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https://doi.org/10.1016/j.senol.2020.10.001
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Pathology of breast lesions in female transgender

Patología de las lesiones mamarias en las mujeres transgénero

Dear Editor,

In relation to the article presented by Tresserra et al.,[1] the social and legislative changes that have occurred in recent years regarding sexual diversity, together with the greater availability of specialized health care, have increased visibility, social openness and request for gender confirmation treatments.

Regarding breast surgery, it has led to a notable increase in the number of users at an ever younger age. As surgeons dedicated to the treatment of the breast, since we began breast surgery in gender diversity, we have been especially concerned about the potential risk of breast cancer in transsexual women due to prolonged exposure to hormonal treatment to which individual and hereditary risk factors are added.

Most transsexual women start feminizing treatment one or two years before breast surgery, however the majority of current evidence suggests that neither type nor dosage of estrogen has an effect on final breast size.[2] Furthermore, there is no evidence on these histological and mammographic differences result in clinically significant breast size differences. Some authors suggest that age at de beginning, body mass index and breast individual sensitivity to hormons can influence on final size breast, but there are no evidence based.

The main goal in the next few years would be define witch type of treatment or treatments and at which doses might optimize breast development. When we refer to development, we mean volume incresase. From the histological perspective, it would be better for the trans breast not to acquire female modifications, thus avoiding or reducing the risk of breast pathology typical of cis women.

Although to date no increased risk has been shown compared to cisgender men with estrogen treatment. There are no studies that inform us of the risk in combined treatments (estrogens-progestogens). Some authors point out that it is probably not necessary to undertake population screening in transgender people.[3] However, the WPATH and different

authors[4–6] insist on the recommendation of follow-up, but without a basis that supports how it should be organized, its frequency or its beginning age.

Perhaps the selection of screening and diagnostic method should be tailored depending on clearly defined risk factors and mode of breast construction.[4]

For this reason, it seems to us a priority to educate transsexual women on the need for follow-up, as well as to initiate extensive prospective studies that help us determine when the follow-up should begin, who requires it, how often and what would be the ideal imaging method.

The rest of the commented pathological findings other than breast cancer due to their low frequency and exceptional nature do not deserve a particular search/screening. Just highlight that many of them like myofibrolastoma or adenomyoepithelioma can be detected by conventional radiological methods.

Finally, the suspicion of anaplastic large cell lymphoma (ALCL) associated with implants should not be neglected, whose debut symptom is usually breast inflammation with volume increase and the presence of periprostestyque fluid. Surgeons dedicated to breast surgery in trans women should consider the need for maintained follow-up, both for breast pathologies and for cosmetic and other complications owing to the use of implants.[7]

Conflicts of interest

The authors have no conflicts of interest to declare.

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https://doi.org/10.1016/j.senol.2020.10.005
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