Original article

Favorable Histologic Type Breast Cancer in Lampang Hospital; Clinical Presentation and Outcome

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Abstract
This study aimed to examine the nature of a favorable histologic type of breast cancer in terms of risk factors, clinical presentations, pathologic results, clinical outcomes and prognostic factors for improved diagnosis, predicted prognosis and suitable treatment. A retrospective cross-section analysis of breast cancer database in Lampang Hospital was performed between October 2003 to September 2009, comparing the favorable subtype to larger and unfavorable subtype invasive ductal carcinoma that had no other specification (IDC-NOS). Of 1,045 cases, three favorable types were medullary, mucinous and tubular subtype with an incidence of 2.1, 1.9 and 0.1% respectively. Compared to IDC-NOS, the mucinous subtype was found in older-aged women, who had a previous history of benign breast cancer. Despite better prognostic factors such as less pathologic node involvement or more positive estrogen receptor (ER), the patients with the mucinous subtype had similar clinical outcome under the same standard treatment as IDC-NOS. Although the medullary subtype had worse prognostic factors, it showed better clinical outcome than IDC-NOS. No impacted prognostic factor detected either subtype. It was concluded that under standard treatment, the mucinous subtype had a was similar, and medullary better, clinical outcome than IDC-NOS.


Keywords: prognostic factor, medullary, mucinous, IDC-NOS, ER, standard treatment.

It is generally accepted that breast cancer is a common disease in the world including Thailand. The incidence of breast cancer is increasing nowadays. However it is a heterogeneous disease with various impact factors and different outcomes. Histologic type is one of factors that are nonnegligible before any designed treatment.

According to one of the most popular practice guideline of breast cancer, the “National Comprehensive Cancer Network” (NCCN), triages and recommends treatment guidelines for favorable histologies that are different from others. These favorable histologies are tubular, colloid and medullary carcinoma. In fact, they are among the most common histologies including the invasive ductal carcinoma that has no other specification (IDC-NOS). Previous literature concluded that favorable subtypes had a better prognosis than IDC-NOS. In addition, favorable subtypes showed better clinicopathologic and prognostic factors. In general, there is no clinical data sufficient enough to diagnose various subtypes unless they are for tissue diagnosis.

Except the histologic type, standard treatment
was applied in accordance with prognosis factors such as clinical stage and pathologic characteristics. However, it is still questionable whether these groups would rather be treated below the standard guidelines due to the good prognosis. In most series, there was insufficient data to conclude the proper treatment of the favorable subtype, due to a limited number of cases. General recommendations of treatment do not differ from other histologies, which are based on other prognostic factors.

This study aimed to investigate the nature of these favorable subtypes with respect to risk factors, clinical presentations, prognostic factors, and clinical outcome in comparison with a larger group of ICD-NOS. We also tested the prognosis factors and various types of treatment that may have impact on the outcome. All data were analyzed together in order to collect possible clinical information for future diagnosis of the histologic type before tissue biopsy, predict more accurate prognosis and choose the best way of treatment for improving the outcome of these patient groups in our hospital.

**MATERIAL AND METHOD**

A retrospective cross-section analysis of breast cancer cases from the database in Lampang Hospital was performed between October 2003 and September 2009. All breast cancer data had been evidenced by histologic diagnosis. The exclusion criteria included cases lost to follow-up or referred to higher-level hospitals. We collected general information; possible risk factors for CA breast; clinical presentations; clinical staging based on the American Joint Committee of Cancer (AJCC); treatment modalities; and pathologic data in various entities, including histologic type, grade, hormone status and finally HER-2 status. Histologic types were categorized according to the World Health Organization (WHO) classification. The histologic grades were categorized in 3 classes, according to the modified Bloom-Richardson score. ER and PR positive cells were those with more than 10% nuclear staining. HER-2 status was tested by immunohistochemical staining (IHC) and considered positive when membranous staining was strong (3+). HER-2 was negative if it was IHC 1+. We excluded IHC 2+ due to the high cost of FISH testing.

Most cases received standard treatment, which corresponded to the clinicopathologic characteristics. The operational treatment was divided into any form of mastectomy or no mastectomy with breast conservative therapy (BCT). Adjuvant chemotherapy was used when the tumor size was larger than 2 cm, or had positive pathologic nodes or high histologic grade. Radiation therapy was used in cases of BCT or those with a high tendency of recurrence after surgery. The hormonal treatment was used in cases that were ER or PR positive.

