Breast Cancer and Menopause

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Briana Schwarz: All right. Thank you so much for joining us. Hello, everyone. All right. Good evening. I want to thank everyone for joining Sharsheret tonight for a webinar on breast cancer and menopause. I'm Briana Schwarz, Sharsheret's Florida Regional Director, and tonight we will be learning from two of the top experts in the field, Dr. Kate Lampen-Sachar and Peggy Cottrell. They will share insight on risk factors and screening recommendations. We are grateful to tonight's webinar sponsors, the Greater Miami Jewish Federation and the Miami Cancer Institute, which is part of Baptist Health South Florida. It is thanks to their support that we are able to continue to provide our series of educational webinars. Whether you are a Sharsheret supporter or joining us through one of our partner organizations, which are H3: Health, Hope, Healing, the Jewish Federation of Orlando, NA'AMAT or the Florida region of Women's League of Conservative Judaism, we welcome you all to tonight's program. Stay tuned at the end of the webinar to learn more about the work of these incredible partner organizations.

Before we begin, a few housekeeping items. Today's webinar is being recorded and will be posted on Sharsheret's website along with the transcript. Participants' faces and names will not be in the recording. If you would like to remain private throughout the webinar, you can turn off your video and rename yourself or you can call into the webinar and instructions to do so are in the chat box now. You may have noticed that all participants were muted upon entry. Please keep yourself on mute throughout the call. If you have any questions, which I expect many of you will have, please put them in the chat box either publicly or click on Sharsheret in the chat box to submit a private question directly to me.

We received many questions in advance of the webinar and anticipate many questions in the chat box. We will do our very best to answer all the questions but anything not answered tonight will be addressed by email over the next week. We recommend that you keep your screen on speaker view which will enable you to see the presenter when she is speaking. You can find this option in the upper right hand corner of your screen.

Sharsheret has been providing telehealth services to the breast and ovarian cancer communities for 20 years. And the past year and a half has not changed that. We continue to be there for each and every one of you. As we move into the webinar itself, I'd like 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 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 a health problem. If you have any questions that are specific to your medical care, we recommend that you speak directly with your health provider with any questions you may have regarding a medical condition. Always seek the advice of your physician when you have questions regarding your medical condition.

Before we hear from our two presenters, I'd like to introduce you to Mali Schwartz, a Sharsheret caller to briefly share her personal experience with breast cancer. Mali.

Mali Schwartz: Sure. Thank you, Briana for that lovely introduction. And also thank you for letting me share my thoughts about menopause and what it meant to me. I just want to say I've been involved with Sharsheret for four years now, and they've been really very supportive about anything that I wanted to try or to do. I want to let you know that I was 66 years old when I got my HER2 positive breast cancer diagnosis. I had been enjoying my freedom after having raised four children. And I was enjoying my new hobbies such as painting and creative writing, which I didn't have the opportunity to do before. And I was well into my menopause when I was diagnosed in September, 2017.

Menopause for me is a time of rediscovery, a ritual a rite of passage into an era of wisdom, freedom and personal power. Did you know an older woman who was postmenopausal was called a crone? A name that was introduced into the English language in 1390. A crone was considered to be disagreeable in nature or a wise woman, depending on who was doing the defining. She also served as a midwife and helped women through birth process.

I think that today women are lucky to be able to live longer and enjoy the process of tapping into areas that they can explore, that they were never able to as younger women, when they were busy with their careers and raising their families. Menopause can be a time to reflect back on our lives, a time to become more whole and more complete. I also think that women are more intuitive at certain times of their lives. I know that when women are pregnant, and also I think menopause, can make women more intuitive as well. Any kind of major hormonal shifts in the body.

And for me, thinking about painting images that related to my breast cancer helped me to process my thoughts around my protocol, such as chemotherapy, radiation therapy and surgery. It helped me to work through my symptoms of depression, and anxiety. Did you know that research has found that art therapy access is healing faster, because it's forges a deeper mind body connection? Art helped me to give voice and to clarify my thoughts, something concrete and representational that reached into the depth of what I was experiencing. It was a visual journal for my own self-expression. I believe that women need to put themselves first when they receive a breast cancer diagnosis. They need to think about what will help them deal with their protocol and to be able to give themselves the space they need where healing can take place.

