

Straight talk about breast cancer with Drs. Wallace and Blair

By Scott LaFee | October 01, 2013

Worldwide, breast cancer comprises more than one-tenth of all cancers affecting women. In the United States, a woman's chance of developing invasive breast cancer at some point in her life is about 12 percent. The American Cancer Society estimates more than 261,000 new cases of breast cancer will be diagnosed this year; nearly 40,000 American women will die from the disease.

October is National Breast Cancer Awareness Month, marking the 27th anniversary of organized efforts to raise breast cancer awareness through education, information and improved access to screening services. While much progress has been made, challenges and controversies remain. We asked [Anne M. Wallace, MD](#), professor of clinical surgery at UC San Diego's School of Medicine and director of the Comprehensive Breast Health Center at UC San Diego Moores Cancer Center, to discuss the state of breast cancer prevention and treatment and [Sarah Blair, MD](#), a specialist in oncology surgery at Moores Cancer Center, to talk about inflammatory breast cancer, a particularly difficult form of the disease.

Question: There is an on-going debate over how often a woman should get a mammogram to screen for breast cancer. What do you recommend?

Wallace: Three major organizations – the American Cancer Society, the American College of Radiologists and the Society of Surgical Oncology – all still recommend that a woman get a baseline mammogram at age 40 unless she is considered higher risk. Follow-up mammograms should be every year after that.

Q: Recent studies have called into question the effectiveness of mammography, with some suggesting the baseline mammogram shouldn't be done until a woman reaches age 50.

Wallace: Those results were based on statistics, some valid, some arguable. The researcher weighed risk-benefit ratio and concluded that the number of lives saved between 40 and 50 did not justify the aggravation or level of worry that screening mammography and possibly unnecessary biopsies may cause. The researchers did not refute that there is some survival with large numbers of women screened between 40 and 50.

On the other hand, a recent Swedish study showed that starting women on mammography at age 40 rather than 50 was associated with a 26 percent reduction in risk of death from breast cancer. The key point is that every woman should have a balanced discussion with her physician about what is best for her. These conversations should always be happening, even more so now.

Q: Aside from mammography, what can women do to improve breast health?

Wallace: Increasingly, data is showing that higher body fat content is linked to increased breast cancer risk. We suggest that a woman keep her weight right around what it was when she graduated high school. The key is to not progressively gain weight.

Also, a recent study showed a doubling of invasive lobular breast cancer with increased alcohol consumption. As little as one glass per day means a higher risk for breast cancer. But again, each woman should discuss this with her physician to determine what's best for her.

Q: What do you think about preventive mastectomies?

Wallace: Any woman considering a prophylactic mastectomy must have a long discussion with a skilled breast surgeon who is a major part of a larger breast cancer team. This is not a surgery to undertake lightly. Make certain your surgeon does a lot of breast-cancer related surgeries, not just occasionally.

Prophylactic mastectomy can prevent breast cancer. While that is good news, there is still no corresponding change in mortality. A woman should be aware of these differences and discuss seriously their options with a skilled breast cancer surgeon to avoid unnecessary surgery.

Q: What does the future hold for breast cancer treatment?

Wallace: The next decade will be all about biologics. Chemotherapy kills cells, good and bad. What we need is targeted therapy. For example, the drug herceptin dramatically changed mortality rates for women with HER2-positive breast cancer. We need more such targeted treatments. And the PARP inhibitor shows great promise for BRCA-associated cancers and potentially with triple negative breast cancers.

On the surgical side, we are making advances in nipple-sparing mastectomies for some women and our expectations for reconstruction look better and better. But we must remember that surgical therapy varies widely, depending upon the situation. There is no cookie-cutter answer.

Q: Inflammatory breast cancer or IBC is uncommon, but notoriously aggressive. The 5-year survival rate is just 34 percent, according to the National Cancer Institute, compared to rates as high as 87 percent for other forms of invasive breast cancer. What are the symptoms?

Blair: IBC is a rare type of breast cancer (about 2 percent of all breast cancers) in which patients have rapidly growing tumors that show signs in the skin. This type of cancer has a worse

prognosis and is often fatal. The signs are redness and swelling of the skin of the breast, sometimes nipple retraction and often pain and a lump inside the breast.

It is more common in younger women than other types of breast cancer, and can be difficult to distinguish from more common breast infections, which are common in younger women.

Women who have these symptoms should see their doctor and get breast imaging. Often they will be treated with antibiotics for a week or so. If the symptoms resolve, then it's safe to conclude the redness was due to infection. If the redness persists, then a biopsy should be considered.

Q: Is it easier or more difficult to diagnose than other forms of breast cancer?

Blair: IBC can be difficult to diagnose on a mammogram. An ultrasound can be useful in this circumstance to look for an abscess (a walled off collection of pus) to explain the symptoms of redness, mass and pain. If an abscess is not clearly seen, then a needle biopsy of a mass seen on the ultrasound should be considered.

Q: What is standard treatment?

Blair: Once the diagnosis is made, other imaging studies, such as a breast MRI and possibly a CT scan, may be needed to assess the spread of the disease, to see if it is confined to the breast. Treatment usually starts with chemotherapy to shrink the tumor and to decrease the redness and swelling. If the patient responds well, then usually a mastectomy or removal of the whole breast is needed to get rid of all the disease, including the lymph nodes under the arm. Once the patient heals from surgery, radiation is given to treat any microscopic cells in the surrounding skin of the chest.

Q: Compared to other forms of breast cancer, IBC has a poor survival rate. Why is that?

Blair: Unfortunately, IBC is a poorly understood entity. At this point, we do not have any specific markers or genes that tell us whether a particular case of cancer is IBC and requires a particular type of chemotherapy. We do know that historically patients present with a rapidly developing, dramatic form of breast cancer and that over time, it tends to recur quickly despite aggressive treatment.

Q: Why are cases of IBC reportedly becoming more common, while other breast cancers are in decline?

Blair: IBC incidence has slightly increased from two cases per 100,000 (woman-years) to 2.5 cases per 100,000 (woman-years). However, it is known to be more common in African-American women compared to white or other ethnic groups. I do want to stress that this is an extremely rare type of breast cancer that has gotten a lot of publicity lately in the press. There is a lot of

public awareness right now about IBC, which is good, but most women who develop redness of the breast do not have inflammatory breast cancer.

Q: What does current research say about any particular or new targets for future IBC therapies?

Blair: We do know that with aggressive combination treatment of chemotherapy, surgery and radiation, there has been a modest increase in survival in patients with IBC. In the future, once we map the genes associated with IBC, we can come up with specific targets to treat it. At this point, there are more questions than answers.

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