

A PUBLICATION OF THE DAILY INDEPENDENT
FOR BREAST CANCER AWARENESS MONTH



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The latest in **screening guidelines**

Emotional toll of **cancer survival**

A local **survivor's story**

MAKING THE BEST DECISION

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NEW RESEARCH: IVF effects, genetic testing, metastasis

Designed By Aaron Crutchfield for the Daily Independent



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In their own words

Members of the Young Survival Coalition, an organization for those diagnosed with breast cancer before age 40, shared their advice for survivors struggling with their emotions.

"Time is a big healer, but whenever someone passes, these feelings come back. It also reminds me how fragile life is and that my cancer could come back at any point."

– Jennifer Johnson, senior director of mission marketing and communications

"I would say it's OK to sit with feelings for a bit, as long as you understand where they're coming from. Therapy is a wonderful way to explore these feelings and all the other effects that cancer brings."

– Grace Cook, regional field associate (Northeast)

"Yes, it is common to feel guilty that you survive when others have not, but the sad reality is that survivors cannot truly say that their cancer treatments were 'successful.' There is always the chance that cancer can return, at any time. So I find that survivor's guilt is frequently coupled with the fear that I could be 'next' and also die of my disease."

– Michelle Esser, senior program manager, research and advocacy

"When I think of all the women we've lost it can be overwhelming grief. Instead I try to remember a memory of them, something that struck you that they said or did. That way we are keeping their memory alive without the grief surrounding it, at least not as much. They want us to live, to enjoy our time on this earth and do what we can with it. I remind myself that daily and try to live in the present as much as possible."

– Nicole Taylor, regional field manager (West)

"These feelings are normal! When survivors reach out to me to talk about these feelings, they have heard me say, 'You are right where I would expect you to be. It's a process. It will take time. It will shift, so have some faith about that.'"

– Jean Rowe, associate director, survivorship programs

"Talk about it! Whether to a fellow survivor, family member, therapist, friend. You will quickly realize others feel the same way and understand."

– Medha Sutliff, senior regional field manager (Midwest)



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MAKING THE BEST DECISION

Treatment advice varies for DCIS

By **Melissa Erickson**
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The best way to treat — or not to treat — a possible precursor to breast cancer has women considering their options while experts offer conflicting advice. A new review published in the journal JAMA Oncology stresses that the best care is to actively treat ductal carcinoma in situ, also known as DCIS.

DCIS occurs when abnormal cells are confined to the milk ducts in the breast. Often called “pre-cancer” or “stage zero” cancer, the most accurate term is simply DCIS, said Cleveland Clinic radiation oncologist Dr. Chirag Shah.

“Pre-cancer is a misleading term. Stage zero can refer to other things such as LCIS (lobular carcinoma in situ). It’s best to simply call it DCIS,” he said.

50/50 chance

If a woman is diagnosed with DCIS, she is at higher risk for developing an invasive form of cancer, Shah said.

“Without treatment we know that 50 percent of the time, roughly, these cancers can become invasive cancers so that’s the reason that we do treat them aggressively and don’t just observe them,” he said. “Of the people who are treated for DCIS who later develop cancer, half of those occurrences are invasive cancers.”

Diagnosis of DCIS has soared in recent decades because of an increase in mammography screenings, Shah said. Radiologists with better tools are now able to find smaller lesions and are paying attention to smaller amounts of calcifications.

While more women are being diagnosed with DCIS, there’s not a lot of data available for researchers to review because most people with DCIS have been treated rather than untreated, Shah said.

Shah and his team reviewed 50 studies to determine the best course of treatment for DCIS: a conservative wait-and-see approach or the standard regimen of surgery, radiation and endocrine therapy.

After summarizing the data, the group found that actively treating DCIS with the standard regimen is still the best option for most people. According to the review, data show that radiation after surgery can reduce the risk of cancer recurring in the breast.

“The results of our review demonstrated at this time DCIS is best managed using traditional treatments, so surgery, followed by radiation in appropriately selected women,” said Shah.

Research ongoing

Not all DCIS becomes invasive cancer, and that leads some people to doubt the value of undergoing surgery. For women who choose a more conservative approach, Shah suggests they do so “under the guidance of a clinical trial.”

To find a trial near you that matches your diagnosis, visit the clinical trials page on the National Cancer Institute’s website, cancer.gov/about-cancer/treatment/clinical-trials/search.

The area of DCIS continues to evolve and research is ongoing, Shah said. For now, it’s important for women diagnosed with DCIS to talk to their doctor about the benefits and risks of each treatment option.

