Frozen Sections and Breast Biopsies

To the Editor—I read with interest the article by Niemann et al on frozen sections. I applaud their decision not to perform rapid sections on routine breast biopsy specimens with nonpalpable or small (≤1 cm) discrete lesions. However, I must wonder why intraoperative consultation, with or without frozen section, is being performed on any of these cases. Niemann et al have specifically excluded biopsy specimens in which there is a medical indication for frozen section (eg, cases progressing to mastectomy or lumpectomies in which margins are being assessed). In cases with discrete lesions larger than 1 cm, tissue can be saved for hormonal receptor assays, to be sent later after the diagnosis of carcinoma is confirmed. This precludes the need for frozen section. In view of these considerations, I can only wonder what role the fee-for-service environment plays in the continuance of this practice in American hospitals.

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REFERENCE

The Authors' Reply

To the Editor—We appreciate the comments of Drs Wightman and Givelber. Both question whether there is any role for performing frozen sections on routine diagnostic breast biopsy specimens, even those with discrete lesions larger than 1 cm. In response, we believe that there are two primary indications for performing a frozen section. One indication is to provide the pathologist with information necessary for the immediate management of the tissue. For example, we routinely perform a frozen section and a touch preparation on diagnostic lymph node biopsy specimens, then based on the findings we appropriately divide the specimen for immunophenotyping or cultures or submit it entirely for light microscopy.

The other, and more common, indication for a frozen section is to provide the clinician with information necessary for the immediate management of treatment for the patient. This most frequently takes the form of an intraoperative frozen section to provide direction to the surgeon during the surgical procedure.

However, there are other instances in which a frozen section is indicated to direct the immediate management of the treatment, for example, freezing uterine contents to identify products of conception. We believe that our decision to freeze breast lesions larger than 1 cm falls into this latter category. If the frozen section demonstrates a malignancy, then immediate counseling and planning for additional therapy can be initiated. If there is a discrete lesion and the frozen section is benign, then the patient can be cautiously reassured, alleviating some of the anxiety that invariably accompanies the presence of a breast mass.

If judiciously handled, breast lesions larger than 1 cm should provide adequate material for both frozen section examination and nonfrozen permanent sections. In this setting, there is considerably less risk of inadvertently destroying or distorting the only diagnostic tissue by performing a frozen section. Certainly, if there is any concern that the diagnosis may be compromised, then a frozen section should not be performed.

Ultimately, the decision to freeze or not to freeze should reside with the pathologist and should be based on careful gross examination of the tissue, knowledge of the clinical setting, and an understanding of the implications of the diagnosis. In our practice, for discrete breast lesions larger than 1 cm we believe that we can provide information that expedites treatment management with minimal risk of compromising the specimen. We believe that this is a worthwhile application of our resources and we continue to perform frozen sections on these selected cases. On a practical note, however, cases with a discrete breast lesions larger than 1 cm represent a progressively decreasing percentage of our breast biopsy specimens.

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REFERENCES