

Inflammatory Breast Cancer. Shoot First!

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Editorial

Inflammatory Breast Cancer (IBC) is an aggressive form of breast cancer associated with reduced survival rates. Its primary clinical characteristics include:

- Rapid onset of symptoms developing over weeks or a few months (≤ 6 months).
- Diffuse erythema ranging from red, pink, or purple, occupying at least one-third of the breast [1].
- Diffuse dermatologic edema (peau d'orange) accompanied by warm, thickened skin.
- Breast pain.
- Breast enlargement.
- A rapidly growing breast lump (either self-detected or clinically diagnosed), though this is not present in all cases.
- Palpable lymph nodes.

Although the typical diagnostic criteria require a symptom duration of no more than six months, longer delays are common in clinical practice. These delays often occur because patients are initially misdiagnosed with mastitis and treated with prolonged courses of antibiotics without further investigation.

It must be emphasized that the diagnosis of IBC is primarily clinical, supported by the pathologic confirmation of invasive carcinoma *via* a core needle biopsy, which is mandatory in all cases. A full-thickness skin punch biopsy may also be performed to detect dermal lymphatic invasion by tumor cells [2]. However, this pathologic finding is not required to confirm the diagnosis. Ultimately, IBC is diagnosed through clinical presentation combined with the pathologic confirmation of invasive carcinoma, regardless of whether dermal lymphatic invasion is present.

While a mammogram (mandatory in all cases) can reveal a tumor, and unique signature genes have been proposed as hallmarks for diagnosis [3], the diagnosis remains strictly clinical alongside the confirmation of a breast malignancy.

The standard therapeutic approach consists of neoadjuvant therapy, followed by mastectomy, and post-mastectomy radiotherapy (among others).

Common Myths Related to IBC:

1. IBC is a purely pathologic diagnosis.
2. A clinical diagnosis is insufficient without pathologic confirmation of skin infiltration.
3. IBC should be excluded if the duration of the condition exceeds six months.
4. Red skin coloration is present in the clinical diagnosis of all cases.

Conclusion

The diagnosis of IBC must not be delayed. When clinical suspicion arises, prompt action is vital-"shoot first" (initiate immediate investigation and referral).

https://youtu.be/s8i7xRT58W8?list=PLbnTY0GhrEBd60_ZK9vtekMkqaVn4UIXb

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