

Manchester Cancer
Breast Problems in Children - Guidelines
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In the absence of a dedicated paediatric breast service in the network, breast units often get paediatric referrals. The following guidelines are suggested:

Neonates and children up to 10

All referrals should go to paediatrics

This includes conditions such as: neonatal gynaecomastia, abscesses, precocious puberty, unilateral breast bud development, galactorrhoea.

10-15 years

It is appropriate for some conditions in this age group to go to a dedicated breast unit with one-stop breast imaging available rather than a paediatric clinic. It is acceptable for the breast clinic to be predominantly for adults, but units should consider having a separate waiting area for children or see them first in the clinic.

Conditions where referral to a breast clinic is appropriate:

- Distinct lump in developing breast tissue, significant asymmetry, abscesses, bloody discharge, macromastia.
- Conditions where referral to paediatrics is appropriate:
- Galactorrhoea, severe gynaecomastia, delayed puberty.

16 years old and over

Children of 16 or over should be referred to the breast clinic.

Notes:

Lumps

Children with a distinct lump in otherwise normally developing/developed breast tissue should have an ultrasound, this is usually sufficient to make a diagnosis. Triple assessment is not indicated for solid lesions typical of a fibroadenoma, fat necrosis, intramammary node, or lipoma (1). Invasive tests (eg FNA, core biopsy) and surgical excision should be avoided unless absolutely necessary. Most children with fibroadenomas can be discharged or offered review after 6-12 months to reassess the size. Giant fibroadenomas (over 5cm) can grow rapidly and should be excised. Phyllodes tumours should be excised with clear margins, and any malignant phyllodes referred to the sarcoma service at SMUHT. Any surgery performed must follow national standards (see ref 2).

Breast cancers are extremely uncommon in children, and when they do occur they are usually a metastases from elsewhere. A strong family history suggesting a Li Fraumeni mutation or a history of chest irradiation should raise suspicion.

Gynaecomastia

Gynaecomastia is common and peaks at age 13-14. It usually settles within 2 years. Severe gynaecomastia out of keeping with body habitus should be referred to the paediatricians for

exclusion of Klinefelter's, testicular feminisation, hormone secreting tumours, thyroid dysfunction etc.

Abscesses

Neonatal abscesses are managed by paediatricians, with iv antibiotics and referral to paediatric surgery if they fail to settle. Abscesses in older children are treated by ultrasound guided aspiration and antibiotics, with surgery reserved for cases that have necrotic skin.

Pain

The developing breast bud can be tender and patients should be reassured and advised to use simple analgesia. Older children can have fibrocystic changes which may respond to dietary advice (reduce caffeine and fatty foods).

Nipple discharge

Milky discharge (galactorrhoea) can occur from gynaecomastia, but should be referred to paediatrics for exclusion of pituitary, thyroid and renal problems. Clear or bloody discharge can occur in boys and girls due to mammary duct ectasia. The discharge is usually unilateral, and an ultra-sound may show dilated ducts. The discharge usually settles spontaneously. Surgery is not recommended if the diagnosis is certain.

Macromastia

Breast reduction surgery should be avoided until the breasts have stopped growing.

Asymmetry

Asymmetry due to one breast bud growing before the other is quite common, most differences even out with time and do not need investigating or treating. Asymmetry due to a discrete mass should be investigated with an ultra-sound scan. Gross asymmetry may be suitable for symmetrising surgery with unilateral tissue expander, and patients can be referred to their local breast surgeon for assessment, or to a paediatric surgeon.

Surgery in children

Any units performing surgery in children should make sure the correct governance procedures around admission, ward staffing, anaesthetist care, surgeon, paediatric cover etc. are in place (ref 2). For children aged 16-17 the choice of treatment on an adult or children's ward will depend on local service provision; however it is preferable that the patient has a choice of treatment in either environment.

References

- 1 Best Practice Diagnostic Guidelines for Patients Presenting with Breast Symptoms, ABS, November 2010.
- 2 Royal College of surgeons; Standards for Children's Surgery, 2013