Someone that has touched me deeply with his words is Dr. Bernie S. Siegel. He's written many books, one of them is Love, Medicine and Miracles. He has cared for and counseled innumerable patients. He believes that there is a marked difference between the ideal of healing versus curing someone. Healing comes from a deep, spiritual, inner connection with oneself while curing comes from an outside source, something that is done to you. I think it is vital for women to

have something that they want to live for so they can lead an authentic life. I align with Sharsheret's mission and how they support women in a variety of ways, emotionally, spiritually and physically as they undergo the fight of their lives.

Sharsheret, who just celebrated its 20th anniversary is an amazing resource for women to have and we are blessed that we have something like this in this day and age, and I want to thank you and back to Briana. Thank you.

Briana Schwarz: Oh, Mali, thank you so much for sharing-

Mali Schwartz: Oh, you're welcome.

Briana Schwarz: ... those words with us. Thank you.

Mali Schwartz: [inaudible 00:08:25].

Briana Schwarz: So with that in mind, I want to introduce our first of two terrific professionals who we will be having on tonight's program. Dr. Kate Lampen-Sachar is a breast radiologist from Miami Cancer Institute. Dr. Lampen-Sachar is a board certified breast radiologist and an attending radiologist at Baptist Health Breast Center of Miami Cancer Institute in Miami, Florida. She is also the vice chairman of radiology and an assistant professor of radiology at Herbert Wertheim College of Medicine, Florida International University. Kate was previously faculty at New York Presbyterian Hospital, Weill Cornell Medicine Center. She completed a breast and body oncologic imaging fellowship at Memorial Sloan Kettering Cancer Center. Kate also graduated from Weill Cornell Medical College with the Alpha Omega Alpha honor and continued on to medical residency at New York Presbyterian Hospital, Weill Cornell Medical Center.

Kate remains active in the academy of breast imaging community. She has published in her main area of interest which is breast cancer and breast MRI. She has authored several articles and peer reviewed medical journals including the Journal of Thoracic Oncology, Emergency Medical Medicine Journal, and the Annals of Surgical Oncology, and she has presented research in the International Conference, the Radiologic Society of North America and she currently sits on the Breast Imaging Review panel for the RSNA, and is the vice chairman of the RSNA digital and live education committee.

If that's not enough, Kate is also an active lecturer in the Miami community. She has lectured annually for the Breast Cancer Symposium, presented through Baptist Health, has given continuing medical education courses for local physicians who treat breast cancer and has given several refresher courses to breast imaging technologists. Kate is a member of the Council of Advisors for the Young Survival Coalition, an organization which supports young women diagnosed with breast cancer. And if you haven't had a chance to hear her speak

before, you're in for a real treat this evening. So Dr. Lampen-Sachar, thank you for joining us, the floor is yours.

Dr. Kate Lampen...: Oh, my goodness. Thank you. Thrilled to be here. I love talking about mammography. It's something that I'm really passionate about. Happy to do it anywhere, anytime, at the gym, cocktail parties, you name it, I'm game. So I'm just very excited to be here tonight, and to hopefully, dispel a few myths and as always, happy to answer any questions. So I wanted to just... Perfect. Just making sure I didn't have the timer on this. I do have a few slides that I wanted to share with you, which hopefully will answer some questions that you may have. I love this little graphic, because I think that in the past few years, there has been a lot of confusion, a lot of poor press regarding mammography. And among those of us that diagnose and treat breast cancer, we frankly don't understand why the data is what it is. And it's very pro mammography, and unfortunately, a lot of articles really give it a bad rap. So hopefully today, I can answer some more questions.

To take a step back, I think that it's important to understand just a little bit about the statistics. So what makes an ideal screening test? There's been a long standing quest for a modality for screening that will lower false positives, increase true positives that are worth treating and improve sensitivity. So the answer that I'm first going to address, for the general population of average risk women is screening mammography annually, starting at age 40. And provided that a woman remains in good health with a life expectancy of greater than five years, we recommend continuing, annually up until age 40. And these recommendations here, are those that are the guidelines published by the American College of Radiology, the Society of Breast Imaging, the Society of Breast Surgeons, I'm drawing a blank now on the society that governs breast oncologist but them as well, and the American College of Obstetrics and Gynecology also abide by this recommendation. So if you leave with anything today, tell your friends, family members yearly mammography and annually.

