Breast Cancer Awareness:
How to Create Your Personal Screening Plan

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Melissa Rosen:

Thank you so much for being here. My name is Melissa Rosen. I'm the Director of Training and Education at Sharsheret, and I want to thank you for joining tonight's webinar, Breast Cancer Awareness: How to Create Your Personal Screening Plan. Today's webinar is sponsored by The Siegmund and Edith Blumenthal Memorial Fund, as well as the Sylvester Comprehensive Cancer Center, which is part of the University of Miami Health System.

Before we begin, I have a few housekeeping details to share. This webinar is being recorded and will be posted on Sharsheret's website, along with a transcript. Participants' faces and names will not be in the recording. You may have noticed that all participants were muted upon entry. Please do keep yourself muted throughout the call. We recommend that you keep your screen on speaker view. This will enable you to see the presentation clearly. You can find this option in the upper right hand corner of your screen. I want to say that we've received many impressive questions before today's webinar and expect there will be additional questions now. Please use the chat box, which you can access from the bottom of your screen, and we will do our very best to answer all the questions. We'll focus in particular on the ones that will affect most people on this call, but all questions will be answered. Even if we run out of time, we will be in touch with you.

As a reminder, Sharsheret has been providing telehealth services to the breast and ovarian cancer communities for almost 20 years, and although we could never have imagined the world that we are in right now, through our services, we've been preparing for this moment and continue to be there for you each and every day. As we move into the webinar itself, I want to remind you that Sharsheret is a national not-for-profit cancer support and education organization and does not provide any medical advice or perform any medical procedures. The information provided by Sharsheret is not a substitute for medical advice or treatment for specific medical conditions. You should not use this information to diagnose or treat any health problem. Please, of course, seek the advice of your physician or a qualified health provider with any questions you might have regarding your medical condition.

Okay, let's get to it. Tonight's presenters have a wealth of knowledge and experience, and we're going to begin with a personal story from Jamie Gurvitch, who is a member of Sharsheret's Link program, and who lives in Boynton Beach, Florida. So Jamie, I bring the webinar to you.

Jamie Gurvitch:

Hi, everyone. Can everyone hear me?

Melissa Rosen:

Absolutely.

Jamie Gurvitch:

Okay, great. First, I want to say thank you to Sharsheret and not only the ones that are on the webinar this evening, but everyone else behind the scenes, in the scenes, because when I was diagnosed with breast cancer in 2009 and introduced to Sharsheret through a close friend of mine, it was instantaneous the connection that they supported me back from 2009 until today. Not only for me, but for my husband, my children, and my parents, so thank you, Sharsheret. I want to start with saying that.

In 2009, I had a scheduled mammogram from my gynecologist after my annual checkup. I had felt something maybe a month or two before, and I knew I was going for my annual exam, so I thought I would mention it to my gynecologist at the time and then follow up with a mammogram. I did and he said, "Okay, you're due for your mammogram, so we'll send you for your mammogram. It's probably nothing, but we'll check it out." He examined me in the area as well. Everything felt normal. But I did say to him at the time, "I really would like to have a breast ultrasound as well." He said, "That's really not necessary because you don't have any family history and routine is that we start with the mammogram." I said, "I know this is going to sound crazy, but this is the way that my mother takes care of her breasts. She has a mammogram, she has an ultrasound, and I'd like to follow in that plan."

After a few more sentences of conversation, he said, "Okay. I'll write you a prescription for the mammogram and the ultrasound." So I went for my mammogram and they said, "Okay, everything looks good. Stay here and we'll be back in a minute and you'll have your ultrasound." So I had my ultrasound, and during the ultrasound, it was taking a particularly longer time on the left breast in the area where I felt that ... not a lump, but I called it a thickening, and that's how I described it to my gynecologist. I never heard of the word or saw the word "thickening" in literature. I always thought of it and saw the word "lump," which I found interesting because later on, when I was reading material from Sharsheret, I then saw the word "thickening." So I really wasn't in a rush to have my mammogram or call earlier to see the doctor because it wasn't a lump in my mind. It was a thickening, and to me, that isn't breast cancer.

So they were spending time in the area where the thickening happened to have been, and then they stepped out and they came back in and they said, "We're going to spend a little bit more time in that area." Then the radiologist came in, and at the time, I was using a facility in Boca and they said, "We are pursuing this area or re-looking at this area because we do find it suspicious and we recommend that you go to see a breast oncologist ..." no, excuse me, breast surgeon, excuse me ... "To go further and do a biopsy." So I really was very shaken at the time and I actually drove back to my gynecologist's office right then and there. I did not have an appointment, and I sat there until he could speak to me and he recommended a breast surgeon in the Boca area, which I went to. Then within a matter of days, through a biopsy, it was confirmed that that thickening was, in fact, a invasive carcinoma, a breast cancer.

