein en France : identification des femmes à haut risque et modalités de dépistage

- ATCD hyperplasie épithéliale atypique
 - Mammographie annuelle /10 ans
 - +/- Echographie
 - Au terme des 10 ans,
 - Femmes > à plus de 50 ans : D0
 - Femmes < 50 ans DI tous les 2 ans jusqu'au D0
- Evaluation des FdR associés



Facteurs de Risque associés

- Très Haut risque : Indication d'IRM
 - BRCA, ou score indication de CS oncogénétique ≥ 3
 - ATCD irradiation thoracique médicale
 - Risque modéré : Modèles intégrant le risque histologique
 - Modèle IBIS (Tyrer Cuzik)
 - Modèle de Gail
 - Accessible sur internet
- 

Risk Tool

(Click a question number for a brief explanation, or [read all explanations.](#))

1. Does the woman have a medical history of any breast cancer or of ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS) or has she received previous radiation therapy to the chest for treatment of Hodgkin lymphoma?
2. Does the woman have a mutation in either the BRCA1 or BRCA2 gene, or a diagnosis of a genetic syndrome that may be associated with elevated risk of breast cancer?
3. What is the woman's age?
This tool only calculates risk for women 35 years of age or older.
4. What was the woman's age at the time of her first menstrual period?
5. What was the woman's age at the time of her first live birth of a child?
6. How many of the woman's first-degree relatives - mother, sisters, daughters - have had breast cancer?
7. Has the woman ever had a breast biopsy?
 - 7a. How many breast biopsies (positive or negative) has the woman had?
 - 7b. Has the woman had at least one breast biopsy with atypical hyperplasia?
8. What is the woman's race/ethnicity?
 - 8a. What is the sub race/ethnicity?

Calculate Risk

- Risk estimates do not allow one to say precisely which woman will develop breast cancer. In fact, some women who develop breast cancer may have lower estimated risks than some women who do not develop breast cancer.
- The BCRAT was not designed to estimate risk for:
 - Women with a prior diagnosis of breast cancer, lobular carcinoma in situ (LCIS), or ductal carcinoma in situ (DCIS).
 - Women who have received previous radiation therapy to the chest for treatment of Hodgkin lymphoma
 - Women with gene mutations in BRCA1 or BRCA2, or those who are known to have certain genetic syndromes that increase risk for breast cancer.

For women with any of the above medical history other methods to estimate breast cancer risk are better. See '[About the Tool](#)' section for a list of references.

- Recent immigrants from parts of rural Asia, such as rural China, probably have lower risks than projected by the tool.

Race/Ethnicity:

White

5 Year Risk of Developing Breast Cancer

- > This woman (age 50): 4.3%
- > Average woman (age 50): 1.3%

Explanation

Based on the information provided (see below), the woman's estimated risk for developing invasive breast cancer over the next 5 years is 4.3% compared to a risk of 1.3% for a woman of the same age and race/ethnicity from the general U.S. population. This calculation also means that the woman's risk of NOT getting breast cancer over the next 5 years is 95.7%.

Lifetime Risk of Developing Breast Cancer

- > This woman (to age 90): 34.3%
- > Average woman (to age 90): 11.2%

Explanation

Based on the information provided (see below), the woman's estimated risk for developing invasive breast cancer over her lifetime (to age 90) is 34.3% compared to a risk of 11.2% for a woman of the same age and race/ethnicity from the general U.S. population.

