Ductal Carcinoma In-Situ: An Editorial

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Ductal carcinoma in-situ (DCIS) is an increasingly common pre-invasive form of breast-cancer. 27% of all new breast cancer diagnoses in 2008 in the United States were DCIS as opposed to less that 1% before the introduction of national mammographic screening programmes [1].

It is probably the pre-cursor of most invasive breast-cancer but not all DCIS will progress to this stage. So the challenge in the modern treatment of DCIS is to avoid over-treatment.

Historically, DCIS presented incidentally or with a breast mass or nipple discharge. Post introduction of screening it now more commonly presents as asymptomatic calcifications seen on mammography. We know that this latter group have lower rates of local-recurrence after treatment [2,3] and so a proportion of these cases may be less clinically relevant [4]. The question of over-treatment in screening cases has been brought into sharp focus recently by a significant analysis published in the Lancet [5].

Integral to the successful management of DCIS, is surgery to remove the disease with clear margins [6] (this may involve breast conservation or mastectomy with or without reconstructive techniques). Breast radiotherapy and hormonal treatments are also given as adjuvants where appropriate but can these be safely omitted in certain cases?

Treated DCIS has an excellent overall prognosis and so differences in survival have been difficult to demonstrate even in large trials. Differences in local-recurrence rates have been used as a surrogate marker for survival. Radiotherapy was shown to reduce local recurrence in early breast-cancer in 1995 [7] and to be indirectly associated with improved survival in 2005, in that one death was prevented for every four local-recurrences avoided [8]. A direct improvement in overall survival in early breast-cancer attributable to radiotherapy of around one sixth has since been demonstrated [9].

An analysis of long term data on patients treated for DCIS from the NSABP B-17 and NSABP B-24 trials [10] showed that at 15 years, the radiotherapy treated patients had significantly fewer local-recurrences and that this effect increased over time. Of those that did recur 54% were invasive, and for these patients overall survival was lower (HR of death = 1.75, 95% CI = 1.45 to 2.96, P<0.001). The question of over-treatment in screening cases has been brought into sharp focus recently by a significant analysis published in the Lancet [5].

An analysis of the major DCIS trials from the nineties showed a 1% before the introduction of national mammographic screening programmes [1].

The Van Nuys index uses a combination of factors that are known to influence local-recurrence rates (size of tumour, grade and margin width at operation) to generate a score. Low recurrence rates have been reported after breast conserving surgery even in the absence of radiotherapy with the lowest Van Nuys scores [14] and this index is being used to guide treatment decisions.

OncoType-DX-DCIS™ is a genomic assay that aims to guide radiotherapy decisions in DCIS by generating a score which predicts the likelihood of local-recurrence [15]. This score was validated using tissue and recurrence outcomes from the ECOG 5194 study which included patients treated with BCS alone [16].

It is regrettable that a common condition with such a good general prognosis is so variable in its clinical implications. Thankfully, ongoing research (such as that outlined above) will continue to help us answer the uncertainty that remains in trying to best treat patients with DCIS while minimising harm.

References


