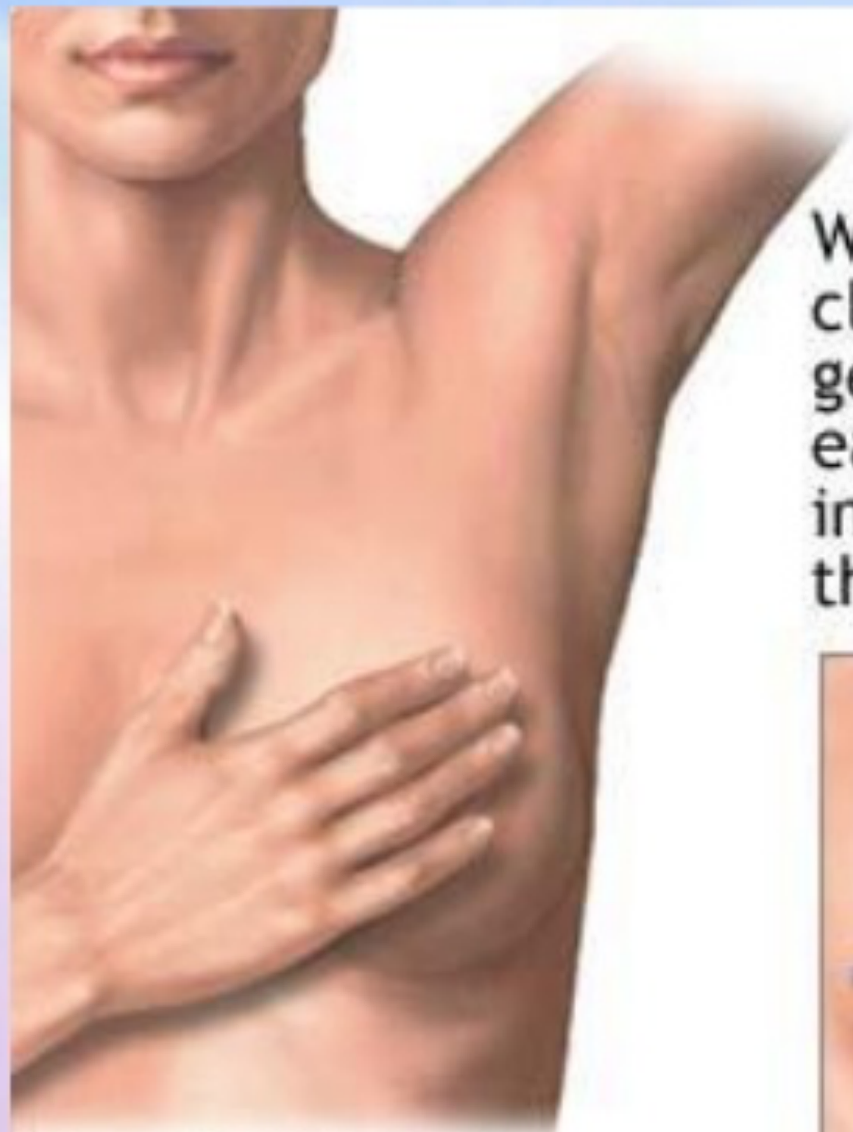
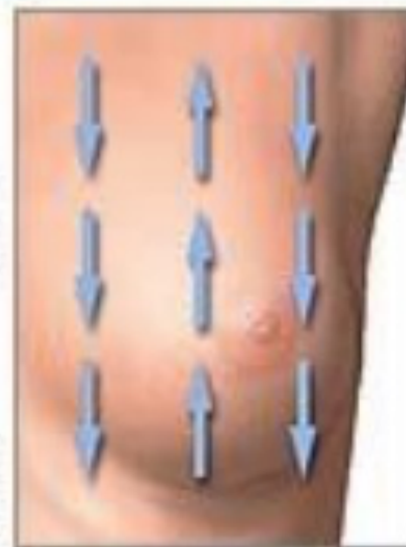
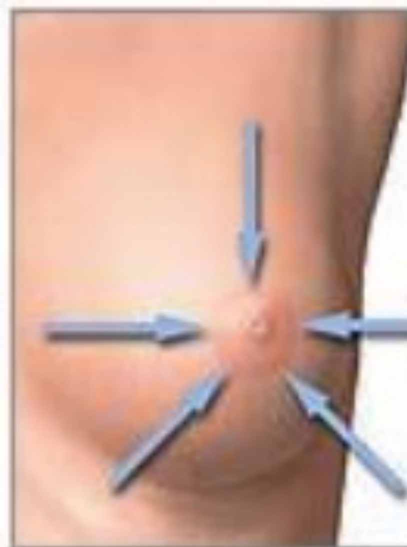
BREAST DISORDER

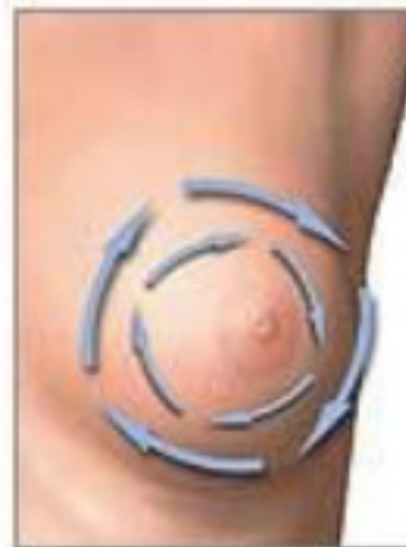
PREPARED BY
Dr.JUSTIN JEYA AMUTHA



With fingertips close together, gently probe each breast in one of these three patterns







Breast self-exam:
Manual inspection
(standing)

A.D.A.M.