I actually had a 87 year old patient that I saw today and unfortunately, she is going to have a little cancer. It's very small, and she'll do really, really well. But she basically asked me, she's like, "Doc, my friend stopped coming in for a mammogram and I came in." And I'm like, "It's really good you came in." And she's 87 and she's a tennis player and she's going to do wonderfully, but if she had stopped, perhaps this would have progressed further whereas now, she's in a place where we'll be really able to treat it.

I wanted to just show a few examples because I am a radiologist, so I love pictures. This was a patient that presented for a screening mammogram. And I know you guys are not radiologists, so I'll help you along here. I'm drawing your attention to this yellow box here that I've blown up. We actually also got three dimensional images, tomosynthesis images on that, and I think you can see, if you can follow my arrow here something that almost looks like it has a star coming out of it. So that was what we refer to as a suspicious mass. It's irregular and it has what I would also call architectural distortion where it looks like the

tissue is actually pulling. So this was a suspicious finding, and that did come out to be a cancer. So that was a screen detected cancer in a postmenopausal woman.

So the question is I've set this guideline and told you about it, why should we be performing yearly screening mammography starting at age 40? Well, there is ample data to support it. And as we have seen, we know that breast cancer incidents increases with age. We have seen that screening mammography alone contributes to the largest reduction in deaths. The general statistic that we utilize is we say that yearly mammography, not every other year, yearly mammography results in greater than a 40% reduction in mortality. And that doesn't account for additional better improvements in chemotherapy surgery, radiation. Mammography alone has the power to do that.

And we also know that three out of four women who died from breast cancer didn't have regular screening mammograms. Unfortunately, I think that the proof in the pudding for us with this has been further validated with COVID and people missing their yearly mammograms. We're starting to see a huge body of literature coming out of people that skipped mammograms, and instead waited 18 months, 24 months we're now seeing even a little bit more before coming in. And we're seeing bigger cancers, we're seeing more aggressive cancers. The breast MRIs that I'm reading are much more complicated, the biopsies that I'm doing are much more complicated. So if that isn't proof, I don't really know what it is.

So there's a lot of different websites that have good information. I really like this website, and you can see there's a good resource here, the patient resources tab, it has a lot of really clear data, it's simple to understand. So I always encourage people to take a look at this if they've any questions or they need any more convincing. And it also has a lovely little tab called myths and facts.

So that would be for the general population. So what do we do with people who are increased risk of developing breast cancer? And we can offer additional things. But it's first let's take a step back, there are multiple risk factors for breast cancer. As one of my colleagues says, There are two main risk factors for breast cancer, age and being a woman, which are basically not modifiable. So unfortunately, we have a lot of things going against us just from the get-go. Family history does play a component in being a risk factor for breast cancer. Ashkenazi Jewish ancestry unfortunately, does. And then various physiologic things come into play, age at first live birth, the number of children that someone had, among many other risk factors.

So knowing that there are many different risk factors, what can we do? We really encourage our general providers or OBGYNs to assess annually for breast cancer risk. So what does that mean? It actually doesn't mean that much more for them, because they're already asking basically all the questions that would go into calculating someone's risk, they just actually have to put it in a risk calculator. One of the best tools that we have is called the modified Tyrer-Cuzick

model, and it takes into effect many different risk factors and it will calculate a lifetime risk of breast cancer. And it also will assess the probability of having a BRCA, a BRCA mutation, which, as we know, dramatically increases someone's risk of developing cancer.

So I always, we encourage these discussions and questions to be asked yearly with either your OBGYN or your internist. And actually, we've gone so far as to make recommendations to ask our general providers to start asking these questions on or around age 30, which is even way before we would consider starting screening mammography, but that's just how important it is because we need to figure out who is high risk and who isn't.

Another website that I also refer people to is brightpink.org. I actually, in the last few days, I got an email saying that they are going to be pivoting a little bit. But for now, they still have this functioning. And this quiz is fantastic because it basically asks all of these same risk factor questions, but in very easy to understand way. And what it will do is it will send you a PDF with your risk and explaining what that means, but the best part about it is it allows you to be proactive and to then know exactly what you need to do next.

So I had a close friend who was getting her mammogram and her risk, we calculate risk when we're reading mammograms. It came back very elevated, and I was like, "This doesn't seem quite right." So I went on and I was chatting with her, her mammogram looked fine, and I was like, "Listen, while you're waiting for your ultrasound, pull up this and just calculate your risk and tell me what you get. So I can see if there's something wrong with the way that we're doing it." And it was absolutely correct, and it was a great resource for her.