So my message tonight is if you feel something, say something. Be that advocate for yourself. Schedule your mammograms and ultrasounds and anything else that comes to mind on your own or through other learning areas, through a family member or a friend, and then talk about it. Because the more you talk, the more you learn. The more you learn, the more powerful you feel. Knowledge, to me, is power. Through being introduced through talking to my friend, she recommended Sharsheret, and that provided me with the psychological, the social areas that I needed. They helped me develop questions for my breast surgeon, for the treatment plan that I needed. They helped me understand my pathology report. They helped me find the courage to speak to my children, who were young at the time ... 10, 11, and 12.

Then what was amazing, they introduced me to other women that matched my profile, who in the Sharsheret world are called Sharsheret Links. They spoke to me, stayed with me through my whole journey, and now I'm actually a Link for other women that I'm a match to. So know your body as well, and talk about it and reach out to people that you trust. That's my story.

Melissa Rosen:

Jamie, thank you so much for sharing such a personal story. I know that by sharing your story, other people will be inspired to get the tests they need and advocate for themselves, so thank you.

Jamie Gurvitch:

You're welcome.

Melissa Rosen:

I want to introduce our second speaker for the evening, Dr. Elisa Krill-Jackson. Dr. Krill-Jackson is a board certified hematologist and oncologist at Sylvester Comprehensive Cancer Center. She completed her residency and internship at Brigham and Women's Hospital in internal medicine, and her fellowship in medical oncology was done at Tufts. Her hematology and oncology fellowship was done at the University of Miami Jackson Memorial Hospital. Dr. Krill-Jackson has been treating breast cancer patients in South Florida for over 23 years. She specializes in breast cancer, gynecologic cancers, as well as hematology.

She believes in educating her patients about their conditions so that they can work together as a team in fighting the cancer. While using the most state-of-the-art treatments and clinical trials, she believes in treating the whole patient with compassion and supporting the patient's physical and emotional needs. Dr. Krill-Jackson?

Dr. Elisa Krill-Jackson:

Hi. Thank you for having me. I'm going to tell you a little bit about what I do. First, hopefully not all of you have had to see a medical oncologist, but what I do is I try, initially, to educate my patient and form a team with them. Not all breast cancers are the same, so getting information from friends, family is not always helpful. Many people will come to me, either after or before the surgery, assuming that if the surgery takes out the tumor that they're home free. Unfortunately, we know that that's not the case for women with breast cancer in many cases because sometimes, microscopic cells will have spread at the time of diagnosis to other parts of the body. If we let them grow over time to a point where you can see it or feel it in another part of your body, we cannot cure that breast cancer. So my job when somebody comes with an initial diagnosis of breast cancer is to determine what is the risk that they still have tumor cells somewhere else in the body and what is the best therapy to kill those cells.

So depending on the type of cancer they have, if it's estrogen-sensitive, if it's HER2-positive, if it's triple-negative, we will come up with a plan as to whether they should be on hormonal therapy, or chemotherapy followed by hormonal therapy, or chemotherapy and even immune therapy we're using now for some triple-negative breast cancers, and targeted therapy for HER2 cancers. So that's what I do when somebody has a breast cancer.

Now, I also see patients who may be at a higher risk for breast cancer because they've had a finding on a mammogram and a biopsy that showed, for instance, atypical hyperplasia or they have a strong family history of breast cancer. In that case, what we can do is we can test them for a BRCA gene. But we don't have to just test people who have a family history. In fact, there's a lot of people who believe anybody who's Ashkenazi Jewish should be tested for a BRCA1 and 2 mutation because 2.5% of Ashkenazi Jews carry this mutation. In fact, a friend of mine has a foundation called Yodeah, which is the Hebrew word for "know," which concentrates on testing all Ashkenazi Jews. And you can find people who have a mutation who have not had cancer, and they can take steps to prevent cancer.

What I'll also do in somebody who might be at high risk for breast cancer is to help them form a plan as to how they can reduce their risk or detect cancer early. We can do that with mammograms and MRIs. We can also do that with certain medications. We know that certain antiestrogens like Tamoxifen, Evista, anastrozole will decrease the risk of breast cancer in somebody who's high risk by 50%. That's one of my other roles that I play in women who are pre-vivors.

Now, it's really, really an exciting time for us to be in medical oncology. We're getting so many new and different treatments, and we're curing more women with this. We have a lot of targeted therapies now. For instance, we know that if the cancer has a HER2 protein, we have about five or six different medicines now that are approved for HER2-positive breast cancer that we can use to treat women, some of which will increase our cure rates. We also have immune therapy now, which we expect shortly to be approved for therapy before surgery to help increase the chance of curing somebody with a triple-negative breast cancer.

I think the most important thing to say is, if you feel something, just like Jamie Gurvitch said ... If you feel something, don't put it off. You should be getting your mammograms, depending on your family history, 10 years before the earliest diagnosis in your family. If you have a mutation, starting at age 25. But you shouldn't put it off, even during the pandemic. We are safely seeing patients, we are safely doing mammograms. This pandemic's going to last a while. You need to get into your doctor for your regular screenings. Thank you.

