

How to Manage 'Breast' Pain.

Breast pain is the commonest presenting breast complaint to GPs and the commonest reason for referral to the Breast Unit. Nearly 70% of women develop breast pain at some point in their lives but in only 1% of patients with true breast pain is it related to breast cancer. It is however a major source of worry and anxiety for patients, with many convinced they have breast cancer. The anxiety caused can perpetuate the symptoms and for some lead to psychological morbidity such as loss of self-esteem and depression.

Breast pain can be divided into cyclical and non-cyclical breast pain with non-cyclical being divided into true breast pain and referred pain.

Cyclical breast pain

Younger women often present because of an increase or change in the pain they normally experience before or during a period. Seventy-five per cent of women with breast pain have cyclical breast pain worse around the time of menstruation. This is linked to changes in hormone levels and mainly affects premenopausal women. It may be associated with heaviness, tenderness, pricking or stabbing pains and can affect one or both breasts or the axillae. This type of pain is common and often self-limiting. It usually stops after the menopause unless HRT is taken.

Non-cyclical breast pain

Non-cyclical breast pain is continuous pain not related to the menstrual cycle. It is either true breast pain or extra mammary pain that feels as if it is coming from the breast. The majority of non-cyclical pain seen in clinic is non-breast and originates from the chest wall e.g. musculoskeletal pain and chondrochondritis (Tietze syndrome) or other conditions such as shingles and fibromyalgia. Often this pain is also described as sharp or stabbing, often through the nipple and radiating to the axilla.

Diagnosis

It is important to take a history and examine the breasts. Is there a strong family history of breast cancer? Is the pain cyclical or non-cyclical, has the patient felt a lump, can you feel a lump? Take the patient's age into consideration, breast cancer is much less common under the age of 40. After examining the patient's breast with them lying supine, examine the patient on their side with their arm raised. In this position tenderness from the chest wall will be felt in the mid axillary line and beneath the breast. The costochondral junctions of the opposite breast can be examined at the same time. Tenderness over the costochondral junctions is unlikely to come from the breast.

A good way of examining the chest wall and breast separately is to examine the patient on their side with their arm raised. The chest wall can be easily palpated and the costochondral junctions.

There are symptom patterns that are very unlikely to be related to breast cancer e.g. young women with tender lumpy breasts or older women with breasts that are symmetrically lumpy on both sides and minor or moderate breast pain with no lump. It is very common for premenopausal women to have tender lumpy breasts before a period. In the absence of a lump, breast cancer is very unlikely.

Women with musculoskeletal chest wall pain will often not recall any injury as the pain is due to inflammation which can take 2-3 days to develop. If examined from the front the pressure through the breast will usually elicit pain so it is important to examine the patient on the side as well.

With breast pain, it is worth asking about smoking and caffeine intake as both appear to sensitize the breast and breast pain becomes more common. We are seeing a link between low vitamin D levels and breast pain. Again this can be worth checking and treating.

Management

This will depend on the cause. In the absence of a lump or other worrying signs most patients can be reassured and do not need to be referred to breast clinic.

For cyclical pain a pain diary may help. Breast cancer care has a helpful leaflet on breast pain (<http://www.breastcancercare.org.uk/breast-cancer-information/breast-awareness/benign-breast-conditions/breast-pain>) which can offer women good advice and includes a diary.

Cyclical breast pain

- Reassurance that the pain is not due to breast cancer and an explanation as to its hormonal nature may be all the management that some women require.
- A better-fitting bra and simple analgesia is the first line of treatment. Simple non-opioid analgesia can be helpful for mild discomfort.
- Topical diclofenac or ibuprofen may be helpful. There is some consensus that topical non-steroidal anti-inflammatory drugs (NSAIDs) are effective and well tolerated, but the evidence is inconclusive.
- Changing from the contraceptive pill to a mechanical method is sometimes helpful if symptoms are severe.
- Although there is little evidence to support its use, some women find a soft support sleep bra helpful at night.
- Will resolve spontaneously in 20-30% but has a high recurrence rate (~60%).
- There is little evidence to support the use of evening primrose oil. There is convincing evidence to support the safe use of AgnusCastus as a treatment of cyclical mastalgia.
- Treatments will generally need to be continued for 3 months to see an effect.
- Tamoxifen may be prescribed by the breast clinic but is not licensed for treatment of breast pain. Its side effect profile must always be considered and off set against the severity of the pain.

Non-cyclical pain

- Resolves spontaneously in 50% of women.
- Most patients are happy with simple reassurance that the pain is not from the breasts and that examination is normal.
- Chest wall pain often responds to NSAIDs. We usually prescribe ibuprofen for 2-4 weeks.
- Referred pain should be appropriately treated.
- For true diffuse breast pain a support bra, and oral or topical NSAIDs may be helpful.
- Acupuncture has been reported as beneficial in a pilot study and could be considered.

Who to refer

- Any patients who on examination are found to have a lump, blood stained nipple discharge or other signs of breast cancer should be referred to the breast unit.
- Breast pain (with no lump) that does not go away with reassurance or wearing a well supporting bra.
- Breast pain that is persistent or refractory to first-line treatments or painkillers.
- Exceedingly anxious patients who are not reassured by their GP.
- Unilateral persistent pain in post-menopausal women.

All referrals will be seen within 2 weeks whatever symptoms they have. From a large study in Edinburgh, 2.7% of patients who were referred to their breast unit with pain as their main symptom were diagnosed with cancer. The vast majorities of patients we see are reassured and discharged back to General Practice. In women under the age of 40 years a mammogram is not indicated unless a worrying lump is found. We don't perform an ultrasound unless we find a lump. We rarely use Tamoxifen as a treatment for pain unless the patient finds it difficult to work or sleep. Most patients will get better on their own after reassurance.