So let's say you calculate your risk and you know that you are high risk, what do you do next? So this is all about girl power, take control. So there's been a lot of published data and new recommendations, and this is really a great article that was published. And basically, it recommends for women that are high risk, greater than a 20% lifetime risk of breast cancer, recommends that they undergo yearly mammography along with yearly breast MRI. And that really has the highest sensitivity for detecting breast cancer. And from a physiologic and pathologic perspective, I won't go through all this, but there are so many compelling arguments for why MRI is a good tool.

So just I wanted to drive home, a little bit with a one example from the literature and I have so many more images, but I think that in this case that a picture is worth 1000 words, this really shows it. So this was a woman who had a moderate family history of breast cancer. Her mammogram showed pretty dense breast, which is the image here on the left, and we didn't detect anything, it looks completely normal. She went on to have a breast MRI and arrow marks the spot we see what is a four millimeter, so less than a quarter of an inch, little tiny mass and that was a breast cancer. So this is something that is so treatable, basically, quote, curable. But it really would have been missed with

mammography. I'll take a pause here, because we certainly have another wonderful speaker, but I'm happy to answer any questions.

Briana Schwarz: Thank you so much, Dr. Lampen-Sachar. Thank you. Before we take questions I want to hear from Peggy first, and then we will have an opportunity to open up. We had many questions come in before tonight, so I have a whole list of ones to get through and then I see that some are coming in through the chat. So thank you. Our next presenter is Peggy Cottrell, Sharsheret's genetics program coordinator. Peggy is a graduate of the Sarah Lawrence College Master of Science in Genetic Counseling program, at Sharsheret, Peggy consults with women and families and answers individual questions about their family histories, BRCA mutations and personal risk of hereditary breast and ovarian cancer and contributes to the development and implementation of Sharsheret's hereditary cancer resources and programs. Peggy, the floor is yours. Thank you for joining us this evening. You are muted, Peggy.

Peggy Cottrell: I did that the other day. So I'm sharing my screen, I haven't said anything important yet. But I'm going to talk also, hopefully for just about 10 minutes so we leave plenty of time for questions. So BRCA1 and BRCA2 are two big players in hereditary breast and ovarian cancer, and people who have Ashkenazi Jewish ancestry have a much higher risk to be a carrier of one of these mutations one in 40, whereas the risk in the general population is more like one in 400, so about 10 times higher. And one of the important things to remember is that men are just as likely to carry mutations as women. It's easy for people to forget this, they're thinking about, "What is my risk of breast cancer? I must look on my mother's side." But it's just as important to look at the family history on your father's side to see what's going on there as well. And it sometimes happens, when the family tree predominates in men, that these cancers are more hidden.

So what we're looking for to see if someone should have a genetic test, and here these cancers are not all associated with BRCA1 and 2, because when we're doing genetic testing nowadays, we're usually looking for other things outside of BRCA1 and 2. So we're looking to see if there are cancers like breast, ovarian, prostate, pancreatic, also colon, uterine, melanoma or male breast cancer. And see if these are on either side. And then anyone with at least one Ashkenazi grandparent may also consider doing testing, even though they don't have very much of a family history of cancer.

Now, insurance may not cover in that case, but genetic testing has become much more affordable. And once the testing is done, and here's a really important piece, it's really important to share the results with other people in the family. And sometimes people will say, "Well, yeah, I'll tell my kids. But do I really have to call that cousin who makes me crazy?" You really should call everybody who you can think of who is related to you by blood if you find something inherited, because you could be giving them the information they need to save their lives.

So sometimes a family tree is incomplete. And unfortunately, especially for people with Ashkenazi ancestry, they may have had family members who were murdered during the Holocaust. And so there are a smaller number of family members to look for. Sometimes families are just small, people don't have a lot of siblings, sometimes family members are out of touch. As I mentioned, there may be a preponderance of male family members and paternal inheritance, where it's coming from the side of the family where there aren't as many women. Now, again, reminding you, men are just as likely to be carriers, but they are less likely to get cancer than women with BRCA1 and 2 mutations.

So the reason why we talk about all those other kinds of cancer is that most current testing is done as a panel. And this means that we're looking at a whole bunch of different genes that could all be predisposing to the same types of cancer. And so here we have a little picture, two little pictures. The first one on the right, excuse me, the first on the left is demonstrating that one kind of cancer could be caused by a lot of different gene mutations. And BRCA1 and 2 are right there on the top, but you can see lots of other ones that may be on a panel test, and they could all be contributing to breast cancer risk.