Melissa Rosen:

Thank you so much. That was great information. Building on that information, I want to introduce our third presenter for the evening. Our third presenter is Dr. Jessica Crystal. Dr. Crystal is an assistant professor of surgery in the Division of Surgical Oncology at the University of Miami Miller School of Medicine. She's fellowship trained in complex general surgical oncology and board certified in general surgery. She also completed a research and clinical fellowship in surgical oncology and immunotherapy at the National Institute of Health and National Cancer Institute. She specializes in the management of patients with breast and cutaneous malignancies. Dr. Crystal practices at both Sylvester Cancer Center and Jackson Memorial Hospital, where she works with a multidisciplinary team to provide individualized evidence-based care to her patients. Dr. Crystal, thank you for joining us. You are muted.

Dr. Jessica Crystal:

Hi. Thank you for having me. Can you hear me?

Melissa Rosen:

We can.

Dr. Jessica Crystal:

Great. This is certainly very dear to my heart, as I've had, unfortunately, family members affected by breast cancer. And I am Ashkenazi Jewish, so I feel privileged to speak with everyone and to speak with my colleagues. As mentioned, I'm a surgeon at the University of Miami, and tonight, I'd just like to share a little bit of information regarding what is the role of surgery in the management of breast cancer, particularly in patients with a BRCA mutation.

I'd like to give you a little bit of perspective, and when I see patients, I think of them in two ways when they have a BRCA mutation. One is if they have cancer, and the other is if they don't have cancer yet. If they have cancer, I like to talk to them about initially the cancer that has been detected, like Ms. Gurvitch. If they do have cancer, I'll talk to them about what it means for them to have that particular type of cancer and I'll talk to them about trying to remove that cancer and remove as many of the cells possible that cancer has spread to. In a patient who doesn't have BRCA, this would mean just removing the tumor, checking lymph nodes in the area that it typically spreads to, which is under the underarm, and then going from there and determining what other surgery needs to happen. And ultimately, sometimes if it's just a simple breast-conserving surgery, that's all they need. Sometimes patients need a little more surgery, which is like a mastectomy. That's typically what I would offer a patient who has a BRCA mutation.

You might say, "Doctor, why are you removing the whole breast?" The reason is is because we know that there's an increased risk of an additional breast cancer in the same breast, and unfortunately, in the opposite breast as well. So when a patient comes to me with a BRCA mutation and does have breast cancer, I talk to them about more surgery than just the usual breast cancer patient that comes to me. That involves removing both breasts, checking the axillary, or the underarm for the lymph nodes. Then after that, I talk to them about reconstruction. Reconstruction is typically done by the plastic surgeon, which is not my specialty. But I talk to them about the different options, whether it be just removing the breast tissue and having a prosthesis, or whether the plastic surgeon would put an expander in, or go straight to that implant.

So that's the patient with breast cancer, and then I refer to my colleague, Dr. Krill-Jackson, who helps me manage afterwards, in addition to the radiation oncologists. One of the best parts about working at a comprehensive cancer center is that all of us work very closely, including Dr. Yepes, so that we're a well-oiled machine. And so when a patient comes to us, we all know our roles and we know very well how we transition to them and transition the care, and who takes which lead at which point so we're able to tailor treatment to each patient.

Now, the other patients I see are patients with the BRCA mutation but no breast cancer. You might say to me, "Well, why are we doing breast surgery in these patients?" Women feel very strongly about having womanly figures and keeping their breasts. What is important to remember is these are risk-reducing procedures to try to prevent you from developing a breast cancer in either breast and ultimately saving your life. So when patients like that come to me, I tell them they have three options. One, potentially, you could do some risk-reducing therapy. Two, you could have increased surveillance. Or three, you could have bilateral mastectomies. In that situation, we remove all the breast tissue. Sometimes, you can maintain the nipple-areola complex, but that would be a discussion we would have to have. When we remove all the breast tissue, you reduce your risk of having breast cancer by 90%.

You say, "Doc, you're a surgeon. Shouldn't you be removing all the breast tissue?" Ideally, we try to, however, it's a really, really fine line of where breast tissue ends and the tissue giving the blood supply to the skin starts. And so since we don't want to sit there with you under anesthesia and a microscope checking every single cell of breast there, we make our best judgment in removing as much breast tissue as we can see to hopefully eliminate that risk of you developing breast cancer. But if we did it otherwise, you or the person would be under anesthesia for days.

The other surgeries typically involved in BRCA patients are risk-reducing Salpingo-oophorectomies, or the removal of the tubes and the ovaries. These can be done together or individually, depending on somebody's decision for having children. It can vary at the time that you have it, whether you have already completed your childbearing years. Typically, for BRCA1 patients, we'll talk to them about getting it around 35 to 40, and BRCA2, 40 to 45. This is associated with the risk of developing ovarian cancer. It's important to remember that ovarian cancer is pretty difficult to identify until it's too late, so that's one of the reasons why we really want to keep an eye on those ovaries when you have that BRCA mutation.

There is some discussion on whether or not to perform hysterectomies at the time. It's not routinely indicated because even though there's only a very small risk of uterine cancer in people with BRCA mutants and it's not always the case and it can cause other morbidities. That, in summary, is the gist of my role in the BRCA patient and patients with breast cancer. When, heaven forbid, you ever need me, we'd be happy to walk you through your personalized treatment plan. Thank you.

