Follow-up of Abnormal Breast Findings

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Abnormal Breast Findings include the following:

CBE results of:
- Nipple discharge, no palpable mass
- Asymmetric thickening/nodularity
- Skin Changes (Peau d’orange, Erythema, Nipple Excoriation, Scaling/Eczema)
- Dominant Mass
- ? Unilateral Breast Pain

Mammogram results of:
- ACR 0 – Assessment Incomplete
- ACR 4 – Suspicious Abnormality,
- ACR 5 – Highly Suggestive of Malignancy
Abnormal CBE Results
Nipple Discharge

- Third most common breast complaint by women seeking medical attention after lumps and breast pain
- During breast self exam, fluid may be expressed from the breasts of 50% to 60% of Caucasian and African-American women and 40% of Asian-American women
Nipple Discharge cont.

- Palpation of the nipple in a woman who **does not** have a history of persistent spontaneous nipple discharge - not recommended

  Rationale: Non-spontaneous nipple discharge is a normal physiological phenomenon and of no clinical consequence

- Infections (E.g. abscess) should be treated with incision and drainage or repeated aspiration if needed (consider antibiotics)
Nipple Discharge is of Concern if it is:

- Blood stained, serosanguinous, serous (watery) with a red, pink, or brown color, or clear
- 90% of bloody discharges are intraductal papillomas; 10% are breast cancers
- Appears spontaneously without squeezing the nipple
- Persistent
- On one side only (unilateral)
- A fluid other than breast milk
Nipple Discharge cont.

Non-lactating women who present with a *unilateral, spontaneous* nipple discharge (whether clear, serous or bloody) should be referred for *diagnostic breast imaging and surgical evaluation*

Diagnostic mammograms in these instances may be negative, **but should never delay further diagnostic evaluation**
# Types of Nipple Discharge

<table>
<thead>
<tr>
<th>Discharge Color</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milky – involves more than one duct</td>
<td>galactorrhea due to medicines or anovulation</td>
</tr>
<tr>
<td>Clear, watery or yellowish – involving one duct</td>
<td>breast cancer or fibrocystic breast condition</td>
</tr>
<tr>
<td>Clear, watery or yellowish – involving multiple ducts or bilateral</td>
<td>fibrocystic breast condition</td>
</tr>
<tr>
<td>Pink, rusty or bloody – involving one or more ducts</td>
<td>intraductal papilloma, in situ or invasive breast cancer</td>
</tr>
<tr>
<td>Greenish black or brown, sticky, tarry – involving one duct</td>
<td>mammary duct ectasia, breast cancer</td>
</tr>
<tr>
<td>Greenish black or brown, sticky, tarry – involving more than one duct</td>
<td>mammary duct ectasia</td>
</tr>
<tr>
<td>Creamy, pus-like (purulent)- involving any duct</td>
<td>infection, abscess, mastitis</td>
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Nipple Discharge Follow-up

- CBE: Identify color/consistency of discharge

- Mammogram: If a suspicious mass together with nipple discharge present – refer for additional imaging? and surgical consult

- Further Diagnostic Tests:
  --Ductogram/Galactogram – not a reimbursable BCCCP code.
  --Contact NC – may map procedure to a BCCCP CPT code. Evaluated on a case by case basis.
A 50-year-old woman with serous discharge from her right nipple.

Galactography reveals contrast-agent filling defect approximately 4 cm from her nipple.

Cytology of the smears from her nipple discharge revealed normal epithelial cells.

Histopathology after surgery revealed a solitary intraductal papilloma in a cystic lesion.
Nipple Discharge Evaluation

- A 42-year-old woman with serous discharge from her left nipple.
- Galactography revealed contrast-agent filling defects approximately 1.5 cm from her nipple.
- Cytology of smears of secreted fluid revealed malignant epithelial cells.
- Histopathology after surgery revealed intraductal carcinoma.
BCCCP Medical Protocol
Follow-up of Abnormal CBE Results
NIPPLE DISCHARGE

Non-Spontaneous: Multiduct

1. Refer for Diagnostic Mammogram
2. Educate to stop compression of breast and report any spontaneous discharge

Mammogram result determines if breast consult and additional f/u required (See Diagnostic Mammogram Follow-up Evaluation)

Persistent and reproducible on Exam
Spontaneous, unilateral, single duct and clear or colorless, serous, sanguineous or serosanguineous