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The August after I moved to Ridgecrest, I began to have a green fluid leak from my right breast. I was 34 years old, so I didn't think too much of it. But it became more frequent and even managed to appear through three layers of clothing. I became more concerned as fall approached, and I mentioned it to some girlfriends at a social gathering. My initial appointment with my new primary care physician, Dr. Goonesinghe, wasn't until mid-November because the schedule was full when I called to become a new patient. So, I waited until then to take any action medically. That was a mistake.

At my appointment with Dr. Goonesinghe, almost as an afterthought, I mentioned to her this green fluid and its frequency. She became gravely concerned, took the cell phone from her pocket, called another doctor and insisted that I be seen the next morning. Room was made for me in Dr. Stemmer's schedule and I met him in his office. He didn't seem too worried, but we needed a plan to figure out just what was wrong. Soon, I was scheduling what felt like every test known to man: CT scan, MRI, isotope something-or-other (that I couldn't hug my kids for days after), ultrasound, bloodwork, green fluid sampling, and on and on. There were no definitive answers. I honestly didn't care what it was. At this point I just wanted to know something!

On my youngest child's fifth birthday, I went into the hospital to have a biopsy. We met with Felicia, who made sure I knew what was happening and why. She seemed affected by my age and possible cancer. Everything went well during the procedure with Dr. Stemmer, but coming out of the anesthesia was a bit of an ordeal. The nurse wanted me out of the Outpatient Pavilion rather quickly. But, my body relished in the complete relaxation from the anesthesia. Nausea set in the quicker they woke me up, and food made it worse. Eventually, I was released and attended my son's birthday party at our friends' home in my robe.

We awaited the pathology. Luckily for me, two different pathologists looked at the sample. One doctor found nothing to be alarmed at. The doctor in Pasadena found that I had a type of cancer known as Ductal Carcinoma in situ (or DCIS). I had abnormal cells growing in the mammary ducts, but they were "in place." As Dr. Stemmer told me and my husband, Spencer, the news, I was in a fog of anticipation and exhaustion. I didn't understand what he'd told me; it was serious based on the look on Spencer's face. We went downstairs on the eve of New Year's Eve to schedule surgery. I called some close friends and family while we waited for our turn at the desk. I was still unsure about what the news was and what was happening until Spencer butted into my phone conversation: "No. It IS cancer." Then, it sunk in. Once we were called back to schedule the partial mastectomy, Felicia once again helped us through the paperwork process. This time, just days after our first encounter, her emotions overcame her and she wept for me.

We "celebrated" New Year's Eve with friends by

In my own words my FIGHT with DCIS

By Megan Hall
For the Daily Independent



PHOTO BY YARI MOWER

playing games and laughing with friends. As I joked and made fun of my situation, I was mourning privately the loss of my health, a symbol of femininity, and the breast that had been favored by all three of my children as nursing infants.

The morning of my surgery, I was completely confident in Dr. Stemmer's hands. We were nervous about how I would react to the anesthesia and the placement of my IVs, but like childbirth, subsequent hospital trips lead to better self-advocating. Soon, I was off to sleep with a guarantee from Mike the anesthesiologist that I would not have a sore throat when I woke up.

Post-surgery, I again relished the anesthesia. Spencer had to squeeze my foot to remind me to breathe, and I wasn't glad for the reminders. I was uncomfortable in my tightly wrapped corset of bandaging. But, I was allowed to wake up at my pace and felt much better doing so. By the end of

the day, Dr. Stemmer came to visit and counsel with me. He strongly suggested that I stay overnight and I agreed. I ended up staying up late that night watching an Ax Men marathon. The nurse came to check on me and asked if I was in pain. I honestly didn't know. She offered me some pain medication and I was happy to try it. Soon, I was asleep.

Days later I was in Dr. Stemmer's office to have my bandages removed. His handiwork was meticulously beautiful. While the margins had been much larger than expected (which means more of the breast was removed than anticipated), I still had a breast and a scar so hidden it seemed miraculous to me. Even though the change in my physical appearance affected me negatively for years after surgery, I have always been grateful that such a skilled surgeon took such care of me and my scar.

I attended church the Sunday after my surgery. I didn't know what the rigors of the next phase of treatment would be for me. I needed to be there with people who had loved, prayed, and cared for me and my family so deeply in the recent weeks. I needed to take the sacrament in case I wouldn't be able to attend church during treatment. I needed to put real faith into my healing process.

