

DUKTAL KARSİNOMA İN SİTU RADYOLOJİK GÖRÜNTÜLEME BULGULARI

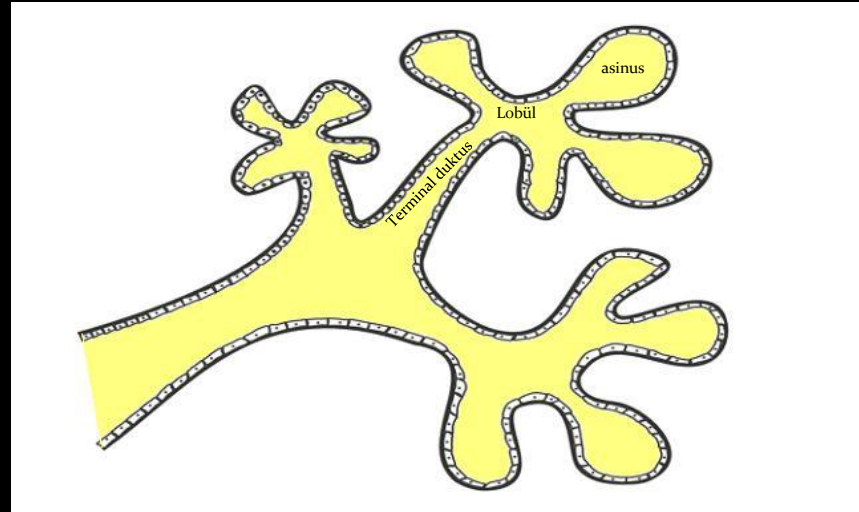
DR.CÜNEYT YÜCESOY

DIŞKAPI YILDIRIM BEYAZIT EĞİTİM VE ARAŞTIRMA HASTANESİ
RADYOLOJİ KLİNİĞİ

DUKTAL KARSİNOMA İN SİTU (DKİS)

- BAZAL MEMBRANIN KORUNDUĞU TERMİMAL DUKTAL LOBÜLER ÜNİTE İÇİNDE NEOPLASTİK HÜCRE PROLİFERASYONU

Terminal duktal lobüler ünite



DKİS RADYOLOJİSİ

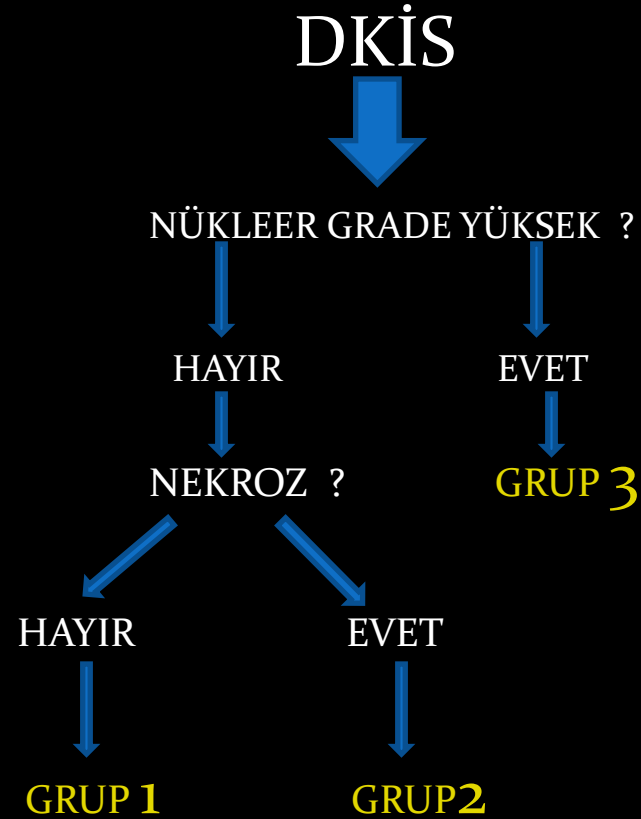
- DKİS TEK BİR HASTALIK OLMAYIP NÜKLEER DERECELENDİRME TEMELİNE OTURAN HETEROJEN HASTALIKLAR GRUBUDUR
- HASTALIĞIN NÜKLEER DERECELENDİRMESİ PROGNOZU ÖNEMLİ ŞEKİLDE ETKİLEDİĞİ GİBİ RADYOLOJİK BULGULAR DA DEĞİŞKENLİK GÖSTEREBİLMEKTEDİR

DKİS RADYOLOJİSİ- SINIFLAMA

- YAPISAL
 - SOLİD
 - KRİBRİFORM
 - PAPİLLER
 - MİKROPAPİLLER
- KOMEDO NEKROZ
 - VAR
 - YOK
- NÜKLEER GRADE
 - YÜKSEK
 - ORTA
 - DÜŞÜK

WHO Classification of tumours of the breast
4 th edition 2012

VAN NUYS SINIFLAMASI



DKİS RADYOLOJİSİ

DKİS MEME KANSERLERİ İÇİNDE ;

TARAMA MAMOGRAFİ ÖNCESİ % 5 
TARAMA MAMOGRAFİ SONRASI % 20-30 

Rosner D Ann Surg. 1980;192(2):139-147
Blichert-Toft M World J Surg. 1988;12:845-851
Ward BA Arch Surg. 1992;127(12):1392-1395.

DKİS RADYOLOJİSİ

- TARAMA MAMOGRAFİSİNİN OLAĞAN KULLANIMI SONRASI DKİS ORANLARININ % 30 CİVARINA YÜKSELMESİ İLE MEME KANSERİNDEN ÖLÜMLERİN % 30 CİVARINDA AZALMASI DA ANLAMLI
- BAZI DKİS OLGULARININ İNVAZİV HASTALIĞA DÖNÜŞMEDİĞİNİ BİLMEKTEYİZ SON ZAMANLARDA YAPILAN ÇALIŞMALAR DA DAHA ÇOK BU AYRIMI YAPMAYA ODAKLANMAKTADIR.

DKİS RADYOLOJİSİ-MODALİTELER

MAMOGRAFİ

ULTRASONOGRAFİ

MAGNETİK REZONANS GÖRÜNTÜLEME

BİLGİSAYARLI TOMOGRAFİ (CEbCT) ??

DKİS RADYOLOJİSİ- MAMOGRAFİ

- DKİS DUYARLILIK %87-95
- EN SIK BULGU MİKROKALSİFİKASYONLAR
%50-75
- KALSİFİKASYON - DKİS GRADE İLİŞKİSİ ??
- MİKROKALSİFİKASYONLARIN TİPİ İLE
HİSTOLOJİK GRADE KESİN OLARAK
ÖNGÖRMEK HALEN PEK MÜMKÜN DEĞİL

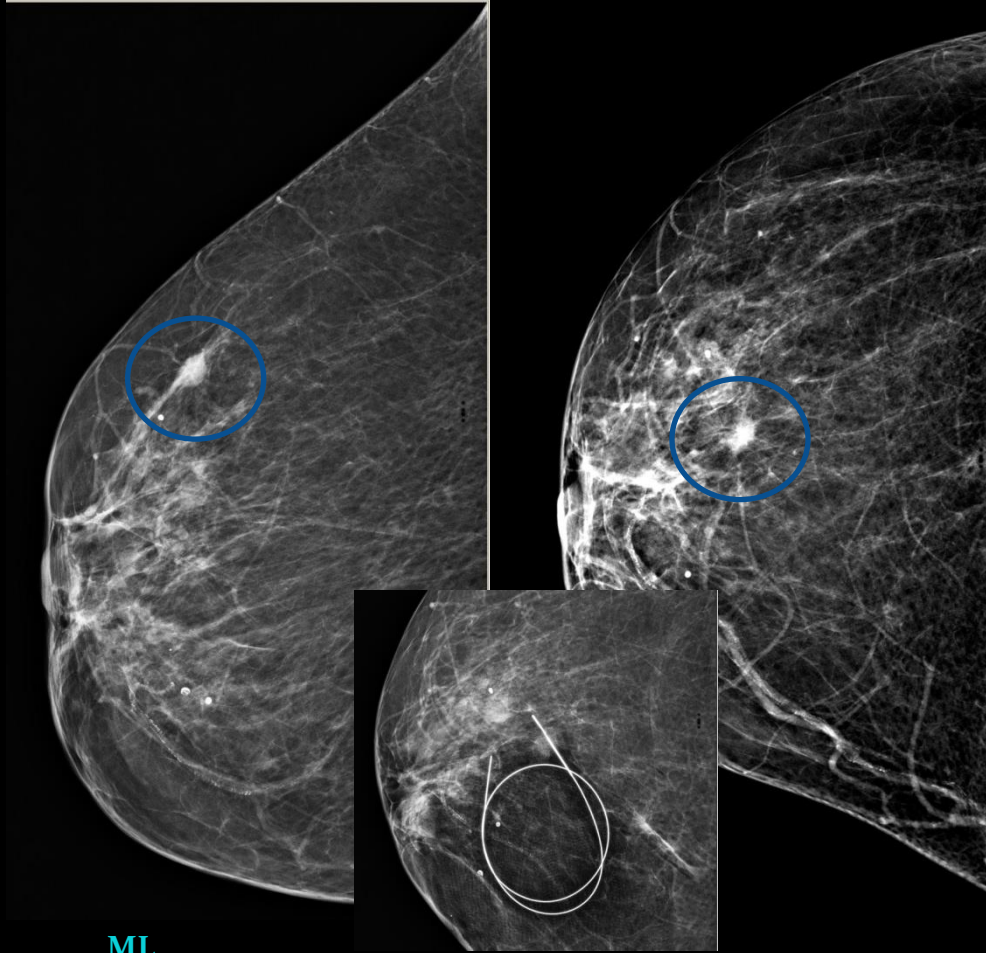
DKİS RADYOLOJİSİ- MAMOGRAFİ

MİKROKALSİKASYONLAR DİĞER BULGULAR

- AMORF
- KABA PLEOMORFİK
- İNCE PLEOMORFİK
- İNCE ÇİZGİSEL DALLANAN
%50-75

- KİTLE % 10
- YAPISAL BOZULMA %7-13

DKİS RADYOLOJİSİ- MAMOGRAFİ



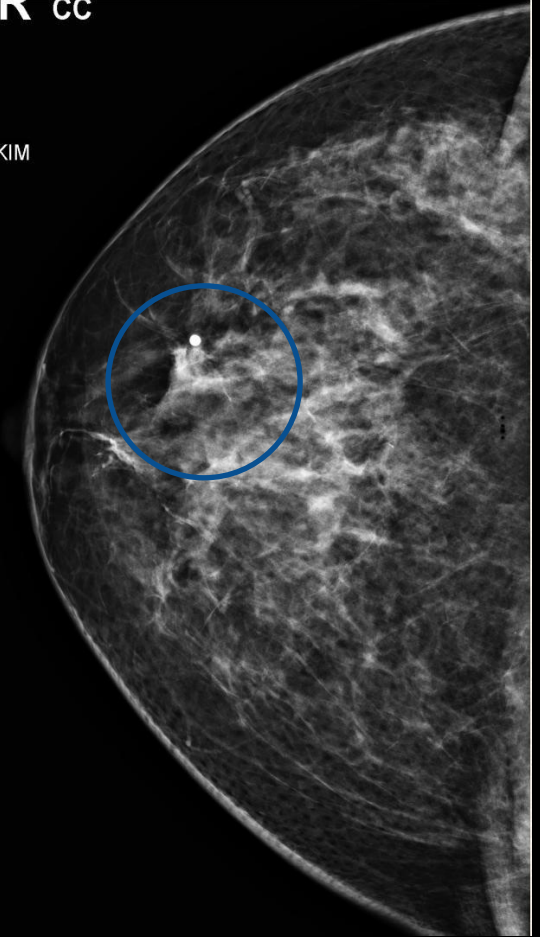
ML

CC

KİTLE

ORTA DERECE DKİS

MARK ÇEKİM

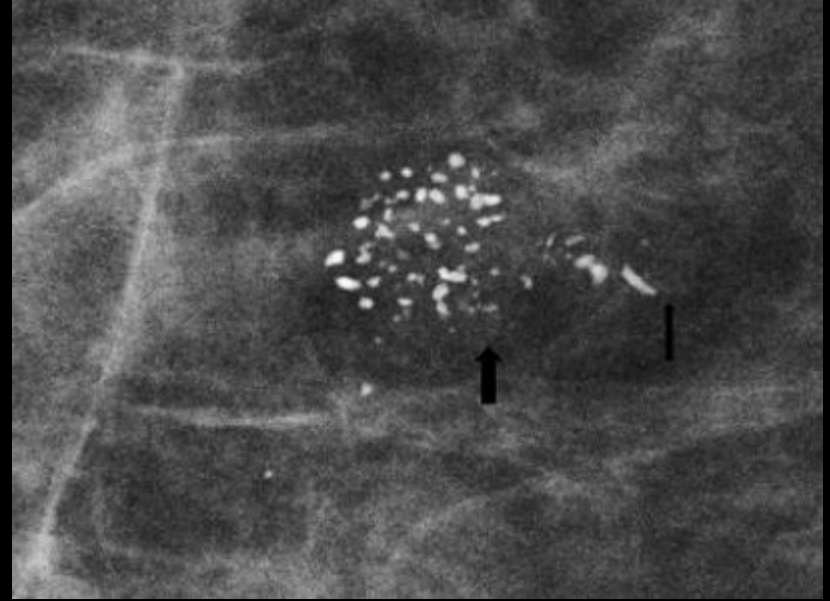
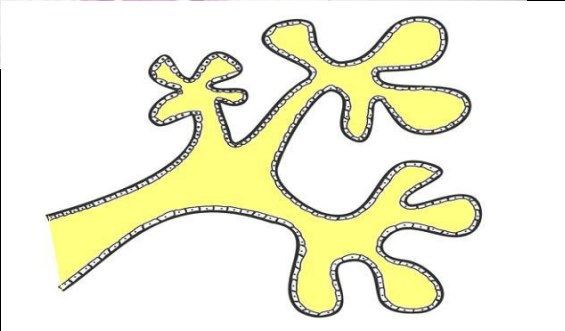
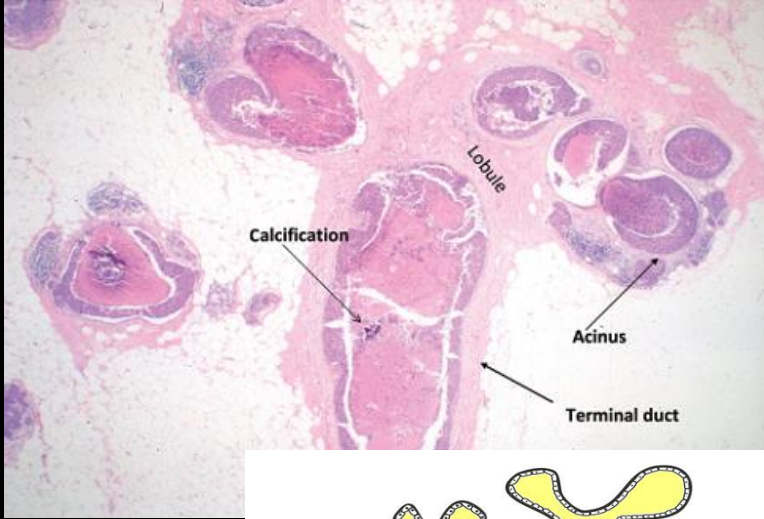