Refer for:
Diagnostic Mammogram +/- Ultrasound Breast Consult

Further diagnostic follow-up** per surgeon recommendation

** Diagnostic follow-up may include tissue biopsy or recommendation for ductogram (NOTE: Ductogram not reimbursed by BCCCP - may be mapped for reimbursement)
Abnormal CBE Findings
Asymmetrical Thickening vs. Breast Mass

- Despite widespread use of screening mammography, breast cancer presents as a palpable mass in the majority of cases.
- 4:1 prevalence of benign breast mass compared to malignant.
- Variation in breast tissue nodularity among pre and post menopausal women is considerable.
Asymmetrical Thickening or Lump

- Challenge to clinicians: Is the area of concern part of the normal physiologic nodularity of the breast or is it a dominant mass?
- Physiologic nodularity is often referred to as fibrocystic disease - designation is incorrect
- Such nodularity is, in fact, physiologic. - the issue is not one of treatment but of follow-up monitoring
- Breast consult to decide if immediate or short-term follow-up required.
Asymmetrical Thickening or Lump

- Providers need to decide how to best follow patients with dense and nodular breast tissue so as to maintain high sensitivity without sacrificing specificity in the clinical breast examination.
- Reassuring women about what they are finding on their own may alleviate some of the anxiety.
- For patients with normal breast cancer risk, annual examination by a health care provider is recommended.
BCCCP Medical Protocol
Follow-up of Abnormal CBE Results
ASYMMETRIC THICKENING/NODULARITY

Refer for
1. Diagnostic Mammogram
2. Ultrasound
3. Breast Consult

Mammogram/US Results
ACR 1, 2, 3

Per Surgeon:
Clinically assessed as benign
Breast consult for Physical Exam at 3-6 mos
Further f/u based on surgeon’s recommendations

Per Surgeon:
Clinically suspicious

Mammogram/US Results
ACR 4, 5

Tissue Biopsy**

Benign
Dx Mammogram/US in 6-12 mos for 1-2 years

Atypical Hyperplasia
Possible Excisional Biopsy per surgeon/radiologist recommendation

Malignant
Enroll in BCCCP MTA if eligible

** Tissue biopsy can include any of the following:
(Incisional, Core Needle, US Guided, Stereotactic, Excisional)
Abnormal CBE Results
Skin Changes (Red Flags)

**Nipple retraction**
- Cancer until proven otherwise!
- Suggests retroareolar mass

**Peau d'orange**
- Breast skin dotted like the skin of an orange
- Very ominous sign – carcinoma when present over a lump; suggests lymph node involvement
Skin Changes (Red Flags)

Paget’s Disease of the Nipple
• Skin Retraction
• Skin Dimpling/Puckeringing (skin pulled in by an underlying carcinoma)

Breast Erythema
• In non-lactating women: Ominous if persistent mastitis greater than 2 weeks; suggests inflammatory carcinoma
• In elderly women: erythema with ulceration may suggest neglected carcinoma

Visible lump
• May be due to cysts, giant fibroadenoma, carcinoma
Enlarged right breast with nipple retraction
Peau d' orange on underside of breast not visible in previous photo
Paget’s Disease of the Nipple
Breast Erythema:
Inflammatory Carcinoma
Skin Changes – Follow-Up

- Diagnostic work-up for any unilateral breast skin changes or nipple retraction
- An inflammatory appearance of the breast in any woman older than 40 should be considered inflammatory breast cancer until proven otherwise
- Bilateral diagnostic mammography is the first line of investigation - should be followed by a surgical consultation and a biopsy of the breast and skin.
Possible infection vs. cancer

- Subtle skin changes (rash, scaliness)
- Refer to surgeon (unless NP can prescribe antibiotics)
- Re-evaluate after antibiotics completed
- If not resolved, refer for diagnostic work-up to rule out cancer
**BCCCP Medical Protocol**

**Follow-up of Abnormal CBE Results**

**SKIN CHANGES**

**CLINICAL FINDING:**
1. Clinically suspicious of inflammatory breast cancer: Peau'd orange or Erythema  OR
2. Clinically suspicious of Paget's Disease: Nipple Excoriation, scaling, or eczema