Clinical outcome was evaluated in terms of 5 years disease free survival (5 yr. DFS) and 5 years overall survival (5 yr OS). The 5 yr DFS was calculated from the percentage of patients who had no recurrence before 5 years divided by the sum of all the above patients and those that had recurrence within 5 years the diagnosis date. Five years overall survival was calculated from the percentage of patients who did not die before 5 years divided by the sum of all the above patients and those who died within 5 years from the diagnosis date.

Statistical analysis was performed by the Stata program version 11, the compared t-test, Fisher’s exact and survival analysis and Cox’s proportional hazard model. All data were considered a significantly different when the P value was less than 0.05.

**RESULTS**

From the initial 1,063 breast cancer cases, 18 were excluded from this study due to lack of the pathologic report (n=12), loss to follow-up (n=4) and referral to a higher level hospital (n=2). Thus, data collected from 1,045 cases were used finally in this study. There were 43 cases (4.12%) with favorable histology (Fig. 1). Of these, 22 patients (2.1%), 20 patients (1.9%) and 1 patient (0.1%) were diagnosed with medullary, mucinous and tubular subtypes, respectively. The tubular subtype was excluded due to the small number of patients. The median age at first diagnosis was 52 yr. (19-91) and median follow-up time 50 months.
Risk factors and clinical presentations that were compared between IDC-NOS and the medullary subtype and were IDC-NOS and mucinous subtype are summarized in Table 1. These comparisons showed that cases with the mucinous subtype were older at diagnosis than those with IDC-NOS (mean 60 against 53 yr., \(p=0.010\)) and had had previous benign breast disease previously \((p=0.010)\). Other risk factors had no statistically significant difference. Most common clinical presentations of all histologic types were mass lesions (IDC-NOS 98.5%, medullary and mucinous subtypes 100.0%) and the most common location was the upper outer quadrant (ICD-NOS 38.4%, medullary subtype 59.1% and mucinous subtype 35.0%). However, there was no significant difference between groups. Clinical stage, pathologic result and treatment modalities are depicted in Table 2, which shows no difference in tumor size or clinical stage. Both the negative clinical and pathologic lymph node was found more frequently in the medullary subtype \((p=0.012, < 0.001)\). The negative pathologic lymph node was found more in the mucinous subtype \((p=0.002)\). More cases of the medullary subtype with negative ER and PR were found than in IDC-NOS in this study. Conversely, the mucinous subtype had more positive ER than IDC-NOS \((p=0.009)\). There was no difference in HER-2 status in any group.

All patients received the standard treatment (Table 2) in accordance with the clinical stage and pathologic results, as discussed earlier. Fewer hormones and less radiation therapy were found in medullary subtype of this study, compared with IDC-NOS \((p=0.002, 0.038)\). This might be due to fewer ER-positive cases and less pathologic lymph node involvement. We also found that treatment of the mucinous subtype did not follow the standard treatment in terms of fewer hormones used, despite more ER positive cases (hormones used in 9 of 16 ER positive cases).

Prognosis of the medullary subtype was better than the IDC-NOS (Table 3) with regard to both 5-yr DFS and OS, however, only 5-yr OS was significantly different. The mucinous subtype had no difference in prognosis from the IDC-NOS. Similarly, the survival analysis demonstrated no difference in prognosis in any group (Fig. 2a, b).

The only worse prognostic factor for DFS cases of mucinous subtype was hormone use (Table 4). No prognostic factor of either subtype had impact on DFS.

DISCUSSION

The percentage of histologic types varies in most studies, even though they might show the same results. A large proportion of IDC-NOS (65-75%) and uncommon histologic types including favorable subtypes, accounted for less than 10% of all breast cancer\(^{(9-12)}\). Similar to the results in this study, the incidences of medullary (2.1%), mucinous (1.9%) and tubular (0.1%)
Table 1. The common risk factors and clinical presentations