Melissa Rosen:

Thank you so much, Dr. Crystal. Before I introduce our final speaker for the night, I want to remind you that if you have any questions, this is a good time to put them into the chat because we've left a good amount of time for questions.

Melissa Rosen:

With that, I want to introduce Dr. Monica Yepes. Dr. Yepes is an associate professor of clinical radiology at the University of Miami Miller School of Medicine. She is a board certified radiologist who was fellowship trained in breast imaging at the combined Jackson Memorial/University of Miami program. She has worked at the University of Miami Miller School of Medicine for the past 19 years and served as division director of breast imaging and director of breast imaging services at Sylvester Comprehensive Cancer Center since 2013. She has also served as fellowship director, director of breast MRI, and co-chair of the Radiology Research Committee. She's been a member of the American College of Radiology Appropriateness Committee and during that time, co-authored multiple articles that establish evidence-based breast imaging guidelines. She, too, is passionate about patient care and minimally invasive techniques for breast biopsy and treatment, and innovative imaging techniques for high-risk patients. With that, Dr. Yepes. Please unmute. Yep.

Dr. Monica Yepes:

Thank you so very much for that very kind introduction. It's such a pleasure to be with all of you tonight. I've been with Sharsheret before and it's always a pleasure to speak to you.

I am the breast radiologist, and I guess it's only fitting that I'm the last person to speak to you as one of the speakers, because usually in real life, I'm probably one of the first people to speak to you. I have the unfortunate task of walking you through that very first diagnosis. The very most important part of what I do is to try to detect cancer at an early stage, and hopefully, ideally, before you feel anything, before there's a thickening, before there's a lump, before there's any retraction of the skin or any clinical changes. So the whole goal of what we do is to try to identify cancers when they are clinically silent. How do we do that? By doing very judicious and very careful screening.

The second part of what I do is to try to determine what is the best screening regimen for you. How do we do that? Just like everything in medicine, we're going towards personalized strategies. We try to accomplish that by first trying to identify your risk factors, and that's why when you come into a good screening facility, you should be asked a number of questions which entail what kinds of biopsies you've had in the past, if you've had hormone treatments in the past, and what your family history is. So as you all know, it's not just a matter of family breast cancer history, but other cancers as well. We ask about ovarian cancers, we ask about pancreatic cancers, melanomas, prostate cancers in the males in the family because that, as we've discussed previously, helps us determine whether you might be at risk of having some type of genetic mutation because we know that all these cancers come in clusters in the family.

So that's the first thing. We try to establish what your risk factors are. Second, once we do your first mammogram, we try to determine what kind of breast tissue you have. Do you have fatty tissue or do you have dense tissue? Breasts on a mammogram are made up of essentially those two types of tissue. The difficulty with dense tissue means that when we do your mammogram, your mammogram looks very white and unfortunately, cancers on your mammogram are white as well. So finding a white cancer on a white mammogram is extremely difficult, and that's why we sometimes have to pull out some more tools from our toolbox to try to find a small cancer. That's when we may try to use an ultrasound or use some contrast-enhanced studies, which we can talk about in a minute.

We try to determine which is the best type of screening for you based on all of these characteristics. And not only which tools we'll use, but when we should use them. When we determine that someone is at high risk ... for example, there's a family history as Dr. Krill mentioned ... if there are first-degree relatives with breast cancer who were diagnosed at premenopausal age, before the age of 50, then we recommend the daughter, the sister, et cetera, to begin screening 10 years prior to the diagnosis in that first-degree relative. For example, if mom was diagnosed at 45, then daughter should begin screening at age 35.

When we identify that there is a genetic mutation, then we recommend beginning even earlier. So screenings should begin at age 25 with MRI and annually, and then we should begin with mammograms as ... Sometimes we have to begin very early at 25 as well, but we tend to try to postpone until 30. So no later than 30, and with MRIs every year. What we recommend is staggering them. What does that mean? For example, if I get my mammograms done in January, I should get my MRIs done in June. That way I'm doing one test or the other every six months.

Now, speaking of mammograms, before I forget, it's important that you try to request having tomosynthesis with your mammogram. Tomosynthesis, or 3D mammography, is a mammogram that, instead of just performing two views of the breast, performs multiple low-dose views through each of the breast and it reconstructs the breast in very, very tiny slices. What that does is it allows us to see through the dense tissue much more accurately than when we don't have that tomosynthesis. It's kind of a win-win situation because not only does it allow us to see smaller cancers and difficult cancers, but it also increases our accuracy by removing some of the things that cause errors, false-positive findings. So sometimes we see things that are normal tissue and we think they're cancer, but with the tomosynthesis, we can kind of discern that a little bit better.

In a nutshell, that's what we do in terms of screening. One other tool that we can use, especially for patients that are not at such a high risk that they require MRI but are not at average risk, is that we can use contrast-enhanced mammography. That's a relatively new tool that we're using and that we have at Sylvester, and it's a mammogram with contrast, which is a contrast that's different than the one that we use for MRI. The one that we use for MRI is gadolinium, and the one that we use for this is iodine. Sometimes patients may have contraindications for one or the other, and so we have that other modality that we can use.

