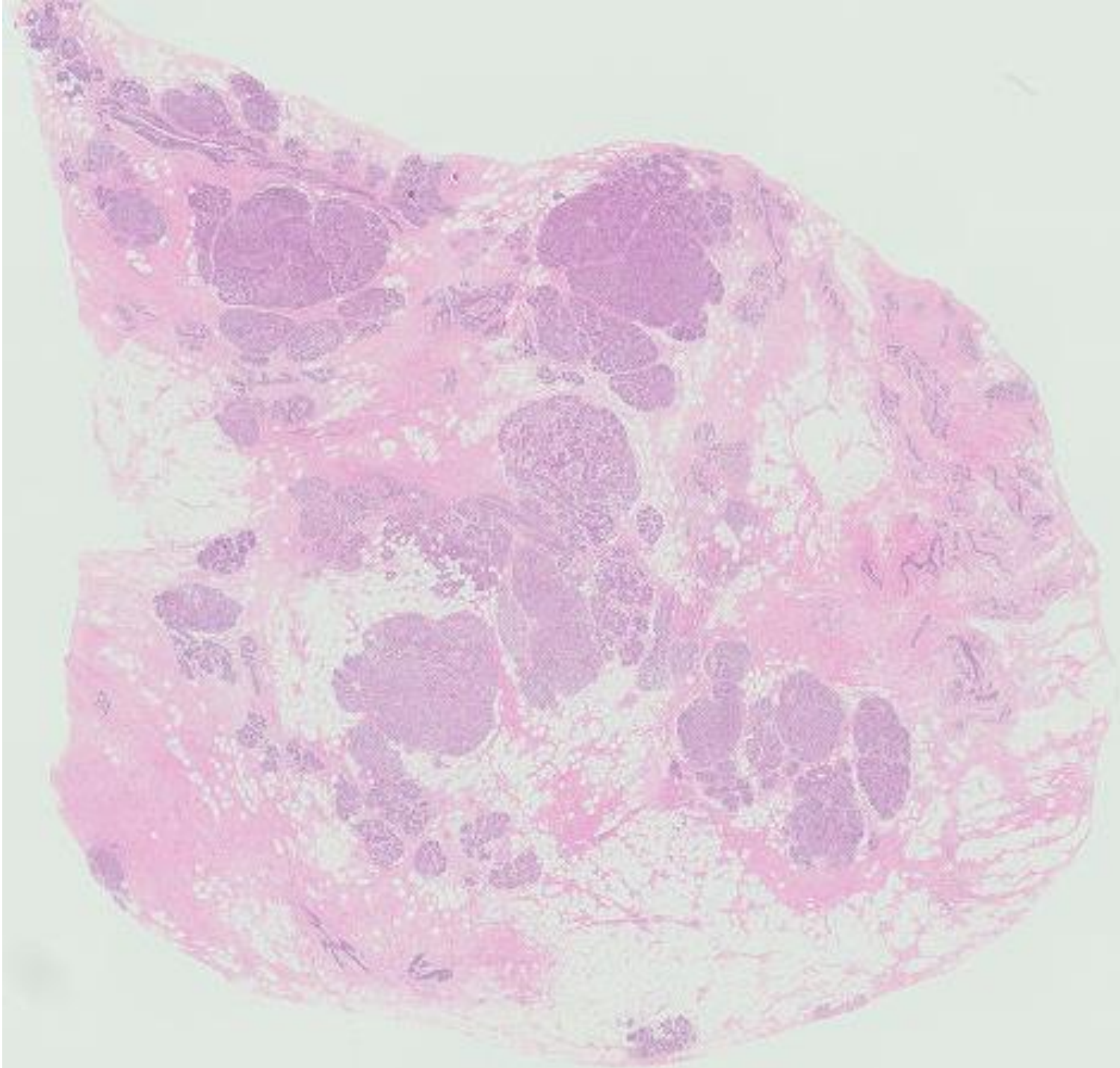


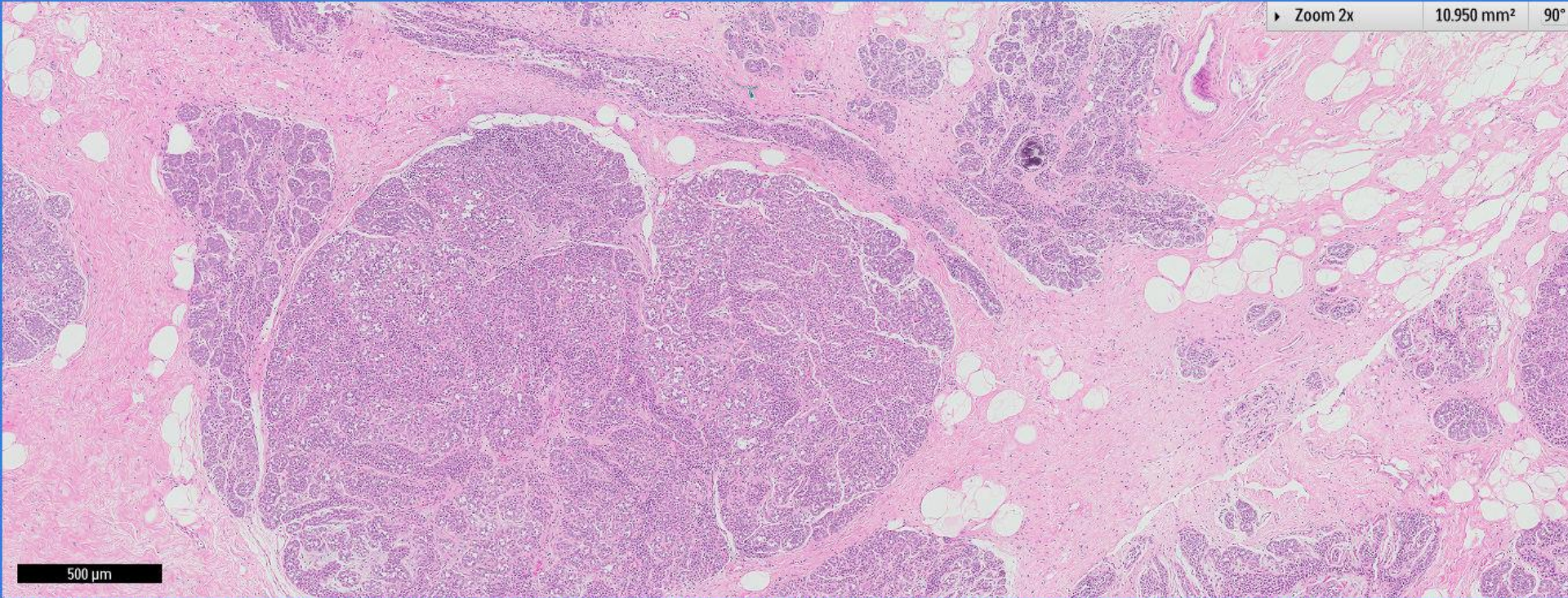
## Case 12

40 year old Chinese woman underwent a right skin sparing mastectomy for a core biopsy diagnosis of ductal carcinoma in situ.

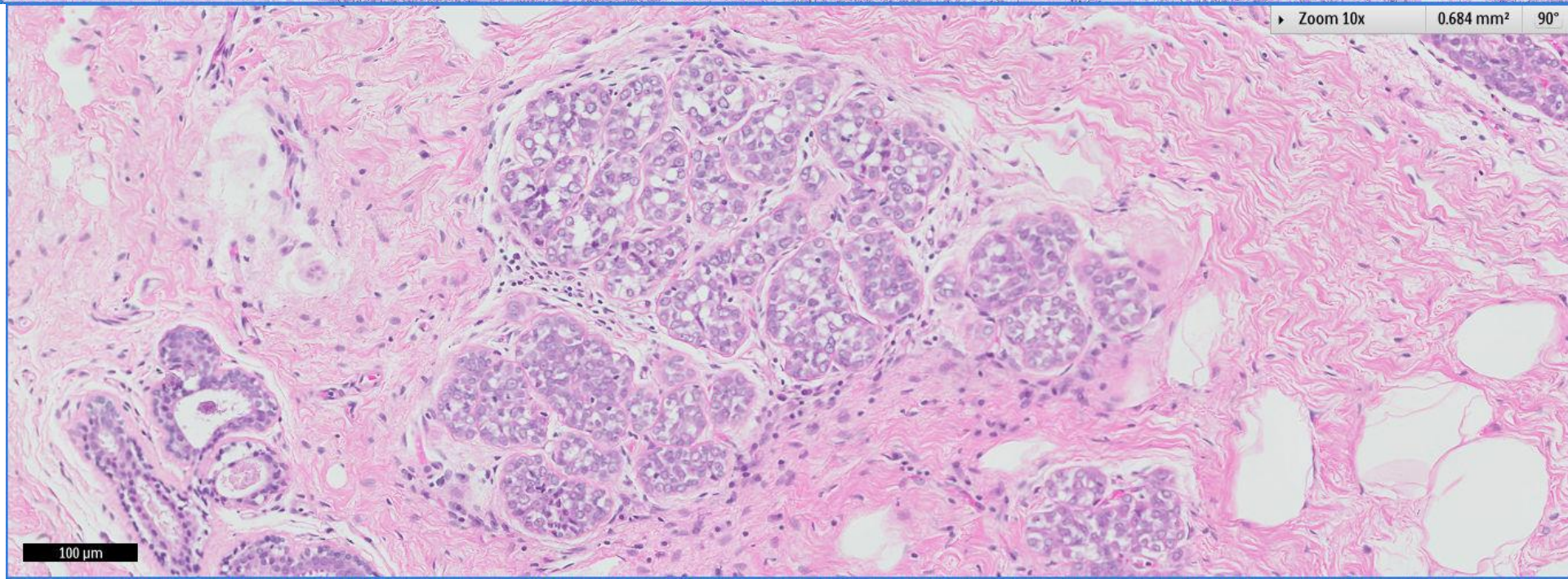
Macroscopically, the breast contained a confluent mass of multiple small discrete pinkish nodules in the upper outer and inner quadrants.

