



L'examen clinique mammaire

La Palpation

UMP SETIF 1

Pourquoi réaliser une palpation mammaire?

- Ne pas oublier d'inspecter et palper les seins pour dépister un cancer
- Quel intérêt / aux mammographies?
- Détecter des cancers à croissance rapide passés inaperçus entre 2 mammographies (10%)

Sa sensibilité pour le dépistage

- 54% de diagnostic de cancers
- Dépend de la profondeur de la tumeur
- Dépend de la consistance des seins
- 10% des cancers ne sont pas dépistés par l'imagerie mais par la clinique
- Un seul essai clinique comparant examen clinique et mammographie : pas de diminution de la mortalité

Sensibilité

- Chiffres améliorés par l'apprentissage clinique, (modèle en silicone)
- Durée de l'examen : 3 mn par sein
- Selon la taille de la lésion
 - 67% d'échec quand < 9 mm
 - 50% d'échec quand entre 10 à 19mm
 - 22% d'échec quand > 22 mm

Spécificité pour le dépistage

- Moins de faux positifs qu'avec la mammographie
- Spécificité de 94% environ (donc 6% de femmes indemnes de cancer ont un examen alarmant)

Quand?

- En début de cycle
- Toujours à la même période pour les femmes ménopausées prenant un THS
- Quand la patiente a remarqué une anomalie
- Rythme optimal? inconnu, entre les mammographies

L'inspection dynamique

- Patiente assise ou debout: bras pendants, puis bras levés, puis pectoraux contractés (faire mettre les mains sur les hanches)
- Signes cutanés: voussure, attraction, ride, Inflammation, peau d'orange, déformation du galbe
- Les mamelons: rétraction, modifications d'orientation, ulcération, écoulement
- Aspect global des seins

Article de M. ESPIÉ et coll., pages 1056 à 1073

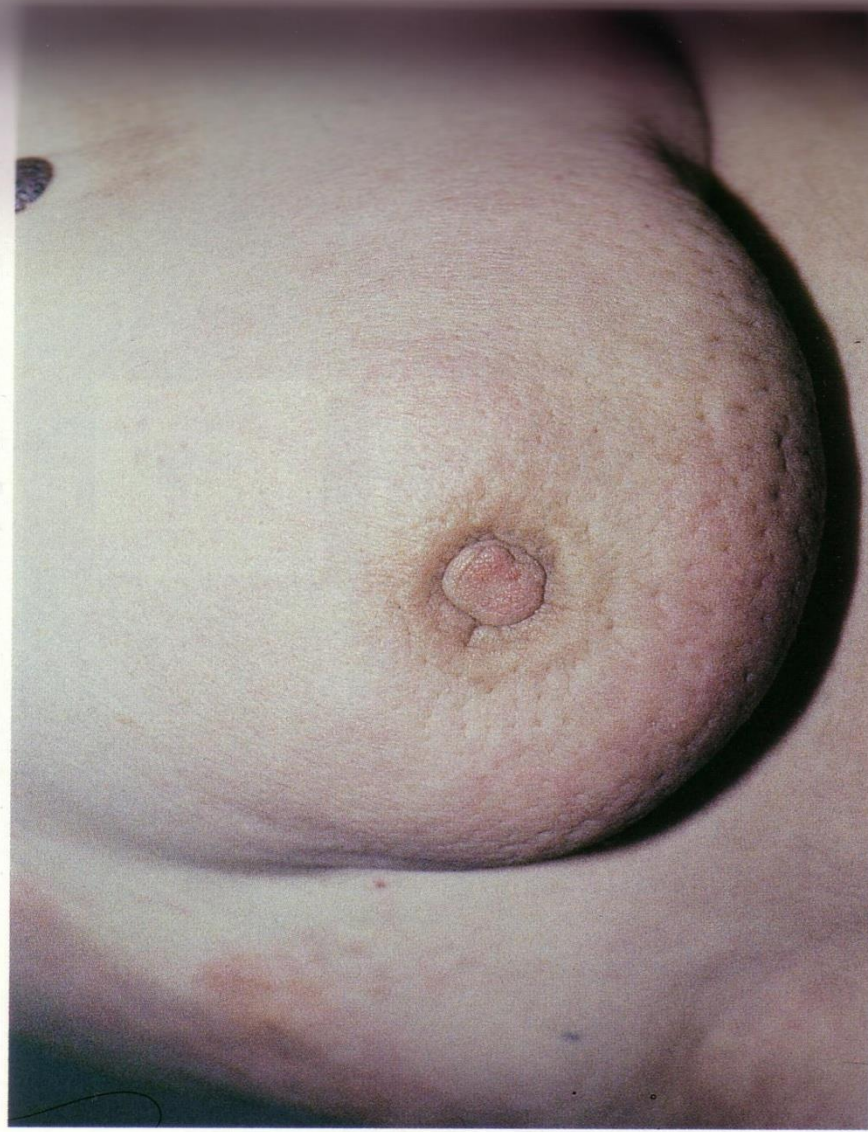
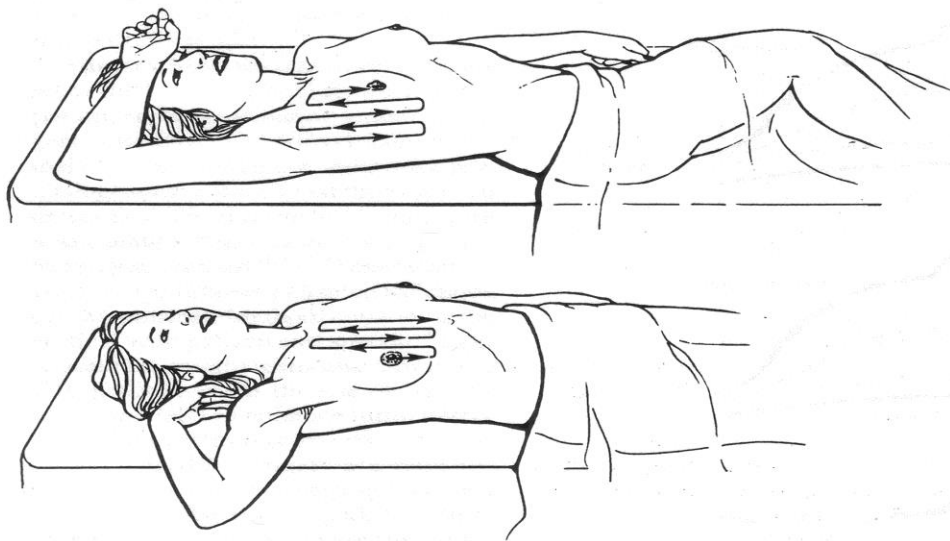


