IDIOPATHIC GRANULOMATOUS MASTITIS; VARIOUS CLINICAL PRESENTATIONS AND CHALLENGES IN THE MANAGEMENT

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Submitted 19 October 2022; accepted 07 January 2023

ABSTRACT

Background: The term idiopathic granulomatous mastitis (IGM) or granulomatous lobular mastitis generally refers to any condition that causes a granulomatous inflammatory reaction within the breast or conditions for which the etiological factors cannot be identified. The study aims to describe the various clinical presentations of the disease and various management options.

Methods: This retrospective cross-sectional study included 97 patients who were diagnosed with the disease in the period from 2016 – 2021. Female patients complaining from IGM who accepted to be enrolled in the current study were included.

Results: The mean age of patients was 33.85 years. Most patients were healthy with no clinical history of chronic diseases or autoimmune diseases, although thyroid diseases were the commonest associated medical diseases. The mean clinical course of the disease was around 11.06 months, and most of them presented with a painful breast lump, followed by a painless lump, skin redness, and edema as common forms of presentation. The mean size of the lump was 22.7 mm. The upper outer quadrant was the commonest affected site among single cases, although the majority were multiple with different sites. Ultrasound was done for all patients, mammography for 2.1%, and MRI for 1%. Tissue sampling was done using FNAC in 19.6 %, tru cut biopsy in 59.8%, and excisional biopsy in 70.1% of them. The vast majority of patients received medical therapy with a mean duration of therapy of 7.13 months. All patients received different types of antibiotics, steroids were administered in 42.3 % of patients, and immune therapy in 6.2% of them. Some forms of surgical interventions were done for 96.9% of patients, lumpectomy and drainage of the abscess were the commonest forms of surgical interventions, and in 68% of patients, multiple interventions were required. Quinolone group and β-lactam antibiotics were the 2 most commonly administered antibiotics. The response to the management was good in 72.16% of patients, followed by poor response in 22.66%, and 2.06% of patients had a worsening course of the disease even after the management. After the management of the patients with IGM in our study, 69.07% of patients showed no relapse, while the remaining 30.93% showed relapse after the

Conclusion: IGM is a clinically challenging disease. The most important initial step is appropriate diagnosis and exclusion of cancer by biopsy. Selection of treatment must be individualized. Complete surgical resection helps much in patient management and results in reducing the site effects of medical treatment, particularly steroids.

Duhok Med J 2023; 17 (2): 86-97.

Keywords: idiopathic granulomatous mastitis (IGM), Duhok, Iraq.

Idiopathic granulomatous mastitis (IGM) is a rare chronic inflammatory condition of the breast that was defined for the first time in 1972 by Kessler and Woollock and was later described in more details in 1977 by Cohen. The term

https://doi.org/10.31386/dmj.2023.17.2.9

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idiopathic granulomatous mastitis or granulomatous lobular mastitis generally refers to any condition that causes a granulomatous inflammatory reaction within the breast or conditions for which the etiological factors cannot be identified.[1]

The exact cause for the development of the disease is not known but several theories are currently present that may suggest the development of this rare disease. The first step in the development of the disease is thought to be nonspecific lobulitis involving multiple lobules then followed by reactive inflammatory cell infiltration. This inflammation when become chronic will result in granuloma formation with central suppurative necrosis. Permanent inflammation occurs following perforation of the ducts and contact between the secretion and stromal cells. Autoimmunity against a secretions that are extravasated from the lobules is also considered to cause this event.[1]

The disease mostly affects middle aged ladies, but any age can be affected. The clinical presentation of IGM is variable and depends on the severity of the disease, patients may present with breast lump, abscess, nipple retraction, hyperemia in breast skin, edema, ulceration and fistula occurrence, or some patients may present with a hard mass that mimics malignancy. Systemic symptoms are usually not present, although some patients with abscess development may have fever, sweating and malaise.[1]

It is important to differentiate IGM from carcinoma of the breast. Tissue biopsy remains the gold standard to confirm the diagnosis, and the histopathology typically shows the characteristic distribution of granulomatous inflammation in all cases, also there may be infiltration of multi-nucleated giant cells, epithelioid histiocytes, and plasma cells. Other diagnostic modalities such as ultrasound, mammography, or MRI of the breast may also help to evaluate the extent of the disease and contralateral breast affection.[1-3]