The section provided is from this area.

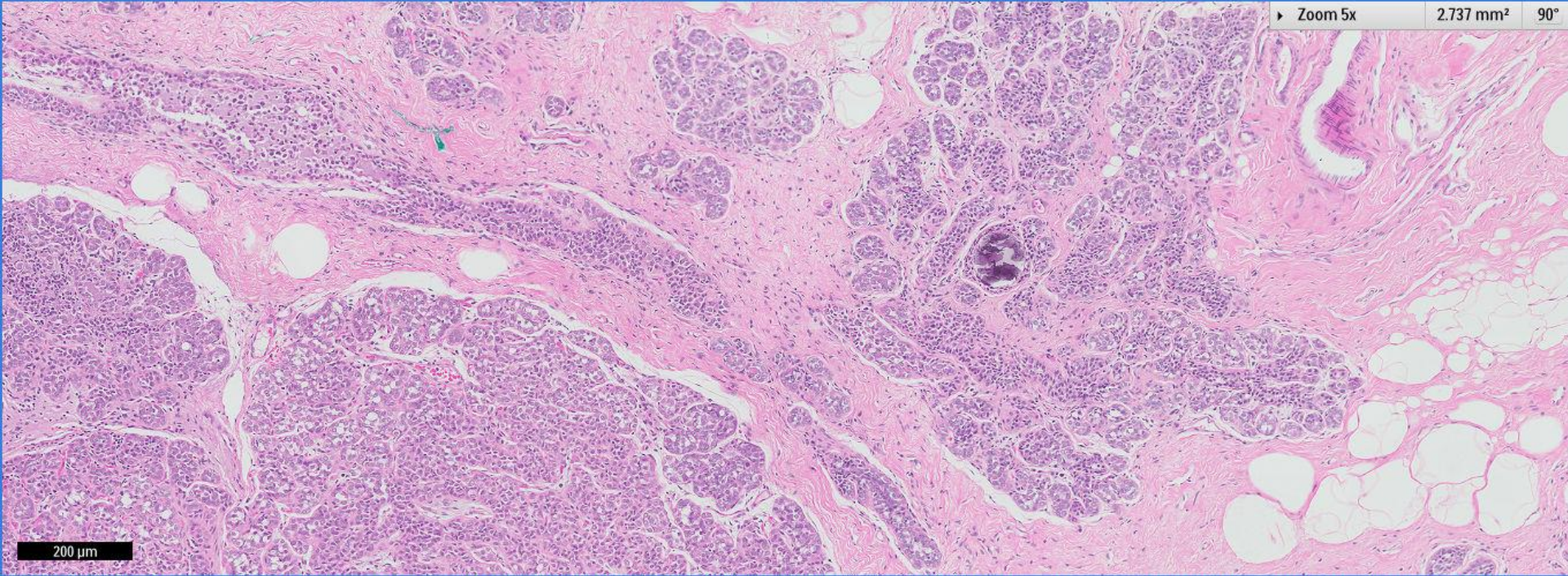




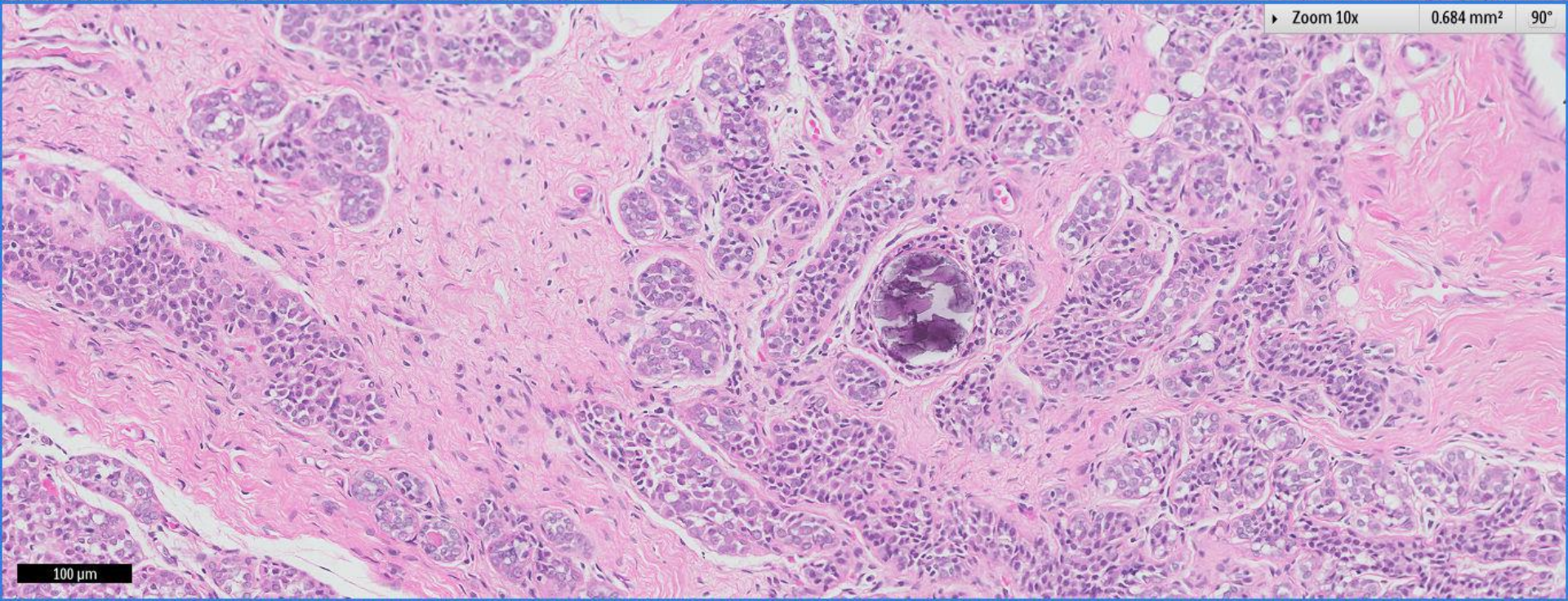
500 μm



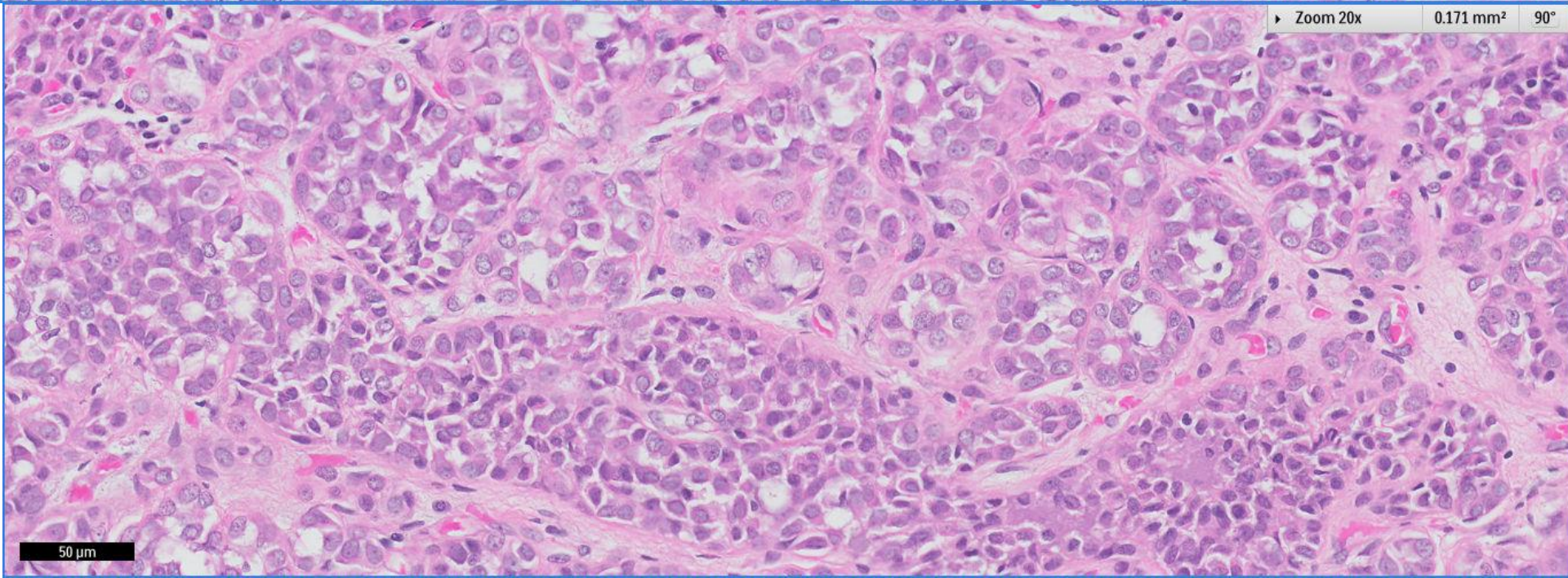
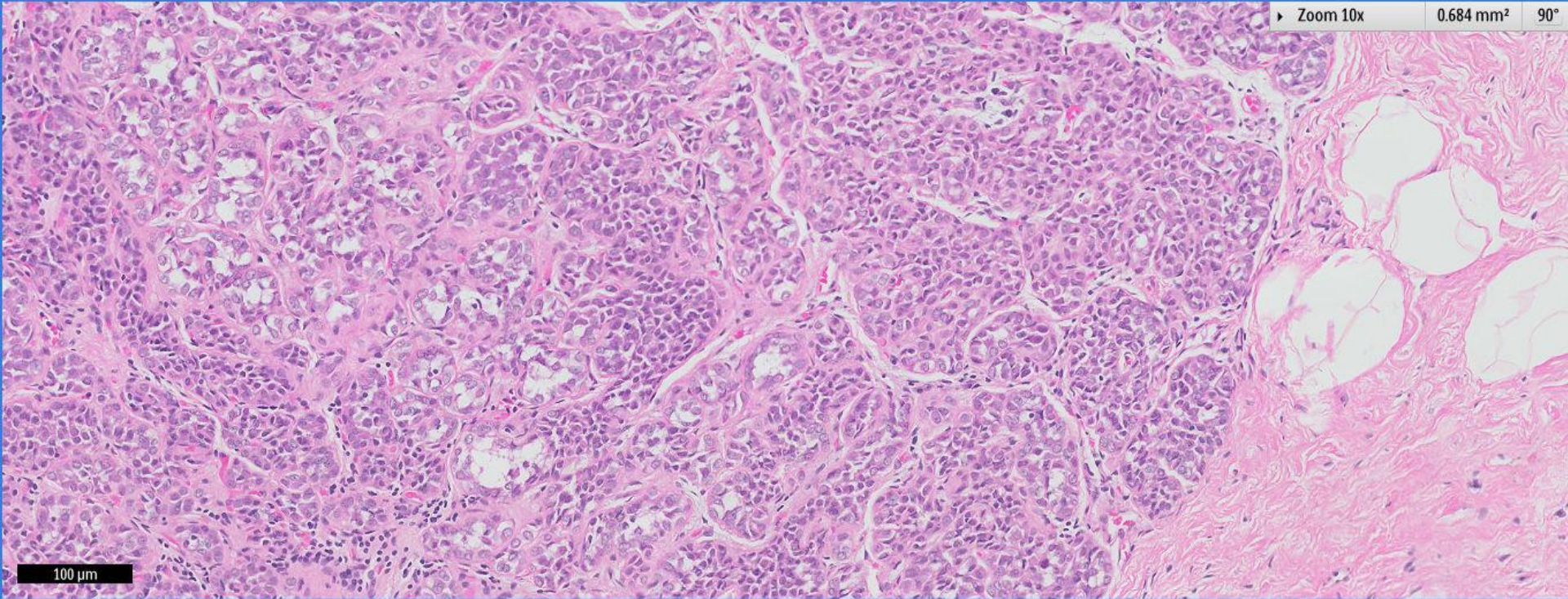
100 μm