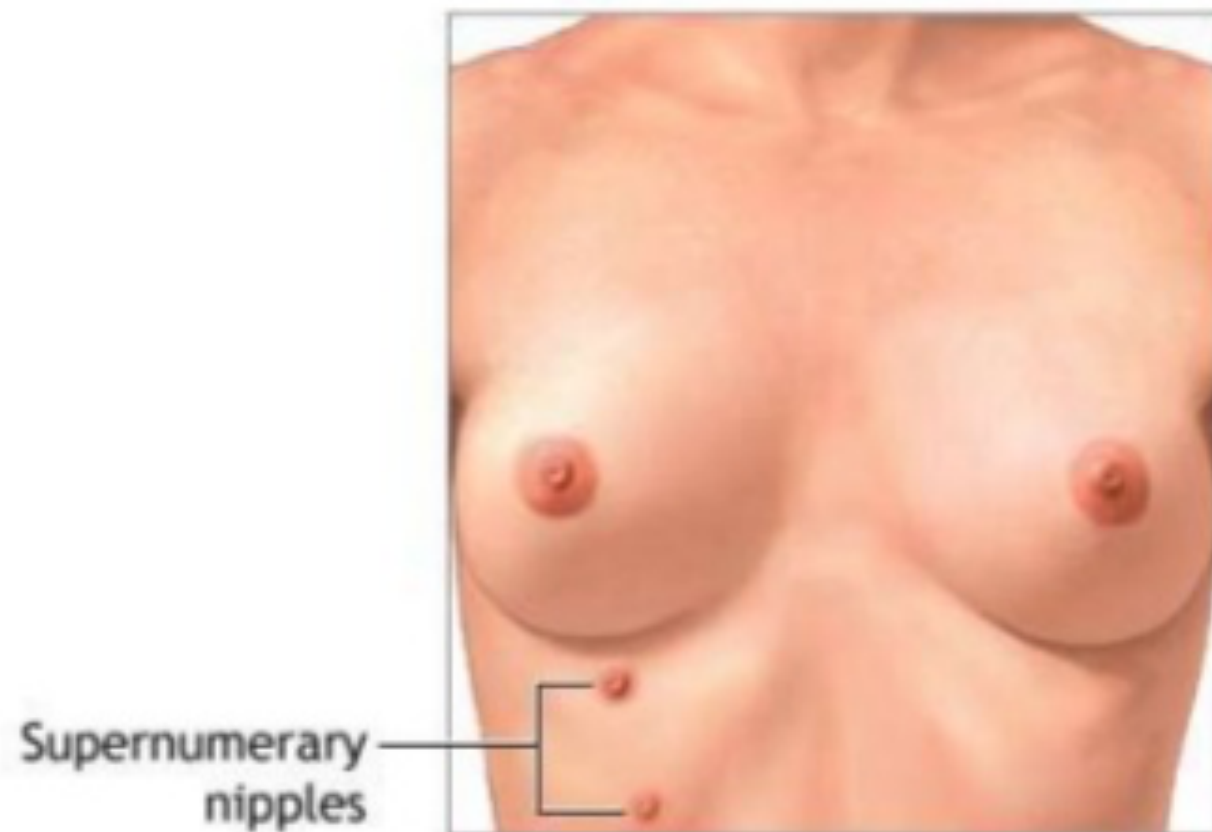
POLYMASTIA

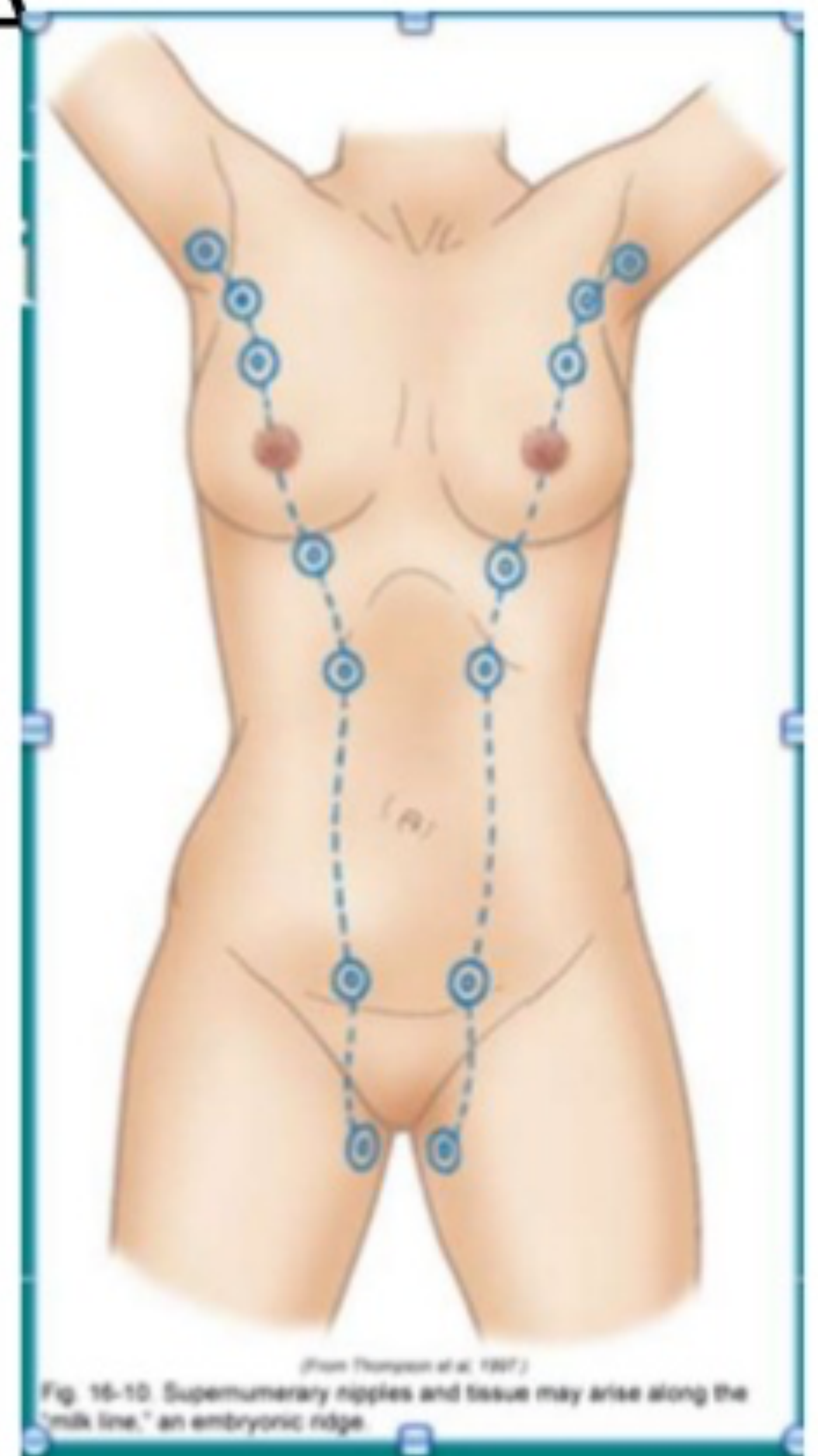
THE PRESENCE OF SUPERNUMERARY BREASTS.

OCCURRENCE AVERAGES FROM 0.22% - 6%

POLYTHELIA

THE PRESENCE OF SUPERNUMERARY NIPPLES.