YAPISAL BOZULMA

ORTA DERECE DKİS

DKİS RADYOLOJİSİ- MAMOGRAFİ

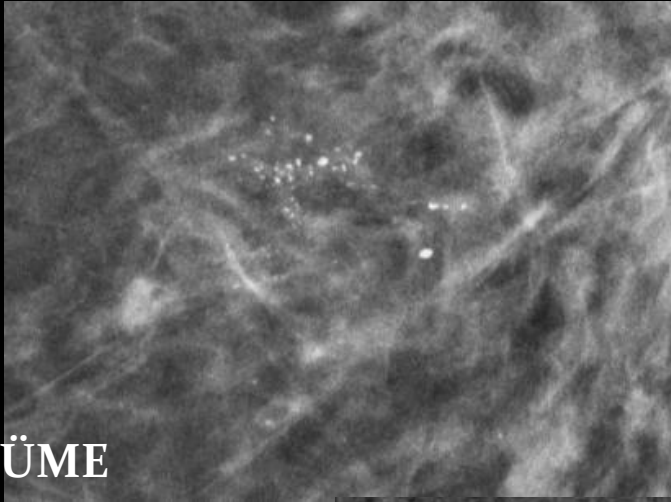
MİKROKALSİFİKASYONLARIN TİPİNİ VE DAĞILIMINI BELİRLEMEK AÇISINDAN TDLU ANATOMİSİNİ BİLMEK ÖNEMLİ



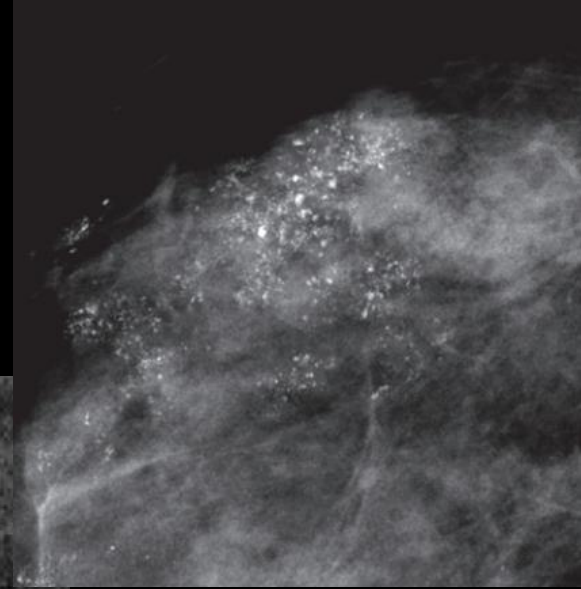
LOBÜL VE ASİNİLERİ DOLDURMUŞ KABA HETEROJEN KALSİFİKASYONLAR VE TERMİNAL DUKTUSU DOLDURAN MİKROKALSİFİKASYONLAR - KOMEDO TİP DKİS

DKİS RADYOLOJİSİ- MAMOGRAFİ

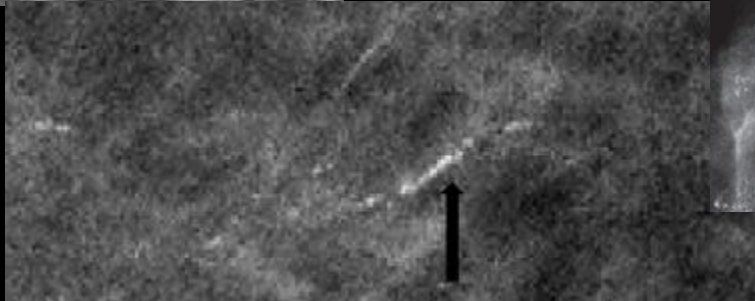
MİKROKALSİKASYONLAR- DAĞILIM



KÜME



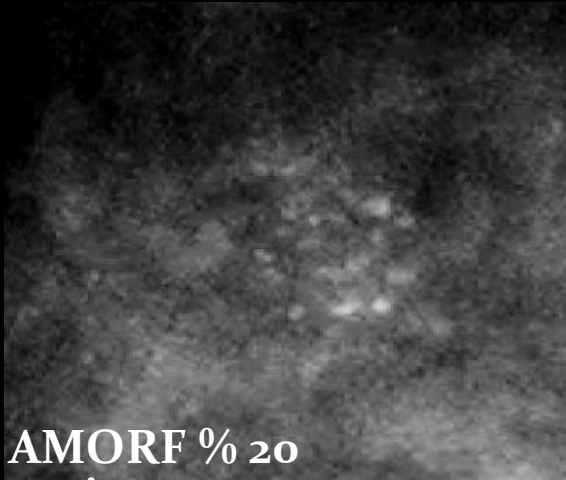
SEGMENTAL



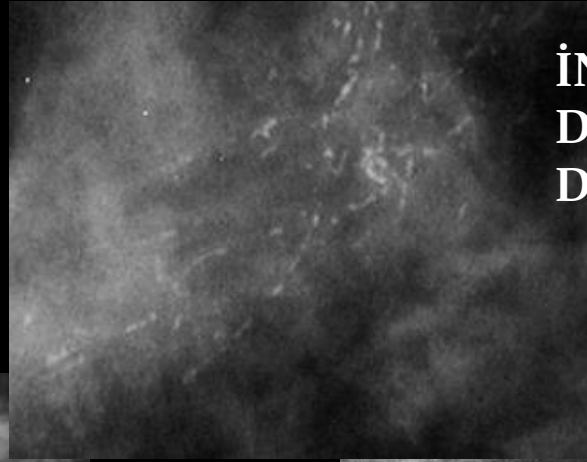
ÇİZGİSEL

DKİS RADYOLOJİSİ- MAMOGRAFİ

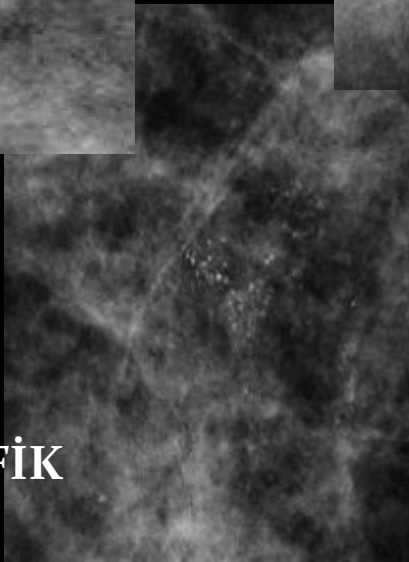
MİKROKALSİKASYONLAR –MORFOLOJİ



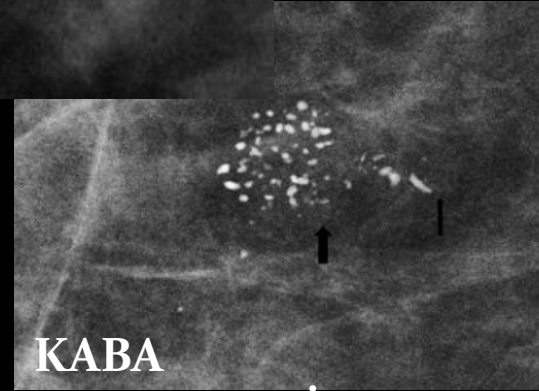
AMORF % 20
DKİS



İNCE ÇİZGİSEL
DALLANAN -% 80
DKİS



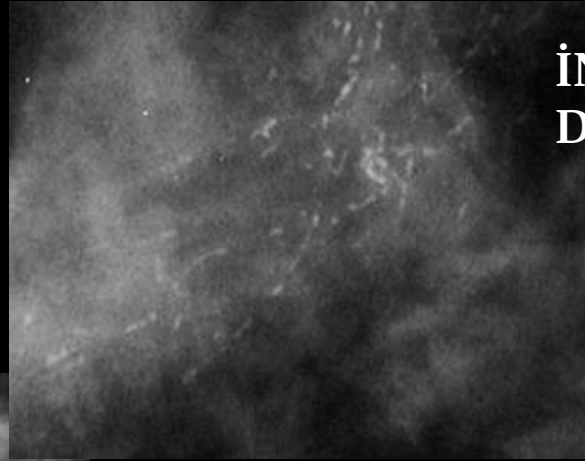
İNCE
PLEOMORFİK



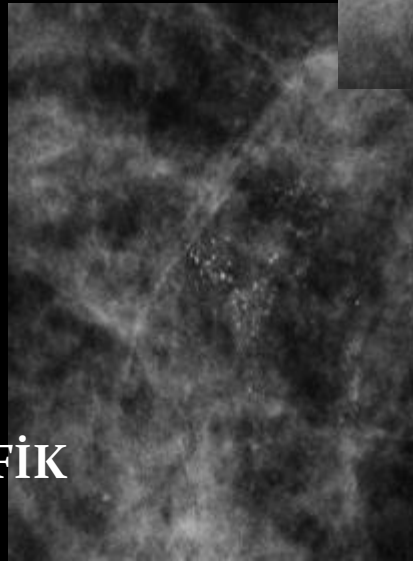
KABA
PLEOMORFİK

DKİS RADYOLOJİSİ- MAMOGRAFİ

MİKROKALSİKASYONLAR – HİSTOPATOLOJİK GRADE



İNCE ÇİZGİSEL
DALLANAN



İNCE
PLEOMORFİK

YÜKSEK GRADE VE
NEKROZLA
İLİNTİLİ

Yamada T Radiographics. 2010;30(5):1183-98
D'Orsi CJ. Natl Cancer Inst Monogr. 2010;2010(41):214-7.

DKİS RADYOLOJİSİ- US

- SON YILLARDA TEKNOLOJİK GELİŞMELER KULLANIMINI ARTIRMIŞTIR
- COMPOUND GÖRÜNTÜLEME, MICROPURE vs... İLE DAHA ÇOK KALSİFİKASYON GÖRÜNTÜLEME
- HASTALIĞIN İNVAZİV KOMPONENT VARLIĞI SAPTAMA
- BİYOPSİ KILAVUZLUĞU
- MR SONRASI İKİNCİ BAKI
- AKSİLLAR DEĞERLENDİRME

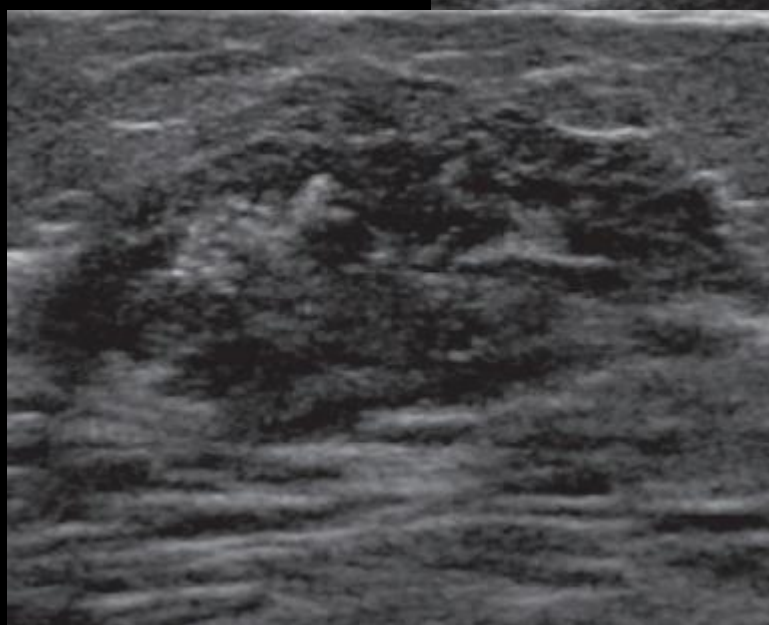
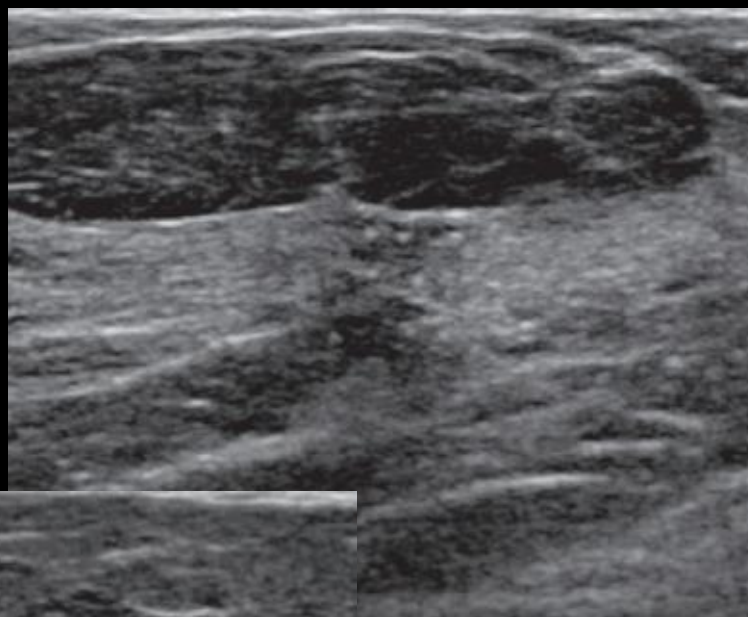
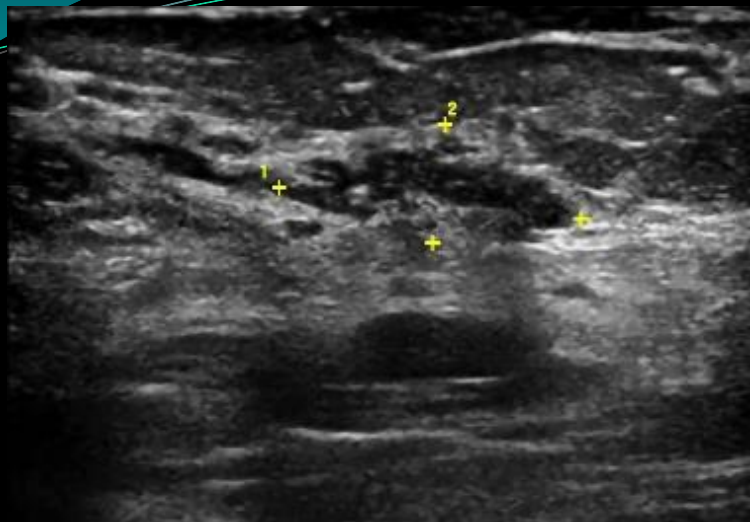
DKİS RADYOLOJİSİ- US

