Before Their Time: Understanding the Rise in Cancer Among Younger Women

National Webinar Transcript

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Presented by:

About Sharsheret

Sharsheret, Hebrew for “chain”, is an international non-profit organization, that 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 regional offices in the Midwest, Northeast, Southeast, West, and Israel, Sharsheret serves 275,000 women, families, health care professionals, community leaders, and students. 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, approximately 25% of those we serve are not Jewish. All Sharsheret programs serve all women and men.

As a premier organization for psychosocial support, 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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Melissa Rosen:

Thank you so much for being here and welcome to the Sharsheret Summit. I'm Melissa Rosen. I'm the director of training and education at Sharsheret, and I'm so excited that you are here with us this evening for this important program. Thank you to the sponsors of today's program and the annual Sharsheret Summit, Merck, AstraZeneca, Novartis, Pfizer, Lilly, Daiichi-Sankyo, City of Hope, Eisi, GSK, and the Cooperative Agreement 24-0061 of the Centers for Disease Control and Prevention, and thank you to all of our National Summit partners. You were muted as you entered today's program. 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 can do so, and that is on the bottom left of your screen.

You can also choose to rename yourself if you prefer to remain anonymous, and you can do that by clicking the three dots on the top right of your photo square, but instructions on how to do this are in the chat box now. To call in, you can do that as well, and that's in the chat box, too. We now have closed captioning. To display live captions on the bottom bar, click Captions and then Show Captions. You will be notified when the recording and transcript of today's program is posted on the Sharsheret website. Please feel free to share that link with anyone who may be interested. I want to remind you that Sharsheret is a national not-for-profit cancer support and education organization. It does not provide-

Speaker 2:

And then [inaudible 00:02:15]

Melissa Rosen:

Can everybody please mute? And does not provide any medical advice. The information provided by Sharsheret and tonight's speaker is not a substitute for medical advice. You should not use this information, of course, to diagnose or treat a personal health problem. If you have any questions that are specific to you and your medical care, always seek the advice of a physician or qualified healthcare provider. Okay. Tonight's program is part of the 2025 Sharsheret Summit, and I am excited to share more about that summit toward the end of the program, but the focus of tonight's program is Before their Time: Understanding the Rise of Cancer Among Younger Women.

We've all heard the news reports and read the articles, whether it's an academic study or a magazine reporting the diagnosis of a famous young actor, whatever it is, it's hard to ignore the fact that it's no longer a rarity to hear of a young person's diagnosis. Together tonight, we're going to not only explore some theories as to why this may be happening, but also some things we can do to reduce our risk. Before we ask our medical expert to join us, we have a different type of expert with us. Aliza is a Sharsheret caller who has her own experience with breast cancer at a young age. She's agreed to share a bit of her story with us tonight, so we are going to welcome Aliza to the screen. Thank you.

Aliza:

Hi, everyone. My name is Aliza, and I am 33 years old. I am an occupational therapist, wife, and a mom to two daughters, Sara, who's six and a half, and Lily, who is four. Three years ago, in March 2022, when I was 30 years old, I was diagnosed with stage two triple negative breast cancer. My story really starts a few months before that in August 2021 when my younger daughter Lily was three months old, and I felt a small lump under my armpit. I figured it was a swollen lymph node from breastfeeding, which is a common occurrence. I ignored it, and it went away when I stopped nursing. Fast-forward to November when I went for my annual appointment at my doctor where I asked her to do a very thorough breast exam because of what I had felt in the summer. She originally said she would send me for an ultrasound

to see, but after doing the breast exam, she said she really didn't feel anything and didn't think imaging was necessary.

So I went home not thinking about my breast health again until March. I highlight the story to show you how easy it is as a young woman to dismiss health concerns as part of the normal period, pregnancy, postpartum hormones experience. In March, I started having sporadic nipple pain. I didn't think much of it because it wasn't very often or too painful, and I assumed my period was coming or it had something to do with being less than a year postpartum. After about two weeks of this, my old boss who happens to be a breast cancer survivor herself sent out an email to all employees that she was out that day because she was getting something non-cancerous removed from her skin, and she wanted to remind everyone that we had four hours free time to do cancer screenings like a mammogram or colonoscopy, all things that at 30 years old, I wasn't eligible for because I was too young, but I realized that there was something I could do, a self-exam.