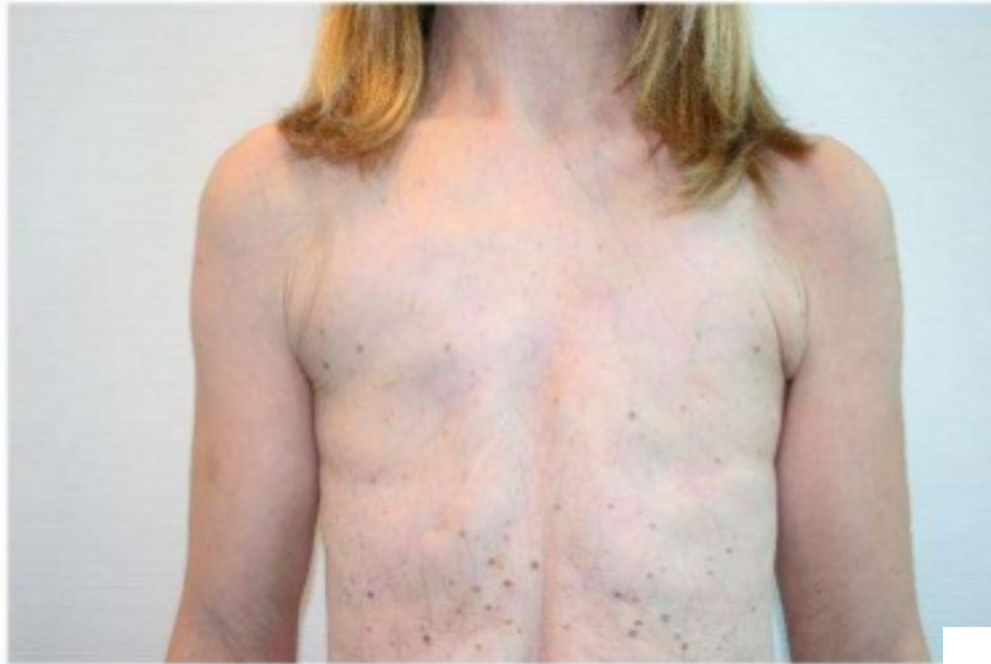




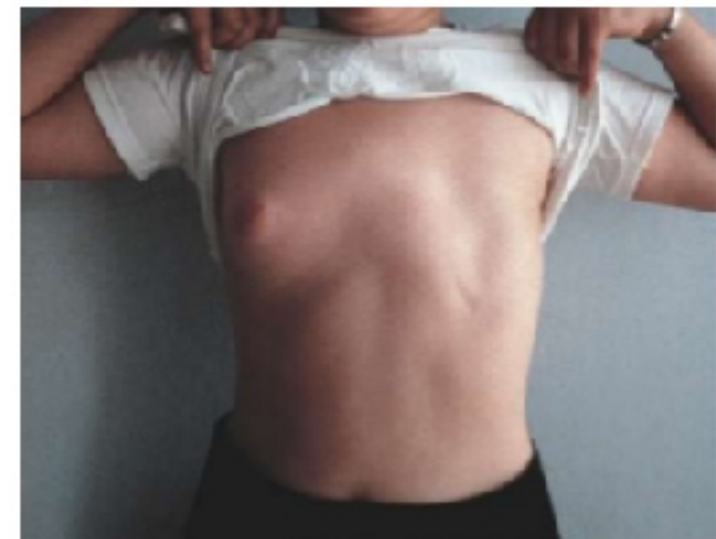
(From Thompson et al. 1997.)

Fig. 16-10. Supernumerary nipples and tissue may arise along the "milk line," an embryonic ridge.

