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Breast Self Examination: To Do or Not To Do?

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ABSTRAK

Ini adalah satu kajian retrospektif untuk melihat presentasi kanser payudara dan cara ianya dikesan dikalangan pesakit di Hospital Kuala Lumpur. Sebanyak 366 rekod pesakit dari Klinik Endokrin dan Payudara dianalisa. Hasil kajian menunjukan kebanyakan pesakit adalah dalam lingkungan umur 40-49 tahun (39.6%). Sebanyak 81.4% pesakit menunjukkan ketulan pada payudara dan mengesan ketulan ini sendiri (97.3%). Diameter min tumor semasa presentasi adalah 4.7± 3 cm. Sebanyak 1.6% penyakit di kesan oleh kakitangan perubatan dan 1.1% lagi dikesan melalui mamogram. Kesimpulannya, kebanyakan pesakit mengesan ketulan pada payudara mereka sendiri. Ini mencadangkan bahawa kaedah pemeriksaan sendiri payudara boleh digunakan sebagai saringan untuk mengesan tanda-tanda awal kanser payudara, sekiranya kemudahan mamogram tidak ada. Pengesanan awal melalui pemeriksaan sendiri dapat menawarkan pilihan rawatan dan kualiti hidup yang lebih baik sungguhpun terdapat bukti yang menyatakan bahawa kaedah ini tidak dapat mengurangkan mortaliti kanser payudara.

Kata kunci: Kanser payudara, peperiksaan sendiri payudara

ABSTRACT

This is a retrospective descriptive study done to look at common presentation and method of detection of breast cancer. A total of 366 case records of patients attending the Breast and Endocrine Clinic at Hospital Kuala Lumpur were reviewed. The peak age of breast cancer presentation was 40 to 49 years (39.6%). Most (81.4%) patients presented with a lump in the breast and the lump was mainly self-detected (97.3%). The mean tumour diameter on presentation was 4.7± 3 cm. Medical staff detected the disease in 1.6% cases and 1.1% of cases were detected by mammogram. Most women detected the lump themselves, suggesting that Breast Self Examination (BSE) can be used for detection of the disease in places where there is cost and availability constrains for mammogram. Early detection with BSE can possibly offer better treatment options and quality of life despite the evidence that it does not reduce the mortality due to breast cancer.

Key words: Breast cancer, Breast Self Examination (BSE).

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INTRODUCTION

Breast cancer is the commonest cancer among females in most parts of the world, with an increasing incidence in developing countries (GLOBOCCAN 2000). In Malaysia, it accounts for 30.4% of newly diagnosed cancer and it is the commonest cancer in females of all ethnic groups (The National Cancer Registry 2002). The Ministry of Health (MOH) Malaysia, has advocated the practice of Breast Self Examination (BSE) as a screening tool for breast cancer since 1996. The Malaysian Clinical Practice Guidelines on management of breast cancer 2002, formulated by the Academy of Medicine and the Ministry of Health, is also in favour of monthly BSE for women aged 20 and above.

In the West however, the trend is moving away from BSE as there are controversies with regard to its practice. The Canadian Task Force on Preventive Health Care (CTFPHC) and the United States Preventive Services Task Force (USPSTF) states that there is insufficient evidence of benefit for or against BSE based on the review of a number of studies. One large trial, The Shanghai Trial (Harris and Kinsinger 2002), claims that there is no evidence of reduction in mortality by performing BSE. The National Guideline Clearinghouse (NGC 2004) states that BSE causes undue anxiety, and increase in the number of physician visits for evaluation of benign breast biopsies in those who were taught BSE. The objective of this study is to determine how breast cancer was detected in a referral center, and how this information, along with the recent controversies, be used to justify the practice of BSE in our local setting.

