The Girlfriends' Guide to Breast Cancer Screening

National Webinar Transcript

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SHARSHERET®
The Jewish Breast & Ovarian Cancer Community

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Brianna Schwarz: Everyone and welcome. Thank you for joining us today for our Girlfriends Guide to Breast Cancer Screening. I'm Brianna Schwarz, Sharsheret's Florida Regional Director. In the spirit of today's theme of educating our girlfriends, I will be co-leading today's webinar with my colleague and friend, Jenna Fields, the California Regional Director of Sharsheret. Today's program is part of our Sharsheret Summit, an initiative marking Breast Cancer Awareness Month. Over the course of 10 days, Sharsheret is offering a unique array of national programs, campaigns and opportunities.

We're putting a link in the chat to register for the summit programs. Two upcoming highlights include on Wednesday, October 13th at 9:00 PM Eastern, 6:00 PM Pacific, is an Instagram Live, which is "Ask Us Anything: Cancer Genetics Beyond BRCA." On Thursday, October 14th at 1:00 PM Eastern and 10:00 AM Pacific, we have Therapeutic Baking 101, which is a webinar for our Embrace community, and again, the link to that is in the chat. For those of you who may be new to Sharsheret, we help Jewish women and families facing breast and ovarian cancer, as well as those who are at elevated genetic risk through free, confidential, and personalized support and resources.

We also provide health education throughout the country. Before we begin, a few housekeeping items. You were muted as you entered today's program, so please stay on mute so that we can clearly hear today's presenters. As always, this program will be recorded. No faces or names will show on the recording other than those of the presenters, but if you wish to turn your video off for privacy now, you have the option to do that. It is on the bottom left side of your screen. You can also choose to rename yourself, if you prefer to remain anonymous.

You can do that by clicking on the three dots in the top right of your photo square. You will be notified when the recording and transcript of today's program is posted on the Sharsheret website, so please feel free to share those links with anyone who may be interested. I want to thank our wonderful sponsor for today's webinar, [inaudible 00:02:15], and to all of the sponsors for the Sharsheret summit, a slide was on earlier, and will be on at the end of the program.

Just a reminder 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 a health problem. Always seek the advice of your physician or qualified health provider with any questions

you may have regarding a medical condition. Now, I'm going to turn it over to my girlfriend, Jenna Fields, California, Regional Director for Sharsheret. Jenna?

Jenna Fields: Hi everybody. I am so excited to be here with my girlfriends today, and I'm really excited to learn more about screening. I think for all of us, we have different motivations for attending this webinar, whether you have a family member that was diagnosed, maybe you yourself have been diagnosed, or perhaps you have hereditary risk for cancer. We want you to know that wherever you are, Sharsheret is here for you. We have social workers on staff that provide individualized support to guide you through this process, help you figure out questions to ask your doctor, to give you the emotional support you need and handholding, whether you've been diagnosed or you're a caregiver, or you're high risk.

We also have a peer support network that's available where we match women with each other, so you can ask questions and learn from other women who've been through this. We also have a genetic counselor on staff. We're going to be talking just a little bit about genetics today. Our genetic counselor is available to provide more information for you and your family. Of course, we're going to put everything in the chat where you can figure out how to reach out to us if you need to. In the spirit of girlfriends, Brianna and I decided that there was no one better to share her personal story today, than our partner, our Illinois Regional Director for Sharsheret, Eve who's going to tell us a little bit about her journey with cancer screening. Welcome Eve.

Eve Kleinerman: Thank you, Jenna. I am so thrilled to be here and it's great to be together, all of us girlfriends all at once. I'm going to talk a little bit about my own personal background with breast screening. I grew up knowing that my family had a strong cancer history on both sides. My grandmother had breast cancer. My aunt then was diagnosed with breast cancer. It really shouldn't have come as a shock to us when my mother was diagnosed as well. I'm the youngest of four daughters. By the time I came to an age of cancer screening and to make choices for my own health, I had three really good examples with the same genes that I had to follow and decide what to do.

I always would go into my OBGYNs office each year, and I was ready to talk about our family history, talk about breast cancer and prostate cancer, and this is what we need to deal with. I was always met with, "Let's talk about your genetics." I knew about our family's genetics. I didn't really need to start with the conversation there. I really wanted to move forward and talk about when do I get to get my first mammogram? Not that that's an exciting thing for most people, but when you know that this is part of your life, you know this is what's next.

Doctors, to no fault of their own said, "Well, let's talk about genetics first, before we jump into a referral for a mammogram." It took a little bit of time, but eventually we covered the genetics that I already knew, and I was able to see my own breast specialist who was really excited that I had come then. She

was a little bit concerned that I hadn't come a few years earlier, but she said, "This is really the time," and that for people with my family history, it was important to get in. Even if you feel like, when you read that title of the doctor, and you feel like, "That's not for me, I don't have breast cancer," it's to do it before you have breast cancer.

She feels like not enough of her patients are doing that. We came in and we talked about what were those options? By way of my background, I have a sister who had chosen to go the prophylactic surgery route, and so she had had a double mastectomy with reconstruction. I had sisters who had gone the route of doing screenings, some with different types of screening. Each doctor had a slightly different answer. I wasn't sure what was ahead of me. I did know that I was still in that stage of having my babies and I wanted to be able to breastfeed, and I didn't want to start with surgeries then, and so I really wanted to talk about screening options.

She was very, very calming and let me know that the possibilities with screening these days are so amazing. We set up a schedule doing alternating mammograms and breast MRIs, with the option of an occasional ultrasound, if that was necessary. The mammogram started out and that was totally fine. I feel like we talk a lot in breast screening world about mammograms, and almost all of our mothers and grandmothers hopefully have had mammograms, and so you've heard about it, and you can think about it and conceptualize it.

It's when you get to the breast MRI that was a little bit of an odd experience because maybe you've had an MRI of your knee or your back, or something for a different part of your body. The breast MRI, to me, just felt different. You're lying in this weird position on the table and you're trying to stay really still. Of course, my luck was that after my first breast MRI, unfortunately I got that dreaded phone call from a doctor saying, "We need to do some follow-up screening. There's a suspicious mass that we've found."