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>DIC-NOS</th>
<th>Medullary</th>
<th>p-value (vs IDC-NOS)</th>
<th>N (%)</th>
<th>p-value (vs IDC-NOS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk factor Sex (female: male)</td>
<td>883:3 (99.7:0.3)</td>
<td>22:0 (100:0.0)</td>
<td>1.000</td>
<td>20:0 (100:0)</td>
<td>1.000</td>
</tr>
<tr>
<td>Age at presentation (yr., mean±SD)</td>
<td>53.09±11.98</td>
<td>50.77±0.51</td>
<td>0.369</td>
<td>60.10±11.69</td>
<td>0.010</td>
</tr>
<tr>
<td>Status (married:single)</td>
<td>841:45 (94.9:5.1)</td>
<td>19:3 (86.4:13.6)</td>
<td>0.105</td>
<td>20:0 (100:0)</td>
<td>0.618</td>
</tr>
<tr>
<td>Education (university: university, higher)</td>
<td>824:62 (93.0:7.0)</td>
<td>19:3 (86.4:13.6)</td>
<td>0.204</td>
<td>19:1 (95.0:5.0)</td>
<td>1.000</td>
</tr>
<tr>
<td>Family history CA breast (no: have)</td>
<td>876:10 (98.9:1.1)</td>
<td>22:0 (100:0.0)</td>
<td>1.000</td>
<td>20:0 (100:0)</td>
<td>1.000</td>
</tr>
<tr>
<td>History benign breast dis. (no: have)</td>
<td>849:37 (95.8:4.2)</td>
<td>20:2 (40.9:9.1)</td>
<td>0.243</td>
<td>4:16 (20.0:80.0)</td>
<td>0.010</td>
</tr>
<tr>
<td>Menarche (yr., mean ± SD)</td>
<td>15.02±1.67</td>
<td>14.72±1.28</td>
<td>0.411</td>
<td>15.15±1.60</td>
<td>0.737</td>
</tr>
<tr>
<td>Hormone use (no: use)</td>
<td>733:153 (82.7:17.3)</td>
<td>20:2 (90.9:9.1)</td>
<td>0.403</td>
<td>16:4 (80.0:20.0)</td>
<td>0.764</td>
</tr>
<tr>
<td>Chronic alcohol intake (no: use)</td>
<td>853:33 (96.3:3.7)</td>
<td>20:2 (90.9:9.1)</td>
<td>0.207</td>
<td>19:1 (95.0:5.0)</td>
<td>0.539</td>
</tr>
<tr>
<td>BMI (kg/m²) (mean ± SD)</td>
<td>23.45±4.24</td>
<td>22.89±3.23</td>
<td>0.598</td>
<td>23.32±3.78</td>
<td>0.907</td>
</tr>
</tbody>
</table>

Clinical presentation

| Mass                                 | 873 (98.5)       | 22 (100.0)       | 1.000                | 20 (100.0) | 1.000                |
| Discharge                            | 14 (1.6)         | 0 (0.0)          | 1.000                | 1 (5.0)    | 0.166                |
| Pain                                 | 159 (18.0)       | 7 (31.8)         | 0.100                | 5 (10.0)   | 0.385                |
| Other                                | 56 (6.3)         | 0 (0.0)          | 0.391                | 0 (0.0)    | 0.629                |

Location of mass

| Upper outer quadrant                 | 340 (38.4)       | 13 (59.1)        | 7 (35.0)             |
| Upper inner quadrant                 | 162 (18.3)       | 6 (27.3)         | 5 (25.0)             |
| Lower outer quadrant                 | 84 (9.5)         | 0 (0.0)          | 4 (20.0)             |
| Lower inner quadrant                 | 42 (4.7)         | 0 (0.0)          | 1 (5.0)              |
| Other                                | 258 (29.1)       | 3 (13.6)         | 3 (15.0)             |

subtypes are nearly equal to those of previous studies (2.4%, 2.0% and 0.8% respectively). We observed a small number of tubular subtypes, which might be explained by the unclear pathologic criteria used in the past.

As consistent with other studies,12-14 the mucinous cases were older at diagnosis than the IDC-NOS ones. Older cases could be more likely to have had previous benign breast disease than younger patients. This may explain why the mucinous subtype has more previous benign breast disease than IDC-NOS in this study. The mucinous subtype found in younger cases was consistent with the previous series.(2,10-12) However, there was no difference in this study (mean 51 against 53 yr., \( p = 0.369 \)).

This study found no difference in other risk factors for breast cancer among groups. As in our data, the most common presentation in all groups was breast mass located in the same part at the upper outer quadrant without correlation with the histologic subtype. From our results, old age and a previous history of benign breast disorders correlated with the mucinous subtype.