Refer for:
1. Mammogram +/- Ultrasound
2. Breast Consult

Tissue Biopsy (Core Needle, Excisional, Nipple Biopsy or Punch biopsy of Skin (Skin biopsy not reimbursed by BCCCP - contact MDCH Nurse Consultant)

- **Biopsy Results: Benign**
  1. Reassess clinical/pathology correlation
  2. Consider Breast MRI (not reimbursed by BCCCP)
  3. Consider Repeat Biopsy

- **Biopsy Results: Malignant**
  Enroll in BCCCP MTA if eligible

Based on NCCN Breast Cancer Screening and Diagnosis Clinical Practice Guidelines v.1.2010

Revised June 2010
Abnormal CBE Findings
Breast Mass

Characteristics of Malignant CBE Findings
True masses are generally:
• asymmetrical in relation to the other breast
• distinct from the surrounding tissues
• are three dimensional

Cancerous mass:
• may be firm
• have attachments to skin or deep fascia with dimpling or nipple retraction
Benign CBE Findings

Characteristics of Benign Lesions
• Have discrete, well defined margins
• Are generally mobile

NOTE:
• **DO NOT** rely on palpation alone to determine a malignant from benign mass
• Full diagnostic work-up is required to confirm malignant from benign mass
Abnormal CBE Findings

Cysts vs. solid masses

- Cysts can be difficult to distinguish by palpation from solid masses
- Studies show equivocal results
  -- In one study, 58% of 66 palpable cysts were correctly identified by physical examination
  -- In a second study, 4 surgeons performed physical exams independently – they agreed on the need for biopsy in 73% of 15 masses subsequently proven malignant

An imaging evaluation is necessary in almost all cases to characterize the type of lesion
Drawbacks of Imaging for Breast Abnormalities

- Not all palpable breast masses will be visualized with conventional imaging techniques
- Breast Cancer Detection Demonstration Project (BCDDP), which began in 1970, found 9% of cancers by CBE alone – this % is now less due to improvements in imaging technology

A NEGATIVE MAMMOGRAM SHOULD NEVER OVERRULE A STRONGLY SUSPICIOUS FINDING ON PHYSICAL EXAM – FURTHER FOLLOW-UP IS REQUIRED BEYOND THE MAMMOGRAM
Abnormal CBE Findings
Clinical management of breast mass

Breast cancers present clinically in varied ways

When a mass is found consider the following:
Patient age, menstrual cycle (and whether the change in symptoms are associated with the cycle), hormone use, trauma, durations, changes over time, individual risk factors, & presence of mass in one breast or both breasts.
BCCCP Medical Protocol
Follow-up of Abnormal CBE Results
DOMINANT MASS (formerly lump/mass)

Based on NCCN Breast Cancer Screening and Diagnosis Clinical Practice Guidelines v.1.2010

** Tissue biopsy can include any of the following: (Incisional, Core Needle, US Guided, Stereotactic, Excisional)

** Diagnostic Mammogram**

Bi-Rads Results
ACR 1, 2, or 3

- Perform Ultrasound
- **No Abnormality (Bi-Rads 1)**
  - (Immed F/U) Breast Consult AND Tissue biopsy OR (STF) Dx. Mamm/US q 6 mos x 1-2 years to assess stability per surgeon recomm.

- **Solid Mass?**
  - (Immed F/U) Breast consult AND possible Tissue Biopsy* per surgeon recommendation

- **Simple Cyst**
  - (No F/U) Resume annual screening

Bi-Rads Results
ACR 4 or 5

- **Perform Ultrasound**
- **No Abnormality (Bi-Rads 1)**
  - (Immed F/U) Breast Consult AND Tissue biopsy OR (STF) Dx. Mamm/US q 6 mos x 1-2 years to assess stability per surgeon recomm.

- **Solid Mass?**
  - (Immed F/U) Breast consult AND possible Tissue Biopsy* per surgeon recommendation

- **Simple Cyst**
  - (No F/U) Resume annual screening

- **Complex Cyst**
  - Breast Consult AND any/all of the following per surgeon’s recommendation:
    1. STF - CBE, Mammogram, US q 6-12 mos for 1-2 years to assess stability OR
    2. (Immed F/U) Fine Needle Aspiration OR
    3. (Immed F/U) Tissue Biopsy*

- **Atypical Hyperplasia**
  - Possible Excisional Biopsy per surgeon/radiologist recommendation

