# Diagnostik und Therapie früher und fortgeschrittener Mammakarzinome



Guidelines Breast
Version 2019.1D

FORSCHEN
LEHREN
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## Pathologie


Screened data bases: PubMed 2018.

Search Query:

(Breast Diseases/PA[mh] AND ("2018/01/01"[dp] : "2019/01/01"[dp]) AND ("english"[la] OR "german"[la])

Guidelines screened

- Interdisziplinäre S3-Leitlinie für die Diagnostik, Therapie und Nachsorge des Mammakarzinoms. Aktualisierung 2017
- NCCN Breast cancer V.I.2014Cochrane: Decision aids for risk communication update 2009
- EUSOMA position paper: Diagnosis of breast disease
- Royal College of Pathologists & NHS Breast Screening Programme, Pathology Reporting of Breast Disease, January 2005
- European guidelines for quality assurance in breast cancer screening and diagnosis 4th Edition

1. Arbeitsgruppe Qualitätssicherung Pathologie in der konzertierten Aktion zur Brustkrebsfrüherkennung in Deutschland (2002).

Anleitung Mammapathologie.

2. Stufe-3-Leitlinie Brustkrebs-Früherkennung in Deutschland 2008. http://www.senologie.org/download/pdf/s3_brustkrebsfrueherkennung_2008.pdf
3. Association of Directors of Anatomic and Surgical Pathology (1996). Recommendations for the reporting of breast carcinoma. Mod Pathol. 1996 Jan;9(1):77-81.
4. Deutsche Krebsgesellschaft und beteiligte medizinisch-wissenschaftliche Fachgesellschaften (2008). Interdisziplinäre Leitlinie Diagnose und Therapie des Mammakarzinoms der Frau. http://www.senologie.org/download/pdf/s3_ll_mammaca_11_02_2008.pdf
5. Lester SC, Bose S, Chen YY, et al: Members of the Cancer Committee, College of American Pathologists. Protocol for the examination of specimens from patients with invasive carcinoma of the breast. Arch Pathol Lab Med. 2009 Oct;133(10):1515-38.
6. Reiner-Concin, S. Lax. Mammakarzinom Pathologie. In: Manual der gynäkologischen Onkologie. Arbeitsgemeinschaft für gynäkologische Onkologie (AGO) der Österreichischen Gesellschaft für Gynäkologie und Geburtshilfe (OEGGG) A. Reinthaller, L. Hefler (Hrsg.) http://www.ago-manual.at/inhalt/i-mammakarzinom/15-pathologie/
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9. Royal College of Pathologists (UK) (2005). NHSBSP guidelines for pathology reporting in breast disease. http://www.cancerscreening.nhs.uk/breastscreen/publications/nhsbsp58.html
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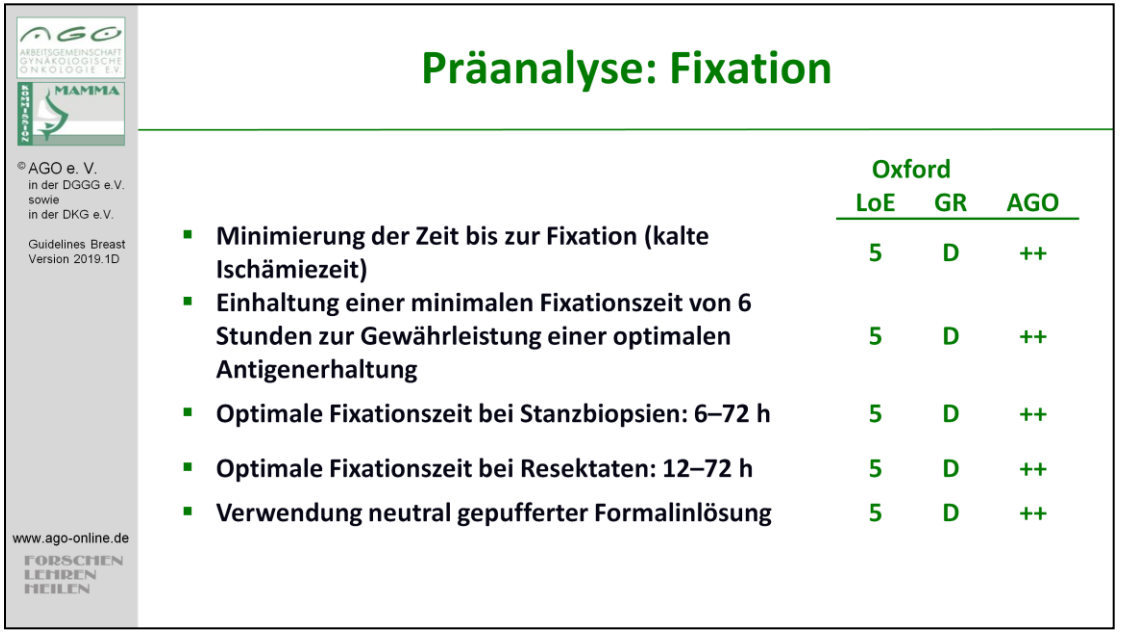



Antigen preservation

1. Apple, S., Pucci, R., Lowe, A. C., et al. (2011). The effect of delay in fixation, different fixatives, and duration of fixation in estrogen and progesterone receptor results in breast carcinoma. American Journal of Clinical Pathology, 135(4), 592–598.
2. De Cecco, L., Musella, V., Veneroni, S., Cappelletti, V., Bongarzone, I., Callari, M., et al. (2009). Impact of biospecimens handling on biomarker research in breast cancer. *BMC Cancer*, *9*, 409. http://doi.org/10.1186/1471-2407-9-409
3. Kalkman, S., Barentsz, M. W., & van Diest, P. J. (2014). The Effects of Under 6 Hours of Formalin Fixation on Hormone Receptor and HER2 Expression in Invasive Breast Cancer: A Systematic Review. American Journal of Clinical Pathology, 142(1), 16–22.
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7. Wolff, A. C., Hammond, M. E. H., Allison, K. H. et al. (2018). Human Epidermal Growth Factor Receptor 2 Testing in Breast Cancer:

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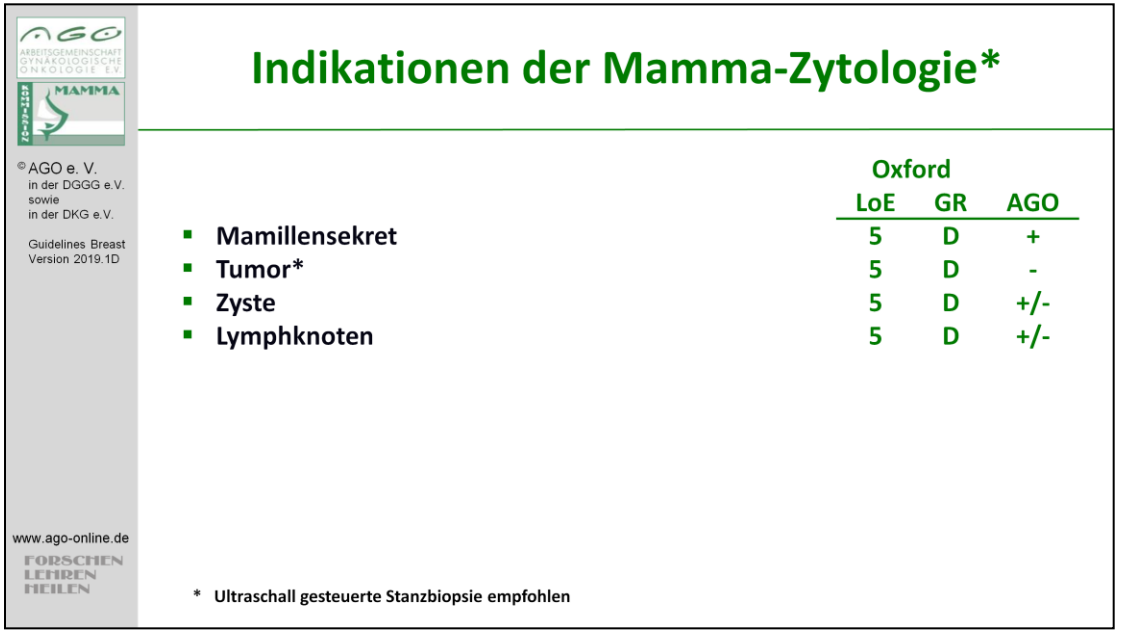
Retraction artifacts

1. Ragage, F., Debled, M., MacGrogan, G., et al. (2010). Is it useful to detect lymphovascular invasion in lymph node-positive patients with primary operable breast cancer? *Cancer*, *116*(13), 3093–3101.
2. Lester, S. C., Bose, S., Chen, Y.-Y., et al. (2009). Protocol for the examination of specimens from patients with invasive carcinoma of the breast. Arch Pathol Lab Med, 133(10), 1515–1538.





