

Management of patients with gynaecomastia in a single centre – a retrospective analysis

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Introduction

Gynaecomastia is a benign enlargement of glandular breast tissue in males (1). The Psychological consequences include anxiety, depression and reduced self-esteem (2). Most cases are idiopathic however other causes of gynaecomastia includes hyperthyroidism, alcoholic liver disease, hypogonadism, hyperprolactinaemia and hypopituitarism (1). Patients may be referred to Endocrinologists for management of underlying endocrine abnormalities.

Aims of Audit

- Gain information on the underlying aetiologies of gynaecomastia to improve the quality of service provided by UHB.
- To assess current practice with a view to improving quality of service , rationalise investigations and treatment pathway.

Methods

The audit registration was accepted by the Clinical Audit Registration and Management System (CARMS) at QEHB. A Health Informatics search identified 42 patients with documented gynaecomastia under endocrine follow up between 2013-2018. 2 had incomplete data and were excluded from further analysis. A structured proforma was completed for each patient. Data collected on: demographics, clinical features on presentation, investigation results, treatment, underlying diagnosis and outcome. Baseline investigations: Measure liver, thyroid and kidney function, serum testosterone, oestradiol, LH, FSH, prolactin and b-hCG (3).

Limitations

“Improvement in symptoms” was documented reduction of gynaecomastia as noted following consultation. A better way of assessing symptom improvement could be to ask patients rate improvement on a scale of 1 to 10. Long term follow up of patients that were discharged from endocrinology and surgery is unknown due to limited access of clinical portal. Access to GP records and patient interviews would provide better insight into alternative treatments pursued by patients following tertiary outpatient care

Discussion

Gynaecomastia is hypothesised to be due to an imbalance between oestrogen and androgens. It is associated in those with raised oestrogen and reduced androgens (4). Being overweight is therefore a risk factor due to the additional oestrogen secreted from adipose. Over half of the cohort had a BMI > 25 (fig.4). Adjusting modifiable lifestyle factors such as weight should therefore be emphasised in the management of gynaecomastia. The major medical interventions documented are androgens, anti-oestrogens and aromatase inhibitors. (4) In 2018, a 10-year prospective cohort study published in the Breast Journal that investigated the role of Tamoxifen in idiopathic gynaecomastia (5). 81 patients were treated and 90% had symptomatic improvement with Tamoxifen therapy.

Recommendations

Doctors should offer a holistic approach in the management of gynaecomastia, addressing modifiable risk factors, treating underlying causes and consider trialling medical therapy in the management of resistant cases. Larger scale prospective studies are needed to investigate medical treatment options, such as Tamoxifen, in the management of resistant gynaecomastia.