200 μm



100 μm



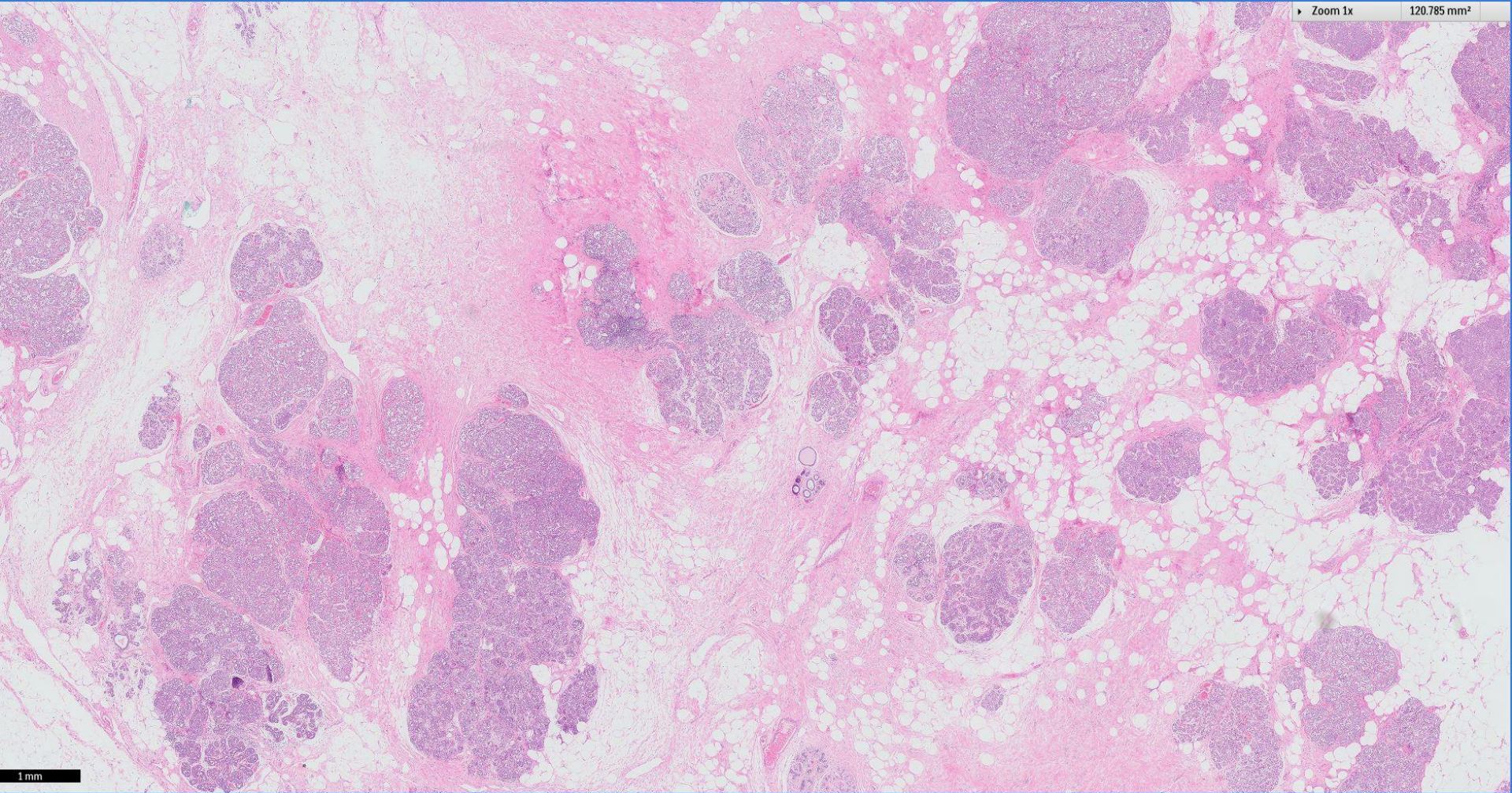
*Gardens by the Bay ~ an aerial view*





Zoom 1x

120.785 mm<sup>2</sup>

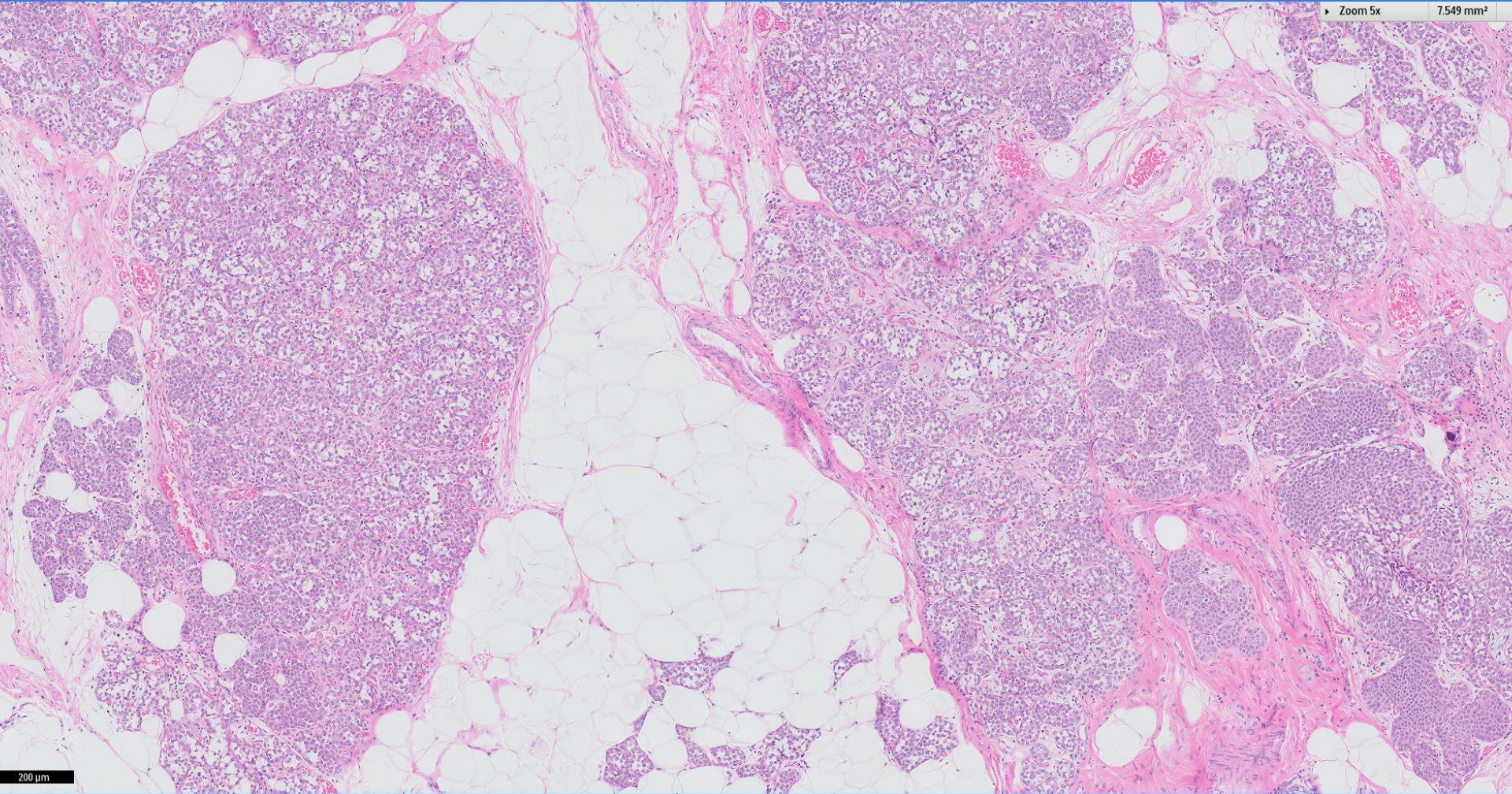


1 mm



Zoom 5x

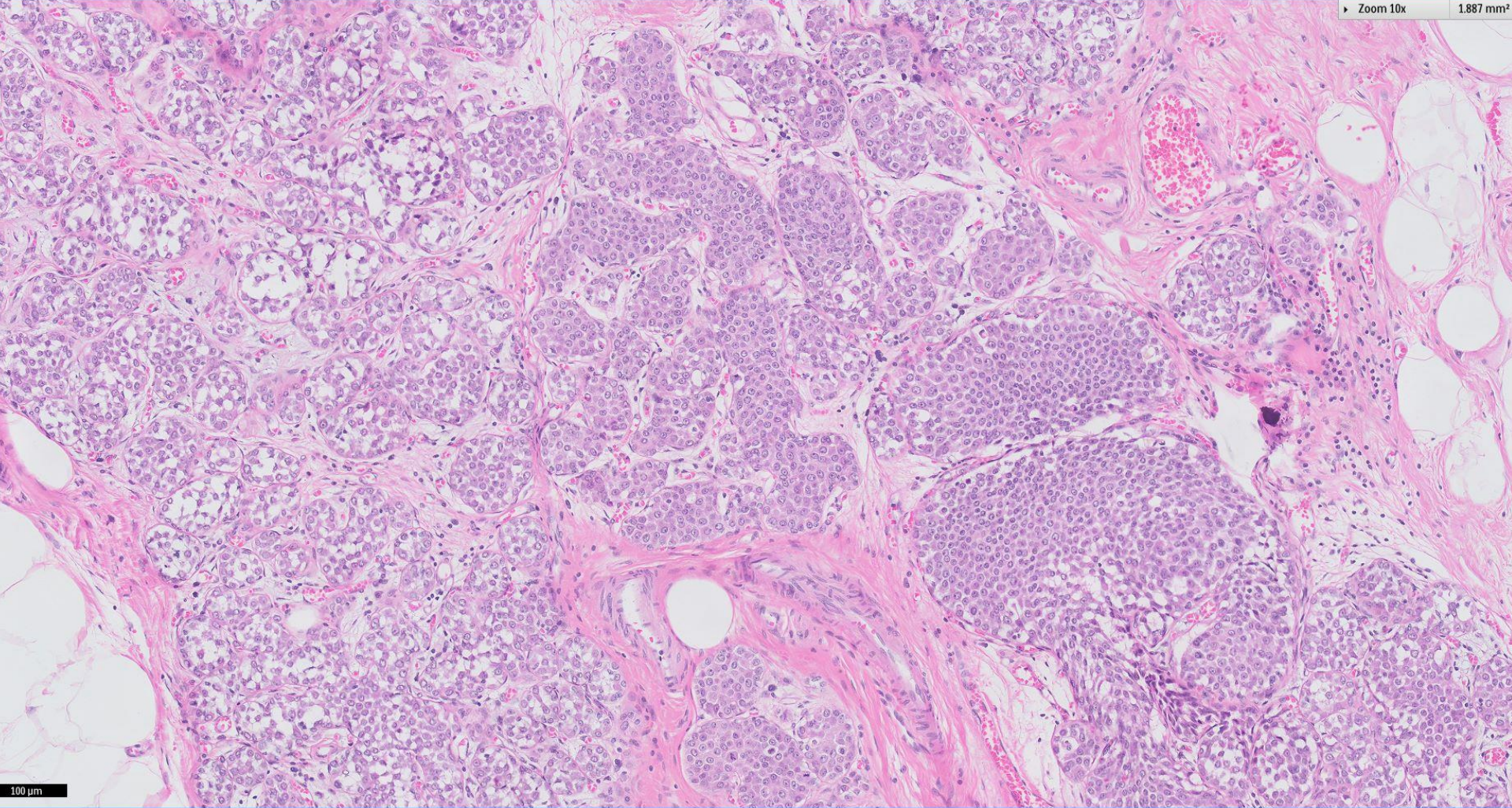
7.549 mm<sup>2</sup>



200 μm

Zoom 10x

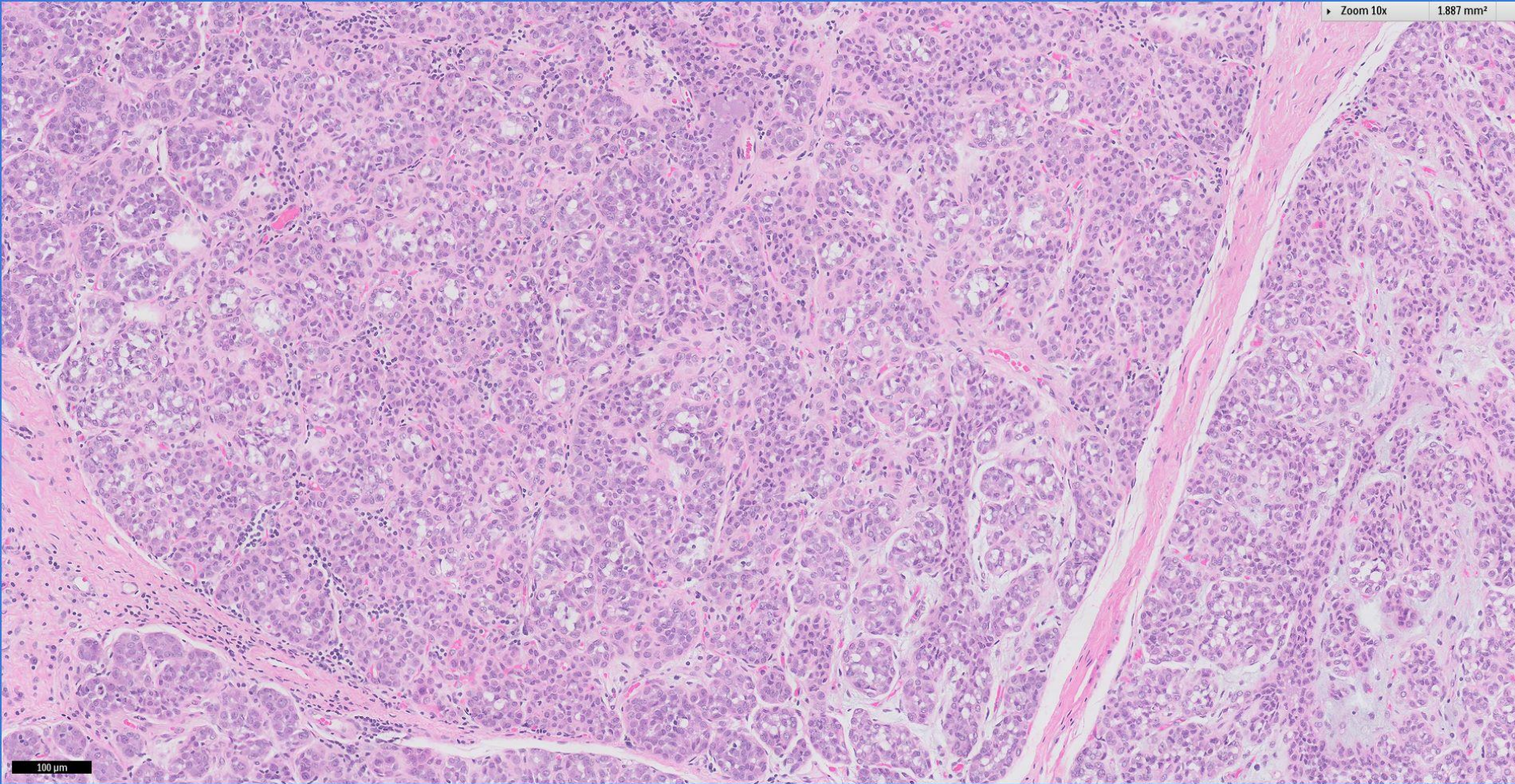
1.887 mm<sup>2</sup>



100 μm

Zoom 10x

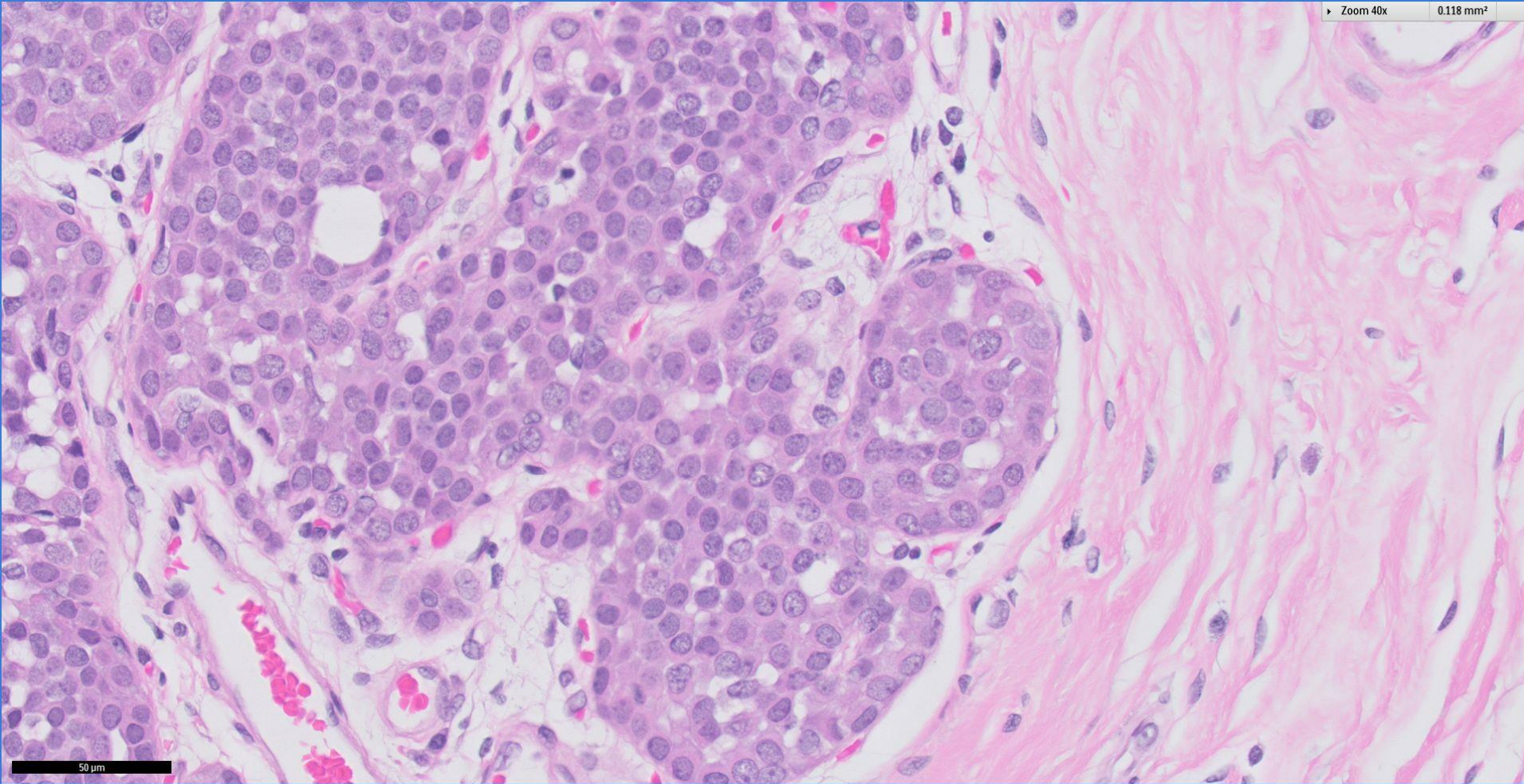
1.887 mm<sup>2</sup>



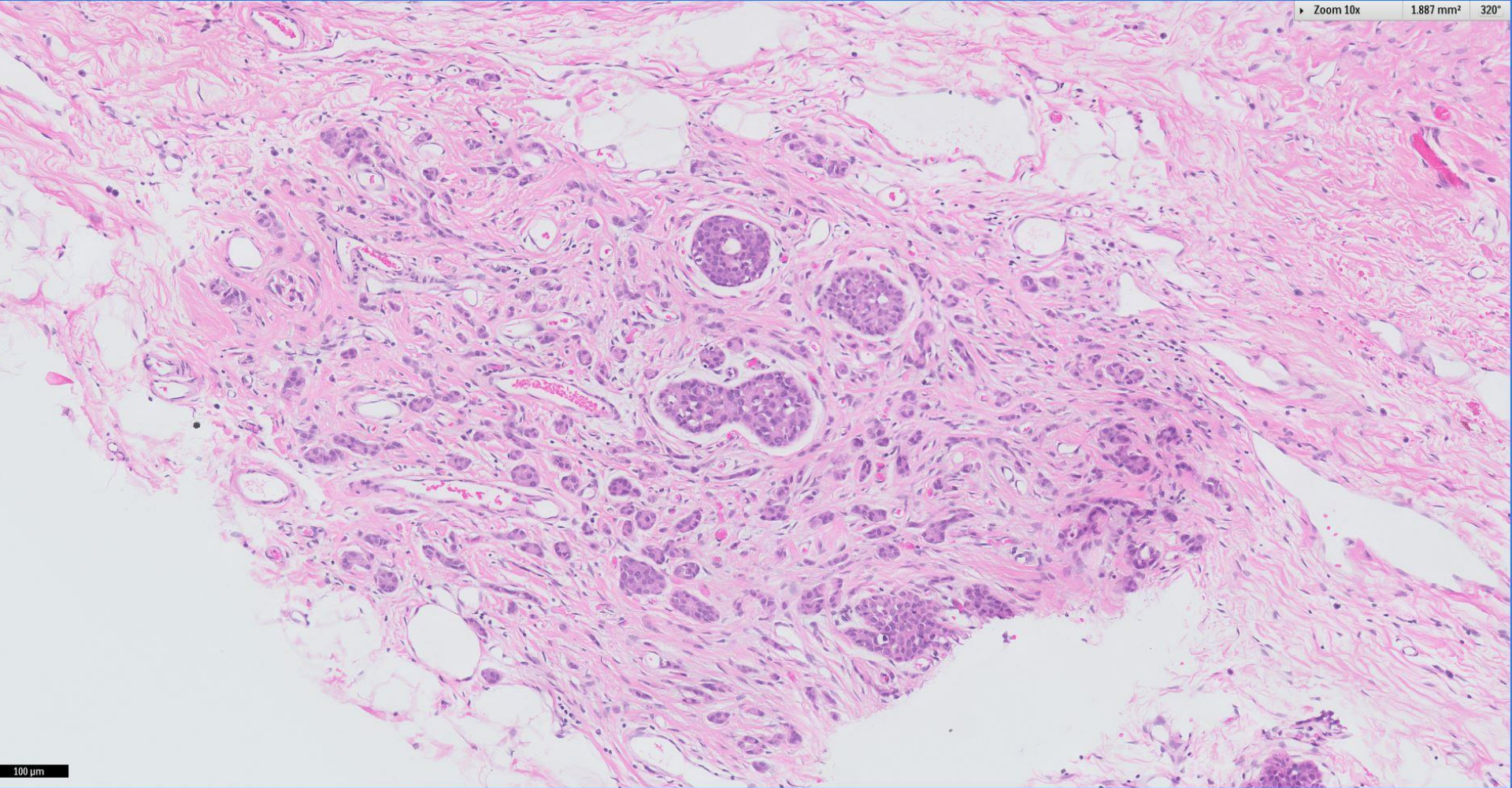
100 μm

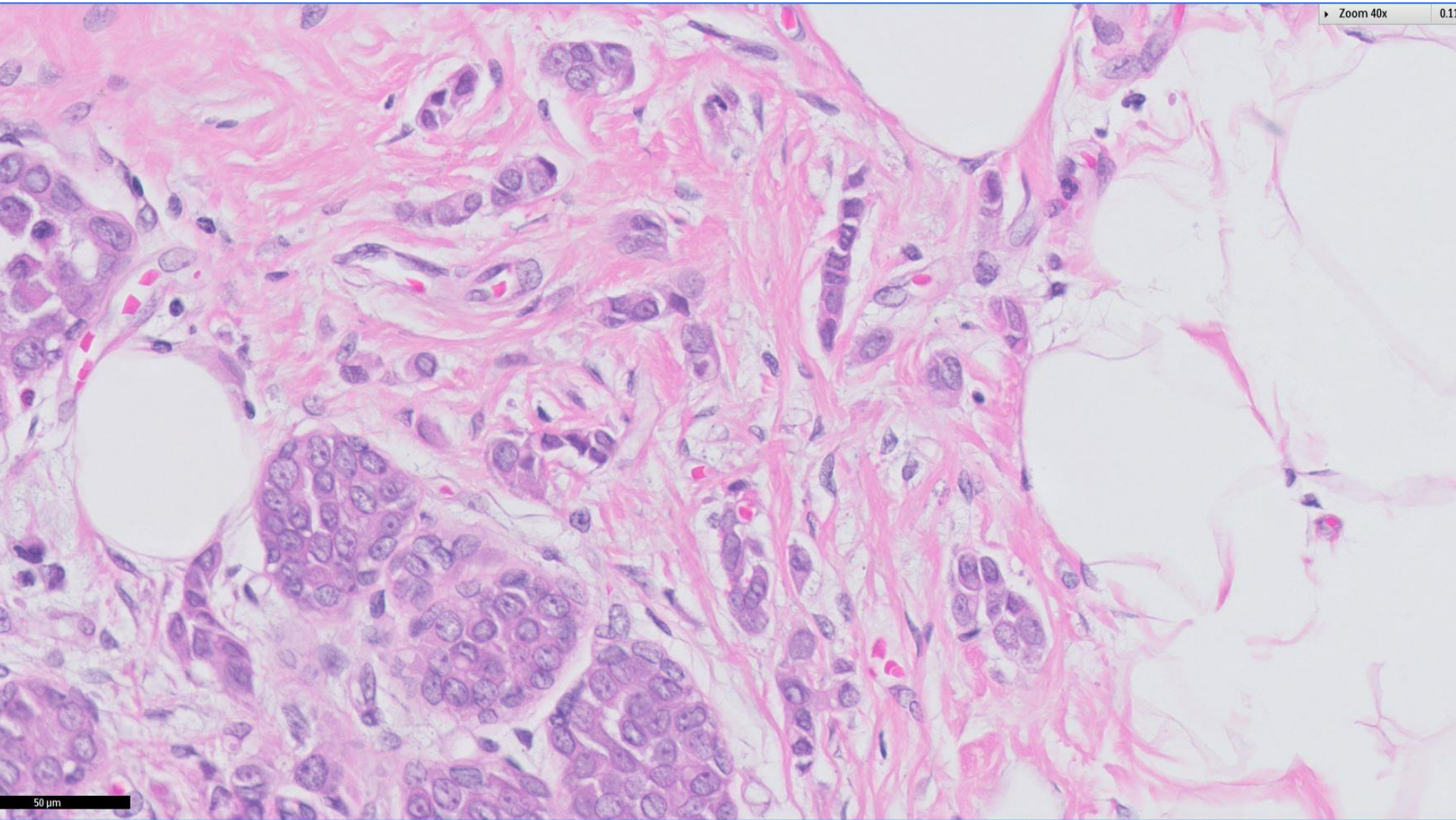
Zoom 40x

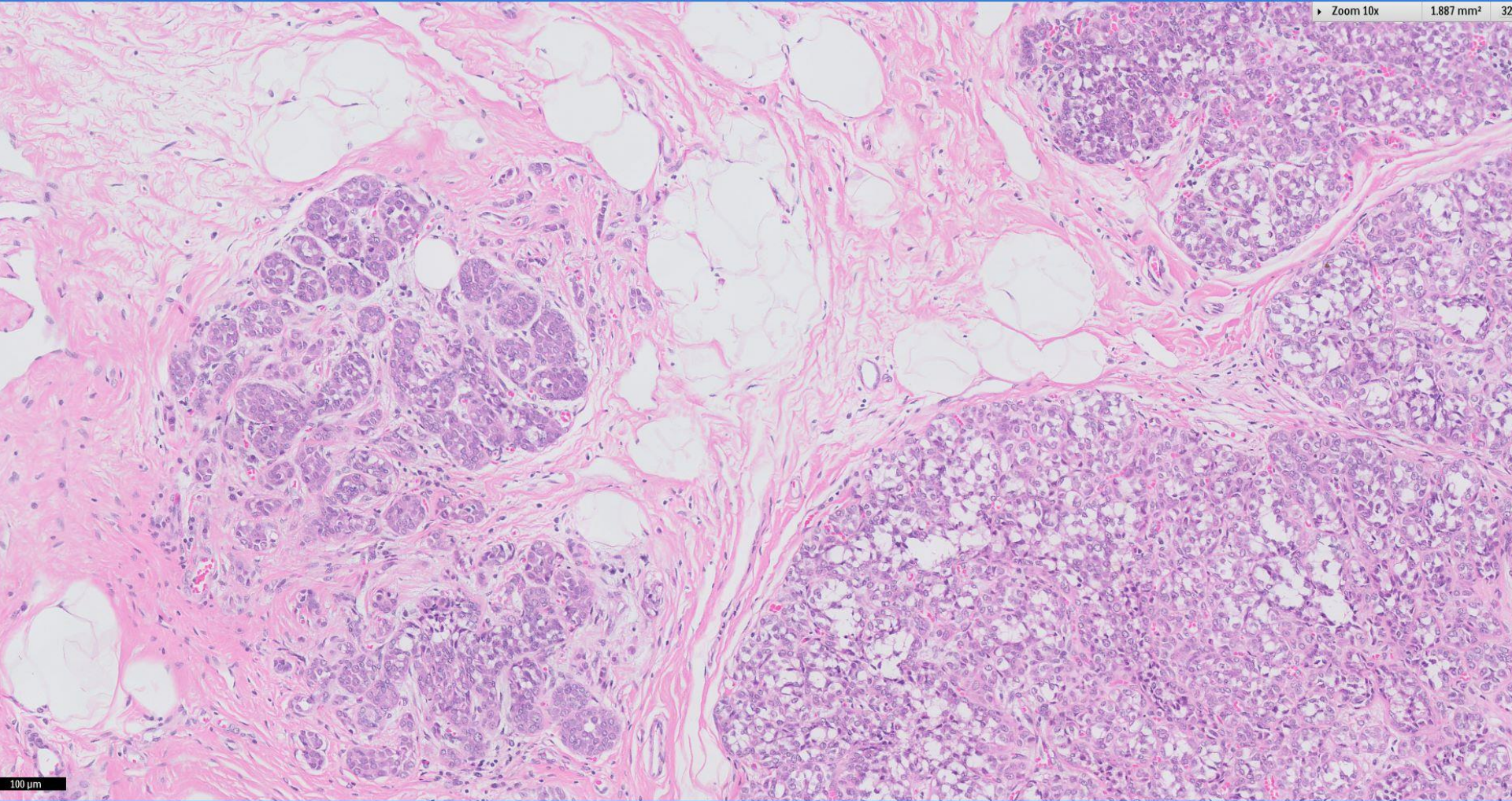
0.118 mm<sup>2</sup>

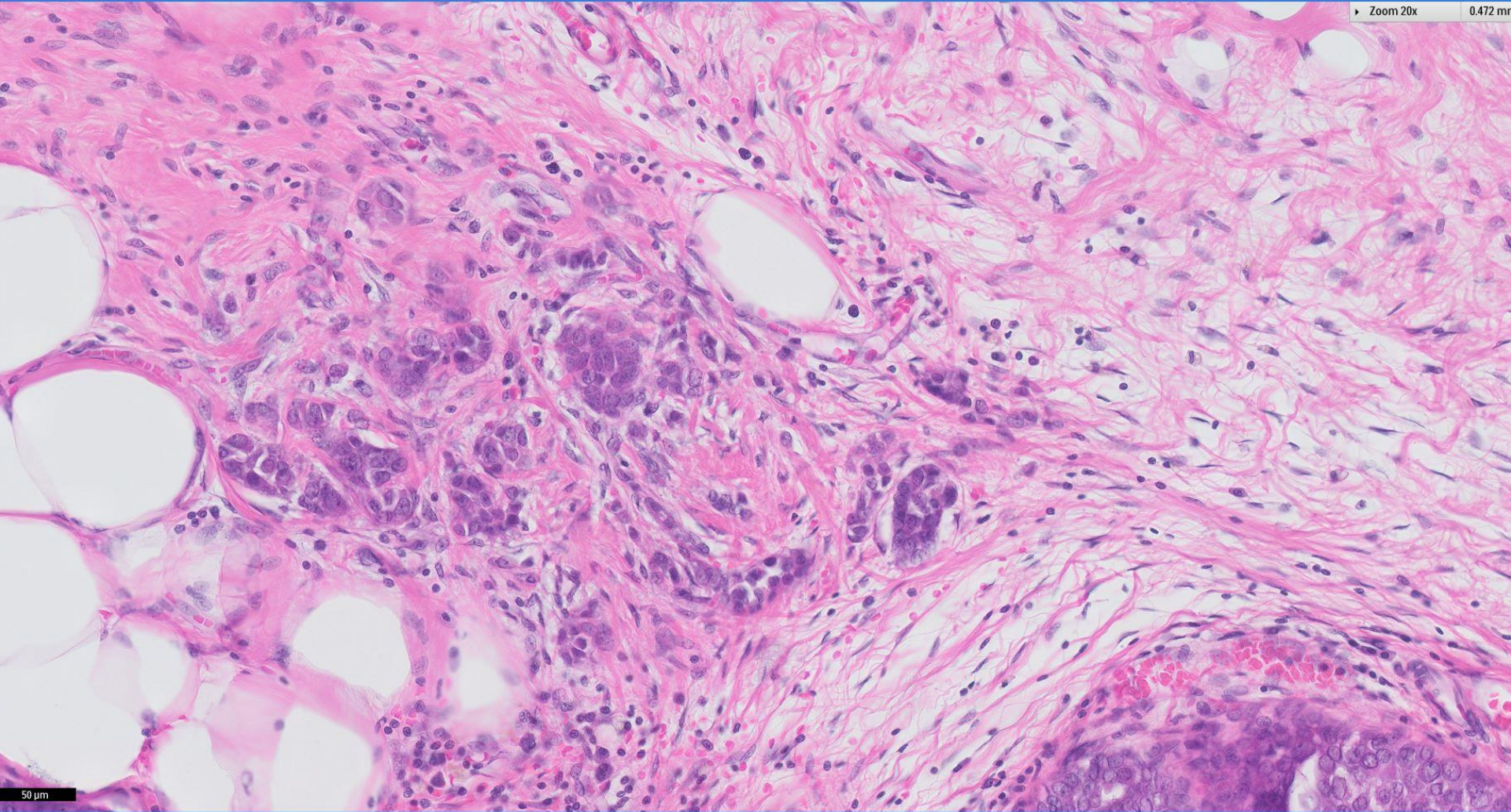


50 μm