1. Day, C, N Moatamed, AM Fimbres, et al: A Retrospective Study of the Diagnostic Accuracy of Fine-Needle Aspiration for Breast Lesions and Implications for Future Use. Diagnostic Cytopathology 36, no. 12 (November 30, 2008): 855–60.
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3. Tse, G M K, T K F Ma, P C W Lui, et al. Fine Needle Aspiration Cytology of Papillary Lesions of the Breast: How Accurate Is the Diagnosis?. Journal of Clinical Pathology 61, no. 8 (August 2008): 945–49. doi:10.1136/jcp.2008.057489.
4. Ibrahim AE, Bateman AC, Theaker JM, et al. The role and histological classification of needle core biopsy in comparison with fine needle aspiration cytology in the preoperative assessment of impalpable breast lesions. J Clin Pathol 2001;54:121–5.
5. He, X., Wang, Y., Nam, G., Lourenco, A. P. et al. (2018). A 10 year retrospective review of fine needle aspiration cytology of cystic lesions of the breast with emphasis on papillary cystic lesions. *Diagnostic Cytopathology*. http://doi.org/10.1002/dc.24123
6. Bruzzone, M., Saro, F., Bruno, S. et al. (2018). Synergy of cytological methods in the pathological staging of breast cancer: Axillary fine-needle aspiration and intraoperative scrape cytology of the sentinel lymph node. *Diagnostic Cytopathology*, *46*(11), 919–926. http://doi.org/10.1002/dc.23995
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needle aspiration cytology correlation. *Journal of Cancer Research and Therapeutics*, *14*(5), 1071–1074. http://doi.org/10.4103/0973-1482.191053



Statement: Routine workup in step sections

1. Hahn, M., Krainick-Strobel, U., Toellner, T. et al. (2012). Interdisciplinary consensus recommendations for the use of vacuum-assisted breast biopsy under sonographic guidance: first update 2012. *Ultraschall Med*, *33*(4), 366–371. http://doi.org/10.1055/s-0032-1312831
2. Sinn, Gerber, Brucker et al. (2017): DCIS und Risikoläsionen. In: AWMF: S3-Leitlinie Früherkennung, Diagnostik, Therapie und Nachsorge des Mammakarzinoms, S. 79 - 89.

Statement: Correlation with imaging

1. Heywang-Köbrunner SH, Sinnatamby R, Lebeau A, et al; Consensus Group. Interdisciplinary consensus on the uses and technique of MR-guided vacuum-assisted breast biopsy (VAB): results of a European consensus meeting. Eur J Radiol. 2009 Nov;72(2):289-94
2. Sinn, Gerber, Brucker et al. (2017): DCIS und Risikoläsionen. In: AWMF: S3-Leitlinie Früherkennung, Diagnostik, Therapie und Nachsorge des Mammakarzinoms, S. 79 - 89.

Statement: Frozen section diagnosis on core biopsies

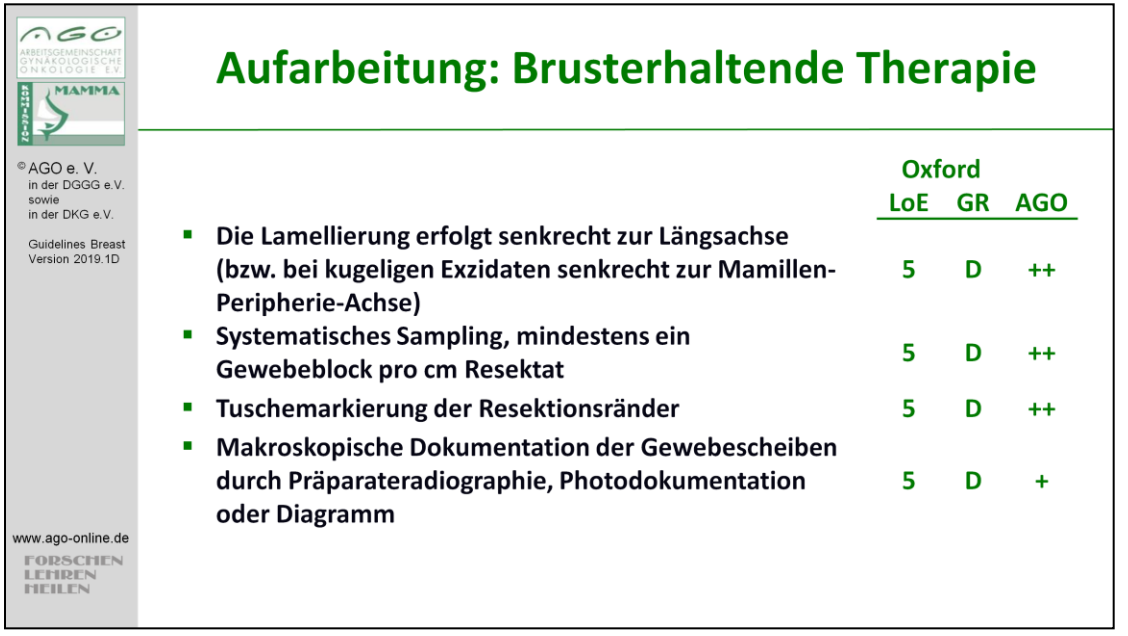

1. Lebeau, Gerber, Brucker et al. (2017): Pathomorphologische Untersuchung. In: AWMF: S3-Leitlinie Früherkennung, Diagnostik, Therapie und Nachsorge des Mammakarzinoms, S. 100 - 139.
2. Dämmrich, M., Thomssen, C., Hillemanns, P. et al. (2012). Intraoperative pathologische Sofortuntersuchung in der Mammachirurgie. *Der Pathologe*, *33*(5), 424–429. http://doi.org/10.1007/s00292-012-1596-6


Statement: Routine evaluation of ER/PgR and HER-2 status


1. Dekker, T. J. A., Smit, V. T. H. B. M., Hooijer, G. K. J. et al. (2013). Reliability of core needle biopsy for determining ER and HER2 status in breast cancer. *Annals of Oncology*, *24*(4), 931–937. http://doi.org/10.1093/annonc/mds599
2. Meattini, I., Bicchierai, G., Saieva, C. et al. (2017). Impact of molecular subtypes classification concordance between preoperative core needle biopsy and surgical specimen on early breast cancer management: Single-institution experience and review of published literature. *European Journal of Surgical Oncology : the Journal of the European Society of Surgical Oncology and the British Association of Surgical Oncology*, *43*(4), 642–648. http://doi.org/10.1016/j.ejso.2016.10.025


Statement: Turn-around time < 24h


1. Amendoeira I, Apostolikas N, Bellocq et al. Quality assurance guidelines for pathology: Open biopsy and resection specimens. In: Perry N, Broders M, de Wolf C, Törnberg S, Holland R, von Karsa L, Puthaar E (eds) European guidelines for quality assurance in breast cancer





1. Sinn HP, Anton HW, Magener A, et al. Extensive and predominant in situ component in breast carcinoma: their influence on treatment results after breast-conserving therapy. Eur J Cancer. 1998 Apr;34(5):646-53.
2. Connolly JL, Boyages J, Nixon AJ et al. Predictors of breast recurrence after conservative surgery and radiation therapy for invasive breast cancer. Mod Pathol. 1998;11:134-139.
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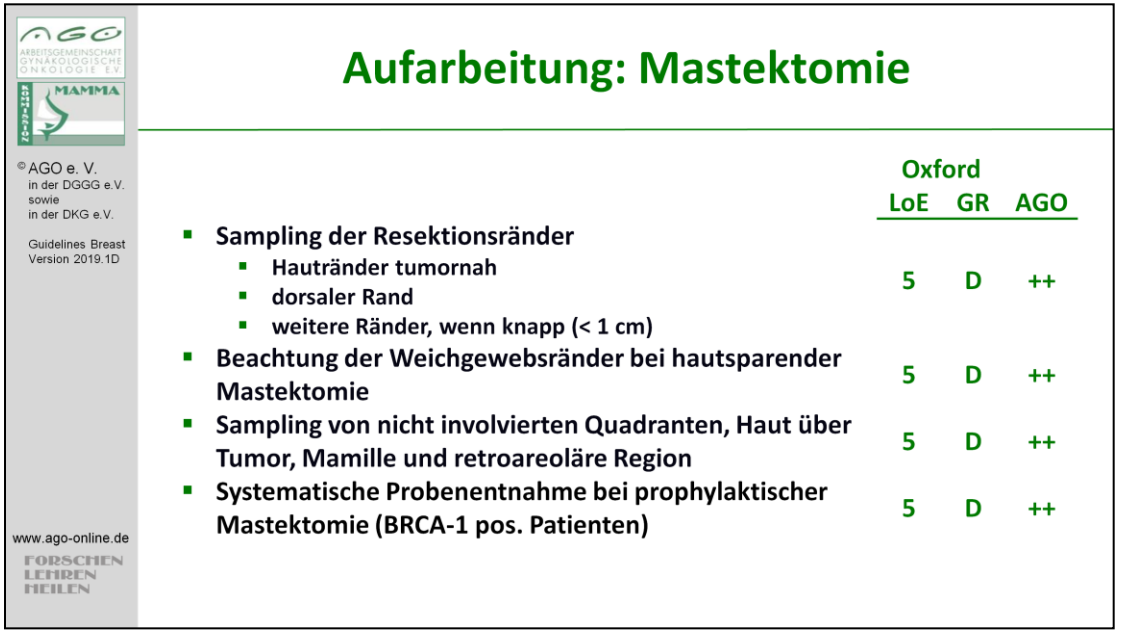