BILATERAL AMASTIA



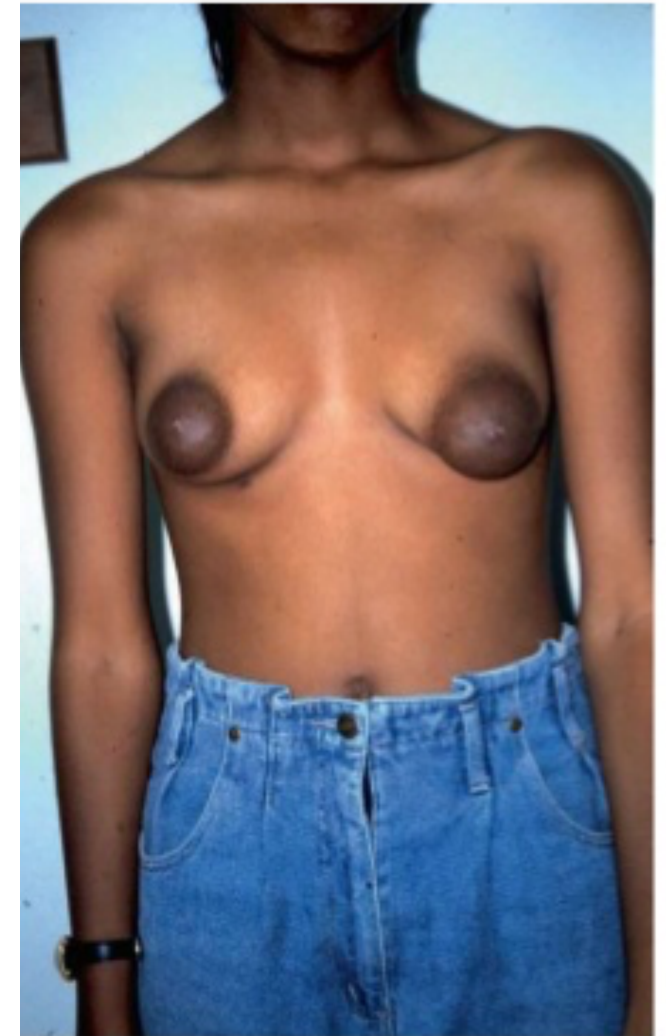
UNILATERAL AMASTIA



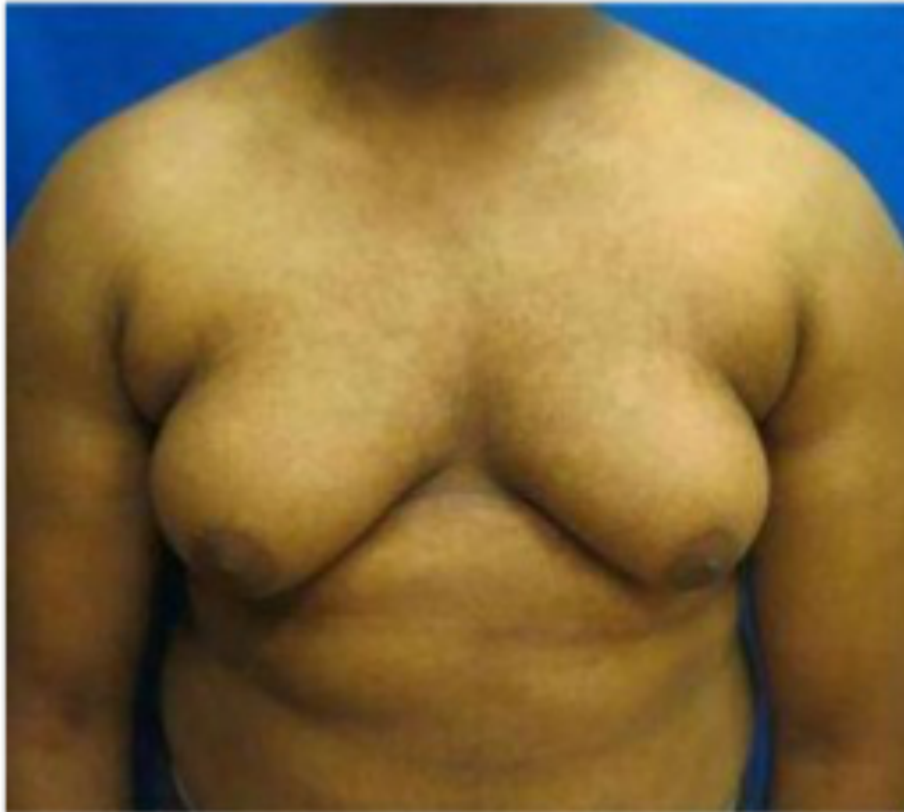
TUBULAR/ TUBEROUS BREAST

HERNIATION OF BREAST TISSUE INTO THE AREOLA.

ALSO KNOWN AS THE SNOOPY – NOSED SYNDROME.



GYNECOMASTIA

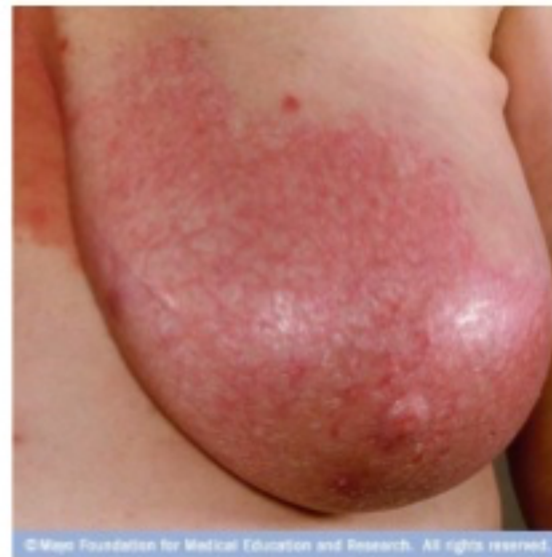


The most COMMON FORM OF BREAST HYPERPLASIA.

Mastalgia: Mastitis

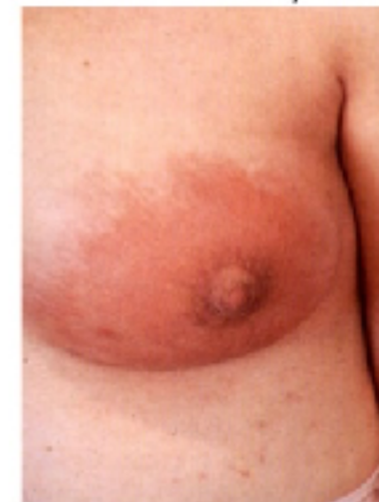
- Presentation
  - Usually seen in breastfeeding mothers
  - Unilateral, swollen, wedge-shaped area of breast
  - Pain, redness, induration (hardening)
  - Systemic symptoms (high fever, malaise, chills)

- Treatment
  - Rest, fluids
  - **Dicloxicllin** 500mg QID x 10-14d
  - Continue frequent breast feeding



Mastalgia: Inflammatory Breast Cancer

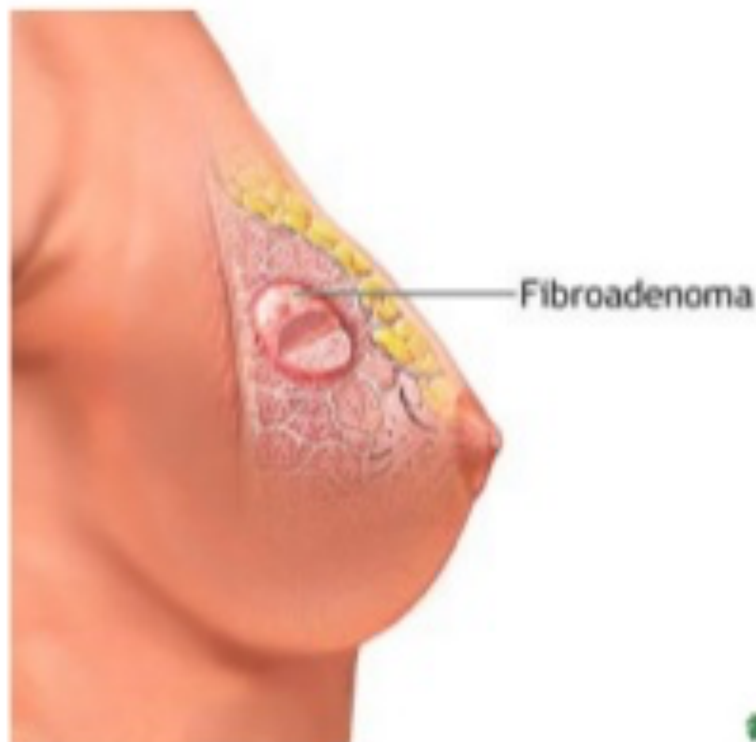
- Inflammatory breast cancer



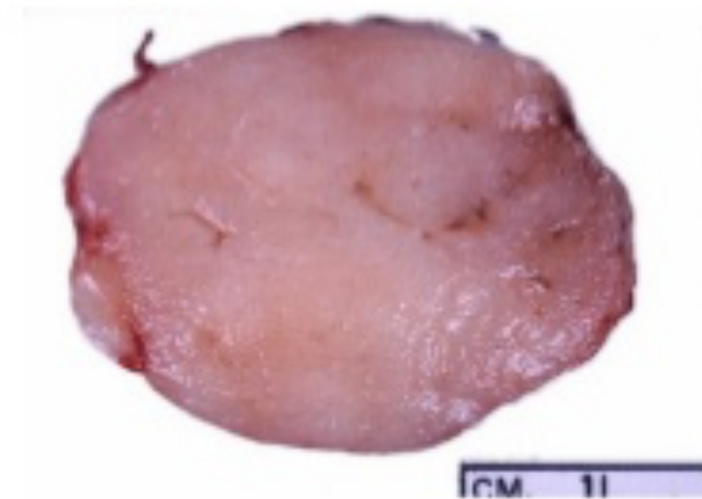
- Peau d'orange-dimpling of involved skin due to retraction caused by lymphatic involvement and obstruction
- Associated erythema
- Cellulitis may mimic inflammatory carcinoma

