

# Brief Note on Breast Cancer

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## Description

Breast Cancer (BC) is the most common cancer in women, accounting for approximately 30% of all female cancers. The mean age of incidence varies between countries. While it is 62 years in the United States, it is 48 years in the Arab countries. For example, according to a recent statistic of mine in Syria, 20% of cases occurred before the age of 40 (compared to 8% in the US). A significant percentage of our breast cancer cases occur at childbirth ages with high estrogen levels, especially during pregnancy, leading to aggressive cancer. When treating breast cancer, we must think about its biology.

## Causes of breast cancer

- Increasing age
- Family history
- Inheritance of mutations in the genes BRCA2, BRCA1

## Survival depends on the following five factors

- Lesion size
- Grade
- Lymph nodestatus
- Hormone receptor status
- Patient age

We must keep in mind that any lump in the breast or a new change in the breast should be considered cancer unless proven. Otherwise, especially if the patient is over 40 years of age. Mammography and ultrasound (U/S) should be performed routinely. Mammography is only 85% to 90% accurate, so it is essential to detect abnormal changes that did not appear on mammography and ultrasound.

Speculative lesions and cluster micro classifications are important in mammography. In U/S, irregular, inhomogeneous, hypoechoic

lesions with a vertical shadow length greater than the horizontal length are compatible with malignancy. Axillary Lymph Nodes (LN) that have lost their fatty centers are consistent with malignancy. The accurate diagnostic tool is Fine-Needle Aspiration (FNA) Biopsy (Bx) or true cut biopsy. This last biopsy allows us to do Immuno Histo Chemical (IHC) and to know the hormonal receptors

We must resort to the Excisional Biopsy and Path examination of the entire lesion if we clinically suspect that the lesion is cancerous. Neoadjuvant chemotherapy is used in large lesions to reduce the size of the amenable and make it accessible for conservative surgery. In this way, we also know the response rate to this chemotherapeutic agent and protocol. Once operability is established, we must choose the type of surgery: Modified Radical Mastectomy (MRM) vs Conservative Surgery (CS). Conservative Surgery (CS) is considered the standard of care. Statistics have shown the same results as traditional MRM. The indications (absolute and relative) for CS are clearly defined: most importantly, the absence of micro classifications in other quadrants, the acceptable size of the lesion/breast size, the radiotherapy center available in the vicinity, and in particular, patient acceptance of the low percentage of local recurrences with CS.

We emphasize that even with local recurrence if it occurs after radiation therapy, a wider excision or salvage mastectomy will be performed. Survival would be the same. If the patient continues to have concerns about the possibility of a local recurrence, it is best to opt for a mastectomy or a Nipple-Sparing Mastectomy (NSM). MRM is indicated for large lesions or when a cesarean is contraindicated or when a cesarean is performed and Radiotherapy (RT) is not available in the area. Still a large number of sterile saline solutions in the armpit and under the flap then aspirate all the saline solution through the hemovac (used to remove fluids that build up in an area of your body after surgery) section at the end of the operation and maintain negative pressure.

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