So the next morning, I did a self-breath exam and found a lump which felt like a small popcorn kernel. I called my doctor who said it was probably a fibroadenoma, which is a non-cancerous tumor that is somewhat common in young women. He did not dismiss me and told me to find a local imaging office where I could get a mammogram and ultrasound, and for that, I'm extremely grateful. Many friends have told me that their doctors have dismissed them or told them it was nothing and that they were too young, and they did not recommend imaging. And by the time the doctor agreed to look further into it, it was too late. When I went for my mammogram, I wasn't too concerned. I was 30 years old, a young mother with no family history or medical history of any kind. I had never even been to the hospital besides for giving birth.

When I got the results of my biopsy, I was shocked. The next couple of weeks were a whirlwind of doctor's appointments and blood work where I did genetic testing for 16 genes, which all came back negative, established a treatment plan, and very importantly, froze embryos to preserve my fertility. I was so grateful to have my two healthy children, but in my community, most people have at least three children, and that is something we were planning for ourselves as well. Many friends who have done IVF for fertility reasons tried to connect with me about that, but the IVF process was a way station for me to get to the chemotherapy part of my journey, and I felt annoyed that they didn't understand that I was more focused on cancer treatment. I underwent five months of chemotherapy and had a double mastectomy all while being a mom to a three and a half year old and a one-year-old. While everyone around me was getting pregnant again, planning birthday parties for their kids, and packing lunches, I laid in my bed and worried about how scared my young kids would be if they saw my bald head.

I am, thank God, healthy now and back to work and doing regular mom things, but throughout the whole experience, I felt very disconnected from my friends my age moving on in life and their careers while family planning was put on hold and I had to go on leave from my job. I still feel that way sometimes when I'm sitting in book club and people are complaining about trivial things and this huge life-changing thing happened to me. I'm so happy that my family and friends, the people closest to me don't get it, but it makes for a lonely experience sometimes. I've met other young breast cancer survivors, such as my Sharsheret peer supporter along the way who have become my people who understand and relate. I try to make my cancer experience meaningful and post Instagram reminders every month for people to do their self-exams. I'm grateful every day for my health, and I'm so grateful to be here tonight sharing my story so other people won't feel alone. Thank you.

Melissa Rosen:

Aliza, thank you so much for your openness in sharing your story. It's so important for us to hear other stories so that we know we're not alone, right? You said it can be a lonely experience, and just hearing

that somebody has a similar story makes all the difference, so we're very grateful to you. We really appreciate you. Okay. Now, I'm going to welcome Dr. Funmi Olopade. We're so grateful to have her. She's the Walter L. Palmer Distinguished Service Professor of Medicine and Human Genetics and the founding director of the Center for Clinical Cancer Genetics and Global Health at the University of Chicago Medicine. Her research is focused on gaining better understanding of the root causes of cancer in diverse populations. Dr. Olopade is internationally renowned for her expertise in breast cancer, and her research has advanced early detection, treatment, and prevention of breast cancer in women at high risk for the disease. A distinguished scholar and mentor, Dr. Olopade has received numerous honors and awards, including honorary degrees from six universities and a 2005 MacArthur Fellowship, which you may know as the genius grant. We're so grateful to have you. Dr. Olopade, welcome.

Dr. Funmi Olopade:

Thank you very much, and I'm really touched by that story. Thank you so much for your bravery and your boldness in getting us started by sharing your beautiful story. So if I may share my screen, and I hope you can see me on the screen, what I would really like to do is to talk to all of you about not just what I know, but where we're trying to get to, to really make sure no woman has to repeat the story of what you went through because what is important for us is to begin to ask why do we have a rise in breast cancer among younger women and why have we focused on when you get to 50, go and get your mammogram or when you get to 40 because we really can do better than we are doing currently, and I think women like you are teaching us that we can do better.

I have no disclosure, but I do want to thank the companies that have supported this webinar. One of the things that I've done in the last three years is to actually chair the American Cancer Society National Breast Cancer Roundtable, and we just concluded our national meeting last week, and I was there with the American Cancer Society chair and the chief patient officer. The reason why I wanted to share that story with you is because the story of our survival of young women is a story that I have lived with in Chicago for the last, I would say, since 1991 when I joined the faculty at the University of Chicago. Two years ago, I ran the marathon for Sharsheret because young women from the North Shore when I first started would come, and they were the ones that actually taught me how to care for young women with breast cancer and, beyond caring for them, how to think about the future and what's the future going to be, more young women going to be diagnosed or are we going to be able to do something about it?