Clinicopathologic characteristics of the favorable subtype that were less aggressive than IDC-NOS were reported in most series.(9,12,17-23) These included smaller tumor size, less lymph node involvement, lower histologic grade, positive ER or PR and negative HER-2. From previous reports, the prognostic factors of favorable subtypes were similar to or worse than the IDC-NOS; namely, same tumor size in medullary(24) and mu-
Favorable histological type breast cancer

cinuous\(^{(14)}\) subtypes. In addition, more ER and PR negative tumors were found more in the medullary subtype, when compared with IDC-NOS\(^{(10,25-26)}\).

In this study, the less aggressive characteristics in the favorable group were observed; for example, less lymph node involvement but more cases with a positive hormonal receptor the mucinous subtype. Conversely, some same or less favorable prognostic factors were also found, such as the similarity in tumor size, more cases with a negative hormonal receptor in the medullary group and no difference in histologic grade or HER-2 status in all groups. This analysis was based on the majority of cases, but some missed data of pathologic prognostic factors was also found (Table 2); for example, the number of hormonal status cases in the medullary group was only 14 from a total of 22 cases (63.6%). This was because the hormonal receptor, HER-2 status, lymph node biopsy, and histologic grading could not be determined in all cases, especially in the earlier years.

Although some prognostic factors of this study seemed to have favorable features; for example less lymph node involvement and ER positive mucinous subtype, they did not show a significant difference when compared with IDC-NOS.

<table>
<thead>
<tr>
<th>Table 2. Clinicopathological characteristics and treatment</th>
<th>n (%)</th>
<th>p-value (vs IDC-NOS)</th>
<th>p-value (vs IDC-NOS)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Characteristic</strong></td>
<td>IDC-NOS</td>
<td>Medullary</td>
<td>Mucinous</td>
</tr>
<tr>
<td>Tumor size</td>
<td>257:587 (30.5:69.5)</td>
<td>4:18 (18.2:81.8)</td>
<td>0.249</td>
</tr>
<tr>
<td>size (cm, mean±SD)</td>
<td>3.58±2.22</td>
<td>3.48±1.77</td>
<td>0.836</td>
</tr>
<tr>
<td>Clinical node status</td>
<td>557:288 (65.9:34.1)</td>
<td>20:2 (90.9:9.1)</td>
<td>0.012</td>
</tr>
<tr>
<td>Stage</td>
<td>225 (25.4)</td>
<td>4 (18.2)</td>
<td>3 (15.0)</td>
</tr>
<tr>
<td>2</td>
<td>441 (49.8)</td>
<td>16 (72.7)</td>
<td>14 (70.0)</td>
</tr>
<tr>
<td>3</td>
<td>159 (17.9)</td>
<td>2 (9.1)</td>
<td>0.363</td>
</tr>
<tr>
<td>4</td>
<td>21 (2.4)</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Pathologic node number</td>
<td>319:361 (46.9:53.1)</td>
<td>17:2 (89.5:10.5)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Histologic grade</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well diff</td>
<td>96 (15.6)</td>
<td>0 (0.0)</td>
<td>1 (16.7)</td>
</tr>
<tr>
<td>Int. diff</td>
<td>238 (41.1)</td>
<td>1 (50.0)</td>
<td>4 (66.7)</td>
</tr>
<tr>
<td>Poor diff</td>
<td>245 (42.3)</td>
<td>1 (50.0)</td>
<td>1 (16.7)</td>
</tr>
<tr>
<td>ER status</td>
<td>297:340 (46.6:53.4)</td>
<td>13:1 (92.9:7.1)</td>
<td>0.001</td>
</tr>
<tr>
<td>PR status</td>
<td>332: 305 (52.1:47.9)</td>
<td>12: 2 (85.7:14.3)</td>
<td>0.014</td>
</tr>
<tr>
<td>HER-2 status</td>
<td>236: 41 (85.2:14.8)</td>
<td>2:0 (100.0:0.0)</td>
<td>1.000</td>
</tr>
<tr>
<td>Operation</td>
<td>71: 746 (8.7:91.3)</td>
<td>1:21 (4.5:95.4)</td>
<td>1.000</td>
</tr>
<tr>
<td>BCT:mastectomy</td>
<td>676:210 (76.3 :23.7)</td>
<td>21:1 (95.5:4.5)</td>
<td>0.038</td>
</tr>
<tr>
<td>Radiation</td>
<td>160:726 (18.1:81.9)</td>
<td>2:20 (9.1:90.9)</td>
<td>0.401</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>459:427 (51.8:48.2)</td>
<td>19:3 (86.4:13.6)</td>
<td>0.002</td>
</tr>
</tbody>
</table>
Table 3. Five year prognosis

