



**DRAFT STATEMENT**  
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**NATIONAL INSTITUTES OF HEALTH**  
**STATE-OF-THE-SCIENCE CONFERENCE STATEMENT**  
Diagnosis and Management of Ductal Carcinoma In Situ (DCIS)  
September 22–24, 2009

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*The statement reflects the panel's assessment of medical knowledge available at the time the statement was written. Thus, it provides a "snapshot in time" of the state of knowledge on the conference topic. When reading the statement, keep in mind that new knowledge is inevitably accumulating through medical research.*

**Introduction**

Ductal carcinoma in situ of the breast, or DCIS, represents a spectrum of abnormal cells confined to the breast duct and is a risk factor for invasive breast cancer development. DCIS either has not yet invaded beyond its intraductal origin or may never possess the ability to invade neighboring tissues as is characteristic of invasive breast cancer. In general, the discovery of DCIS occurs as a consequence of screening for invasive breast cancer. DCIS has no specific screening modality, and its diagnosis is similar to that for invasive breast cancer. The etiology of DCIS is presumably heterogeneous, making assessment of prognosis based on pathology and imaging highly variable. On the basis of pathologic and molecular studies, DCIS may represent a precursor to invasive breast cancer; however, the proportion of untreated DCIS that will progress to invasive breast cancer is unknown.

Although DCIS was first described a century ago by Dr. Joseph Bloodgood, its natural history is poorly understood and is unlikely to be fully elucidated. The clinical entity, DCIS, has changed over time with the advent of screening and the development of highly sensitive detection technologies capable of identifying breast abnormalities long before they become palpable. The earliest reports of DCIS, originally referred to as "comedo carcinoma," describe its detection as either a breast lump or as a result of abnormal discharge from the nipple. Not until the development and widespread application of mammography in the early 1980s did detection of DCIS occur primarily through mammographic screening for invasive breast cancer. Despite the relatively indolent nature of DCIS, its name includes the word "carcinoma;" therefore, its diagnosis carries a negative connotation for both patients and physicians. Because the current

diagnosis and treatment of DCIS have considerable emotional and physical impact for women diagnosed, it is critical to develop methods that enable a more precise determination of those patients who are at risk for the development of invasive disease. It is also important for the medical community to consider eliminating the inclusion of the term “carcinoma” in this disease, as DCIS is by definition not invasive—a classic hallmark of cancer.

Since the advent of widespread screening for invasive breast cancer in the early to mid-1980s, the detection, and therefore, incidence of DCIS have increased dramatically. With the prevalence of DCIS and our current inability to determine those women with DCIS who are at high risk for invasive breast cancer, it is essential that we critically evaluate the available data concerning the diagnosis and management of DCIS. Patient outcomes in DCIS trials have focused mainly on survival, local recurrence, and invasive breast cancer. The significance of DCIS recurrence as an endpoint is not clear. Few data use other important outcome parameters, including patient-reported outcome measures and quality-of-life parameters. The excellent survival of patients who have DCIS heightens the importance of these additional outcome measures. There is also a need to explore health economic issues and perform comparative effectiveness analyses. Finally, a top priority is a prioritized list of critical feasible research questions, the answers to which will result in tangible improvements in quality of life for those who have a diagnosis of DCIS.

The focus of this State-of-the-Science document is to provide a summary of critically reviewed scientific data and opinions presented by experts and attendees that relate to this extraordinarily important problem. The primary challenges for the panel members in weighing the totality of this evidence have been: (1) data concerning the natural history of DCIS are relatively lacking because it is usually treated by at least surgical excision upon discovery; (2) the precise classification of DCIS has changed over time as methods to detect ever-earlier disease become available and the precision of pathologic examination is enhanced through diagnostics that specifically, and with great sensitivity, identify very small numbers of malignant cells in surgical specimens; and (3) robust, randomized clinical trials exploring the various therapeutic interventions in patients with DCIS have been relatively few in number.