What I learned later is that oftentimes this does happen with your first breast MRI, because they've never seen your breast in that way, and they're just seeing it all for the first time, especially when you're young and you have dense breasts. It was a terrible two weeks where, to be totally honest, I thought over those two weeks, maybe I should just go the prophylactic surgery route, screening is not for me. But once I got the results that I was totally benign, that I was doing okay, I let the next six months pass without thinking about surgery again. Actually, last month I went for my next breast MRI and I started to have that thought again, like, can I deal with stress? Is this stress worth it?

For right now, it is, but I think that talking to others, hearing from others who are going through that routine of screening, that you're alternating your mammograms and your MRIs, and your ultrasounds, and having others to talk to, whether for me, it's my own sisters, or those that Sharsheret, or, if one doesn't have family members, talking to a peer support at Sharsheret, it's just so helpful to hear that others are going through this experience and you don't have

to decide to go through a surgery yet. You can keep that on the back burner, which is how I feel, and that maybe my decision will change year to year, but for right now, this is where I'm at and I'm comfortable.

But again, it's so important to be prepared and know what you're getting into. That way, you can definitely feel good about your decision, because if you have to go into that MRI or mammogram feeling like maybe you're making the wrong decision, then it might not feel like the right call. I highly recommend talking to others about it, and if you have any concerns, also ask your doctor because I think that the MRIs are so nerve wracking, but definitely the right call for me for right now. I just want to thank you all for being here and for letting me share my story about breast screening. I can't wait to hear from our presenters today.

Jenna Fields: Thank you so much, Eve. I know we turned the tables on you. You're usually the one leading these webinars. Today we got to hear a little bit of your story and I know it definitely sparked questions for me, and I'm excited to learn more from the Boobie Docs. Without further ado, I'm going to introduce our wonderful Boobie Docs, Dr. Robyn Roth and Dr. Adrienne Rosenthal, who are Diagnostic Radiologists at MD Anderson at Cooper University Healthcare. They both received their medical degree from Albert Einstein College of Medicine.

Dr. Roth did her fellowship at University of Pennsylvania. Dr. Rosenthal did hers at Albert Einstein. They are hosts of the podcast, The Boobie Docs: The Girlfriends' Guide to Breast Cancer, Breast Health and Beyond, and bring their expertise to Instagram. If you don't follow them, they're @boobiedocs. Last week they were on the Today Show and now they're here with us. We are so excited to welcome you, and without further ado, the floor is yours.

Dr. Adrienne Ro...: Well, thank you for having us. We're thrilled to be here. Another high being with Sharsheret. Last week, we got to be on the Today Show. It was so much fun. More of just a plug so that women can start annual screening at the age of 40. A lot of women don't know that. That was our mission for our Today Show appearance. We got to check that box and we're thrilled to be here today. Thanks for having us.

Dr. Robyn Roth: We love Sharsheret.

Dr. Adrienne Ro...: We love Sharsheret.

Dr. Robyn Roth: Big fans. Big fans.

Dr. Adrienne Ro...: Big fan girls, and doctors.

Dr. Robyn Roth: All right, we're going to get started because we have a lot of stuff to cover in this lecture, and we were supposed to keep it 30 minutes or less. We're going to talk fast, but if you have questions, I see a chat box. We're going to have some time at the end for everyone to ask questions. A little bit about ourselves. Let

me just make sure this is working. This is me. I am Dr. Robyn Roth, Robyn Gartner, for those who know me from college. I went to college with Brianna. I'm from South Florida. I went to the University of Florida, went to med school in New York with Adrienne at Albert Einstein College of Medicine, that's where we met.

Dr. Adrienne Ro...: That's how it started.

Dr. Robyn Roth: Yup. Like you said, I went to Montefiore in Penn for residency and did my fellowship at Penn. I have three kids that are young, two, four, and six.

Dr. Adrienne Ro...: There I am. What it... yeah, give you my info. I'm from Cherry Hill, New Jersey, which is where we practice now. I went to Barnard undergrad. Robyn and I overlapped at Einstein. I then went to Einstein in Philadelphia for a residency, and then Cornell for breast fellowship. I'm a mom of three boys, five, seven and nine.

Dr. Robyn Roth: Just a quick story for those who don't follow us. We've been best friends since day one of med school. Actually, our third friend is also a Boobie Doc. Her name is Caryn Gamms. She's on your medical advisory board, which is really cool. I think she's the one who put us on your radar. We did intern here. We've been working together at Cooper for several years and every day is a blessing.

Dr. Adrienne Ro...: Yes, but enough about us.

Dr. Robyn Roth: Yeah. We call ourselves the Boobie Docs. My grandma always called it boobies, breast boobies. We started this in 2018 to talk about breast health in an approachable way. We recently launched our podcast, which we're really excited about, and we hope people get lots of good information from there. Check it out every... New episodes every two weeks. The goals of the lecture are really to talk about who gets breast cancer and who's at increased risk, talk about breast cancer screening controversies, of which there are many, illustrate the effect of breast density on screening mammogram, and ways to improve cancer detection. But the real goals are to answer your questions regarding when do you start screening? How often? Do I need an extra screening test, and what happens if I'm newly diagnosed with breast cancer? Who gets breast cancer?

Dr. Adrienne Ro...: One in eight women in the U.S. will develop invasive breast cancer over her lifetime. That translates to 12%. One in 833 in men, so we're dealing with a much smaller number. It's the second most common cancer in the U.S. in women after skin cancer, and breast cancer became the most common cancer globally as of 2021 accounting for 12% of all new annual cases worldwide, according to the World Health Organization. It's the second, most common cancer, death in women, surprisingly after lung.

Dr. Robyn Roth: This year over... it affects a lot of women and then their families, so an estimated 281,000 will be diagnosed with invasive breast cancer. When you're talking about DCIS or in situ early cancer, that's much higher than that also. Another 49,000 of in situ cancer. That's when we would like to catch it, when it hasn't spread beyond the duct. An estimated 43,000 women will die this year from breast cancer. It is a treatable disease if it's caught early, but obviously, that's why early detection is key, but certainly many lives are lost in breast cancer.

When we talk about breast cancer, we always talk about age 40. That's the magic number, but really rates... about 5% of cases do occur in women under age 40. When you choose a screening test, when to start for a screening test, you have to choose the most cost-effective way to save the most lives. It's not like women... 40 is an arbitrary number where the curve starts increasing. Breast cancer becomes more common as you get older, most common in women over 70, but it still remains a leading cause of cancer death in women ages 20 to 59. It's also the most common cancer during pregnancy in the postpartum period, and you look at this line right here is the 40.