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N (%)</th>
<th>p-value</th>
<th>N (%)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DIC-NOS</td>
<td>Medullary</td>
<td>vs IDC-NOS</td>
<td>Mucinous</td>
</tr>
<tr>
<td>5-yr DFS</td>
<td>84.3</td>
<td>100.0</td>
<td>0.238</td>
<td>77.8</td>
</tr>
<tr>
<td>5-yr OS</td>
<td>72.3</td>
<td>100.0</td>
<td>0.005</td>
<td>77.8</td>
</tr>
</tbody>
</table>

Figure 2a. Disease free survival analysis curve

Figure 2b. Overall survival analysis curve

Figure 2. Kaplan-meier survival curve.

better prognosis than IDC-NOS. This contradicts the very good prognosis of most studies.\(^\text{(2-4,9-13)}\) Despite an unclear reason, our possible explanation might be specific features of our population such as smaller number of cases or short duration of follow-up. The wrong histologic diagnosis might be formed from unclear pathologic criteria. We did not classify mucinous subtypes into pure or mixed subtypes and this might be another explanation. Previous studies\(^\text{(12,27-28)}\) reported that a pure mucinous subtype had a better prognosis than a mixed mucinous one or IDC-NOS. A similar
Favorable histological type breast cancer

The medullary subtype showed a better prognosis in terms of 5 yr OS, despite less favorable prognostic factors such as negative ER. Despite the insignificant difference, the medullary subtype had a higher 5 yr DFS than IDC-NOS (100 against 84.3%, \( p=0.238 \)) and almost a significant difference in survival analysis (\( p=0.007 \)). Better prognosis, despite less treatment of either hormone or radiation in the medullary subtype, may be due to good prognostic intrinsic factor of the medullary subtype itself.

This study\(^{29} \) reported a similar prognosis in the BCT group, but the number of cases was small (28 cases of medullary, 12 the mucinous subtypes and 389 of IDC-NOS) and duration of follow up short (median 61 months).

Unlike the results of previous studies,\(^{14,30} \) which reported factors of survival in the favorable subtype (age, tumor size, node status, clinical stage, ER, PR status and type of treatment), no prognostic factor was detected in this study, except for hormone use in the mucinous subtype. This may be due to the limited number of cases and short duration of follow-up. Recurrence was only 1 from a total of 22 cases of medullary subtype (4.5%), 5yr was DFS at 100%, 2 from a total of 20 cases had mucinous subtype (10% not show in the table) and in 77.8% 5 yr DFS, the median follow up time was 50 months. Our observation, despite hormone usage in the mucinous subtype; was less than standard treatment, as discussed earlier, and data showed a poorer outcome if hormones were used. This may support the concept of a good prognosis by the intrinsic factor of the mucinous subtype itself, whether hormones were used or not. From the above reasons, there is no evidence to exclude the involvement of prognostic factors because all of them may have impact on disease progression.