Once we've identified a cancer, we have to determine how we're going to biopsy that cancer. Ideally, you want the radiologist to do that biopsy, because we do the biopsies with a small needle and we want to remove the least amount of tissue that we need to to get to that diagnosis. We're going to try to do it using one of the modalities that we see the cancer on, whether it's ultrasound, whether it's mammography, or whether it's MRI. We're going to guide our biopsies to ensure that we get a very accurate diagnosis, because that is what's going to be used by Dr. Krill and by Dr. Crystal to determine what is the best way to treat that cancer. Do we need to do chemotherapy first because it's an aggressive type of cancer, or do we do surgery first because the patient will be better off with surgery and maybe having chemotherapy afterwards? So that's the second thing that we do, perform that biopsy.

Then once we know that the patient has cancer, we have to stage that cancer. What does that mean? We have to identify the extent of the disease. Is it limited to one area of the breast so that Dr. Crystal can do just a lumpectomy? Or has it spread to other areas of the breast so that she needs to do a mastectomy? Has it spread to the lymph nodes? Sometimes it's helpful to know that in advance so that we can determine whether that patient might benefit from chemotherapy before surgery, or whether she needs a more extensive surgery in the axilla. We also help determine whether it has spread to the nipple, whether it has spread to the chest wall, because all of these things are going to help the oncologists and the surgeons determine what kind of treatment they have to do.

And so this is kind of in a nutshell what the radiologist does. As Dr. Crystal mentioned, we all work very closely, very hand-in-hand, because what one sees, the other needs to determine what kind of treatment has to be performed.

Melissa Rosen:

Thank you so much to all of you. In very little time, you have imparted a great deal of knowledge, and that's wonderful. We have a lot of questions that have come in, so if you don't mind. With regard to genetics and genetic mutations, I'm going to try and put these questions together. First, there actually was a question about understanding what BRCA1 and 2 mutations are and what the implication is. There were also questions about differences in screening plans for people who have other mutations, such as CHEK2 or things like that. So would the most appropriate person please ... because it kind of crosses a couple of speakers here. So would the most appropriate person please work to answer that? We'd be grateful.

Dr. Elisa Krill-Jackson:

I think we can probably all speak to that, but I'll take the ball here. BRCA1 and 2 mutations are the most common hereditary mutations causing breast cancer. They also increase the risk for ovarian cancer. So for instance, a BRCA1 mutation will increase the risk of ovarian cancer to somewhere between 20 and 40% in a woman's lifetime, whereas as BRCA2, it's more like 15%. But ovarian cancer is not easily curable, it's not easily detectable early, so we highly, highly recommend prophylactic surgery for the tubes and ovaries. We recommend it when people are done childbearing. In BRCA1, we like to do it age 35, although we can delay if somebody is still planning on having children, and BRCA2, we recommend age 40.

The risk for breast cancer in both of these mutations is in that 80% lifetime range. Having your ovaries out early will decrease your risk of having breast cancer. And when young women are diagnosed with these mutations, we will often recommend that they have prophylactic mastectomies. Some women will want to screen, in which case we do what Dr. Yepes said. We start at age 25 and we generally alternate mammogram with an MRI every six months. But these cancers ... BRCA1 and 2 mutations can have very aggressive cancers that pop up between screenings, and these cancers tend to be aggressive enough to require chemotherapy. That's why ... and I think Dr. Crystal would agree ... we highly recommend in young women who are found to have these mutations prophylactic surgeries to prevent cancers.

There are other mutations which increase the risk for breast cancer and certain other cancers, for instance, CHEK2 that somebody asked about. CHEK2, as opposed to an 80% lifetime risk of breast cancer, is somewhere in the 20 to 30% risk, but probably high enough to justify MRI screening once every year alternating with mammograms every six months. Like BRCA2 mutations, it can also increase the risk for male breast cancer. Then there are several other mutations. The most common and the other higher risk one, PALB2 mutations. But depending on the mutation, you need to see a genetic counselor, a breast surgeon, a breast oncologist, and discuss with the radiologist what the best screening program is for you. We generally will reserve prophylactic surgeries for BRCA1 and 2 mutations at this point.

Melissa Rosen:

Thank you. Between the questions we received and your really wonderful answer, what's clear is that the topic of genetic mutations is a large one, and it can be very confusing if you're not in a medical field. One of the ways Sharsheret helps is through our Genetics for Life program. We have an amazing genetic counselor on our team who is able to take calls to help people understand what their risk might be, help address concerns, help discuss screening options and opportunities. And so that's definitely something to keep in mind if you have questions with regard to genetic mutations or the concern about genetic mutations. And thank you, because somebody just mentioned that she was in touch with our genetic counselor and she was amazing.

Something else that I ... A misconception I want to point out is that somebody indicated in a question that they might think that Sharsheret services are for the Jewish community. We are a Jewish organization and we offer culturally meaningful support, but I want to make it clear that Sharsheret's programs are open to absolutely everyone, regardless of religious affiliation. That's very important.

