CHAPTER V

DISCUSSION

The term "lobular carcinoma in situ" was immediately adopted by most pathologists even though no definitive evidence of its malignant nature had been demonstrated. Since 1941 Foote and Stewart(1) who noted the clinical significance of LCIS as being generally multifocal and has the potential to progress to an invasive carcinoma. Subsequent studies and reviews noted a high frequency of bilaterality(2). The bilaterality may be synchronous or metachronous.

The incidence of pure LCIS in biopsied specimen has been reported to constitute about 1-6% of breast cancer cases (15, 16). However, 22-25% of those patients were reported to have intraductal or invasive carcinoma in subsequent surgical biopsies (17-19). Interestingly, in our study none of pure LCIS was observed, all of them were coexisting with invasive carcinoma either invasive lobular carcinoma (ILC) or invasive ductal carcinoma (IDC), in the same ratio (lobular: ductal = 1:1) while other results in the literatures show the difference ratio (lobular<ductal). However, in cases of combined LCIS with DCIS, The coexisting invasive component ratio between IDC: ILC is 4:0. Thus, our study demonstrates the nature of LCIS which is always found as incidental finding that does not form the palpable mass and is rarely recognized by mammographic study or breast examination. Although we did not see a case of LCIS alone from biopsy specimen, our data also support the recommendation to perform a surgical biopsy in most patients after pure LCIS is detected in a needle core biopsy specimen(20).

In most cases of classical LCIS, the diagnosis can be easily made by morphology from routine histologic basis alone. However, for pleomorphic and necrotic variants, it can be difficult to distinguish from DCIS, which recently some studies suggested the PLCIS has more aggressive phenotype(2, 8, 9). Although, E-cadherin staining has been known to be useful to differentiate these two lesions, as LCIS normally reveals loss of E-cadherin expression, however, approximately 16% of lobular carcinoma have been reported to express E-cadherin by immunohistochemical staining, possibly detection of E-cadherin protein dysfunction (10). Our study, none of our LCIS cases (CLCIS ans PLCIS) revealed faint or positive E-cadherin staining, however, focal positive and focal loss positive staining were found in approximately 50%.

According to other studies, the usefulness of p120 catenin expression in cases of lobular lesions while ductal carcinoma revealed negative results has been demonstrated (11). Thus, the use of both E-cadherin and p120 studies provide more specificity in distinguishing between lobular and ductal carcinoma. Our study encountered similar problem therefore additional p120 staining in those of our cases may provide more accurate diagnosis of each problematic case.

In conclusion, it is still a need to distinct between LCIS and DCIS, and always be aware of the possibility to encounter non-classical type of LCIS due to the different in management between LCIS and DCIS. Combined E-cadherin and p120 stainings are recommended to confirm the diagnosis of LCIS. Further clinical follow-up studies to define the natural history and the most appropriate management for each patient of classical and non-classical LCIS ,which become heterogenous in nature should be carried on.