This State-of-the-Science Conference, held on September 22–24, 2009, in Bethesda, Maryland, was convened by the National Cancer Institute and the Office of Medical Applications of Research of the National Institutes of Health to explore and assess the current scientific knowledge regarding the Diagnosis and Management of Ductal Carcinoma In Situ. For the purpose of this statement, the term DCIS refers to the complete replacement of normal ductal cells with abnormal cells confined to the ducts without invasion. It should be noted that the panel did not address any issues related to invasive breast cancer nor did they address lobular carcinoma in situ (LCIS) or atypical ductal hyperplasia (an earlier part of the spectrum in the development of DCIS).

The key questions that the panel was asked to address were the following:

1. What are the incidence and prevalence of DCIS and its specific pathologic subtypes, and how are incidence and prevalence influenced by mode of detection, population characteristics, and other risk factors?

2. How does the use of MRI or sentinel lymph node biopsy impact important outcomes in patients diagnosed with DCIS?
3. How do local control and systemic outcomes vary in DCIS based on tumor and patient characteristics?
4. In patients with DCIS, what is the impact of surgery, radiation, and systemic treatment on outcomes?
5. What are the most critical research questions for the diagnosis and management of DCIS?

During the first 2 days of the conference, experts presented information on each of the key questions. After weighing the scientific evidence, including the data presented by the speakers, input from attendees, and a formal evidence report commissioned through the Agency for Healthcare Research and Quality (AHRQ), an independent panel prepared and presented a draft of this State-of-the-Science Statement addressing the conference questions. The evidence report prepared for the conference is available at [www.ahrq.gov/clinic/tp/dcis.htm](http://www.ahrq.gov/clinic/tp/dcis.htm).

**1. What are the incidence and prevalence of DCIS and its specific pathologic subtypes, and how are incidence and prevalence influenced by mode of detection, population characteristics, and other risk factors?**

DCIS incidence in the United States increased more than sevenfold from 1973 through the late 1990s and has since leveled off. The most rapid increases were among women aged 50 years and older. The current age-adjusted incidence rate of DCIS is 32.5 per 100,000 women; at ages 50–64, the incidence is approximately 88 per 100,000. Currently, for every four diagnoses of invasive breast cancer, there is one diagnosis of DCIS. Risk of DCIS is rare in women younger than 30, is low in women under age 40, but increases steadily from age 40 to 50. The risk increases much more slowly after age 50 and plateaus after age 60.

As of January 1, 2005, an estimated one-half million U.S. women were living with a diagnosis of DCIS. The prevalence is greater in White women than in Black women and women of other races/ethnicities. Assuming constant incidence and survival rates, it is estimated that more than 1 million women will be living with diagnosed DCIS by 2020.

The increase in rates of DCIS is highly and consistently associated with the concurrent increase in rates of mammography screening. Screening data from developed countries indicate that rates of increase and incidence of DCIS are similar to those in the United States.

The natural history of DCIS is poorly understood. Tumor characteristics generally involve both qualitative and quantitative features. The qualitative features of DCIS refer to the histologic pattern of ductal proliferation (spread of abnormal cells) and include the architectural pattern; high-, intermediate-, and low-grade cytologic (structural) features; and the presence or absence of central necrosis (localized tissue or cell death). The most aggressive form is called comedo-type with high-grade cellular and nuclear features; this form is frequently associated with central necrosis and microcalcifications (small deposits of calcium). The other architectural

types consist of cribriform (appearing to have open spaces or small holes), papillary (having fingerlike projections), micropapillary (having smaller fingerlike projections), and solid types. More than one-half of DCIS cases include at least two different histologic types in the same breast.

The average tumor size of DCIS is approximately 1–1.5 centimeters; about one-half are high grade. “Noncomedo” comprises the largest histologic subtype; its incidence continued to increase through 2006. In contrast, the rate of the comedo subtype is much lower, peaked in 1995, and leveled off and then declined through 2006. These time trends by subtype are affected by changes in pathological reporting and coding conventions used by the Surveillance Epidemiology and End Results (SEER) registries ([www.seer.cancer.gov](http://www.seer.cancer.gov)). Special studies are needed to establish the true rates and trends by histologic subtype. Of note, SEER captures data on DCIS but not atypical ductal hyperplasia (representing a part of the spectrum in the evolution of DCIS).

While few studies have focused on risk factors for DCIS, most suggest that the risk factors are the same as those for invasive breast cancer. These include high mammographic density, family history of breast cancer (e.g., BRCA-positive), increasing age, menopausal estrogen with progestin therapy, late age at menopause, nulliparity (no births), late age at first birth, and high postmenopausal body mass index.