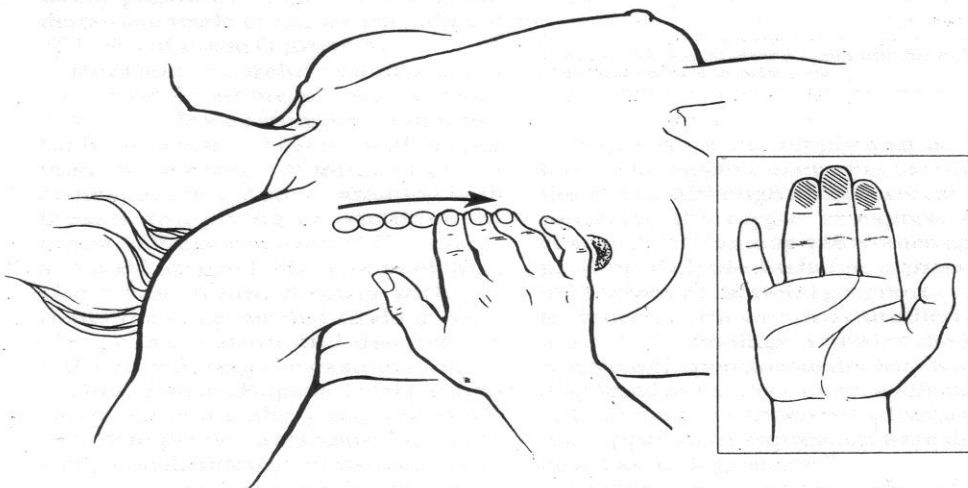
Photo 1 : Peau d'orange rétraction du mamelon (p. 1058)

La palpation mammaire

- Patiente en position couchée, un bras sous la tête.
- Utiliser la pulpe des 3 doigts médians, avec 3 niveaux de pression pour chaque mouvement (superficiel, intermédiaire et profond), petits mouvements circulaires
- Méthodique, par quadrant, ou en spirale à partir du mamelon, ou par bandes = **toute la surface de chaque sein**
- Ne pas oublier la zone rétro aréolaire.

Figure 1. Position of Patient and Direction of Palpation for the Clinical Breast Examination

Top, The figure shows the lateral portion of the breast and bottom, the medial portion of the breast. Arrows indicate vertical strip pattern of examination. See "Suggested Approach" section for complete description.

