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464 - THE IMPORTANCE OF MANAGING B3 LESIONS: A CASE REPORT

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The lesions of uncertain malignant potential of the breast, classified as B3, besides increasing the relative risk for breast cancer, have very heterogeneous abnormalities and raise a big question when defining conduct. A good multidisciplinary evaluation is necessary, comparing biopsy and imaging examination results. This study reports the case of a 54-year-old patient, without other risk factors for breast cancer, who was referred to MAMARJ, a mastology clinic, from a gynecology service, in November 2019 for evaluation of category 4 mammography, due to alterations in the right breast: linear and heterogeneous calcifications in the upper outer quadrant (UOQ) and punctiform and grouped calcifications lower inner quadrant (LIQ). Mammotomies were indicated, and histopathological reports were compatible with columnar cell hyperplasia with a focus on planar atypia — in the UOQ — and adenomyoepithelioma and columnar cell hyperplasia without atypia — in the LIQ. She was taken to surgery to remove the lesion from the UOQ (histopathology without malignancy). In July 2020, she underwent a mammography with a category 2 (BIRADS) report due to parenchymal distortion from previous surgery, and a ultrasonography with sparse cysts and bilateral ductal ectasia (category 3). One year later, in July 2021, she presented mammography — amorphous calcifications in the upper quadrants and punctate calcifications in the LIQ, near the clip from previous mammotomy. A mammotomy of the calcifications in the upper quadrants was performed. The diagnosis of the vacuum-guided biopsy was columnar cell changes with minimal architectural atypia in the upper quadrants. Removal of the lesion from the upper quadrants and the LIQ (target of the previous mammotomy) was indicated. The histopathological diagnosis was ductal carcinoma in situ (LIQ), associated with an atypical ductal hyperplasia, microcalcifications, and flat epithelial atypia. Immunohistochemical panel: estrogen receptor (ER) was positive, progesterone receptor (PR) was positive, and human epidermal growth factor receptor type 2 (HER2) was negative. The upper quadrant lesion was compatible with a focus on intraductal proliferation with discrete atypia. A simple mastectomy was performed with immediate reconstruction in the right breast. The mastectomy was indicated mainly because it was the patient's choice. As suggested, since the first diagnosis of B3 lesion and after that of ductal carcinoma in situ, the patient did not accept chemoprevention. It should be noted that risk-reducing mastectomy is cited only rarely for the prevention in cases of even recurrent and multicentric premalignant lesions, as in this case.