

DOWNLOAD PDF TREATISE ON THE DISEASES OF THE BREAST AND MAMMARY REGION.

Chapter 1 : Full text of "A treatise on the diseases of the breast and mammary region"

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Previous Section Next Section Introduction The vast majority of the lesions that occur in the breast are benign. Much concern is given to malignant lesions of the breast because breast cancer is the most common malignancy in women in Western countries; however, benign lesions of the breast are far more frequent than malignant ones [1 9]. With the use of mammography, ultrasound, and magnetic resonance imaging of the breast and the extensive use of needle biopsies, the diagnosis of a benign breast disease can be accomplished without surgery in the majority of patients. Because the majority of benign lesions are not associated with an increased risk for subsequent breast cancer, unnecessary surgical procedures should be avoided. The incidence of benign breast lesions begins to rise during the second decade of life and peaks in the fourth and fifth decades, as opposed to malignant diseases, for which the incidence continues to increase after menopause, although at a less rapid pace [2 14]. In this review, the most frequently seen benign lesions of the breast are summarized as developmental abnormalities, inflammatory lesions, fibrocystic changes, stromal lesions, and neoplasms. Previous Section Next Section Developmental Abnormalities Ectopic breast mammary heterotopia , which has been described as both supernumerary and aberrant breast tissue, is the most common congenital abnormality of the breast. Supernumerary breast tissue is seen mostly along the milk line; the most frequent sites are the chest wall, vulva, and axilla. It may vary in its components of nipple polythelia , areola, and glandular tissue polymastia. However, an anatomic location outside the milk line should not preclude a diagnosis of ectopic breast tissue, because there are many well-documented, unusual sites of such tissue, including the knee, lateral thigh, buttock, face, ear, and neck [15]. Aberrant breast tissue is usually located near the breast, most commonly in the axilla. They usually have a nipple and areola and a separate duct system from that of the normal breast. When the nipple is absent, the presence of the accessory breast tissue is difficult to identify. The accessory breast tissue responds in the same way as normal breast tissue to physiological influences. The absence of a duct system may cause symptoms of obstruction during lactation and may be mistaken clinically for a carcinoma. Accessory breast tissue and polymastia are more common among Asians, especially Japanese, than whites [16]. Recognition of ectopic breast tissue is important because it can serve as a milieu for the development of a variety of benign and malignant lesions encountered in the normal breast. It has been reported that ectopic breast tissue is more prone to malignant change and that ectopic breast cancer occurs at an earlier age; however, malignancies in ectopic breasts are very rare [16 18]. Excessive breast growth macromastia can be seen in pregnancy as well as during adolescence. Acquired hypoplasia, on the other hand, is usually iatrogenic, most commonly subsequent to trauma or radio-therapy. The complete absence of both breast and nipple amastia or presence of only nipple without breast tissue amazia is rare [23]. Inflammatory and Related Lesions Mastitis A variety of inflammatory and reactive changes can be seen in the breast. While some of these changes are a result of infectious agents, others do not have a well-understood etiology and may represent local reaction to a systemic disease, or a localized antigen-antibody reaction, and are classified as idiopathic. Inflammatory breast cancer, as the name suggests, mimics an infectious or inflammatory etiology. It often develops without a palpable mass lesion and is often initially misdiagnosed. In fact, most patients with inflammatory breast cancer are diagnosed after an initial treatment with antibiotics or anti-inflammatory therapies failed to show clinical improvement. Mammographic and sonographic evaluation are helpful in establishing the diagnosis. Image-guided biopsy of the abnormal breast parenchyma or skin biopsy confirms the diagnosis. A negative skin biopsy should not be used to exclude the diagnosis. Acute Mastitis Acute mastitis usually occurs during the first 3 months postpartum as a result of breast feeding. Also known as puerperal or lactation mastitis, this disorder is a cellulitis of the interlobular connective tissue within the mammary gland, which can result in abscess formation and