So let me tell you why. This year, I actually started a preventive oncology clinic, and I kept telling everyone that, "Well, I don't treat breast cancer anymore. Maybe you can talk to one of my colleagues." The reason why I changed my clinic name to preventive oncology is because for decades, the American Cancer Society has kept breast cancer facts and figures. I can also see there's a global cancer observatory where we've been keeping facts and figures. I think last year, what became really annoying and alarming for all of us was when I started my career, we will talk about 178 women getting diagnosed with breast cancer, but fast-forward, we're now talking about, this year, 310,000 women getting diagnosed with breast cancer. Can you hang on a minute? Let me just close this door. Getting diagnosed with breast cancer. And because of that alarming figure, I kept asking myself, "Why is that the case?"

And for those of you who are on, can you see the women who are diagnosed under the age of 40? So 1,360 with DCIS and then 13,000 invasive breast cancer and the deaths, more than 42,000 each year. And so, while we really celebrate the fact that we have more awareness, we cannot really be happy with the state of affairs where we're still having more than 13,000 women diagnosed with breast cancer under 40, and we have no strategy for how women like our speaker would be diagnosed and have a chance to survive breast cancer. So that's why we started really thinking about what else can we do? I can go on and on about why this is happening, but one of the things that you will see on this slide is this is the incidence rate and this is the mortality.

The good news is that because you are diagnosed with cancer doesn't mean you're going to die from it, but anyone who has been diagnosed with breast cancer would have that fear for the rest of their life, and that's what our young survival has shown, right? What else can we do? I've put arrows here to talk about even for black women, there's a declining incidence of breast cancer, but what I think has been alarming for all of us is that there's an increasing mortality in... These are black women. These are Asian women. And so, as we begin to think about what is it that we're diagnosing and what is it that we're treating, we really need to begin to ask about what else can we do.

So this is the trend that we were tracking since 1975. You can see the trend that got us to say, "Let us start screening women over the age of 50." And so, most women will think, "Oh, I'm too young. I don't need to worry about breast cancer." And then, look at the trend in women over the age of 20 and then ages 20 to 49. So on all ages, we have 1% per year increase. Between 20 to 49, we have 1.4% per year increase in the incidence. And then, for older women, of course, 0.7% per year. So even though older women were diagnosing more, we see this increase in incidence, and that's what got us thinking why and what should we be thinking about.

So these are all facts that we are looking at, but I think what is most important is that we now know that breast cancer is not one cancer. So you can see hormone receptor-positive breast cancer and hormone receptor-negative breast cancer. So when we ask you to go and get your mammogram every two years or we ask you to go and get a mammogram every year, it's because we are assuming that everybody's going to get hormone receptor-positive breast cancer that's going to grow slowly. So we started saying, "Well, maybe we don't need to screen every year. Maybe we need to screen every two years." But you can see, the more we screen, the more we got DCIS. You see that rise in incidence? Then, look at hormone receptor-negative breast cancer. It didn't matter, white, Asian, black, Hispanic, you can see just flat. We haven't been able to really make a difference even for white women in the incidence of hormone receptor-negative breast cancer. So that's why we've been really focused on trying to figure out what's going on with hormone receptor-negative breast cancer.

One of the things that's also interesting is if you look at stage at diagnosis from 1998 to 2021, so if you are diagnosed local, regional, distant, and you can see that, yes, local, we can get by going to have mammograms. That's your hormone receptor-positive breast cancer. But all of this, some women, before they know it, they have distant metastasis. They're diagnosed with metastatic breast cancer. So that's really why we ask ourselves, breast cancer is not the same. What is going on with hormone receptor-negative breast cancer and what can we do about hormone receptor-negative breast cancer?

So that's where we then started really talking about, "Okay, what have we done that has made significant difference?" So you can see why everyone thinks, "Oh, October, we've beaten breast cancer," because we had this very high death rate, and then we have a sharp 44% decline because of the treatment. If we just screened and we kept seeing the increasing number, this was going to be the expected incidence trajectory. But by screening and being able to treat effectively, we see this graph that we averted 517,000, almost 520,000 averted deaths because women went to get mammograms, but that's not sufficient, right?

Anyone who's had to be treated for breast cancer, I say, "Well, this incidence was going higher and higher," and you can see for white women, because they tend to get estrogen receptor-positive breast cancer, it started going down. But then, for black women, the incidence is not going down. And then, for other populations, it's just flat. And this is why we started asking, "Well, America is a country of immigrants. What is going on in terms of who is diagnosed with local breast cancer, regional, distant, and then unstaged?" This area is really why we see 24%, 31%. So just with the story you told us, we cannot guarantee that everybody will be diagnosed at an early stage. So this is why we really need to think a little bit differently, and every woman now has to begin to ask, "What is my risk for breast

cancer," because the data are really not encouraging for us that as much as we ask everyone to go and get the mammogram, we still have 310,000 new cases in 2024.