In the days that followed, there were visits to oncologists and the hospital to get ready for radiation. I scheduled my life around 9:40 a.m. for the next seven weeks, Monday through Friday. Having to endure it all made me angry. So, as I made healthier dietary changes, I also walked 3-5.5 miles each day. I lost a lot of weight and gained some sanity amidst the loss of control. I also realized that my faith, my family, my friends, and my walks helped me gain perspective and a positive attitude about the whole thing. Sometimes, as I listened to other cancer patients in the waiting room talk about their treatment and recovery, I felt like a Pollyanna among rainclouds. I cannot imagine letting the cancer of negativity affect healing.

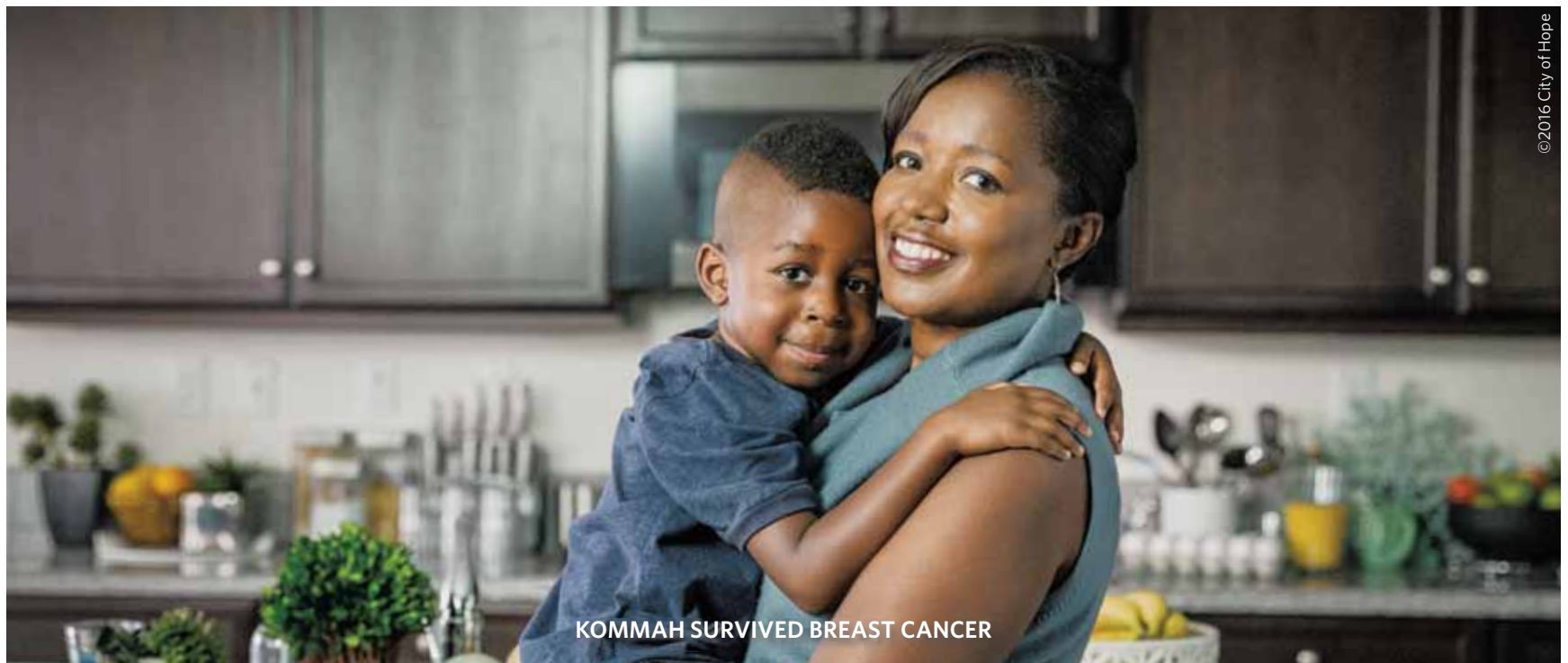
Just after my 35th birthday, I finished my radiation treatments. I found that I missed my daily interactions with the tech, Jeremy, and my cohort patients. I did not, however, miss having to fight for my life every day. I still celebrate that fact and try to make healthier choices consistently in lieu of future diagnoses which are a very real possibility for anyone diagnosed with cancer. I had "the" cancer to have — Stage 0, fully excised by surgery except for micro-blips treated by the radiation — yet I'm still susceptible and more likely to have a variety of future cancers.

