Lobular Carcinoma More Alarming Than Thought

BY BRUCE JANCIN
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SAN ANTONIO — Lobular carcinoma in situ is not always the indolent disease it has long been considered to be, Dr. Bruno Cutuli said at a breast cancer symposium sponsored by the Cancer Therapy and Research Center.

Nor is lobular carcinoma in situ (LCIS) simply a risk factor for invasive breast cancer, as has been the traditional view. In fact, some LCIS lesions are precursors of invasive breast cancer—and as such, may warrant more aggressive local therapy, such as whole-breast radiotherapy following surgical excision, said Dr. Cutuli, a radiation oncologist at the Courlancy Polyclinic, Reims, France.

LCIS accounts for 1%-2% of all breast cancers and 15%-20% of all in situ carcinomas. The age-specific incidence reportedly jumped 2.6-fold between 1980 and 2001, for two likely reasons.

One is increased mammographic screening. Although LCIS isn't usually visible on mammography, it is often discovered on biopsy of a cyst, fibroadenoma, or other mammographically detected abnormality.

The other factor involved in the steep rise in LCIS since 1980 was probably the widespread use of hormone therapy, according to Dr. Cutuli.

Dr. Cutuli presented a retrospective study of 330 cases of pure LCIS in 325 patients treated during 1985-2000 at 12 French cancer centers. The patients' median age was 49 years, and 35% were postmenopausal. A first- or second-degree family history of breast cancer was present in 29%. In 24% there was prior benign breast disease.

Local recurrence rates following various therapies were illuminating. Lumpectomy was undergone by 77%; these patients had a 19.2% ipsilateral local recurrence rate during a median follow-up of 8.2 years. Of particular concern was that 60% of these local recurrences were invasive.

Antidepressants Ease Monthly Dysphoria

SAN FRANCISCO — Women with premenstrual dysphoric disorder usually respond rapidly to the first treatment cycle of an antidepressant, allowing intermittent dosing that follows the menstrual cycle, Dr. Andrea J. Singer said at Perspectives in Women's Health sponsored by Ob.Gyn. News.

Three selective serotonin reuptake inhibitors (SSRIs) are approved for the treatment of premenstrual dysphoric disorder (PMDD)—fluoxetine, sertraline, and paroxetine. "You don't necessarily have to have people on these long term to see a benefit," said Dr. Singer, director of women's primary care at Georgetown University Medical Center, Washington.

Dr. Singer is on the speakers' bureau of Pfizer Inc., which makes sertraline. Ob.Gyn. News is published by the International Medical News Group, a division of Elsevier.

PMDD causes severe premenstrual symptoms that result in significant impairment of normal function, usually during the last 6-7 days of the menstrual cycle. American women with PMDD experience the symptoms on average for 8 years during their reproductive lives, she said.

Because the disorder is intermittent and treatment with an SSRI brings rapid onset of improvement, intermittent therapy is sufficient, which lowers medication costs and limits side effects, compared with treatment of overt depression. In addition, low doses typically are effective for PMDD.

Diagnosis of PMDD requires the exclusion of underlying overt depression and the presence of at least five symptoms, including at least one of four core symptoms: anger/irritability; depressed mood; moodiness; and anxiety/edginess/nervousness. Other symptoms include fatigue or lethargy, decreased interest in usual activities, insomnia or hypersomnia, difficulty concentrating, food cravings or appetite changes, feeling overwhelmed, headache, breast tenderness, bloating, and joint or muscle pain.

For women with PMDD on oral contraceptives, a pill containing drospirenone and ethinylestradiol improved PMDD symptoms in several studies. Other data suggest shortening the hormone-free interval during oral contraceptive regimens to 3-4 days can improve some symptoms.

—Sherry Boschert