Pathology and clinical relevance of radial scars: a review

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Radial scar (RS) is a benign, well recognised, radiological and pathological entity. Histologically, it is characterised by a fibroelastotic core with entrapped ducts and surrounding radiating ducts and lobules. Postmortem studies indicate that these lesions are present commonly in the population, especially in association with benign breast disease. In recent years, their clinical relevance has assumed more importance with the introduction of population based screening programmes. The exact pathogenesis of RS is unknown. Accumulating evidence indicates that they are associated with atypia and/or malignancy and, in addition, may be an independent risk factor for the development of carcinoma in either breast. In view of the association with atypia and malignancy, excision biopsy is justified in RS, although it has been argued that core biopsy evaluation and surveillance may be appropriate in selected patients.

Radial scar (RS), also known as complex sclerosing lesion, is a well recognised radiological and pathological (although not necessarily synonymous) entity. Historically, RS has been referred to by several different terms, including sclerosing papillary proliferation,1 infiltrating epitheliosis,2 indurative mastopathy,3 benign sclerosing ductal proliferation,4 and non-encapsulated sclerosing lesion.5 Although postmortem studies6–8 indicate that these lesions are present commonly in the population, especially in association with benign breast disease,9–10 their clinical relevance has assumed more importance in recent years with the advent of population based screening programmes. RS are benign lesions, but accumulating evidence indicates that they are (1) associated with atypia and/or malignancy and (2) may be an independent risk factor for the development of carcinoma in either breast.

RADIOLOGY

The mammographic appearances of RS are well documented. They are characterised by an area of architectural distortion and are defined according to the criteria of Tabar and Dean11; namely, (1) the presence of a central radiolucency, (2) the presence of radiating long thin spicules, (3) varying appearance in different projections, (4) radiolucent linear structures parallel to the spicules, and (5) the absence of a palpable lesion or skin changes (fig 1). The absence of macrocalcifications is also considered a feature.

“It is generally accepted that the term radial scar refers to lesions less than 1 cm, whereas complex sclerosing lesion is used to describe lesions 1 cm or larger” However, as many groups have demonstrated,12–20 none of these findings is specific and similar features may be seen in carcinomas. It has been emphasised that calcifications may occur in RS,21 being the only abnormality in some cases.12 14 In addition, not all demonstrate a radiolucent centre. Ultrasonography fares no better in the differentiation of RS from malignant lesions.22 The notion that RS are impalpable has been challenged, and Wallis et al recorded that six of 24 cases in a screening programme presented with clinical masses.19

PATHOLOGY

Grossly, RS lesions may mimic carcinoma because of their stellate configuration with central puckering and cream/yellow elastotic flecks, in addition to their firm texture.23 Histologically, RSs are pseudo-infiltrative lesions, the appearance of which may vary according to the plane of section or the stage of evolution. Classically, they characterised by a fibroelastotic core with entrapped ducts demonstrating a dual myoepithelial and epithelial layer, with surrounding radiating

Figure 1  Characteristic mammographic appearance of radial scar.

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Abbreviations: DCIS, ductal carcinoma in situ; ER, oestrogen receptor; RS, radial scar
demonstrates a perineural pattern of invasion in some cases. It is important to note that the demonstration of a perineural pattern of invasion in RS should not be considered a diagnostic feature, as it is not infrequently seen in areas of adenosis or papillomatosis.

**PATHOGENESIS**

The pathogenesis of RS remains obscure. It has been postulated that these lesions arise as a result of unknown injury, leading to fibrosis and retraction of surrounding breast tissue, thus imparting a stellate configuration. Associations with duct ectasia and duct obliteration have also been suggested, in addition to a chronic inflammatory response. However, central duct obliteration and elastosis may also be seen in carcinomas. Battersby and Anderson performed an ultrastructural study of RS derived from 38 patients; they defined an initial “cellular” phase characterised by abundant central myofibroblasts, followed by a later “mature” phase with fewer myofibroblasts, prominent elastic/collagen fibres, and parenchymal distortion. In another study, microvessel density was increased in a subset of RS lesions at the periphery, with reduced vascularity in the central “older” fibrotic zone. There does not appear to be an association with menopausal status, parity, or contraceptive use, or with cytotoxic/tamoxifen treatment.

It has also been hypothesised that there is a derangement of the normal stromal/epithelial interaction in RS. In an mRNA study of nine cases of RS, a variety of vascular stromal factors were examined, including collagen type 1, fibronectin, thrombospondin 1, vascular permeability factor/vascular endothelial growth factor, and its receptor KDR. Interestingly, a similar pattern of expression was documented in four control breast carcinomas, although expression was generally focal and less intense in RS. In a separate study, Iqbal and co-workers looked at allelic imbalance (chromosomes 16q and 8p) in addition to both oestrogen receptor α (ER-α) and Ki67 expression by means of immunohistochemistry. They showed some evidence of ER dysregulation with respect to Ki67 within hyperplastic areas of RS, but found no significant allelic imbalance compared with background breast.