Moving on to another question. We've spent a lot of time talking about people who are high risk. But for the average woman who has done her research, she knows what her family's cancer history is, she knows about her own personal health history, she's had a conversation with her gynecologist about risk, and she just needs her regular screenings because the vast majority of diagnoses are not related to mutations. So Dr. Yepes, can you talk about what an average person without any known risk factors should be doing in terms of creating a screening plan?

Dr. Monica Yepes:

Perfect. That's a great question. Just to kind of put things into perspective, we consider high risk, needing MRI, someone who has a greater than 20% lifetime risk of having breast cancer, which means that the average risk is somewhere in between 12 to 15%. So that's the person who has no first-degree relatives, no early breast cancers in their family. So the recommendation is simple. Start at 40, and every year. It's the clearest guideline of all. It has been very controversial, because unfortunately, controversial things hit the headlines. So you've probably heard in the news hundreds of times that the USPSTF says we should start screening at 50 and every two years.

Not to get political, but here's the deal. All of the randomized control trials have shown without any doubt that beginning as early as age 40 saves more lives and that you save more lives and more consistently when you do it annually. So starting at 40, annually. Very simple. We can start at 50 and every two years, but what happens? We're going to miss 12% of breast cancers that occur between ages 40 and 50, and there are 17% of all breast cancer deaths occur between ages 40 and 50. So we do need to start at age 40 on those patients who have average risk.

And mammogram. Yearly mammogram. If they have dense breast tissue, we may consider adding that ultrasound. Now, the advantage of the ultrasound is that it can pick up ... So on average, when we do screening mammography on an average-risk patient who has no symptoms ... Now remember, this is without symptoms. If there are symptoms, that's a different story. That's not considered a screening mammogram. So for screening mammograms, we should be picking up around three to seven cancers per every 1,000 women screened. When we add ultrasound to that, we add another three to seven cancers. But only if they have dense breast tissue, and this is where it's important to clarify. Patients who do not have dense breast tissue do not benefit from an ultrasound, because if anything, that ultrasound makes us do more unnecessary biopsies. So that's an important thing.

Melissa Rosen:

Thank you. Any advice from any of you for women who want to have that screening mammogram at 40 but are getting pushback from their insurance companies?

Dr. Monica Yepes:

Theoretically, in the United States at this point in time, you should not. You should be able to get your mammogram beginning at age 40. We hope that moving forward, these recommendations from the USPSTF, which is the United States Preventative Services Task Force, don't influence Medicare and start causing trouble with that.

Melissa Rosen:

Okay. What advice do any of you have for someone who is nervous about getting routine screenings because of the ongoing pandemic?

Dr. Monica Yepes:

For two to three months at the beginning of the pandemic, all the major societies ... breast imaging, the breast oncology, and the breast surgeons ... everyone got together and really sat down and thought about this, and with much hesitation, they put forward that the risk of contracting COVID might be higher than the risk of not detecting a cancer for a short period of time. That's very important. It was just supposed to be something for one to three months until we got a better handle on this, until we figured out what was going on, until we figured out how to prevent it, how to not spread it, and how to better treat it.

So those three months have passed. Now, we don't know everything about it, but we have figured out how to distance within the hospitals. Everybody's wearing their protective equipment. Everything is cleaned and disinfected after each and every patient. We're keeping our waiting rooms at minimum capacity so that everybody can social distance. And so we are making it safe so that everybody can come back, and I think that's a very important message from tonight, is that we need to stop medical distancing. We need to come back.

Melissa Rosen:

A very important message. Thank you.

Dr. Elisa Krill-Jackson:

I will tell you that we've been seeing patients all the way through the pandemic. I don't think I ever had a point in time that I wasn't busy seeing patients. And we were seeing patients with immune suppression on chemotherapy, and we did so very safely. I know of no cases where COVID was transmitted in our office. We have very careful procedures. I tell my elderly patients, my patients who have immune suppression, that they can safely come in our office and we have not seen a problem.

Melissa Rosen:

That's great. That's great. For Doctors Crystal and Krill-Jackson, somebody asked, "Are there different ways that you are connecting with patients now that facial expressions and the use of touch is no longer available to us?"

Dr. Jessica Crystal:

Well, I could start. I practice the art of smizing. But being a surgeon, wearing a surgical mask is daily routine to me, so I'm able to communicate in all ways. But I was going to bring up just before anyways, is we individualize our care to each and every patient anyways. So we do other measures that we think that patients need while practicing social distancing, and we only have interactions that are absolutely necessary. So when you come in to see us, there are going to be certain moments that we cannot social distance, and that is just more important. But we'll only do the necessary items that are important, and we're going to take all the precautions necessary to avoid any contraction or spread of COVID.

Dr. Elisa Krill-Jackson:

Now, I'll tell you, I had a patient today on the phone who I've been seeing every other week for four or five months during her chemotherapy, and today we had a telehealth consultation and she says to me, "Oh my gosh, I almost never see your face. I get to see your face now on telehealth," because I was in my office alone without a mask, and that was lovely for her. So our patients can see our masks, but I think we do smile with our eyes. At the beginning of the pandemic, we found other ways to hug. I would touch foot to foot as a new hug. I think there's nothing to substitute for a hug, and unfortunately, in my area of expertise, there are a lot of emotional moments. I have to examine somebody's neck. I'm standing face-to-face with them, but I'm wearing my N95 mask and they're wearing a mask, and honestly, I think that touch is important.