Figure 2. Palpation Technique

Pads of the index, third, and fourth fingers (inset) make small circular motions, as if tracing the outer edge of a dime.

stressed palpation. The approach outlined below is derived from a review of the research literature and owes much to the work of Baines and colleagues^{3,21,79,86} and Pennypacker and colleagues⁸⁷⁻⁹¹ because of their work in standardizing the examination. Our recommendation incorporates practices from the Mammacare method, because its components have been validated in independent investigations of CBE technique.^{71,72,92}

Palpation. Variables important in palpating the breast correctly are (1) patient position, (2) breast boundaries, (3) examination pattern, (4) finger position, movement, and pressure, and (5) duration of the examination.

Patient Position. Clinical breast examination requires flattening breast tissue against the patient's chest; she should be supine during the examination. The importance of maneuvers to flatten the breast depends on breast size; they are particularly useful in women with large breasts. To flatten the lateral part of the breast, have the patient roll onto her contralateral hip, rotate her shoulders back into a supine position, and place her ipsilateral hand on her forehead (FIGURE 1). To flatten the medial part of the breast, the woman should lie flat on her back and move her elbow up until it is level with her shoulder (Figure 1).

Breast Boundaries. Breast tissue extends laterally toward the axilla and superiorly toward the clavicle. To be sure that all breast tissue is examined, it is best to cover a rectangular area bordered by the clavicle superiorly, the midsternum medially, the midaxillary line laterally, and the bra line inferiorly.

Examination Pattern. Palpation begins in the axilla and extends in a straight line down the midaxillary line to the bra line (Figure 1). The fingers then move medially, and palpation continues up the chest in a straight line to the clavicle. The entire breast is covered in this manner, going up and down between the clavicle and the bra line. To examine all breast tissue, rows should be overlapping. This vertical strip pattern (or lawnmower tech-

nique) was found to be more thorough than concentric circles or a radial spoke pattern.⁹² In 1 study, two fifths of physicians used no discernible pattern at all.⁶⁹

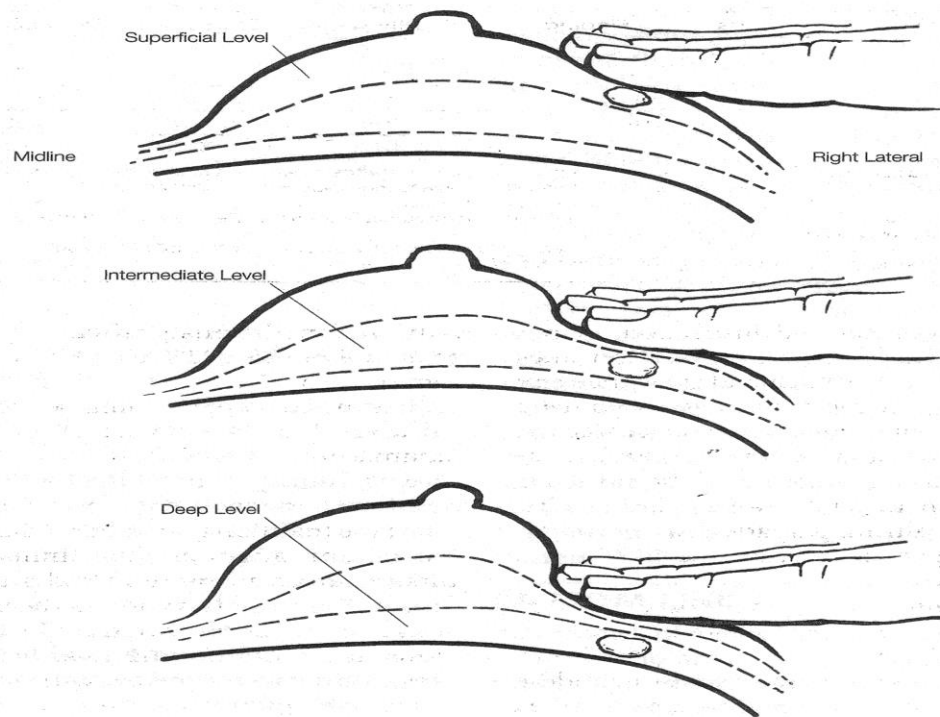
Fingers. Most texts scarcely describe what the fingers should do during palpation, an ironic situation since the fingers must detect and differentiate abnormal lumps in breast tissue. Behavioral psychologists have shown that the finger can detect a soft (20-durometer) 2-mm lump in simulated breast tissue when specific techniques are used.^{88,90,93} These researchers developed a breast palpation technique (the Mammacare Method) combining the vertical strip pattern and specific finger techniques, taught using discrimination skill practice (with the use of silicone breast models) to enhance lump detection. Their method is described below.