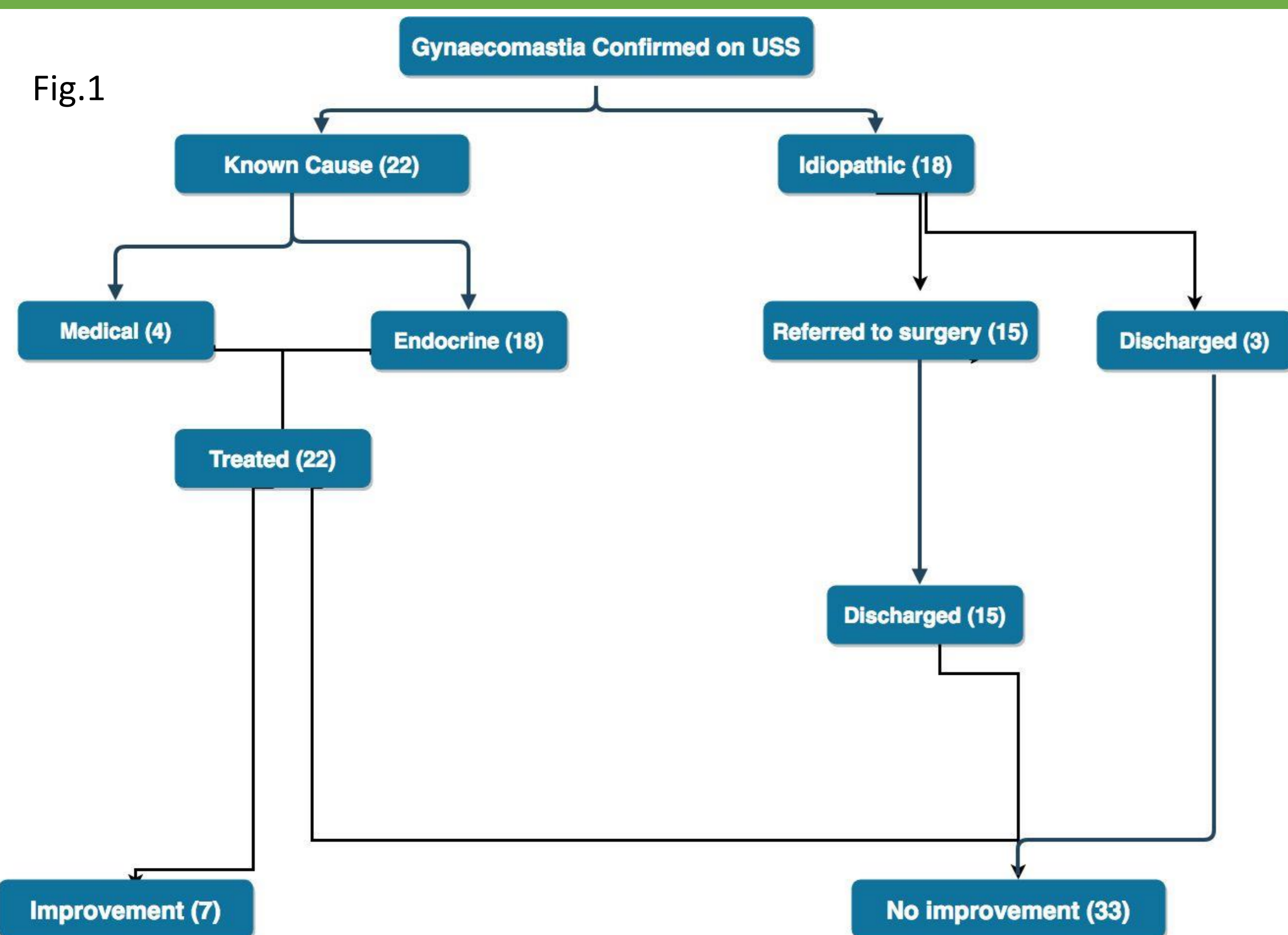
Conclusion

The analysis identifies an unmet demand for medical intervention in the treatment of idiopathic gynaecomastia. As well as the need for definitive guidelines to be referred to in the management of such patients.