- **Benign**
  - Dxmammogram/US in 6-12 mos for 1-2 years

- **Malignant**
  - Enroll in BCCCP MTA if eligible
**Diagnostic Mammogram**

- **Bi-Rads Results ACR 1, 2, or 3**
  - **Perform Ultrasound**
    - **No Abnormality (Bi-Rads 1, 2, 3)**
      - **(Immed F/U) Breast Consult AND Tissue biopsy OR (STF) Dx. Mamm/US q 6 mos x 1-2 years to assess stability per surgeon recomm.**
    - **Solid Mass?**
      - **(Immed F/U) Breast consult AND possible Tissue Biopsy* per surgeon recommendation**
    - **Simple Cyst**
      - **(No F/U) Resume annual screening**
    - **Complex Cyst**
      - **Breast Consult AND any/all of the following per surgeon's recommendation:**
        1. STF - CBE, Mammogram, US q 6-12 mos for 1-2 years to assess stability OR
        2. (Immed F/U) Fine Needle Aspiration OR
        3. (Immed F/U) Tissue Biopsy*

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**NOTE**: Surgical Consult can be ordered per clinician/client request

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**Tissue biopsy can include any of the following: Incisional, Core Needle, US Guided, Excisional or Stereotactic, (NOTE: Surgical Consults are NOT required prior to stereotactic biopsies ordered by radiologist)
CBE Result: Dominant Mass
(Coded as Abnormality/Rule Out Cancer)

IF the Mammogram AND Ultrasound Results are ANY combination of ACR 1, 2, OR 3
Refer for Follow-up

- Surgical Consult AND
- Possible Tissue Biopsy (per surgeon’s recommendation) OR
- 6 month follow-up Diagnostic Mammogram* and/or Ultrasound* along with Surgical Consult*

*BCCCP will reimburse
CBE Result: Dominant Mass (Coded as Abnormality/Rule Out Cancer)

IF the Mammogram Result is ACR 1, 2, OR 3
AND
Ultrasound Result shows SOLID mass

Refer for Follow-up
- Surgical Consult AND/OR
- Tissue Biopsy (per radiologist’s OR surgeon’s recommendation)
CBE Result: Dominant Mass  
(Coded as Abnormality/Rule Out Cancer)

IF the Mammogram Result is ACR 1, 2, OR 3  
AND  
Ultrasound Result shows SIMPLE CYST  
■ No Follow-up Required

NOTE:
■ If cyst painful may refer to surgeon to perform FNA  
■ Post FNA mammogram/US will be reimbursed to determine if cyst refilled
CBE Result: Dominant Mass  
(Coded as Abnormality/Rule Out Cancer)

IF the Mammogram Result is ACR 1, 2, OR 3 AND Ultrasound Result shows COMPLEX CYST

Refer for Follow-up
Surgical Consult AND any/all of the following per surgeon’s recommendation:
- Fine Needle Aspiration* AND/OR
- Tissue Biopsy* OR
- CBE, and/or Mammogram, and/or Ultrasound in 6 months to assess stability OR

NOTE: *BCCCP will reimburse consult post aspiration/biopsy to assess stability of cyst
BCCCP Medical Protocol
Follow-up of Abnormal CBE Results

**DOMINANT MASS**

**Diagnostic Mammogram**

- **Bi-Rads Results ACR 4 or 5**
  - Breast Consult AND Tissue Biopsy*
    - Biopsy Result
      - **Benign**
        - Dx Mammogram/US in 6-12 mos for 1-2 years
      - **Atypical Hyperplasia**
        - Possible Excisional Biopsy per surgeon/radiologist recommendation
      - **Malignant**
        - Enroll in BCCCP MTA if eligible

**NOTE:** Surgical Consults are NOT required prior to stereotactic biopsies ordered by radiologist.
Pre/post Biopsy Questions
(Contact NC for guidance)

- Abscess post biopsy
  (Will reimburse for surgeon’s f/u visits; cannot reimburse for I & D or antibiotics)

- Lymph node biopsy
  (If to r/o breast cancer, can map lymph node biopsy to BCCCP code; cannot reimburse if to r/o anything unrelated to breast cancer)

- Atypical hyperplasia –
  (Can reimburse for Excisional biopsy and 6 month f/u mammogram/surgical consult; cannot reimburse for oncology referral or chemoprevention therapy)
Follow-up of Breast Pain