### ***Recommendations for Future Research***

- Basic descriptive epidemiology studies of DCIS, by pathologic subtypes, using consistent criteria over time and across registries are needed. To facilitate this goal, we recommend that the U.S. pathology community adopt national standardized reporting of DCIS.

## **2. How does the use of MRI or sentinel lymph node biopsy impact important outcomes in patients diagnosed with DCIS?**

Magnetic resonance imaging (MRI) and sentinel lymph node biopsy are two diagnostic techniques that can be used to inform the management of patients who have DCIS. MRI is increasingly used in the pretreatment evaluation of patients who have DCIS to determine the local extent of the known DCIS, identify multicentric tumors, and evaluate for disease in the contralateral breast. Sentinel lymph node biopsy is a surgical procedure to remove the lymph node that first receives drainage from the tumor site. Sentinel lymph node biopsy has largely replaced routine axillary lymph node dissection for staging invasive breast cancer because it is less invasive and has lower associated morbidity while preserving diagnostic accuracy. For the majority of women who have DCIS treated with excision, sentinel lymph node biopsy is not necessary. DCIS sentinel lymph node biopsy may be considered at the time of mastectomy because there is a chance that invasive cancer will be found in the specimen, and once a mastectomy has been done there is no longer an opportunity to perform sentinel lymph node biopsy. Involvement of the axillary lymph node influences treatment decisions and prognosis. A number of unanswered questions exist about the risks and benefits of using these two diagnostic techniques in patients who have DCIS, particularly as they relate to important outcomes such as

the recurrence of DCIS, progression of DCIS to invasive cancer, patient quality of life, and overall survival.

### ***What We Know About MRI in DCIS***

Historically, breast MRI has been used in two primary applications: for early detection in individuals at high risk of breast cancer and to further evaluate patients who have a current breast cancer diagnosis. There is now increasing use of MRI in DCIS. Progress in diagnostic MRI has been made over the past decade, owing to several advances that have improved the imaging's spatial resolution and increased contrast differentiation between normal and abnormal breast tissue.

For DCIS, most studies have found that MRI is more sensitive than mammography for detecting multicentric disease; however, limited data exist on the specificity of MRI in this setting. The results of studies comparing MRI to mammography and pathological evaluation for determining the size of a DCIS are inconsistent. Overall, MRI is believed to slightly improve on mammography, but has been found to both underestimate and overestimate the size of DCIS lesions relative to pathological analysis. Importantly, the ways in which surgically resected breast tissues are processed can limit the accuracy of pathologically based tumor measurements as well. MRI also is used to detect occult DCIS or breast cancer in the contralateral breast, but can result in false-positive and false-negative results.

### ***What We Need To Know About MRI in DCIS***

A number of questions remain about the use of MRI in DCIS. To what degree does the improved sensitivity of breast MRI inform treatment decisions, and how does MRI affect the rates of breast biopsy, local excision, local excision with radiotherapy, and mastectomy? Beyond management concerns, we do not know how MRI influences outcomes such as recurrence of DCIS or invasive breast cancer or independent effects of MRI interpretation on patient anxiety and patient quality of life. Given that the majority of treated DCIS lesions will not progress to invasive breast cancer, to what degree does breast MRI in this setting result in overdetected, meaning the detection of biologically insignificant lesions. What are the psychological, physical, and medical costs associated with MRI-based overdetected, and do barriers to access to the technology exist? Finally, can we identify MRI features that can be combined with clinical and biological characteristics to better stratify risk in patients who have DCIS?

