Epidemiological features of papillary carcinoma of the breast in a developing community

Wilson IB Onuigbo*

Department of Pathology, Medical Foundation and Clinic, Nigeria

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*Corresponding author: Wilson IB Onuigbo, Department of Pathology, Medical Foundation and Clinic, 8, Nsukka Lane, Enugu 400001, Nigeria, Email: wilson.onuigbo@gmail.com

Abstract

A separate challenge in characterizing papillary carcinoma of the breast is related to the fact that a large proportion of the literature consists of individual case reports. The scarcity of information was remedied from certain centers. The present paper seeks, therefore, to add materials obtained from a histopathology data pool covering the Ibo or Igbo Ethnic Group domiciled in a developing community in Nigeria.

Keywords: Breast Cancer; Papillary; Developing community; Nigeria

Introduction

In presenting an overview of papillary carcinoma of the breast, Pal’s associates [1] asserted thus: “A separate challenge in characterizing papillary carcinoma is related to the fact that a large proportion of the literature devoted to this entity is comprised of individual case reports.” Therefore, the present paper considers materials accruing from a histopathology data pool such as the one established in Birmingham (UK) for facilitating epidemiological analysis [2]. In particular, papillary breast carcinomas of the Ibo or Igbo Ethnic Group, which is domiciled in the South Eastern part of Nigeria [3], are analyzed.

Investigation

From the 1970s, the author received at a Reference Pathology Laboratory situated in Enugu, the capital city of the Eastern Region of Nigeria, biopsy specimens together with detailed information. The data are analyzed in respect of papillary carcinoma of the breast in Table 1(Figure 1).

<table>
<thead>
<tr>
<th>S/No.</th>
<th>Lab No.</th>
<th>Initial</th>
<th>Age</th>
<th>Side</th>
<th>Town</th>
<th>Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>B 145/72</td>
<td>OK</td>
<td>38</td>
<td>-</td>
<td>Enugu</td>
<td>Udekwu</td>
</tr>
<tr>
<td>2</td>
<td>B 1011/72</td>
<td>OE</td>
<td>55</td>
<td>R</td>
<td>Onitsha</td>
<td>Ofomata</td>
</tr>
<tr>
<td>3</td>
<td>B 1150/73</td>
<td>OM</td>
<td>56</td>
<td>R</td>
<td>Akahaba</td>
<td>Oju</td>
</tr>
<tr>
<td>4</td>
<td>B 248/75</td>
<td>OL</td>
<td>50</td>
<td>R</td>
<td>Emekuku</td>
<td>Desarkar</td>
</tr>
<tr>
<td>5</td>
<td>H 153/80</td>
<td>NO</td>
<td>50</td>
<td>R</td>
<td>Afikpo</td>
<td>Molloy</td>
</tr>
<tr>
<td>6</td>
<td>181/86</td>
<td>EE</td>
<td>40</td>
<td>R</td>
<td>Emekuku</td>
<td>Catelo</td>
</tr>
<tr>
<td>7</td>
<td>UH 892/87</td>
<td>OC</td>
<td>43</td>
<td>L</td>
<td>Enugu</td>
<td>Nwabuniko</td>
</tr>
<tr>
<td>8</td>
<td>UH 2634/87</td>
<td>OD</td>
<td>38</td>
<td>R</td>
<td>Umuahia</td>
<td>Mbanaso</td>
</tr>
<tr>
<td>9</td>
<td>UH 2685/87</td>
<td>UN</td>
<td>43</td>
<td>R</td>
<td>Umuahia</td>
<td>Mbanaso</td>
</tr>
</tbody>
</table>
Discussion

Tabulation elevates Enugu, the cosmopolitan city, with 7 cases, i.e., almost half of the series. Interestingly, Dr. Aghaji preponderated with 2 cases, the rest being distributed among 5 individual doctors. As for the remaining half of the cases, Dr. Mbanaso preponderated with 3 cases, while Missionary Hospitals took pride of place in the remainders. Incidentally, Dr. Mbanaso himself co-authored with me the important message concerning the usefulness of a centrally based Laboratory to a distant hospital [4]. This is important because there was argument in UK about distance militating against the usefulness of such a laboratory [5].

It is worth noting that all the above personal cases were distinctly invasive. This is unlike the many reports on encapsulated papillary carcinoma [6-9] and even the intracystic variety [10, 11]. Of course, explanations were attempted in all of them (Table 2) (Figure 2).

Table 2: Age distribution.

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤30</td>
<td>1</td>
</tr>
<tr>
<td>31 – 40</td>
<td>6</td>
</tr>
<tr>
<td>41 – 50</td>
<td>8</td>
</tr>
<tr>
<td>51+</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
</tr>
</tbody>
</table>

It was better appreciated elsewhere. Thus, as in the previously mentioned article [1], “The scarcity of information underscores the need for further treatment- and outcome-related studies in papillary carcinoma of the breast.” On the other hand, by calling it “solid papillary carcinoma” [12], it was defined as a “distinctive form of papillary carcinoma characterized by closely apposed expansive, cellular nodules.”

In contrast, I am persuaded that my documented examples bore the imprint of their picturesquely papillary. Thus, my descriptions ranged across “frankly papillary,” “marked papillary arrangement,” and “thrown into papillary folds.” In other words, as Pal and colleagues appreciated [1], “Distinction of invasive papillary carcinoma from non-invasive forms is critical, as each entity carries a unique prognosis.” In the words of Rakha’s group [6], “However, the classification of papillary carcinoma (whether they are in situ or invasive), its behavior, and management remain a matter of debate.” No! Such debate should not continue.

References


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