



## The Dreaded Callback

### *An Explanation of the Diagnostic Mammogram to Help Ease Your Mind*

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Good for you! You just had your annual screening mammogram. It wasn't *all* that bad. You knew that approximately 200,000 women are diagnosed with breast cancer each year and approximately 40,000 deaths per year result. You also knew that early detection is the key to survival. But you just received a telephone call asking you to return for additional imaging. Panic sets in, but what does being called back really mean? Sometimes our worst fear is fear of the unknown. This article explains the process of the dreaded callback and what you might encounter at your second visit.

First of all a screening mammogram is like any other screening test. It helps identify people that *potentially* have breast cancer. A set of x-rays is taken of the breasts, then a radiologist, a doctor who is specialized in diagnostic imaging, later reviews the images and compares them to any prior images to determine if something is different, new, or looks worrisome for breast cancer. If something looks suspicious, the patient is brought back for additional images, called a diagnostic mammogram (note that a diagnostic mammogram can also be performed when a patient is having symptoms such as a new lump, pain or nipple discharge). When the patient returns, additional images are obtained to determine if the area of concern is real and what it may be.

Many times the area of concern may not be a real finding. After further pictures are taken, the lesion is no longer evident. This is often due to superimposed or overlapping normal breast tissue. After more pictures using different techniques are obtained, the breast tissue spreads out and no lesion is identified. The abnormality was just a false reading on the screening mammogram. No further testing is needed and the patient comes back in a year for her annual screening mammogram. But what if the area is persistent, or real? Then the radiologist has to figure out what it is. Generally the area of concern is due to calcifications, a mass or distortion of the breast tissue.

Calcifications in the breast can arise from many causes. Some are actually in the skin or blood vessels and are not associated with the breast tissue where cancer occurs. Even if the calcifications are in the breast tissue, they can still be benign, or not due to cancer. Special magnification views of the calcifications allow the radiologist to examine them in detail. If they have a benign appearance, the test is complete and the patient returns to her yearly screening mammogram schedule. Sometimes they are most likely benign, but the radiologist will follow them in six months to keep an eye on them. However, if they are suspicious, a biopsy will be performed to obtain a diagnosis.

Biopsies of calcifications are usually performed stereotactically. The patient lies on her stomach on a special table with the breast positioned through a hole. The breast is placed in compression and mammograms at different angles are obtained. The calcifications are identified and targeted with the aid of a computer. After the

skin is cleaned off and local anesthetic is administered, a needle is placed at the targeted location and a few tiny pieces of breast tissue are removed. Multiple images are taken during the exam to insure the needle is positioned properly and the correct area is being biopsied. An x-ray of the tissue sample is also obtained to be certain the tissue contains the worrisome calcifications. The tissue is then sent to the laboratory for processing and reviewed by a pathologist, a physician who studies changes in tissue or organs caused by disease. A tiny metallic marker is placed into the breast to identify where the biopsy was performed and an additional mammogram is taken after the procedure. The actual biopsy only takes a couple minutes, but proper positioning, imaging, and targeting of the calcifications takes longer. The whole procedure can last up to an hour. Results are often received the next day.

If the patient has been called back for a possible mass or distortion in the breast and it is persistent after further mammographic images, an ultrasound is usually recommended. Ultrasound uses sound waves rather than radiation that x-rays use to produce an image. It is another way of examining the area in question. Often a possible mass is actually not a mass, but a fluid filled sac called a cyst. Ultrasound can help distinguish a cyst from a solid mass. A simple cyst is benign and the patient can return to her yearly screening mammogram. Occasionally the cyst may contain debris and the radiologist might follow it in six months or drain it with a needle under ultrasound guidance, called a cyst aspiration.

A solid mass in the breast can also be benign, but most often requires a biopsy for a definitive diagnosis. The least invasive way to obtain a diagnosis is with an ultrasound guided biopsy. Just as for the breast ultrasound examination, the patient lies on her back on the exam table. The lesion is located with ultrasound. The skin is cleaned off and local anesthesia is administered. A biopsy needle is placed into the area of concern and a few tiny tissue samples are obtained. This is performed while the physician is watching with ultrasound to insure the lesion is being biopsied. A biopsy marker may be placed in the area and a mammogram taken after the procedure. The tissue is then sent to the pathologist for further evaluation.

The dreaded callback can be stressful, but hopefully knowing that most findings on a screening mammogram are not cancer, or even real, can ease some of the anxiety. If a biopsy is required, the explanations above will help prepare you for your procedure so you know what to expect beforehand. Just remember, early detection is the key and you took the first step by getting your screening mammogram!

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