- KALSİFİKASYON
- KALSİFİKASYON DIŞI BULGULAR

DKİS RADYOLOJİSİ- US

KALSİFİKASYON

- MAMOGRAFİDEKİ KALSİFİKASYONLARIN %23-45 US DE İZLENEBİLMEKTE
- YÜKSEK GRADE DKİS VE KOMEDO VARLIĞINDA KALSİFİKASYON DAHA SIK
- DUKTAL DEĞİŞİKLİKLER VE KALSİFİKASYONLAR YÜKSEK GRADE DKİS EN SIK BULGUSU
- KALSİFİKASYONLAR
 - DUKTUS İÇİ
 - KİTLE İÇİ
- SKLEROZAN ADENOZİS,ADH,İNTRADUKTAL PAPİLLOM ,FİBROADENOM İLE KARIŞABİLİR



DKİS RADYOLOJİSİ- US

KALSİFİKASYON DIŞI BULGULAR

- DKİS YAKLAŞIK % 23 KALSİFİKASYON DIŞI BULGULAR İLE KARAKTERİZE

SOLID KİTLE
MİKROKİST KÜMESİ
KOMPLEKS KİSTİK KİTLE
ANORMAL DUKTAL PATTERN

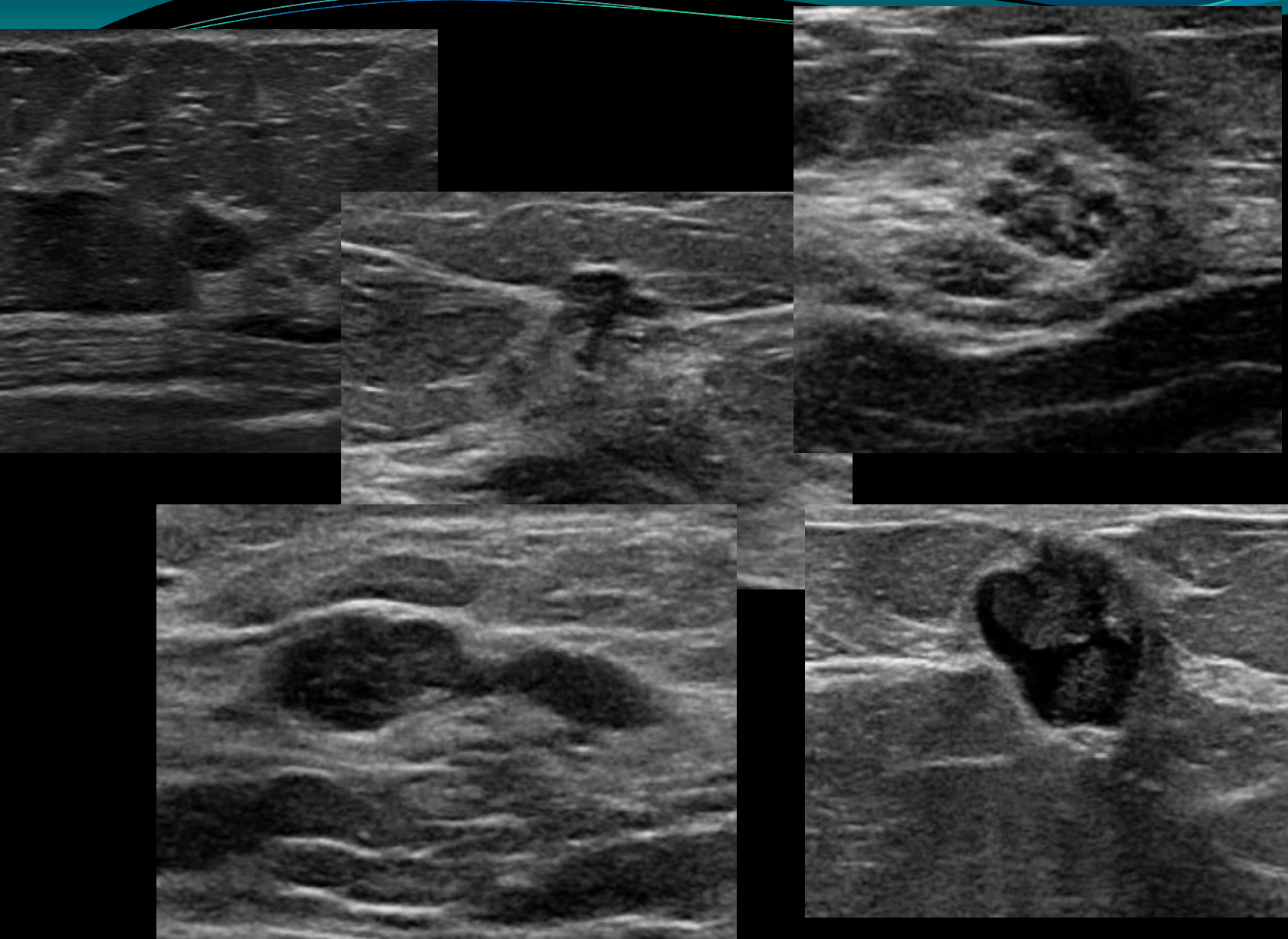


Table 1
US Features of 64 DCIS Mass Lesions

US Features	No. of Lesions			Diagnosed at Second-Look US
	Total	Calcified	Noncalcified	
Shape				
Irregular	40	16	13	11
Oval	23	5	16	2
Round	1	1	0	0
Margins				
Circumscribed	12	1	9	2
Angular	15	5	4	6
Indistinct	20	9	9	2
Microlobulated	15	6	7	2
Spiculated	2	1	0	1
Orientation				
Not parallel	22	5	10	7
Parallel	42	17	19	6
Echogenicity				
Hypoechoic	53	18	23	12
Complex cystic	3	0	2	1
Isoechoic	6	3	3	0
Mixed	2	1	1	0
Echotexture				
Homogeneous	27	1	19	7
Heterogeneous	37	21	10	6

US Appearance of Ductal Carcinoma in Situ¹

ONLINE-ONLY
SA-CME

Lilian C. Wang, MD • Megan Sullivan, MD • Hongyan Du, MB, MS
Marina I. Feldman, MD, MBA • Ellen B. Mendelson, MD

Acoustic transmission				
Enhancement	15	4	11	0
Normal	39	15	14	10
Shadowing	10	3	4	3
Internal vascularity				
Present	32	11	14	7
Absent	18	6	9	3
Not recorded	14	5	6	3
Calcifications				
Yes	21	20	0	1
No	43	2*	29	12
Ductal extension				
Present	8	2	4	2
Absent	56	20	25	11

Note.—Breast Imaging Reporting and Data System criteria.

*Two of the lesions classified as calcified DCIS at mammography did not demonstrate visible calcifications at US.

Table 1
US Features of 64 DCIS Mass Lesions

US Features	No. of Lesions			Diagnosed at Second-Look US
	Total	Calcified	Noncalcified	
Shape				
Irregular	40	16	13	11
Oval	23	5	16	2
Round	1	1	0	0
Margins				
Circumscribed	12	1	9	2
Angular	15	5	4	6
Indistinct	20	9	9	2
Microlobulated	15	6	7	2
Spiculated	2	1	0	1
Orientation				
Not parallel	22	5	10	7
Parallel	42	17	19	6
Echogenicity				
Hypoechoic	53	18	23	12
Complex cystic	3	0	2	1
Isoechoic	6	3	3	0
Mixed	2	1	1	0
Echotexture				
Homogeneous	27	1	19	7
Heterogeneous	37	21	10	6

US Appearance of Ductal Carcinoma in Situ¹

ONLINE-ONLY
SA-CME

Lilian C. Wang, MD • Megan Sullivan, MD • Hongyan Du, MB, MS
Marina I. Feldman, MD, MBA • Ellen B. Mendelson, MD

Acoustic transmission				
Enhancement	15	4	11	0
Normal	39	15	14	10
Shadowing	10	3	4	3
Internal vascularity				
Present	32	11	14	7
Absent	18	6	9	3
Not recorded	14	5	6	3
Calcifications				
Yes	21	20	0	1
No	43	2*	29	12
Ductal extension				
Present	8	2	4	2
Absent	56	20	25	11

Note.—Breast Imaging Reporting and Data System criteria.

*Two of the lesions classified as calcified DCIS at mammography did not demonstrate visible calcifications at US.

Correlation Between Sonographic Findings and Clinicopathologic and Biologic Features of Pure Ductal Carcinoma In Situ in 691 Patients

Marion E. Scoggins¹
Patricia S. Fox²
Henry M. Kuerer³
Galene M. Rauch¹
Ana P. Benveniste¹
Young Mi Park^{1,4}
Sara A. Lari⁵
Savitri Krishnamurthy⁵
Wei T. Yang¹

Keywords: breast neoplasm, ductal carcinoma in situ, mammography, ultrasound

DOI:10.2214/AJR.13.12221

Received November 5, 2013; accepted after revision July 5, 2014.

The University of Texas M.D. Anderson Cancer Center is supported in part by the National Institutes of Health through a cancer center support grant (CA016672).

¹Department of Diagnostic Radiology, The University of Texas M.D. Anderson Cancer Center, 1515 Holcombe Blvd, Unit 1250, Houston, TX 77030. Address correspondence to M. E. Scoggins (m.scoggins@mdanderson.org).

²Department of Biostatistics, The University of Texas M.D. Anderson Cancer Center, Houston, TX.

³Department of Surgical Oncology, The University of Texas M.D. Anderson Cancer Center, Houston, TX.

⁴Department of Radiology, Inje University College of Medicine, Busan, Korea.

⁵Department of Pathology, The University of Texas M.D. Anderson Cancer Center, Houston, TX.

AJR 2015; 204:878–888

0893-803X/15/2044-878

© American Roentgen Ray Society

OBJECTIVE. The objective of our study was to compare the sonographic features of pure ductal carcinoma in situ (DCIS) lesions with the initial clinical presentation and histopathologic findings.

MATERIALS AND METHODS. The images and records of 691 patients with pure DCIS who underwent preoperative mammography and whole-breast sonography as part of staging workup in a single institution from January 1, 1996, through July 31, 2009, were reviewed. The BI-RADS sonography lexicon was used when reviewing the sonographic studies. Histopathologic features recorded included estrogen receptor (ER) status, nuclear grade, and presence or absence of comedonecrosis. Statistical comparisons were made using the Student *t* test, chi-square test, Fisher exact test, Kruskal-Wallis or Wilcoxon rank-sum test, multiple logistic regression analysis, and Pearson correlation coefficient.

RESULTS. A total of 304 (44%) tumors were visible on mammography and sonography; 315 (46%), on mammography only; 58 (8%), on sonography only; and 14 (2%), on neither mammography nor sonography. The most common sonographic appearance of DCIS was an irregular hypoechoic mass with indistinct margins and normal posterior features that was indistinguishable from invasive carcinoma. Patients with symptomatic high-nuclear-grade DCIS, dense breasts, and comedonecrosis were younger and had larger tumors on sonography than asymptomatic women with nondense breasts and low-nuclear-grade and noncomedo DCIS. Women with ER-negative DCIS were older and had larger tumors on sonography than women with ER-positive DCIS. ER-negative tumors were more frequently visible on sonography than ER-positive tumors ($p = 0.007$). High-grade DCIS ($p < 0.0001$) and comedo DCIS ($p < 0.0001$) presented more frequently as microcalcifications, architectural distortion, and ductal changes on sonography than low-grade DCIS or noncomedo DCIS.

CONCLUSION. Of the 691 pure DCIS lesions, 362 (52%) were visible on sonography and presented most commonly as a mass. Lesion visibility of DCIS on sonography was not related to nuclear grade or the presence of comedonecrosis.

Ductal carcinoma in situ (DCIS) is a malignant proliferation of ductal epithelial cells in the terminal ductal lobular unit confined by an intact basement membrane. DCIS encompasses a spectrum of disease classified at microscopic examination on the basis of nuclear grade, the presence of comedonecrosis, and architectural pattern [1]. These histologic characteristics provide important prognostic information: high-nuclear-grade tumors, the presence of comedonecrosis, and solid or cribriform architectural patterns are associated with a higher probability of local recurrence when treated with breast conservation [2–4].

Biologic evaluation in patients with breast cancer includes testing for estrogen re-

ceptor (ER) status to provide additional information for breast cancer prognosis and treatment. The ER is expressed in approximately 69% of DCIS lesions and is inversely related to nuclear grade; that is, ER expression is higher in well-differentiated lesions [5]. A lack of ER expression confers a poor prognosis because of aggressive behavior [6, 7].