septicemia. It is diagnosed based on clinical symptoms and signs indicating inflammation. Risk factors fall into two general categories: Because the duration of symptoms before starting treatment is found to be the only independent risk factor for abscess development, early diagnosis and early management of mastitis is of value [26]. However, there is little consensus on the type or duration of antibiotic therapy and when to begin antibiotics. Because lactation mastitis is a process of subcutaneous cellulitis, detection of pathogens in breast milk may not always be possible, so breast emptying with frequent nursing or manual pumping and beginning empiric antibiotherapy seems to be the most appropriate approach [26 , 27]. When puerperal mastitis-associated abscess occurs, incision and drainage are usually recommended; however, suitable patients assessed by ultrasonography can also be treated without surgery by needle aspiration and antibiotics with excellent cosmesis [26]. Identification of the etiology requires microbiologic and immunologic testing in addition to histopathologic evaluation. Many different types of organisms can cause granulomatous mastitis [28 , 29]. Tuberculosis of the breast is a very rare disease. However, both clinical and radiological features of tuberculous mastitis are not diagnostic and easily can be confused with either breast cancer or pyogenic breast abscess by clinicians. Remembering the fact that traveling from one place to another in the global world has been increasing and that the prognosis for complete cure with appropriate antituberculous drug therapy is excellent, this entity should also be taken into consideration. Definitive diagnosis of the disease is based on identification of typical histological features under microscopy or detection of the tubercle bacilli with mycobacterial culture [30]. This diagnosis can be made only by excluding other possible causes of granulomatous lesions. An autoimmune localized response to retained and extravasated fat- and protein-rich secretions in the duct has been postulated, but the etiology of the disease remains largely unknown [31]. Histologically, chronic noncaseating granulomatous inflammation is typically limited to lobuli. The recommended therapy of idiopathic granulomatous mastitis is complete surgical excision whenever possible plus steroid therapy. Foreign Body Reactions Foreign materials, such as silicone and paraffin, which are used for both breast augmentation and reconstruction after cancer surgery, may cause a foreign body-type granulomatous reaction in the breast. Foreign body granulomatous response associated with multinucleated giant cells surround silicone. Fibrosis and contractions may lead to clinically apparent firm nodules that may be tender. The disease is caused by squamous metaplasia of one or more lactiferous ducts in their passage through the nipple, probably induced by smoking [10]. Keratin plugs obstruct and dilate the proximal duct, which then becomes infected and ruptures. The inflammation eventuates in abscess formation beneath the nipple, which typically drains at the margin of the areola [10 , 33]. Abscess drainage to allow for resolution of the acute inflammation and then complete excision of the affected duct and sinus tract is successful in most cases, but abscesses may recur when the process develops in another duct [33 , 34]. Mammary Duct Ectasia Mammary duct ectasia, also called periductal mastitis is a distinctive clinical entity that can mimic invasive carcinoma clinically. It is a disease of primarily middle-aged to elderly parous women, who usually present with nipple discharge, a palpable subareolar mass, noncyclical mastalgia, or nipple inversion or retraction. The pathogenesis and the etiology of the disease are still being debated. Smoking has been implicated as an etiologic factor in mammary duct ectasia [35 , 36]. This association appears to be more important in young women who smoke [37]. Mammary duct ectasia is usually an asymptomatic lesion and is detected mammographically because of microcalcifications. The most important histologic feature of this disorder is the dilatation of major ducts in the subareolar region. These ducts contain eosinophilic, granular secretions and foamy histiocytes both within the duct epithelium and the lumen. The inspissated luminal secretions may undergo calcifications that may be the presenting sign in many patients [38]. Mammary duct ectasia generally does not require surgery and should be managed conservatively [39]. There is no evidence in the literature indicating that mammary duct ectasia is associated with an increased risk for breast cancer. In some patients, clinical presentation and mammographic findings may suggest malignancy, and biopsy may be required to exclude malignancy. Fat Necrosis Fat necrosis of the breast is a benign nonsuppurative inflammatory process of adipose tissue. It can occur secondary to accidental or surgical trauma, or it may be

