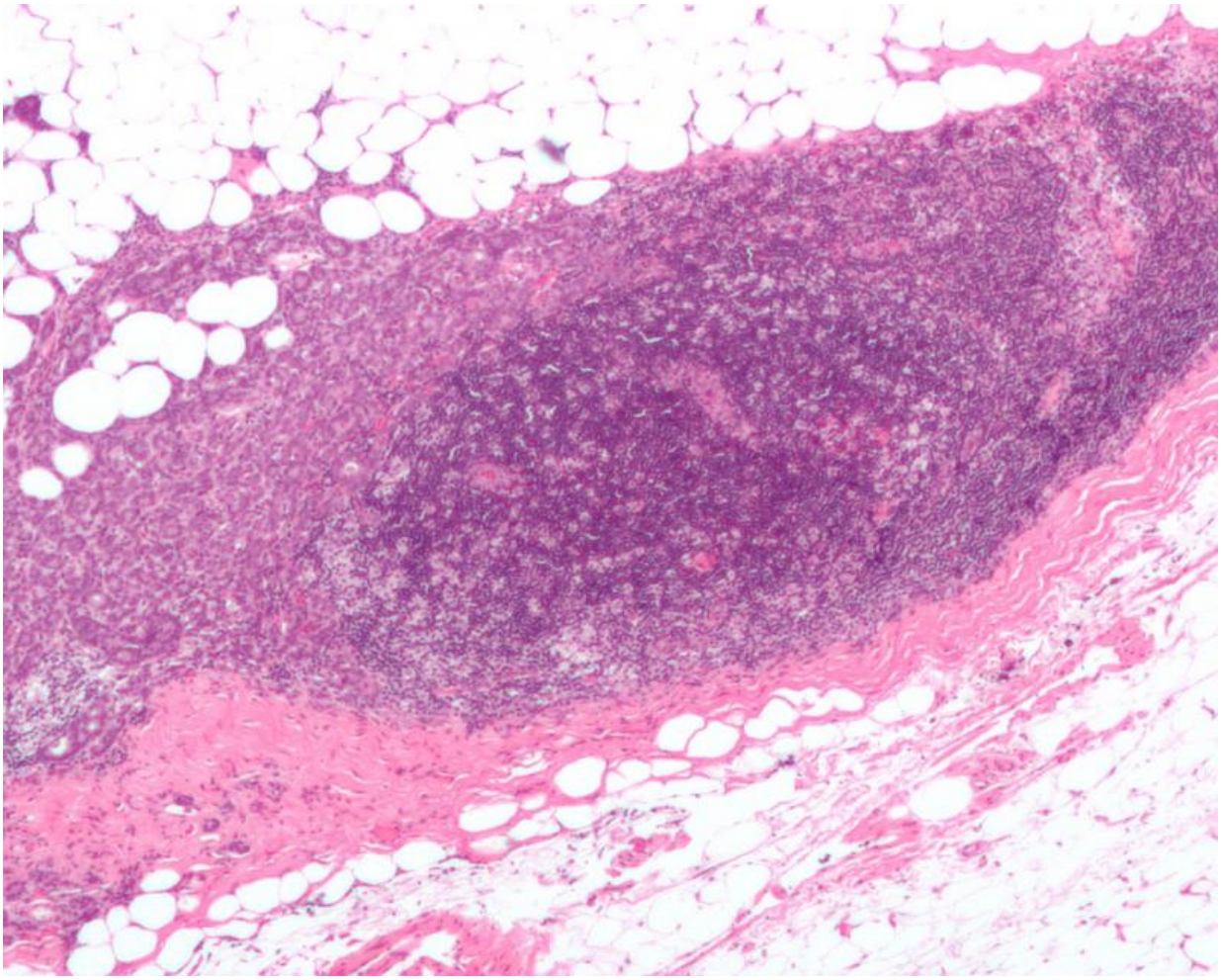
Stage 0 breast cancer: When should you wait and see?

October 13 2015, by Judy Peres, Chicago Tribune



Micrograph showing a lymph node invaded by ductal breast carcinoma, with extension of the tumour beyond the lymph node. Credit: Nephron/Wikipedia

In cancer, as in other areas of medicine, early detection can save lives. But the screening tests used to find early tumors also detect disease that would never cause problems - disease you'll die with but not from. Managing those cases means giving potentially harmful treatment to patients who won't benefit.

