Second Opinion, Please

Benign Breast Swelling

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80 Torridon Road, Catford, London SE6

22 January 1971

Dear Ivo,

Mrs. X.Y., aged 29, is married with three children. Some four months ago she came to see me complaining of tenderness in both breasts for four to five days prior to her periods. The tenderness, which amounted to actual pain on the first day of her period and the day before, rapidly cleared by the third and fourth days. At first she had thought little of it having heard of other women who had similar problems, but at the time she sought my advice she had discovered a lump in her right breast.

On examination, I could not define the swelling she described, but agreed that both breasts were "lumpy", the right being somewhat larger than the left. There were no glands in the axillae and a chest x-ray was normal.

On further questioning she told me she had had premenstrual headaches as a teenager and some dysmenorrhoea during the early months of her marriage.

I decided she was probably suffering from premenstrual syndrome and prescribed bendrofluazide as a diuretic to be taken 5 mg daily for a week prior to her period.

I saw her the following month, when she told me there had been considerable improvement. I suggested continuing with the diuretic and she agreed. She did not return as requested the following month but appeared in surgery a month ago with a return of her symptoms. Once again examination confirmed my original finding, the right breast remaining somewhat larger than the left. I again prescribed a diuretic, but on this occasion she has had no benefit. I should be glad of your opinion on the further management of this lady.

Lewisham Hospital, London S.E.13

5 February 1971

Dear Roger,

Thank you for your letter about this lady, who complains of painful breasts in the two or three days before her period. Her symptoms were at first relieved by the bendrofluazide you gave her, but recently she has had severe discomfort—even taking this as you prescribed.

On examination there is coarse nodularity of the whole of both breast-discs. Her period is due in a few days' time, and the breasts are diffusely tender, with particular tenderness in some of the larger nodules in the right breast. Like you, I can feel no abnormal axillary or cervical glands.

I am sure you will agree that we are not worried about

a tumour in this lady's case. I have made a point of being seen to examine her breasts very carefully, and of reassuring her most strongly that there is no question of her having a cancer (although I do not think this particular lady is worried on this point). I have explained to her briefly that her problems are due to an ill-understood hormonal upset, which is so common as to be regarded as physiological. I have told her that, even without treatment, it is extremely likely that her symptoms would not last very long, and that most women of her age group presenting with this pain would only have it over the course of a few menstrual cycles.

I would certainly persist with the diuretic, and I have suggested that she might take a mild pain-killer as well, should she need it. Some women are helped by wearing an unusually firm bra', although some find the pressure of this intolerable. I find that most women are helped by wearing a comfortable bra' in bed to support the breasts while they sleep.

I would do no more at this stage. I am reluctant to use a hormone preparation. I have occasionally given norethisterone, starting on the fifteenth day of the cycle for ten days, with success; but I would only do this for a particularly troublesome case and only for a short time. I am certain it would be wrong to excise the more tender nodules in the hope of relieving the source of the pain—I am quite sure that other areas would become painful.

I would very much like to see her again in two weeks from now, when her period will be over. I think it is helpful to see the breasts at their two extremes of activity—premenstrually and postmenstrually. In a worrying case, it is reassuring to see a painful nodular area become much smaller and much less tender after the menses.

Lewisham Hospital, London S.E.13

26 February 1971

Dear Roger,

When I saw this lady here again today—a fortnight after her last period—there was quite definitely less tenderness in the breasts, and some reduction in nodularity—enough for me to feel that the diagnosis of benign mammary dysplasia was confirmed.

I have no suggestions to make other than those in my last letter. I have not arranged to see her again, but please let me know if you like me to do so.

80 Torridon Road, Catford, London S.E.6

7 December 1971

Dear Ivo,

Following your suggestions for firmer support of the breast and reassurance, our patient, Mrs. X. Y. did well and was able to stop taking bendrofluazide after some three months. The following month she came to see me to discuss contraception. I felt she had done well and, albeit a little reluctantly, I started her on a low-oestrogen contraceptive.

Catford, London SE 6

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Lewisham Hospital, London S.E.13

IVO SMITH, M.CHIR., F.R.C.S., Consultant Surgeon

Now, after six months on the "pill", she has come to see me with a definite and this time discrete swelling in the right breast. You will recall this was the larger of the two breasts when you last saw her.

There is a small gland in the axilla and the rest of the breast, including the left breast, remains nodular.

I am sorry to trouble you about this lady again but I should be glad of your opinion on this much more definite swelling which is now present.