### ***What We Know About Sentinel Lymph Node Biopsy in DCIS***

Sentinel lymph node biopsy is reasonable in women undergoing mastectomy for DCIS. The value of sentinel lymph node biopsy in DCIS depends on the incidence of sentinel lymph node metastasis. The incidence of sentinel lymph node metastasis in patients with an excisional diagnosis of DCIS is approximately 5%. These pooled data are limited because different studies have blurred the distinctions between pure DCIS and DCIS with microinvasion (DCISM). Similarly, positive sentinel lymph node metastases are inconsistently defined. Moreover, the significance of positive sentinel lymph node metastases in patients who have DCIS is indeterminate given that the majority of them are micrometastases or isolated tumor cells. Existing studies of sentinel lymph node biopsy have been reported in highly selected patient

populations that may not represent the general population of women who have DCIS. Studies of the impact of sentinel lymph node biopsy for DCIS on subsequent treatments have been limited to descriptions of single, not multicenter, practices. Finally, although sentinel lymph node biopsy is less invasive than axillary lymph node dissection, multiple studies have shown that sentinel lymph node biopsy is associated with some risk of complications, including lymphedema (swelling that most often occurs in the limbs; about 3%), impaired shoulder movement (about 3%), arm or shoulder pain (about 8%), and numbness (about 12%).

### ***What We Need To Know About Sentinel Lymph Node Biopsy in DCIS***

Although roughly 5% of patients with an excisional diagnosis of DCIS are found to have positive sentinel lymph node biopsy results, uncertainty still remains about the significance of isolated tumor cells or micrometastases in the lymph nodes. As well, it is not clear what role sentinel lymph node biopsy plays in DCIS with microinvasion. Studies are needed to determine the effects of sentinel lymph node biopsy for DCIS on the important outcomes of recurrence of DCIS or invasive cancer and patient quality of life.

### ***Recommendations for Future Research***

- Determine the comparative effectiveness of MRI with regards to the management of DCIS, particularly surgical management, following diagnostic biopsy.
- Evaluate and improve breast MRI techniques to enable discrimination between DCIS that requires intervention and DCIS that may be managed with active surveillance.
- Determine the prognostic significance of sentinel lymph node micrometastases in DCIS.

### **3. How do local control and systemic outcomes vary in DCIS based on tumor and patient characteristics?**

DCIS does not recur systemically in the vast majority of women who are treated. Due to the low mortality rates, the primary outcomes of DCIS studies focus on the development of a local recurrence of DCIS or invasive breast cancer. Recurrence as an adverse outcome in many studies has not been consistently defined. Features that have been associated with a higher risk of local recurrence or progression to invasive disease are patient characteristics such as young age, race, symptomatic presentation, and tumor characteristics, such as high nuclear grade, comedo necrosis, and tumor size. For women undergoing local excision, the width of the resection margin is also critical to prognosis.

### ***What We Know***

#### **Patient Characteristics**

Numerous studies, including randomized controlled trials, show a consistent association between younger age at diagnosis and an increased risk for adverse outcomes. These studies also demonstrate poorer outcomes among women who presented with symptoms, compared with

women whose DCIS was detected by screening mammography alone. In addition, several studies—including one of more than 15 years of SEER data (1988–2003)—demonstrate higher breast cancer mortality and recurrence rates among Black women who have DCIS compared with White women who have DCIS. These differences persisted when controlling for differences in age, tumor characteristics, and treatment but not for differences in screening rates or mode of presentation. Keeping in mind the overall high survival rates for DCIS, the absolute difference in mortality is small, but the differences in race warrant further investigation. The prognostic impact of other risk factors, such as reproductive factors and mammographic density, also warrant further study.

### **Tumor Characteristics**

An understanding of the tumor biology of DCIS is needed to determine the invasive tendency, recurrence probabilities, and response to therapy. Our current knowledge is limited to the identification of surrogate markers for clinical behavior and outcome. Tumor characteristics associated with recurrence and progression to invasive carcinoma include the microscopic features of the tumor, the topographic nature (size, location, and extent) of the tumor, and the adequacy of its surgical resection.

High-grade DCIS and the architectural pattern of comedo-necrosis are strongly associated with local recurrence and progression to invasive carcinoma. The finding of microinvasive carcinoma associated with DCIS is a predisposing risk factor for recurrence and dissemination. DCIS that is extensive in distribution, is large in size, or involves the surgical resection margin predicts a high likelihood for local recurrence. Wider disease-free surgical margins are associated with a decreased risk of local recurrence, but controversy exists as to the optimal margin size.

Studies of molecular characteristics demonstrate that the presence of estrogen receptors in DCIS is associated with a decrease in ipsilateral (same breast) recurrence. However, these studies have not simultaneously shown the impact of tumor grade. Limited evidence about other molecular markers is insufficient to stratify prognostic groups. The combination of prognostic tumor factors is likely to be more informative than single factors used in isolation.

