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Why the term of low grade ductal carcinoma *in-situ* should be changed to borderline breast disease: Diagnostic and clinical implications

During the last several years, increased public awareness, advances in breast imaging and enhanced screening programs have led to early breast cancer detection and attention to cancer prevention. e numbers of image-detected biopsies have increased and pathologists are expected to provide more information with smaller tissue samples. ese biopsies have resulted in detection of increasing numbers of high-risk proliferative breast disease and , , , , cancers. e general hypothesis is that some forms of breast cancers may arise from established forms of ductal carcinoma , , , , (DCIS) and atypical ductal hyperplasia (ADH) and possibly from more common forms of ductal hyperplasia. However, this is an over simpli cation of a very complex process, given the fact that the majority of breast cancers appears to arise de-novo or from a yet unknown precursor lesion. Currently, ADH and DCIS are considered as morphologic risk factors and precursor lesions for breast cancer. However, morphologic distinction between these two entities has remained a real issue that continues to lead to over diagnosis and overtreatment. Aside from morphologic similarities between ADH and low grade DCIS, biomarker studies and molecular genetic testing's have shown that morphologic overlaps are re ected at the molecular levels and raise questions about the validity of separating these two entities. It is hoped that as we better understand the genetic basis of these entities in relation to ultimate patient outcome, the suggested use of the term of borderline breast disease can minimize the number of patients who are subject to overtreatment.

Biography

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