Before implementation of mammography screening programs, DCIS accounted for fewer than 5% of breast cancers [8]. DCIS now accounts for 15–20% of all breast cancers and typically presents as microcalcifications on screening mammography in asymptomatic patients [9, 10]. In the evaluation of DCIS, sonography primarily serves as an adjunct to mammography. Adjunctive sonography is

TABLE 5: Sonographic Features of 362 Pure Ductal Carcinoma In Situ Lesions

Sonographic Feature	No. (%)	Posterior features	
Masses	276 (76)	Enhancement	20 (7)
Shape		No posterior features	104 (38)
Oval	60 (21)	Combined pattern	9 (3)
Round	13 (5)	Shadowing	62 (22)
Irregular	153 (55)	Unknown	81 (29)
Unknown	50 (18)	Orientation	
Margin		Parallel	130 (47)
Circumscribed	33 (12)	Not parallel	62 (22)
Not circumscribed		Unknown	84 (30)
Indistinct	115 (42)	Calcifications in mass	
Microlobulated	40 (14)	Calcifications present	67 (24)
Angular	21 (8)	Vascularity	
Spiculated	15 (5)	Not detectable	23 (8)
Unknown	52 (19)	Present adjacent to lesion	8 (3)
Echogenicity		Diffusely increased in surrounding tissue	28 (10)
Anechoic	2 (1)	Present in lesion	45 (16)
Hyperechoic	2 (1)	Not assessed	62 (22)
Isoechoic	8 (3)	Unknown	110 (40)
Complex cystic and solid	52 (19)		
Hypoechoic	195 (70)		
Unknown	17 (6)		

Sonographic Feature	No. (%)
Others	86 (24)
Microcalcifications alone	33 (38)
Architectural distortion	
Without calcifications	23 (27)
With calcifications	10 (12)
Ductal abnormalities	
Dilatation	8 (9)
Dilatation, intraductal echoes, intraductal calcifications	5 (6)
Dilatation, intraductal echoes	2 (2)
Dilatation, intraductal calcifications	1 (1)
Intraductal echoes, intraductal calcifications	1 (1)
Others ^a	3 (3)

DKİS RADYOLOJİSİ- US

KİTLELER EN SIK

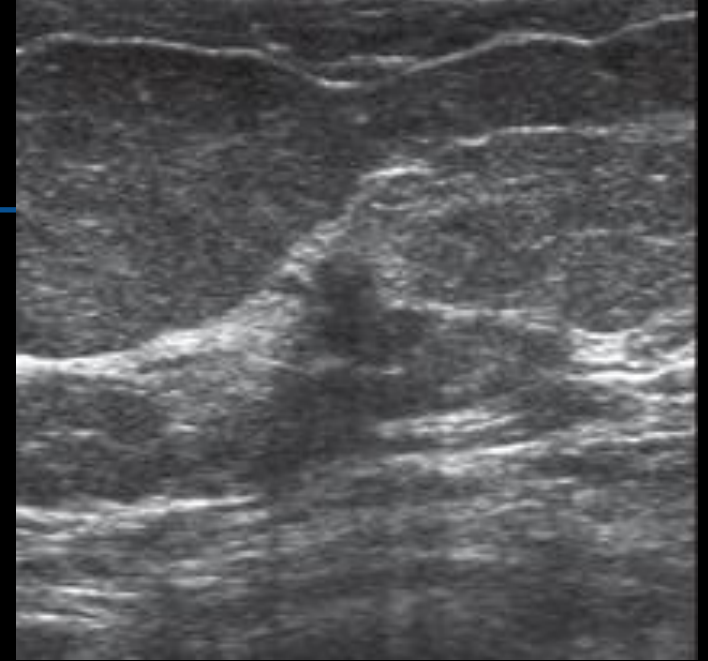
HİPOEKOİK

DÜZENSİZ ŞEKLİ

BELİRSİZ KENARLI

NORMAL POSTERİOR GEÇİRGENLİĞİ OLAN

İNVAZİV KİTLELER İLE BENZER BULGULAR !!!!



Correlation Between Sonographic Findings and Clinicopathologic and Biologic Features of Pure Ductal Carcinoma In Situ in 691 Patients

Marion E. Scoggins¹

OBJECTIVE. The objective of our study was to compare the sonographic features of pure

- HEM MAMOGRAFİ HEM US GÖRÜNÜR %44
 - YALNIZ US % 8
 - YALNIZ MAMOGRAFİ %46
- 691/362 HASTA
%52

- KALSİFİKASYON
- DÜZENSİZ ŞEKİL
- POSTERİOR GÖLGE



YÜKSEK GRADE DKİS

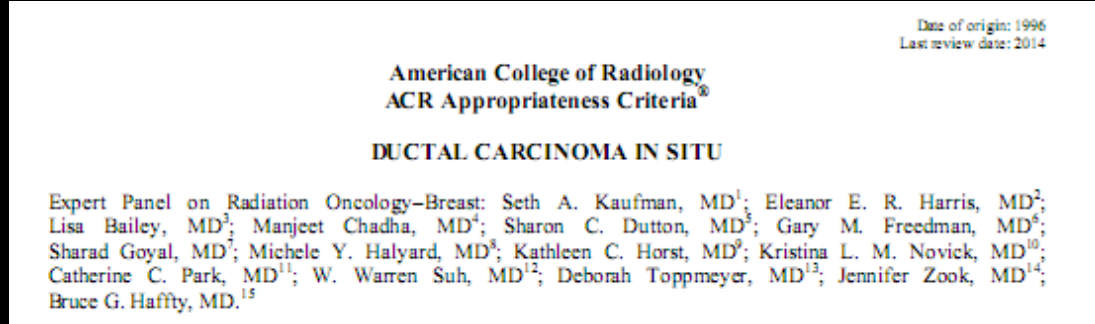
Correlation Between Sonographic Findings and Clinicopathologic and Biologic Features of Pure Ductal Carcinoma In Situ in 691 Patients

Marion E. Scoggins¹

OBJECTIVE. The objective of our study was to compare the sonographic features of pure

- MAMOGRAFİDE KALSİFİKASYON BULUNAN DKİS DAHA AGRESİF
- KALSİFİKASYONLAR YÜKSEK GRADE VE KOMEDO LEZYONLARDA NON KOMEDO VE DÜŞÜK GRADE LEZYOZLARA GÖRE DAHA SIK
- DENS MEME YAPISI OLAN HASTALARIN DENS OLMAYANLARA GÖRE KİTLE BOYUTU DAHA BÜYÜK
- ER (-) OLAN HASTALAR ER (+) OLAN HASTALARA GÖRE US DE İKİ KAT DAHA GÖRÜNÜR
- ER(-) HASTALAR DAHA YAŞLI VE US DE DAHA BÜYÜK TÜMÖR BOYUTUNA SAHİP
- LEZYON GÖRÜNÜRLÜĞÜ NÜKLEER GRADE VE KOMEDO NEKROZLA İLİNTİ DEĞİL

DKİS RADYOLOJİSİ- MRG



- GEÇMİŞ YILLARDA MRG KULLANIMI DKİS İÇİN PEK ÖNERİLMEZKEN GÜNÜMÜZDE İNVAZİV KANSERLERE GÖRE FARKLI TANISAL ÖZELLİKLERİNİN ORTAYA KONULMASIYLA OLDUKÇA SIK KULLANILMAYA BAŞLANMIŞTIR

DKİS RADYOLOJİSİ- MRG

Date of origin: 1996
Last review date: 2014

American College of Radiology
ACR Appropriateness Criteria®

DUCTAL CARCINOMA IN SITU

Expert Panel on Radiation Oncology—Breast: Seth A. Kaufman, MD¹; Eleanor E. R. Harris, MD²; Lisa Bailey, MD³; Manjeet Chadha, MD⁴; Sharon C. Dutton, MD⁵; Gary M. Freedman, MD⁶; Sharad Goyal, MD⁷; Michele Y. Halyard, MD⁸; Kathleen C. Horst, MD⁹; Kristina L. M. Novick, MD¹⁰; Catherine C. Park, MD¹¹; W. Warren Suh, MD¹²; Deborah Toppmeyer, MD¹³; Jennifer Zook, MD¹⁴; Bruce G. Haffty, MD¹⁵

AVANTAJ

- MULTİSENTRİSİTE
- YAYGINLIĞINI GÖSTERME
- MİKROKALSİFİKASYON (-) OKÜLT DKİS GÖSTERMESİ
- DENSE MEMELERDE

DEZAVANTAJ

- YÜKSEK YANLIŞ (+) ORANLARI
- GEREKSİZ İŞLEMLERE YOL AÇMASI
- HASTA KAYGISININ ARTMASI

DKİS 'TE MRG KULLANIMI YETERSİZ CERRAHİ VE POZİTİF CERRAHİ SINIRA BAĞLI REEKSİZYON ORANINI AZALTMAKTADIR

DKİS RADYOLOJİSİ- MRG

DUYARLILIK

DKİS % 77 -96  İNVAZİV TM % 97-100

YÜKSEK GRADE DKİS  DÜŞÜK GRADE DKİS

DKİS RADYOLOJİSİ- MRG

- MRG DE KANSER SAPTAMA 3 TEMEL NEDENE BAĞLIDIR
 - TÜMÖR ANJİOGENEZİ
 - ARTMIŞ VASKÜLARİTE
 - ARTMIŞ GEÇİRGENLİK

DKİS RADYOLOJİSİ- MRG

- KONTRASTSIZ SERİLERDE DKİS GENELLİKLE SEÇİLMEZ
- BAZEN T₂ A SERİLERDE DUKTAL SEKRESYON VE NEKROZA BAĞLI PARLAK İZLENEBİLİR

KONTRAST TUTULUMU

- | | |
|--------------|--------|
| • KİTLE DIŞI | %60-81 |
| • KİTLE | %14-41 |
| • FOKAL | %1-12 |

DKİS RADYOLOJİSİ- MRG

KİTLE DIŞI KONTRASTLANMA

- KONTAST DAĞILIMI

- FOKAL
- ÇİZGİSEL
- DUKTAL
- SEGMENTAL
- REJYONEL
- MULTİREJYONEL
- DİFFÜZ

- İÇ KONTRASTLANMA
PATERNİ

- CLUMPED (ARNAVUT KAL)
- HETEROJEN
- HOMOJEN
- CLUSTERED RİNG (KÜME HALKASAL)

DKİS RADYOLOJİSİ- MRG

KİTLE DIŞI KONTRASTLANMA

• KONTRAST DAĞILIMI

- FOKAL
- ÇİZGİSEL
- *DUKTAL ??
- SEGMENTAL
- REJYONEL
- MULTİREJYONEL
- DİFFÜZ

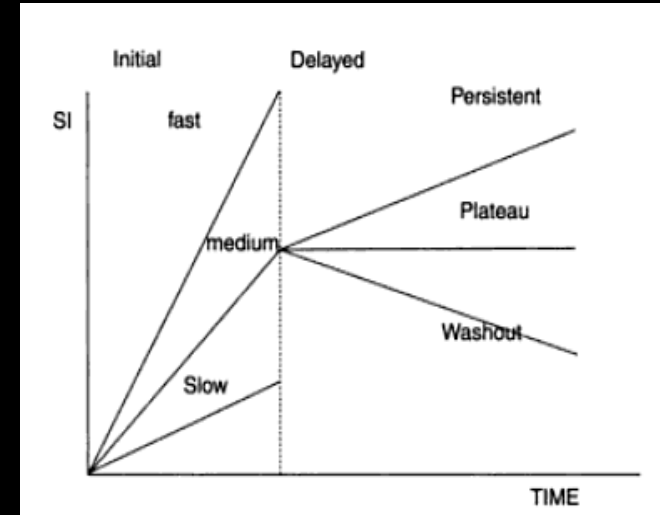
• İÇ KONTRASTLANMA PATERNİ

- CLUMPED (ARNAVUT KAL)
- HETEROJEN
- HOMOJEN
- *RETİKÜLER -DENDRİTİK
- CLUSTERED RİNG (KÜME HALKASAL)

DKİS RADYOLOJİSİ- MRG

KONTRAST KİNETİĞİ

- OLDUKÇA DEĞİŞKENLİK GÖSTERMEKTEDİR
- ERKEN FAZ – İLK 2 DK
 - HIZLI
 - ORTA
 - YAVAŞ
- GEÇ FAZ – 2 DK SONRA
 - TİP 1 PERSİSTAN (SÜREKLİ)
 - TİP 2 PLATO
 - TİP 3 WASHOUT (YIKANMA)