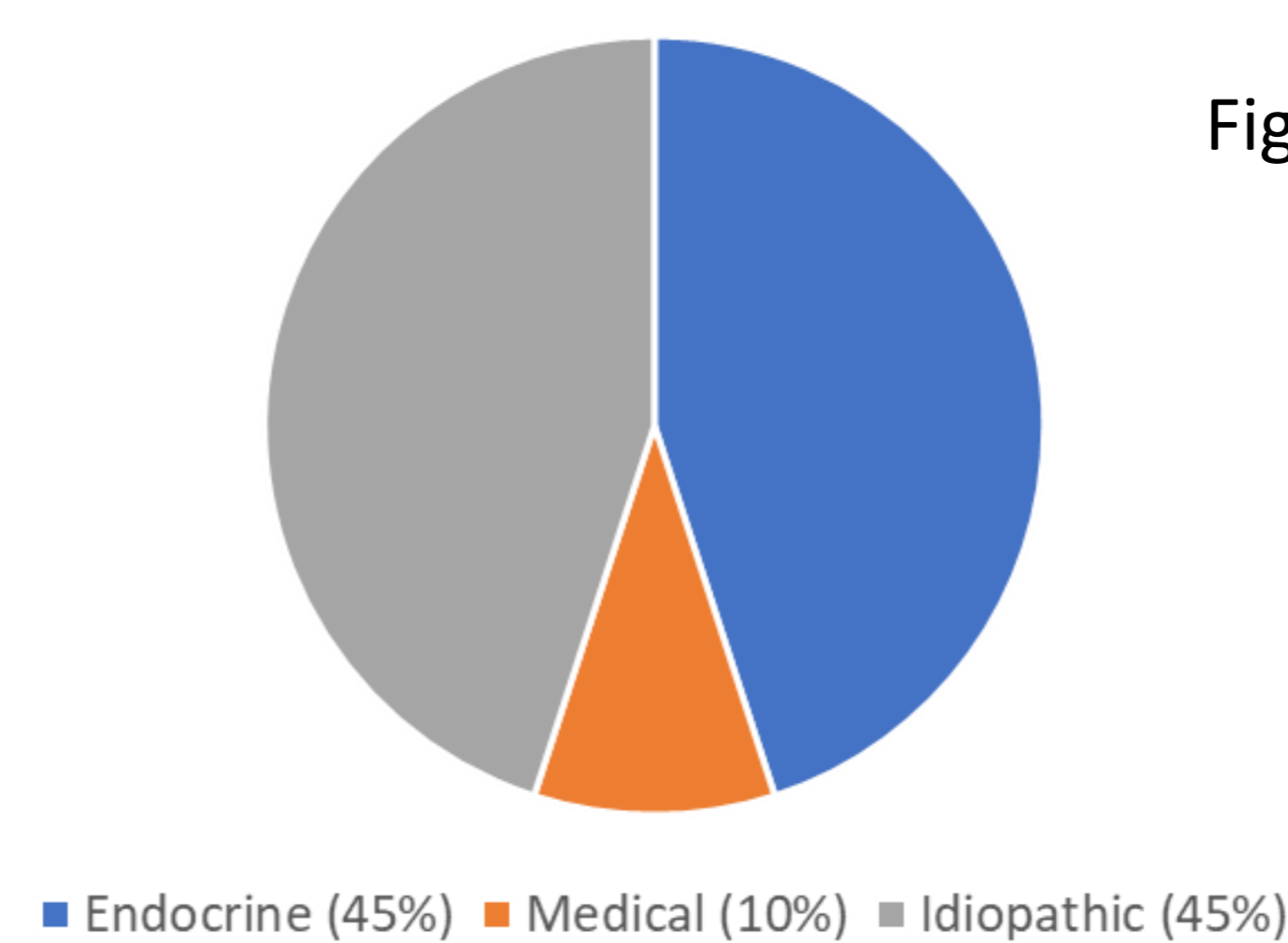
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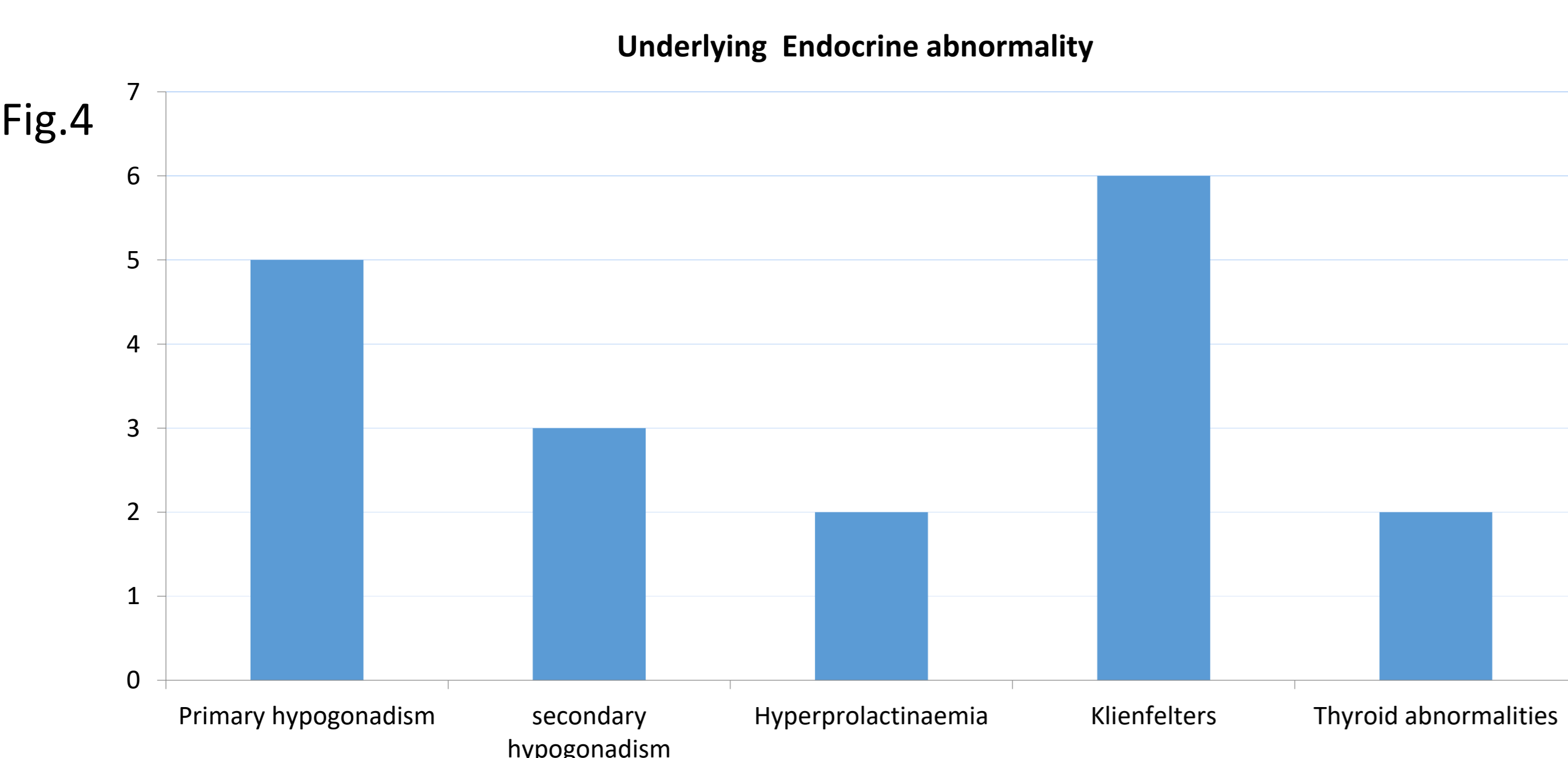