MATERIALS AND METHODS

Case notes of patients diagnosed with breast cancer from January 1996 to December 1997 were reviewed. All Malaysian female patients were included. Those with missing files were excluded. Case notes were reviewed manually and entered into a pre-coded data collection form. Breast cancer presentation was divided into those with lump, skin manifestations (retracted nipple, peau d'orange or ulcers) and those without any symptoms. The detection of the changes was categorised into those detected by the patients, medical personnel and mammogram. The average tumor diameter was recorded as documented in the patient's file. The results were analysed using the Statistical Package for Social Sciences (SPSS) software version 11.5.

RESULTS

A total of 394 case notes were reviewed of which 366 were selected. Twenty-eight were excluded including 18 whose files were missing, five cases were foreigners, four had incomplete socio-demographic information, and one was a male patient. The age group most commonly affected were those between 40 to 49 years (39.6%) with a mean of 48.6 $\pm$ 11.8 years. The vast majority (97.3%) of these patients detected the disease themselves. Medical staff detected 1.6% cases and 1.1% cases were detected by mammogram. The commonest mode of presentation is a breast lump (81.4%) followed by skin changes over the breast (17.5%). The mean tumour diameter on presentation was 4.7$\pm$ 3 cm.

DISCUSSION

The peak age group for breast cancer presentation is similar to the study done by Yip and Ng 1996 and Hisham and Yip 2003. The common presenting symptom is a breast lump (81.4%), and most patients detected it themselves (97.3%). This is in contrast to an American study (Osteen et al 1994) where the number of women who presented with a breast lump was 42.2% and the rate of detection of the lump by the patients themselves was 43.9%. Although this figure appears lower, it must be

emphasised that more than half of the lumps in that study were detected by screening mammogram; 56.1% compared to 1.1% in this study. This reflects the active role of screening mammogram in America. Another possible contributing factor is that women in this study probably detected the lump more easily because it was large. More Malaysian women presented with tumours greater than 2cm (77.9%) compared to their counterparts in America (37.3%) and Singapore (63%) (Yip and Ng 1996).

Detection of the disease by mammogram in this study is 1.1%, which is much lower compared to the American study (Osteen et al. 1994). This is probably because the screening program in Malaysia recommended by MOH does not include mammogram as a mass-screening tool except in high-risk cases due to limited resources. In America, annual mammogram is done for all women 40 years and above as recommended by the American Joint Committee for Cancer (Leitch et al. 1997) based on meta-analysis of recent trials.

Although breast cancer was mostly detected by patients, it is uncertain whether it was detected on routine BSE or was merely an incidental finding due to the presence of a large lump but this information may be used to create awareness regarding the disease for early detection. There is no conclusive evidence that BSE reduces mortality but there are studies which have shown that the practice of BSE leads to detection of cancer in earlier stages and with less lymph node involvement (Huguly and Brown 1981 and Hill et al. 1988).

Detection of disease based on mammographic screening is very low in this study may be due to limited resources or due to the fact that it may not be used frequently enough as a screening tool to make an impact. Primary Care Physicians need to carefully select patients for mammogram to avoid under or over utilisation. Screening mammogram in Malaysia is recommended for women of 40 years and above since this is the peak age at presentation, instead of the current recommendation of 50 years of age. A large number of cases will be missed if screening is done 10 years beyond the peak age of presentation. Screening mammogram is costly but will probably be more economical than bearing the management cost of advanced stage disease with chemo and radiotherapy.

There is no doubt that mammogram is a sensitive tool (sensitivity & specificity of 95 - 97%) and can detect lesions of up to 12mm, (Mushin et al. 1998) but BSE practice can be encouraged in countries and centres where there is cost and availability constrains for a mammogram. This can offer better options for treatment and a better quality of life if cancer is detected at an earlier stage.

This study, being retrospective, has limitations. Incomplete or missing case notes could not be analysed. The documentation of the records was inconsistent, hence there was difficulty retrieving the relevant data. There may be a selection bias, as the sample studied represents the population attending a single hospital, hence may not give a true reflection of the disease presentation in the country.

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