Funding for Yale Cancer Answers is provided by Smilow Cancer Hospital. Welcome to Yale Cancer Answers with your host Doctor Anees Chagpar. Yale Cancer Answers features the latest information on cancer care by welcoming oncologists and specialists who are on the forefront of the battle to fight cancer. This week, it's a conversation about why young women develop breast cancer with Doctor Mariya Rozenblit. Dr Rozenblit is an instructor of medicine and medical oncology at the Yale School of Medicine, where Doctor Chagpar is a professor of surgical oncology.

Maryia, before we dive into what I'm sure is going to be a really interesting topic, tell us a little bit more about yourself and what it is you do. I see all types of breast cancer, but my personal interest is in young women who develop breast cancer. So you know, breast cancer is one of these malignancies that is so very common. Can you kind of give us a bit of a landscape of who gets breast cancer?
Do we, generally speaking, see this in younger women, older women? Kind of set the scene for us. Breast cancer typically occurs in women in their 50s and 60s, and in that age group breast cancer is pretty common. It happens in about one out of every eight women. Breast cancer in younger women is what we consider when the woman is diagnosed before the age of 40, and that’s actually pretty rare and happens in about 5% of breast cancers that we see. So you know the obvious question that I am certain every listener is thinking about right now is. How do young women get diagnosed with breast cancer younger than 40? Because I thought we were all supposed to start getting mammograms at the age of 40. So how does that happen? So that’s a great question. So a lot of women that we see self palpates something so they feel something or they notice a change in their breast and they go to their primary care doctor and it gets diagnosed from there.
And then other women have a family history of cancer or perhaps breast cancer in their family and got tested and actually were found to have a genetic mutation and followed with a high risk clinic. And perhaps it was picked up. Through imaging through that clinic, so I want to dive into both of those scenarios independently, so the first is women who self palpate a mass. Now there has been a lot of controversy about self breast exam, whereas other organizations continue to advocate for this. Kind of moved away from self breast exam, whereas other organizations continue to advocate for this. So what’s the answer? Should women be doing a breast exam every month, and if So what should they be looking for and if not? How do these things get picked up? So that’s a great question. I think part of the reason why it’s controversial is because it’s difficult for people who are not medically trained to pick up something when they feel their own breast, and that’s understandable. They haven’t been trained to do so,
0:03:43.15 –> 0:03:45.81 and so I think part of the controversy
0:03:45.81 –> 0:03:48.69 is that we don’t want women to become
0:03:48.69 –> 0:03:51.159 super anxious and to worry about this
0:03:51.159 –> 0:03:53.639 and to constantly be checking for it.
0:03:53.64 –> 0:03:55.788 On the other hand.
0:03:55.79 –> 0:03:56.97 At least in my clinic,
0:03:56.97 –> 0:03:58.74 I’ve definitely seen some women
0:03:58.74 –> 0:04:00.85 who found it on their own,
0:04:00.85 –> 0:04:02.025 and then that’s what prompted
0:04:02.025 –> 0:04:03.61 them to go to the doctor.
0:04:03.61 –> 0:04:05.969 So I think in an ideal world,
0:04:05.97 –> 0:04:08.35 if somebody is going to see their,
0:04:08.35 –> 0:04:10.065 whether it’s their primary or
0:04:10.065 –> 0:04:12.689 their OB GYN on a regular basis
0:04:12.689 –> 0:04:14.769 and getting a physical exam
0:04:14.769 –> 0:04:17.407 through them at least once a year,
0:04:17.41 –> 0:04:19.06 that’s usually sufficient and they
0:04:19.06 –> 0:04:21.289 don’t have to do their own exam.
0:04:21.29 –> 0:04:22.886 But if they know that they
0:04:22.886 –> 0:04:23.95 have a family history,
0:04:23.95 –> 0:04:26.263 or if they know that they have a genetic.
0:04:26.27 –> 0:04:26.585 Mutation.
0:04:26.585 –> 0:04:28.79 I think it’s OK for them to
0:04:28.79 –> 0:04:31.006 do it on their own just to
0:04:31.006 –> 0:04:33.1 keep an extra eye on things.
0:04:33.1 –> 0:04:35.249 And if they ever find anything worrisome,
0:04:35.25 –> 0:04:37.063 they can always point it out to
0:04:37.063 –> 0:04:38.6 their primary or their OB GYN.
0:04:39.57 –> 0:04:43.362 OK, so at what age should women start
0:04:43.362 –> 0:04:46.339 either doing self breast exams if
0:04:46.339 –> 0:04:49.851 they’ve got a high risk family history