These are all the people that are going to be diagnosed before age 40, and that's really the people that... We support the self-breast exam because we think that if you're not being screened, it's really up to you to find changes in your breasts, which is why we really support being aware of how your breasts look and feel. I know women often say, "My breasts are so lumpy." That's normal for you though. If it becomes not lumpy, or there's a lump that feels different than the other lumpy breast, that's when you start to get concerned., and that's what we're really trying to emphasize here,

Dr. Adrienne Ro...: There are so many women in the under 40 category who have been diagnosed with breast cancer, people telling them that they're too young to have breast cancer, and unfortunately, breast cancer doesn't follow that rule as some of the other cancers that we know about.

Dr. Robyn Roth: We have a high Ashkenazi Jewish population in our community, and we see lots of women in their 30s, and even in their 20s, being diagnosed with breast cancer, so it does happen.

Dr. Adrienne Ro...: As you know it's part of your mission-

Dr. Robyn Roth: Yes.

Dr. Adrienne Ro...: ... which we love about you guys.

Dr. Robyn Roth: The two greatest risk factors for developing cancer, or just being female and getting older, you risk doubles, if you have a first degree relative affected with breast cancer, but only 5% to 10% of cases have a known genetic predisposition, which means about 90% don't, most commonly BRCA1 and BRCA2, but 85% of

women diagnosed with breast cancer have no family history. That's important to remember. My cousins ended up being BRCA out of nowhere, had a spontaneous mutation and developed breast cancer in their 30s. We didn't have any known genetic risk. Now we do. Mutations can spontaneously occur, too.

Dr. Adrienne Ro...: Breast cancer demographics, it's most common in whites, closely followed by the blacks community. Black women have higher incidence rates before-

Dr. Robyn Roth: Age 40.

Dr. Adrienne Ro...: ... age 40, so 20% to 40% of higher breast cancer mortality rates. The higher percentage of more aggressive or more aggressive triple negative cancers, and there's less access to mammography and genetic counseling. Delays in diagnosis and treatment negatively affects this and less likely to be diagnosed with stage one VCA, twice as likely to die of early breast cancer, which is pretty dramatic when you break that down.

Dr. Robyn Roth: Yeah. There are certainly racial disparities in breast cancer screening that are very important, not only in screening, in treatment as well. When you're talking about breast cancer risk factors, we really break it down into modifiable and non-modifiable. Things you can't change, being female, getting older genetic causes, family history of breast cancer, usually in a first degree relative, personal history of breast cancer, ethnicity we talked about. Dense breast tissue makes it harder to find breast cancer, but it's also an independent risk factor for developing cancer.

The earlier that you've had periods, like the longer you're having menstrual cycles is a factor. If you've ever had chest wall radiation, if you've had cancer when you were younger, and you had mantle cell lymphoma, about 20 years later... actually eight to 10 years later, you're at risk for developing cancer. Things that are modifiable, so things that people can change, so having children is slightly protective. Oral contraceptives have a slight increase risk, hormone therapy. Breastfeeding has a slight risk reduction. Alcohol, obesity, those all increase your risk for breast cancer.

Who is at risk? Like we said, genetic space increase risk, strong family history in first degree relatives. I'll show you how we calculate your lifetime risk, which you could do online. If you ever had chest wall radiation, personal history of breast cancer and dense breast tissue, those diagnosed with premenopausal breast cancer. If you're diagnosed before age 50, or if you've ever had an atypical biopsy, if you had a biopsy that showed atypical ductal hyperplasia or LCIS.

This is an important recommendation from the Society of Breast Imaging and the American College of Radiology that I want to point out. It says, "All women, especially black women and those of Ashkenazi Jewish descent should be evaluated for breast cancer risk by age 30, to identify the people that may

benefit from early screening or more frequent screening." I don't know how many people are actually doing that. I don't think I've ever been screened before.

Dr. Adrienne Ro...: I was actually screened, coincidentally, because that's when I got my Jewish genetic testing at Einstein for my pregnancies. I believe I got the information that I was BRCA negative at that point, but certainly, I'm not in the main stream of situations with women in their 30s. It is something to be aware of, I think, part of your mission.

Dr. Robyn Roth: Yeah. I think that you could do it online, and I'll show you how. Breast cancer risk assessment, if you plug it into the tool and you're over the 20% to 25% lifetime risk, that's considered high risk. Those are the people that we would say you should see a genetic counselor and they may benefit from supplemental MRI, in addition to the screening mammogram. The American Cancer Society supports three models to predict your lifetime risk of breast cancer. We use Tyrer-Cuzick most commonly, which looks like this. If you go online, you could type in Tyrer-Cuzick Risk Calculator, it's also called the IBIS model, and you could plug this in. If you're over 40 and you know your breast density, they do take that into account. That's a new development.

Dr. Adrienne Ro...: If you don't know your breast density, you can reference your-

Dr. Robyn Roth: Your report.

Dr. Adrienne Ro...: ... mammogram or your mammogram report.

Dr. Robyn Roth: Yeah, but you leave that out if you don't have it. It asks your age, BMI, when you had your first period, how many kids you have, all that stuff. This is a good tool. This is what some genetic counselors might use. This is an important slide. Who should be referred to a genetic counselor? When we start having patients that are diagnosed with premenopausal breast cancer, so before age 50, multiple breast cancers, or a second cancer in the same breast, triple negative cancer before age 60... Ashkenazi Jewish descent tend to have a strong family history of a higher risk of BRCA.

We'll talk about that, and also, strong family history. When you start hearing breast, ovarian, pancreatic, multiple different types of cancers in family members, especially first degree relatives, they would benefit from a genetic counselor. But honestly, I think anyone can benefit from a genetic counselor and they might tell you, "You're not at high risk," and you'll feel better. BRCA and BRCA1, and BRCA2 are the most common because of hereditary breast cancer, but they only make up about...

Hereditary breast cancers only make about 5% to 10% of all breast cancers, but BRCA counts for 25% to 30% of hereditary breast cancers. Here are some other ones, so ATM, PTEN, PALB, TP53, which is Li-Fraumeni. Some genetic things that

you might've heard of, CHEK2. Yeah, and people with BRCA or hereditary breast cancer tend to be diagnosed earlier around age 40 to 45, about 20 years earlier than other people with breast cancer, than a normal person.

