MASTOPATHY AND BREAST CANCER RELATIONSHIP

Mastopathy is the most common fibrocystic breast lesion found in 1/5-1/3 of women aged 35-50 years. Breast cancer is the most commonly diagnosed cancer at women, representing 17.5% of all deaths in women. Relationship between fibrocystic mastopathy and breast cancer poses an essential problem. Considered from epithelial and stromal tissue response to hormonal stimulation, predisposing or premalignant histological lesion site, ductal carcinoma association with benign lesions raise the issue of increased risk of developing carcinoma in situations where fibrocystic mastopathy presents histological intraductal epithelial hyperplasia, especially the atypical form.

This paper has proposed the study of breast carcinoma with particular background of fibrocystic mastopathy considered as a form of association. The study included 1583 patients who were divided into two groups. A lot of 1373 of patients aged 20-70 years were addressed to Surgical Clinic I Targu Mures to which had been established after histopathological diagnosis following surgery: breast carcinoma (542), fibrocystic mastopathy (599) fibrocystic breast carcinoma and mastopathy (232). The other lot included 187 patients aged between 27-74 years operated in Cancer Institute Cluj-Napoca, who had histopathological diagnosis of fibrocystic mastopathy, fibrocystic breast carcinoma developed on mastopathy and breast cancer with distance fibrocystic mastopathy. They also performed at this lot immunohistochemical evaluation of hormone receptors.

Results of the study revealed statistically that if in the first lot with breast carcinoma incidence occurs after the age of 50 years, in case with fibrocystic mastopathy incidence occurs between 40-50 years, and the incidence of association between breast cancer and fibrocystic mastopathy is increased by a decade earlier than in patients with non-associated carcinoma. The most frequent combination (73.7%) was between invasive ductal carcinoma and fibrocystic mastopathy.

In the second group of 187 patients, there were retained 169 cases that had been diagnosed with malignant tumors and fibrocystic mastopathy. Regarding structure by age association was found for the same incidence of both lesions (range 40-50 years) as with the first group.

We also performed a statistical study of breast carcinoma developed on particular fibrocystic mastopathy, reporting under the hormonal aspect. Numerical analysis was made by histopathological differentiation of patients by type and degree of SBR malignancy. For patients diagnosed with ductal carcinoma SBR 1 degree associated with fibrocystic mastopathy, 73% had significant hormone receptor expression. For those diagnosed with ductal carcinoma SBR 2 degree associated with fibrocystic mastopathy, 84% had significant hormone receptor expression. For patients diagnosed with ductal carcinoma SBR 3 degree associated with fibrocystic mastopathy, only 20% had significant hormone receptor expression.

The study is justified by the fact that breast carcinoma currently, despite the progress made lately in the prevention and early recognition, continues to be a significant problem of tumor pathology. The age of developing breast carcinoma by the ground of fibrocystic mastopathies is earlier. After 60 years the most common carcinoma is situated away from the fibrocystic mastopathy. Lobular carcinoma in situ association with fibrocystic mastopathy was
beneficial to the discovery of an early form of the disease regardless of age. For patients diagnosed with invasive ductal carcinoma associated with fibrocystic mastopathy, significant hormonal expression steadily deteriorated depending on the degree of malignancy. Hormonal status of patients diagnosed with invasive ductal carcinoma, away from fibrocystic mastopathy, was considered more favorable and has large variations in the classification of patients into a high degree of malignancy compared to hormonal status of patients who had carcinoma associated with fibrocystic mastopathy.

Although you can not prove that there is a real continuity between benign hyperplasia and cancer, this can be installed starting from all hyperplasia structures, passing through a phase distinct from the border atypical hyperplasia.