or seeing their family physician or OB GYN for a clinical breast exam? Should that start at 18 or later, how does that work? So early breast cancer is still very rare, so the recommendation for the majority of women remains the same, which is probably around the age of 40. You can start to do these self exams and that’s around the time when most women would start doing mammograms as well. Unless of course you know have a known genetic mutation and then you would follow what the high risk clinic is telling you and based on what genetic mutation you have, you might want to start screening earlier. So let’s talk a little bit about genetic mutations. Then you mentioned having a family history. Now family histories can vary right? So some people might have a mother who was diagnosed at the age of 75. Others might have aunts or cousins who were diagnosed earlier. What counts is a significant family history. When should women start worrying about that and start asking about genetic testing? Sure, that’s a great question, so we have a whole set of guidelines that actually defines what is a higher
risk family history and they’re a little bit complicated, but in general, what we consider high risk is if you have a first degree relative with breast cancer, and we know that that puts somebody at twice as high of a risk as the general population of getting breast cancer. So even if it’s not a first degree relative, but if you have multiple family members with cancer and sometimes it depends on what type of cancer some cancers are more closely associated together than others, so I would say if there’s a first degree relative or if there are multiple family members, or if there’s a family member who was diagnosed at an early age. So like we were talking about earlier than 40, that’s a reason to just maybe check in with a primary care doctor and seeing if you would be eligible to see a genetic counselor to talk about that a little bit more. And So what age should you be thinking about genetic testing? I know that some people you know, they know their family history.
or not and maybe they have young
children Pediatrics populations.
Should those people be getting tested?
Should they be getting their kids tested?
At what age should people
pursue genetic testing?
That’s a great question, so in general,
most of our screenings start around
the 20s for this very high penetrance.
Genetic mutations that
we worry about the most.
Nothing really starts earlier than that,
so we usually if somebody tests positive,
the genetic counselors are really great
about counseling them about who needs to
get tested in the family and at what age.
But in general, when it comes to kids.
They don’t have to get tested
until they’re in their 20s and
and that’s really beneficial.
And you know several different factors.
First, they’re old enough to to
take the benefits and the risks
into account on their own and
make that decision on their own,
and then they don’t have to worry about it.
While they can’t do anything about it,
so it’s better to get tested a little bit
closer to when actual you can actually
put a treatment plan into effect.
If it comes back positive.
0:08:44.97 –> 0:08:47.53 So I would say in your mid 20s or late
0:08:47.6 –> 0:08:49.854 20s you can kind of start thinking
0:08:49.854 –> 0:08:51.976 about it and if you’re eligible,
0:08:51.976 –> 0:08:54.613 talk to a genetic counselor and they
0:08:54.613 –> 0:08:57.405 really do a good job of going through
0:08:57.405 –> 0:08:59.526 extensive family history of many
0:08:59.526 –> 0:09:02.435 generations and kind of giving you a
0:09:02.435 –> 0:09:04.736 good risk assessment of what genetic
0:09:04.736 –> 0:09:06.704 tests you might be eligible for.
0:09:07.87 –> 0:09:10.88 Surly obvious question then is.
0:09:10.88 –> 0:09:13.31 Can people under the age of
0:09:13.31 –> 0:09:15.64 mid 20s get breast cancer?
0:09:17.12 –> 0:09:20.825 So we really have not seen that there
0:09:20.825 –> 0:09:24.515 are other types of mutations that.
0:09:24.52 –> 0:09:26.225 Have other types of cancers
0:09:26.225 –> 0:09:28.363 associated with them, and some of
0:09:28.363 –> 0:09:30.589 them are more of childhood cancers,
0:09:30.59 –> 0:09:33.37 so some things like P53.
0:09:33.37 –> 0:09:35.402 You know that’s a gene that can cause
0:09:35.402 –> 0:09:37.08 many types of different cancers,
0:09:37.08 –> 0:09:38.488 and that’s something that
0:09:38.488 –> 0:09:39.544 can affect children.
0:09:39.55 –> 0:09:41.692 But in general,
0:09:41.692 –> 0:09:44.289 unless you have that kind of you
0:09:44.289 –> 0:09:47.085 know what we refer to as a syndrome.
0:09:47.09 –> 0:09:48.614 Usually we don’t see breast cancer
0:09:48.614 –> 0:09:50.24 in such a young population.
0:09:50.89 –> 0:09:53.734 OK, but I think that the
0:09:53.734 –> 0:09:56.19 caveat to that you had.
0:09:56.19 –> 0:09:59.01 Alluded to earlier.
0:09:59.01 –> 10:00.381 Still applies, right?
So if you are 21 and you see something that is unusual for you different, causing concern, you should still say something. Is that right? Yeah, absolutely. I think it never hurts to just get it checked out by a medical professional and sometimes it can be reassuring and sometimes you might just need some extra imaging to take a closer look.