Dr. Adrienne Ro...: The BRCA mutation, one in 40 Ashkenazi Jewish people carry a BRCA1, or BRCA2 mutation, both men and women. It's about 10 times higher than the general public. There's increased risk of breast, ovarian, prostate, pancreatic cancer, and melanoma, and black women are more common than white women to carry BRCA, but less than Ashkenazi Jewish, but are less likely to be offered genetic counseling. How is breast cancer detected?

Screening mammography is our gold standard, early detection of breast cancer in asymptomatic women. It's those cancers that are not being felt on the surface of the breasts, but rather in the deeper areas, the smaller cancers, the earlier stage cancers. Mammography was popularized in the 1970, and it has been shown to significantly reduce breast cancer mortality time and time again, with multiple evidence-based studies. The MQ... sorry.

Dr. Robyn Roth: You know what? I had a more updated slide, but MQSA is Mammography Quality and Standard Act of 1992. It basically was made in '92 to make sure that all mammography sensors have the same level of quality. There's lots of physics and testing that is done by the mammography centers, and also for the doctors and technologists, we have to read a certain amount of mammograms every year in order to maintain certification. It actually says that you have to have standardized reports. I wanted to show this because I think that the mammography reports can be very confusing-

Dr. Adrienne Ro...: Yes.

Dr. Robyn Roth: ... if you've ever read it. I highly encourage you to, after hearing this lecture, because it'll make more sense, but at the end of each report...

Dr. Adrienne Ro...: I have to plug this by saying that once you understand the lexicon, mammography becomes surprisingly, shockingly easy to understand. It's like a recipe for a cake. We put in one of four things for breast density, one to four things for our BI-RADS classification, how suspicious... or, no, one in six things, how suspicious we think it is. Our intention now is to break that down so that you can get your report in the mail and understand exactly what it says from the top to the bottom of the report.

Dr. Robyn Roth: Right. They're always going to say, by law, it has to include your breast density, so number one. I feel like people in the past have overlooked that. We know obviously it means more now. We'll talk about that. Also, at the end of each report, there's a BI-RADS category. That stands for Breast Imaging Reporting and Data System. This is what it would look like. Off a screening mammogram, you could only get as zero, one or two. Okay, zero means we need more information.

Unfortunately, if you have an obvious cancer on a screening mammogram, you're there for a screening mammogram, you're going to get a zero. Okay, they're going to say, "We need more information." It's also the same if we need your old films, you're going to get a zero. Off a screening mammogram, you really can't tell how suspicious we are unless you read the report, but most of the time, it's a zero. One means it's negative. One and two mean it's normal. That's what we're hoping for. If it is a zero, that means that we bring you back for a diagnostic mammogram... oh, sorry.

We bring you back for a diagnostic mammogram. We do additional views if we need, we do an ultrasound if we need, we meet with the radiologist, and then we tell you what we think. We tell you either it's probably benign. There's a certain category that falls into that. We're saying it's essentially less than 2% chance of cancer. If it falls into that category, we follow you every six months for two years. We're not just making it up. There are certain instances where it falls into the BI-RADS three category. When it starts to get suspicious, so you get a category four or five, four means it's suspicious, but it's anywhere between 2% and 95%, it's huge.

Dr. Adrienne Ro...: Yeah.

Dr. Robyn Roth: You could have a cyst that's a little complicated, that needs to be aspirated, that's a four, but also a very suspicious mass might be a 4C. Not all masses or biopsy recommendations are created equal.

Dr. Adrienne Ro...: I think it's 25% of the BI-RADS score is cancer.

Dr. Robyn Roth: Yeah.

Dr. Adrienne Ro...: One out of four biopsies that we do end up needing to go to surgery. That's pretty still reassuring. If you get a BI-RADS four category, you're still in a good spot, where it potentially might not end up being cancer.

Dr. Robyn Roth: The category five means it's highly suggestive, meaning if we biopsy it and we get benign, we're going to say, "It needs to come out. I don't buy it. Something's not right here." All right.

Dr. Adrienne Ro...: Then the last category is just if you've been diagnosed with cancer, and we're still using imaging to follow you in some way, shape or form.

Dr. Robyn Roth: Exactly. All right. This is where it gets dicey. When should you start screening mammogram?

Dr. Adrienne Ro...: It's not dicey for us.

Dr. Robyn Roth: No, it's not dicey for us. It should be an easy question, right? But it really depends on who you ask, and it's overwhelming how many different

recommendations are out there. I'm going to break it down by organization, but I'm going to start with this. At 40, every year saves the most lives, okay? Recommendations are out there from other institutions, but all societies agree that 40 every year saves the most lives.

Dr. Adrienne Ro...: You shouldn't be scratching your heads right now.

Dr. Robyn Roth: Okay. American College of Radiology and the American College of Gynecology support at 40 every year. American Cancer Society says 45, with the option to start at 40, and then it also says annually until you're 55, then every two years, but the option to continue screening mammogram every year. Really, they're like choose your own adventure, which one they're...

Dr. Adrienne Ro...: They seem confused. People following their guidelines are probably confused, their patients are probably confused.

Dr. Robyn Roth: U.S. Preventative Taskforce says 50 every two years, and then... all right, so they're all over the place. Then when do you stop? Some of them say 75, which is crazy to me because my mom is 75 and she's a good 75.

Dr. Adrienne Ro...: My grandma is 101 in November.

Dr. Robyn Roth: I mean, if you follow her Instagram, you know that her grandma Leena had breast cancer four times, including a few weeks ago.

Dr. Adrienne Ro...: There are good years after 75, people. We've seen it.

Dr. Robyn Roth: Right. We typically say, continue screening. As long as you're in good health and your life expectancy is going to be a few years, and you're willing to undergo additional testing and biopsies if warranted, or treatment. Treatment doesn't mean you have to get chemotherapy. Her grandma was just diagnosed with breast cancer for the fourth time. She's getting something called cryotherapy, where they just freeze it. There's lots of, non-invasive... minimally invasive ways to treat breast cancer, that doesn't mean you have to have a major surgery.

This is why there's conflicting recommendations. The reason is because the earlier you start, the denser you are and the harder it is... You're going to have more benign things that exist in your breasts, so you're more likely to get called back for something that is not cancer. You're going to have more mammograms over your lifetime and you may warrant a biopsy... you may need to a biopsy to see that it's not cancer, and basically, they cite the anxiety with that whole experience as why women should not get it.

