Inflammatory Breast Cancer (IBC) is the most aggressive manifestation of primary breast cancer. Fortunately it is a relatively rare form of this disease accounting for only 1-6% of breast cancer cases per year. It is seen more often in African American women than in Caucasians and other ethnic groups. Its incidence has doubled over the past twenty years, a much larger increase than has been seen in non-inflammatory breast cancer during the same time frame. The median age is between 45 to 55 years of age, but can occur in younger or older patients. Symptoms should guide the diagnosis and age should not be used to exclude it.

IBC has a classic clinical presentation with patients presenting with a rapid onset of breast swelling. The classic criteria were first described by Haagensen in the 1940’s and are still used today.

These manifestations include:
- Diffuse breast erythema (redness)
- Edema of the breast skin (>66% of the breast)
- Peau d’Orange (orange peel skin)
- Warmth
- Enlargement
- Tenderness
- Induration (skin thickening)
- Axillary lymph node involvement
- Metastatic disease
- Rapidly progressing symptoms

Pathologically, there is extensive lymphovascular involvement of the dermal (skin) lymphatic channels by tumor cells or tumor emboli. This requires a biopsy of the breast skin and microscopic examination to diagnose. This phenomenon is what causes the characteristic skin changes seen in IBC. Typically, patients will initially be treated with antibiotics for a presumed breast infection; however, if the symptoms continue for more than a week, a more aggressive diagnostic approach is warranted.

Diagnostic imaging studies like mammography and ultrasound that are usually so helpful in the diagnosis of primary breast cancers are not as helpful in diagnosing Inflammatory Breast Cancer. Usually, mammography and ultrasound will only show thickening or edema of the skin as the tumor does not usually form a mass but is diffusely spread throughout the breast tissue. MRI and PET scans are now thought to be the most sensitive imaging studies as they can show the extensiveness of the disease, lymph node involvement, metastases to other organs, and response to induction chemotherapy.

The diagnosis of IBC is usually made with clinical exam along with a core needle breast biopsy and skin biopsy. This will show the cancer in the breast tissue along with the dermal lymphatic invasion of the skin that is characteristic of this disease.

Once Inflammatory Breast Cancer is diagnosed, the standard of care requires having a team of dedicated specialists involved in the complex...
Coastal Carolina Breast Center is the area’s only surgical practice dedicated solely to breast health and is one of only eight centers in South Carolina to be accredited by NAPBC. Recognized as a Center of Excellence, Coastal Carolina Breast Center demonstrates a commitment to patient education, advocacy, and awareness of advanced breast cancer treatments. In the last fifteen years, they have treated an estimated 25,000 patients.

management of this disease. This team includes surgeons, radiologists, pathologists, radiation oncologists, medical oncologists, breast cancer navigators, and support groups. Over the last twenty years, this multidisciplinary team approach has lead to a substantial improvement in survival for this once uniformly lethal disease. The five year overall survival rates are 40% with this approach.

Today, the treatment evolves around the use of upfront or preoperative chemotherapy, called neoadjuvant or induction chemotherapy, as opposed to performing surgery as the initial treatment option. The use of Anthracycline and Taxane based chemotherapy is the mainstay of this approach. Depending on the degree of response to the chemotherapy, mastectomy and lymph node dissection, followed by chest wall radiation therapy, is the current recommendation. Reconstruction can then be performed at a later date. The sequence of therapy is greatly dependent on the response to the initial trial of chemotherapy, such that close monitoring by the multidisciplinary team is important.

Furthermore, the response of the tumor to chemotherapy is a critical predictor of overall survival. Currently newer agents such as Herceptin and Lapatinib are being used in clinical trials to treat IBC patients that are HER-2 neu-receptor positive. Estrogen and progesterone receptor positive patients are treated with Tamoxifen or an Aromatase Inhibitor after all other therapies are completed.

In conclusion, Inflammatory Breast Cancer is a relatively rare, aggressive form of primary breast cancer that has a classical clinical presentation that can be confused with a breast infection. Early recognition along with an aggressive multidisciplinary approach with a team of specialists is the key to treating this disease.

“Inflammatory Breast Cancer is a relatively rare, aggressive form of primary breast cancer.”

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