

## RACCOMANDAZIONI PER LE VISITE SENOLOGICHE

secondo: U.S. Preventive Services Task Force, Canadian Task Force on the Periodic Health Examination, American Cancer Society, National Cancer Institute (1,2)

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### RACCOMANDAZIONI GENERALI

La visita periodica delle mammelle deve rientrare tra gli accertamenti periodici alla stessa stregua della visita dal medico di famiglia, dal ginecologo o quella dal proprio dentista.

Le visite periodiche permettono di riscontrare lesioni precancerose e tumori di piccole dimensioni, riducendo così la mortalità per carcinoma: si pensi alla rarità del carcinoma dell' utero in fase avanzata, o alla diminuzione delle dimensioni del tumore mammario alla diagnosi rilevata in questi ultimi anni.

### SCREENING DEL CARCINOMA DELLA MAMMELLA

| ETÀ                           | ESAMI SENOLOGICI           | CONSIGLI   |
|-------------------------------|----------------------------|--|
| > 35 (pazienti non a rischio) | CBE                        | 1 volta/anno   |
| > 35 (pazienti a rischio)     | CBE<br>Mammografia di base | 1 volta/anno   |
| 40+                           | CBE                        | 1 volta/anno + Gram ogni 3 anni<br>+ insegnamento di BSE |
| 40-49                         | CBE                        | 1 volta/anno Gram + BSE                                  |
| 50-75                         | Mammografia                | 1 volta/2 ann1 Gram + BSE                                |

CBE: visita senologica;

BSE: autopalpazione.

Gram: PAP test

### BIBLIOGRAFIA

1. National Cancer Institute. Working guidelines for early detection: rationale and supporting evidence to decrease mortality. Bethesda, Md.: National Cancer Institute, 1997.

2. American Cancer Society. Summary of current guidelines for the cancer-related checkup: recommendations. New York: American Cancer Society, 1998.

| Definitions of Risk | Screening Recommendations <sup>d</sup> | Other Options |
|---------------------|--|---------------|
|---------------------|--|---------------|

|  | Clinical Breast Exam  | Mammogram   |  |
|--|---|---|--|
| <p><b>Usual</b><br/>Two or more reproductive risk factors (see checklist) with no family history</p> <p>Weak family history (i.e., two or fewer distant relatives with breast cancer, or 1<sup>st</sup> degree relative with post menopausal breast cancer)</p>  | Annual after age 20   | Annual after age 40   |  |
| <p><b>Moderate –Histology</b><br/>Atypical ductal hyperplasia (ADH)<br/>Atypical lobular hyperplasia (ALH)<br/>Lobular carcinoma in situ (LCIS)<br/>Previous history of ductal carcinoma in situ (DCIS)<br/>Previous history of invasive breast cancer</p>   | At least once per year  | Annual after diagnosis  | Referral to high-risk counseling<br>Chemoprevention<br>Prophylactic mastectomy and/or oophorectomy |
| <p><b>Moderate –Radiation<sup>a</sup></b><br/>Thoracic radiation &lt; age 30</p>   | Annual after age 20   | Annual after age 40 or 10 years after radiation   |  |
| <p><b>Moderate –Strong Family History</b><br/>Any 1<sup>st</sup> or 2<sup>nd</sup> degree relative with breast cancer &lt; age 50<br/>Two or more relatives with early onset breast cancer in the same lineage</p>   | At least once per year  | Annual after age 40 or 5–10 years earlier than youngest affected relative, but not before age 25.   |  |
| <p><b>High</b> –Features associated with 10% or greater prior probability of carrying a BRCA1/BRCA2 mutation<br/>Personal history of breast cancer diagnosed age 40, or ovarian cancer<br/>Family history of breast cancer age 40 in 1<sup>st</sup> degree relative<br/>Family history of breast cancer age 40 in paternal 2<sup>nd</sup> degree relative<br/>Family history of breast cancer in two 1<sup>st</sup> degree relatives, at least one diagnosed age 50<br/>Family history of ovarian cancer and breast cancer in one 1<sup>st</sup> or 2<sup>nd</sup> degree relative or in close relatives in the same lineage<br/>One or more male relatives with breast cancer<br/>Known carrier of a BRCA1 or BRCA2 mutation, or close relative with known mutation<br/>Note: Women of Ashkenazi Jewish ancestry may be included despite fewer affected relatives or later age onset.</p> | At least once per year  | Annual after age 40 or 5–10 years earlier than youngest affected relative, but not before age 25.   | Referral to high-risk counseling<br>Chemoprevention<br>Prophylactic mastectomy and/or oophorectomy |
|  | After age 25, at least once per year.<br>Consider twice yearly. | Annual after age 25 or individualized based on earliest age onset in family. Preliminary data suggest that alternating MRI and mammography every six months may be helpful.<br>Note: More Intensive screening for mutation carriers |  |

The **Gail Model** calculates actuarial estimates of future breast cancer risk based on race, age, reproductive risk factors, maternal family history, and previous biopsy status. The computerized version of the Gail Model is available at: <http://bcra.nci.nih.gov/brc/>. The Gail Model score represents the cumulative risk of developing cancer over the next five years. For values >2, consider high-risk counseling. However, the Gail Model may underestimate the risk for those with a strong family history of breast cancer. In these cases the Claus Model may provide more useful information.

The **Claus Model** is an empiric risk model that predicts a woman's chance of developing breast cancer based on her family history. This model considers the number for affected relatives in both the maternal and paternal lineages (up to two), their relationship to the patient (whether they are first or second-degree relatives) and the age of onset of breast cancer in each relative. It does not factor in ethnic background, whether the cancer was bilateral, or a family history of ovarian cancer. All eight Claus Model tables are available at: [www.rmf.harvard.edu/bca](http://www.rmf.harvard.edu/bca).