OK, great so you know when we talk about breast cancer in younger populations. So under the age of 40 is rare. So 5% are these cancers different from what we see in the older population? Yeah, so in general these breast cancers tend to be a little bit more aggressive. And So what we mean by that is they tend to grow a little bit faster. By the time these women come to us, they’re usually a bigger size than something that would be you know. Picked up on a screening mammogram, yeah, and and so you had mentioned earlier when we were talking about genetic testing that one of the things that would prompt genetic testing is having a family member who was diagnosed at a young age.
So is that something that you recommend?

For all patients who get breast cancer at a young age is to get genetic testing. Or does that really rely on their family history so all women who are diagnosed with breast cancer before the age of 40 are eligible for genetic testing and we do refer them? It can be very helpful, like if they come back with a positive mutation. Sometimes that can change. What kind of surgery they might opt for and then as you mentioned, it’s very helpful for their family members. To know as well.

So many of us have heard that breast cancer when diagnosed at an early age tends to be more aggressive as you mentioned. Do we know why that is in younger patients? So we don’t quite know why that is and there’s a lot of research being done about it. We think that on some level it probably has to do with the hormone levels. The estrogen levels are much higher in young women, so that might prompt more growth, but we also see a lot of what we call triple negative breast cancers in these young women that
are not driven by hormone levels, so it’s a little bit unclear. We do know that about 20 to 30% of these young women do end up testing positive for genetic mutations, and so perhaps those mutations are contributing to their cancer being more aggressive as well.

Terrific, well, we’re going to take a short break for a medical minute, but on the other side of the break, I hoped to find out more about how treatment algorithms might be different in younger women diagnosed with breast cancer.

So please stay tuned to learn more with my guest Doctor Mariya Rozenblit.

Funding for Yale Cancer Answers comes from Smilow Cancer Hospital, where a wide spectrum of advanced strategies for the diagnosis and treatment of gynecological cancers are offered. To learn more, visit yalecancercenter.org.