DKİS RADYOLOJİSİ- MRG

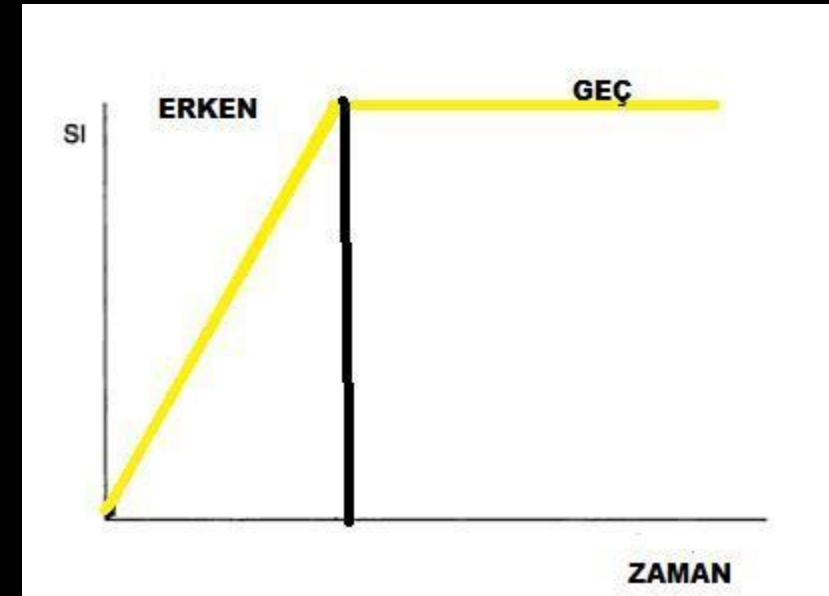
KONTRAST KİNETİĞİ

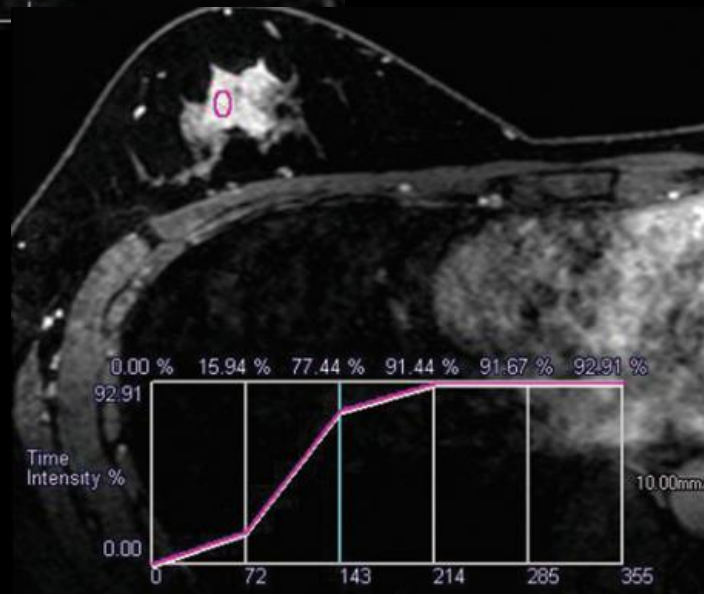
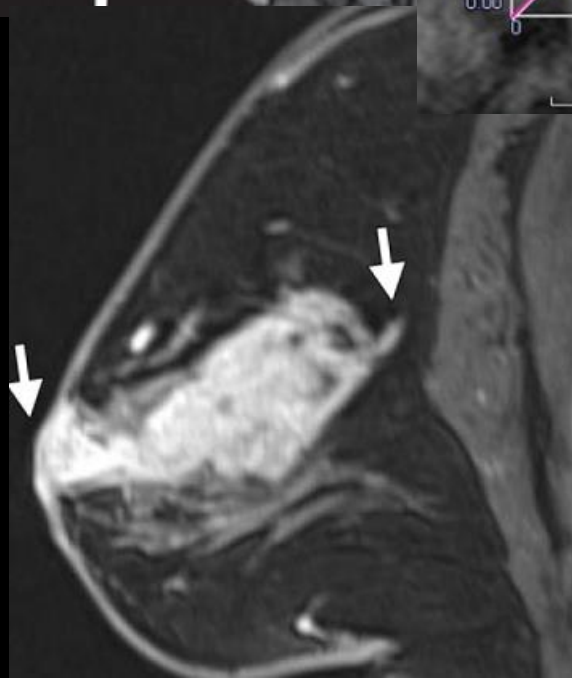
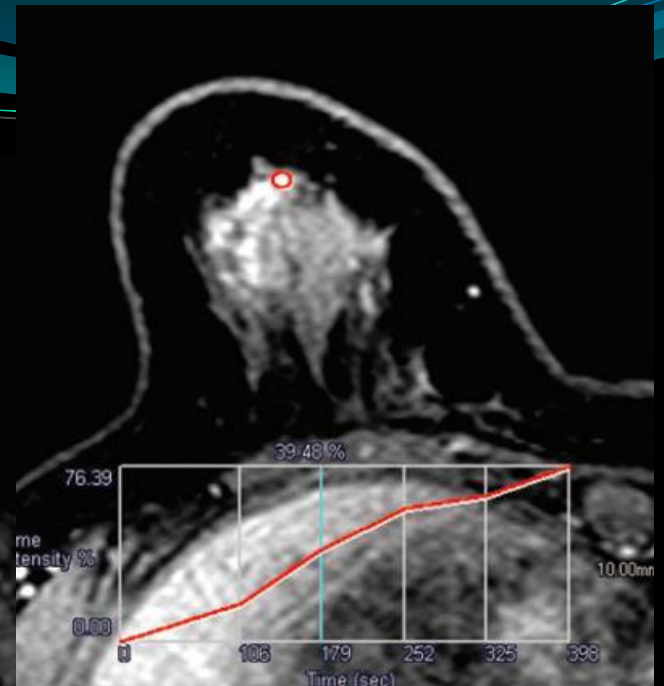
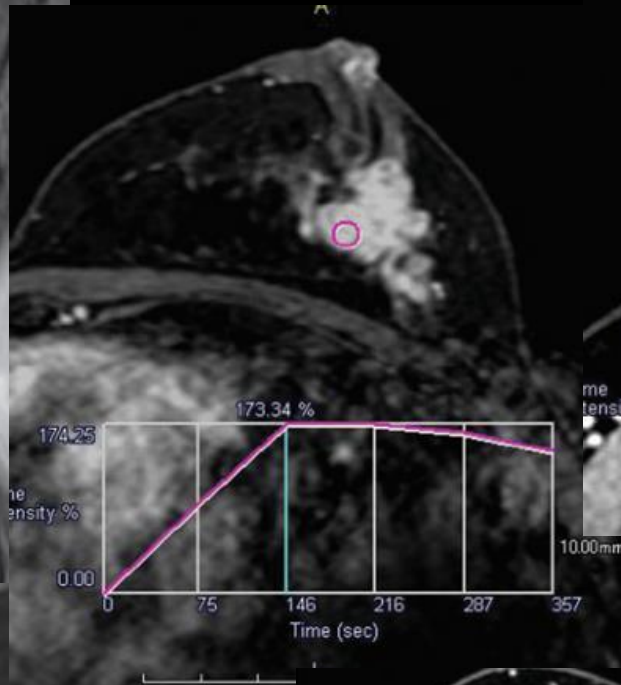
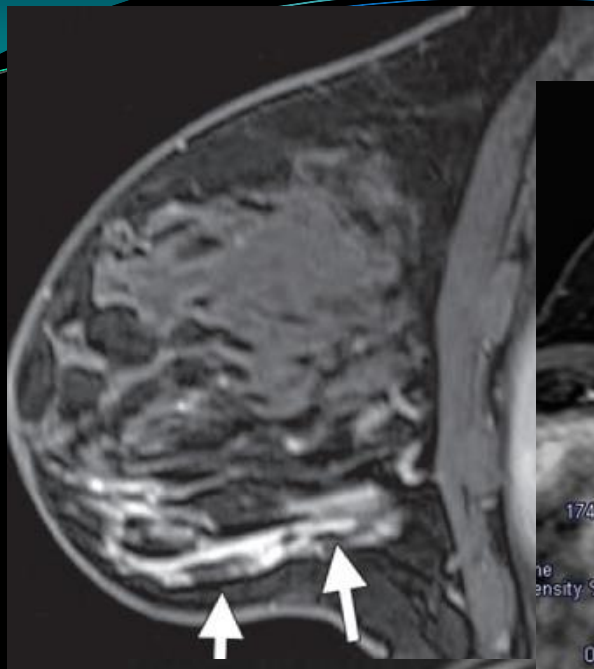
- ERKEN FAZ – İLK 2 DK

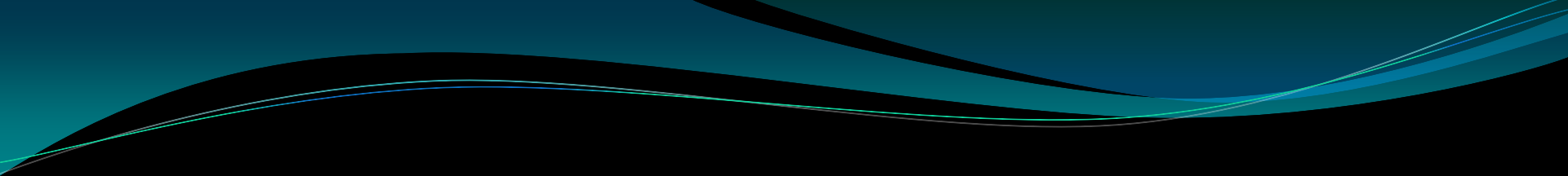
- **HIZLI** % 49-68
- ORTA
- YAVAŞ

- GEÇ FAZ – 2 DK SONRA

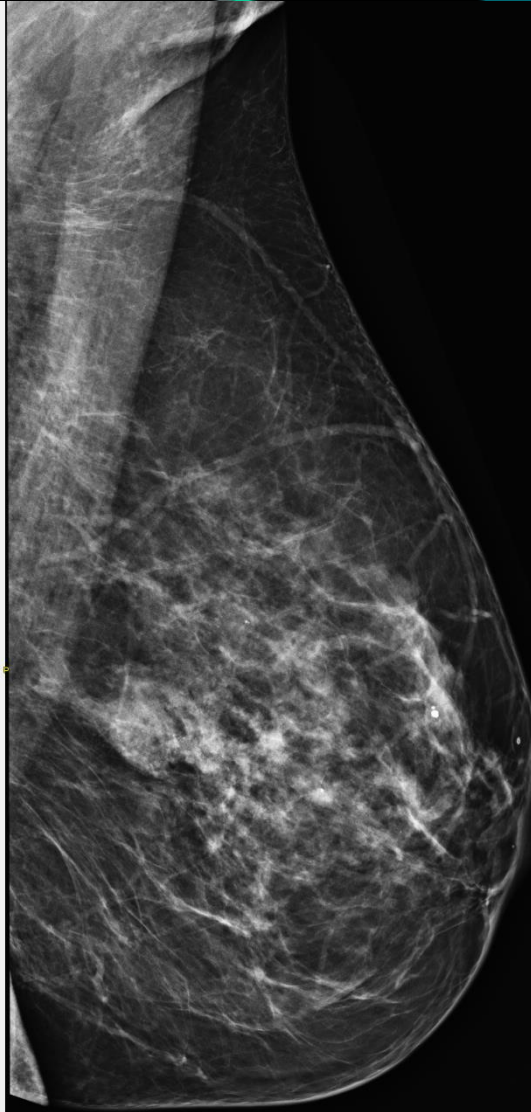
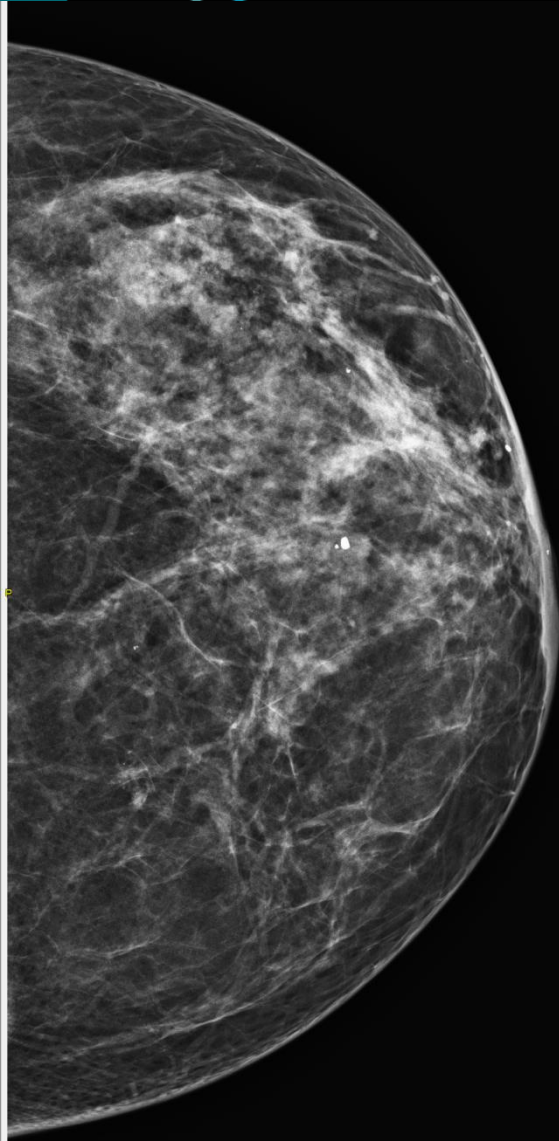
- TİP 1 PERSİSTAN (SÜREKLİ) %20-30
- **TİP 2 PLATO** %20-52
- TİP 3 WASHOUT (YIKANMA) %28-44