DCIS, or ductal carcinoma in situ, is the poster child of this dilemma. Before routine mammograms, only about 1 percent of U.S. breast cancer cases were DCIS. Now nearly 65,000 women a year - about 22 percent of those with breast cancer - are diagnosed with DCIS.

DCIS, also known as Stage 0 breast cancer, is not life-threatening, and not all cases will progress to invasive cancer. But because there is no reliable way to determine which ones will, nearly all DCIS is surgically removed with a lumpectomy or mastectomy (and sometimes the healthy breast is removed prophylactically). Most DCIS patients also are offered radiation and drugs.

While many experts believe this simply is the price that must be paid to save lives, an increasingly vocal minority are working to find ways to reduce overdiagnosis and overtreatment, especially of DCIS.

These researchers got a big boost in August from a new study of more than 100,000 women diagnosed with DCIS between 1988 and 2011. The study, by Dr. Steven Narod of Women's College Hospital in Toronto, showed that DCIS patients had the same risk of dying of breast cancer - just over 3 percent within 20 years - as women in the general population. In other words, the surgery, radiation and drugs didn't make any difference for the vast majority of patients.

A small minority - women under 35, African-Americans and those with especially aggressive molecular features - had a significantly higher chance of dying of breast cancer. Ironically, they did so despite the

aggressive treatment they received.

Virtually all the women were treated, so the Narod study could not show if treatment was better than no treatment. But a separate study published in June identified 1,169 DCIS patients who had somehow escaped surgery and compared them with 56,053 women who got the recommended operation. Breast cancer deaths were slightly higher for women with intermediate- and high-grade DCIS who did not have surgery, but there was no difference for women with low-grade DCIS: Just over 1 percent of those women had died of breast cancer after 10 years, whether they had had surgery or not.

The researchers, led by Dr. Yasuaki Sagara of Brigham and Women's Hospital in Boston, suggested watchful waiting for low-grade DCIS. "From these results, we could consider recommending a strategy of nonoperative management with active surveillance similar to that used ... in prostate cancer," they wrote.

Most doctors, however, are unwilling to change current practice without more evidence that it's safe. Dr. Otis Brawley, chief medical officer at the American Cancer Society, has called for a large clinical trial comparing mastectomy, lumpectomy and no surgery for women with DCIS. At least two such trials are underway in Europe.

A few U.S. centers already are allowing some low-risk DCIS patients to skip surgery after being informed of the risks and benefits.

"I give people with low-grade DCIS the option of chemoprevention or monitoring," said Dr. Laura Esserman, director of the breast care center at the University of California-San Francisco. Chemoprevention refers to taking a pill such as tamoxifen for several years, which is known to halve the risk of breast cancer in women at higher-than-average risk for the disease.

Esserman is among those who consider DCIS a risk factor rather than a disease that merits immediate treatment. She is a founder of the Athena Breast Health Network, a collaboration between UCSF and four other UC medical campuses. The network plans to screen 150,000 California women for breast cancer, collect information on their health and other risk factors, and begin a decades-long tracking process that some have compared to the Framingham Heart Study. The network will include a registry of DCIS patients, many of whom Esserman expects will opt for watchful waiting or chemoprevention rather than surgery.

"A lot of people are anxious to avoid unnecessary treatment," she said.

Esserman also favors changing the name of the disease from DCIS to, say, IDLE, for indolent lesion of epithelial origin - something that doesn't contain the word "cancer" or "carcinoma." Studies have shown that many women overestimate the danger of a DCIS diagnosis and that reframing it as a high-risk condition rather than as cancer leads patients to choose less aggressive treatments.

A new genomic test makes it somewhat easier for doctors and patients to decide on a course of treatment. The DCIS Score rates the chance that a given patient's disease will recur or progress to invasive cancer within 10 years. Those classified as low risk are allowed to skip radiation, and in some cases they may be offered the option of avoiding surgery too.

Dr. Shelley Hwang, chief of breast surgery at Duke Cancer Institute in Durham, N.C., said she also sees DCIS patients who would rather watch it than treat it. But she noted that doctors don't yet have conclusive proof that certain types of DCIS can safely go untreated.

"We need to collect the data that will allow for clear risk communication with patients so they can make their own decisions about their care," she said. "The DCIS Score, other risk-stratification factors, and the

biospecimens we get from the European studies will help us identify those low-risk patients."