The management of the disease is sometimes difficult and many management options are available and are tailored for each individual case depending on the disease severity and the type of clinical presentation. Some patients may be managed with conservative management such as antibiotics, steroids, and different types of immune therapy or immune-modulatory drugs. Some patients require surgical intervention like lumpectomy, quadranectomy, or in some advanced cases and because of the wideness of the disease, mastectomy may be required. The most important step in the management is to differentiate it from cancer.[4-6]

The aim of the study is describing the various clinical presentations of the disease, and various management options. These factors will be evaluated to study the most frequent clinical courses and the most effective way for diagnosis and management.

PATIENTS AND METHODOLOGY

In this Retrospective cross-sectional study that involves 97 female patients, data were collected from the period from 2016 to 2021. This collection was done using a specially designated questionnaire including the various clinical presentations, imaging and other diagnostic interventions, and other forms of treatment and surgical interventions. Female patients complaining from IGM and who accepted to be enrolled in the current study were included. Male patients and those who refused to be enrolled in this study were excluded. Ultrasound was done for all patients who

were enrolled in this study, mammography was done for 5 cases and MRI was done for 1 patient. Tissue sampling was done using FNAC in 19 women, tru cut biopsy in other 58 patients, while excisional biopsy was performed in the remaining 68 women. Data were analyzed and correlated to various patient characteristics displayed in terms of frequency, mean, median, and standard deviations. The correlation is done using the two-tailed t-tests, chi-square test ($\chi 2$), and Fisher's exact test. In the results of the analyses with 95% confidence interval, values $p < 0.05$ will be considered significant. The statistical calculations will be done in the Statistical Package for Social Sciences (SPSS 25:00 IBM: USA).

RESULTS

The mean age of the affected patients was 33.85 years, and 93 (95.9%) of them were married and non-lactating during the course of the disease. About 80 patients (82.5%) of the involved individuals were healthy with no clinical history of any chronic disease or autoimmune diseases, although thyroid diseases were the commonest associated medical disease, 96 patients (99%) of the involved patients had no any previous history of breast trauma. Table 1.

Table 1: The various characteristics of the involved patients.

Category	Subcategories	Frequency	Percentage
Age (M;SD) Range: 20-45 years		33.85	5.669
Lactation during the disease course	Yes	8	8.2
	No	89	91.8
Marital status	Married	93	95.9
	Single	4	4.1
Number of children (M;SD) Range: 0-11		3.42	2.272
Other medical diseases	No other disease	80	82.5
	Hypertension + Dyslipidemia	2	2.1
	Diabetes mellitus	3	3.1
	Thyroid diseases	7	7.2
	Hypertension	3	3.1
	Rheumatoid arthritis	2	2.1
History of other auto-immune diseases	Yes	2	2.1
	No	95	97.9
Family history	Yes	21	21.6
	No	76	78.4
History of breast trauma	Yes	1	1.0
	No	96	99.0

The mean duration of the disease in our was around 11.06 months, and 45 patients (46.4%) presented with a painful breast lump, followed by painless lump, skin redness and edema as a common forms of presentations. The mean size of the lump was 22.7 mm. Around 30 patients (30.93%) had a moderate intensity of pain. Around 27 patients (27.8%) had multiple sites involvement, similarly the same number of patients had upper outer quadrant breast involvement. Table 2 & figure 1.

Table 2: The various types of clinical presentations of the involved patients.