- Most common breast complaint
- Etiology is unclear – most commonly occurs 1 week prior to menses and in some women on HRT
- Causes worry and anxiety about breast cancer
  (Among women with breast pain who have a normal CBE and radiologic studies, cancer will be found in about 0.5% upon f/u)
HCP should determine the cause of pain:
- Location and duration of the pain
- Unilateral or bilateral
- Patient ranked discomfort (scale 1-10)
- Whether the pain is cyclic, changes with menstrual cycle or related to HRT
- Whether the pain has altered patient’s lifestyle (interfered with exercise, hugs, sexual activity, sleep)
Common cause of pain
Fibrocystic Breast Condition

- Occurs from changes in the glandular and stromal tissues of the breast
- Changes are related to a woman’s menstrual cycle and the hormones, estrogen and progesterone
- Women with fibrocystic breasts often have bilateral cyclic breast pain or tenderness that coincides with their menstrual cycles
Most fibrocystic breast lumps are found in the upper, outer quadrant of the breasts (near the axilla, armpit, region), although these lumps can occur anywhere in the breasts.

Fibrocystic breast lumps tend to be smooth, rounded, and mobile (not attached to other breast tissue), though some fibrocystic tissue may have a thickened, irregular feel.

Fibrocystic lumps or irregularities are often tender to touch and may increase or decrease in size during the menstrual cycle.
Fibrocystic Breast Condition

- Symptoms of fibrocystic breasts include: cysts, fibrosis, lumpiness, areas of thickening, tenderness, and pain.

- Fibrocystic breasts are not risk factors for breast cancer, but it can make breast cancer more difficult to detect.

- Screening mammograms may be more difficult to perform because the breast density associated with fibrocystic breasts may eclipse breast cancer on the mammogram.

- Additional imaging, biopsy, cyst aspiration may be needed.
Fibrocystic Breast Tissue on a Mammogram

- Mammogram shows thickenings which are typical of fibrocystic disease
Breast Pain: Is a referral needed?

Ask the client the following questions:

- **Unilateral** vs. bilateral?
- Cyclic vs **non-cyclic**?
- **Constant** vs. intermittent?
- Persists **daily** for more than a couple of weeks
- Localized to **one** specific area of breast (not related to injury)
- Getting **worse** over time
- **Interferes** with daily activities

If Breast Pain meets above criteria - refer for breast consult
Follow-up of Breast Pain unrelated to cancer dx

- Inform the woman that mastalgia is very common
- Interventions to use: substituting a more supportive bra, lowering/changing estrogen dose, decreasing caffeine intake, ? Drug intervention I.e. evening primrose oil, danazol, bromocriptine, vitamin therapy I.e. Vitamin E (800u), Vitamin B6 or niacin
- Cyclic pain is more responsive than non-cyclic pain
Mammogram Results Requiring Short-term or Immediate Follow-up

Short-term Follow-up
- ACR 3: Probably Benign

Immediate Follow-up
- ACR 0: Assessment Incomplete
- ACR 4: Suspicious Abnormality
- ACR 5: Highly Suggestive of Malignancy
Mammogram Result

ACR 3: Probably Benign Finding

- Finding has < 2% risk of malignancy; not expected to change over f/u interval but radiologist wants to establish its stability

- 3 findings classified as probably benign:
  -- non-calcified mass
  -- focal asymmetry
  -- cluster of round calcifications

- Majority of findings can be managed through initial STF (6 mos) up to 2 years (monitor closely as f/u often coincides with annual screening)
Probably Benign Calcifications
Importance of close monitoring

- The odds for invasive carcinoma versus DCIS are statistically significantly higher among patients with increasing or new microcalcifications.

L image
Patient with a few heterogeneous coarse calcifications - BIRADS 3.

R image
Six month follow up showed calcifications had increased in number; DCIS was found at biopsy.
Mammogram Result:
ACR 0: Assessment Incomplete-Need Additional Imaging Evaluation

- Additional imaging evaluation may include: spot compression, magnification, special magnification views, and/or ultrasound
- Further follow-up beyond second imaging depends on final mammogram results
Mammogram Result:
ACR 4: Suspicious Abnormality

- Reserved for findings that do not have classic appearance of malignancy but have a wide probability of malignancy > than ACR 3 findings

- Follow-up recommended based on appearance/characteristics of findings

- Surgeon may choose to monitor as short-term follow-up
Breast Calcifications

- Microcalcifications are tiny bits of calcium that may show up in clusters or in patterns (like circles) and are associated with extra cell activity in breast tissue.
- Scattered microcalcifications are usually a sign of *benign* breast tissue.
- *Probably benign* calcifications have < 2% risk of breast cancer (monitored q 6 months x 1 year).
- *Suspicious* calcifications (tight clusters) can indicate early breast cancer.

