



## BREAST CONCERNS

### DEFINITION

Breast concerns in women of all ages are often the source of significant fear and anxiety. These concerns can take the form of palpable masses or changes in breast contours, skin or nipple changes, congenital malformation, nipple discharge or breast pain (cyclical and non-cyclical).

1. Palpable breast masses may represent cysts, fibroadenomas or cancer.
  - a. Cysts are fluid-filled masses that can be found in women of all ages, and frequently develop due to hormonal fluctuation. They often change in relation to the menstrual cycle.
  - b. Fibroadenomas are benign solid tumors that are caused by abnormal growth of the fibrous and ductal tissue of the breast. More common in adolescence or early twenties, but can occur at any age. A fibroadenoma may grow progressively, remain the same size, or regress.
  - c. Masses that are due to cancer are generally distinct dominant solid masses. They may also be merely thickened areas of the breast or exaggerated lumpiness or nodularity. It is impossible to diagnose the etiology of a breast mass based on physical exam alone. Failure to diagnose breast cancer in a timely manner is the most common reason for malpractice litigation in the U.S. Skin or nipple changes may be visible signs of an underlying breast cancer. These are danger signs and require MD referral.
2. Non-spontaneous or physiological discharge is fluid that may be expressed from the breast and is not unusual in healthy women.
3. Galactorrhea is a spontaneous, multiple duct, milky discharge most commonly found in non-lactating women during child bearing years. It occurs as a result of increasing prolactin levels from physiological, pharmacological, pathological or functional causes.
4. Cyclical breast pain is usually bilateral (but not always) and premenstrually. The cause is unknown, but thought to be hormone-related, sensitivity to methylxanthines (caffeine) or dietary fat intake.
5. Noncyclical breast pain is anatomical rather than hormonal and far less common than cyclical pain. Etiology is poorly understood.
6. Variations in breast development may be obvious from birth or manifest at puberty. These variations include:
  - a. Amastia
  - b. Hypomastia/Poland's Syndrome
  - c. Supernumerary breasts/accessory nipples
  - d. Nipple inversion
  - e. Very large breasts
  - f. Very small breasts
  - g. Asymmetrical breasts.

There is no clinical significance with these variations, although be alert that this aberrant breast tissue is subject to all the problems of normally situated tissue.

### SUBJECTIVE

May include:

1. Palpable breast mass or change in density- single or multiple areas affected; unilateral or bilateral. May feel soft or firm and either well or ill defined. May develop rapidly within days (more common with cysts) or slow change over months. May be painful (more common with cysts), or nontender (fibroadenomas or cancer).
2. Change in breast contours or notable asymmetry.