Category	Subcategories	Frequency	Percentage
Duration of the disease/ months (M;SD) Range: 1-69		11.06	11.933
Presentation	Breast abscess / abscesses	7	7.2
	Painful breast lump	45	46.4
	Skin redness ± edema	12	12.4
	Discharging sinus ± lump	10	10.3
	Painless breast lump	14	14.4
	Nipple discharge	1	1.0
	Multiple breast lumps	4	4.1
	Breast lump ± skin redness or edema	4	4.1
Size of the lesion (mm) , M;SD Range:10-70		22.70	8.897
Site	Right	37	38.1
	Left	37	38.1
	Bilateral	23	23.7
Breasts involved	Single	74	76.3
	Both breasts	23	23.7
Quadrant involved	Upper outer quadrant	27	27.8
	Upper inner quadrant	9	9.3
	Lower outer quadrant	13	13.4
	Lower inner quadrant	9	9.3
	Subareolar	12	12.4
	Multiple sites	27	27.8
Pregnancy during the disease	Yes	25	25.8
	No	72	74.2

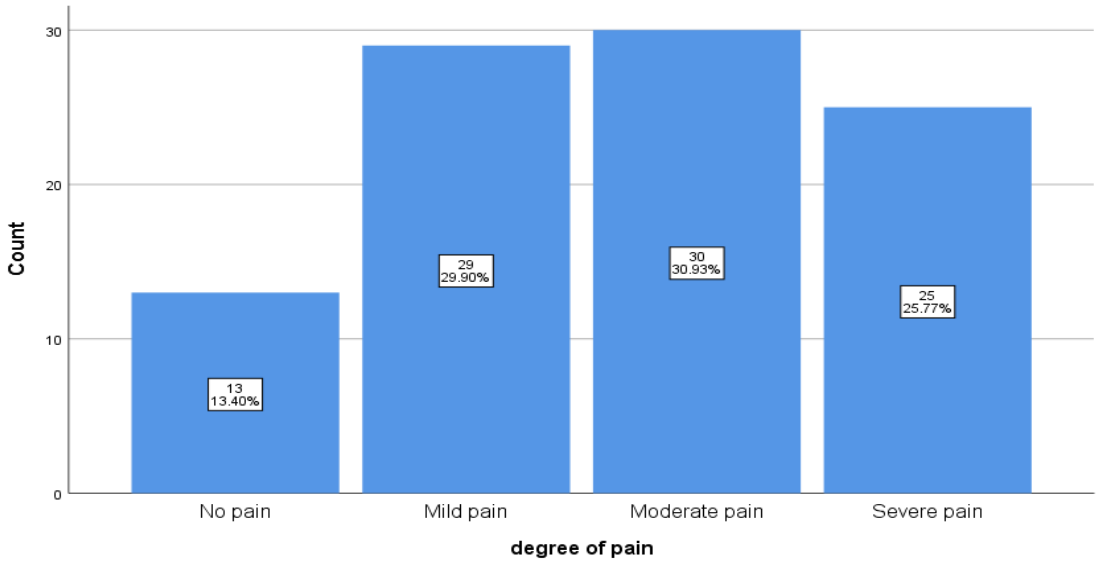

Figure 1: A simple bar chart showing the intensity of pain of the involved patients.

Prolactin level was within normal limits in 63 women (64.9%) and elevated in other 24 women (24.7%). Histopathological, there was evidence of granuloma formation with foreign body-type multinucleated giant cells and chronic inflammatory infiltrate in 85.6% of patients. Table 3.

Table 3: Showing the different diagnostic modalities that were done for the patients in this study.

Category	Subcategories	Frequency	Percentage
FNAC	Done	19	19.6
Tru-cut	Done	58	59.8
Excisional biopsy	Done	68	70.1
Prolactin	Normal	63	64.9
	Elevated	24	24.7
	Not assessed	10	10.3
Histopathology	Granuloma +chronic inflammatory cells	9	9.3
	Granuloma + multinucleated giant cells + chronic inflammatory cells	83	85.6
	Granuloma + multinucleated giant cells + necrosis	5	5.2

Of the study cases, 96 (99%) patients received medical therapy with a mean duration of therapy of 7.13 months. All patients received different types of antibiotics, steroids were administered in 42.3 % of patients, and immune suppressive therapy in 6.2% of them. Some forms of surgical interventions were done for 96.9% of patients, lumpectomy and drainage of the abscess were the commonest forms of surgical interventions, and in 68% of patients' multiple interventions were required. Table 4.

Table 4: Showing different types of medical therapies and interventions.