Breast Mass: Fibroadenoma

- Fibroadenoma
  - Solitary, firm, rubbery, mobile mass
  - Women < 30 yrs
  - Slow growing (? hormonally mediated)



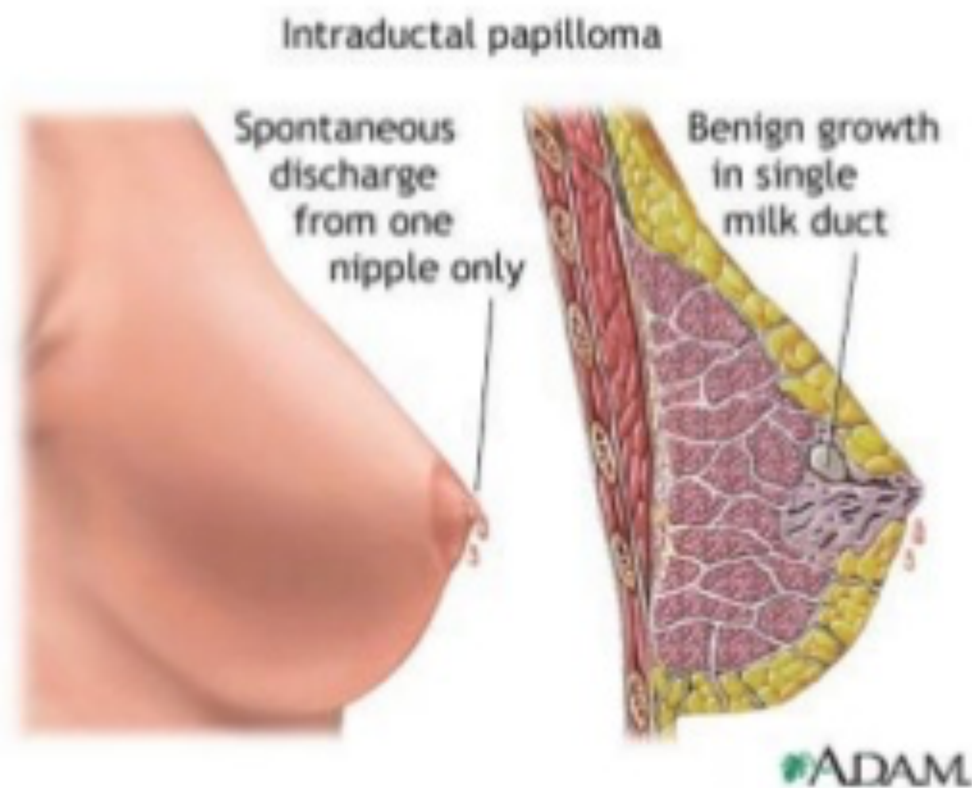
ADAM



Fibroadenoma gross specimen
- Firm, tan, lobulated
- Well circumscribed mass
- Variable size

Breast Mass: Intraductal Papilloma

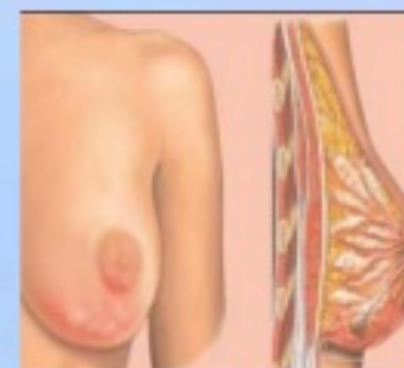
- Intraductal papilloma
  - Unilateral bloody nipple discharge
  - Sub-areolar intraductal mass



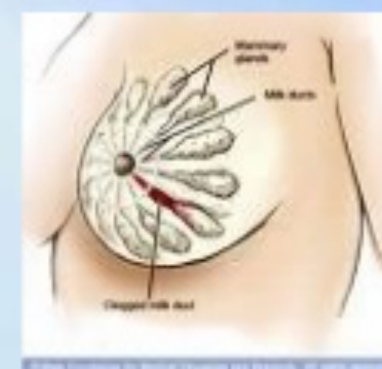
Intraductal papillary neoplasm with fibrovascular cores lined by benign ductal and myoepithelial cells

Breast Mass

- **Galactocele**
  - Milk filled cyst from over distension of a lactiferous duct.
  - Presents as a firm non tender mass in the breast,
  - Commonly in upper quadrants beyond areola.
  - Diagnostic aspiration is often curative.



- **Duct ectasia:**
  - Generally found in older women.
  - Dilatation of the subareolar ducts can occur.
  - A palpable retroareolar mass, nipple discharge, or retraction can be present.
  - Tx involves excision of area