There's a higher recall rate in younger women. We don't have things to compare it to, like Eve said. We're seeing your breast for the first time, so as you come and get established, we know what your breasts look like. The first times are always the hardest, no matter when you start. It may lead to anxiety and

unnecessary biopsies. It says while early screening reduces breast cancer mortality, there are a number of potential harms, including false positive results, so a biopsy that's not cancer, that result in unnecessary biopsies, increase the stress and anxiety related to a possible diagnosis of cancer.

Yeah, I just want to say, this op-ed came out, don't you worry you're pretty little ahead about breast cancer. We don't do this for men. Men, we say prostate exam starting... I don't even know what the recommendations are, but nobody puts their personal opinions into the recommendation of... well, men can't handle it, so I don't think we should be doing the same for women.

Dr. Adrienne Ro...: I can't remember if this was one of my mentors and colleagues, but someone in my past said this. No one ever died from a breast biopsy. Think about it.

Dr. Robyn Roth: Right, and not to minimize a breast biopsy. We do them all the time. I always say the anxiety is the worst part, waiting for the results. There's a possibility you might have cancer. You probably don't, but you don't know where we're at. But then most people get the diagnosis and move on with their lives. If it's benign, we thank God and we move on with our lives. There are a few people that it was really traumatic and I get that, and they might not be the people that would want to do screening every year. It's really about what you value. Would you value finding breast cancer early at the risk of having a biopsy that wasn't cancer, over your 10 year course of extra mammograms?

But what we do know is that annual screening mammography starting at age 40 leads to the greatest reduction in mortality and saves the most lives. We say average risk. If you're high risk, this is different, but average risk women should start at age 40 every year. Higher risk women should start earlier, may benefit from supplemental screening modalities. We usually say age 30 or 10 years before your earliest first degree relative, so if your mom was at 45, you might want to start at 35. If you're high risk, you may benefit from MRI or ultrasound. That's more for average risk. There's also contrast enhanced mammography. We'll talk about it a little bit. We do that here at Cooper.

Dr. Robyn Roth: Yeah. I'll do this. Why age 40? Breast cancer is a big deal for women in their 40s. It happens. Women in their 40s are productive members of society. They're usually working. They usually have young kids. One third of all years of life loss are from women diagnosed in their 40s. If you die at 45, you've lost a big chunk of potential years of life, as opposed to somebody who's diagnosed in their 80s, it's a little different. They might not have as long to live. A woman's life saved in their 40s is a big deal. All of the organizations agree that starting at 40 saves the most lives.

That's what we'll leave you at. What we tell our patients, starting at 40 saves most lives, early detection of breast cancer leaves the better prognosis. It depends on you and your values. Would you be willing to go through a biopsy only to find it wasn't breast cancer, but at the potential of finding breast cancer

in an earlier stage? If the answer is yes, you might want to start at 40 every year. That's what I can say about that.

Dr. Adrienne Ro...: Nice.

Dr. Robyn Roth: Thank you. That's a tough one because we get asked that a lot and there's no easy answer, and it's really a personal opinion.

Dr. Adrienne Ro...: Just to give you a little tour of what our office space looks like, standard mammographic views, when you're in that machine, getting compressed, we're getting two views of each breast, the craniocaudal view, which is from superior to inferior, as Robyn is demonstrating, and then mediolateral oblique. It's at a 45 degree angle, so we can see that pectoralis muscle. Can you please show Dr. Roth-

Dr. Robyn Roth: Here we go.

Dr. Adrienne Ro...: ... the pectoralis muscle? There it is. All right. Very nice. That's our standard mammogram. Digital breast tomosynthesis was approved by the FDA. It minimizes the effect of overlapping breast tissue. It increases cancer detection and it decreases callback rate, particularly those false positives that-

Dr. Robyn Roth: it's still not cancer.

Dr. Adrienne Ro...: ... both you and we hate having to address, so it's most helpful on baseline studies in women with dense breasts. We can double the dose of standard 2D mammography, but lower than the MQSA recommendation of three milligrams. Even though it's an increased dose from 2D, we are entirely comfortable with the dose, and ultimately in the benefit of increasing breast cancer detection at an earlier stage.

Dr. Robyn Roth: A lot of places now are getting rid of the 2D mammogram completely. You get a reconstructed 2D mammogram off a 3D mammogram, and we're feeling more comfortable that that gives us the information that we need. Most people are getting 3D mammograms or digital breast tomosynthesis when they get their mammogram. Screening, I want to break down the difference between screening and diagnostics. Screening, by definition, means you're asymptomatic. You're just picking a woman that's of the age and doing the annual test.

The patients at our institution, they usually come in for the mammogram and leave, and they get the results in the mail within 30 days. It's usually in their chart much quicker than that. If something's abnormal, you'll have to come back, as opposed to a diagnostic mammogram. A diagnostic mammogram, or a study, is when a patient has a breast complaint, certainly a lump, pain, discharge. They usually meet with a doctor and get results that day. We get additional mammogram views, an ultrasound if needed. It's a different type of study. Symptomatic patients usually require a diagnostic mammogram, a

diagnostic examination on a screening examination. Exception would be bilateral diffuse, intermittent in breast pain, which is considered a normal type of breast pain.

If you're under 30, we would usually start with an ultrasound. Also, if you're pregnant, we might start with an ultrasound, but mammograms are fine in pregnancy. We try to avoid them if we can, but if we need to, we definitely do it. What if you have a lump and you're told your imaging is normal? This happens sometimes. There are some cancers that are really not seen well on imaging. Invasive lobular cancer is one of those cancers, or even inflammatory breast cancer may look really bad on a patient, but on imaging, we don't see anything. I always tell people, if there's a lump that's getting bigger, we don't ignore it.

With the mammogram and ultrasound, we would send you to a breast surgeon and they would decide, based on how it feels, they might want to biopsy it based on palpation, or they might want to get an MRI. Just because a mammogram and an ultrasound is normal, doesn't mean you don't have cancer. The rate of cancer with a negative mammogram and ultrasound is under 4%. It's not zero. It's small, but it's not zero. If you have a lump that is growing, that just doesn't feel right to you, I would tell you to go see a breast surgeon and they will decide what to do next.

Dr. Adrienne Ro...: That's also where that self-breast exam comes into play. You just know that it's not right, because you've been feeling your breasts for X many years.