Category	Subcategories	Frequency	Percentage
Medical treatment	Yes	96	99.0
	No	1	1.0
Duration of medical therapy (Months) Range: 1-72		7.13	9.319
Steroids	Yes	41	42.3
	No	56	57.7
Immune suppressive therapy	Yes	6	6.2
	No	91	93.8
Surgery	Yes	94	96.9
	No	3	3.1
Type of surgery	No surgery	3	3.1
	Drainage of abscess	19	19.6
	Lumpectomy	28	28.9
	Quadrantectomy	3	3.1
	Mastectomy	1	1.0
	Lumpectomy + drainage	43	44.3
Number of interventions	No intervention	3	3.1
	Single time	28	28.9
	Multiple times	66	68.0

Quinolone group and β-lactam antibiotics were the 2 most commonly administered antibiotics. Table 5.

Table 5: Different types of antibiotics that were administered by the patients who were involved in this study.

Antibiotics	Frequency	Percent
Flagyl + Quinolone group	9	9.3
Quinilones + β- lactam antibiotics + Rifamycin group	4	4.1
Quinolone group	17	17.5
Aminoglycosides + Quinolones + Rifamycin groups	3	3.1
Cephalosporine group	7	7.2
β-lactam antibiotics + Quinolones + Rifamycins	1	1.0
Rifamycins + Quinolones	6	6.2
β-lactam antibiotics + Aminoglycosides	1	1.0
β-lactam antibiotics + Rifamycins	4	4.1
β-lactam antibiotics + Cephalosporines	2	2.1
β-lactam antibiotics	12	12.4
β-lactam antibiotics + Quinolones + Rifamycins	6	6.2
Aminoglycosides + Cephalosporines	3	3.1
β-lactam antibiotics + Quinolones	5	5.2
Aminoglycosides + Quinolones	7	7.2
Cephalosporines + Quinolones + Rifamycins	5	5.2
Quinolones + β-lactam antibiotics + Flagyl	2	2.1
Quinolones + Cephalosporines	3	3.1

The response to the management including medical and surgical ones was good in 72.16% of patients, followed by poor response in 22.66%, 2.06% of patients had a worsening course of the disease even after the management. Figure 2.

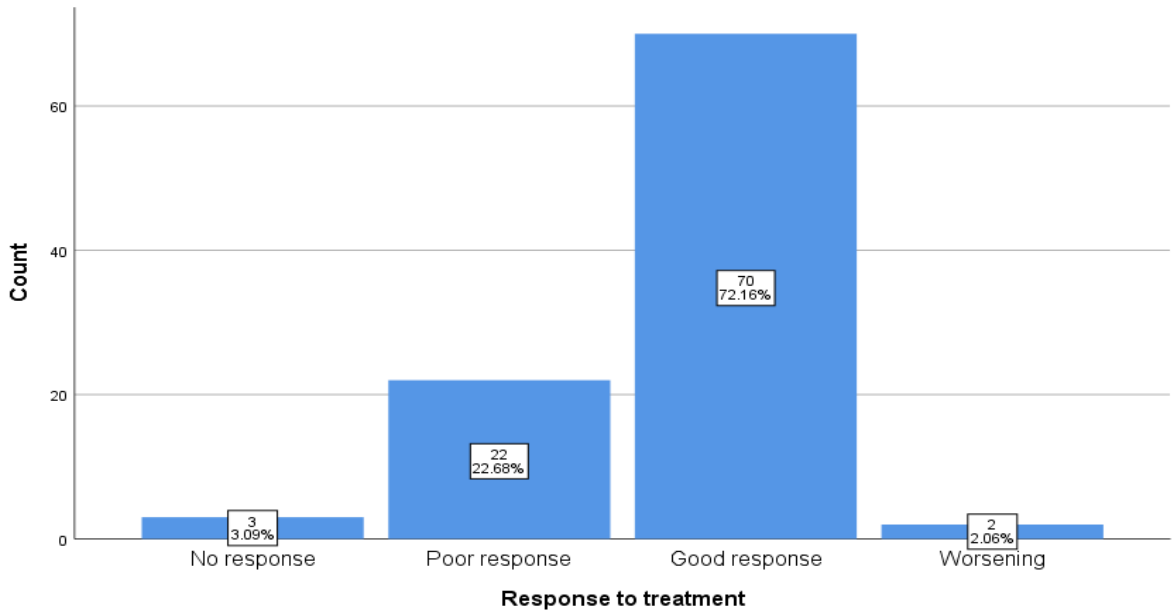

Figure 2: A simple bar chart showing the resopnses of the patients to the different treatment modalities.