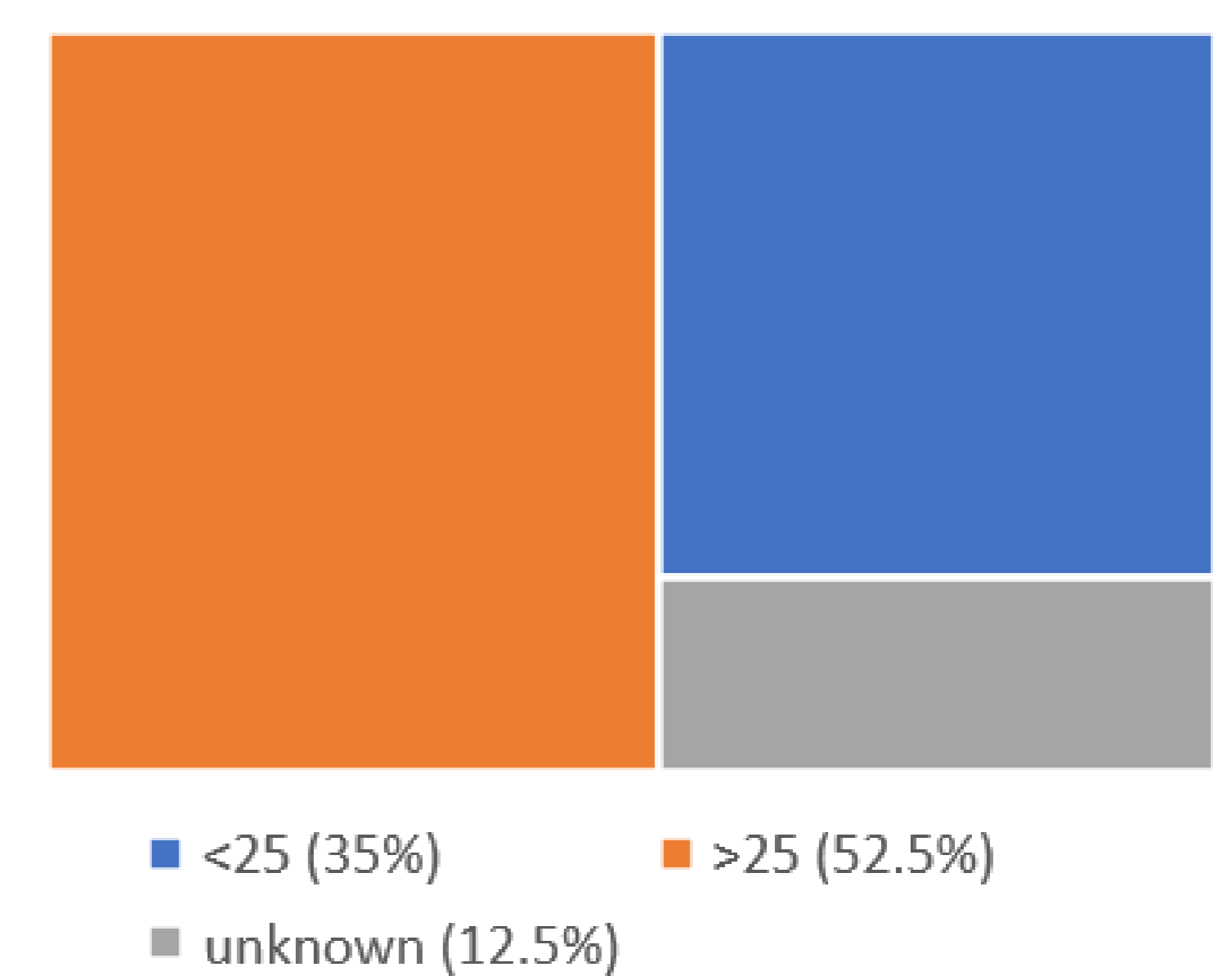
Results



Cause of Gynaecomastia



BMI



Medical treatment offered

