

FAQS: ATYPICAL HYPERPLASIA

UNDERSTANDING YOUR PATHOLOGY REPORT: A FAQ SHEET

When your breast was biopsied, the samples taken were studied under the microscope by a specialized doctor with many years of training called a pathologist. The pathology report tells your treating doctor the diagnosis in each of the samples to help manage your care. This FAQ sheet is designed to help you understand the medical language used in the pathology report.

1. What does “hyperplasia” mean?

The normal breast is made of ducts that end in a group of blind-ending sacs (lobules). “Hyperplasia” indicates that there is an abnormal growth of cells within the ductal-lobular system of the breast, but it is not cancerous. Hyperplasias are benign. Some have more marked abnormal appearances under the microscope and these are called “atypical” hyperplasias.

2. What does it mean if my report says that the hyperplasia is “ductal” or “lobular”?

The two major patterns of hyperplasia seen in the ductal-lobular system of the breast are referred to as ductal or lobular, depending upon their appearance under the microscope.

4. What does it mean if my report mentions E-cadherin?

E-cadherin is a test that the pathologist uses to help determine if the hyperplasia is ductal or lobular. If your report does not mention E-cadherin, it means that this test was not necessary to make the distinction.

5. What is the significance of “atypical ductal hyperplasia (ADH)”?

ADH is an abnormal appearing growth of cells within the breast ducts that is associated with an increased risk of subsequent breast cancer. If ADH is found on needle biopsy, a surgical excision (lumpectomy) is usually performed to see if there is worse abnormality present in the breast. If only ADH is found on a surgical excision (lumpectomy), follow-up is usually sufficient.

6. What is the significance of “atypical lobular hyperplasia (ALH)”?

ALH is also an abnormal appearing growth of cells within lobules of the breast that is associated with an increased risk of subsequent breast cancer. If ALH is found on needle biopsy, it is controversial whether subsequent excision needs to be performed to rule out a worse abnormality in the breast or if follow-up is sufficient. If ALH is found on an excision (lumpectomy), follow-up is usually sufficient.

7. What does it mean if my report mentions special studies such as high molecular weight cytokeratin (HMWCK), CK903, CK5/6, p63, muscle specific actin, smooth muscle myosin heavy chain, calponin, or keratin?

These are special tests that the pathologist sometimes uses to help make the correct diagnosis of a variety of breast lesions. Whether your report does or does not mention these tests has no bearing on the accuracy of your diagnosis.

8. What does it mean if my report also says any of the following terms: “usual duct hyperplasia”, “lobular hyperplasia”, “adenosis”, “sclerosing adenosis”, “radial scar”, “complex sclerosing lesion”, “papillomatosis”, “papilloma”, “apocrine metaplasia”, “cysts”, “columnar cell change”, “collagenous spherulosis”, “duct ectasia”, “fibrocystic changes”, “flat epithelial atypia”, or “columnar cell change with prominent apical snouts and secretions (CAPSS)”?

All of these terms are non-cancerous changes that the pathologist sees under the microscope and are of no importance when seen on a biopsy where there is ADH or ALH.

9. What does it mean if my report mentions “microcalcifications” or “calcifications”?

“Microcalcifications” or “calcifications” are minerals that are found in both noncancerous and cancerous breast lesions and can be seen both on mammograms and under the microscope. They are reported by the pathologist to show that the abnormal area with calcifications seen on the mammogram was successfully sampled by the biopsy. Without accompanying worrisome changes in the breast ducts or lobules, “microcalcifications” or “calcifications” alone have no significance.