Microcalcifications shown on mammogram; calcifications are present through ductal patterns.
Microcalcifications are found in ~ half of women > age 50, and 1/10 women < age 50

Benign macrocalcifications are larger and randomly spread throughout the breast. No follow-up care is usually needed.

Microcalcifications are small, appear clustered and have irregular shapes. Suspicious for cancer. Refer for biopsy.
Types of Calcifications
Mammogram Abnormality
ACR 5: Highly Suggestive of Malignancy

- High probability (≥ 95%) of being cancer

- Type of biopsy performed depends on lesion identified

- More than one biopsy may be performed and/or combined with sentinel node imaging or delayed after neoadjuvant chemotherapy
BCCCP Medical Protocol
Follow-up of DIAGNOSTIC Mammogram Results

Diagnostic Mammogram Follow-up

ACR 0 - Assessment
Incomplete - Work-Up
Required

ACR 1 - Negative
ACR 2 - Benign Finding

ACR 3 - Probably
Benign

ACR 4 - Suspicious
Abnormality
ACR 5 - Highly Suggestive
of Malignancy

Diagnostic work-up includes any or all of the following:
1. Comparison to Prior Films
2. Diagnostic Mammogram
3. Ultrasound as indicated

Routine Screening: Annual CBE/Mammogram/ Breast
Awareness
EXCEPTION: IF CBE Abnormal - additional work-up
required to include any or all of the following: Ultrasound, Breast Consult, Tissue Biopsy

Diagnostic Mammogram at 6 months then
every 6-12 months x 1-2 years
If return visit uncertain or client very anxious
consider consult and possible biopsy

Benign
Dx Mammogram/US in
6-12 mos for 1-2 years

Atypical Hyperplasia

Possible Excisional Biopsy
per surgeon/ radiologist
recommendation

Malignant
Enroll in BCCCP MTA
if eligible

Breast consult
Referral for Tissue Biopsy**
Case Study # 1

- CBE Result: Probably Benign
- Screening Mammogram Result – ACR 0
- Diagnostic Mammogram Result – ACR 0
- Ultrasound confirms complex cyst.

Next steps?
**Diagnostic Mammogram**

**BI-Rads Results** ACR 1, 2, or 3

### No Abnormality (Bi-Rads 1, 2, 3)

### Solid Mass?
- **(Immed F/U)** Breast Consult AND possible Tissue Biopsy* per surgeon recommendation

### Simple Cyst
- **(No F/U)** Resume annual screening

### Complex Cyst
- Breast Consult AND any/all of the following per surgeon’s recommendation:
  1. STF - CBE, Mammogram, US q 6-12 mos for 1-2 years to assess stability OR
  2. (Immed F/U) Fine Needle Aspiration OR
  3. (Immed F/U) Tissue Biopsy*

**NOTE: Surgical Consult can be ordered per clinician/client request**

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**Tissue biopsy can include any of the following: Incisional, Core Needle, US Guided, Excisional or Stereotactic,**

**(NOTE: Surgical Consults are NOT required prior to stereotactic biopsies ordered by radiologist)**

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**Based on NCCN Breast Cancer Screening and Diagnosis Clinical Practice Guidelines v.1.2010**

**Revised June 2010**
Case Study # 2

- CBE – not performed
- Mammogram performed at Screening Fair; Result: ACR 0
- Referred to BCCCP
  Diagnostic Mammogram Result:
  - L breast – ACR 2 - simple or complicated cysts without suspicious masses
  - R breast  ACR 4 - solid nodule 10 o clock appears suspicious

Next Steps
**Tissue biopsy can include any of the following: Incisional, Core Needle, US Guided, Excisional or Stereotactic,**

**(NOTE: Surgical Consults are NOT required prior to stereotactic biopsies ordered by radiologist)**
Oncology Nursing:
My Career, my Choice, my Passion

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