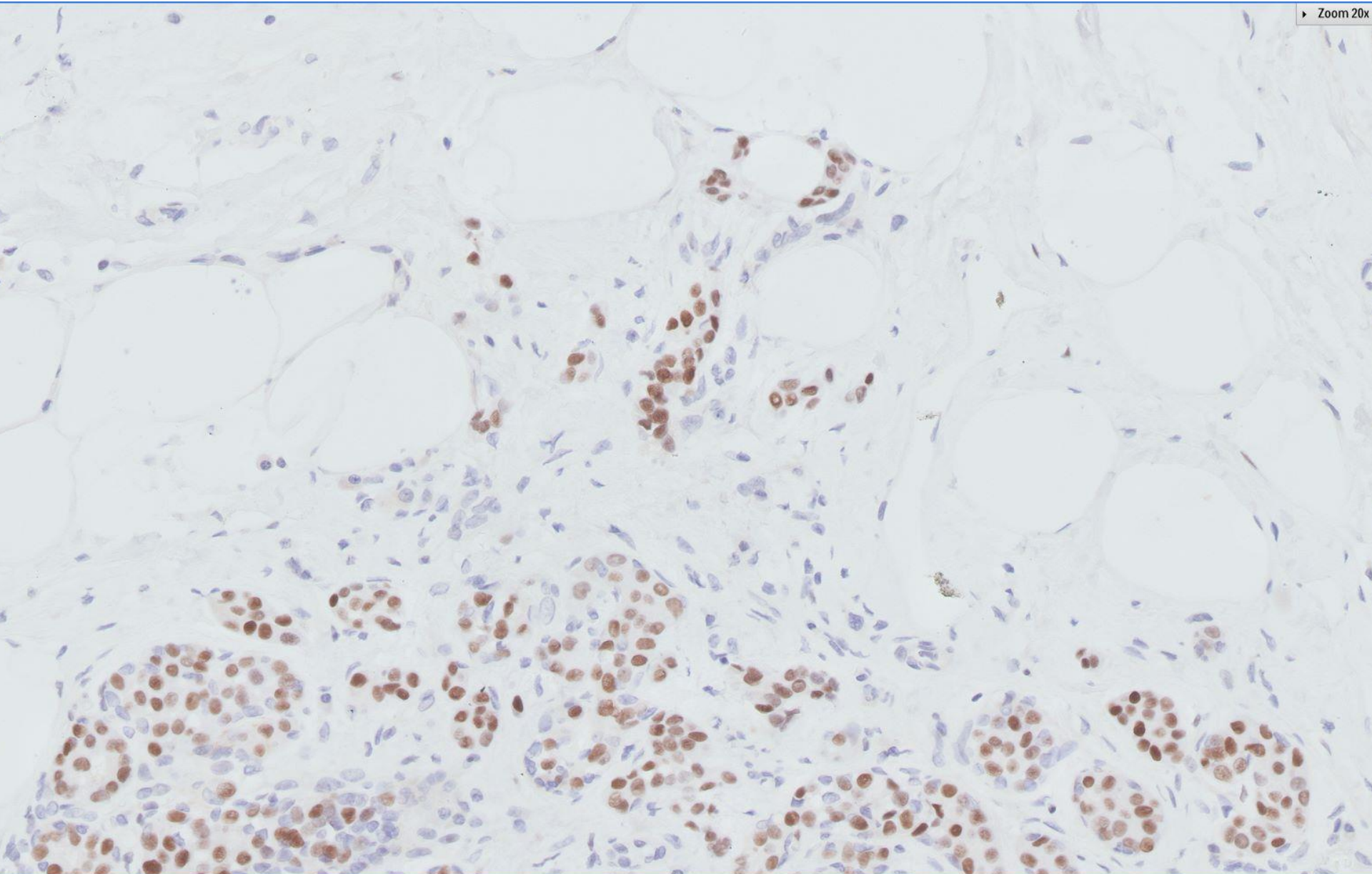




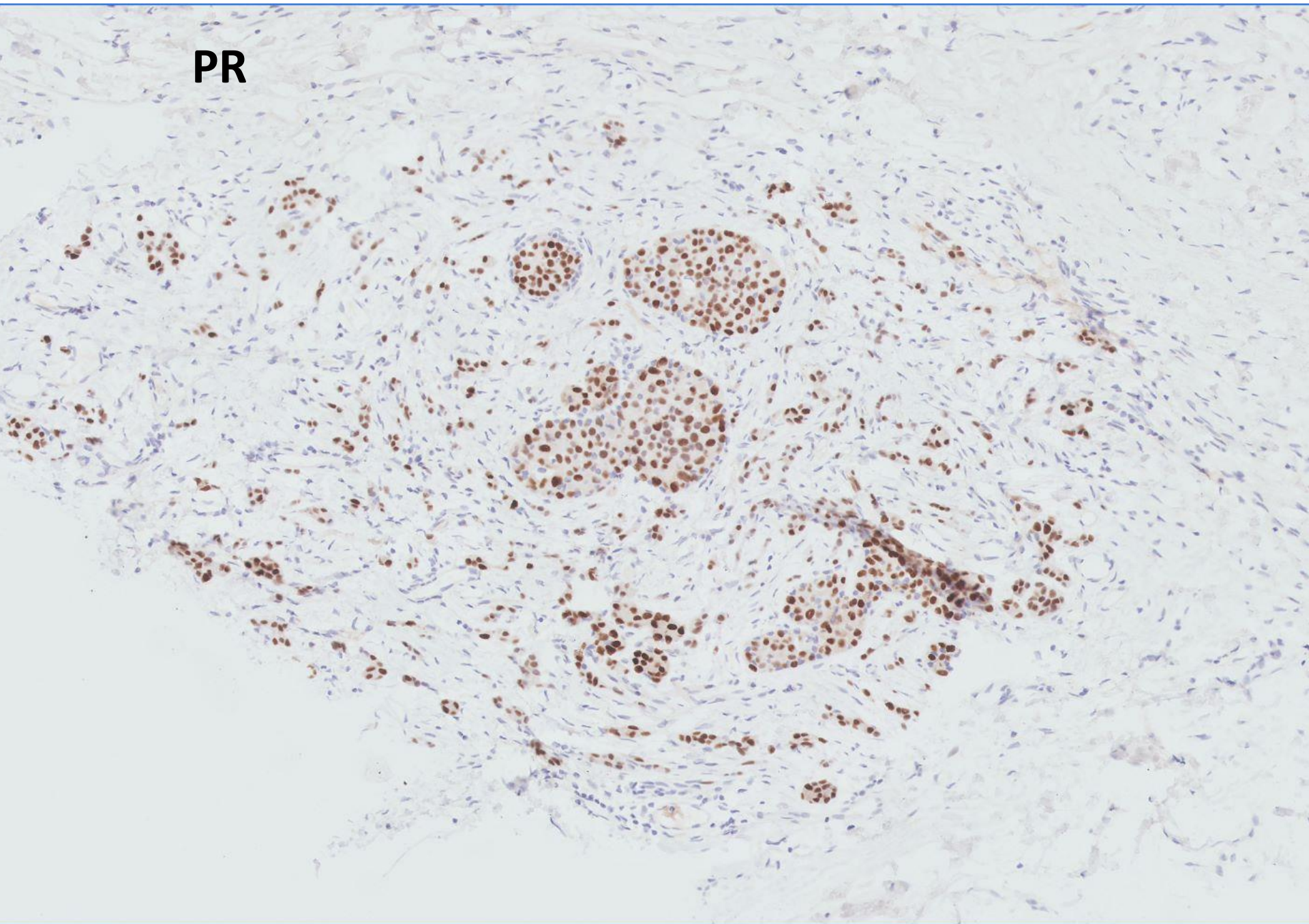




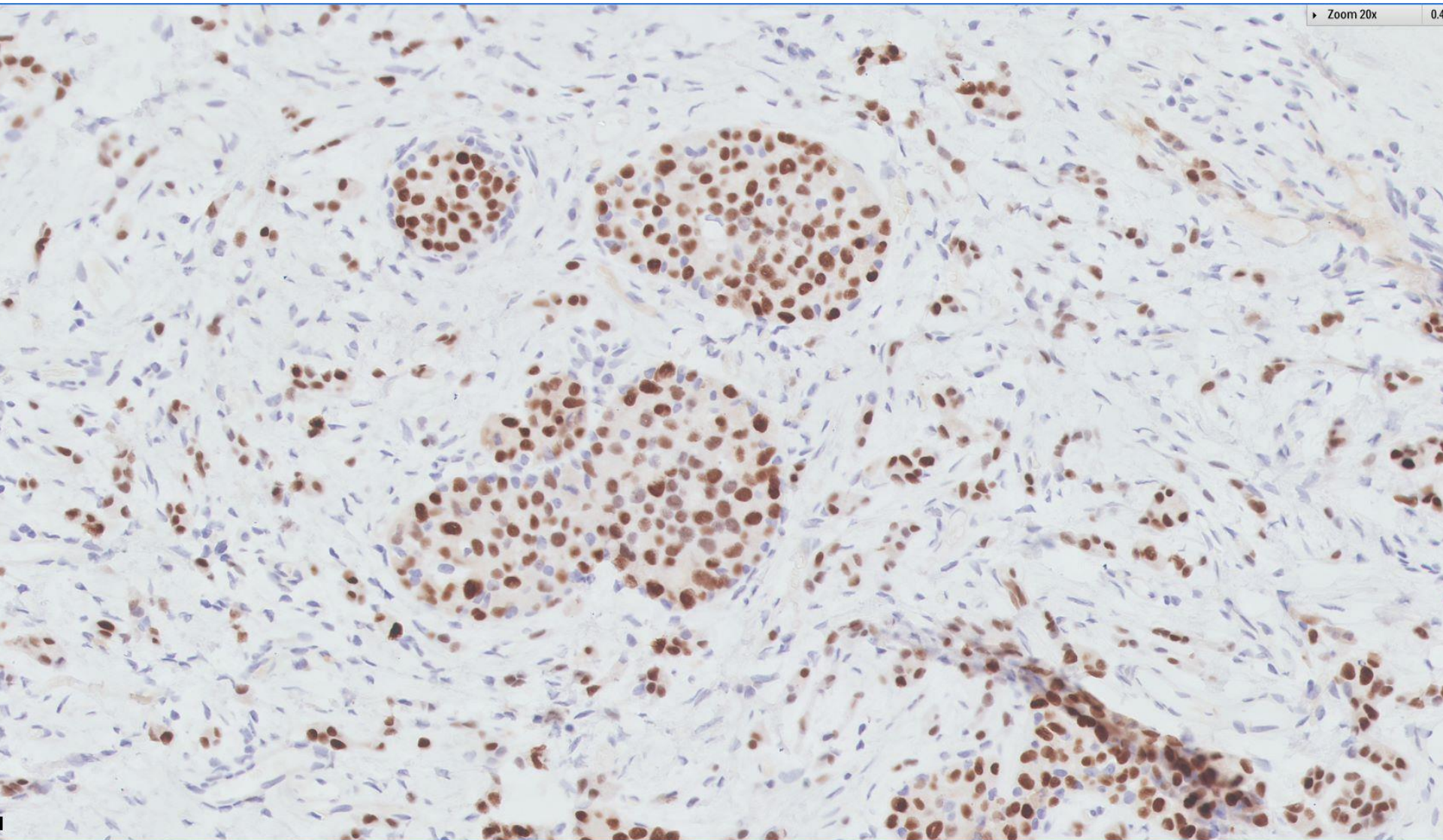
ER



PR



PR



# Diagnosis

Right breast, skin sparing mastectomy ~

***Florid lobular neoplasia comprising both atypical lobular hyperplasia and lobular carcinoma in situ, 7cm, with calcifications.***

***Invasive lobular carcinoma, 1.3mm.***

***Microinvasive lobular carcinoma, 0.4mm, 0.4mm, 0.3mm.***



Singapore  
General Hospital

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Division of Pathology

since  
**1821**  
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International Academy of Pathology  