Dr. Robyn Roth: Yeah. This was on the news when I was making this a few years ago, and the foremost breast common breast complaints, so NAPSS. Changes in your nipple, armpit, pain and skin and shape is a good way to remember it. Breast symptoms should not be ignored. About 43% of breast cancers present with some kind of symptom, despite screening. It's more likely to present with a palpable area of concern if you've never had screening, or haven't come in a while. Patients are usually younger that present with lumps, obviously because they might not be in the screening age.

We wanted to touch on this. Again, when you talk about controversial topics, there's lots. Breast imaging, so more about the physical exam. As of 2015, the American Cancer Society no longer recommends the clinical breast exam or self-breast exam for average risk women at any age. That doesn't count for high risk. They cite the number of false positives that women might find something and need a biopsy that is benign, and lack of evidence. But I mean, from our own common sense and knowledge, we know that women find their own cancer.

About 40% of breast cancers are discovered on palpation. Nearly 80% of young white women diagnosed with breast cancer find the abnormality themselves. About 4% of breast cancers are diagnosed before age 40, before the earliest recommendation for average risk women to start screening mammograms. Take home point, just know your breasts, know and be aware of how they look and feel, and be aware of a change. It's common sense, and that's the only way that

we're going to find cancers before age 40, unless you're... People find it by accident often, and they're not even doing a physical exam, but if you're thorough about it, then you'll notice changes. Right.

Dr. Adrienne Ro...: Feel it on the first. We've been very involved with the feel it on the first campaign since we created this Instagram handle. From a technical standpoint, a lot of experts will say to do it on a day seven to 14, after the first day of your last menstrual period, but from a practical standpoint, as busy people who have lives to manage and other lives to manage, feeling it on the first of every month is the most practical way. That's why we endorse that particular campaign, and we've gotten a lot of, I think... It's been a very interesting... This is new for me.

Dr. Robyn Roth: Yeah. We post about it, because it just makes sense. The cancer community really supports it because there's so many young motivated cancer patients are like, "I found my cancer. Thank you for saying that," because I think that they get confused when they hear the American Cancer Society not supporting it. I think they like that when doctors... we know that it helps save lives, so we're just doing what makes sense.

Dr. Adrienne Ro...: It's doable. This is something you can do lying down, do it the same time every month. You can do it in the shower, standing up. Do it the same time every month, just try and hone in on that familiarity of the way your breast feels.

Dr. Robyn Roth: Exactly. So-

Dr. Adrienne Ro...: I want to talk about breast density. I love breast density.

Dr. Robyn Roth: You talk about breast density.

Dr. Adrienne Ro...: Breast density, whenever we assign a breast density, it's the ratio of fatty tissue, which is the gray that you're seeing in this image, to fibro glandular tissue, which is the white that we're seeing in the image. The reason why it's so... and you can see the breakdown. The majority of people fall in the two middle categories. The two denser categories-

Dr. Robyn Roth: 50%.

Dr. Adrienne Ro...: ... are 50%. It's that heterogeneously dense breast tissue, which may obscure small masses, that's our buzz statement, an extremely dense breast tissue, which is 75% to 100% of that white ratio, to only 25%, that very small amount of fatty tissue. That's going to be the hardest for us to... that's a beautiful graphic.

Dr. Robyn Roth: I don't know who's doing that, but I like it. It's Pauline.

Dr. Adrienne Ro...: It's got to be Pauline. Those two ratios of density are particularly challenging for us because breast cancer is white. It's like trying to find a snowflake in a snowstorm. You could see how a white little cancer hanging out in that gray

tissue would be much easier to detect. In fact, you can see. Look. Show that tiny little mass. That's... we love...

Dr. Robyn Roth: That's what we're looking for.

Dr. Adrienne Ro...: That's what we're looking for, and you can see how hard it would be to see something like that in the extremely dense category and the heterogeneously dense category. Like we said, about 50% of women fall into this dense breast tissue category. Unfortunately, it does lower the sensitivity of mammography for independent reasons and also for user error that we know about. Mammography misses every other cancer in women with dense breast tissue. That's-

Dr. Robyn Roth: That's a scary one.

Dr. Adrienne Ro...: Yeah, it is very scary. It's very scary for us to see that.

Dr. Robyn Roth: Yeah. I think we're better than that, but you know what? I think that's radiology dependent, but I mean...

Dr. Adrienne Ro...: But just to give you an idea that we know it's not a perfect science. We know we're missing stuff. It's been shown, so we need to use the other tools that we have in our wheelhouse, the ultrasound, the MRI, to really increase that early cancer detection rate.

Dr. Robyn Roth: It's also an independent risk factor, so having dense breast tissue...

Dr. Adrienne Ro...: You love that point. I love that about you.

Dr. Robyn Roth: I do. It's important because it's in the model.

Dr. Adrienne Ro...: It's good. It's like the more breast tissue you have, the more likely something in that breast tissue is going to develop a cancer.

Dr. Robyn Roth: Yeah. It's not small. It's one to two times increased cancer risk. Is it really that bad or are we just covering our tush? It's a little bit of both, but... It's totally not. Look, so this is a 30 year old that came in with a palpable abnormality in her right breast. We saw it on ultrasound, but before I even did anything, I was like, well, I want to do a contrast mammogram, because I bet there's more stuff in there. She's got bilateral multifocal cancer that you really can't see. I mean, maybe if you're lucky, you would call this, but no, and also this.

This is her same breast. I mean, you can see this one, but there's two on the left that we don't see at all. This just shows you what we're dealing with on the regular. Breast density has become a really hot topic thanks to Dr. Nancy Cappello. She was diagnosed with stage three C breast cancer two months after having a normal mammogram, and she basically uncovered that it was... The

doctors knew about dense breast tissue, but patients weren't being made aware of it. Her advocacy, she started passing legislature to get insurance cover for screening ultrasound, and also having density reporting to the patient, or letters about density, notification letters, which we're going to talk about.

Right now, 37 states, it might even be higher than that, and D.C. require some level of breast notification after a mammogram, but this is important. Not all states, including New Jersey, tell you about your personal breast density. It says you may have dense breast tissue. You don't even know if you do. You have to actually go back to your report-

Dr. Adrienne Ro...: Everyone gets a report.