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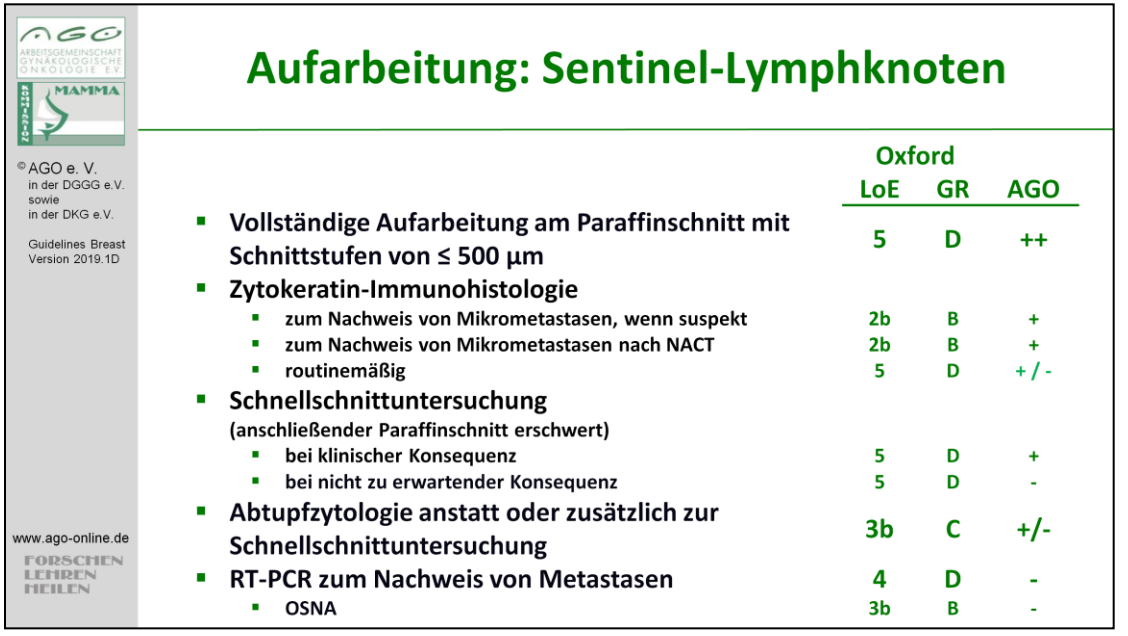
3. A. Reiner-Concin, S. Lax. Mammakarzinom Pathologie. In: Manual der gynäkologischen Onkologie. Arbeitsgemeinschaft für gynäkologische Onkologie (AGO) der Österreichischen Gesellschaft für Gynäkologie und Geburtshilfe (OEGGG) A. Reinthaller, L. Hefler (Hrsg.) http://www.ago-manual.at/inhalt/i-mammakarzinom/15-pathologie/





Statement: Evaluation of sentinel node biopsy

1. Maguire, A., & Brogi, E. (2016). Sentinel lymph nodes for breast carcinoma: an update on current practice. *Histopathology*, *68*(1), 152–167. http://doi.org/10.1111/his.12853

Statement: Full workup using step sections of ≥ 500 µm on paraffin embedded tissue

1. Maguire, A., & Brogi, E. (2016). Sentinel lymph nodes for breast carcinoma: an update on current practice. *Histopathology*, *68*(1), 152–167. http://doi.org/10.1111/his.12853

Statement: Frozen section

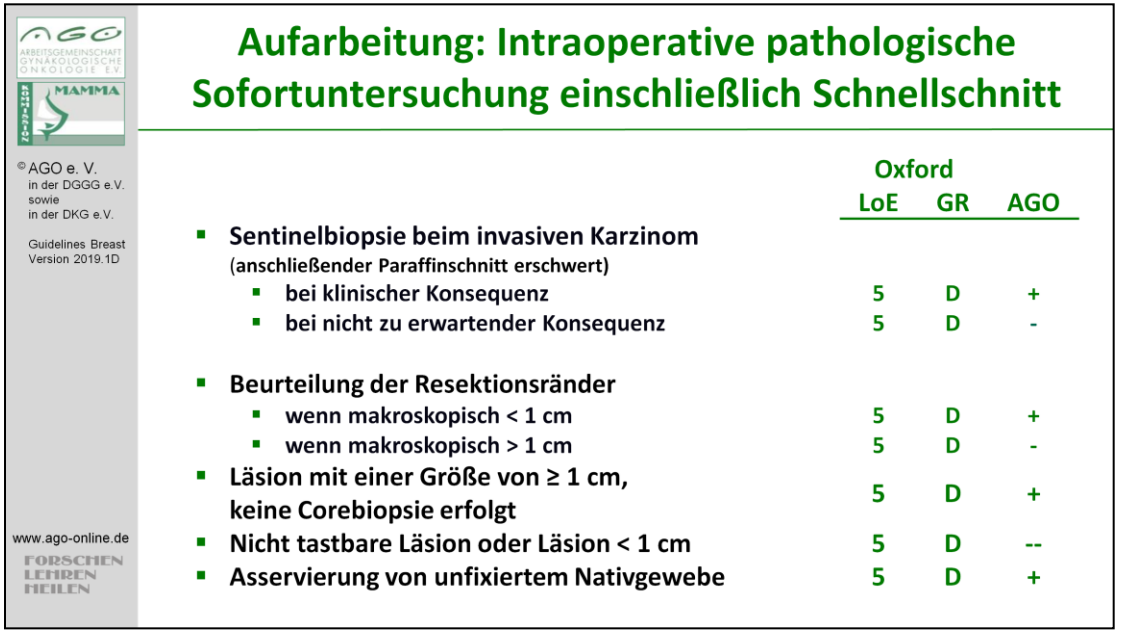
1. Langer, I., Guller, U., Berclaz, G. et al. (2009). Accuracy of frozen section of sentinel lymph nodes: a prospective analysis of 659 breast cancer patients of the Swiss multicenter study. *Breast Cancer Research and Treatment*, *113*(1), 129–136. http://doi.org/10.1007/s10549-008-9911-x

Statement: Imprint cytology instead or in addition of frozen section


1. Layfield et al. Intraoperative assessment of sentinel lymph nodes in breast cancer. The British journal of surgery (2011) vol. 98 (1) pp. 4-17
2. Upender, S., Mohan, H., Handa, U. et al. (2009). Intraoperative evaluation of sentinel lymph nodes in breast carcinoma by imprint cytology, frozen section and rapid immunohistochemistry. *Diagnostic Cytopathology*, *37*(12), 871–875. http://doi.org/10.1002/dc.21120


Statement: RT-PCR for epithelial genes


1. Layfield, D. M., Agrawal, A., Roche, H. et al. (2011). Intraoperative assessment of sentinel lymph nodes in breast cancer. *The British Journal of Surgery*, *98*(1), 4–17. http://doi.org/10.1002/bjs.7229
2. Visser, M., Jiwa, M., Horstman, A. et al. (2008). Intra-operative rapid diagnostic method based on CK19 mRNA expression for the detection of lymph node metastases in breast cancer. *International Journal of Cancer Journal International Du Cancer*, *122*(11), 2562–2567. http://doi.org/10.1002/ijc.23451





Statement: Sentinel node biopsy for invasive cancer

1. Kühn T, Bembenek A, Decker T et al. A concept for the clinical implementation of sentinel lymph node biopsy in patients with breast carcinoma with special regard to quality assurance. Cancer 2005; 103: 451-461.
2. Grabau D, Rank F, Friis E. Intraoperative frozen section examination of axillary sentinel lymph nodes in breast cancer. APMIS 2005; 113: 7-12.
3. Van Diest PJ, Torrenga H, Borgstein PJ et al. Reliability of intraoperative frozen section and imprint cytological investigation of sentinel lymph nodes in breast cancer. Histopathology 1999; 35: 14-18.

Statement: Closest margin of resection

1. Reiner-Concin A, Lax S. Mammakarzinom. In: Manual der gynäkologischen Onkologie (Reinthaler R, Helfer L, Hrsg.). http://www.ago-manual.at/inhalt/i-mammakarzinom/15-pathologie/
2. Kraus-Tiefenbacher U, Scheda A, Steil V, et al.Intraoperative radiotherapy (IORT) for breast cancer using the Intrabeam system. Tumori. 2005;91:339-45

Statement: Lesions ≥ 1 cm, without core biopsy


1. Reiner-Concin A, Lax S. Mammakarzinom. In: Manual der gynäkologischen Onkologie (Reinthaler R, Helfer L, Hrsg.). http://www.ago-manual.at/inhalt/i-mammakarzinom/15-pathologie/
2. Fitzgibbons PL, Connolly JL, Page DL. Updated protocol for the examination of specimens from patients with carcinomas of the breast. Arch Pathol Lab Med 2000; 124:1026- 1033. (ACR)
3. Amendoeira I, Apostolikas N, Bellocq et al. Quality assurance guidelines for pathology: Open biopsy and resection specimens. In: Perry N, Broders M, de Wolf C, et al (eds) European guidelines for quality assurance in breast cancer screening and diagnosis; Office for Official Publications of the European Communities, Luxembourg, 2006, pp 256-311

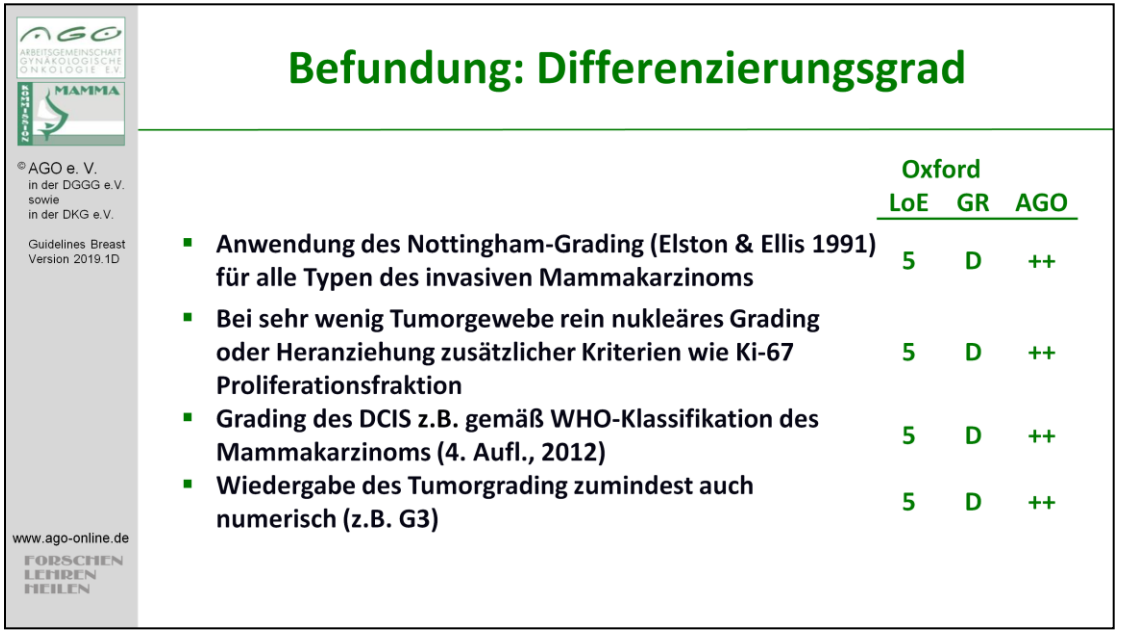

Statement: Non-palpable lesions or lesions < 1 cm


1. Morrow M, Strom E, Bassett L et al. Standard for the management of ductal carcinoma in situ of the breast (DCIS). CA Cancer J Clin 2002; 52: 256-276.