Singapore Division

## Definition


Lobular neoplasia (LN) refers to the entire spectrum of atypical epithelial lesions originating in the terminal-duct lobular unit (TDLU) and characterized by a proliferation of generally small, non-cohesive cells, with or without pagetoid involvement of terminal ducts. The designations atypical lobular hyperplasia (ALH) and lobular carcinoma in situ (LCIS) are widely used to describe the variable extent of proliferation of the lesion. The distinction between atypical lobular hyperplasia and classic lobular carcinoma in situ is based on the extent of involvement of individual lobular units {1055,1056,1058}.

The type of invasive cancer that may arise following LN can be either lobular or ductal. Although all types of invasive carcinoma have been observed after a diagnosis of LN, invasive lobular carcinoma or special-type carcinomas are seen with higher frequency than in the general breast-cancer population (6,268,447, 1056).

Features useful for identifying which patients diagnosed with LCIS will eventually develop an invasive carcinoma have not been elucidated through clinical or pathological features (1056,1219).

The current consensus is that LN constitutes both a risk factor and a non-obligate precursor for subsequent development of invasive carcinoma in either breast, of either ductal or lobular type, but only in a minority of women after long-term follow-up.

**WHO 2012**



Histological features, including degree of pleomorphism, bulk of disease, solid-duct involvement and presence of comedo necrosis are being used to distinguish potentially more aggressive and established forms of LCIS that would appear from the limited existing evidence to merit consideration for complete excision. The definition of what constitutes bulky disease or “florid” LCIS remains debatable, but would generally incorporate involvement of several contiguous lobules by LCIS often with accompanying mass formation. Importantly for cases of classic LCIS, there is no indication that excision to negative margins is useful, and we do not recommend reporting margin status for classic LCIS. Likewise, we do not advocate the need to report presence of classic LCIS at margins when areas of pleomorphic LCIS in the same case have already been completely excised. Classic LCIS with comedo necrosis at margins can be problematic, and will require careful pathological review as stated above, as well as close discussion with the clinical managing team.

***WHO 2012***

 Breast  
Pathology  
Course 2016



*Pathology Building 1958-2013, by Ong Kim Seng*