	<ol style="list-style-type: none"> <li>3. Nipple discharge- milky, serous, opalescent, yellow, green or bloody. Unilateral or bilateral; Spontaneous or with compression.</li> <li>4. History of certain drugs that may cause nipple discharge including but not limited to: oral contraceptives, Depo Provera, antihypertensives, tranquilizers, tricyclic antidepressants, muscle relaxers, antidepressants antipsychotics, illicit drugs (marijuana, heroin, opiates), various herbal supplements, etc. Refer to PDR or drug manual of choice.</li> <li>5. Skin of breast may be erythematous, flaking, crusting, dimpling or ulcerative. Skin may be nontender, or may itch or burn.</li> <li>6. New onset of nipple inversion or loss of usual inversion.</li> <li>7. Pain in breasts- may be aching, burning, shooting, or stabbing in nature. May or may not be associated with cyclical hormonal changes.</li> <li>8. Sudden onset of chills, fever, malaise, and breast pain with or without a breast mass.</li> <li>9. Mass in axillary or supraclavicular area.</li> <li>10. Congenital defects such as supernumerary nipples or breast agenesis.</li> <li>11. Normal physiological changes- youthful dense firm breasts, or physiological changes secondary to hormonal fluctuation such as swelling and/or pain prior to menses. Changes associated with recent pregnancy or lactation.</li> <li>12. Fear of cancer</li> <li>13. Symptoms of other endocrine disorders such as hypothyroidism, acromegaly, Cushing's Syndrome, PCOS, hyperprolactinemia, etc.</li> <li>14. Assessment and documentation of family history of breast cancer</li> <li>15. Assessment and documentation of whether or not breast self exams (BSE) are regularly performed.</li> </ol>
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<p><b>OBJECTIVE</b></p>	<p>Must include:</p> <ol style="list-style-type: none"> <li>1. Clinical breast exam and full documentation of findings as described below.</li> </ol> <p>May include:</p> <ol style="list-style-type: none"> <li>1. Clinical breast exam which identifies an abnormality. Characteristics may include: <ol style="list-style-type: none"> <li>a. Presence of a mass- unilateral or bilateral, soft or firm, well defined or irregular, fixed or mobile, smooth or coarse.</li> <li>b. Abnormal skin and nipple changes: Change in contour of breast, skin dimpling, retraction, flattening or deviation of the nipple. Cancer frequently causes fibrosis or scar tissue formation. Contracting this fibrotic tissue produces alterations in breast contours and skin dimpling. This may also flatten or deviate the nipple. Peau d' orange and increased venous prominence is produced by lymphatic blockage, which often affects the areola first. Oozing, fissures, or ulcers may be present in Paget's Disease which is a rare type of cancer affecting the mammary ducts and invading the skin. Edema and/or increased venous prominence may represent inflammatory breast cancer.</li> <li>c. Nipple discharge from multiple ducts either spontaneously or with breast manipulation; bilateral or unilateral. Discharge may be milky, greenish yellow, multicolored, opalescent or serous. Bruising may be present from frequent breast manipulation.</li> <li>d. Inverted nipple(s). Unilateral or bilateral. Permanently inverted nipples that don't manifest until puberty. The nipple can be pulled out of the sulcus in which it lies. Flattening, broadening, and true retraction are absent.</li> <li>e. Fever, swelling or pain with palpation of breasts.</li> <li>f. Lymphadenopathy in axillary and/or supraclavicular area.</li> <li>g. Congenital deformities such as unusually small deformed breasts with underdeveloped pectoralis muscle and rib (hypomastia/Poland's Syndrome). Breast tissue may be present but nipple is absent. Referred to as amastia and is usually</li> </ol> </li> </ol>
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	<p>associated with scoliosis and rib deformities.</p> <p>h. Extra breast tissue or nipple(s). (Supernumerary breast/accessory nipples). Occurs in 10% of the population, and can appear anywhere along the milk ridge. May lactate and often mistaken for skin tag or mole. Extra breast tissue often appears in axilla and it may feel hard and cyst-like that swells and hurt premenstrually.</p> <p>2. Signs of other endocrine disorders including but not limited to: enlarged thyroid, hirsutism, habitus suggestive of Cushing's Syndrome or PCOS</p> <p>Document findings in descriptive terms. Mass(es) should be described assuming a clock position of location, distance from nipple, size in centimeters, consistency, shape, presence of tenderness, mobility or lack thereof, associated skin changes and presence of lymphadenopathy. Diagrams are helpful. Also document presence or absence of lymphadenopathy or other abnormal systemic findings.</p>
<b>LABORATORY</b>	<p>May include:</p> <ol style="list-style-type: none"> <li>1. Pregnancy test</li> <li>2. Thyroid screen</li> <li>3. Occult blood testing of nipple discharge to rule out presence of blood</li> <li>4. Serum Prolactin.</li> </ol>
<b>ASSESSMENT</b>	<p>Breast concerns which may include any of the following: Breast mass, abnormal skin or nipple changes, congenital malformations, nipple discharge or cyclical/noncyclical breast pain.</p>
<b>PLAN</b>	<ol style="list-style-type: none"> <li>1. Firm masses, particularly in postmenopausal women: refer client to MD for further diagnostics, management and treatment. A breast ultrasound and/or mammogram (as age appropriate) may be ordered while awaiting referral appointment as indicated.</li> <li>2. Painful, soft masses: may be re-examined 7-10 days after onset of menses. If mass persists, refer to MD.</li> <li>3. Abnormal skin or nipple changes: refer to MD for further management.</li> <li>4. Nipple discharge: Halt precipitating event (i.e. nipple manipulation) or consider eliminating causative medication as appropriate. Reevaluate in 3 months if client has any of the following: Normal menstrual cycles, history of pregnancy, lactation or hormonal contraceptive use within the past year. Bloody discharge requires an immediate referral to MD.</li> <li>5. Breast pain: Mammogram and/or breast ultrasound if indicated. Trial of NSAID's, low fat diet, caffeine and sodium restriction, Vitamin E supplement (400-800 IU/day), Evening Primrose Oil 3grams daily (avoid if seeking pregnancy), combined birth control pills/ring or switch to lowered estrogen and/or progestin effect. If unresponsive to any of these measures, consult/refer with MD as appropriate.</li> <li>6. Congenital malformations: Assess client's knowledge and acceptance. Referral to Plastic Surgeon if requested by client.</li> </ol>
<b>CLIENT EDUCATION</b>	<ol style="list-style-type: none"> <li>1. Teach/review BSE and proper nipple hygiene (mild soap/water and keeping nipples dry).</li> <li>2. Allay client's concerns regarding breast findings.</li> <li>3. Discuss importance of referral appointment, and encourage appropriate follow-up.</li> </ol>
<b>CONSULT / REFER TO PHYSICIAN</b>	<ol style="list-style-type: none"> <li>1. Referral to MD as indicated for specific breast concerns as noted in the Plan section.</li> <li>2. May arrange for appropriate labwork, mammogram and/or ultrasound prior to referral appointment.</li> </ol>

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