Evaluation: History

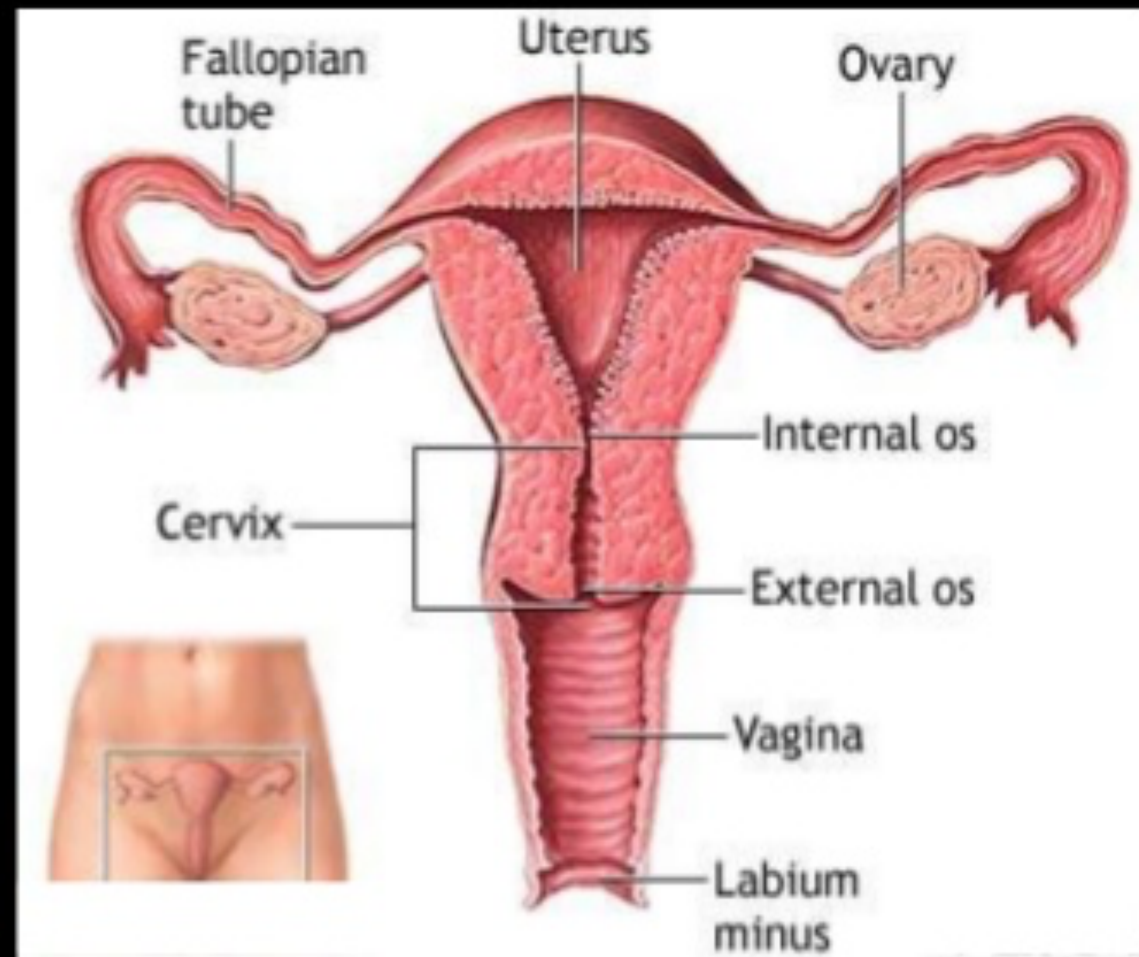
- History:
  - Change in general appearance of breast (size, symmetry)
  - New or persistent skin changes
  - New nipple inversion
  - Breast pain (cyclic vs. noncyclic, duration, location in breast)
  - Breast mass (how it was discovered, duration, change in size, location)
  - Relationship of mass to menstrual cycles
  - Nipple discharge (unilateral vs. bilateral, color)
  - Medications (e.g. hormones)
  - Risk factors for breast cancer

Evaluation: Physical Exam

- Clinical Breast Exam:
  - Inspect (relaxed, arms raised, hands on hips)
    - Breast symmetry
    - Skin changes (dimpling, retraction, edema, ulceration)
    - Nipples (symmetry, inversion/retraction, discharge)
  - Palapation (breasts, axillae, entire chest wall)
    - Pain
    - Masses
    - Regional lymph nodes (Axillary and Supraclavicular)
  - Documentation
    - "Clock" system
    - Location of concern and abnormality
    - Distance from areola
    - Size of mass

What is PID ?

- An infection of
  - vagina (Colpitis)
  - Cevix (Endocervicitis)
  - Uterus (Endometritis)
  - Fallopian tubes (Salpingitis)
  - Ovaries (oophoritis),
  - Pelvic peritonitis
  - Tubo-ovarian abscess



CLASSIFICATION OF GENITAL TRACT INFECTIONS

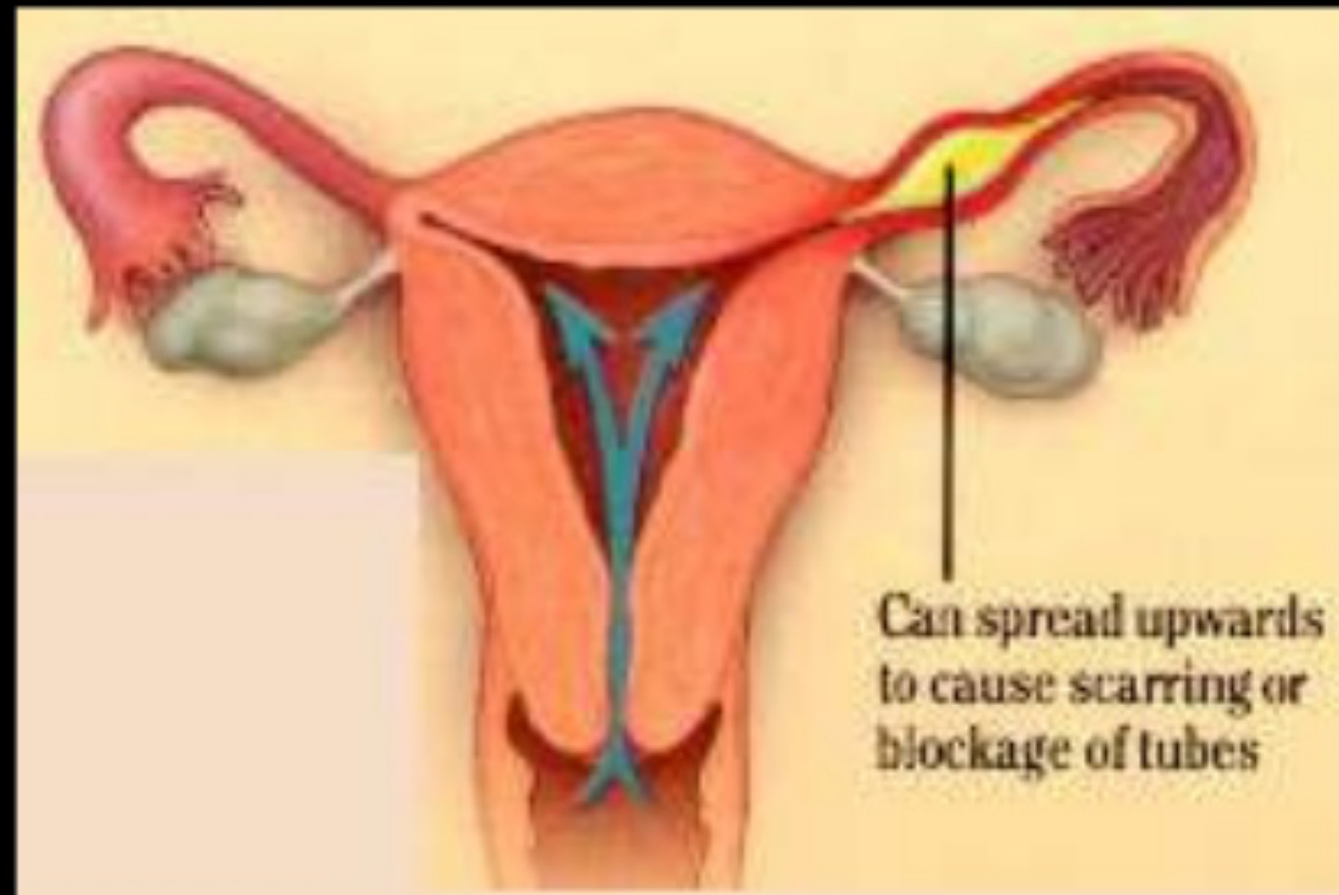
A. According to etiology:

- **Specific** **(**caused by N.gonorrhoeae and TB**)**
- **Nonspecific** **(**caused by Staphyloccocus, Streptococus, E.Coli, Proteus, Chlamydia trachomatis, Mycoplasma hominis, viruses, etc.**)**

B. According to clinical picture:

- **Acute**
- **Chronic**

How do women get PID?



Bacteria move upward from vagina or cervix into reproductive organs.

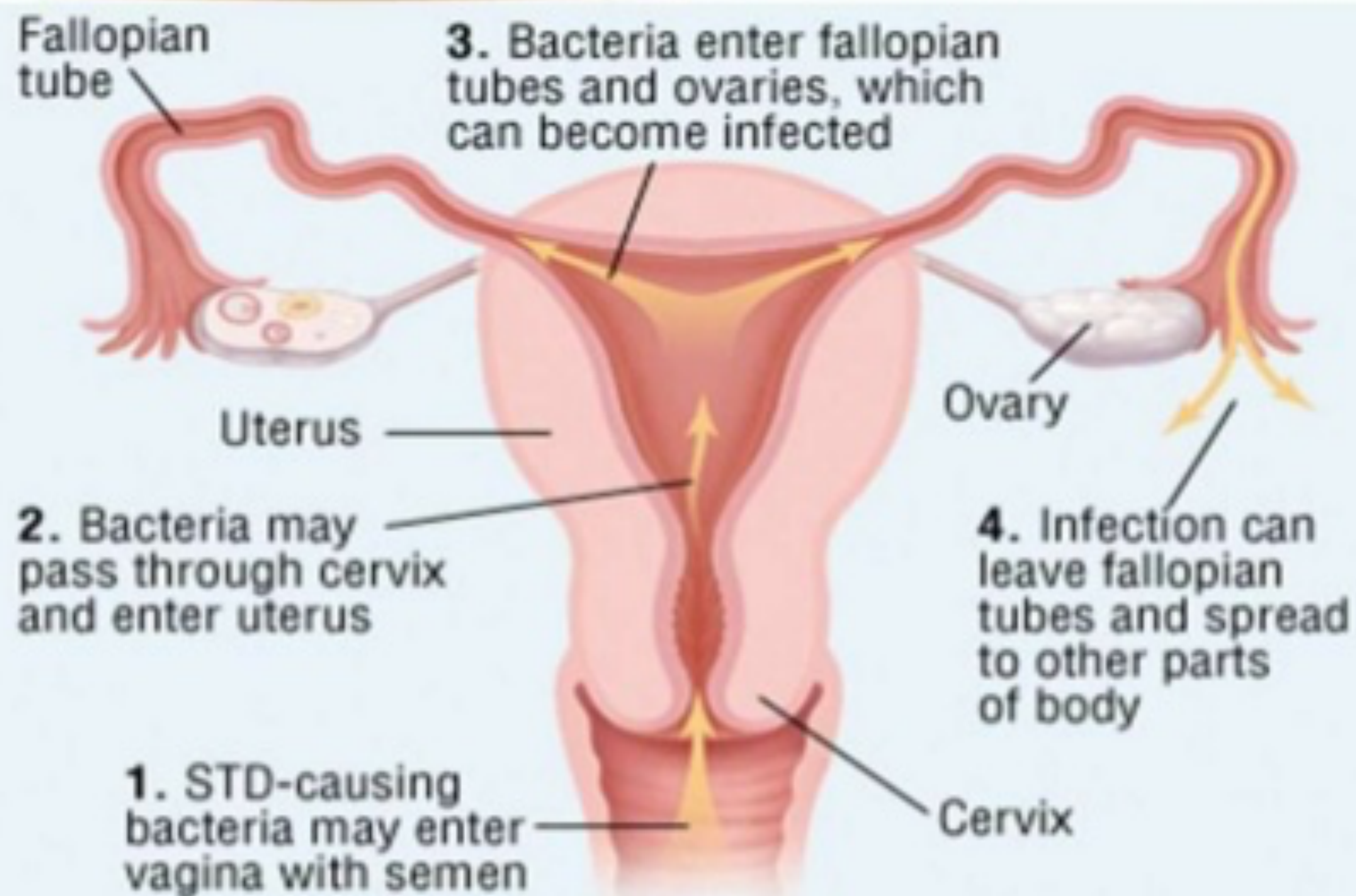
Risk factors

- Adolescence
- History of PID
- Gonorrhea or chlamydia, or a history of gonorrhea or chlamydia
- Male partners with gonorrhea or chlamydia
- Multiple partners
- Current douching
- Insertion of IUD
- Bacterial vaginosis
- Oral contraceptive use (in some cases)
- Demographics (socioeconomic status)

Symptoms

- lower abdomen pain, may worse when move
- pain during or after sex
- bleeding between periods or after sex
- lower back pain
- sense of pressure or swelling in the lower abdomen
- fever (often with chills)
- feeling tired or unwell
- abnormal vaginal discharge
- nausea, vomiting and dizziness
- leg pain
- increased period pain
- increased pain at ovulation
- dysuria, frequently urination

PATHOPHYSIOLOGY



Investigation

- Laboratory may be entirely normal
- An elevated leukocyte count does not distinguish PID from other diagnoses
- Cervical cultures for gonorrhea or Chlamydia require 3-7 days for results
- HIV and syphilis testing should be recommended
- Pelvic ultrasonography can detect pelvic abscesses
- Laparoscopy when the diagnosis is unclear or when the patient fails to improve.