I still see too many doctors too often. I still have my bad days but have learned to listen to my body. I am so grateful every time I wash my hair or wear my seatbelt without pain. For five years after Jan. 4, 2011, I held a pink posse walk in my neighborhood where friends and family gathered with me to celebrate another year of being cancer free. Now that I'm five years post-op, I can admit that I had to look up my surgery date. What once consumed me no longer rules my days.

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BEYOND the BREAST

When cancer spreads, the race for treatment becomes a marathon

By **Melissa Erickson**
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Living with metastatic breast cancer is like running a marathon, says Dr. Mariana Chavez MacGregor, assistant professor of breast medical oncology at the University of Texas MD Anderson Cancer Center. There is no cure for metastatic breast cancer, but you have to concentrate on the fact that you're still running, you're still in the race.

"Metastatic breast cancer is treatable but can't be cured," said Shirley Mertz, president, Metastatic Breast Cancer Network. "Although it varies by subtype, median survival is two to three years."

What it is

Also known as Stage IV breast cancer, metastatic breast cancer refers to cancer that has spread outside of the breast in which it originated and outside of the lymph nodes and mammary glands.

"If it stays within the breast, if that's the extent of it, it's Stage I, II or III breast cancer," said Dr. Keerthi Gogineni, breast oncologist at the Winship Cancer Institute of Emory University. "If it goes outside that zone, to lymph nodes further away — lymph nodes in the groin, to the bone, liver, lungs, brain, even the skin — it's Stage IV breast cancer."

"It's not limited to cancer in what we consider important organs. It could be in

the bones, which we don't think of as critical organs."

Treatment of metastatic breast cancer is a hot topic as oncologists and others in the field seek to maximize both length and quality of life for women and men living with Stage IV breast cancer.

"As a general rule with few exceptions, metastatic breast cancer is incurable. While you can live significantly longer, you will die of breast cancer. The goal is to live longer and preserve quality of life," MacGregor said.

"Some types of metastatic cancer can be cured with current treatments. Lance Armstrong had metastatic testicular cancer, and we can say that he is cured, but metastatic breast cancer is incurable in 2016. Although it can't be cured, it can be treated," said Mertz.

While doctors can't offer a cure, "the cancer can be very well controlled and you can live for years," Gogineni said.

'Very treatable disease'

Different subtypes of metastatic breast cancer respond better to different treatments.

"The tools are different for each. You have to take into account the symptoms, the goals of care, the support at home," MacGregor said.

"The main thing is to control the cancer, to shrink the cancer where we know it exists and keep it from taking root in different parts of the body, to balance the side effects of treatment and improve quality of life," Gogineni said. "I tell my patients it's a very treatable disease."

While other forms of breast cancer can be influenced by early detection, metastatic breast cancer presents a tough question.

"There's no proof that identifying metastatic breast cancer earlier before symptoms appear actually changes the treatment or the effectiveness of the treatment," Gogineni said. "It's hard for people to understand."

"Mammograms are important, but early detection is not a breast cancer cure. In fact, most of the 155,000 U.S. people currently living with metastatic breast cancer were originally treated for early stage breast cancer — their cancer came back five, 10, 15 and even 17 years later — even though they took excellent care of themselves and had regular mammograms," said Mertz, who was diagnosed with metastatic breast cancer in 2003. "It would be wrong to say that mammography doesn't save lives. But as the American Cancer Society's Otis Brawley said, we need to use it with caution, explain its limitations and realize that we need a better test."

Men and women living with metastatic breast cancer should be vigilant rather than paranoid, Gogineni said. If a health issue doesn't resolve itself normally — for example, a sore back from working in the yard lingers longer than expected or a seasonal illness knocks you down for longer than normal — see your doctor.

"Follow up on what's not normal," Gogineni said. "Be an advocate for yourself."

As years pass and you're back to seeing your primary care doctor or gynecologist, "remind your team if something starts brewing. Be sure to say, 'I have a history of breast cancer,'" Gogineni said.

Some facts about metastatic breast cancer, from the Metastatic Breast Cancer Foundation:

1. No one dies from breast cancer that remains in the breast. Metastasis occurs when cancerous cells travel to a vital organ, and that is what threatens life.
2. An estimated 155,000 Americans are currently living with metastatic breast cancer.
3. Metastatic breast cancer accounts for approximately 40,000 deaths annually in the US.
4. Treatment for metastatic breast cancer is lifelong and focuses on control of the disease and quality of life.
5. About 6 to 10 percent of people are Stage IV from their initial diagnosis.
6. Early detection does not guarantee a cure. Metastatic breast cancer can occur 5, 10 or 15 years after a person's original diagnosis and successful treatment checkups and annual mammograms.
7. Twenty to 30 percent of people initially diagnosed with early stage disease will develop metastatic breast cancer.
8. Young people, as well as men, can be diagnosed with metastatic breast cancer.
9. Metastatic breast cancer is not an automatic death sentence. Although most people will ultimately die of their disease, some will live for many years.