Lewisham Hospital, London S.E.13

17 December 1971

Dear Roger,

I remember Mrs. X. Y. very well. As you say, she now has a more discrete swelling in the right breast, in addition to the generalized nodularity which she had before. I agree that there is a small, soft, mobile gland in the right axilla.

I always advise women whom I see with signs and symptoms of benign mammary dysplasia to avoid the contraceptive pill, because I believe that some breasts become more active on it. I think that, almost certainly, what we are seeing in this lady's case is a "flare-up" of her benign dysplasia from taking the "pill"; and I think that the firmer, larger nodule in the right breast is a group of cysts, or possibly a more fibrotic area, associated with this benign process.

I am sure that she should now be taken off the "pill" and should be re-examined in a month's time. I have taken the liberty of telling her to stop taking the "pill" as from today, and have made an appointment to see her again four weeks from now.

I have suggested that she make an appointment to see you soon to discuss alternative contraceptive measures.

Lewisham Hospital, London S.E.13

21 January 1972

Dear Roger,

When I saw this lady again today she had been off the contraceptive pill for a month. There has certainly been a reduction in the generalized nodularity in the breast-discs; but I am a little worried because the more discrete mass in the right breast, which you pointed out, has changed very little since I saw her last.

I still feel that this lump is likely to be part of the benign process, but that we must now have a histological diagnosis. I have therefore arranged for her to come into hospital for biopsy excision next Wednesday.

Lewisham Hospital, London S.E.13

11 February 1972

Dear Roger,

I excised Mrs. X. Y.'s right breast lump last Wednesday. You will be glad to hear that it was benign. The histological report reads as follows:

"The cysts are lined by regular cuboidal to columnar epithelium, which shows little evidence of papillomatosis. Surrounding tissue is of the coarse collagenous type. Sections taken from adjacent breast tissue show some intraduct epitheliosis with sparse lymphocytic infiltration of the stroma as well as microcyst formation, with apocrine metaplasia of the epithelium.

The appearances are characteristic of cystic mammary dysplasia. There is no evidence of malignancy."

When I saw her again today the wound was soundly healed, and I have removed her sutures. I have discharged her from further follow-up but please do not hesitate to let me know should you wish me to see her again.

Any Questions?

We publish below a selection of questions and answers of general interest

Treatment of Plantar Warts in Schoolchildren

What is the treatment for plantar warts in schoolchildren, and what precautions should be taken in schools to prevent spread of the condition?

Plantar warts are spread by barefoot activities in schools, the warty pupils presumably leaving the virus for others to pick up. The incidence among schoolchildren was found¹ to be just above 2%. While all barefoot activities are suspect it is probable that swimming baths are the chief source of infection. However, there seems to be little convincing evidence that plantar warts are commoner or more troublesome among the users of swimming pools where no inspection for the presence of plantar warts is carried out, than in those pools where infected individuals are excluded. The harm caused by excluding young children for weeks from communal swimming pools without at the time making available effective treatment is probably greater than any damage they might do by adding to the already present but undetected reservoir of infection.

Ideally it is desirable that all bearers of plantar warts should be dissuaded from going barefoot in public places, but this ideal is not always easy to obtain. An encouraging experiment was reported recently to the British Association of Dermatology showing that bathers who wore light plastic socks ("Plastsoks") were protected. Footwear itself can be a source

of infection so that it is most undesirable for shoes to be shared.

The viruses of simple and mosaic warts are apparently serologically identical² and most children rapidly acquire immunity to plantar warts and get rid of them with or without the many "treatments" which are available. Certainly there seem to be as many opinions as dermatologists about the best way of treating plantar warts. Two facts are generally agreed: (1) infections have a definite but variable life span; (2) warts that cure themselves spontaneously disappear without trace. Thus whatever treatment is adopted time is an ally and any treatment that can leave a scar behind is undesirable. This excludes irradiation and excision. A single very painful wart may be treated best by curetting it with a surgical spoon under local anaesthesia, whereas the multiple but relatively painless mosaic warts call for prolonged treatment by soaking the sole of the foot in a 5% aqueous solution of formaldehyde for 10 minutes every night. Most cases lie between these extremes.

Another method is to apply pieces of 30% salicylic acid plaster to each wart cut to the right size, and to hold them in position with an adequate covering—usually three turns of Elastoplast—so that they will remain in position during a week's usage of the foot. The dressing is renewed weekly and any macerated tissue scraped away with a scalpel blade. Possible complications include allergy to Elastoplast and aggravation of tinea pedis. The former may be overcome by applying an inert inner covering such as a layer of zinc gelatine