I still touch my patients with their permission, with masks on, if they need it, because I think that's something we learned was so important at the beginning of the pandemic. And if we touch hands, I tell them to go wash their hands before they leave the room, and I wash my hands before and after. I think we can do that safely. So for the most part, we maintain our distance, but I think there are certain points in time where touch is still very important, and I think it can be done safely in the medical setting.

Melissa Rosen:

Thank you. I have a couple of specific medical questions that we received. Somebody asked if Evista is indicated for a postmenopausal woman with a BRCA2 mutation.

Dr. Elisa Krill-Jackson:

I think Evista's a great drug for that. We have a number of different drugs that will decrease your risk for breast cancer, and in a BRCA2 population ... not necessarily BRCA1, but in BRCA2 population, Evista should do a good job reducing risk. Again, it will not eliminate risk, and an interval cancer that pops up between screenings still may need chemotherapy, but Evista's a great drug because it helps bone density at the same time as it reduces risk of breast cancer by about 50%. It doesn't have terrible side effects. It slightly increases the risk of blood clots in the legs, just like birth control. It doesn't seem to increase the risk of uterine cancer like Tamoxifen does, and it doesn't cause the joint aches and severe vaginal symptoms that the aromatase inhibitors can.

And just speaking of the vaginal symptoms, for those of you in the audience who have had breast cancer and have been treated for breast cancer, make sure that you're telling your doctors if they don't ask you about sexual health problems. I think a lot of people are hesitant to bring that up. I try to ask all my patients about it. It's a sensitive topic and people are hesitant to bring it up. There's a lot of things we can do, either hormonally or non-hormonally. Even in some patients who've had breast cancer, sometimes we can use a slight amount of vaginal hormones, but there's lots of non-hormonal ways of improving this. One of our colleagues is starting a sexual health clinic for survivors of gynecologic and breast cancers at the University of Miami, so lots of new and exciting things for us here.

Melissa Rosen:

Amazing. I'm going to ask one other similar question, but I'm going to remind everyone on the call that these aren't specific prescriptions for your own particular situation and that you have to talk to your own doctor. But another question was, "Is radiation and Tamoxifen sufficient for a DCIS diagnosis with no lymph node involvement for a person who is mutation negative and HER2 negative?"

Dr. Jessica Crystal:

I think that that situation should be specifically discussed with your doctor. You need to really get a good analysis of the pathology of the specimen. Make sure that the margins are negative, make sure that there's no components of invasive cancer as well. So I encourage whoever asked that to discuss it directly with the doctor or even get a second opinion, but I don't think this would be the appropriate format to discuss some of those nuances.

Melissa Rosen:

Perfect, thank you. Okay, so there were a lot of questions ... and this is the last group of questions. But there were a lot of questions about definitions and one treatment or screening versus another. Somebody just asked, "Could you explain margins?"

Dr. Jessica Crystal:

When I think of margins, margins are the edges of the specimen that I remove. So typically, if I'm doing a breast-conserving surgery, which could also be called a partial mastectomy or a lumpectomy, I'm looking at the amount of tissue around whatever I've removed. Maybe it's a breast cancer or a DCIS or some other unusual lesion. And the pathologist, another team member, will look at the areas around the tissue under a microscope and make sure there's no abnormal cells, particularly cancer. If there are abnormal cells there, then the margin may not be clear. This is the principle that exists not just in breast conserving surgery, it also exists in mastectomy. It's a similar principle for the whole breast. In addition, it's the principle that we use in all cancer surgeries, and the amount of area from where the cancer ends to normal tissue, the amount that's acceptable oncologically varies depending on the type of cancer as well. So not all cancers are made the same, and that's important to remember.

Melissa Rosen:

Thank you.

Dr. Jessica Crystal:

Sure.

Melissa Rosen:

Dr. Yepes, a couple of questions about screening technologies. One of them is, somebody asked ... She believes she's learned that small specialized MRIs are a better option than mammograms in locating new cancers. Can you discuss the difference between technologies? We heard from Jamie earlier that she was able to convince her doctor to give her a prescription not just for a mammogram, but for a sonogram. But can somebody ask for an MRI if they feel more comfortable with that?

Dr. Monica Yepes:

By small MRI, I presume they're talking about abbreviated MRI? Is that what ... So MRI is a very long examination. If you do all the sequences that we traditionally do, it takes about 30 to 40 minutes, about 30 minutes. And so there are some new trials looking at a much shorter version of that, and it's called an abbreviated MRI which can take five, up to 10 minutes. And so, what we're finding is that those abbreviated MRIs have as much information as the full MRI as a screening tool. So that's why certain patients who are at high risk might benefit from that abbreviated MRI. What the future might hold is that abbreviated MRIs might even be better than mammograms, but I say that as future because we still have to see a lot of evidence for that.