WHO-Classification

1. Lebeau, A., Kriegsmann, M., Burandt, E., et al (2014). Invasive Mammakarzinome: Die aktuelle WHO classification. Der Pathologe, 35(1), 7–17.
2. Lakhani SR, Ellis I, Schnitt S et al. (2012) WHO Classification of Tumours of the Breast. IARC Press, Lyon
3. Tan, P. H., & Ellis, I. O. (2013). Myoepithelial and epithelial-myoepithelial, mesenchymal and fibroepithelial breast lesions: updates from the WHO Classification of Tumours of the Breast 2012. Journal of Clinical Pathology, 66(6), 465–470. doi:10.1136/jclinpath-2012-201078
4. Viale, G. (2012). The current state of breast cancer classification. Annals of Oncology : Official Journal of the European Society for Medical Oncology / ESMO, 23 Suppl 10(suppl 10), x207–x210. doi:10.1093/annonc/mds326



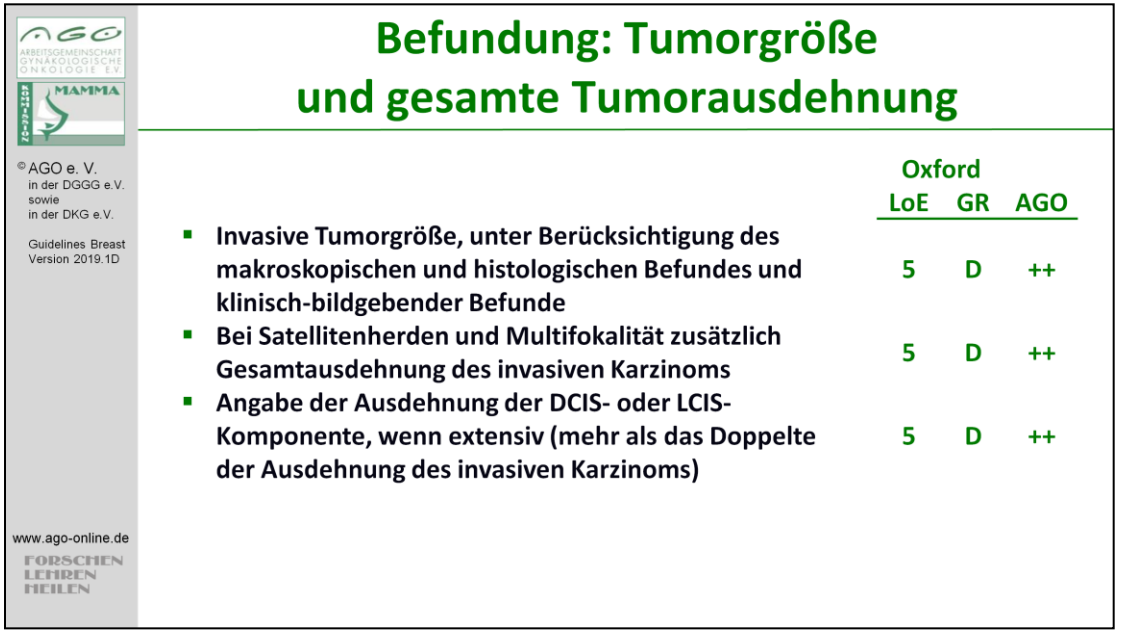


Grading

1. Elston, C., & Ellis, I. (1991). Pathological prognostic factors in breast cancer. I. The value of histological grade in breast cancer: experience from a large study with long-term follow-up. Histopathology, 19(5), 403–410.
2. Lakhani SR, Ellis I, Schnitt S et al. (2012) WHO Classification of Tumours of the Breast. IARC Press, Lyon
3. Rakha, E. A., Reis-Filho, J. S., Baehner, F., et al. (2010). Breast cancer prognostic classification in the molecular era: the role of histological grade. Breast Cancer Research : BCR, 12(4), 207.
4. Rakha, E. A., El-Sayed, M. E., Lee, A. H. S. et al. (2008). Prognostic Significance of Nottingham Histologic Grade in Invasive Breast Carcinoma. Journal of Clinical Oncology : Official Journal of the American Society of Clinical Oncology, 26(19), 3153–3158

Grading of invasive lobular carcinoma

1. Rakha, E. A., El-Sayed, M. E., Menon, S., et al. (2007). Histologic grading is an independent prognostic factor in invasive lobular carcinoma of the breast. Breast Cancer Research and Treatment, 111(1), 121–127.





Determination of tumor size

1. Pritt, B., Tessitore, J. J., Weaver, D. L. et al(2005). The effect of tissue fixation and processing on breast cancer size. Human Pathology, 36(7), 756–760.
2. Varma, S., Ozerdem, U., & Hoda, S. A. (2014). Complexities and challenges in the pathologic assessment of size (T) of invasive breast carcinoma. Advances in Anatomic Pathology, 21(6), 420–432.

Multifocality

1. Hilton, J. F., Bouganim, N., Dong, B., et al. (2013). Do alternative methods of measuring tumor size, including consideration of multicentric/multifocal disease, enhance prognostic information beyond TNM staging in women with early stage breast cancer: an analysis of the NCIC CTG MA.5 and MA.12 clinical trials. Breast Cancer Research and Treatment, 142(1), 143–151.
2. NHS (2005) Pathology Reporting of Breast Disease. IA Joint Document Incorporating the Third Edition of the NHS Breast Screening Programme's Guidelines for Pathology Reporting in Breast Cancer Screening and the Second Edition of The Royal College of Pathologists' Minimum Dataset for Breast Cancer Histopathology http://www.cancerscreening.nhs.uk/breastscreen/publications/nhsbsp58-low-resolution.pdf

3. Perry N, Broeders M, de Wolf C, et al. European guidelines for quality assurance in breast cancer screening and diagnosis. Fourth edition--summary document. Annals of Oncology. 2008 Apr 1;19(4):614–22.
4. Tot, T., Gere, M., Pekár, G., et al. (2011). Breast cancer multifocality, disease extent, and survival. Human Pathology, 42(11), 1761–1769.

Extensive intraductal component (EIC)

1. Mai, K. T., Perkins, D. G., & Mirsky, D. (2003). Location and extent of positive resection margins and ductal carcinoma in situ in lumpectomy specimens of ductal breast carcinoma examined with a microscopic three-dimensional view. The Breast Journal, 9(1), 33–38.
2. Smitt, M. C., Nowels, K., Carlson, R. W., et al. (2003). Predictors of reexcision findings and recurrence after breast conservation. International Journal of Radiation OncologyBiologyPhysics, 57(4), 979–985
3. Schnitt, S. J., Connolly, J. L., Khettry, U., et al. (1987). Pathologic findings on re-excision of the primary site in breast cancer patients considered for treatment by primary radiation therapy. Cancer, 59(4), 675–681.
4. Sinn, H. P., Anton, H. W., Magener, A., et al. (1998). Extensive and predominant in situ component in breast carcinoma: their influence on treatment results after breast-conserving therapy. European Journal of Cancer, 34(5), 646–653.



TNM staging (7th ed.) according to UICC und AJCC

1. UICC (2010) TNM: Klassifikation maligner Tumoren. 7. Aufl. Wiley-VCH Verlag GmbH
2. American-Joint-Committee-on-Cancer (2010) AJCC cancer staging manual. Springer, New York; London

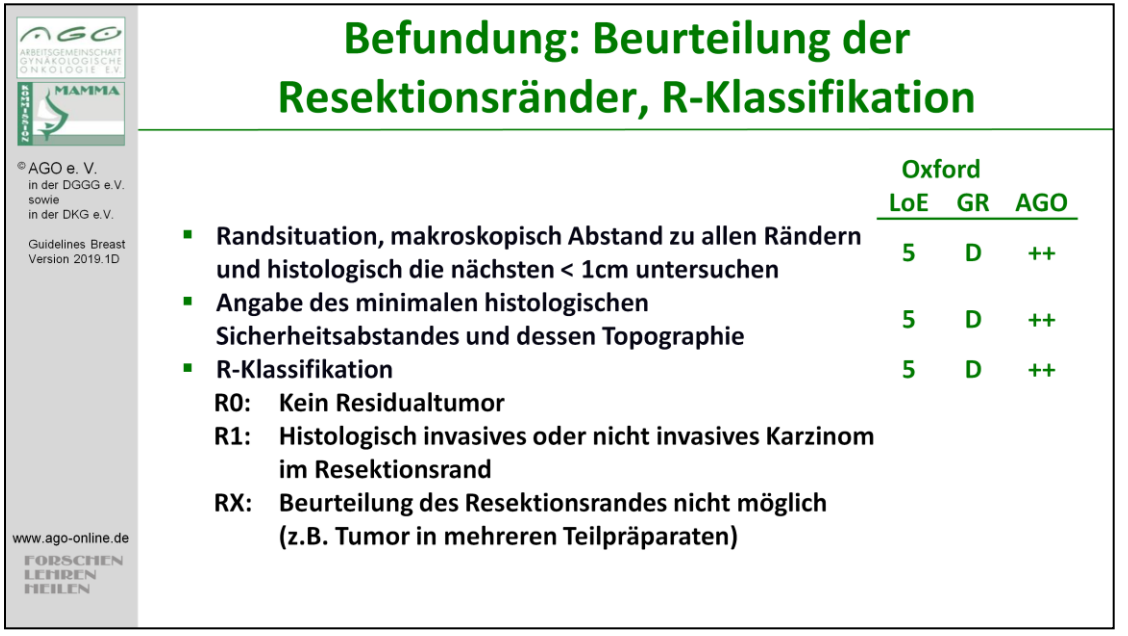
pT4b category: Involvemant of the skin

1. Wieland, A., Louwman, M., Voogd, A., et al. (2004). Determinants of prognosis in breast cancer patients with tumor involvement of the skin (pT4b). The Breast Journal, 10(2), 123–128. doi:21279 [pii]
2. Harms, K., & Wittekind, C. (2009). Prognosis of women with pT4b breast cancer: the significance of this category in the TNM system. European Journal of Surgical Oncology : the Journal of the European Society of Surgical Oncology and the British Association of Surgical Oncology, 35(1), 38–42. doi:10.1016/j.ejso.2007.11.016