Dr. Robyn Roth: ... see if you have dense breast tissue. Then if you do, then an ultrasound or MRI might be for you, if you want that extra level of screening. This is actually what the New Jersey mandates that our letter says. Your mammogram may show that you have dense breast tissue as determined by the BI-RADS, da, da, da, da, da. Talk to your doctor about this. We basically tell people, women with dense breast may benefit with ultrasound, MRI. If you're high risk, we usually alternate them every six months.

We'll do a mammogram in January and then an MRI six months later in June. The pros is that it increases sensitivity, if you do it with a mammogram, to 95% to 100%. We're able to find smaller node negative cancers at earlier stages, what we're going for. The cons is it may lead to unnecessary biopsies of benign masses, but usually, like I said, the first one's the hardest. Once we know what your breasts look like, then we know that, oh, that mass has been there. That's just Jenna, and then just ignore it. I talked about this a minute ago, but contrast mammography, not a lot of places have it, but if they do, it's a great test. It combines mammography with IV contrast.

It makes this physiologic component, like MRI. Abnormal tissue will enhance more than background. It has increased sensitivity, but the reason we can't do it on everybody, it's invasive. You have to get an IV injection. You have to get labs if you're over 60, but it's so beautiful. Look at this. This is a mammogram, this is dense tissue, and this is a normal screening mammogram. You could see that she's extremely dense and now she's completely normal. We feel confident about that. If we made this for everybody, we wouldn't have a job, but I wish they would do this for everybody.

We tell patients supplemental screening with ultrasound in the setting of dense breast tissue should be a thoughtful choice after a risk assessment, and weighing the risk and benefits. We encourage women to get more information from their doctors. Okay. Treatment of breast cancer, I'll let you...

Dr. Adrienne Ro...: Okay. We always say breast cancer treatment is not one size fits all. It depends on the stage, the presence or absence of hormone receptors, the three main of

which we look at our ER, estrogen receptors, progesterone receptors, and HER2/NEU protein involved with cell growth. Regardless, it usually includes some combination of surgery, radiation therapy, chemotherapy, and/or hormone therapy, or targeted therapy. Those are the tools that we have. Oftentimes, a lumpectomy will be followed by radiation.

That's considered the breast conservation therapy approach, and that's been shown to be just as effective as mastectomy for patients with only one site of cancer in the breast and tumor under four centimeters. Ultimately, this ends up being a conversation that you have with breast surgeon and he or she breaks down all the different factors that are involved in terms of breasts, your own personal breast size and the ratio of tumor to breast, but it's possible that as an alternative, you may shrink the tumor before surgery with neoadjuvant chemotherapy, if the patient desires breast conservation therapy to hit those ratios.

Dr. Robyn Roth: Yeah. I'm going to plug our episode one. If you ever have to see a breast surgeon, episode one of our podcast, we sit down with the breast surgeon and ask her all the questions that you would ask, if you were newly diagnosed with breast cancer. I think this is a good... we talk a lot about this in that episode. When we talk about staging, we're really trying to get tumors under two centimeters. The point of a screening mammography is to catch it before it's palpable, because once it's palpable, it's pretty big. You're not going to really feel it unless it's...

Dr. Adrienne Ro...: Or superficial.

Dr. Robyn Roth: Or superficial, but usually we're trying to catch tumors before they're two centimeters. That would be a stage one, if it doesn't have lymph node mets. I'm not going to go too much into this, but that's what we're going for. Breast cancer mortality has a great... people don't like this slide because they're like, "Five years? I want to live 20 years," but you got to start somewhere. Stage one, it's like 100%, and stage two, it's up there as well. If you catch it early, there's good prognosis. Even if it's later stage, there's still good prognosis. There's still a lot of life to be lived. In summary, we've gone over who gets breast cancer and who's at increased risk.

We talked about all the screening controversies and then some, talked about the appropriate workup and a difference between screening and diagnostic, and showed the effect of breast density, and talked about ways to improve image screening surveillance. There's no clear consensus on when to start and how often. It really is an individual choice based on what you value. Starting at age 40 every year saves them a lives. Dense breast tissue lowers our ability to detect cancers, and you benefit from supplemental screening. It's also an independent risk factor for breast cancer.

Dr. Adrienne Ro...: She loves that point.

Dr. Robyn Roth: I do. You might want to consider a supplemental screening if you're motivated for early detection. Bunch of references, and then there's more, but just wanted to say thank you so much for this opportunity-

Dr. Adrienne Ro...: Thank you so much.

Dr. Robyn Roth: ... to talk to our people about this important topic.

Jenna Fields: Wow. That was-

Dr. Robyn Roth: Questions, I guess.

Jenna Fields: ... amazing! Yes. Thank you so much, Robyn and Adrienne. We're going to get into some questions.

Dr. Robyn Roth: Somebody asked about invasive lobular cancer. That was the one I talked about that can be hard to detect on screening mammograms. MRI. MRI for invasive lobular.

Dr. Adrienne Ro...: Absolutely. We don't see it... Ultrasound is the worst. Often we don't see it on mammography at all. When we're lucky, we see it on one view, and contrast enhanced mammo.

Dr. Robyn Roth: Yeah, contrast enhanced mammo…

Dr. Adrienne Ro...: If you can't get an MRI, contrast enhanced mammo would be an alternative.

Dr. Robyn Roth: Yeah. Invasive lobular is one of those cancers that it's often in many sites and you can't tell, so MRI is important for staging and for going...

Dr. Robyn Roth: A cyst. Somebody asked about cysts. Benign cysts, she said that it was benign. Oh, well, we know that cysts benign because they meet certain criteria. If they're calling it a cyst, they usually mean that it has...

Dr. Adrienne Ro...: It's five points. We look for five things.

Dr. Robyn Roth: An imperceptible wall. It's round, it's circumscribed, it's got posterior acoustic enhancement.

Dr. Adrienne Ro...: If it hits all those five points, we're 100% confident that it's a cyst.

Dr. Robyn Roth: But they could always aspirate and make sure it goes away, if anyone's concerned.

Dr. Robyn Roth: Should I be tested for genetic testing with a history of cancer in the family? I would see a genetic counselor, honestly. If you have a concern and... because honestly, if you have a first degree relative with breast cancer, especially if it's a

pre-menopausal diagnosed, then you probably meet criteria to meet with a genetic counselor. I think anyone can benefit from meeting with a genetic counselor.