To learn more about National Metastatic Breast Cancer Awareness Day on Oct. 13, visit www.mbcn.org.



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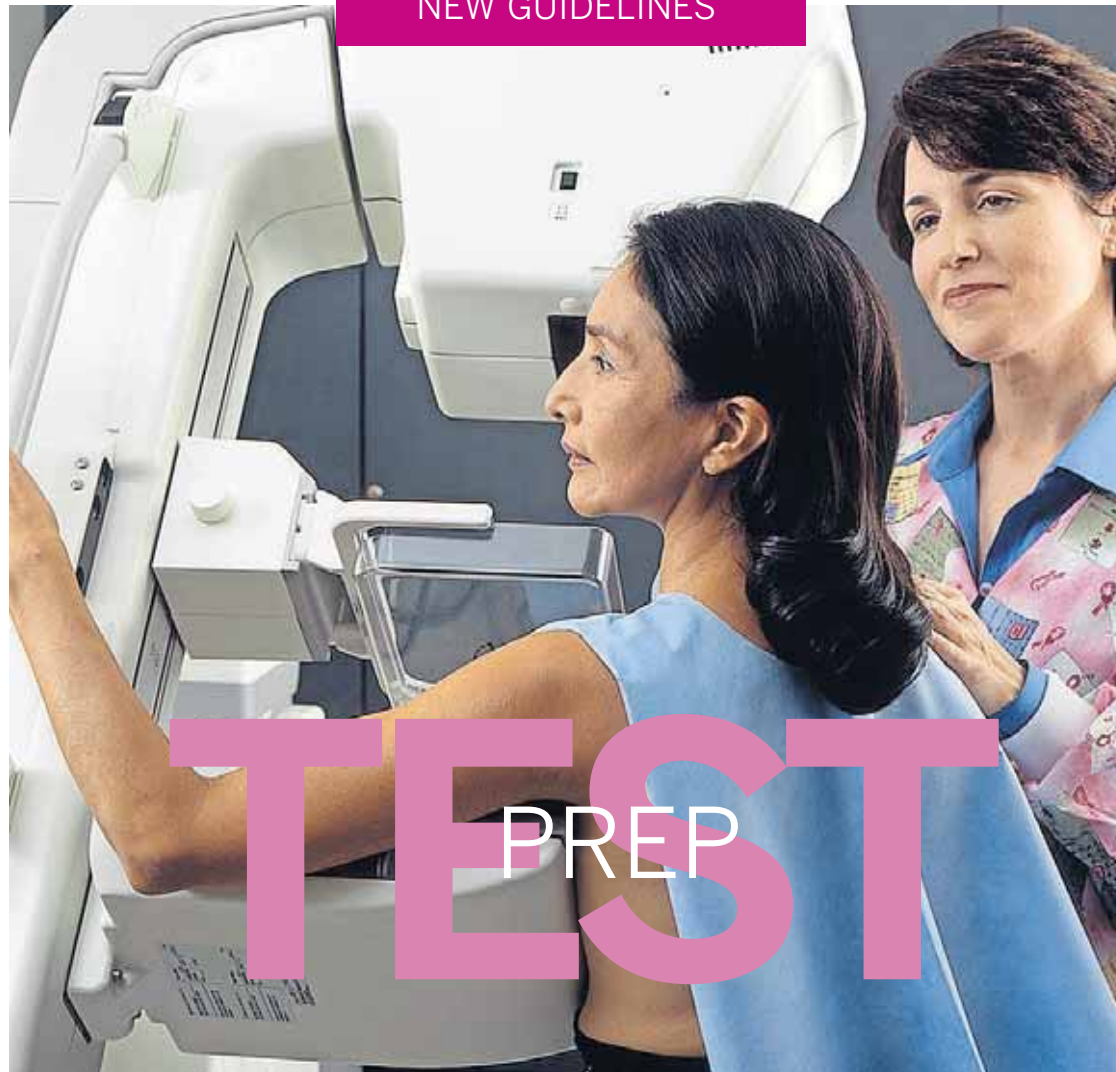
NEW GUIDELINES

By Melissa Erickson
More Content Now

The guidelines for when, how many and at what age a woman should get a mammogram can be confusing, especially for those with an increased risk of breast cancer.