Incidence continues to rise 1% per year even as mortality falls, and steeper incidence increase among younger women, 1.4% per year, than among older women, 0.7 per year. Asian American, Pacific Islander women had the largest increase in both younger, 2.7% per year, and older women. Breast cancer death rates have fallen 44% since 1989, but American Indian, Alaska Native women have experienced no progress. And black-white mortality disparity remains large, 38% higher death rates with 5% lower incidence. So this is really why the American Cancer Society then say, "Well, what can we do to get more women diagnosed at an earlier stage when you have the best chance to be diagnosed?" So this is where we celebrate successes in our treatment, and I'm glad that my young survivor did get chemotherapy, that she is in fact in remission.

The question is why do some people respond to therapy and some don't respond to therapy? What are the different types of breast cancer? Can we do better in knowing the risk factors for all the different types of breast cancer? I'm afraid that's why we all have to focus on advancing more research. All the gains that we have had is why we celebrate that more women are surviving. But this October, it should not be sufficient for us to say more women are surviving. We have to really double down on doing more research in all populations so that we can actually begin to know how to prevent breast cancer. So then, let's talk about what have we learned about risk factors, and I always say the only risk factor for breast cancer is that you're a woman. And now, beyond being a woman, you have to ask yourself, "Am I at risk for triple-negative breast cancer, ER-negative breast cancer, ER-positive breast cancer? What is my risk?"

This is a woman I treated in my neighborhood, 68-year-old white woman. We asked her to go and get mammograms every two years. You can see she got it March 6th, 2003. She went back two years later. This was March 8th, 2005. She was only two days later than usual. How many women actually go every year on the day they're supposed to go? I'm guilty. They've been running after me to come and get my mammogram because I haven't had time to go. And this woman did everything we asked her to do, and still, we didn't have the right drugs, and this woman was one of the most impressive white women I treated. I was like, "It's not about being black or white or Asian." It's about all of us personalizing a risk factor for breast cancer because she wasn't expecting to have this aggressive triple-negative breast cancer at 68.

So that's why right now, when everyone comes in and they are diagnosed with aggressive breast cancer, we are asking everybody to undergo genetic testing. I'm glad that your doctor offered genetic testing for you because now, we know that even for the treatment of every patient now, we have immunotherapy, we have chemotherapy, we have HER2-targeted therapy. Breast cancer is not the same anymore, and that's why it is absolutely important that anyone who is diagnosed with breast cancer, no matter what the stage, that you try to make sure that you have a genomic assay to tell you what type of breast cancer you have and that they target the type of medication that you're going to get because treatment and prompt treatment is so key. I know that even our patient said, "Well, I needed to make decisions," and she made the decision that was right for her. "I'm going to have a double mastectomy."

Some women are going to say, "No, I just want to make sure I have a chance to survive." So we have what we call increased surveillance. So for young women who are diagnosed, we're not going to tell them wait and get a mammogram because we know mammogram would not work well in a 31-year-old, and that's why many of these women, even when they test negative, are choosing to have bilateral mastectomy. But can we do secondary prevention when we do that genetic test? Can that genetic test inform us of what we need to do to prevent a second cancer? And that's really why I have learned so much by taking care of young women in my clinic that now, many of my young women are living to 78

and 80, and they're asking me, "What should I have done when I did that? I took my ovaries out or I knew I had a BRCA mutation, and now, I want to make sure that I never have to deal with breast cancer."

And then, if you identify to have a mutation or genes that increase the risk for your family members, then those family members, those young women now should be coming to think about do they also want to have risk-reducing surgery or do they want to have increased surveillance? And the increased surveillance is the good news that I am really hoping that I can share with you on this platform today because it doesn't even matter what your risk was when you got breast cancer. It matters that at the time that you are diagnosed that we begin to ask, "Why did you get breast cancer beyond being a woman?" The other thing is if a male breast cancer comes in, "Why did they get breast cancer?"

Well, we know that sometimes breast cancer can occur in men because they have a BRCA2 mutation. So every patient should ask, "How and why did I get breast cancer so that I can figure out what to do for prevention going forward?" And this is where we now have lifestyle prevention, we have chemo prevention, things that we can actually use to lower the risk because we started the studies in the '90s, looking for what else can we do to lower the risk for breast cancer, and definitely, if you are at risk for estrogen receptor-positive breast cancer, we have medications that can actually lower your risk. But how about young women? How do we find that 31-year-old before they have cancer? So this is why we, in 2004, actually began to say, "You know what? There are women who need better imaging even at 31."