pT4d category: Inflammatory breast cancer

1. Yamauchi, H., Woodward, W. A., Valero, V., et al. (2012). Inflammatory breast cancer: what we know and what we need to learn.

The Oncologist, 17(7), 891–899. doi:10.1634/theoncologist.2012-0039





Pathological margin assessment

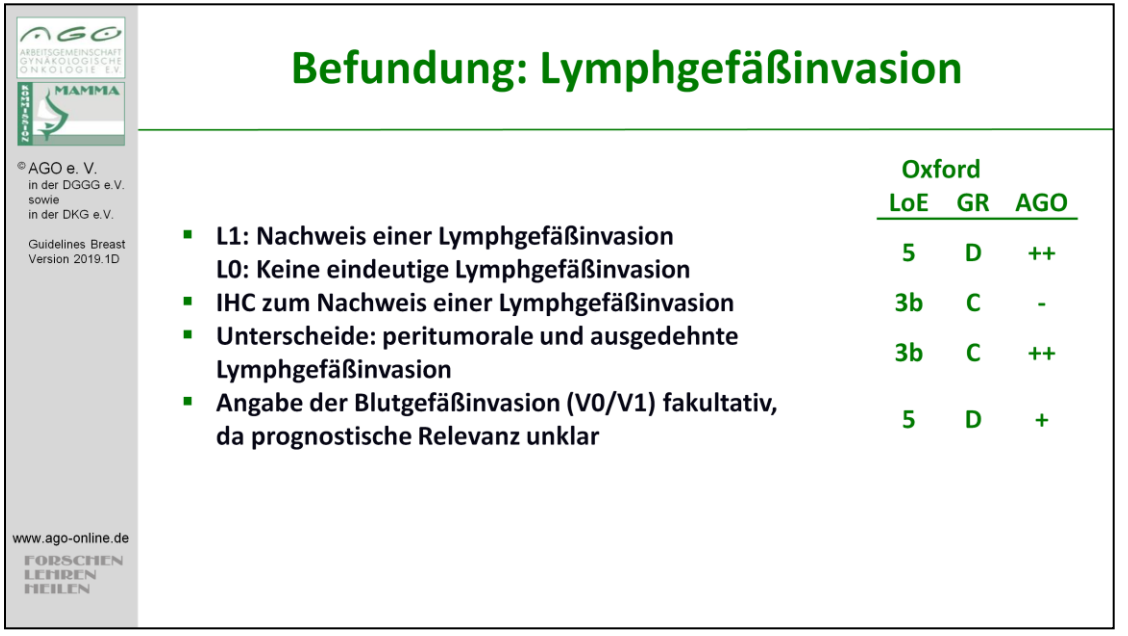
1. Dooley, W. C., & Parker, J. (2005). Understanding the mechanisms creating false positive lumpectomy margins. American Journal of Surgery, 190(4), 606–608. doi:10.1016/j.amjsurg.2005.06.023
2. Graham, R. A., Homer, M. J., Katz, J., et al. (2002). The pancake phenomenon contributes to the inaccuracy of margin assessment in patients with breast cancer. American Journal of Surgery, 184(2), 89–93.
3. Houssami, N., & Morrow, M. (2014). Margins in breast conservation: a clinician's perspective and what the literature tells us. Journal of Surgical Oncology, 110(1), 2–7. doi:10.1002/jso.23594
4. Houssami, N., Macaskill, P., Marinovich, M. L., et al. (2014). The association of surgical margins and local recurrence in women with early-stage invasive breast cancer treated with breast-conserving therapy: a meta-analysis. Annals of Surgical Oncology, 21(3), 717–730.
5. Keskek, M., Kothari, M., Ardehali, B. et al. (2004). Factors predisposing to cavity margin positivity following conservation surgery for breast cancer. European Journal of Surgical Oncology, 30(10), 1058–1064. doi:10.1016/j.ejso.2004.07.019
6. Schnitt, S. J., Moran, M. S., Houssami, N., et al. (2014). The Society of Surgical Oncology-American Society for Radiation Oncology Consensus Guideline on Margins for Breast-Conserving Surgery With Whole-Breast Irradiation in Stages I and II Invasive Breast

Cancer: Perspectives for Pathologists. Archives of Pathology & Laboratory Medicine. doi:10.5858/arpa.2014-0384-ED

7. Yeap, B. H., Muniandy, S., Lee, S.-K., et al. (2007). Specimen shrinkage and its influence on margin assessment in breast cancer. Asian Journal of Surgery / Asian Surgical Association, 30(3), 183–187. doi:10.1016/S1015-9584(08)60020-2

R-Classifikation

1. UICC (2010) TNM: Klassifikation maligner Tumoren. 7. Aufl. Wiley-VCH Verlag GmbH





Definition of L- and V-Classification

1. UICC (2010) TNM: Klassifikation maligner Tumoren. 7. Aufl. Wiley-VCH Verlag GmbH

Detection of angioinvasion

1. Manfrin, E., Remo, A., Pancione, M. et al. (2014). Comparison between invasive breast cancer with extensive peritumoral vascular invasion and inflammatory breast carcinoma: a clinicopathologic study of 161 cases. American Journal of Clinical Pathology, 142(3), 299–306. doi:10.1309/AJCPOXKX67KRAOVM
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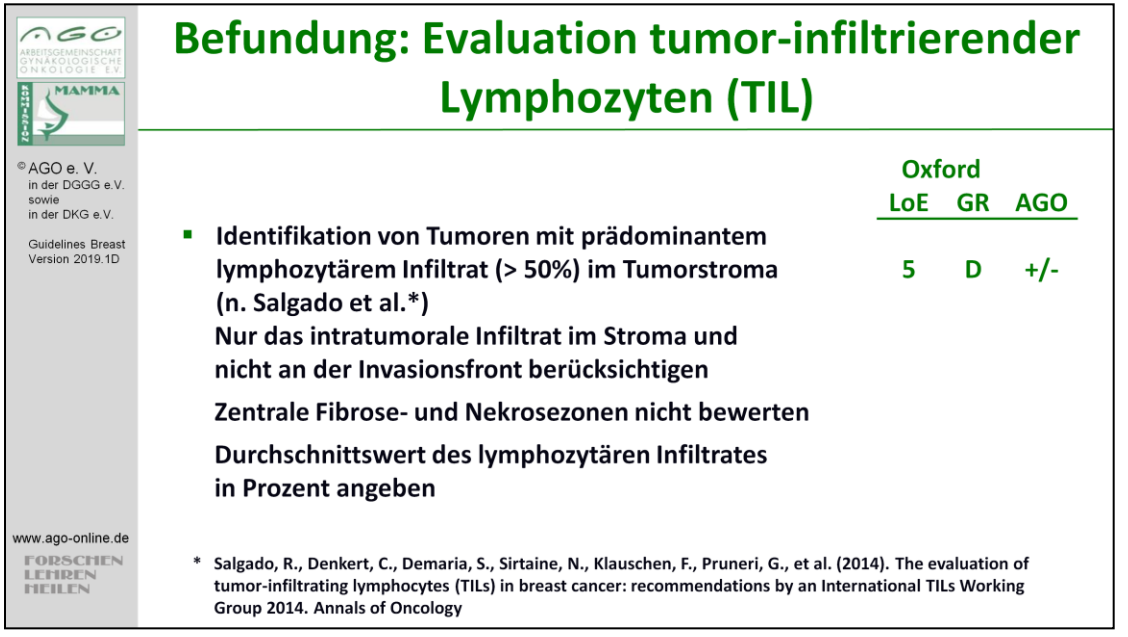


