Transcript Details

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Improving Risk Stratification Screening & Evaluation for Breast Cancer

Announcer:
Welcome to *Project Oncology* on ReachMD. On this episode, sponsored by Lilly, we're joined by Dr. Pallav Mehta, who's the Director of Integrative Oncology and Practice Development at the MD Anderson Cancer Center at Cooper University Health Care. He's also the Medical Director and the Chief at the Division of Hematology/Oncology at Holy Redeemer Hospital and Medical Center in Meadowbrook, Pennsylvania. And he's here to give us a fresh look at the updated prevention and risk screening strategies for breast cancer. Let's hear from Dr. Mehta now.

Dr. Mehta:
We at MD Anderson Cooper have, as part of our genetics and high-risk program, a fairly well-developed risk assessment strategy. We see patients based on various parameters, including family history, breast biopsies and whether any abnormal cells were noted on a breast biopsy or if we have patients in our system already whose family members are interested in understanding their own individual risk.

When we see these patients – again, these are women who have not had a diagnosis of breast cancer –we first determine whether or not they are a candidate for germline testing, so genetic testing. The guidelines for genetic testing have evolved a lot over the last few years, so I think it's important as oncologists to understand what the new guidelines are and what the new indications are for genetic testing, because I think what I've seen in colleagues, both near and far, is that we are potentially limiting our ability to test women as far as genetic risk goes. But assuming their genetic testing is fine, or that they do not warrant genetic testing, then we put them in the risk assessment bucket.

So, the two models that we use for risk assessment, as most centers around the country use, are the Gail model, which is the National Cancer Institute's tool, and the IBIS model, which is also known as the Tyrer-Cuzick model. There are advantages and disadvantages to both models. We tend to use the Gail model to look at the potential benefit of chemo prevention with the selective estrogen receptor modulators, tamoxifen and raloxifene, tamoxifen in premenopausals, and raloxifene in postmenopausals. And we use the the IBIS Tyrer-Cuzick model and to some extent, the Gail model to look at lifetime risk, which is what we use to determine whether or not a woman needs high-risk screening or enhanced screening.

Enhanced screening protocols vary throughout institution to institution. What we use, and what many centers use, is alternating annual digital mammography with tomosynthesis every six months with breast MRI. That is probably the most common approach that's utilized for enhanced screening, although ultrasound has also been used. There is an ultrasound modality known as ABUS, Automated Breast Ultrasound, which is a screening whole breast ultrasound, so another potential strategy is to consider mammography alternating every six months with ultrasound. MRI is quite sensitive, but many women and people in general, myself included, have claustrophobia and so MRIs can be difficult, plus MRIs take awhile. Patients are often in that chamber for half an hour or more, so it can be quite uncomfortable for some who may have some back issues or whatnot.

From a standpoint of criteria, we use the the Gail model and IBIS model – lifetime risk of 20% or greater – to justify enhanced screening, and then in terms of chemo prevention, with tamoxifen or Evista, we use the Gail model five-year risk of 1.7%, which is based off the NSABP-P1 and the STAR trial. When you look at those trials more closely, however, what you see is that the majority of benefit actually came from women with a greater than 3% five-year risk. So most of us in the high-risk program here, tend to look at women in the 1.7 to 3% range as borderline. And obviously, there's no one variable that makes the decision for us, so we really take into account all facets of a woman's history. Family history is certainly important, and then of course, a woman's own personal decision around her concerns

around these medications. I think what we've seen over the last decade or so is a lot of misinformation about the potential risks, often overestimating the risks of these medications, which by-and-large we have had for a few decades and we certainly know a lot about. Overall, the risk benefit ratio for women in the right range does favor that they really consider taking these medications for five years. And based on the data, it can reduce their lifetime risk of ever developing breast cancer by almost 50% - it's about 45-47%.

Announcer:
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