Now, no matter how small that MRI is, it still requires contrast enhancement, so you have to be given contrast. You still have to go into that MRI tunnel and it still causes claustrophobia, so it has some limitations and some people may have contraindications to it. But we suspect that in the future, it might be a very, very, very valuable part of most screening protocols. So it's not widely available yet, and the problem is that, ideally, because it's shorter, it should cost less than a full MRI, and we still have to work on that part of the equation of being able to charge less for it. So sometimes it boils down to economics.

Melissa Rosen:

I'm going to ask you two questions that I want to get in because they were good questions, but we're running out of time, so I want to ask you to answer them quickly. But a couple of people asked if you could explain what BI-RADS is, and also ABUS 3D mammography with ABUS or A-B-U-S. It's not a term I'm familiar with.

Dr. Monica Yepes:

The BI-RADS is just the language that we use as breast imagers, and so it's a category that's assigned to each mammogram so that whoever reads our mammograms knows what we're recommending. So a BI-RADS 4 means that there's something suspicious that needs to be biopsied. You're not too suspicious. BI-RADS 5 means that you're very suspicious, that this is almost certainly cancer. BI-RADS 1 and 2 means that everything is fine, you can come back in a year, and BI-RADS 3 means that there's something, but I just want to see you again in a couple of months. I want to do a follow-up. Those are the important ones. 1 and 2 negative, 4 and 5 you need a biopsy, and 3 we'll see you in six months.

Melissa Rosen:

Okay, great. Thank you. Okay, I want to thank all of our presenters this evening for sharing your experience and your expertise. Really a ton of very helpful, practical information. I just want to remind you that Sharsheret is here for you, continues to be here for you and your loved ones during this time. We provide emotional support, other programs designed to help you navigate the cancer experience. All are free, completely private, one-on-one. Our number is 866-474-2774. Our social workers and genetic counselor are there for you. You are our priority.

Two things I want to finish with. One is, many of you know ... and if you don't, I'm going to tell you now ... that we have many, many webinars coming up or that are recorded and on our website now. Please check out them because they have really important information on them. But there is one upcoming program that you might not think to look for. Our special program is called LOL! Links of Laughter, and it's Monday, November 16th at 8:00 PM Eastern Time. This virtual night of comedy and entertainment features SNL and Netflix stars and really does promise a lot of laughter, which is something we can all use right now. For more information, you can visit our website. We also are going to put a link to it in the chat.

The final thing I would like to ask is, also in the chat, there will be a link to a very brief evaluation survey that we'd like you to click right now to take a moment to do. I can promise you, as someone who works on part of the team that works on programming here, that your evaluations really impact the future programming we do. So thank you for joining us. Thank you for presenting to us, and please take a moment to fill out that survey, and we look forward to seeing you again. Good night.

Dr. Monica Yepes:

Thank you so much.

Dr. Elisa Krill-Jackson:

Good night. Thank you.

Dr. Jessica Crystal:

Good night.

Jamie Gurvitch:

Good night.

Melissa Rosen:

Good night.

About Sharsheret

Sharsheret, Hebrew for “chain”, a national non-profit organization, improves the lives of Jewish women and families living with or at increased genetic risk for breast or ovarian cancer through personalized support and saves lives through educational outreach.

With four offices (California, Florida, Illinois, and New Jersey), Sharsheret serves 150,000 women, families, health care professionals, community leaders, and students, in all 50 states. Sharsheret creates a safe community for women facing breast cancer and ovarian cancer and their families at every stage of life and at every stage of cancer - from before diagnosis, during treatment and into the survivorship years. While our expertise is focused on young women and Jewish families, more than 15% of those we serve are not Jewish. All Sharsheret programs serve all women and men.

As a premier organization for psychosocial support, Sharsheret’s Executive Director chairs the Federal Advisory Committee on Breast Cancer in Young Women, Sharsheret works closely with the Centers for Disease Control and Prevention (CDC), and participates in psychosocial research studies and evaluations with major cancer centers, including Georgetown University Lombardi Comprehensive Cancer Center. Sharsheret is accredited by the Better Business Bureau and has earned a 4-star rating from Charity Navigator for four consecutive years.

Sharsheret offers the following national programs:

The Link Program
- Peer Support Network, connecting women newly diagnosed or at high risk of developing breast cancer one-on-one with others who share similar diagnoses and experiences
- Embrace™, supporting women living with advanced breast cancer
- Genetics for Life®, addressing hereditary breast and ovarian cancer
- Thriving Again®, providing individualized support, education, and survivorship plans for young breast cancer survivors
- Busy Box®, for young parents facing breast cancer
- Best Face Forward®, addressing the cosmetic side effects of treatment
- Family Focus®, providing resources and support for caregivers and family members
- Ovarian Cancer Program, tailored resources and support for young Jewish women and families facing ovarian cancer
- Sharsheret Supports™, developing local support groups and programs

Education and Outreach Programs
- Health Care Symposia, on issues unique to younger women facing breast cancer
- Sharsheret on Campus, outreach and education to students on campus
- Sharsheret Educational Resource Booklet Series, culturally-relevant publications for Jewish women and their families and healthcare Professionals

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