Atypical Lobular Hyperplasia(ALH), and Focal Lobular Carcinoma in Situ (LCIS)

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We use the term " lobular neoplasia" to indicate the full range of in situ changes with characteristic cells initially diagnosed as LCIS in 1941.

Lobular neoplastic breast disease in women has been considered a special type of premalignancy since 1941 [1]in a paper that also described the related pattern of"infiltrating lobular carcinoma". During the 20-30 years following the description of lobular carcinoma in situ (LCIS), the term "lobular neoplasia" (LN) has been used for a spectrum of lobulocentric distortion by characteristic cells that varied from marked [2](lobular carcinoma in situ) to minimal [3] - (minimally atypical lobularhyperplasia, not recognizing a risk as high as welldeveloped ALH). Atypical lobular hyperplasia (ALH) is the diagnostic term most frequently used [4-6] to denote most lesions in this series. The cancer risk implications of ALH have been verified in formal follow-up studies[7-10].

Cancer risk assessment is quantitatively elevated if the advanced patterns of lobular carcinoma in situ are present - this demands extensive distortion, filling and distention of a lobular unit(Page et al., 1991), and is usually seen in a background of many lobular units with diagnostic ALH . Another pattern that adds somewhat to risk is the involvement of true ducts with cells of ALH in the presence of ALH in lobular units(Page et al., 1988). However, this finding is restricted to a single study, andthe implication of raising subsequent risk of cancer from a range of 4 times to 7 times that of the general populationi is not reliable as a predictor for an individual woman.

The co-existence of pattterns of lobular neoplasia with extensive distension, filling, and distortion of true 2 ducts may necessitate the application of the clinical implications of ductal carcinoma in situ, despite a dominance of the type of cytology seen in lobular neoplasia(Fisher et al., 1996).

Patient age is always a strong consideration in understanding clinical management. This is particularly true for ALH in which the implications of cancer risk fall after the menopause(Marshall et al., 1997; Page et al., 1985). With the current appropriate interest in breast cancer prevention, these lesions have taken on an even greater clinical importance. It is likely that many of thepatients in the National Surgical Adjuvant Breast Project's prevention trial that benefitted most from the prevention/intervention of tamoxifen had these lesions of ALH and related to ALH, (termed 'atypical hyperplasia' in pathology reports from biopsies)(Fisher et al., 1998).

Follow-up studies with uniform diagnostic criteria for atypical lobular hyperplasia, recognizing few cases of “LCIS” Also the NSABP studies terming cases “LCIS” only and representing some more extensive cases(Fisher et al, times 2).

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