### ***What We Need To Know***

Despite available research, we are still unable to identify accurately which cases of DCIS will progress to invasive breast cancer and how to prevent this progression altogether. There is a lack of reliable models representing human DCIS to support the comprehensive investigations needed to evaluate cellular and molecular alterations in the epithelium and microenvironment (surrounding area).

### ***Recommendations for Future Research***

- Efforts also need to be directed toward improving the diagnostic accuracy and reproducibility of DCIS classification and grading schemes.

- Research should focus on the molecular events and pathologic and radiographic features governing the progression of DCIS to enable an understanding of the relationship between tumor biology and clinical outcomes.
- Combinations of new and existing clinical, pathologic, and molecular factors should be investigated and validated to better risk-stratify patients who have DCIS. Ease of utilization, predictive ability, reproducibility, and generalizability are important components of research on prognostic models.
- Studies are needed to evaluate the factors contributing to the marked racial disparities in mortality among Black women who have DCIS (compared to White women who have DCIS).

#### **4. In patients with DCIS, what is the impact of surgery, radiation, and systemic treatment on outcomes?**

DCIS is a heterogeneous disease associated with high rates of long-term, disease-free survival (96–98%) when treated with currently available therapies. It is unclear whether all patients who have DCIS uniformly benefit from these interventions. Given the lack of clarity and the incomplete data surrounding the natural history, prognostic factors, and biology of DCIS, important therapeutic questions remain unanswered.

One major question relates to the impact of tumor and stromal biology on therapeutic choices (i.e., treatment versus no treatment, or radiotherapy versus no radiotherapy) and on patient outcomes. The interaction of host factors with the biology of the tumor is poorly understood in DCIS patients. Identifying predictive and prognostic biomarkers that are reflective of biology would better inform therapeutic decisionmaking and should be a research priority.

Better decisionmaking tools are needed to aid patients and their care providers in choosing among therapeutic options. Patients experience anxiety related to the diagnosis of DCIS, the complexity of decisionmaking, and misperceptions regarding outcomes and risks of therapy. Women who have DCIS should have access to the best available information and guidance to help make decisions about their care that reflect their personal circumstances and preferences. Therefore, these issues should be incorporated within the construction and validation of decisionmaking tools. Economic issues and the accessibility and quality of care also should be studied.

#### ***What We Know***

Mastectomy and local excision with radiotherapy are both effective local therapeutic approaches in patients who have DCIS. A randomized controlled trial comparing mastectomy with local excision and radiation has not been done, but current data demonstrate that long-term survival is similar with either approach. Although survival rates are similar, there is a higher local recurrence risk for DCIS with local excision and radiation therapy (12%, half of whom have invasive cancer) than in patients who choose mastectomy (about 1%).



Randomized clinical trials show that radiotherapy after local excision reduces the risk of both invasive and noninvasive local recurrence, compared with local excision alone, with equivalent survival.

Tamoxifen is currently the only Food and Drug Administration-approved systemic agent for preventing local recurrence in patients who have DCIS. Evidence demonstrates a benefit of tamoxifen in estrogen-receptor-positive DCIS. In randomized clinical trials, tamoxifen has been shown to reduce the risk of invasive cancer in the ipsilateral and contralateral breasts, but no survival benefit has been shown. There is currently no defined role for raloxifene in patients who have DCIS. There is no role for chemotherapy in patients who have pure DCIS.

### ***What We Need To Know***

The risk of DCIS in the contralateral breast is generally low. Although women are increasingly choosing prophylactic mastectomy of the contralateral breast, no clear data exist to suggest that this improves outcomes. The reasons for this increase require further study.

Randomized clinical trials demonstrate that all subsets of patients benefit from radiotherapy in terms of decreased local recurrence. However, there may be a subgroup of women who have DCIS in which the risk of local recurrence is so low that radiotherapy can be omitted. In addition, there also may be a subset of women who can be monitored after biopsy without surgery or other therapies. Tumor size, margin status, biological factors, age, comorbidities, patient preference, grade, and mammographic density may all be relevant factors in such decisionmaking. The favorable long-term survival rate in DCIS justifies the initiation of clinical trials to risk-stratify patients to determine whether these patient subsets exist.