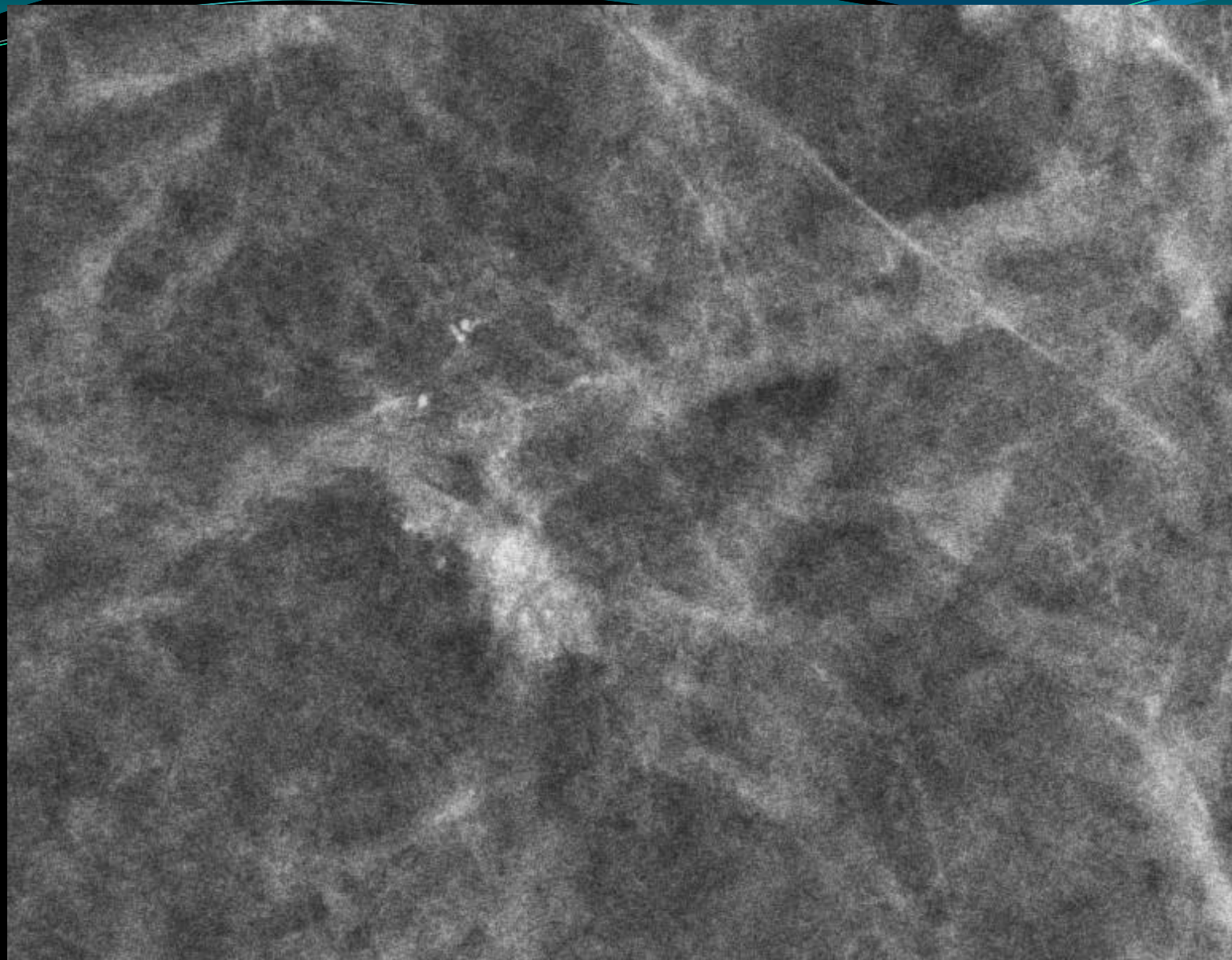
OLGULAR



L MLC

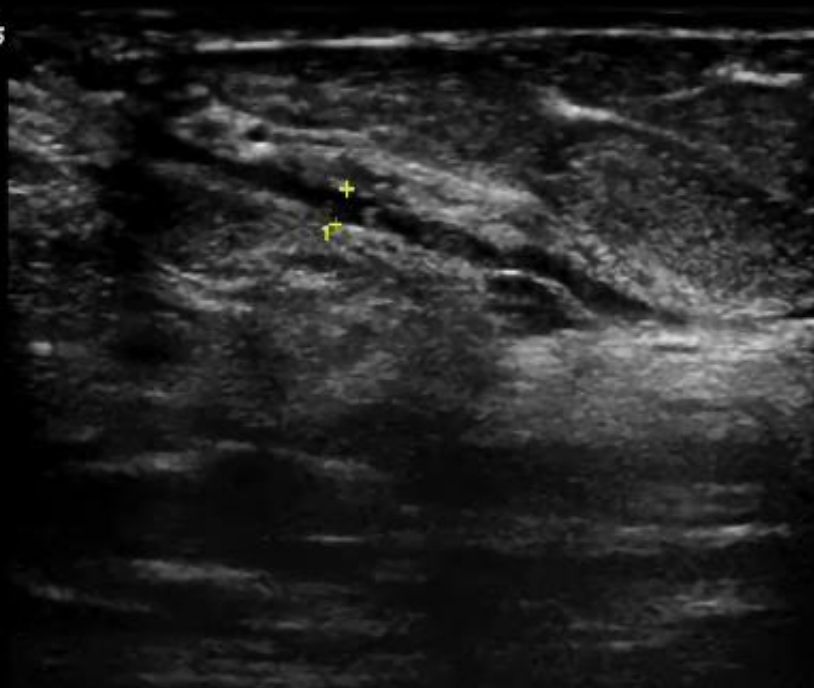
OLGU 1

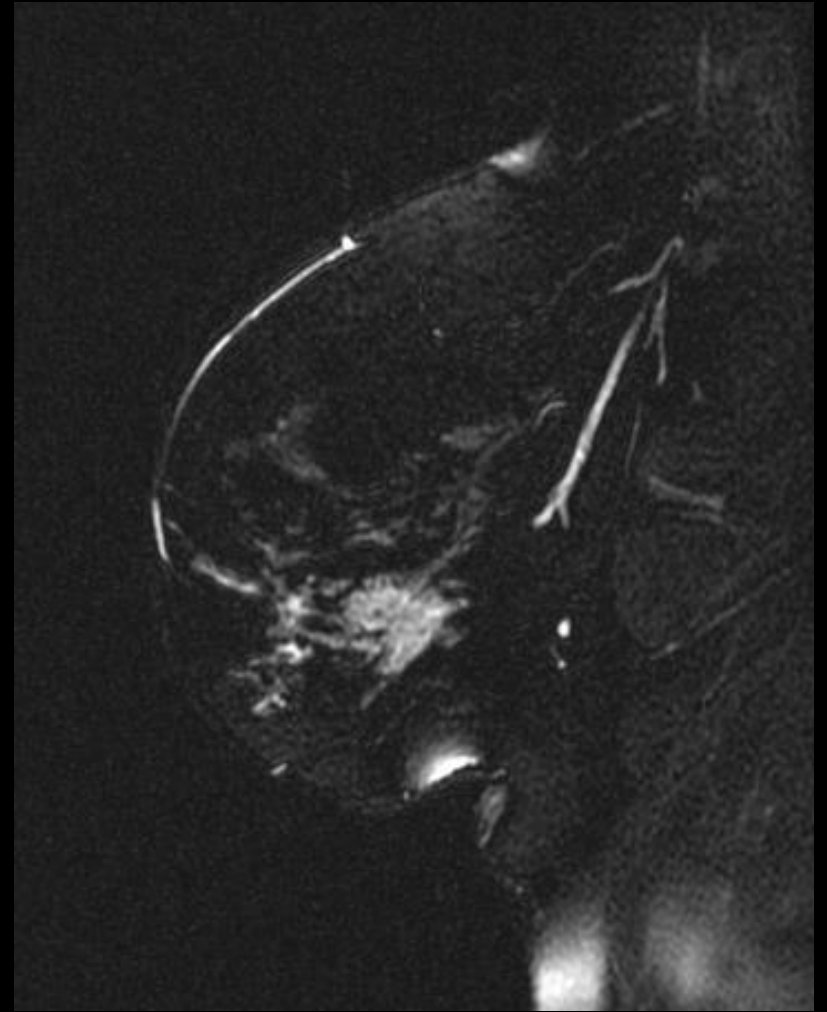
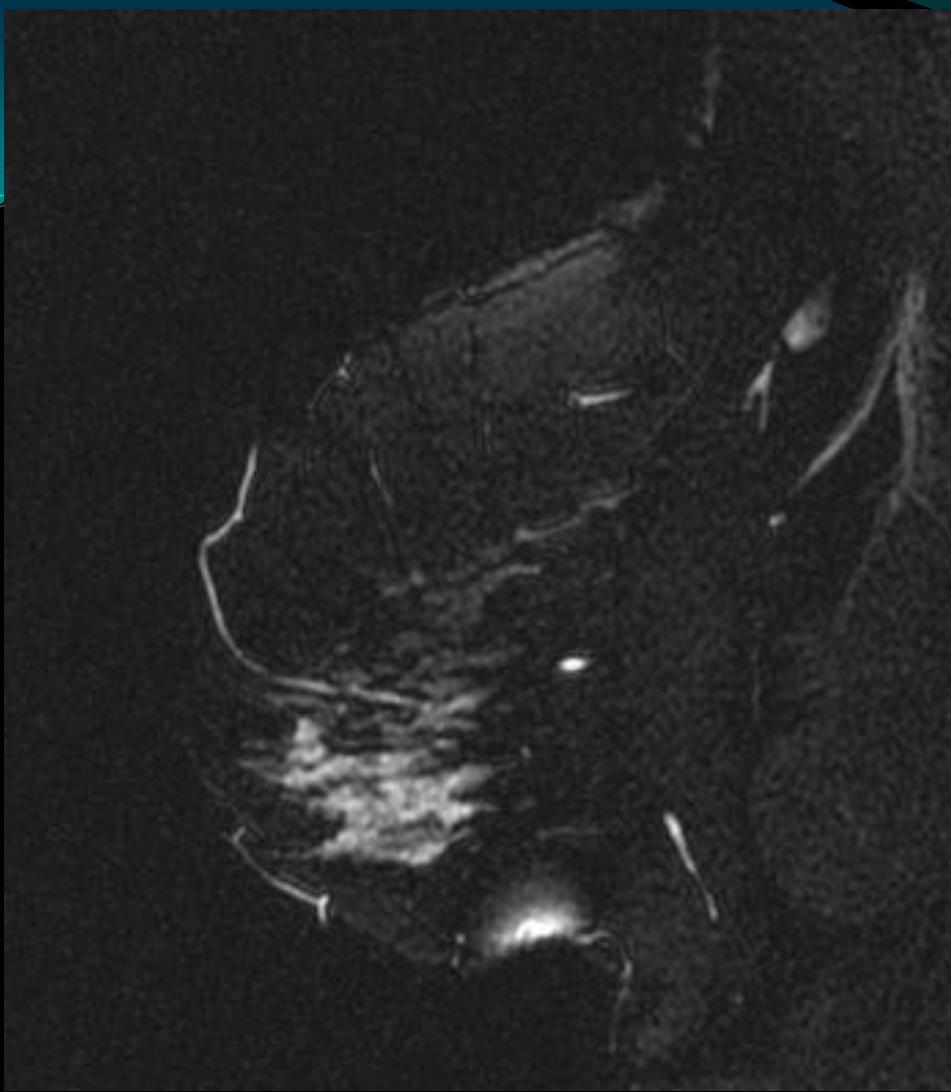
52 YAŞINDA
TARAMA MAMOGRAFİSİ
ŞİKAYET : YOK
AİLE ÖYKÜSÜ : YOK



