RACCOMANDAZIONI PER LE VISITE SENOLOGICHE

secondo: U.S. Preventive Services Task Force, Canadian Task Force on the Periodic Health Examination, American Cancer Society, National Cancer Institute (1,2)

Tradotto e curato dal Dr. G. Antonini

RACCOMANDAZIONI GENERALI

La visita periodica delle mammelle deve rientrare tra gli accertamenti periodici alla stessa stregua della visita dal medico di famiglia, dal ginecologo o quella dal proprio dentista.
Le visite periodiche permettono di riscontrare lesioni precancerose e tumori di piccole dimensioni, riducendo così la mortalità per carcinoma: si pensi alla rarità del carcinoma dell' utero in fase avanzata, o alla diminuzione delle dimensioni del tumore mammario alla diagnosi rilevata in questi ultimi anni.

SCREENING DEL CARCINOMA DELLA MAMMELLA

ETÀ	ESAMI SENOLOGICI	CONSIGLI
> 35 (pazienti non a rischio)	CBE	1 volta/anno
> 35 (pazienti a rischio)	CBE Mammografia di base	1 volta/anno
40+	CBE	1 volta/anno + Gram ogni 3 anni + insegnamento di BSE
40-49	CBE	1 volta/anno Gram + BSE
50-75	Mammografia	1 volta/2 ann1 Gram + BSE

CBE: visita senologica;
BSE: autopalpazione.
Gram: PAP test

BIBLIOGRAFIA

1. National Cancer Institute. Working guidelines for early detection: rationale and supporting evidence to decrease mortality. Bethesda, Md.: National Cancer Institute, 1997.
2. American Cancer Society. Summary of current guidelines for the cancer-related checkup: recommendations. New York: American Cancer Society, 1998.

Definitions of Risk	Screening Recommendations[d]	Other Options

	Clinical Breast Exam	Mammogram	
Usual Two or more reproductive risk factors (see checklist) with no family history Weak family history (i.e., two or fewer distant relatives with breast cancer, or 1st degree relative with post menopausal breast cancer)	Annual after age 20	Annual after age 40	
Moderate –Histology Atypical ductal hyperplasia (ADH) Atypical lobular hyperplasia (ALH) Lobular carcinoma in situ (LCIS) Previous history of ductal carcinoma in situ (DCIS) Previous history of invasive breast cancer	At least once per year	Annual after diagnosis	Referral to high-risk counseling Chemoprevention Prophylactic mastectomy and/or oophorectomy
Moderate –Radiation[a] Thoracic radiation < age 30	Annual after age 20	Annual after age 40 or 10 years after radiation	
Moderate –Strong Family History Any 1st or 2nd degree relative with breast cancer < age 50 Two or more relatives with early onset breast cancer in the same lineage	At least once per year	Annual after age 40 or 5–10 years earlier than youngest affected relative, but not before age 25.	
High –Features associated with 10% or greater prior probability of carrying a BRCA1/BRCA2 mutation Personal history of breast cancer diagnosed age 40, or ovarian cancer Family history of breast cancer age 40 in 1st degree relative Family history of breast cancer age 40 in paternal 2nd degree relative Family history of breast cancer in two 1st degree relatives, at least one diagnosed age 50 Family history of ovarian cancer and breast cancer in one 1st or 2nd degree relative or in close relatives in the same lineage One or more male relatives with breast cancer Known carrier of a BRCA1 or BRCA2 mutation, or close relative with known mutation Note: Women of Ashkenazi Jewish ancestry may be included despite fewer affected relatives or later age onset.	At least once per year	Annual after age 40 or 5–10 years earlier than youngest affected relative, but not before age 25.	Referral to high-risk counseling Chemoprevention Prophylactic mastectomy and/or oophorectomy
	After age 25, at least once per year. Consider twice yearly.	Annual after age 25 or individualized based on earliest age onset in family. Preliminary data suggest that alternating MRI and mammography every six months may be helpful. Note: More Intensive screening for mutation carriers	

The **Gail Model** calculates actuarial estimates of future breast cancer risk based on race, age, reproductive risk factors, maternal family history, and previous biopsy status. The computerized version of the Gail Model is available at: http://bcra.nci.nih.gov/brc/. The Gail Model score represents the cumulative risk of developing cancer over the next five years. For values >2, consider high-risk counseling. However, the Gail Model may underestimate the risk for those with a strong family history of breast cancer. In these cases the Claus Model may provide more useful information.

The **Claus Model** is an empiric risk model that predicts a woman's chance of developing breast cancer based on her family history. This model considers the number for affected relatives in both the maternal and paternal lineages (up to two), their relationship to the patient (whether they are first or second-degree relatives) and the age of onset of breast cancer in each relative. It does not factor in ethnic background, whether the cancer was bilateral, or a family history of ovarian cancer. All eight Claus Model tables are available at: www.rmf.harvard.edu/bca.