So risk-stratified breast cancer screening is now a paradigm shift. We have several studies that are ongoing in Canada, in the UK. In the US, we call it the WISDOM Study, Women Informed to Screen Depending On Measures of risk, and WISDOM is wisdomstudy.org. So if you want to ask your friends, your family members who have not had cancer, go and do your WISDOM Study. I did it. So I wanted to know my risk. And it's because there's been slow implementation and dissemination of innovations in genetic testing and imaging science to community practices.

My daughter and I started a company, CancerIQ, because we're like, "I know this at the University of Chicago, but does everybody in the community have access to this?" So that's why now, at this moment where everybody's worried about NIH funding, we were lucky that the National Cancer Institute really wanted us to do what I call the Chicago Alternative Prevention Study. They funded us, and we're hoping to find 1,000 women who are going to be willing to start screening at age 25 while they're having their babies. They know they're high risk, but they're not interested in having bilateral mastectomy. We have a clinical trial for them, and we're hoping that this clinical trial will go nationwide because we don't ever want young women to be afraid of getting tested because they don't want to be worried about having bilateral mastectomy. So that's one study.

And then, the study that I'm really excited about is how we can really learn, use artificial intelligence to individualize risk assessment and advance screening for early detection and maybe pure interception of breast cancer. This is why I said for those of us who are now older, we're just always very excited to work with very brilliant young men. Shubomi was my post-doc who came to me, really having interest in radiology. And then, Anna Woodard is a PhD in physics who developed breast cancer at 29. Both of them came together and said, she said, "I just got my PhD in physics from Purdue University. Why did I get breast cancer at 29?" And from that moment on, both of them came and was like, "We're going to work together. If we can just use a mammogram, and there's a lot of imaging now that is going on and people are putting AI into imaging because we want to be able to do better with risk prediction."

So they published this paper in 2023, and it was amazing because we were able to actually find women who, within the next five years, are going to develop breast cancer. If we can use that and continue to optimize it, so within the next year or within the next five years, you are going to get breast cancer,

wouldn't be nice to then be able to what we call intercept because we know that we can do this? This particular AI model doesn't depend on whether you're black or white or Asian. There's something in the breast as the breast is beginning to change, and that's why we are excited about it because all of us, even with just one mammogram, may be able to find this predictor, so stay engaged.

But for our Chicago Alternative Prevention Study for breast cancer in diverse populations of high-risk women, we are really looking for 1,000 healthy high-risk women. They have BRCA1, BRCA2, PALB2, P53. There are so many genes now that increase your risk, or now, we are doing a polygenic risk score if your lifetime risk is going to be more than 30% and you have not had prior history of breast cancer. Although now, we're also now recruiting. They've allowed us to recruit cancer survivors with intact breast and germline mutation. So if your doctor says, "You know what? I can do lumpectomy radiation, but you need to have MRI screening," we're going to include those women in our study as well.

What we want to do is they're going to come every six months, and you know, MRI doesn't have a risk other than you are going to need to come in. But now, the MRI techniques are faster, so we're looking. This is what we can see when you get an MRI. You can see the cancer taking blood immediately, and then you can see normal tissue that it takes it slowly. So by being able to characterize these parameters, we're hoping that we'll be able to develop a better tool to actually find cancer. So this is the way we're doing it, full diagnostic MRI that's at baseline, and then abbreviated MRI is just being shown that you can do it faster, and you can do it cheaper. And so, we're looking to do it faster, cheaper so that MRI will not be the $7,000 that it is, that it would actually cost us a lot less, so stay tuned because what we're going to learn is that by doing this, we're going to learn what the breast of young women looks like.

So at baseline, you may not see this, but you can see when that slope starts changing, then this is the slope that's saying, "There's something going on here," and this may be signaling to us that if we compare the mammogram one year prior to invasive ductal cancer diagnosis, this was what the breast looked like and then six months prior, and then you can see how this is going. So this is really allowing us to be able to get serial images every six months. We think that by doing this every six months, we're going to learn a lot about the breast of young women, specifically women under the age of 40 who right now are not getting followed.