But what we see as well, in the second picture, sometimes there is one gene that can be predisposing to many, many kinds of cancer. And so here, TP53 is a particularly nasty inherited mutation, and it can predispose to dozens of different kinds of cancer, in fact, sometimes even cancer in children. And so it's really important, especially if there are rare cancers in your family, not the ones we've been talking about here, which are pretty common, but very rare cancers, talk to your doctor and ask if it's possible that that could be related to something inherited.

So we've already heard so much good information about breast MRIs, and we heard that individuals who are at high risk may qualify for an annual breast MRI, leading to the identification of cancer at a much earlier stage. For women who are high risk, as they get older, it may be easier to screen with mammography. And also as women get older, they use up some of their risk for cancer. And so it's important if you have a family history of cancer and you've been getting an MRI, to have that risk assessment redone, because sometimes people don't need to have that screening anymore.

The other thing that we haven't talked about yet today is the risk reducing surgery. And so people who have some genetic mutations may qualify to have reducing surgery. And so people who have some genetic mutations may qualify to have a mastectomy before they've even been diagnosed with cancer. And that's one very good way to significantly reduce the risk that you'll get in breast cancer. And breast reconstruction is generally paid for by insurance, even though you haven't been diagnosed with cancer because of the genetic mutation.

And generally, when I have women who are older, who have gotten to be in their late 50s, or early 60s and they are wondering, should they have this kind of

surgery when they have a BRCA1 or 2 mutation? Or should they continue to have the careful screening. And the screening, the older one gets, the more sense it makes to continue with screening, and that's not because people become way less likely to get cancer, but it becomes easier to screen, and people have used up some of that big risk that they had when they were younger, just by making it all the way to their 60s, let's say without being diagnosed with cancer. So all of these are important decisions to make with your healthcare team.

The other prophylactic surgery that some people have is removing the ovaries and tubes, and sometimes a hysterectomy as well. And this procedure continues to be important, even as women get older. And so someone doesn't really outgrow the need to think about having their ovaries and tubes removed, if they've tested positive for a mutation that increases the risk for ovarian cancer. And this is the way we save a lot of lives in this business.

So what about people who've already been diagnosed with cancer? And sometimes I talk to women who are older, and they'll tell me, "Listen, I did, I had breast cancer when I was young, it was a long time ago, and I was treated and everything was fine. And back then, they didn't really recommend genetic testing so I've never had testing done. Do I really need to have testing done?" And so generally, I say it's a good idea. And that's a couple of reasons why the results of the test can be beneficial. First of all, if you test positive, it helps to provide the correct information for the testing of other people in the family. So someone who tests negative knows that they don't carry what seems to be causing the cancer in the family. You may still be at risk for another type of cancer. And what we don't want to see is somebody survive many years after breast cancer diagnosis, then be diagnosed with something like ovarian cancer.

And finally, people who have inherited mutations may be able to be treated for their cancer with a targeted medication. So all good reasons to continue getting a genetic test even as you get older.

Now, if you had genetic testing a long time ago, and the results were negative, you may want to consider an updated test. And that's because over time, the technology that we use to do the testing has changed. So your DNA has not changed, it is still the same. But our ability to find those hidden mutations has improved significantly, and also become much more affordable. And so I'm not going to take a lot of time to talk about what's new in genetic testing. But if your testing is more than 10 years old, and your results are negative, then it might be a good idea to readdress that.

So what about genetic counselors? So this is my profession, I think we do a great job explaining the pros and the cons of testing, we help people understand the correct test for not only that matches their personal risks, but also matches the contracts with the insurance company so that it will be covered. And if you do test positively, we're really good at explaining what it is you need to do to make sure that you live to a ripe, old age.

Finally, I want to just briefly mentioned at home testing, this has been something that's become much more popular in the age of COVID. Genetic counseling can very easily be done remotely because there isn't routinely any physical exam. So if you go on the website of the National Society of Genetic Counselors and use the find a counselor search tool, you can find someone to meet with you in-person or by telehealth. There are also organizations that provide genetic testing online. They do offer genetic counseling and Jscreen and Color are two examples of places where you can find this kind of testing. And then finally, importantly, if you have any questions about your family history, if you're wondering if you should have enhanced screening, if you're wondering if you're a good candidate for a genetic test, don't hesitate to reach out to me at Sharsheret, I'd be happy to speak to you, and address your concerns. And I'll be sharing my personal email address in the chat.