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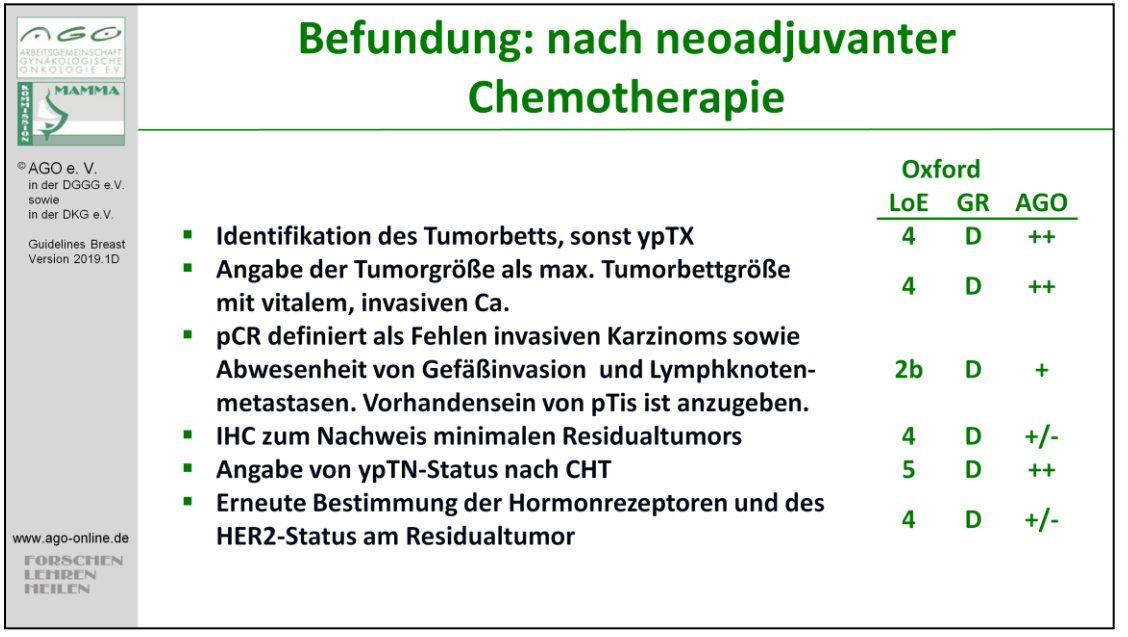



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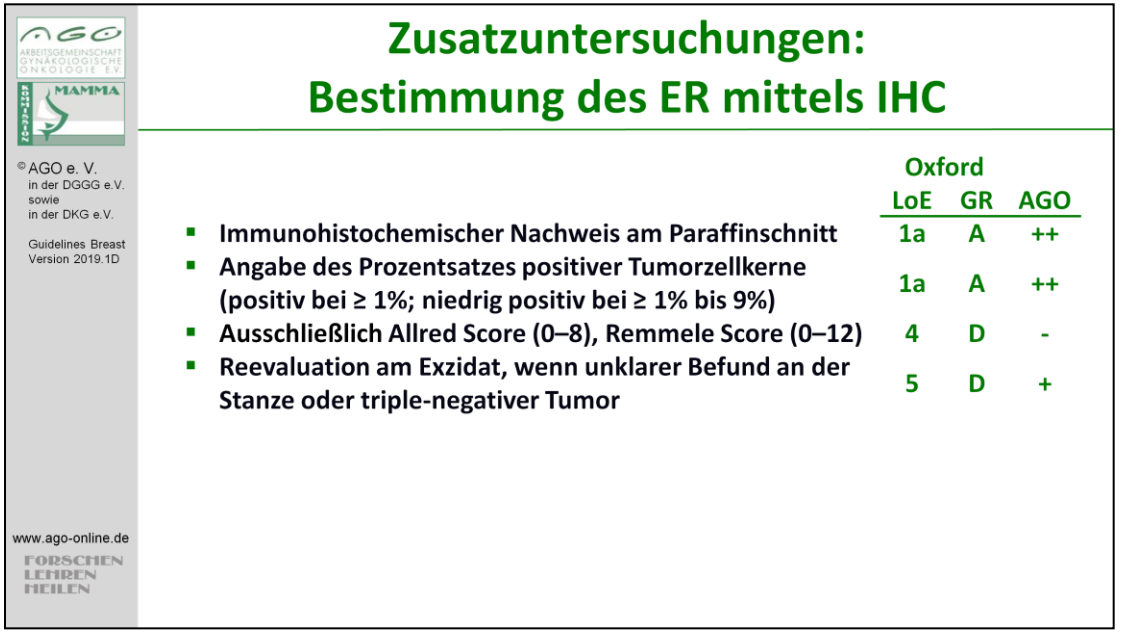



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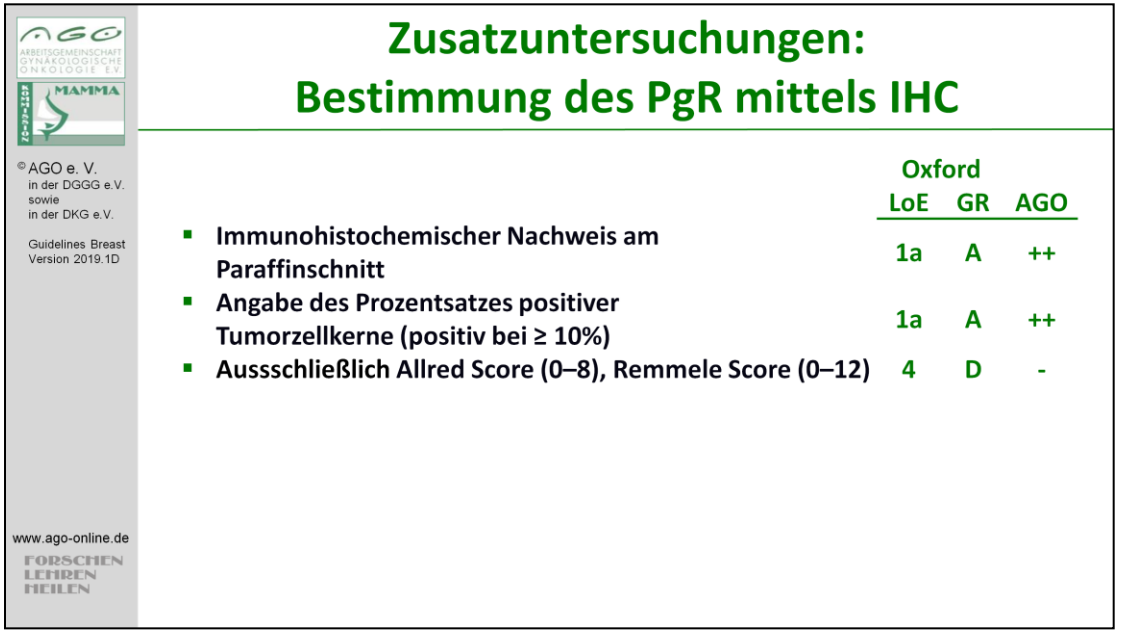



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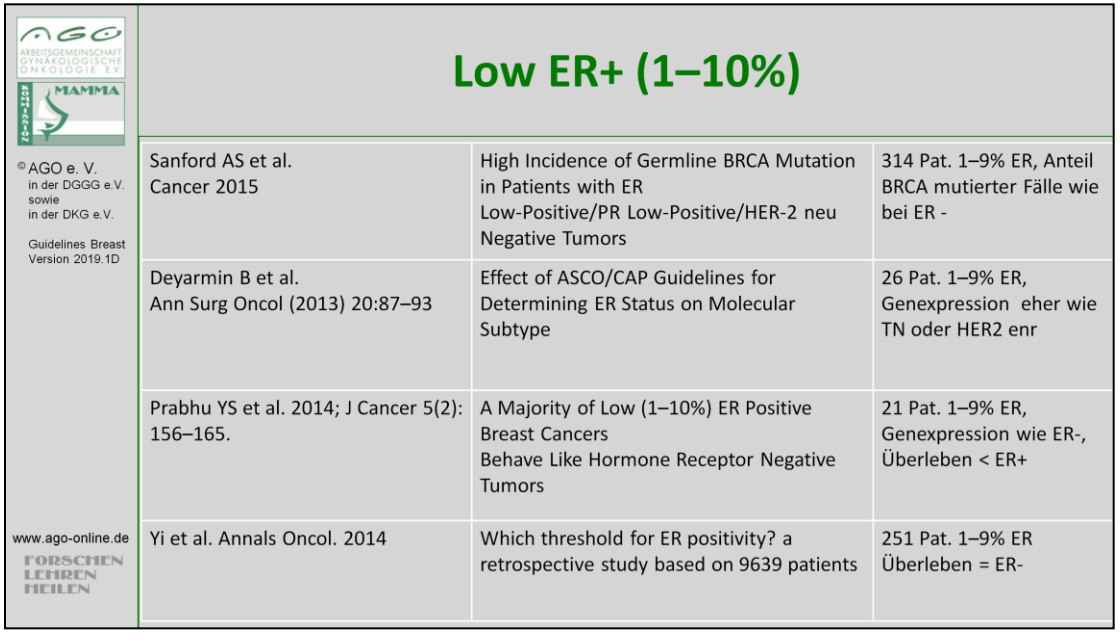