Table 4. Univariate analysis for disease free survival of favorable histology

<table>
<thead>
<tr>
<th>Factor (compared to)</th>
<th>Medullary HR (95% CI)</th>
<th>p-value</th>
<th>Mucinous HR (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yr)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 50 (&lt; 50)</td>
<td>0.98 (0.39-2.48)</td>
<td>0.966</td>
<td>2.38 (0.67-8.53)</td>
<td>0.181</td>
</tr>
<tr>
<td>Tumor size</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 2 cm. (&lt; 2 cm)</td>
<td>0.85 (0.27-2.61)</td>
<td>0.772</td>
<td>2.35 (0.53-10.42)</td>
<td>0.261</td>
</tr>
<tr>
<td>Node status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palpable (not palpable)</td>
<td>1.84 (0.41-8.24)</td>
<td>0.427</td>
<td>2.82 (0.82-9.31)</td>
<td>0.089</td>
</tr>
<tr>
<td>Clinical stage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>stage II (I)</td>
<td>0.74 (0.23-2.34)</td>
<td>0.610</td>
<td>2.26 (0.50-10.15)</td>
<td>0.288</td>
</tr>
<tr>
<td>stage III (I)</td>
<td>6.47 (0.95 - 43.9)</td>
<td>0.056</td>
<td>3.19 (0.49-20.85)</td>
<td>0.226</td>
</tr>
<tr>
<td>Pathologic node number</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 1 node involve (0)</td>
<td>0.47 (0.10-2.11)</td>
<td>0.321</td>
<td>1.81 (0.49-6.61)</td>
<td>0.369</td>
</tr>
<tr>
<td>ER status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>positive (negative)</td>
<td>12.49 (0.78-199.79)</td>
<td>0.074</td>
<td>0.56 (0.15-2.04)</td>
<td>0.377</td>
</tr>
<tr>
<td>PR status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>positive (negative)</td>
<td>0.91 (0.19-4.48)</td>
<td>0.910</td>
<td>0.72 (0.27-1.89)</td>
<td>0.503</td>
</tr>
<tr>
<td>Operation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>mastectomy (BCT)</td>
<td>0.84 (0.11-6.52)</td>
<td>0.870</td>
<td>NA*</td>
<td></td>
</tr>
<tr>
<td>Radiation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>done (not done)</td>
<td>3.71 (0.43-31.82)</td>
<td>0.231</td>
<td>2.79 (0.59-13.23)</td>
<td>0.196</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>done (not done)</td>
<td>2.26 (0.51-10.06)</td>
<td>0.286</td>
<td>0.53 (0.20-1.42)</td>
<td>0.208</td>
</tr>
<tr>
<td>Hormone therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>done (not done)</td>
<td>0.35 (0.08-1.53)</td>
<td>0.162</td>
<td>0.25 (0.09-0.71)</td>
<td>0.009</td>
</tr>
</tbody>
</table>

*NA : no data available
SUMMARY AND APPLICATION

This study tried to understand the nature of favorable subtypes of breast cancer in Lampang Hospital. Medullary and mucinous subtypes were analysed. Old age and previous history of benign breast disease helped in diagnosing mucinous subtypes before biopsy, while no other clinical data supported this. Prognosis of the mucinous subtype was not better, while that of the medullary subtype was better than IDC-NOS. Prognosis does not seem to depend on different treatment; thus, the standard treatment for these groups is useful. We did not detect prognostic factors that impact outcome, due to the small number of cases and short time of follow up.

We suggest that diagnosing benign breast diseases should be performed carefully, while being aware of missed diagnosis, especially in old aged patients, although benign appearance is observed on a mammogram. An attempt to diagnose the histologic type is definitely based on standard criteria because it may effect subsequent treatment. We should be aware of the side effects of over-treatment, especially in old aged people. However, poorer outcome may happen when under-treatment of missed diagnosis such as diagnosing a favorable type instead of IDC-NOS occurs. More accurate treatment of these groups is awaiting study with a larger number of cases.

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อาการทางคลินิกและผลลัพธ์ของมะเร็งเต้านมกลุ่มพลักชั้นเนื้อดีในโรงพยาบาลลำปาง

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บทคัดย่อ
การศึกษานี้มีวัตถุประสงค์เพื่อศึกษาการกระจายของมะเร็งเต้านมกลุ่มพลักชั้นเนื้อดีทั้งด้านปัจจัยเสี่ยงต่อการเกิดโรค อาการแสดงทางคลินิก การรักษาได้ ผลทางพยาธิวิทยา ตลอดจนปัจจัยพยากรณ์โรคในโรงพยาบาลลำปางระหว่างเดือนตุลาคม พ.ศ. 2546 ถึงเดือนกันยายน พ.ศ. 2552 โดยทำการศึกษาถึงกลุ่มพลักชั้นเนื้อดี 3 ชนิด คือ medullary, mucinous และ tubular โดยพบได้จำนวน 2,1,9 และ 0.1 ตามลำดับ เมื่อเทียบกับกลุ่ม IDC-NOS แล้วพบว่า ชนิด mucinous พบในผู้ป่วยอายุมากกว่าและมีประวัติโรคต่อมน้ำเหลืองกว่า IDC-NOS ซึ่งมีการลุกลามที่ต่อมน้ำเหลืองน้อยกว่าหรืออาจมีผลดีกว่า แต่ไม่ได้รับผลการรักษาแตกต่างกัน โดยมีการรักษาแบบมาตรฐานที่เป็นไปตามหลักการที่มีปัจจัยพยากรณ์โรคดีกว่า แต่ไม่ได้รับผลการรักษาแตกต่างกัน

คำสำคัญ: ปัจจัยพยากรณ์โรค, medullary, mucinous, IDC-NOS, การรักษาแบบมาตรฐาน