Oral Treatment

- ***Regimen A***

Levofloxacin 500 mg once daily for 14 days **OR**	+	**Metronidazole** 500 mg twice a day for 14 days
Ofloxacin 400 mg twice daily for 14 days		

•*Regimen B*

1. **Ceftriaxone** 250 mg IM in a single dose
   + **Doxycycline** 100 mg orally twice a day for 14 days

WITH OR WITHOUT
   Metronidazole 500 mg orally twice a day for 14 days

2. **Cefoxitin** 2 g IM single dose and **Probenecid**, 1 g
   orally administered concurrently single dose
   + **Doxycycline** 100 mg orally twice a day for 14 days

WITH OR WITHOUT
   Metronidazole 500 mg orally twice a day for 14 days

3. Third-generation **cephalosporin**
   + **Doxycycline** 100 mg orally twice a day for 14 day

WITH OR WITHOUT
   Metronidazole 500 mg orally twice a day for 14 days

OTHER MANAGEMENT

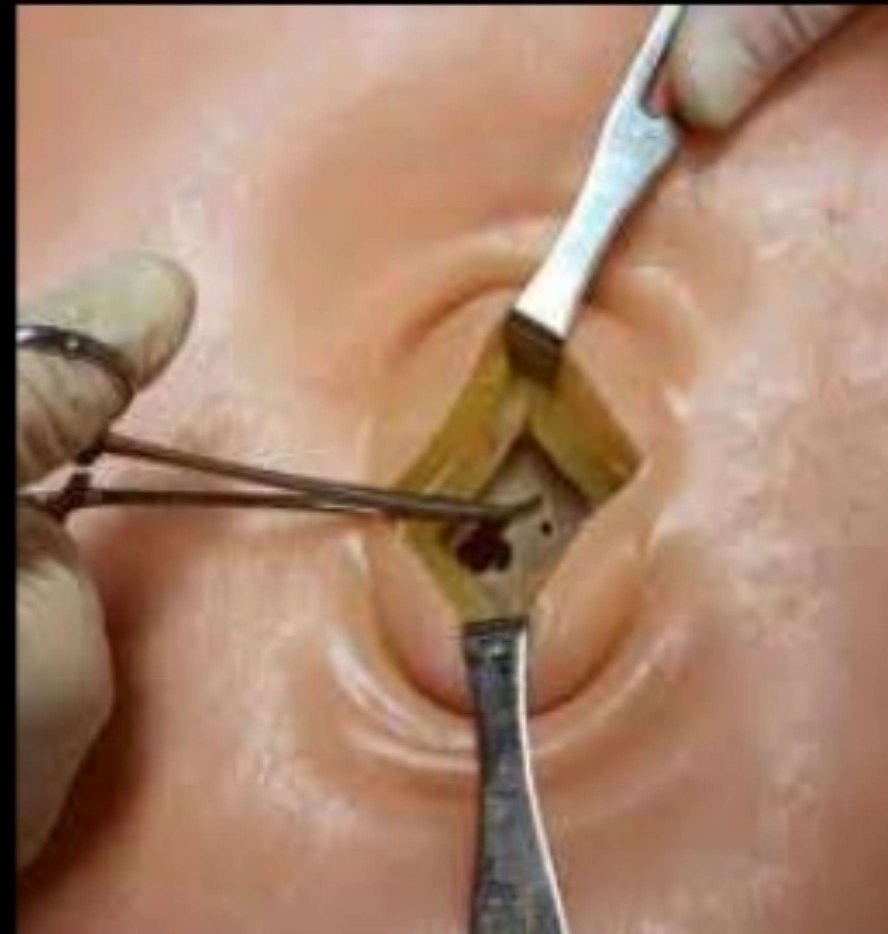
- Application of heat to lower abdomen.
- Sitz bath, improve circulation and decrease pain.
- Bed rest

Surgery

- Rupture abscess invade to peritonium
- Failure medical treatment 48-72 hr
- Abscess does not go away after 2-3 week with persistent abdominal pain

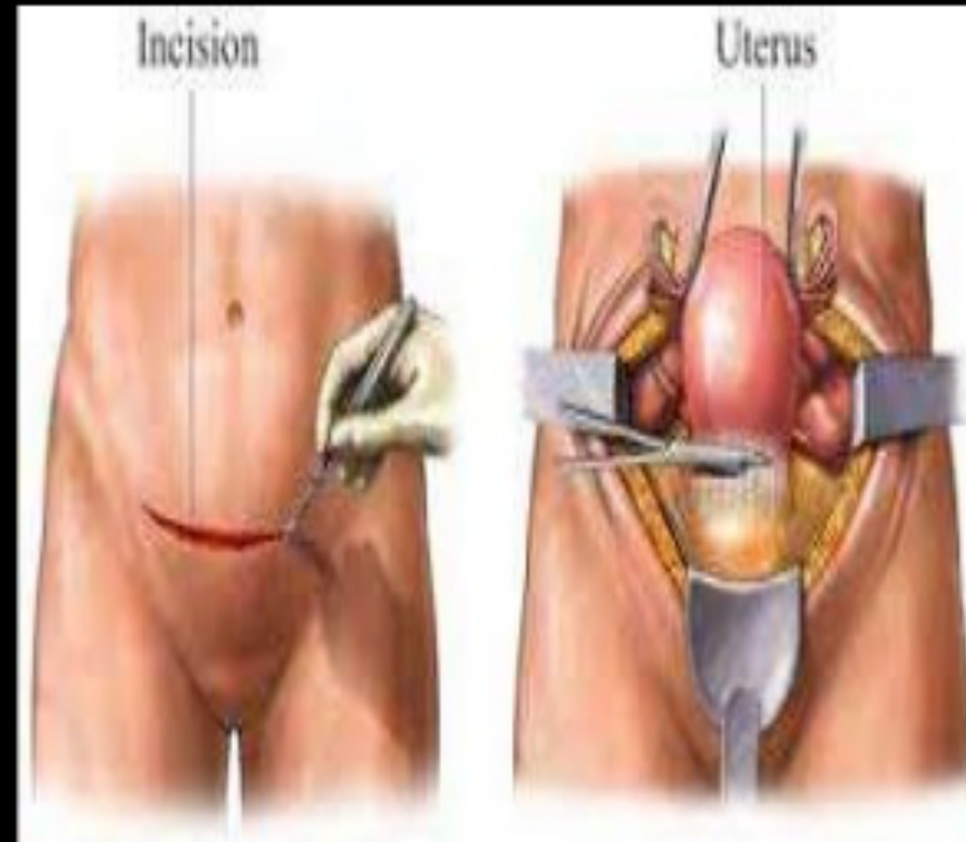
SURGICAL MANAGEMENT

- Surgery is indicated for abscess that fail to resolve with IV antibiotics.
  - Laparatomy



Cont…

- In extreme case of infection and severe pain
  - Hysterectomy



Patient Counseling and Education

- Nature of the infection
- Transmission
- Risk reduction
  - Assess patient's behavior-change potential
  - Discuss prevention strategies
  - Develop individualized risk-reduction plans