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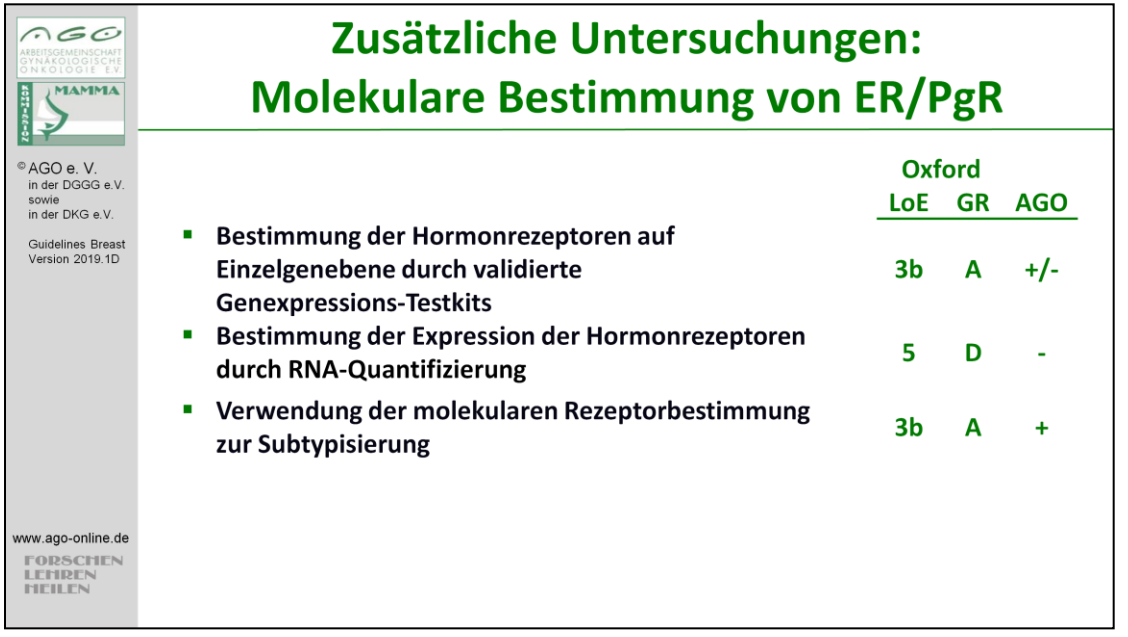



Clinical significance of mRNA expression of ESR-alpha, PgR and concordance with IHC results

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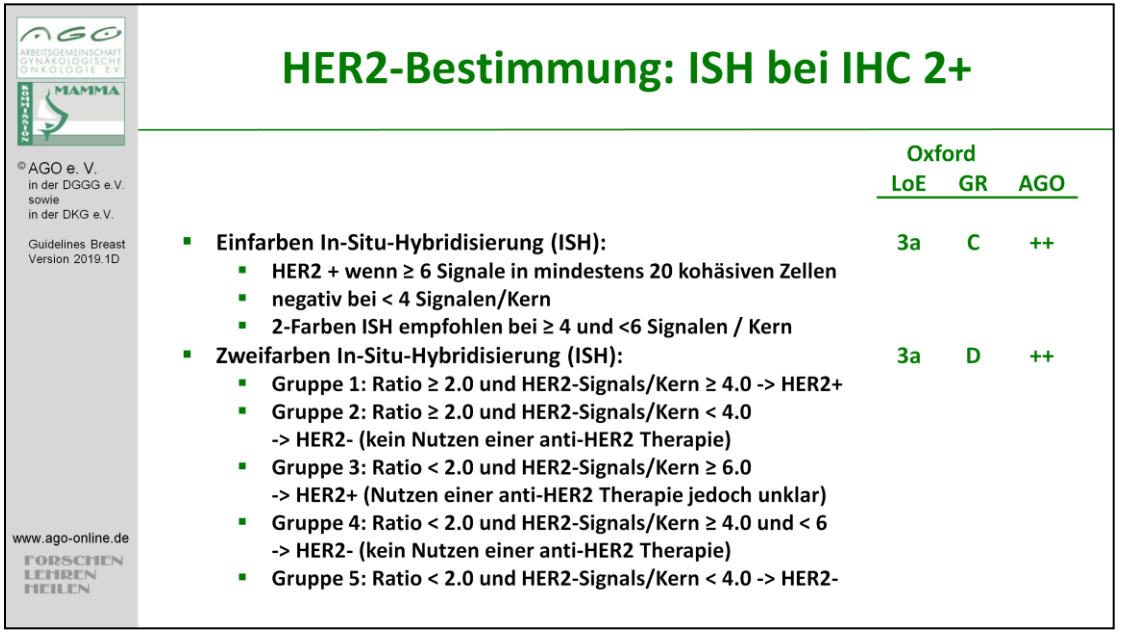



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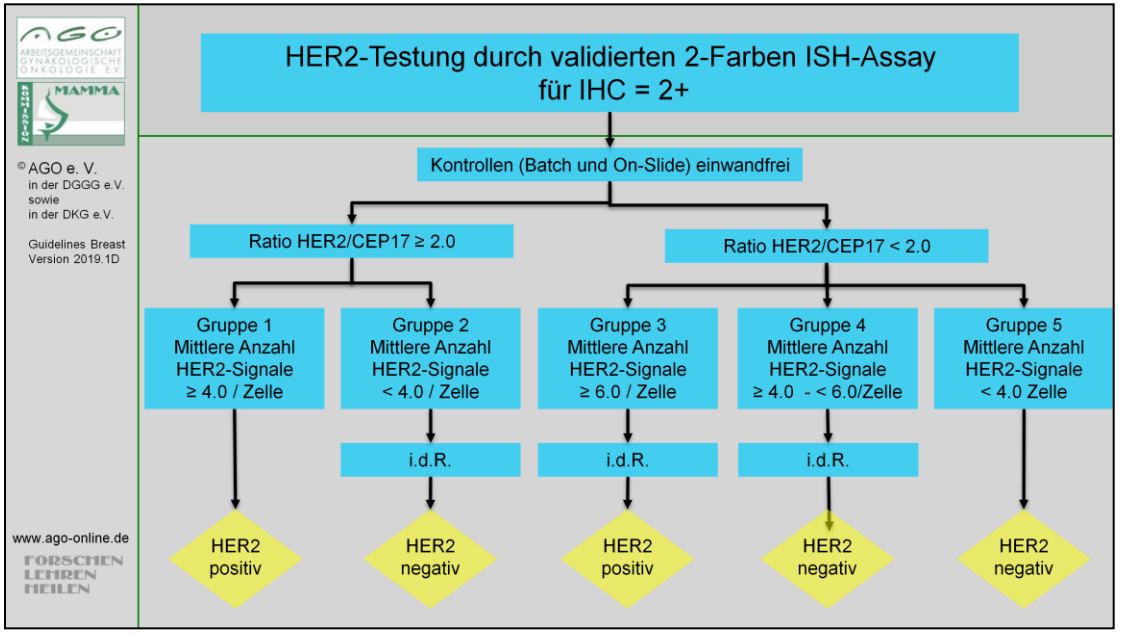
HER2-Testung durch validierten 2-Farben ISH-Assay
für IHC = 2+
Kontrollen (Batch und On-Slide) einwandfrei
Ratio HER2/CEP17 ≥ 2.0
Ratio HER2/CEP17 < 2.0
Gruppe 1
Mittlere Anzahl
HER2-Signale
≥ 4.0 / Zelle
Gruppe 2
Mittlere Anzahl
HER2-Signale
< 4.0 / Zelle
Gruppe 3
Mittlere Anzahl
HER2-Signale
≥ 6.0 / Zelle
Gruppe 4
Mittlere Anzahl
HER2-Signale
≥ 4.0 - < 6.0/Zelle
Gruppe 5
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Guidelines Breast
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FORSCHEN
LEHREN
HEILEN

# HER2-Bestimmung an Stanzbiopsien



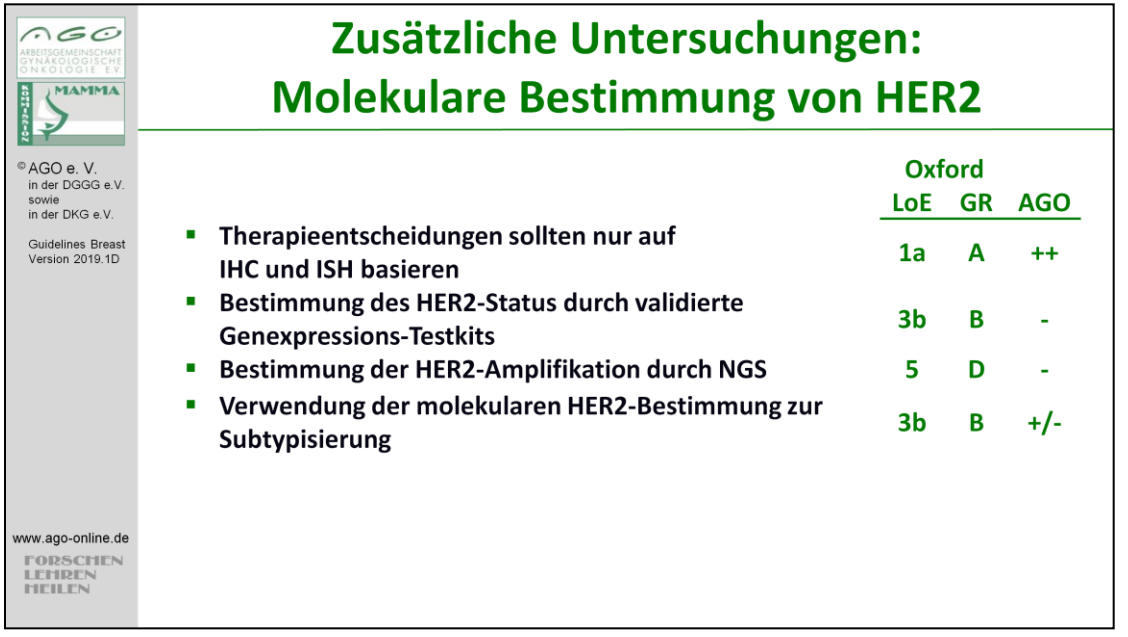
Guidelines Breast
Version 2019.1D

Da eine Falschpositivität an Stanzbiopsien vorkommen kann (3+), sollte vor regelmäßiger HER2-Diagnostik an Stanzbiopsien eine Validierung der Methodik durch Parallelfärbung und Vergleich mit dem Resektat vorgenommen werden. Eine vermehrte Reaktivität des Stanzgewebes äußert sich an vermehrter Hintergrundfärbung, die durch den Vergleich mit normalem duktalem Epithel abgeschätzt werden sollte.

Alternativ oder zusätzlich können alle G1 und G2 Fälle mit HER2 3+ Befund in der Stanzbiopsie durch eine ISH oder eine Parallelbestimmung am Resektat überprüft werden.

