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*Obstetrics • Gynecology • Medical Aesthetics
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Advanced & Minimally Invasive Female Surgery*

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Breast Imaging for Screening

Screening Guidelines:

Patient guidelines for breast cancer screening vary by which organization or society is making the recommendation. Our practice actively encourages women to have regular screening based on an individual's personal risk for breast cancer. Expert opinions vary regarding the benefit of patient self exams and the yearly clinical breast examinations. We encourage women to report any breast changes and reevaluate the plan for screening over time particularly if risk factors change. Since 75% of women who have been diagnosed with breast cancer have NO risk factor at all, we recommend screening at intervals more frequently than the USPTF (United States Preventative Task Force) guideline of every other year after 50 years of age. The ACR (American College of Radiology), SBI (Society of Breast Imaging), BHC (Breast Health Center at CPMC) recommend screening all women with mammography and a clinical breast exam annually starting at 40 years of age. Screening is continued until a women reaches within 10 years of her life expectancy. In 2016, the ACS (American Cancer Society) reaffirmed the importance of yearly screening starting in your 40's. Based on good scientific evidence, women at average risk for Breast cancer commonly have screening mammograms every 1 to 2 years, consider biennial screening after 55 years of age and continue screening until at least 75 years.

Benefits:

In the bay area, 1 in 8 women will be diagnosed with breast cancer in her lifetime. Breast cancer is the #2 cause of death among women in the US; second only to heart disease. The USPTF's recommendation of biennial (every two year) mammograms will reduce false positive results, save on unnecessary procedures and reduce radiation exposure. Unfortunately, with biennial screening, more women (6,500 more) will die of breast cancer each year in the US. Annual screening at 40 years results in an earlier diagnosis of smaller tumors, and will possibly help more women avoid radiation and chemotherapy but has been reported to cause unneeded procedures and concern.

Dense Breast on Mammography:

Nearly one third of all our patients having a mammogram are being told they have "dense breast." Patients of Asian descent have a higher incidence of dense breast tissue. "Dense breast" is by law being reported on results because "dense breast" is an independent risk factor for breast cancer. Having dense breast tissue is associated with a 4-6 times higher lifetime rate of finding breast cancer. Having dense breast makes the reading of a mammogram more difficult, therefore reducing the sensitivity. Fatty breast (the opposite of dense breast) tissue is easier to visualize on mammography. The sensitivity of screening breasts that are fatty is 80-98%. The sensitivity drops significantly with dense breast to a 30-64.4%.

Tomosynthesis:

("Breast Tomo" or "mammography with tomo" or "3D Tomo" or 3 dimensional mammography) is a digital 3D cross sectional imaging test of the breast from different angles that became FDA approved in 2011. Tomo is more detailed, involves 30% more radiation exposure than having a standard routine mammogram but is able to minimize the masking effect of overlying tissue. This results in more detection of smaller invasive cancers, and less false positive results. Breast tomosynthesis may benefit women under 50years, with dense breasts, and women with a personal or family history of breast cancer. Tomo is also better at diagnosing invasive lobular cancer (ILC). Most breast cancers are ductal (DCIS or IDC) in origin and only 12% are lobular in origin. Besides being less common, lobular breast cancers are more

difficult to diagnose in early stages due to the subtle findings on imaging and because they tend to be non-palpable. (Coverage for screening Tomosynthesis greatly improved at the end of 2016.) Women with implants are not candidates for Tomo.

Ultrasound:

Ultrasound has the advantage of no radiation, not being limited by breast density and can detect non-palpable cancers. Whole breast ultrasound is not the standard first-line screening test. Deciding if women with dense breast should get breast ultrasounds for screening depends on coverage and personal risk.

Screening Options:

- 1. For all patients with a lifetime risk for breast cancer of >20% (high risk group), we request for an annual MRI and annual Tomo or 3D mammogram.**
- 2. If the risk is 15-20% (intermediate), we order a Tomo (“mammogram with Tomo”) and breast sonogram or MRI.**
- 3. If a patient with intermediate risk also has dense breasts, we prefer to order both a Tomo and Whole Breast Sonogram but this may not be covered or cost effective.**
- 4. At this time there is limited information, but for our patients with dense breast and an average risk of breast cancer, we prefer annual breast screening by Tomo instead of a standard mammogram. Presently, whole breast sonograms are not routinely performed or available for screening average risk patients with dense breast.**