associated with carcinoma or any lesion that provokes suppurative or necrotic degeneration, such as mammary duct ectasia and, to a lesser extent, fibrocystic disease with large cyst formation [40 , 41]. Clinically, fat necrosis may mimic breast cancer if it appears as an ill-defined or spiculated dense mass, associated with skin retraction, ecchymosis, erythema, and skin thickness [41]. Mammographic, sonographic, and magnetic resonance imaging findings may not always distinguish fat necrosis from a malignant lesion. Even the macroscopic appearance of the benign lesion can suggest a malignant tumor. Histologically, however, the diagnosis of fat necrosis presents no problem, as it is characterized by anuclear fat cells often surrounded by histiocytic giant cells and foamy phagocytichistiocytes [42 , 43]. Excisional biopsy is required if carcinoma cannot be excluded preoperatively [44]. Such changes generally affect premenopausal women between 20 and 50 years of age [2 9]. FCCs may be multifocal and bilateral. The most common presenting symptoms are breast pain and tender nodularities in breasts. Although the exact pathogenesis of the entity is not clear, hormonal imbalance, particularly estrogen predominance over progesterone, seems to play an important role in its development [47]. FCCs comprise both cysts macro and micro and solid lesions, including adenosis, epithelial hyperplasia with or without atypia, apocrine metaplasia, radial scar, and papilloma. Over the years, it has been one of the major issues to determine whether these lesions are a risk factor for the subsequent development of breast cancer. As the use of mammography and the identification of benign breast diseases become more common, it is crucial to identify women who are at an increased risk for breast cancer. Therefore, it is practical to evaluate FCCs under a classification system first proposed by Dupont and Page [48], as nonproliferative lesions, proliferative lesions without atypia, and proliferative lesions with atypia atypical hyperplasia. Nonproliferative lesions include cysts, papillary apocrine change, epithelial-related calcifications, mild epithelial hyperplasia, as well as ductal ectasia, nonsclerosing adenosis, and periductal fibrosis. Proliferative lesions without atypia include moderate or florid ductal hyperplasia of the usual type, sclerosing adenosis, radial scar, and intraductal papilloma or papillomatosis. Proliferative lesions with atypia include atypical ductal and lobular hyperplasia. In each of these lesions, the subsequent risk for breast cancer is associated with the histologic appearance of the lesion [48 51]: Apart from the histologic features, the age at biopsy and the degree of family history of breast cancer are reported to be the major determinants of breast cancer risk after the diagnosis of benign breast disease [51]. According to Hartmann et al. It was also reported, in the same study, that family history of breast cancer is an independent risk factor and that strong family history may increase breast cancer risk even in patients with nonproliferative lesions [51]. Absolute risk, however, for both atypical and nonatypical epithelial proliferations is quite low. Cysts Cysts are fluid-filled, round or ovoid structures that are found in as many as one third of women between 35 and 50 years old. Cysts cannot reliably be distinguished from solid masses by clinical breast examination or mammography; in these cases, ultrasonography and fine needle aspiration FNA cytology, which are highly accurate, are used. Cysts are derived from the terminal duct lobular unit. In most cysts, the epithelial lining is either flattened or totally absent. In only a small number of cysts, an apocrine epithelial lining is observed. Because gross cysts are not associated with an increased risk of carcinoma development, the current consensus on the management of gross cysts is routine follow-up of the patient, without further therapy [53]. The malignancy rate of complex cysts, which is 0. Either a core needle biopsy or surgical biopsy is indicated for these lesions [54 , 56]. Adenosis Adenosis of the breast is a proliferative lesion that is characterized by an increased number or size of glandular components, mostly involving the lobular units. Various types of adenosis have been described, of which sclerosing adenosis and microglandular adenosis merit detailed description [57].