So let me end, I know that you wanted me to talk about risk factors, and I can tell you that we have not studied enough young women to know the risk factors. We can tell you it's the environment. We can tell you it's because they're black, it's because they're fat, because they're not exercising. But there's so many young women who are fit. Well, we know that alcohol, this is one thing that we know that binge-drinking, and this is, for sure, binge-drinking increases the risk for breast cancer. And so, if we now come and we see our patient who are obese or-

Speaker 2:

[inaudible 00:36:16]

Dr. Funmi Olopade:

... have not been exercising, we try to tell them to really do things that can reduce their risk. So this is why we're talking about physical-

Speaker 2:

You made me miss the part where she said, "The only way you can actually reduce your risk of cancer is to stop binge-drinking."

Dr. Funmi Olopade:

No.

Speaker 2:

I'm sorry.

Melissa Rosen:

Can everybody please mute themselves?

Dr. Funmi Olopade:

No, I said... So let me keep going, so existing prevention interventions. So, we can look at all the things that we know, and what I'm saying is that many of us have not been studied. Number one, a lot of young women have not been studied to know why they will get breast cancer before the age of 70. However, when we have studied breast cancer survivors all over the world, just like tobacco, number one cancer that kills women is actually tobacco. So that's why I am putting all of this together as existing prevention interventions because in the next few years, we're going to be asked to think about what we can do to lower our risk so that it's not about us versus them. It's going to be your personal.

So I saw that my BMI was going higher than when I was 40. So guess what? I ran the marathon, and thank you Sharsheret for encouraging me to run the marathon. I was able to, at least just by increasing my physical activity, lost 15 pounds. I have less fat in my diet, more protein so that I can retain my muscles as I'm getting older. And then, some women do risk reducing mastectomy. So I really encourage us to think about it. And this patient who presented to us said, "You know what? I want to lower my risk," and she had a mastectomy. But we studied tamoxifen or raloxifene. Tamoxifen, now, we don't use 20 milligrams. We actually use five milligrams, and that's available for women who really want to do prevention. And we also have aromatase inhibitor, so we have these medications if you need them, and we can use your risk to determine whether you should take them or not. But when we did the study in 1992, women didn't want to do it.

If you have a high cholesterol, you may be asked to take statin. You may be asked to take aspirin. If we can measure your risk, maybe we can convince you to do something to lower the risk. How about gynae cancers, endometrial cancer, pap smear, HPV? We cannot talk about breast cancer without telling our girls to get the vaccine. But now, even now, nobody wants to take the vaccine. So all of the years of work that we have done to know things that we can do to actually make a difference, we're now having to go back to the community to tell them what we know and what we don't know. So I'm just sharing with you what I know, but I do know that we don't know nearly enough.

That's why at the University of Chicago, we're doing a lots of clinical trials. And of course, women, men, prostate cancer, men with BRCA2 mutation, they cannot wait, and we're actually giving them prostate MRI now, just like we're doing MRI for women, the same thing with colorectal cancer and all these other cancers, both men and women. Lung cancer, in particular, if you've been ever a smoker or a drinker, let us screen you with low dose CT screening and help you to stop smoking. So these are all things that are in the horizon, so advances in science and technology will improve outcomes for all cancer patients across the continuum of care. We're talking about, please participate in cutting edge research. We're looking to get samples from women. We're doing big data science. We're making clinical trials available. We're going to every community to improve clinical trial participation because the cures of tomorrow are going to be in clinical trials today. And then, we are asking everybody, "Please personalize your care. Talk to your doctor. If they cannot explain it to you, find another doctor. But please take it upon yourself to personalize your care."

So a new approach is that age-based, one-size-fits-all doesn't work anymore for breast screening. You may need to be screened earlier. Colon screening, cervical screening, prostate screening, one size doesn't fit all anymore. Age is not a risk factor for cancer. We just need to do better with understanding what we're dealing with. Some may need mammograms. Some may need breast MRIs. Some may want to have surgery. Breast MRIs, colonoscopies, nutrition counseling, low-dose lung CT, at-home colon screening, these are all things that we need to do. And if you are not high risk, your doctor may just say, "Well, maybe you need to continue with every two years or maybe screen every three to five years," but we cannot do one-size-fits-all anymore. That's really what everybody is doing all over the world.

This is a Lancet Breast Cancer Commission, an evidence-based roadmap to address urgent breast cancer challenges. And what they're saying is that we need to communicate with the patient, that we need to put the patient at the center of our communication. We need to be inclusive. Call for all of us to have high-quality cancer care. We need to identify and know that women in some societies are at the bottom of society. So we all need to come together as women to begin to think about what we can do. And prevention is really important, and society should make it easier for women to prevent breast cancer. And more than anything, we need to collaborate because collaboration is going to be key to closing the equity gap through global early diagnosis, treatment framework, and innovative technology. So this is where we are now and personalized.