The presence of a positive margin increases the risk of local recurrence. Some retrospective data suggest that larger margins are associated with a lower risk of local recurrence. For those patients who elect to have local excision without radiotherapy, an optimal margin size has not been established. Standardization of procedures, such as specimen handling and margin assessment, is crucial to the implementation of such trials.

Despite appropriate therapy with local excision and radiotherapy, women who have DCIS continue to have a defined risk of recurrent DCIS and invasive breast cancer years after treatment. Retrospective studies suggest that the inclusion of a radiation boost to the excisional cavity will reduce the risk of local recurrence of DCIS or invasive disease.

If radiotherapy is used, whole-breast radiotherapy is the standard technique, although accelerated partial-breast radiotherapy is being studied in ongoing clinical trials. Investigation of partial-breast radiotherapy and accelerated radiotherapy regimens is an appropriate focus of clinical research.

The role of other hormonal therapies in patients who have DCIS is unknown. We await the results of a recently closed randomized clinical trial comparing aromatase inhibitors to tamoxifen for prevention of recurrence in women who have DCIS and have undergone local excision therapy. Targeted molecular therapies also are being evaluated in patients who have DCIS who have undergone local excision with radiation.

It is important to stress that DCIS has a high probability of long-term, disease-free survival and that all current therapies have short- and long-term side effects. Therefore, future therapeutic research efforts should focus on the identification of patients who are at high risk for developing recurrence. Such identification through the appropriate investigation of biomarkers could be helpful in guiding both systemic and local therapy decisions. Biomarker discovery also may aid in the development of novel, less toxic, targeted agents for this population of patients.

### ***Recommendations for Future Research***

- Develop and validate risk-stratification models to identify subsets of women who have DCIS who are candidates for (1) active surveillance only, (2) local excision only, (3) local excision with radiotherapy, and (4) mastectomy.
- Who is at high risk for recurrence of DCIS or the development of invasive carcinoma?
- What do comparative effectiveness analyses tell us about the role of current therapies in DCIS patients?
- Integrate patient-reported outcomes and data on patient perceptions of risk and preferences regarding treatment within current clinical research and, ultimately, decisionmaking algorithms.

### **5. What are the most critical research questions for the diagnosis and management of DCIS?**

In summary, we have identified the following major areas as critical in the advancement of our understanding of DCIS.

- Development of standardized reporting, using controlled vocabularies across all disciplines.
- Collection of consistent and detailed data on the clinical, pathological, radiologic, and molecular characteristic of DCIS.
- Creation of voluntary repositories (multisite databases) of DCIS that would include annotated specimen and imaging repositories.
- Investigation and validation of combinations of new and existing clinical, pathologic, and molecular factors to better risk-stratify patients who have DCIS and thus to identify the optimal therapy for each individual. Ease of use, predictive ability, reproducibility, and generalizability are important components of prognostic model development.
- Further development of decision aids, along with their integration within clinical practice. Their impact on the quality of care for women who have DCIS should be investigated.

- Research on patient–provider communication, informed consent (at time of screening), patient preferences, and decisionmaking for the diagnosis and treatment of DCIS. Decision aids ought to be developed, evaluated, and integrated into clinical practice.
- Investigation of the impact a diagnosis and treatment of DCIS has on the quality of life.
- Comparative effectiveness research on the methods of treatment for DCIS.

## **Conclusions**

Clearly, the diagnosis and management of DCIS is highly complex with many unanswered questions, including the fundamental natural history of untreated disease. Because of the noninvasive nature of DCIS, coupled with its favorable prognosis, strong consideration should be given to elimination of the use of the anxiety-producing term “carcinoma” from the description of DCIS. The outcomes in women treated with available therapies are excellent. Thus, the primary question for future research must focus on the accurate identification of patient subsets diagnosed with DCIS, including those persons who may be managed with less therapeutic intervention without sacrificing the excellent outcomes presently achieved. Essential in this quest will be the development and validation of accurate risk-stratification methods based on a comprehensive understanding of the clinical, pathologic, and biologic factors associated with DCIS.

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The information provided here was accurate at the time of that meeting.

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