The American Cancer Society estimates that more than 65,000 Americans will be diagnosed with head and neck cancer this year, making up about 4% of all cancers diagnosed when detected. Early, however, had a neck, cancers are easily treated.
Clinical trials are currently underway at federally designated Comprehensive cancer centers such as Yale Cancer Center and at Smilow Cancer Hospital to test innovative new treatments for head and neck cancers. Yale Cancer Center was recently awarded grants from the National Institutes of Health to fund the Yale Head and neck Cancer Specialized program of Research Excellence or SPORE to address critical barriers to treatment of head and neck squamous cell carcinoma due to resistance to immune DNA damaging and targeted therapy. More information is available at yalecancercenter.org. You’re listening to Connecticut Public Radio. Welcome back to Yale Cancer Answers. This is doctor Anees Chagpar and I’m joined tonight by my guest Doctor Mariya Rozenblit. We’re learning today about why younger women develop breast cancer and how that might vary from older women. So right before the break, Mariya, you were telling us that most breast cancers are actually diagnosed in what we’ll call older women, but older, so 50s.
0:15:06.986 –> 0:15:10.297 60s in that range and what you’re
0:15:10.297 –> 0:15:13.529 really interested in is women who
0:15:13.529 –> 0:15:16.879 are diagnosed under the age of 40.
0:15:16.88 –> 0:15:20.975 So you had mentioned that these cancers
0:15:20.975 –> 0:15:24.199 sometimes present at a larger size.
0:15:24.2 –> 0:15:27.656 They tend to be a little bit more aggressive,
0:15:27.66 –> 0:15:31.316 and we’re not really sure why that happens,
0:15:31.32 –> 0:15:34.632 but tell us a little bit more about how
0:15:34.632 –> 0:15:38.258 the treatment of younger women might vary
0:15:38.26 –> 0:15:41.494 from how treatment is for older women.
0:15:42.71 –> 0:15:44.862 Sure, so sometimes because
0:15:44.862 –> 0:15:47.552 these women are presenting with
0:15:47.552 –> 0:15:50.606 a larger tumor to begin with,
0:15:50.61 –> 0:15:54.761 they may require chemotherapy along with some
0:15:54.761 –> 0:15:58.149 targeted treatments that we have available.
0:15:58.15 –> 0:16:02.084 And then if the tumors hormone positive,
0:16:02.09 –> 0:16:05.3 that really affects their fertility,
0:16:05.3 –> 0:16:07.64 we often have to give medications
0:16:07.64 –> 0:16:09.727 that induce menopause early for
0:16:09.727 –> 0:16:11.567 hormone positive breast cancers.
0:16:11.57 –> 0:16:13.786 And so we always talk to them about.
0:16:13.79 –> 0:16:15.61 What are their childbearing plans
0:16:15.61 –> 0:16:18.998 and if they would like to see a
0:16:18.998 –> 0:16:20.941 fertility specialist to talk about
0:16:20.941 –> 0:16:22.132 possible fertility preservation
0:16:22.132 –> 0:16:24.4 options before they start treatments.
0:16:24.91 –> 0:16:27.494 So let’s let’s pick up on that before
0:16:27.494 –> 0:16:30.102 we go much further because I think
0:16:30.102 –> 0:16:32.89 that this is a really interesting
0:16:32.89 –> 0:16:35.248 topic and many young women might
0:16:35.248 –> 0:16:37.669 actually be very scared about this.
So you know you’re in your mid 20s or 30s and you’ve just been diagnosed with breast cancer. You were thinking about starting a family. And now you need to get chemotherapy, which will you know, put you at amenorrheic so you’ll stop having your cycles if you’re hormone receptor positive, you might be given something that’ll put you into menopause. Many women might have the question as to whether they can have children and be whether that’s safe, for young women, this becomes a complicated discussion, because if they were planning to start a family, this does delay that, and so we do want them to be on treatments that decrease their estrogen levels and make them amenorrheic for at least a certain amount of time to treat their breast cancer. But after they’re done with treatment, most women, especially if they’re young and in their 20s, Regain their fertility and will actually probably be able to have children on their own, UM, but it’s always nice to talk
about the fertility preservation options and to have you know eggs or embryos stored as an option. And as women get closer to their late 30s or 40s, there is a possibility that they may not regain those estrogen levels, and so it’s good to have those eggs and embryos stored. But in terms of safety, we do have data showing that it is safe to have children, and so after a certain amount of time being treated for breast cancer, we have had women have a healthy pregnancy and have healthy children and it is safe from our standpoint and from the OB GYN standpoint. So having children after a breast cancer diagnosis doesn’t increase your risk of recurrence. Is that right? As far as we know it does not increase the risk of recurrence. What we do worry about? As if. So there’s a certain amount of time after the breast cancer. For example, in the first one to two years where we want to make sure that those estrogen levels are still low. So if somebody wants to have children earlier than that,
we worry about that. But if they completed,
you know that treatment time, then as far as we know it,
then it’s safe to do so. So tell us a little bit more
about fertility options.
People who have gone through IVF,
which is a similar kind of. Process one would think are often
injected with hormones like estrogen, and yet we know that estrogen
for many cancers is a stimulant for that breast cancer.
I mean, what are our fertility preservation options and?
Are they associated with being stimulated with hormones,
and what effect does that have on breast cancer?
So because somebody has already
developed the breast cancer,
we don’t think that being stimulated to increase those estrogen levels for egg or embryo retrieval is that dangerous.
It’s a very short amount of time, and we’re going to treat them
for the breast cancer anyway, so we do think it’s safe. To go through these options and
It’s especially important for women and will affect their childbearing options for many years to come. So we think it’s really important and is that covered by insurance, or is that something that women have to pay for out of pocket?