And really, up until the time when we had this Lancet Breast Cancer Commission, women who were living with metastatic breast cancer, they were not even included in any report. Nobody ever heard of them. Once they went to the surgeon and the surgeon say, "Oh, you have metastatic disease," that was the end of it. We can't have that continue. We all have to continue to work hard at being a community that's not, "I have a mutation. I don't have a mutation. I have ER positive." We need to just take all of us together. So let me say that the American Cancer Society National Breast Cancer Roundtable, our strategic priority areas at the time was that we need to increase risk assessment, risk reduction, and early intervention strategies because we believe it will reduce breast cancer incidence and advanced stage disease. We can treat and cure a lot of breast cancers if we can just give every woman, every man a chance to be diagnosed early, every person to be diagnosed early, access to clinical trials in every community.

Providing all patients access to compassionate, timely, and high-quality breast cancer care will improve patient quality of life and survival and then support and wellness services. This is why Sharsheret is so wonderful, and I'm lucky that I live in Chicago and I've had the ability to work with amazing women. And all this year, I'm going to be dedicating my talk to Shirley Mertz, who lived for 22 years with metastatic breast cancer, and she died July 17th in her home. She died in hospice in the North Shore. And the remarkable thing that this woman taught me was that, "Because I have metastatic breast cancer doesn't mean that I'm not going to live," and she declared October 13th Metastatic Breast Cancer Awareness Day, and she pushed policy to make sure all of us have a chance to survive for 22 years even after metastatic breast cancer. And the reason was that she left her home on the North Shore to come to us to participate in clinical trial.

And then, my Alicia Cook, BRCA1 mutation at age 34, and she survived triple-negative breast cancer, and she thinks it's because she participated in clinical trial. So I thank you all for your patience, and I will take questions.

Melissa Rosen:

Thank you so much. Let me pull. We do have a lot of questions. We're going to get to as many as possible, but it sounds like cancer screening is no longer one-size-fits-all is your message for tonight, and that's a good one. That's definitely a good one for all of us to remember. So a couple of questions that

came in about genomic tests. How do you talk to your patients about genomic tests with regard to risk for recurrence, and how do the results of those genomic tests, excuse me, influence treatment decisions?

Dr. Funmi Olopade:

Yeah, thank you. So one of the things that... You know, I'm a medical oncologist, and my goal for every young woman who comes to me anxious, "I want everything. Just throw everything at me." I would often say to them, "Look, when I started my career in breast cancer, we used to do bone marrow transplant for breast cancer until we actually found Herceptin, and we realized that more was not necessarily better." So that's why now we are at the center of precision medicine. It's not that more is going to be better. Those genomic assays can tell us who needs chemotherapy, who doesn't need chemotherapy, who needs what type of treatment. So after all these years, screening is not one-size-fits-all.

So also, treatment is not one-size-fits-all, so very critical. That's why when patients come to me, I also say, "If you need to have a second opinion, please get that second opinion. I may refer you back to your doctor in your community, but give yourself a chance for that second opinion because it's really key that you get that." It's really one of the reasons why we're all talking about let's make sure that our patients get the ability to access genomic assays.

Melissa Rosen:

Yeah, okay. Thank you. So should those with mutations or strong family history begin their surveillance even younger than current recommendations? What about those without any known risk factors? Should we all be beginning screening younger than the current recommendations?

Dr. Funmi Olopade:

Yeah, so thank you. Great question. Some people know their family history, and based on a lot of work, initially, when I started my work, everyone thought, "Oh, genetic testing is only for Jewish women," and I'm on the south side of Chicago and I'm seeing all these African American, Irish Americans, Italian Americans, everyone from all over, Argentinian, Mexican come to my clinic and they have BRCA1 and BRCA2 mutation. So I've been saying this is not about Ashkenazi women. This is about all women. And the question is, if you're going to be at risk for young-onset breast cancer, the Women Informed to Screen based on Measures of risk, WISDOM Study, so wisdomstudy.org, we've lowered it to age 30. Anyone 30 and above can join the WISDOM Study.

Melissa Rosen:

Do you have to be in Chicago to be part of that?

Dr. Funmi Olopade:

No, it's online. So as I'm speaking now, go to wisdomstudy.org, and we're recruiting 100,000 women. And what we want is for every woman to be able to go and know their risk. When I did my WISDOM Study, it was that my BMI was a little higher than normal, and so I began trying to get my BMI back to where I was at the age of 40. So I think we all can learn about that.