After the management of the patients with IGM in our study, 69.07% of patients showed no relapse, while the remaining 30.93% showed relapse after the management. Figure 3.

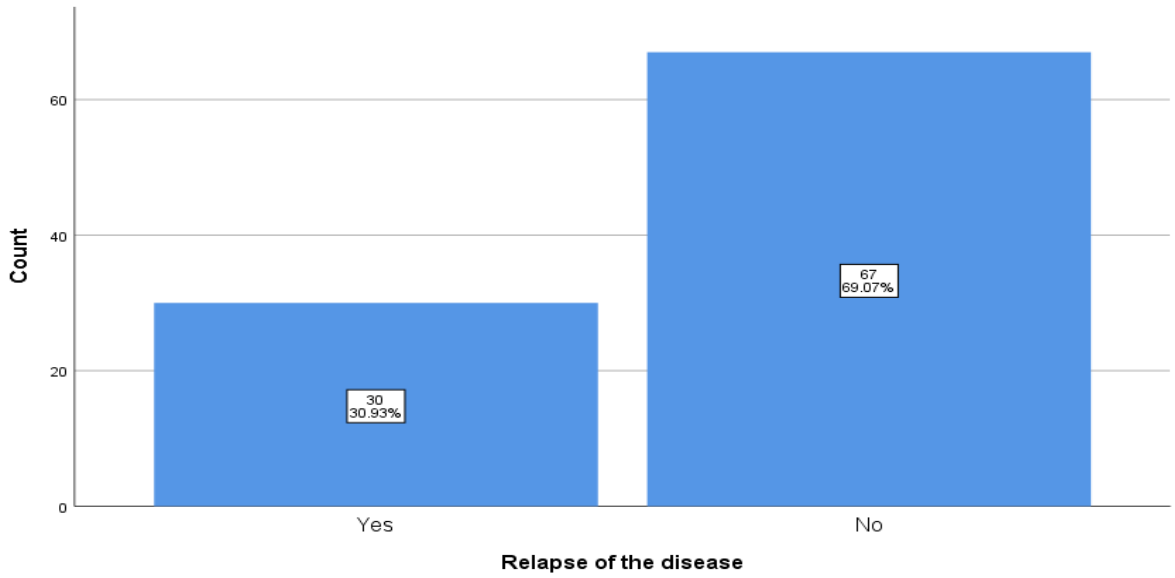

Figure 3: A simple bar chart showing the relapse rate of the patients after the management

DISCUSSION

Idiopathic granulomatous mastitis, also known as idiopathic granulomatous lobular mastitis, is a benign breast lesion that represents both a diagnostic and therapeutic dilemma.[7]

This disease can affect any age group, most studies had found that most patients were affected during the childbearing age, in our study the mean age of our patients was 33.85 years (SD 5.669), studies showed a similar age of affection, although the diseases is reported in variable age groups. Around 8.2% of the patients were lactating during the disease course, the relation between IGM and lactation is not yet well established, although some studies suggest that history of lactation or early failure to complete lactation from a single breast is one of the most important risk factors to develop the disease.[8,9]

Trauma may induce local inflammatory response and the tissue reactions to different noxious agents may result in chronic inflammatory process, it is not well established that trauma is a direct cause for the development of IGM, but some cases and studies have been reported suggesting a possible relation, in our study only 1% of patients had history of breast trauma. There is no clear evidence confirming that IGM has an autoimmune base but some studies showed that the disease may be commoner in patients with other autoimmune disease, in our study only 2% of the patients had history of other autoimmune diseases, and 7.2% of them had history of thyroid diseases.[10,11]