The 3 middle fingers are held together, with the metacarpal-phalangeal joint slightly flexed. The pads (not tips) of the fingers (FIGURE 2) are the examining surface. (Confusion regarding the definition of the finger pad exists even among experienced examiners.⁸⁶) Each area is palpated by making small circles as if following the edge of a dime (Figure 2). At each spot, 3 circles using 3 different pressures—light, medium, and deep—are made to ensure palpation of all levels of tissue (FIGURE 3).

Duration. A careful examination of an average-sized breast (brassiere size B) takes at least 3 minutes (6 minutes for both breasts). This is much longer than the average 1.8 minutes physicians spent in 1 study examining both breasts and giving instructions for breast self-examination.⁹⁴ If it seems awkward to spend this amount of time, clinicians should discuss with patients the time needed to do a complete examination and discuss the procedure during the examination.

Other Issues. Palpation of the supraclavicular and axillary regions to detect adenopathy is a standard part of the CBE, though untested. Breast cancer was found in a significant minority of women with isolated axillary lymphadenopathy and normal CBE results in 2 series (12% and 29%, respectively).^{95,96}

Figure 3. Levels of Pressure for Palpation of Breast Tissue Shown in a Cross-Sectional View of the Right Breast



The examiner should make 3 circles with the finger pads, increasing the level of pressure (superficial, intermediate, and deep) with each circle.

Palpation of the nipple area is performed in the same manner as the rest of the breast. Although some texts call for squeezing the nipple to express discharge,^{44,82,83,97} among 448 women complaining of nipple discharge, expression of fluid was not a useful prognostic sign for cancer. Of the women with otherwise normal CBE findings, 3 (2%) of the 151 women with spontaneous discharges were diagnosed as having cancer, while none (0%) of the 178 women with discharges only apparent by expression were diagnosed as having cancer.⁹⁸

Inspection. The importance of inspection is unproved. Most commonly, directions for inspection suggest that the woman face the examiner

with her arms at her side. The breasts are then inspected for nipple abnormalities, dimpling, and retraction or tethering of the skin. No adequate data support recommendations of some authorities^{61,99,100} to examine women in a variety of other positions, such as raising her hands over her head, putting her hands on her hips and bearing down (to contract the pectoral muscles), or leaning forward to allow the breasts to hang out from the chest.

In a series of 296 breast cancers found on breast examination,¹⁰¹ 96% were discovered on palpation, only 1% by retraction alone, and another 3% by visible nipple abnormalities. The women's position when these visual cues were elic-

La palpation axillaire et sus claviculaire

- Patiente en position assise, main posée sur l'épaule du médecin
- Pour la face antérieure du creux axillaire, patiente de dos
- Cette position permet un nouvel examen mammaire
- peu de cancers découverts ainsi

Que rechercher ? un nodule

- Volume
- Sensibilité
- Consistance
- Situation: en regard d'une anomalie?
- Unique ou multiple?
- Limité ou non?
- Mobile ou non?
- Inspecter le sein controlatéral

Des adénopathies axillaires ou sus claviculaires

- Sus claviculaire : a priori suspect
- Axillaire : suspectes si > 1 cm, empâtées, peu mobiles
- 30% des ganglions axillaires palpés ne sont pas envahis
- 40% d'envahissement axillaire et examen clinique normal

Un écoulement mamelonnaire

- Uni ou bilatéral
- Séreux ou sanglant: à explorer!
- Verdâtre ou bigarré (fréquent chez la multipare en pré ménopause)
- Uni pore ou pluriorificiel

Autres étiologies possibles, iatrogènes

L'autopalpation

- Non recommandée en dépistage systématique (recommandation de grade D)
- Anxiogène
- Génère des examens complémentaires inutiles (x 1,5 à 2 les biopsies à résultat bénin)
- Inconnue: intérêt chez les femmes à haut risque
- 80% des récurrences de cancers sont diagnostiquées par les patientes

Intérêt de l'examen clinique

- Dépister des cancers non vus à la mammographie.
- Dépistage des cancers à croissance rapide, entre 2 mammographies.
- Clairement – performant pour les lésions de petites tailles.
- Mais leur détection précoce modifie-t-elle le pronostic ?