So when it’s related to a cancer diagnosis, it is usually covered by insurance and so the idea here is that you need to know, kind of. Think about that and harvest those ovaries and those embryos before you start treatment. Because, if you’ve gone through chemotherapy, you may not be able to generate those eggs or embryos on your own, so let’s talk a little bit more about other treatment issues that are pertinent, particularly for young women. One is the chemotherapy that you mentioned that many women present to at a younger age, especially with more advanced cancers, need to go through chemotherapy. Is the type of chemotherapy different than for older women? I mean, are you treating them with different drugs, and if so, tell us a little bit more about that.
0:21:27.46 -> 0:21:30.382 So the drugs themselves are pretty
0:21:30.382 -> 0:21:32.83 standard and usually the same.
0:21:32.83 -> 0:21:36.628 It really depends on the size of the tumor.
0:21:36.63 -> 0:21:38.67 If we think that there are
0:21:38.67 -> 0:21:40.76 lymph nodes that are involved,
0:21:40.76 -> 0:21:43.568 really the stage of the tumor drives
0:21:43.568 -> 0:21:45.716 the decision regarding what type of
0:21:45.716 -> 0:21:47.568 chemotherapy to use regarding whether
0:21:47.568 -> 0:21:50.074 we’re going to use a more aggressive
0:21:50.074 -> 0:21:52.169 regimen or a less aggressive regimen.
0:21:53.52 -> 0:21:56.37 And because many of these women,
0:21:56.37 -> 0:22:00.228 as you mentioned, undergo genetic testing,
0:22:00.23 -> 0:22:02.134 are there some chemotherapeutic
0:22:02.134 -> 0:22:04.99 regimens that are geared towards
0:22:05.066 -> 0:22:07.936 particular mutation carriers than others?
0:22:09.23 -> 0:22:12.05 So now it’s very exciting.
0:22:12.05 -> 0:22:14.482 Not prior to surgery,
0:22:16.31 -> 0:22:18.82 There are now a specific
0:22:18.82 -> 0:22:19.824 treatments available.
0:22:19.83 -> 0:22:21.207 So for example,
0:22:21.207 -> 0:22:23.502 if somebody has a BRCA mutation
0:22:23.502 -> 0:22:25.929 or a PALB 2 mutation,
0:22:25.93 -> 0:22:27.69 we now have something
0:22:27.69 -> 0:22:29.45 called a PARP inhibitor,
0:22:29.45 -> 0:22:31.62 which is a pill and we’re able
0:22:31.62 -> 0:22:33.959 to use that if prior treatments
0:22:33.959 -> 0:22:36.174 have not been effective for
0:22:36.174 -> 0:22:37.88 this patient population
0:22:38.17 -> 0:22:40.828 and so that. Is only available
0:22:40.828 -> 0:22:44 after surgery, is that right?
So let’s talk a little bit then about surgeries you had mentioned earlier before the break that you know many of these women may make different decisions about their surgery than older women. Talk to us a little bit more about that. So it really depends on if they have a positive mutation and some mutations. For example Baraka, we know that those increase the risk of getting a recurrence and so by that we mean a breast cancer that comes back in the same breast or in the other breast, and so for that, if the woman has abraka mutation, it is recommended to get a mastectomy and bilateral mastectomy. To decrease the risk of the breast cancer coming back in the other breast as well. OK, and so one of the questions that I know many patients ask is if I have a bilateral mastectomy, Do I still need chemo? Yeah, and that’s a great question, so you know the different treatments kind of affect different parts of breast cancer risk. So the surgery like we talked about decreases the risk of the cancer coming back in the breast specifically.
is the cancer going to come back in other parts of the body. So sometimes breast cancer can come back in the bones or the liver or other organs. And if that happens it’s considered metastatic and at that point we can’t. Cure it so we really want to make sure that we’re preventing our occurrence of metastatic breast cancer, and chemotherapy helps to do that because if there is any kind of microscopic cell that might have escaped from the tumor and gone to the bloodstream, chemotherapy is a treatment that can treat that because it goes everywhere. Great, and so you know. I think it’s important for young women to understand that even if you’re going to decide to have mastectomy, reconstruction is always an option for you as well. If young women wanted to keep their breasts, could they do that, and if so, how do you continue to screen for their breasts, knowing that they may be at increased risk of developing breast cancer? In the same breast or in the other breast? Yeah, absolutely. So it’s always you know the choice of the women on what kind of surgery to do and if
they choose to keep their breast up. We do have breast MRI’s that are available and they’re a little bit more sensitive than mammograms and ultrasounds. And we usually alternate doing those with mammograms.