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Chapter 2 : Alfred-Armand-Louis-Marie Velpeau - Wikipedia

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Published online Apr The authors have declared that no competing interests exist. Conceived and designed the experiments: Received Jan 15; Accepted Mar 8. This article has been cited by other articles in PMC. The survival rate of PD was reported to depend on the characteristics of the underlying carcinoma. This study aimed to investigate the characteristics and survival rate of PD patients with underlying invasive breast carcinoma IBC. The 52 patients were all recruited in this study as the PD group. They tended to have greater chances of lymph node involvement A matched study was then performed to investigate whether the poor survival of patients in the PD group was due to the unfavorable prognosis of the underlying IBC. The match was conducted according to four variables: The 5-year RFS Their survival was worse than that of patients with IBC of similar stage and characteristics. For patients with no clinical PD manifestation who were histologically diagnosed as PD, survival might be worse compared to patients with clinically diagnosed PD. The incidence has been reported to be 0. PD is pathologically characterized by the infiltration of the nipple epidermis by large, clear, ballooned cells, now recognized as malignant breast epithelial cells, which cause an eczematoid eruption on the nipple and areola. PD of the breast typically clinically presents as a skin alteration in the nipple-areola area. This nipple-areolar skin change was first reported by Velpeau in [7]. Three prognostic factors for PD have been reported in different studies to date: The survival rate for PD with carcinoma in situ is better than that for PD with invasive carcinoma. Therefore, the authors believe the prognosis of PD is mostly determined by the pathologic stage of the associated carcinoma although this hypothesis has not been proved by case-control studies. Due to the limited number of patients with PD, case-control studies have been very rare. In the daily clinical practice of Fudan University Shanghai Cancer Center FUSCC , physicians found that patients diagnosed as PD with underlying invasive carcinoma might have much worse survival than patients diagnosed with invasive carcinoma of the same stage. This finding was a challenge to the traditional knowledge of PD. The purpose of this study was to demonstrate this finding by investigating the prognosis of patients with PD and an underlying invasive carcinoma via a cohort-matched study. Women were only eligible for enrollment in this study if all of the following criteria applied: Women were excluded if any of the following criteria applied: All patients have signed written informed consent. Because their underlying carcinomas were all ductal carcinomas, only patients diagnosed with invasive ductal carcinoma IDC without PD were recruited into the control group for further comparison. Seven hundred consecutive patients per year were recruited for the control group. Because the pathologic comparison see results showed that tumors in the PD group expressed more unfavorable prognostic factors than those in the control group, a matched study was performed to compare the survival of patients in the PD group with that of patients with IDC of similar prognostic factors. The matched group was also derived from the database. Pathology Data As part of the routine clinical practice of FUSCC, the breast removed due to mastectomy was carefully reviewed, including tumor, normal breast tissue of other quadrants, nipple-areola area, etc. We collected the complete pathology data including pathology type, tumor diameter, grade, and estrogen receptor ER , progesterone receptor PR , and HER2 status. Follow-up via phone was performed if the patient did not attend her appointment. The time and site of the first detected relapse were recorded, as well as the time and cause of death. Statistical Methods The match was performed according to the four variables mentioned above with SAS 8. The main endpoints were the first relapse relapse-free survival, RFS and mortality due to breast cancer breast cancer-specific overall survival, OS. The significance of any correlation was assessed by the chi-squared test. Survival curves were constructed using the Kaplan-Meier technique. The median age of these patients was 50 years, with a range from 27 to 86 years. Postoperative adjuvant treatment was designed

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according to the current National Comprehensive Cancer Network NCCN guidelines and the judgment of the physicians. Targeted therapy was very rarely used during that period because of its high cost in China at that time. The main clinical and pathological characteristics and the adjuvant treatment of patients in this study are shown in Table 1.

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Arranged in two parts, the first deals with all aspects of diseases of the mammary region in women; the second part deal with diseases of the breast in men. Cancer is a dominant problem here, but the author also discusses inflammation and abscess, induration, cysts, and tumors.

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