Breast lump is the commonest form of presentation in most published studies, in our painful breast lump was the commonest presentation in 46.4% and nipple discharge was the rarest one in 1%, other forms of presentations included painless lump in 14.4%, skin redness with or without edema in 12.4%, discharging sinus in 10.3%, and breast abscess in 7.2%. There were no difference regarding whether the right of the left breast is affected, 76.3% had single breast involvement. Multiple sites were involved in 27.8%, upper outer quadrant was involved in 27.8%, upper inner quadrant in 9.3%, lower outer quadrant in

13.4%, lower inner quadrant in 9.3%, and the subareolar region in 12.4%.[12]

Some authors classify IGM into many categories based on the degrees of severity of clinical presentation such as pain, fever, the size of the mass, abscess formation and other findings, in our study 13.4% had painless disease, and the remaining of the patients have variable degrees of pain. Clinical examination is not enough to distinguish the disease from other pathologies especially cancer, so tissue diagnosis is mandatory to confirm the disease and imaging is also helpful to diagnose the disease extent and abscess formation. The inflammatory markers may be elevated in patients with IGM, in our study some patients were sent for WBC count, CRP, and ESR and they were elevated in the majority of them. All of our patients had tissue examination either by tru cut biopsy in 59.8% or excisional biopsy in 70.1%, FNAC is not helpful in the diagnosis because no enough tissue is gained for histopathological study.[12-15]

IGM may be associated with elevated serum prolactin levels and some authors recommend that normalization of the serum prolactin levels is important after successful surgical resection of the affected segment. In our patients the serum prolactin was elevated in 24.7% of the patients and there was no clear evidence suggesting a possible link.[16]

There are many drugs that are used for the management of patients with IGM such as antibiotics, steroids, and immune-modulatory drugs. Medical therapy is more effective when combined with an appropriate surgical intervention. The presence of Gram-positive bacilli within the granulomas has been documented in some patients, and Corynebacterium kroppenstedii was isolated in some case series, this may establish a possible link between certain bacterial infections and the development of IGM. Several studies demonstrated an association of IGM with Corynebacterium spp. However, consistent isolation of these bacteria require prolonged incubation or specialized growth media. Antibiotics when used, must be according to certain guidelines however the majority of patients reported antibiotics abuse, the most commonly used 2 groups of antibiotics among our patients were quinolone group and β-lactam antibiotics which show response in some patients with early stage of the disease. Other groups of antibiotics that were commonly administered were flagyl and Rifamycins.[17]

Rifampicin is used effectively in certain trials in the treatment of patients with IGM with complete clinical response after 6–9 months and could be used as a solo medical therapy alternative to both surgery and corticosteroids. Rifampicin was used in around 23.7% of our patients and in all of them it was used as a combination therapy with other antibiotics and steroids. It showed variable response rates but the response rate was not studied in this particular study.[18]

Steroids were administered in 42.3% of our patients, and immune therapy was administered in 6.2% of them.

A low oral dose of methotrexate may be used in resistant cases in combination with steroids and surgery and many studies recommend the use of methotrexate in patients with steroid side effects to help steroid withdrawal, it may also help to reduce the disease complications in some patients. Topical steroids have been tried in patients with skin changes with good response rates.[19-21]

Surgery is recommended in disease that show poor initial response to medical treatment, and some authors recommend that surgical resection must be the initial therapy and all other forms of treatment should be used as adjuvant therapies. Some

forms of surgical interventions were done for 96.9% of our patients. The most common type of surgical intervention in our patients was Lumpectomy + drainage of abscess in 44.3% of patients, followed by lumpectomy in 28.9% of them. Other types of surgical intervention included Drainage of abscess in 19.6% and Quadrantectomy in 3.1%, one patients with advance disease required mastectomy.[22, 20]

About 69.07% of our patients showed complete remission and 30.93% showed relapsing disease. Excision and steroids showed lower relapse rates when compared to other treatments, complete excision of the disease is shown to be more superior to all treatments with fewer possible complications and less possibility of drugs adverse effects. The combination of multiple treatment options may reduce the possibility of recurrence.[23, 24]

Conclusion: IGM is a clinically challenging disease. The most important initial step is appropriate diagnosis and exclusion of cancer by biopsy. Selection of treatment must be individualized. Complete surgical resection helps much in patient management and results in reducing the site effects of medical treatment, particularly steroids.

Conflict of interest: There is no any conflict of interest to be declared.