The United States Preventive Services Task Force, a panel of medical experts, released new mammogram guidelines in January that recommended fewer screenings than in the past.

"The United States Preventive Services Task Force evaluated the evidence that has emerged since its last update (2009) and has reconfirmed its conclusion that mammography reduces breast cancer deaths for women 40 and older. The panel recommends that all women ages 50 to 74 be screened every two years, giving this recommendation a 'B' rating. The panel concluded that the benefits of screening women in their 40s are greater than the harms but that the difference is small. For this reason, the panel gave screening women in their 40s a 'C' rating," said Dr. Richard Wender, chief cancer control officer at the American Cancer Society. These guidelines cre-



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ated a sense that the task force "didn't consider screening starting at age 40," Wender said.

But, "The American Cancer Society recommends that all women definitely start by 45 if they haven't started earlier. The United States Preventive Services Task Force says 50 is the definite start date for all. American Cancer Society recommends annual screening until after 55, at which point a woman can transition to every other year," Wender said.

For 'average' women

"This guideline is not for women who have the BRCA mutation or a very

Making sense of screening guidelines



"Guideline groups have different perspectives, so it's not surprising that different groups have somewhat different guidelines, but the differences ... have been overemphasized."

Dr. Richard Wender

strong family history or a personal previous history of cancer. It's for women at average risk. The average risk category is a broad category. Some women have no family history; others may have had one relative with breast cancer. African-American women are at slightly higher risk of developing breast cancer at a young age, and this may influence a decision to start screening at age 40," Wender said.

Why the differences?

Different groups recommend different but similar guidelines as they balance the benefits and harms of screening to make a rec-

ommendation.

"Guideline groups put somewhat different weight on different types of evidence. Guideline groups have different perspectives, so it's not surprising that different groups have somewhat different guidelines, but the differences in the guidelines have been overemphasized. There are more similarities than differences," Wender said.

For example:

- All women should consider beginning screening at age 40.
- All women should begin screening by 50 at the very latest but most will want to start screening before then. American Cancer Society recommends 45 at the latest.
- All women should have regular screening every one to two years from age 50 as long as they remain healthy with at least a 10-year expectancy.

Covered by insurance?

"This is complicated. Congress passed a ruling that mandates coverage of annual mammography for women 40 and older. So the simple version is — yes. It's covered," Wender said. "Far too few women are being regularly screened. Screening saves lives and everyone should be up to date with regular screening."

By Melissa Erickson
More Content Now

No matter what skin color or income level, women with breast cancer deserve the best treatment that America can offer. However, disparities exist between white and minority women and upper- and lower-income women.

While studies looking at cancer care are inconsistent, some have shown “that minority populations have barriers such as distrust, cultural and health literacy barriers that may impact their cancer care,” said Dr. Jacqueline W. Miller, medical director, National Breast and Cervical Cancer Early Detection Program, Centers for Disease Control and Prevention.

“Some studies have shown that black women are more likely to have a delay in following up on abnormal mammograms and receiving cancer treatment or complete treatment compared to white women. Lower-income individuals are more likely to be uninsured, which may impact their ability to receive appropriate care,” said Miller, who is a captain with the U.S. Public Health Service.

Diagnosis of breast cancer can also come later for certain groups.

“Studies have shown that black women are more often found to have breast cancer that has spread beyond the breast (regional and late stage disease) at the time of diagnosis,” Miller said.

While breast cancer affects all women and some men, minority women are more likely to have aggressive subtypes of breast cancer, according to a 2015

study published in Cancer Epidemiology, Biomarkers & Prevention.

Because of this disparity, breast cancer deaths among women will remain because of differences in the aggressiveness of breast cancer, Miller said.

“All women should have equal access to screening, diagnostic and treatment services. Uninsured women should take the

opportunity to get insurance coverage through the Affordable Care Act. Federal, state and local health agencies can help women understand why they need mammograms, what to expect and about timely, high-quality breast cancer care. Community improvements such as making access to walking areas, availability of healthy foods can help women

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For more information

The CDC's National Breast and Cervical Cancer Early Detection Program provides low-income, uninsured and underserved women access to timely breast and cervical cancer screening and diagnostic services and treatment referral across the United States. Find a provider near you atcdc.gov/cancer/nbccedp/

BARRIERS to CARE

Tips for all women to get adequate health screening

reduce their cancer risks,” Miller said.

