

THE DCIS DILEMMA

If you're one of the nearly 55,000 American women this year who will get a diagnosis of DCIS—ductal carcinoma in situ—you're in for a more than just a quick Latin lesson. To help untangle the truth about this confusing breast condition, we turned to Gordon F. Schwartz, M.D., professor of surgery at Jefferson Medical College in Philadelphia, a breast-cancer surgeon and DCIS researcher.

Q: IS DCIS CANCER, OR NOT?

A: DCIS is a noninvasive cancer confined to the milk duct of the breast. While it's technically accurate to call the condition early stage breast cancer, that's easily misinterpreted. Cancer automatically conjures up a life-threatening disease that kills by spreading—and DCIS is noninvasive and does not spread to other organs. Even if left untreated, many cases of DCIS—probably a majority—would never break through the milk ducts to penetrate surrounding tissue. The problem is, we don't know which cases progress to invasive cancer, so we have to treat all of them in some way. Once it's surgically removed, patients with DCIS have less than a 1 percent chance of dying over ten years. In contrast, patients with stage 1 breast cancer have at least a 10 percent risk of dying over ten years.

Q: WHY DO DCIS DIAGNOSES SUDDENLY SEEM MUCH MORE COMMON?

A: We've become better at diagnosing it. Twenty-five years ago, fewer than 5,000 women each year were found to have the condition. But with the rise of routine mammography screening in the late '70s, that number ballooned. Typically DCIS is seen as flecks of calcium on a mammogram—lesions otherwise too small to be felt. Today, DCIS accounts for 25–30 percent of all cancers detected by mammograms.

Q: WHAT'S THE BEST WAY TO TREAT IT?

A: Doctors themselves are divided. A few decades ago, women with DCIS were given just one option: a mastectomy. Today, we know that DCIS generally has an excellent outcome, so the majority of patients with it are treated by lumpectomy followed by radiation. But some doctors—myself included—offer just a lumpectomy alone.

Once the DCIS lesion is surgically removed, doctors may also recommend—sometimes in addition to radiation—follow-up treatment with

an estrogen-blocking agent such as Tamoxifen, or a similar drug if the patient's tumor cells are estrogen-receptor positive. But even in those patients, the benefits are unclear. Some studies suggest that Tamoxifen following lumpectomy or lumpectomy plus radiation may further decrease risk of recurrence by a significant amount. Other studies have questioned that. And no study has yet shown that it has any impact on long-term survival.

Q: HOW DO YOU DECIDE ON TREATMENT?

A: Obviously, mastectomy is the safest choice. It eliminates the problem. But most people are willing to accept some risk to save their breast. There are exceptions: In about 25 percent of patients, DCIS is found in many different ducts throughout the breast or covers an unusually large area. In these cases, it may be impossible to get a good cosmetic result with lumpectomy.

Q: WHAT AM I RISKING IF I OPT FOR LESS TREATMENT?

A: The results of the National Surgical Adjuvant Breast Project, which involved roughly 900 women, found those who opt for lumpectomy alone have an 80 percent chance of staying recurrence-free over eight years. If they choose lumpectomy plus radiation, those odds go up to 90 percent. And when there is a recurrence, what comes back is usually DCIS.

Q: WHY FORGO RADIATION WHEN IT LOWERS RISK OF A RECURRENCE BY 10 PERCENT?

A: Once you have radiation, you usually can't have it again in the same breast. There is too much damage and tissue loss. So the woman who chooses lumpectomy keeps her options open. If her DCIS recurs, she can opt for a lumpectomy, a lumpectomy plus radiation, or a mastectomy. But if it recurs in a woman who has already had radiation, her only option is a mastectomy.

Q: WHAT'S ON THE HORIZON FOR DCIS?

A: One promising experimental treatment is partial breast irradiation. With PBI, we can treat the same breast a second time because the radiation is more focused. Also, soon we may have a "crystal ball" to enable us to distinguish harmless forms of DCIS from the minority that have the potential to become invasive. Breaking the genetic code could help us predict good versus bad outcomes.

—KATHLEEN McAULIFFE