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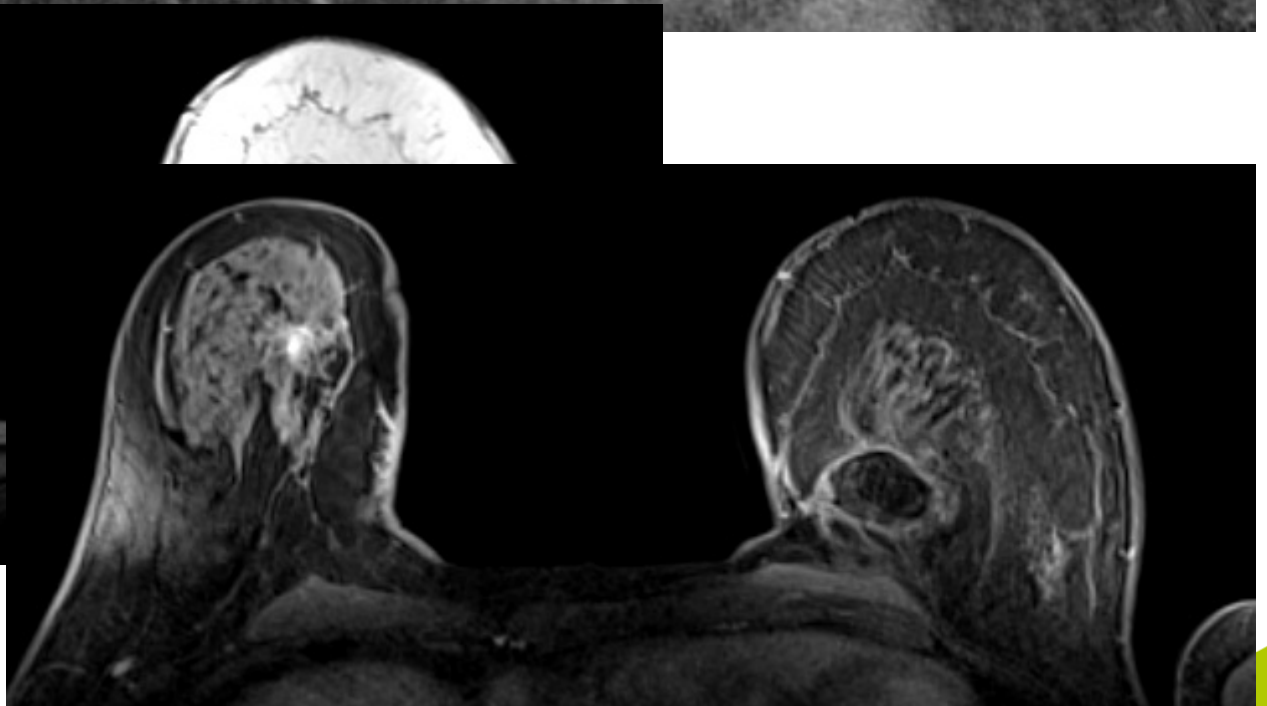
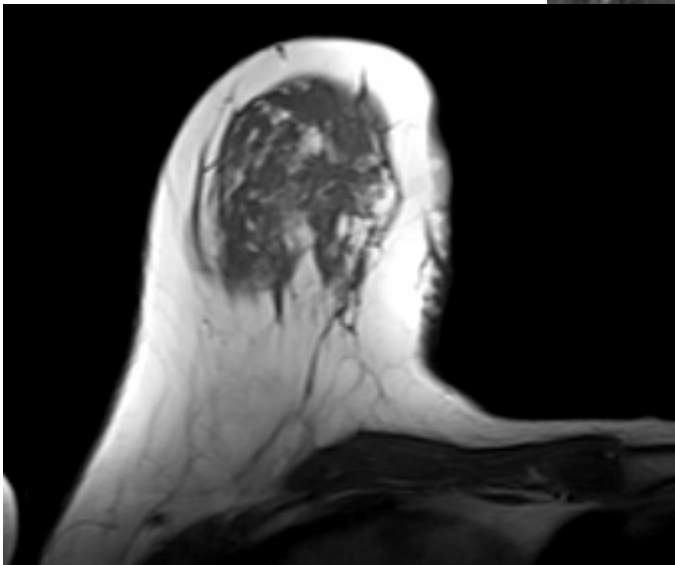
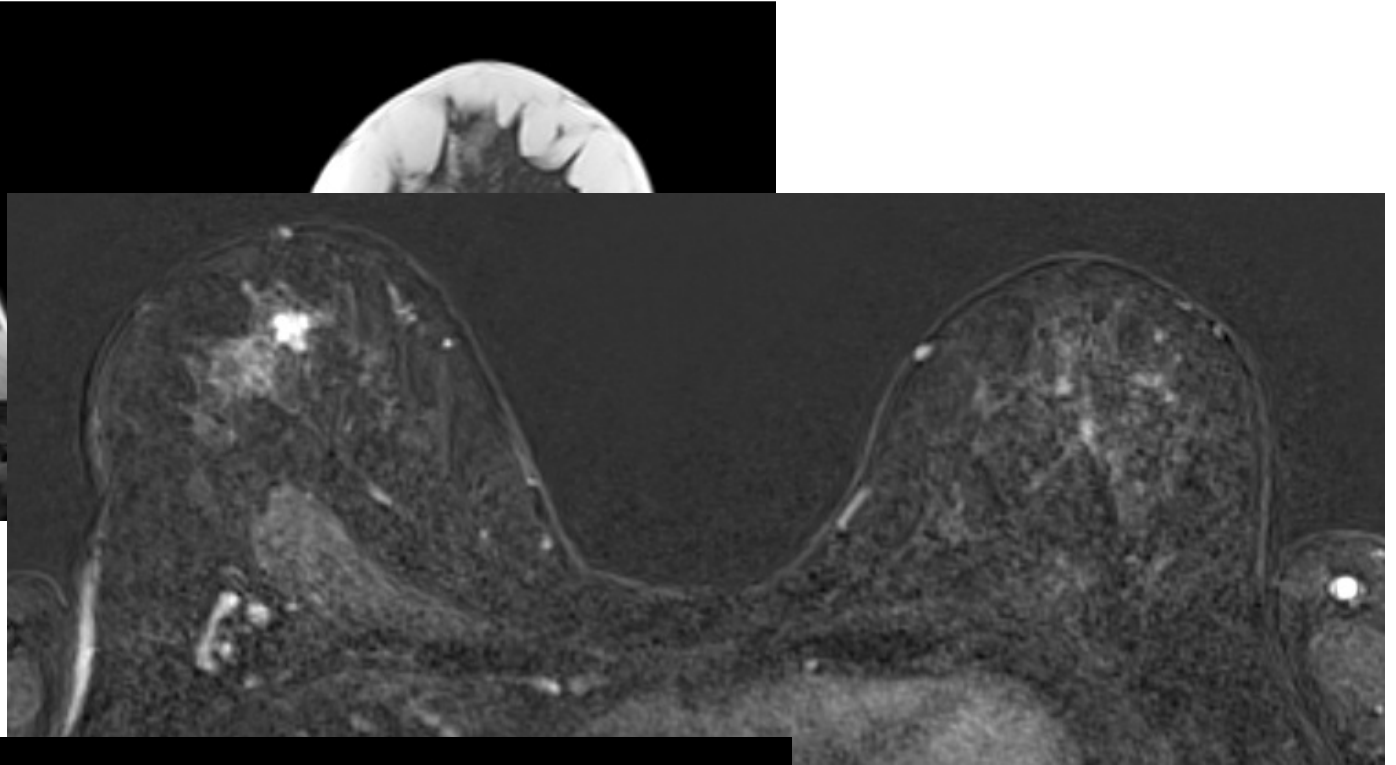
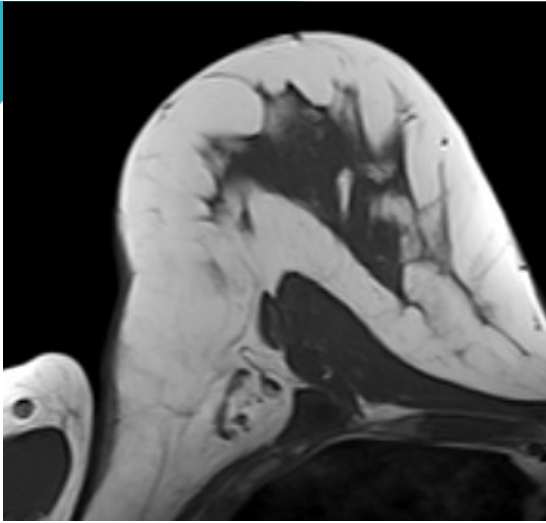
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Discussion en RCP

Prise en charge des atypies découvertes sur biopsies guidées sous IRM ?

- Lésions à risque : 20% biopsies /IRM
 - +++ HEA
 - *Imschweiler T et al. Eur Radiol 2014*
- Etude multicentrique Française : 66 cas HEA
 - Sous-estimation : 26 % (59% CCIS et 41% CCI)
 - Facteurs indépendants de sous estimation :
 - Masse
 - 9 ou 10 G

Prévalence et facteurs de sous-estimation des l'hyperplasie atypique lors des biopsies mammaires sous IRM : Etude rétrospective multicentrique sur 1500 biopsies mammaire sC. VERHEYDEN (Montpellier). JFR 2015.





Quelle place
pour l'IRM dans la prise en charge
des lésions Frontières ?



Limitée !

- Groupe hétérogène de lésion
- Papillome et Cicatrice radiaire
 - Au cas par cas, l'IRM peut conforter l'absence d'indication opératoire
 - Mais discuter la valeur ajoutée de l'IRM
- Atypies : pas d'indication



Merci de votre attention !