Here are some tips to help women get better and equal care:

- Women should review their family medical history and risk factors with their provider, discuss any problems or concerns with their provider and get appropriate screenings and diagnostic care as indicated.
- Women should make sure that they receive their mammogram results and follow up on any abnormalities.
- Women can do things to reduce their risks for getting breast cancer such as exercising regularly, maintaining a healthy weight, limiting alcoholic drinks and avoiding taking hormones.
- All women with breast cancer should have timely, high-quality cancer care based on their diagnosis, including access to clinical trials. If possible, women should work with patient navigators who can answer questions, assist with making sure appointments are kept, and help with understanding of treatment course and expectations.

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EXERCISING after breast cancer

It's a great idea, but here's how
to keep from overdoing it



Routine exercise is an essential element of a healthy lifestyle. Exercise can help people maintain healthy weights, reduce stress and lower their risk for various diseases.

After surviving breast cancer, many survivors wonder if it's safe to return to the exercise regimens they followed prior to being diagnosed. Breast cancer survivors can benefit from exercise, but it's important that they prioritize safety when working out. Survivors who have had breast cancer surgery may be at risk of lymphedema, a condition characterized by swelling of the soft tissues of the arm, hand, trunk, or breast. That swelling is sometimes accompanied by discomfort and numbness, and some people dealing with lymphedema also experience infection.

Breastcancer.org, a nonprofit organization dedicated to providing up-to-date information about breast cancer, notes that some exercise may be especially risky for breast cancer survivors. These exercises include:

- swimming laps using strokes with arm movements
- activities that involve the usage of resistance bands
- pull-ups and push-ups

- certain yoga poses, including downward-facing dog and inversions, that put ample weight on the arms
- elliptical/cross-training machines
- cross-country skiing
- tennis

While breast cancer survivors might want to avoid certain types of exercise, it's important to note that the American Cancer Society recommends exercise after breast cancer surgery. But exercise should be approached with safety in mind, and breast cancer survivors should heed the following tips to ensure their exercise regimens do not compromise their recovery.

- Discuss exercise with your physician and surgeon. Before making exercise a part of your post-recovery routine, speak with your physician and surgeon to determine if there are any movements you should avoid. Your doctor and surgeon can tell you how you will be affected by medications you might be taking as part of your continued recovery.

- Take it slowly. If you were an exercise enthusiast prior to your diagnosis, you must recognize that returning to your pre-cancer regimen may not be possible, or that it's likely to take a while before you feel like your old self again. Take a gradual approach, allowing yourself to build strength and not expecting results to appear overnight.

- Emphasize form. Place a great emphasis on form when exercising after surviving breast cancer. Many breast cancer survivors undergo surgery as part of their treatments, but even those who did not should still prioritize proper form when exercising, even if it means lifting substantially less weight than you might have prior to your diagnosis.

- Don't persist through pain. If you feel any pain upon returning to exercising, stop immediately and speak with your physician and surgeon prior to exercising again.

- Rest between sessions. You likely won't be able to exercise on successive days anytime soon, but build off days into your routine so you can rest and recover.

Exercising after surviving breast cancer can promote recovery, but survivors must be extra careful as they work to get back on track.



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WHAT'S NEXT?

Dealing with guilt
after survival

By Melissa Erickson
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Surviving cancer can take an emotional toll. Survivorship comes with a tangled host of emotions, from joy and relief to even fear and guilt.

After a battle with breast cancer your emotions may seem strange or uncomfortable but are often completely normal. It's common to question why you survived while others did not, but the term "survivor's guilt" is often misused.

"It is not very common to have survivor's guilt in the true sense of the phrase unless the person has lost a close relative or friend to cancer," said medical oncologist Dr. Marleen Meyers, director of the Perlmutter Cancer Center Survivorship Program at NYU Langone. "More often people feel fortunate that

they survived, but many people need to find a reason for why they survived when others didn't."

Coping with the difficult feelings of battling cancer can last after treatments have stopped.

"These feelings can go on for a long time. It is hard to accept that something bad happened (cancer) but something worse did not happen (death). Not having explanations makes people feel vulnerable and feel a loss of control," Meyers said.

Working on acceptance

The journey from diagnosis to a clean bill of health is a long and winding path, and survivors often search for answers: Why did I beat cancer?

"People like explanations and find comfort in clear-cut cause/effect. Often they look for a behavior that is different: smoking, sun exposure, use of hormone replacement.

"It is important to be proactive about your health from the time of diagnosis. By working on lifestyle changes, people get back a sense of control."

Dr. Marleen Meyers

Sometimes people like to think it is because they didn't have a compelling family history. At times survivors' thoughts turn to why they got cancer at all. This is especially true of people who have good lifestyle habits," Meyers said.