Falschpositivität ist wahrscheinlich, wenn HER+ bei G1 Tumoren der folgenden histologischen Typen: infiltrierendes duktales or lobuläres Karzinom, ER und PgR positiv, tubulär, muzinös, kribriform, adenoid zystisches Karzinom (n. WHO)

Im Falle einer Diskrepanz zwischen Resektat und Stanzbiopsie sollte die Probe mit einer Überexpression einer ISH unterzogen werden. Sollte in einer der Proben eine Amplifikation sicher nachgewiesen sein, genügt das für eine eventuelle Indikationsstellung zur anti-HER2 spezifischen Therapie. Die zu erwartende Positivitätsrate liegt bei etwa 15% aller Fälle




Clinical significance of mRNA expression of HER2 and concordance with IHC results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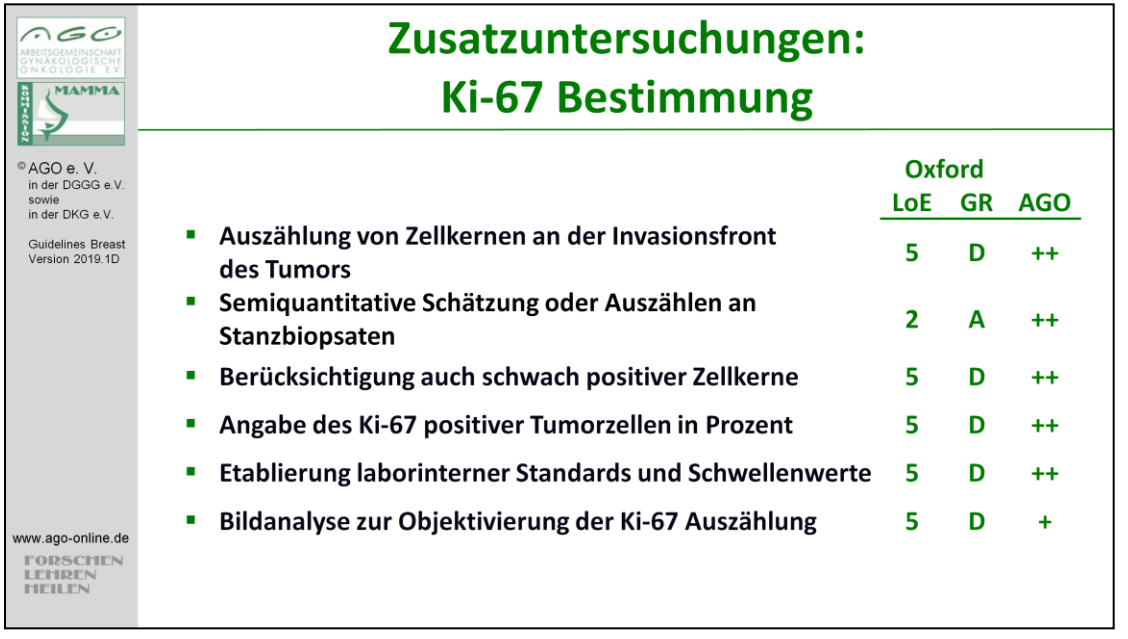


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# Intrinsische Typen des Mammakarzinoms (molekulare und immunohistochemische Definitionen)

- Die sogenannten intrinsischen Typen (basal, luminal A/B-Typ, HER2) sind durch RNA-Expressionsprofile definiert. Es gibt zur Zeit keine allgemein akzeptierte Übertragung in Immunphänotypen, weder in Hinblick auf die notwendigen Marker noch die Schwellenwerte
- Unter praktischen Gesichtspunkten kann aber die Anwendung der Terminologie zur Beschreibung etablierter immunhistochemischer Untergruppen des Mammakarzinoms vertreten werden (ER/PR+ = luminal, HER2+ = HER2-Typ, triple negativ = basaler Typ)
- Der basale Typ weist eine 80% Überlappung mit der triple negativen Untergruppe des duktal invasiven Mammakarzinoms auf (ER <1% & PR <1% & Her2 0/1+/2+ (nicht-amplifiz., Ratio <2)
- Keiner der z.Zt. verfügbaren Marker (Ki-67, Grading, Recurrence Score etc.) kann zuverlässig zwischen den luminalen A and B Typen unterscheiden
- Auch RNA-Messungen sind zur Festlegung des intrinsischen Typs für therapeutische Zwecke nicht geeignet



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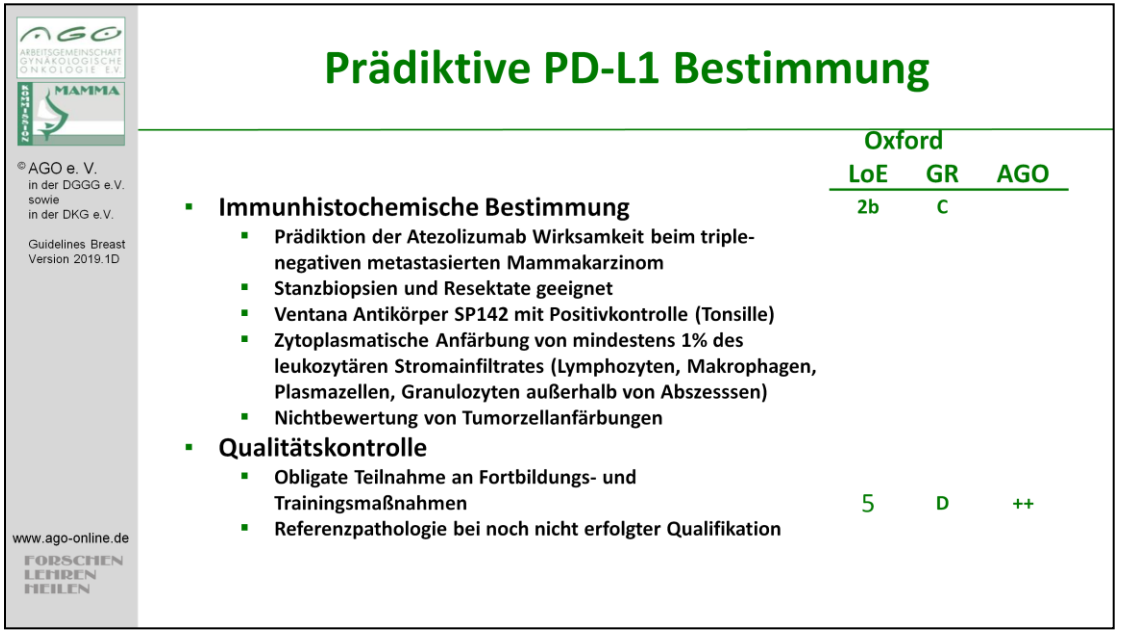



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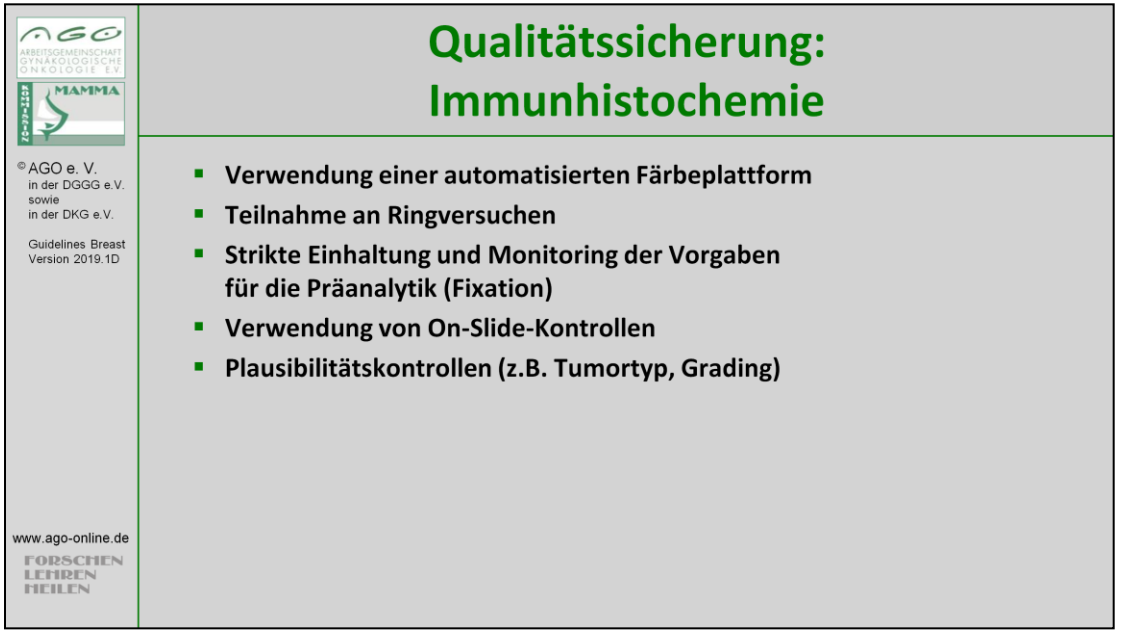



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# Qualitätssicherung: HER2-Bestimmung

- Laufende Dokumentation der HER2-Befunde
- Qualitätsziel: HER2-Positivitätsrate 15%
- Verwendung standardisierter und validierter HER2-Testkits
- Teilnahme an Ringversuchen



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# Qualitätssicherung: Befundung

- **Verantwortlichkeit der Befundung bei ein bis zwei in der Mammapathologie spezialisierten Pathologen**
- **Regelmäßige interdisziplinäre Befundbesprechungen mit radiologisch-pathologischer Korrelationsdiagnostik**
- **Teilnahme an Qualitätszirkeln**



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