Briana Schwarz: Wow. Thank you, Peggy, so much for sharing all of that information. I want to go jump right into questions, because we have had, like I mentioned at the beginning, we had tons of questions that were submitted when everyone registered. But I'm going to start the first question, I actually got six different versions of this question as soon as Dr. Lampen-Sachar stopped speaking, so I'm going to ask that one first. Can you give us an understanding about the differences in mammography, ultrasound and MRI and when it's appropriate to use each of those screening mechanisms?

Dr. Kate Lampen...: Okay. So there is no substitute for mammography. For better or worse, there is no substitute. Mammography is a very sensitive tool. It does not pick up everything and I did see someone comment that it did not pick up their cancer. We don't pick up everything with mammography. Mammography does work best in patients that have, quote fatty or slightly fibrocystic dense breasts. It does not work quite as well in patients that have heterogeneously dense breasts or extremely dense breasts which is that category that we refer to as the dense breast category.

Regardless, even if you have very dense breasts, mammography does something really vital, it detects micro calcifications. And micro calcifications are little tiny flecks of calcium that deposit in the breast tissue. Has nothing to do with diet, but the reason why we care about micro calcifications is because they can be the earliest sign of breast cancer, stage zero what we refer to as DCIS, ductal carcinoma in situ, which is really... As a doctor, we're not allowed to say 100% curable. But it basically is for the vast majority of people completely curable. So regardless of your breast density, women really do benefit from mammography.

Ultrasound is used frequently as an adjunct tool for those women that have dense breasts, because it does increase our cancer detection yield. And is better for soft tissue differentiation. And the statistic that we typically give is it finds an additional three to five cancers per 1000 women. So that's not that great, but it does find some extra. It has no radiation. So I do like it in women that have dense breasts.

We are not at a place, I would say societally to be offering MRI to absolutely everyone. The test takes a long time, it's very expensive. And we find not just cancer, but we find absolutely everything. So we find the good and the bad. And sometimes it can be challenging to determine what is truly cancer and what will turn out to be a benign result, a non-cancerous result and so we need to do a biopsy. So we do find a lot of cancers with MRI, but it's always a cost benefit analysis, not from a finance perspective, but a cost benefit analysis psychologically, because we do end up doing extra biopsies. And so for that reason, it really is reserved for women where we have a specific question that we need to answer, those that are newly diagnosed with breast cancer and for high risk women.

I also saw one question, just to quickly bring that up, about postmenopausal women and the need for breast MRI if you have a history of cancer. So I went back to that article, the ACR article that I had shown earlier while we were doing this, and their criteria is if you have a personal history of breast cancer, and dense breast tissue or you were diagnosed before age 50, then you should have an MRI. So it's not just having had a history of breast cancer qualifies you for additional screening with MRI, it's also, one of those other factors.

Briana Schwarz: Thank you. Peggy. There was a question in the chat about some of the different direct to consumer testing options that are available. You mentioned them in your remarks, but specifically, the question is about 23andMe and the accuracy of the test. Do you want to comment on any of that for us?

Peggy Cottrell: Yeah. So 23andMe is a great test if you want to find out if you really do have 100% Ashkenazi ancestry, or if you're looking for long lost relatives. But if you're concerned about cancer, it's not the right test to take. And so you really want to make sure you have a medical grade test that's going to sequence, because the 23andMe test can detect a couple of mutations in BRCA1 and 2, but it's going to miss the overwhelming, 99.9% of them. So if your concern is cancer, then have a medical grade test. And the ones I mentioned at Jscreen and Color are medical grade tests, or meet with a genetic counselor, and do it the right way.

Briana Schwarz: Dr. Lampen-Sachar, we have a couple of questions that have come in about women who went through medical menopause or forced menopause. Are the screening recommendations for them different because they are postmenopausal at maybe in their 30s or 40s? Are the screening recommendations different?

Dr. Kate Lampen...: So no, they're not. If it's on or after age 40, we always still recommend yearly mammography, it doesn't matter if menopause started earlier or later. In women less than 40, we then need to do that risk calculation to see, there frequently is a rationale behind forced menopause. And perhaps one of those factors is a contributing factor to breast cancer. So in those patients, in particular, it would be vital to calculate risk, because then we might be offering them MRI as well.