Melissa Rosen:

So one follow-up question and then unfortunately we're almost out of time, but if somebody participates in the WISDOM Study, but they don't live near you to see you as a doctor, can they take those results to your average doctor to have the doctor act on them, whether it's New York or Chicago or LA or somewhere in the middle of Iowa or Oklahoma or Montana?

Dr. Funmi Olopade:

Yeah, that's a great question because the study is actually an online study. And what we want to do is anywhere you are, we can now send a kit to you. Remember, if you want to do colorectal cancer screening, we can send a kit to you at home for genetic testing. You can get on a video, and you can get a kit at home. You can do this in the privacy of your home. The results will come to you. And this is exactly why it's important. I know that people talk about they don't want to go for screening. If you don't want to go for screening early, that's why we don't recommend mammograms until the age of 30, right? And MRI is not mammography. That's why the NCI is really interested in having us study it. We are now in the age where we can even do liquid biopsy, but until we study it, mammogram has saved a lot of lives.

Has it led to overdiagnosis? It has led to overdiagnosis, and that's why if anyone wants to know their risk... Everything we do in life about risk, benefit, so if there's no benefit to it, we're not going to say "Do continue doing it," but certainly, when asking a lot of women, and for our Chicago Alternative Prevention Study, our goal is to pair WISDOM with CAPS. So wherever you are in the world, if you have a high risk based on the WISDOM Study, then we're going to roll you over to our new ultrafast abbreviated MRI protocol because we want 100,000 women to get screened, and we want 2,000 women to help us learn how the breast changes as you get younger. So a personal experience, some of my patients, they will come at 25, and then after having four children, they said, "Well, I'm done having my children now. What do I do?"

Well, they haven't had cancer. They've been able to breastfeed their children. They've been able to exercise. The most important thing that these women are doing is lifestyle interventions, and that's why I'm saying you don't have to do everything, but you can at least know your risk and then do lifestyle intervention, and then let us study what's going on. A lot of young women, when they get breast cancer, it's in the post. They've just had a baby. Like that patient, you didn't know you were going to get breast cancer, and your doctor is going to say, "Oh, you were just lactating. Oh, it's just a boil." And then, you have delays. So we don't want any more delays. We want every 30-year-old to talk to their doctor.

Melissa Rosen:

Amazing, amazing. I wish we had more time to continue this conversation. You have given us so much to think about. I will make sure a link to the WISDOM Study is included in the follow-up email, and you mentioned lifestyle interventions a lot. We have some recordings from past webinars on lifestyle interventions. We'll include that as well. But as we conclude now, I want to begin by thanking Aliza for her generosity in sharing her personal story, and I want to thank again Dr. Olopade for sharing your expertise, your experience, and quite clearly your passion. So thank you for that. Please take a moment to complete a brief evaluation survey. The link just went into the chat box now, and you can click it and still listen to the last two minutes of the webinar. I want to remind you that Sharsheret is here for you in many ways.

As promised, I want to share more about our annual Sharsheret Summit for breast cancer and ovarian cancer awareness months. We have some truly amazing national webinars scheduled and hundreds of local programs across the country. The Sharsheret Summit actually has its own website. Let's post that link in the chat box. On this site, you can check out all the programs, both national and local, register for

webinars, and learn more about our summit partners and sponsors, and that link is going into the chat box now. Among the fantastic opportunities, we have a fascinating webinar scheduled for October 23rd that I wanted to make you all aware of. It's entitled In the Waiting Room: Managing Scanxiety, relevant to anyone with heightened risk or facing cancer. This webinar will also actually have a special breakout room for those managing metastatic or advanced cancer. You can register through the summit website or through the Sharsheret regular website.

And of course, a reminder that our wonderful dedicated team of social workers and genetic counselors are there to help you address your concerns. Please do not hesitate to reach out. It's clinicalstaff@sharsheret.org, and that's going in the chat box now. Thank you all for joining us tonight. We look forward to seeing you at more summit programs. Good night.

Dr. Funmi Olopade:

Thank you. And for those running the Chicago Marathon for Sharsheret, please go for it, and thank you for urging me to do it. All of you donate. Good luck.

Melissa Rosen:

We actually have races across the country at this point, so wherever you are, if you're interested, you can reach out to someone at Sharsheret, and we will connect you to the right person. All right. Have a great night, everyone. Bye-bye.

Dr. Funmi Olopade:

Yeah, bye-bye.