Ontario Health
Cancer Care Ontario

High-Risk Benign Breast Lesions Recommendations Report: Quick Reference

Lesion	Initial Management	Follow-Up
Atypical Ductal Hyperplasia **Pure Papillary Lesions with Atypia** **Pure Radial Scars/Complex Sclerosing Lesions with Atypia** **Variant/Non-Classic Lobular Carcinoma in Situ**	• Excision recommended, refer to a surgeon. Decision to excise will be made with patient, considering comorbidities and patient preference. • Provide breast cancer risk assessment and counselling on risk reducing options.	• If excised, annual screening after excision. • If unexcised, follow for 2 years at 6, 12, and 24 months using the original imaging modality, then annual screening.
Pure Papillary Lesions without Atypia	• Referral to a surgeon for consultation recommended. Routine excision not required if pathology is concordant with radiology assessment. Excision should be discussed in context of patient preference and radiologic risk factors.	• If excised, annual screening after excision. • If unexcised and no growth, follow for 2 years at 12 and 24 months using the original imaging modality, then average risk screening.
Pure Radial Scars/Complex Sclerosing Lesions without Atypia **Fibroepithelial Lesions with Increased Stromal Cellularity**	• Referral to a surgeon for consultation recommended. Routine excision not required if pathology is concordant with radiology assessment. Excision should be discussed in context of patient preference and radiologic risk factors.	• If excised, average risk screening after excision. • If unexcised and no growth, follow for 2 years at 12 and 24 months using the original imaging modality, then average risk screening. Follow-up at 6 months can be considered according to local practice.
Mucocele-Like Lesions	• Referral to a surgeon for consultation recommended. Routine excision not required if pathology is concordant with radiology assessment. Excision should be discussed in context of patient preference and radiologic risk factors.	• If excised, annual screening after excision. • If unexcised, follow for 2 years at 6, 12, and 24 months using the original imaging modality, then annual screening.
Spindle Cell Lesions/ Mesenchymal Lesions	• Expert pathology review and involvement of a specialized breast surgeon required. Excision recommended, refer to a surgeon. Decision to excise will be made with	• If excised, annual screening or follow-up according to final diagnosis.

Lesion	Initial Management	Follow-Up
	patient, considering comorbidities and patient preference.	
Classic Lobular Carcinoma in Situ **Atypical Lobular Hyperplasia**	• Referral to a surgeon for consultation recommended. Generally, classic LCIS or ALH do not require excision if breast imaging has ruled out other lesions and is reported as concordant. Excision should be discussed in context of patient preference and radiologic risk factors. • Provide breast cancer risk assessment and counselling about risk reducing options.	• If excised, annual screening after excision. • If unexcised and no growth or change, follow for 2 years at 12 and 24 months using the original imaging modality, then annual screening. Follow-up at 6 months can be considered according to local practice.
Flat Epithelial Atypia (Columnar Cell Change with Atypia)	• Referral to a surgeon for consultation recommended. Routine excision not required if pathology is concordant with radiology assessment. Excision should be discussed in context of patient preference and radiologic risk factors. • Provide breast cancer risk assessment and counselling about risk reducing options.	• If excised, annual screening after excision. • If unexcised and no growth, follow for 2 years at 12 and 24 months using the original imaging modality, then annual screening. Follow-up at 6 months can be considered according to local practice.
Columnar Cell Change without Atypia	• N/A	• Follow-up at 12 months using the original imaging modality, then average risk screening. Follow-up at 6 months can be considered according to local practice.
Microglandular Adenosis	• Obtain pathology review of core biopsy by expert breast pathologist. • Excision recommended if there is any question as to whether the lesion harbours malignancy, refer to a breast surgeon. Decision to excise will be made with patient, considering comorbidities and patient preference.	• If excised, average risk screening or follow-up according to final diagnosis.

This quick reference is a summary of the High-Risk Benign Breast Lesions Recommendations Report, published by Ontario Health (Cancer Care Ontario). The full-length report can be accessed here: cancercareontario.ca/en/guidelines-advice/types-of-cancer/79886

If you have any questions about this document, please contact: OH-CCO_CIDAPInfo@ontariohealth.ca