Briana Schwarz: Thank you. We've got a couple of questions in the chat and beforehand about CHEK2. So Peggy, could you maybe touch on CHEK2 and maybe some of the other genetic mutations that are out there that increase cancer risks?

Peggy Cottrell: So CHEK2 as well as ATM and PALB2 are moderate risk genes that increase the risk of breast cancer, a couple of other cancers, but not to quite the same extent as BRCA1 and 2. And so particularly with CHEK2, there can be an increased risk also for colon cancer and for prostate cancer, so CHEK2 can affect men as well. And it's really important with CHEK2, to pay attention to the family history. Cancer doesn't always seem to track with the CHEK2 mutations in the family. So sometimes people who have the mutation don't get the breast cancer and people who don't have it do get breast cancer. So in a family where there's a pattern of cancer and CHEK2 mutations, I'm going to really want everyone to be cautious about their screening, just because it isn't always clear exactly what's going on.

And then finally, there's a founder mutation CHEK2 in Ashkenazi Jewish population, that's not quite as bad as many other CHEK2 mutations. And actually, some labs call it uncertain and some labs call it likely pathogenic. So there are some differences in opinion. So if you have any of these or questions, specific questions about your family and CHEK2, please be in touch.

Briana Schwarz: And Peggy's email is in the chat if anyone has any questions specifically and wants to get in touch with her. Dr. Lampen-Sachar, we had a woman write in earlier, that she is a 74 year old breast cancer survivor, two times, 11 years apart. Her first cancer was premenopausal, and then her second was postmenopausal in different breasts with a lumpectomy in each breast and radiation each time. She's BRCA negative, but her question is she's 74 years old and as she ages and being a breast cancer survivor twice, what would you recommend as far as screening in this aging population of someone who is postmenopausal and has been a breast cancer survivor?

Dr. Kate Lampen...: Definitely yearly mammography. I am sure that her provider orders diagnostic mammograms. I would recommend that. I can just say from, and this perhaps is not data driven, but this is just me speaking with some of my experience here, there's something clearly different about your breasts that make them more likely to get cancer. I think there's a little bit of proof in that. And so perhaps, even though you're 74, you would benefit from MRI.

One thing I can say is that if you were doing a mammogram and MRI, you don't need an ultrasound. We find everything with the MRI that the ultrasound would have seen. Some people just like to get it and that's fine, but it's truly not necessary. So those would be my recommendations, to definitely go back and speak with your doctor, if you're not doing MRIs. And maybe, when you're looking through some of this criteria, it'll become very clear whether or not an MRI is needed.

I just want to throw in one other thing, just as a side note, I truly, and always advocate for people meeting with a genetic counselor before getting tested and to discuss the results. I've seen too many times where the results come back as unknown significance and unknown variant, and then it changes a few years later, and they're then able to say, "No, this is of no clinical significance," or, "yes, it is of clinical significance." And you need someone that is going to watch your results and follow up on them, and who is the latest and greatest in what the current thinking is on that. And separately, if you do unfortunately, come back with a genetic mutation that requires action, there are so many discussions for family members that really the genetic counselors are very nuanced and very educated in their discussions on that. So I really, I never advocate for testing without meeting with a genetic counselor.

Briana Schwarz: And that's why we have Peggy on staff, because we agree with that sentiment. Peggy, this question's for you, a woman wrote in before that unfortunately, her brother just passed away from metastatic breast cancer. He was diagnosed with breast cancer at age 55, she, the woman writing in, was diagnosed with breast cancer last year at age 69. Neither of them tested positive for the BRCA gene mutation. Do you feel there may be a genetic component to the two cancers, and should her children be concerned?

Peggy Cottrell: Yeah. Yeah. I mean, first of all, I would want to be sure that the testing that was done was a panel test that included other genes, because we do see an increased risk for male breast cancer, with CHEK2 and some of the other mutations as well. But secondly, and importantly, we know there are lots of things that predispose to breast cancer that we don't know how to look for yet. And we're beginning to understand them, there are small changes that are relatively common, and by themselves don't make a big difference. But accumulating in large numbers can have an impact. And so it's really important for children who have two parents who had breast cancer, to be very cautious about their screening, and get some advice about whether in fact, based on their full risk if they need to get a breast MRI as part of their screening.