Funding: The authors are the source of funding.

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پوختە

رێڤەبرنا پراکتیکی یا زێدە موییێ(هیرسوتیزم) لکلینیکێدا

پێشەکی و ئارمانج: هیرسوتیزم ئانکو گەشەکرنا زۆر یا موییێ دوماهیکە ل مێیاندا کو بوی شێوەی یێ ل نێران دا دیاردبیت. کێشەیەکا خەمبارکەر و تارادەیەکێ بەربەلاقە، 5 بۆ 10%ێ ژ ژنان بەری راوەستیانا زڤروکا هەیڤانە تووش دبن ل سەرانسەرێ جیهانێ دا. هەروەسا زۆرجار هیرسوتیزم پەیوەندیەکا بەرچاڤ ب کێمبوونا کوالیتیا ژیانێ و فشارا دەروونی ڤە هەیە. نەڤ لێکولینە بئارمانجا هەڵسەنگاندنا پراکتیکی یا بەلاڤ لڤی دەمی جەم پزیشک و کلینیکێن مە دا کو پەیوەندی ب رێڤەبرنا نەخۆشیا هیرسوتیزمێ هەیە ل هەرێما کوردستانا عێراقێ.

رێکێن کاری: پرسیارنامەیەکا ئەلیکترۆنی سەبارەت پراکتیکیا نها یا رێڤەبرنا هیرسوتیزمێ ب رێکا ئیمەیڵی بۆ 190 پزیشکێن کلینیکی هاتییە هنارتن. 166 ژ پزیشکان راپرسیاری تەمام کرییە ژ پسپۆرییێن جیاواز بوون (پزیشکێن ئالکان، پزیشکێن گشتی هنافان، پزیشکێن زاروکبوونێ، پزیشکێن خێزانێ، پزیشکێن گشتی)، ل باژێرێن جیاواز بێن هەرێما کوردستانا عێراقێ (دهۆک، سلێمانی، هەولێر و هەڵەبجە) بوون.

ئەنجام: ل دەمەک دا 81 (48.8%) ژ هەمی بەرسڤداران توندیا هیرسوتیزمێ ژ لایێ کلینیکیڤە هەڵسەنگاندن بکارئینانا سیستەمێ ژمارا هێرسوتیزمی یا فێریمان-گالوێی یان ژمارەکا هافتا، 85 کەسێن دی (51.2%)، کو زۆربەیا بەرسڤداران پێکهاتبوون، هیچ هەڵسەنگاندنەک نە بو... توندیا هیرسوتیزمێ بهایێ وێ 0.6 p بوو. سەبارەت جوداکرنا نەخۆشییێن شێرپەنجێ، 92.8% ژ بەرسڤداران گوتینە کو بشێوەیەکێ ڕۆتینی پرسیارا نیشانێن مەترسیدار یێن نەخۆشییێن شێرپەنجێ دکەن، و بهایێ pکێمتر بوویە ژ 0.05. سەبارەت بجوداکرنا پروسێسا چارەسەرکرنا زێدەبوونا نەندرۆجینێ، 92.2%ێ ژ بەرسڤداران ب شێوەیەکێ ڕۆتینی پرسیارا بارێ زێدەبوونا نەندرۆجینێ دکەن و بەهای pکێمتر بوویە ژ 0.05. دوماهیک پرسیار سەبارەت چارەسەریا سەرکوتکەرا ئەندرۆجینی پەسەندکری بوو تنێ 41.0%ێ ژ بەرسڤداران چارەسەریا هیرسوتیزمێ دکەن ب تێکەڵکرنا OCP دگەل بلۆکێ ئەندرۆجینێ و بهایێ p کێمتر بوو ژ 0.05.

دەستکەفتییێن ڤەکولینێ: بو مە هاتەدیارکرن کو پراکتیکیا کلینیکی یا نها بۆ رێڤەبرنا هیرسوتیزمێ یا ستاندەرد نەکرییە هەروەسا چەندین بۆشایی لڤێ پراکتیکێدا هەنە. لبەر ڤێ چەندێ پێویستە ڕێنماییێن نیشتمانی بۆ رێڤەبرن و چارەسەرکرنا نەخۆشیا هیرسوتیزمێ بهێنە داراشتن.