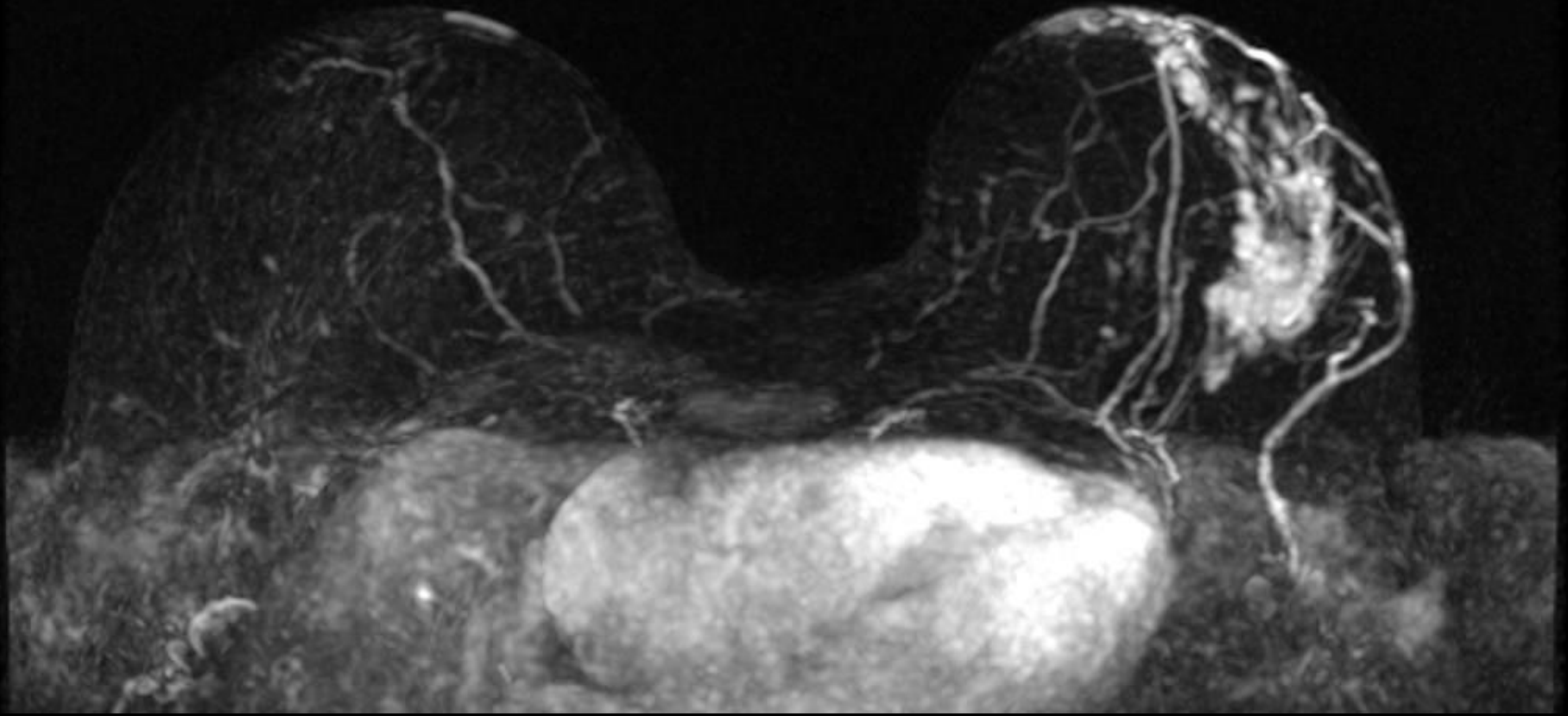


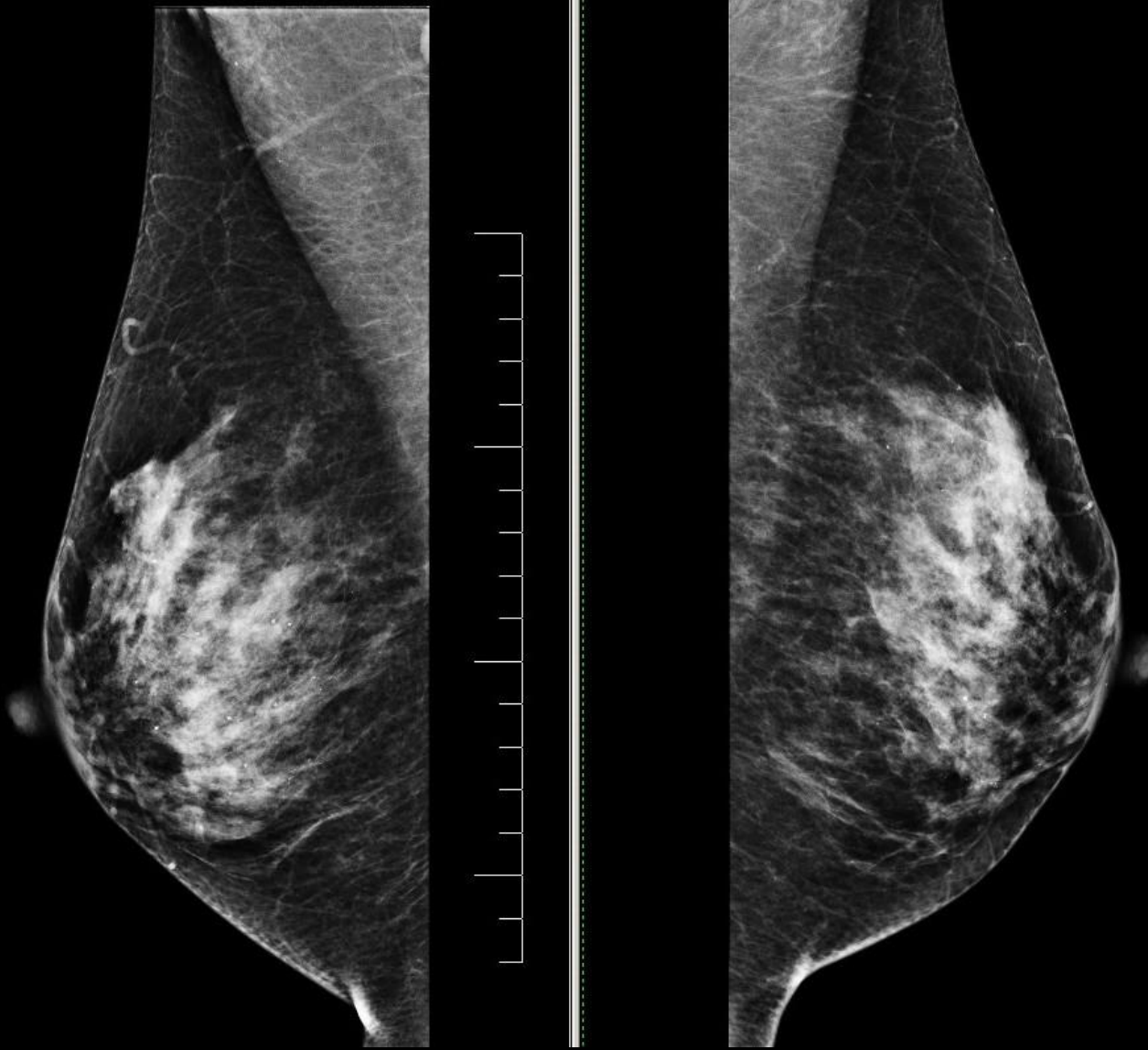
E
56





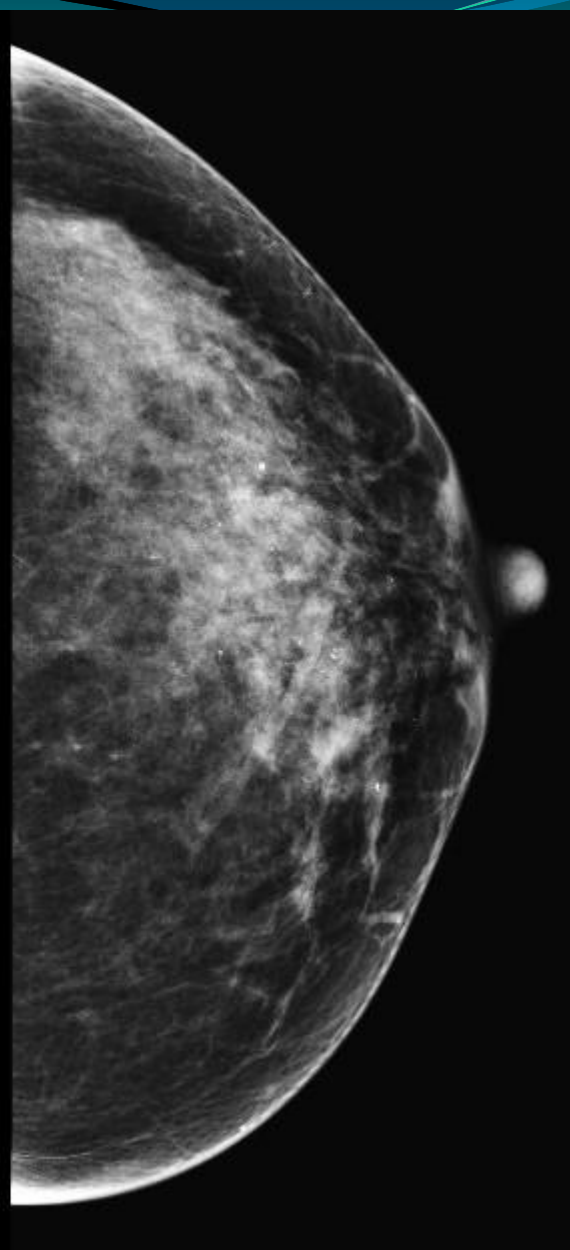
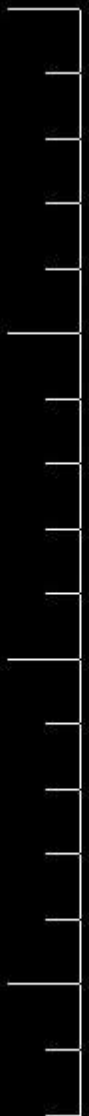
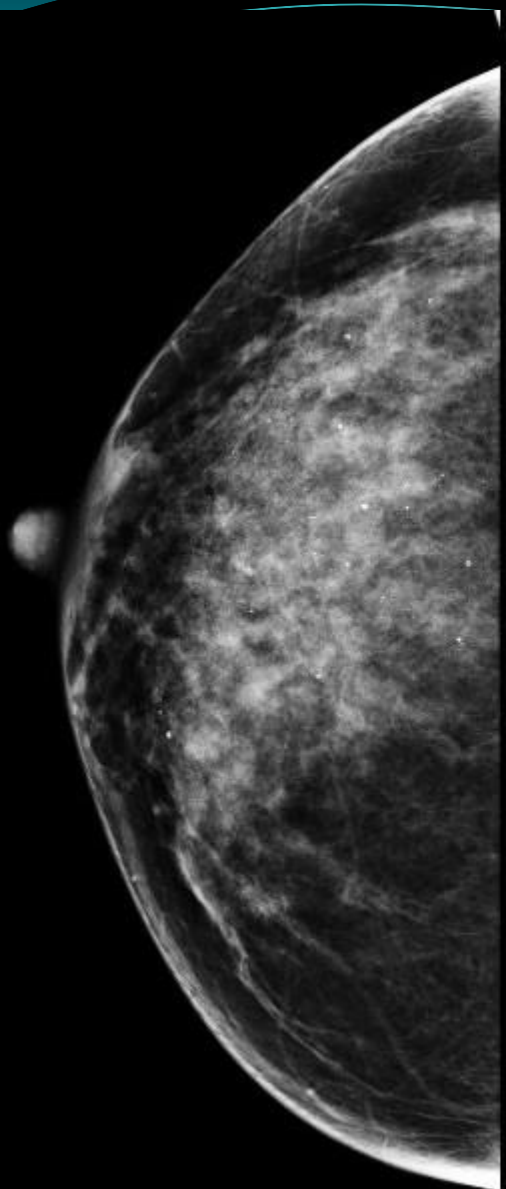
Dr. Serap Gültekin'in
arşivinden



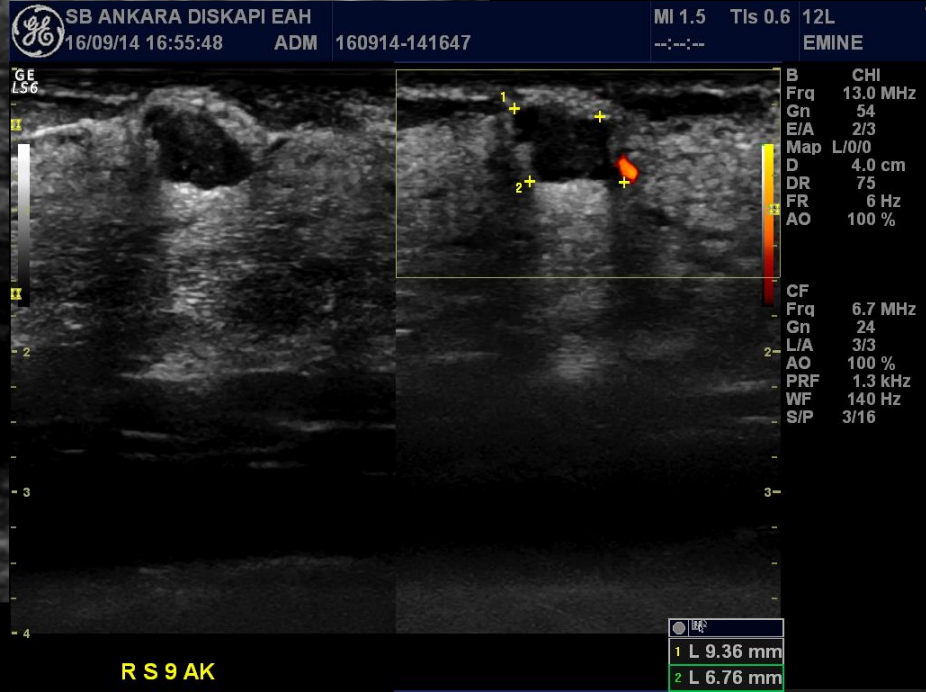


OLGU 2

43 YAŞINDA
TARAMA MAMOGRAFİSİ
ŞİKAYET : YOK
AİLE ÖYKÜSÜ : YOK



GE
LS6



RS 9 AK

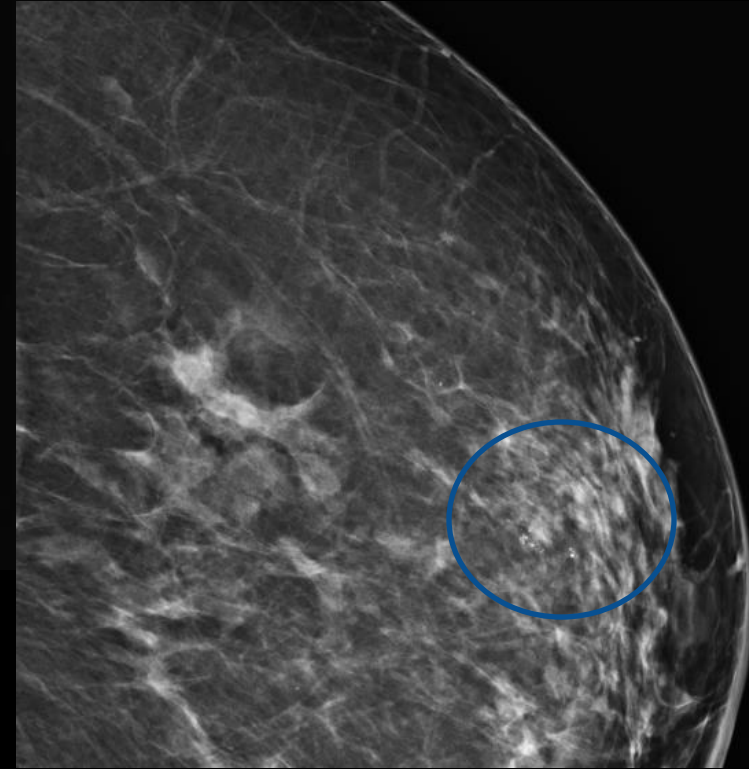
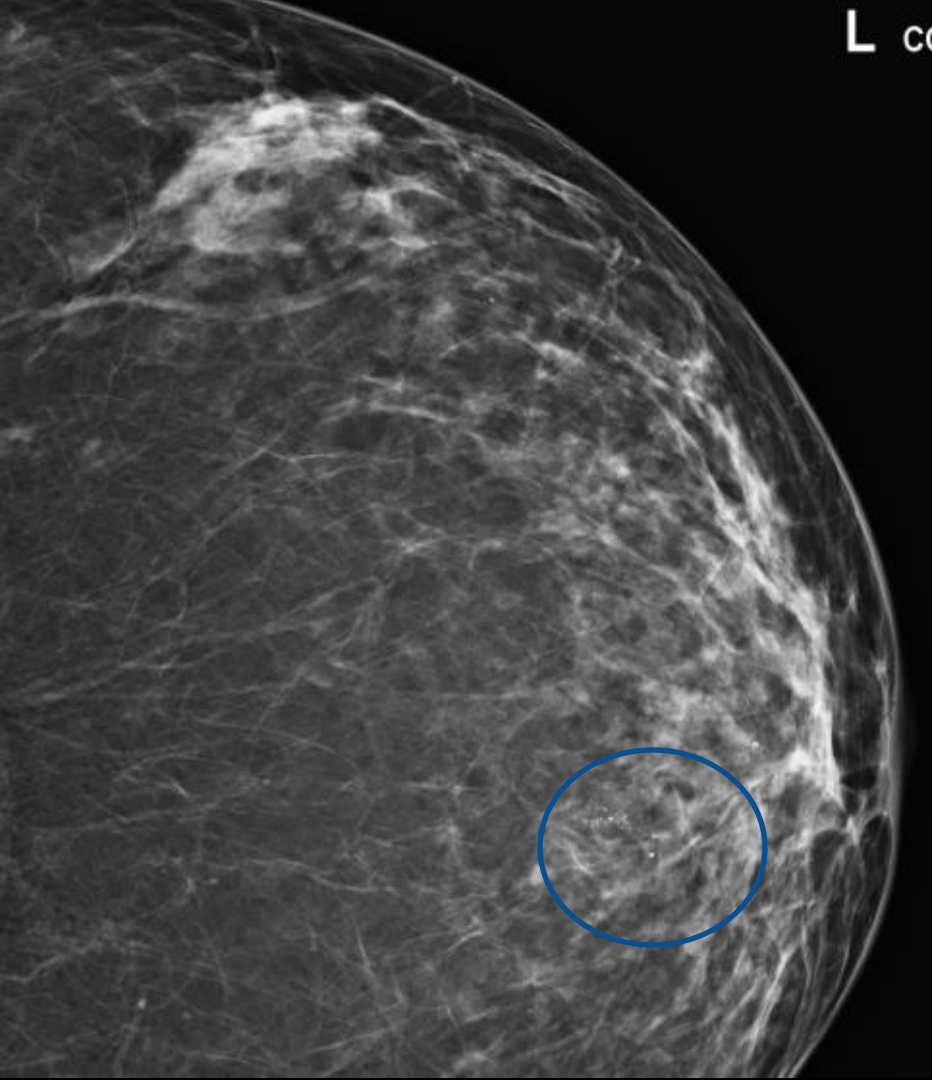
RS 9 AK