So every six months they can get a type of imaging to keep a closer eye on them. You know the other. The other question that comes up, I think in young women and especially in those who may have a genetic mutation, is that genetic mutations like BRCA one and two palb 2 and a number of the other ones not just increase your risk of breast cancer but may increase your risk of other cancers as well. In the main, when we talk about BRCA, we talk about ovarian cancer and so do you recommend that these women also have their ovaries removed and if so, should that be done after they’ve finished having children? Or is that something that would prevent them from having children? Yeah, so it’s a complicated question and we know that for BRCA, whether it’s one or two, you know there’s a different risk in terms of how high the risk is for ovarian cancer.
So it depends a little bit on what type, and we know that for PAL B2 there is a slightly higher risk of ovarian cancer, but we don’t quite know if they necessarily have to get their ovaries out so it really is our risk and benefit discussion that they have benefit discussion that they have with us as well as with the OB GYN. Doctor and and it also depends on where they are in childbearing age, so it is OK to hold off on that surgery until they’re done having children. And we know that even though the risk is higher, the risk for ovarian cancer really becomes highest in their late 30s, early 40s. So if they really do want to have children, it’s OK to hold off on that surgery, and I think the other thing always is with younger women, as with older women as well, but. You know these are women who are getting breast cancer in the primes of their lives. So they may be on a professional track, they may be at the height of their career. They may already have young children. What kinds of things do you recommend in terms of making
sure that the rest of their life, not just their breast cancer, is taken care of? Absolutely, we know that it’s incredibly hard to get breast cancer at such a young age, and you know our treatment affects their body image, their sexual function, their quality of life, their psychosocial health, getting all kinds of cancer, there is a higher financial burden, so we always try to get social work involved and it really is a multidisciplinary team where we have lots of different professionals and. Involved to try to help them of all different aspects of life that are affected by the cancer.

Doctor Mariya Rozenblit is an instructor of medicine and medical oncology at the Yale School of Medicine. If you have questions, the address is canceranswers@yale.edu and past editions of the program are available in audio and written form at yalecancercenter.org. We hope you’ll join us next week to learn more about the fight against
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