Dr. Adrienne Ro...: Yeah, I agree. Here's that... Okay. Can you discuss breast abscesses and how to prevent them? I don't know how to prevent them. I know how to diagnose them on mammogram and ultrasound.

Dr. Robyn Roth: I know. I mean, it's always...

Dr. Adrienne Ro...: That would be like a breast specialist, like a breast surgeon might have more information on that, so we would refer you to your friendly breast surgeon or your family medicine doctor.

Dr. Robyn Roth: I mean, it's more common in breastfeeding, so obviously making sure your breasts are clean and the baby doesn't bite your nipple, and cause a crack that...

Dr. Robyn Roth: Cracked nipples!

Dr. Adrienne Ro...: Oh, and also pumping when you're not breastfeeding is helpful.

Dr. Robyn Roth: Sherry Rosenberg, that's a great question. What are your thoughts on adding breast MRI when your breast cancer risk is in the intermediate?

Dr. Adrienne Ro...: That's a great question.

Dr. Robyn Roth: That is a great question. There's things called a fast MRI, which some places have where it's not the full MRI.

Dr. Adrienne Ro...: I think Penn offers them, right?

Dr. Robyn Roth: Yeah. That's a good test, and there are places that will offer it... you could pay $200 if you want that-

Dr. Adrienne Ro...: At Penn. I don't think... we don't offer fast MRI here, but there are definitely institutions who... and that sensitivity is like 98%, right? 99%. It's the same. It's pretty wide.

Dr. Robyn Roth: If you're high risk, you mentioned six months MRI and mammogram. Is MRI much more useful than ultrasound? I do believe so. It's a much more... it's sensitive.

Dr. Robyn Roth: Yeah, and you just get a global overview of the breast.

Dr. Adrienne Ro...: The false positive biopsy rate does go up with breast MRI. That's why there would be that conversation, but ultimately, in a high risk patient, we end up

biopsying more benign things anyway, so it's a double-edged sword, if that makes sense. Okay.

Dr. Robyn Roth: Lori asked, does a contrast enhanced mammogram use gadolinium? No, it uses iodinated contrast-

Dr. Adrienne Ro...: What a great question.

Dr. Robyn Roth: ... like a CAT scan, and I would use this instead of an MRI, for people that are claustrophobic or can't get MRIs for certain reasons. I think the contrast mammogram is a great tool for those type of people, and it's an easy test. Our surgeons will send them sometimes just as a quick test. No, thank you. Excellent.

Yeah, check out our podcast, The Girlfriend's Guide to Breast Cancer, Breast Health, and Beyond. It's available wherever you get your podcast, Spotify, Apple Podcast.

Dr. Adrienne Ro...: We just roped in two medical students to help us with a Twitter account, so that's-

Dr. Adrienne Ro...: ... our next platform.

Dr. Robyn Roth: A breast self-exam, there are some... we're going to post a TikTok probably, with a breast self-exam on the 1st, but there are so many good TikTok's out there. Follow Feel It on the First. They give lots of good information.

Dr. Robyn Roth: Yeah. Why do you say that women don't want to start mammos at age 40 because the extra lifetime risk of radiation? It's so minimal.

Dr. Adrienne Ro...: It's not significant. It is not significant.

Dr. Robyn Roth: It's like background. If you're flying cross country, it's similar to that. It is real a different...

Dr. Adrienne Ro...: Yeah, it is something that you should not be concerned about in the least. I say that with 100% confidence.

Dr. Robyn Roth: Yeah. Dawn asked a great question. She said, what's the difference between stage and grade? Stage is different than grade. Grade is something that they look at under a microscope, I believe, and they tell how mitosis per high field unit, or something like that. Really doesn't count as a stage. It might tell you that it's more aggressive, but really, it's different than the stage. A stage is when... is it in the nodes? How big is it? That kind of stuff.

Dr. Adrienne Ro...: It can get confusing because a grade is used for staging, but staging takes a look at the bigger picture. Are the lymph nodes involved? Are there other organs that are involved? That's how you get to your stage.

Dr. Robyn Roth: Screening in men, that's actually a great question and I have to look that up. We don't typically screen men, but we do have some that have genetic predispositions that come in for their annual mammogram. Usually they're followed by a breast specialist. I do think there is a role if they have a known... if they're BRCA, but I'm not exactly... I would like to get... That's a great question. I'm going to get back to you about that.

Dr. Adrienne Ro...: We may even touch base with our geneticist.

Brianna Schwarz: We want to say thank you so much for participating.

Brianna Schwarz: It was an amazing, amazing... lots of information. We were getting messages through the chat. I was getting messages, like texts from people saying how great this was and how informative it was. We're hoping that we can... Anyone who has registered for today, you will receive the recording from today. You'll be able... if you missed something or you were looking to grab one of the slides, you'll be able to see the entire presentation. You'll get an email to you and it will be on Sharsheret's website. We are going to put an evaluation into the chat box. We'll put that in the chat box so that you can evaluate today's program and provide feedback on the content, on the presenters.

Dr. Adrienne Ro...: I was not told there would be an evaluation.

Brianna Schwarz: Technology snafu's aside, I think it's good. We mentioned that this program is part of our first ever Sharsheret Summit to mark Breast Cancer Awareness Month. We have some really amazing innovative and educational programs, and they are all fun. I don't know if anything can top today's program on the fun meter, but I promise you'll have really great content the rest of the week. The link to that schedule is in the chat box as well. I just want to personally thank my friend Robyn and her friend Adrienne for participating in today. Like we said at the beginning of the session, if you are not following the Boobie Docs on Instagram, you should be.

They are giving great information out there. We are really excited at Sharsheret to be able to work with you on this webinar and others. If you had any questions that weren't answered in the chat, please feel free to email them to Sharsheret and we are happy to either pass them along, or we also have a genetic counselor on staff who is able to answer any genetics related questions if you have something else. But our information is in the chat. If you have any questions, feel free to let us know. It's been a pleasure doing our Girlfriend's Guide to Breast Cancer, and Breast Health and Beyond with you guys.

Brianna Schwarz: Thank you so much and thank you to everyone who participated.

Dr. Robyn Roth: Thank you so much.

Dr. Adrienne Ro...: Thanks for having us. We really enjoyed being with you.

Dr. Robyn Roth: Yeah, and also, if you follow us on Instagram, you could always send us a question. We're very accessible. Thank you. Have a good day.

Dr. Adrienne Ro...: Take care.

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

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