**BIOLOGICAL RELEVANCE**

Over the years there has been considerable debate as to whether RS is: (1) an incidental, non-relevant finding, (2) a direct precursor of carcinoma, or (3) a marker of neoplastic risk. In Wellings and Alpers’s detailed necropsy based study of 83 random cases compared with 107 cancer associated breasts, RS was a not infrequent microscopic finding, being found in 14% and 26%, respectively. These authors used a subgross technique and noted that the average number of RS lesions was higher in the malignant group; they suggested that RS was a risk factor for carcinoma, rather than being an obligate precursor lesion. In an additional necropsy study of 84 patients with breast cancer, it was recorded that RS was more likely to occur in areas of benign breast change, usually being present in the contralateral breast to carcinoma. In contrast,
Linell et al hypothesised that because some RS lesions showed “transitional features” of tubular carcinomas, they represented direct precursor lesions, as did Fisher et al, who regarded RS as “incipient” tubular carcinoma. Other groups have furthered this claim on the basis of hyaluron expression in the stroma of RS and image analysis data.

“There does not appear to be an association with menopausal status, parity, or contraceptive use, or with cytotoxic/tamoxifen treatment”

In recent years, accumulating evidence challenges this last view and it is likely that breast carcinomas produce a stromal reaction which mimics RS. Although RS lesions are regarded as benign, it is becoming increasingly clear that they are associated with atypia and/or malignancy on histology in a significant number of cases. In some series, malignancy rates of up to 30% have been recorded. In one small study of core biopsy confirmed RS, it was documented that ductal carcinoma in situ (DCIS) or infiltrating carcinoma was present in two of five cases, whereas in the study of Frouge et al on 40 patients with mammographic RS, half were malignant, eight showing evidence of RS on histology. However, as has been suggested, high malignancy rates may be a reflection of small series size, or more likely referral bias. In support of this, Cawson and colleagues recorded a 7% incidence of DCIS in RS in a screened population with no invasive carcinomas. In their definitive histological study of 126 lesions derived from 91 patients, Sloane et al found that the risk of malignancy was related to lesion size (being uncommon in RS < 6–7 mm), patient age (malignancy was not demonstrated in patients under 40), and method of detection (usually screening). This last factor is probably a function of lesion size and age: indeed evidence from the literature indicates that most patients present in the 40–60 age group. It has also been suggested that there is an increased incidence of metaplastic carcinoma in complex sclerosing lesions.

In a longterm study (with a median follow up of 12 years) arising from the Nurses’ Health Study, in which almost 1400 cases of open biopsies for benign breast disease were examined, Jacobs et al found that the presence of RS conferred double the risk of developing subsequent malignancy, regardless of the type of primary breast disease. They recorded that RS was a not infrequent incidental finding (7.1%), and that the increased risk was conferred on both breasts. Importantly, the risk of developing cancer was higher in those with increasing RS size and number. They found no association with age at menarche, parity, age at birth of first child, or body mass index, although women with subsequent malignancy were more likely to have had a positive family history. The evidence suggests that in most cases, low grade carcinomas (both in situ and invasive), with a good prognosis, occur.

**SCREENING MAMMOGRAPHY AND PATIENT MANAGEMENT**

Undoubtedly, the incidence of RS has increased dramatically as a result of population based screening programmes with documented rates of 0.03–0.09%.

We routinely perform needle core biopsies on our cases of suspected mammographic RS (unpublished data, 2003) and it is our screening programme policy to excise all such lesions. In line with other groups, we have found that a preoperative diagnosis is possible in over 85% of cases. When these are stratified according to histologically confirmed RS versus RS mimics, higher diagnosis rates can be achieved in the last group. This is of particular value where the core yields an unequivocal diagnosis of malignancy because it allows definitive surgical treatment at the first operation. We emphasise, in line with others, the importance of adequately sampling the periphery of the lesion, in addition to the centre, because carcinoma (both in situ and invasive) is more likely to develop at the periphery. The value of cytology in the preoperative assessment of RS appears to be limited.

The detection of incidental microscopic RS on needle core biopsies for microcalcifications is more problematic. Because the likelihood of detecting carcinoma is a function of lesion size, it is probable that in the absence of a radiological mass lesion or architectural distortion, a malignant outcome is less likely. Indeed, Philpotts et al documented that of their RS cases (there were no malignancies), 44% presented with calcification. However, the findings of Jacobs and colleagues suggest that at least close clinical surveillance is warranted, analogous to patient follow up for a diagnosis of atypical hyperplasia. In line with this, the studies of both Philpotts and colleagues and Cawson and colleagues showed high atypia rates. Importantly, in the screening based study of Cawson et al, 57% of the RS lesions demonstrated atypical ductal hyperplasia at excision, although this has not been our experience (personal observation, 2003).

**CONCLUSION**

The detection of RS has increased dramatically with the introduction of population based mammographic screening programmes. Because currently we cannot reliably exclude malignancy in RS, and in light of the high atypia rate documented by some groups, it is our opinion that excision biopsy continues to be justified. Nevertheless, we acknowledge that there is an accumulating body of evidence to support close mammographic surveillance in conjunction with thorough core biopsy evaluation in selected patients; this does require further evaluation with larger patient numbers (preferably in a screening setting).
Take home messages

- Radial scar (RS) is a benign, well recognised, radiological and pathological entity.
- Postmortem studies indicate that these lesions are common, especially in association with benign breast disease.
- The introduction of population based screening programmes has provided evidence that RS is associated with atypia and/or malignancy. RS may be an independent risk factor for the development of carcinoma in either breast.
- In view of this association, excision biopsy is justified in RS, but further evaluation with larger patient numbers is needed.

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REFERENCES