الخلاصة

التهاب الضرع الحبيبي مجهول السبب اختلاف الاعراض والتحديات السريرية في العلاج

الخلفية والأهداف: مصطلح التهاب الضرع الحبيبي مجهول السبب أو التهاب الضرع الفصيصي الحبيبي يشير عموما إلى أي حالة تسبب تفاعلا التهابيا حبيبيا داخل الثدي أو حالات لا يمكن تحديد العوامل المسببة لها.

هدف الدراسة: الهدف من الدراسة هو وصف الاعراض السريرية المختلفة للمرض وخيارات العلاج المختلفة.

المرضى والوسائل: شملت هذه الدراسة المقطعية المستعرضة بأثر رجعي 97 مريضا تم تشخيص إصابتهم بالمرض من الفترة من 2016 إلى 2021. تم تضمين المرضى الإناث الذين يشكون من مرض ضرع الحبيبي والذين قبلوا التسجيل في الدراسة الحالية. تم استبعاد المرضى الذكور وأولئك الذين يرفضون التسجيل في هذه الدراسة.

النتائج: بلغ متوسط عمر المرضى 33.85 سنة. كان معظم المرضى يتمتعون بصحة جيدة وليس لديهم تاريخ سريري للأمراض المزمنة أو أمراض المناعة الذاتية ، على الرغم من أن أمراض الغدة الدرقية كانت أكثر الأمراض الطبية المرتبطة شيوعًا. لم يكن لدى معظم المرضى أي تاريخ سابق لصدمات الثدي. كان متوسط المسار السريري للمرض حوالي 11.06 شهرا ، وكان معظمهن مصابات بكتلة مؤلمة في الثدي ، تليها كتلة غير مؤلمة واحمرار في الجلد ووذمة كأشكال شائعة من العروض التقديمية. كان متوسط حجم الكتلة 22.7 ملم. كان لدى معظم المرضى شدة معتدلة من الألم. كان لدى غالبية المرضى إما تورم في مواقع متعددة أو تأثر الربع الخارجي العلوي. تم عمل الموجات فوق الصوتية لجميع المرضى والتصوير الشعاعي للثدي بنسبة 2.1٪ والتصوير بالرنين المغناطيسي لـ1٪. تم أخذ عينات الأنسجة باستخدام خزعة السرنج في 19.6٪ وخزعة حقيقية في 59.8٪، وخزعة استئصالية في 70.1٪ منهم. تلقى الغالبية العظمى من المرضى علاجا طبيا بمتوسط مدة علاج تبلغ 7.13 شهرا. تلقى جميع المرضى أنواعا مختلفة من المضادات الحيوية، وتم إعطاء الستيرويد في 42.3٪ من المرضى، والعلاج المناعي في 6.2٪ منهم. تم إجراء بعض أنواع التداخل الجراحي لـ 96.9٪ من المرضى، وكان استئصال الكتلة الورمية وتصريف الخراج من أكثر التدخلات الجراحية شيوعا، وفي 68٪ من المرضى كانت هناك حاجة إلى تدخلات متعددة. كانت مجموعة الكينولون والمضادات الحيوية بيتا لاكتام هي المضادات الحيوية الأكثر شيوعا التي يتم تناولها. كانت الاستجابة للعلاج جيدة في 72.16٪ من المرضى، تليها استجابة ضعيفة في 22.66٪، و 2.06٪ من المرضى كان لديهم مسار أسوأ المرضى الذين يعانون من الضرع الحبيبي في دراستنا ، لم يظهر 69.07٪ من المرضى أي انتكاس، بينما أظهر 30.93٪ الباقي انتكاسا بعد العلاج.

الخلاصة: (مرض ضرع الحبيبي) مرض صعب، والخطوة الأولية الأكثر أهمية هي التشخيص المناسب واستبعاد السرطان عن طريق الخزعة. يجب أن يكون اختيار العلاج فرديا، وينتج عن الاستئصال الجراحي الكامل استئصال كامل للمرض وتقليل آثار الجانبية للعلاج الطبي وخاصة الستيرويد.