Briana Schwarz: Thank you so much. I think we've gotten through most of the questions that were submitted beforehand. If your question was not answered this evening or if you submitted something in the chat and we didn't get to it tonight, please, the information is in our chat box. We would love for you to follow up with us and we're happy to get you the answers that you are looking for.

As we wrap up our program this evening, I want to thank Mali Schwartz for telling her story so beautifully, and Dr. Kate Lampen-Sachar and Peggy Cottrell for sharing their expertise. Remember that this webinar has been recorded and the transcript and recording will be available on Sharsheret's website in the next couple of days. I know that our panelists answered many questions, and while I'm sure our participants feel more knowledgeable after hearing presentations, please, as I said, reach out to Sharsheret with any specific questions that still needs to be addressed, and we will get back to you.

I would love for you to take a moment, we are putting a evaluation survey into the chat. It is right there, I see it. Thank you, Alyssa. The link to the evaluation is in the chat box. Evaluations really do inform future programming, so please fill it out, thank you. It should only take a minute of your time.

I want to thank tonight's sponsors for the webinar, the Greater Miami Jewish Federation here in South Florida and the Miami Cancer Institute, which is part of Baptist Health South Florida, where our panelist, Dr. Kate Lampen-Sachar is from. I also, I want to thank them for supporting Sharsheret throughout the last year and a half of webinars, they've been tremendous partners to us throughout the years.

I also want to introduce you to tonight's program partners and the work that they do. The first is H3, which stands for Health, Hope, Healing, which originally began as a breast cancer support group to provide a forum to discuss diagnosis and treatment as well as education and information on cancer related health issues. H3 and Sharsheret are partnering on a webinar tomorrow night, and to register for that program, the link is in the chat box. Thank you, Alyssa. My own personal Vanna White.

We also partnered tonight with the Jewish Federation of Orlando whose mission is to nurture a unified Jewish community that transcends generations and neighborhoods. Members of their empty-nesters group are on here this evening. So welcome. We also partnered with NA'AMAT USA, which is a nonprofit volunteer organization, which works with NA'AMAT Israel to provide vital education and social services for women, children and families in need and in Israel. And also, we worked with the Florida region of Women's League of Conservative Judaism, whose mission is to strengthen and unite synagogue women groups, their members and individual members, support them in their mutual efforts to understand and perpetrate conservative Judaism in the home, synagogue and community.

We'd love for you to stay connected with Sharsheret via social media, where we post about events like tonight's program updates and fun ways for you to get involved. So please like us on Instagram and follow us on Facebook, where our Instagram handle is @sharsheretofficial, again in the chat box. Thank you so much. Please remember that Sharsheret is here for you and your loved ones. Sharsheret provides emotional support, mental health counseling and other programs designed to help you navigate through the cancer experience. All our resources are free, completely private and one-on-one. Our number and email address are in the chat box for you to reach out to us. Our social workers and genetic counselor, Peggy are available to everyone. You are our priority, so please feel free to reach out.

Finally, I want to let you know that we have several exciting webinars on a wide range of topics planned over the next few weeks and months. On November 22nd, we have the next installment of Sharsheret in the Kitchen – Lightening Up Holiday Desserts with Paula Shoyer. And if holiday desserts are your thing, our

annual Pies and Prevention Thanksgiving Bake Sale is happening now. So please check our website to find a baker in your area, or let us know if you're interested in baking yourself. Please check our website regularly to see what topics are coming up, and the link for that is in the chat. You also have a link to be able to access recordings and transcripts of all our past webinars on that website, and tonight's, as I mentioned, will be up and running.

I want to thank you so much for joining us this evening. And I'd like to leave you with one thought, as October is wrapping up, it's been Breast Cancer Awareness Month and you have seen pink ribbons and reminders to be aware of our breast health everywhere you go. I hope that you will take those reminders and turn your awareness into action. Schedule your annual screenings, make sure to speak to your family about your health history, schedule an appointment to speak with a genetic counselor and take that awareness, turn it into action and support one another as you're now links in Sharsheret's chain. Thank you so much this evening and I hope to see you all again soon. (Silence).

About Sharsheret

Sharsheret, Hebrew for "chain", is 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

Disclaimer

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health care provider promptly. You should never disregard medical advice or delay in seeking it because of something you have read here.

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