DÜŞÜK DERECE
DKİS

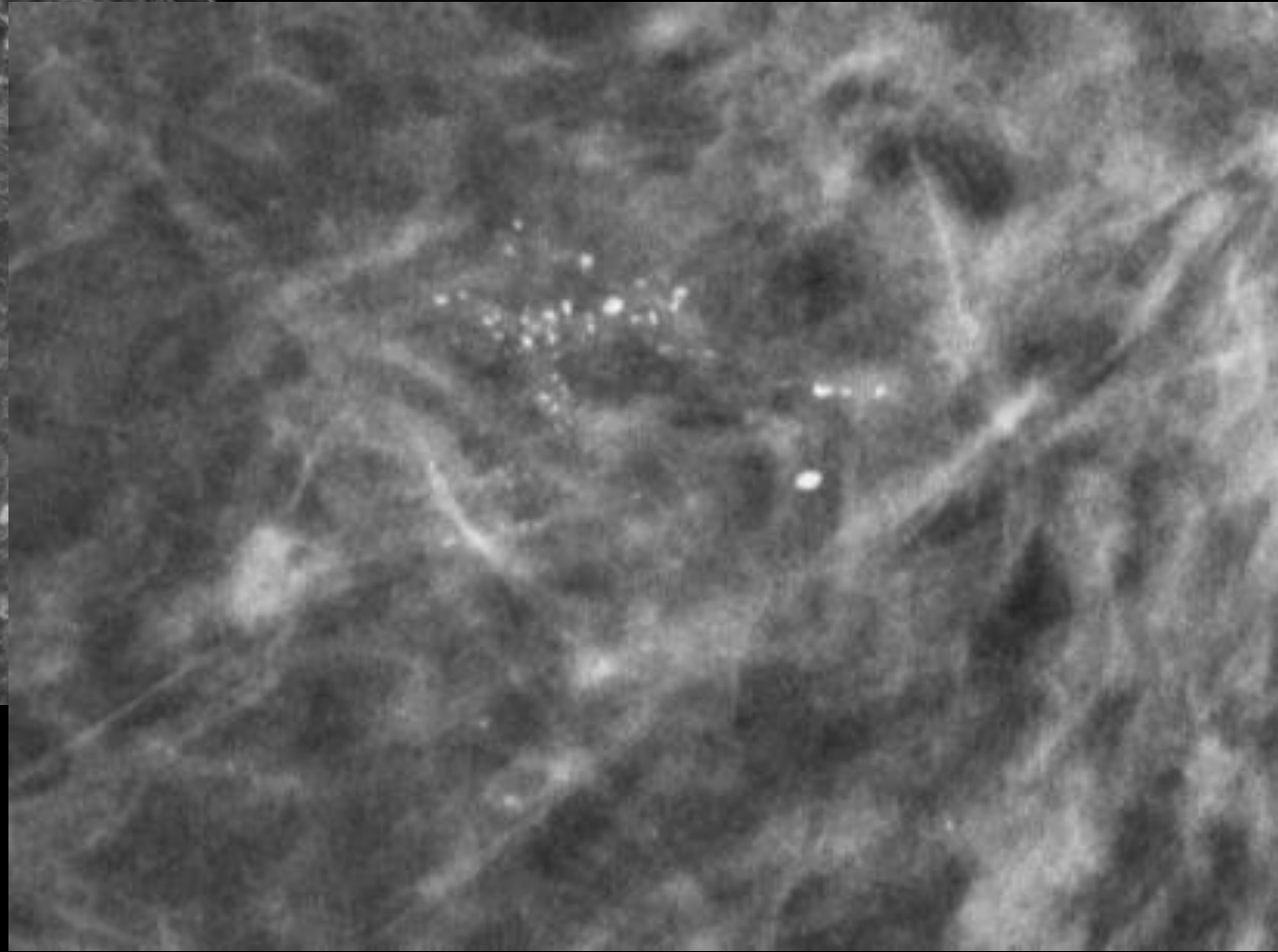
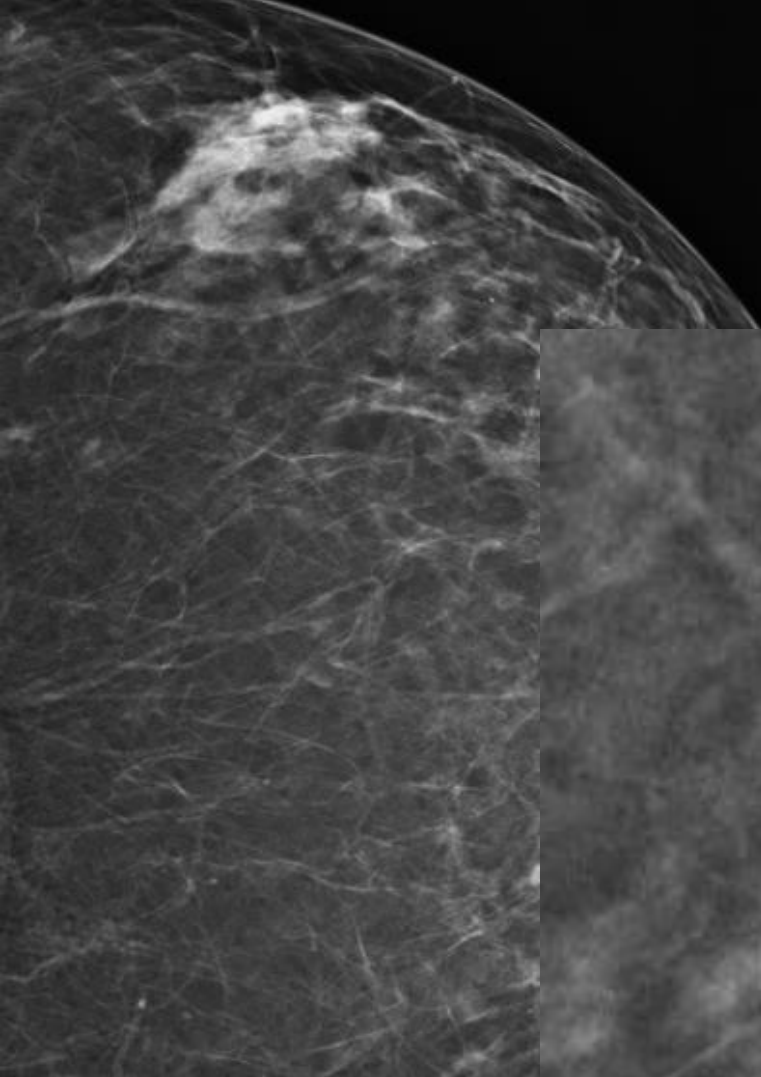
L cc

OLGU 3

55 YAŞINDA
TARAMA MAMOGRAFİSİ
ŞİKAYET : YOK
AİLE ÖYKÜSÜ: YOK



L cc



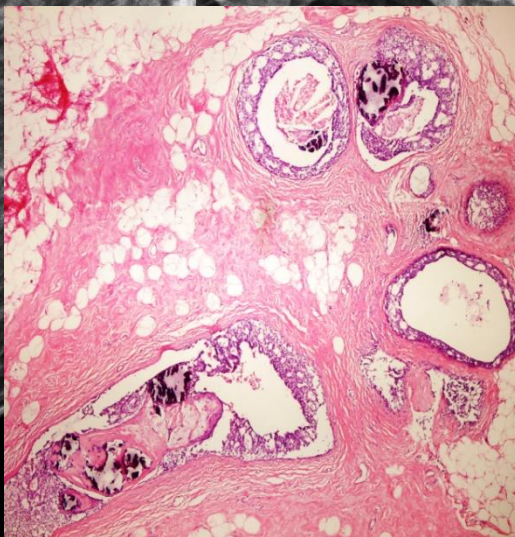
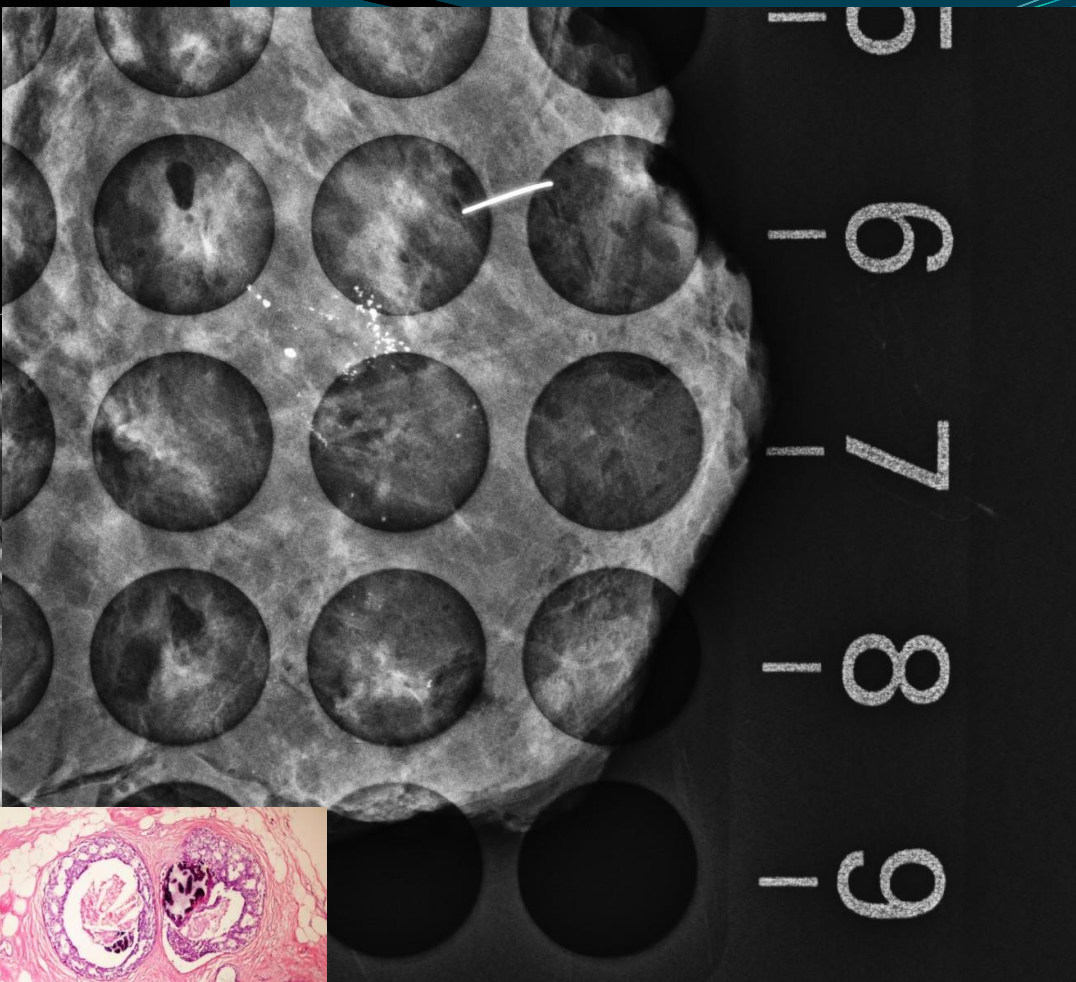
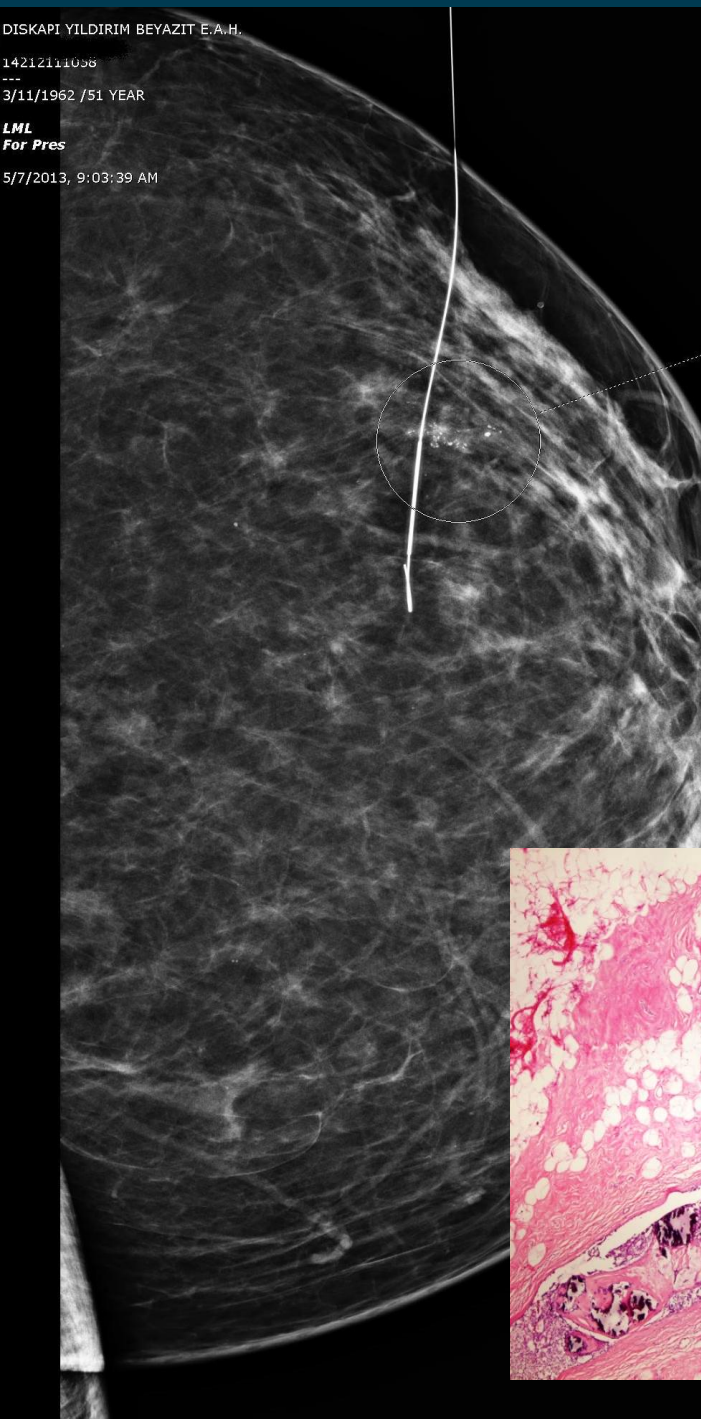
DISKAPI YILDIRIM BEYAZIT E.A.H.

14212111036

3/11/1962 /51 YEAR

LML
For Pres

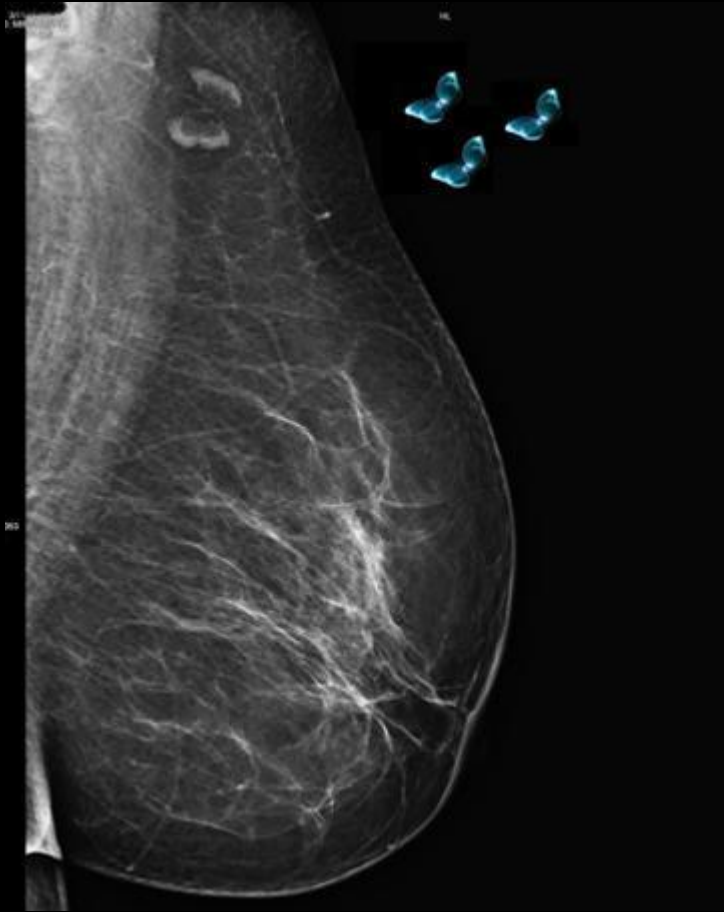
5/7/2013, 9:03:39 AM



ORTA DERECE DKİS

ÖZET

- DKİS TEK BİR HASTALIK DEĞİL, HASTALIKLAR GRUBUDUR
- MAMOGRAFİDE EN SIK BULGU MİKROKALSİFİKASYONLAR OLUP YÜKSEK GRADE İLE İLİNTİLİ OLANLAR İNCE DALLANAN VE İNCE PLEOMORFİK YAPIDA OLANLARDIR
- US'DE KİTLELER SIKLIKLA HİPOEKOİK, DÜZENSİZ ŞEKLİ, BELİRSİZ KENARLI VE NORMAL POSTERİOR GEÇİRGENLİKTE İZLENİRLER
- MRG ÖZELLİKLE HASTALIĞIN YAYGINLIĞI VE MULTİSENTRİSİTESİNİ GÖSTERMEK AÇISINDAN ÖNEMLİDİR
- BİYOPSİ SONRASI SPESMEN GRAFİSİ UNUTULMAMALIDIR



TEŞEKKÜRLER...