Trying to teach people to change what they can and accept the rest is not easy.

"It is important to be proactive about your health from the time of diagnosis. By working on lifestyle changes, people get back a sense of control. Reminding patients that the overwhelming majority of people with cancer survive is also comforting. Also having the opportunity to speak with people who have been through this allows patients to see that life goes on," Meyers said.

Sense of control

Key to overcoming difficult emotions is to stress that there is much the survivor can

do both during and after treatment to feel better and in control.

"Exercise, eating well, meditation are some of the things that help people get through. I encourage people to try to maintain their lifestyle as much as possible," Meyers said. "A diagnosis of cancer is terrifying. It is important to speak with your doctor about your fears of treatment side effects and fears of death."

This is particularly true if the survivor has lost a loved one to cancer and may be waiting for the other shoe to drop.

"It is equally important to live in a 'non-cancer world' both for better quality of life and for distraction," Meyers said. "Finally, for those who suffer with survivor's guilt, it helps to talk to others going through this. In a sense, they are giving back and know they are not alone, and that can be very comforting."



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Our mission is to provide comprehensive, quality primary and women's healthcare. The clinic serves Medicare and Medi-Cal beneficiaries. We also participate in two important special programs that cover the cost of mammograms and annual exams in full. Call today to see if you qualify.

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The Ridgecrest Rural Health Clinic participates in the Every Woman Counts program which provides FREE clinical breast exams and mammograms as well as pap tests.

We also accept Medicare, Medi-Cal and most major insurances, including Family PACT (Family Planning, Access, Care and Treatment).

Call Rural Health at 760-499-3855

 When Breast Cancer is found early, it is easier to treat 

Talk to your Doctor about:

 Your options for Breast Cancer Screening 

 Any changes or concerns & risk factors 

EARLY DETECTION

Genetic testing becomes faster,
cheaper, more available

By Melissa Erickson
More Content Now

A lot has changed in genetic testing for breast cancer since the BRCA1 and BRCA2 gene mutations were discovered 20 years ago. In addition to advanced technology and tools to better find hereditary cancers, what cost thousands of dollars even a few years ago now costs much less, making genetic testing available to more people.

In the past two decades, “cancer genetic testing has changed in two main ways,” said Meagan Farmer, director of cancer genetic counseling at University of Alabama at Birmingham. “First, we know of many more genes associated with cancer predisposition than we did 20 years ago. Second, we can now analyze many of these genes at one time, relatively quickly and at increasingly affordable costs. Next-generation sequencing is the testing technology that allows us to do

this.”

About 10 to 15 percent of most cancers are due to inherited genetic mutations. When these genes are present they greatly increase your risk of developing cancer, said Othman Laraki, president and co-founder of Color Genomics, which offers \$249 at-home cancer gene tests that detect breast, ovarian and other common hereditary cancers. Provide a saliva sample, activate

your account online, mail the kit in, and Color Genomics analyzes your genetic makeup, which is reviewed by a medical professional. A session with a board-certified genetic counselor is included.

“These tests are good, but no genetic test is perfect.”
Megan Farmer, University of Alabama at Birmingham

“People should know that it is important to meet with a genetic counselor or other genetic specialist undergoing testing to help sort through the possibilities of the possible panels available and choose the best match for your personal history.”



What it is

"Next-generation sequencing refers to a technology that can sequence several genes at a very fast pace," said Dr. Mary B. Daly, chairwoman of the department of clinical genetics at Fox Chase Cancer Center, Philadelphia. "The biggest change, however, is the creation of panels that can look for variants in multiple genes all at the same time rather than single-gene testing. As a result, we are discovering many more genes associated with different types of cancer."

Before next-generation sequencing, patients who were suspected of having a hereditary reason for breast or ovarian cancer may have been offered analysis of the BRCA1 and BRCA2 genes, still believed to be associated with more than half of hereditary breast and ovarian cancer cases, Farmer said. Now, patients suspected to have a hereditary cause for their personal or family history of breast or ovarian cancer can be offered an analysis of 20 genes, and the same applies to genetic testing for predisposition to many other cancer types, Farmer said.

As test kits become cheaper and more available, experts caution that not all women need to be tested.

"Candidates for next-generation sequencing are individuals with family histories suspicious for cancer syndromes, individuals whose family history suggests the possibility of more than one cancer syndrome and individuals with cancer at an age earlier than expected," Daly said.

"Red flags include early-onset cancer such as breast or colon cancer before age 50, rare types of cancer such as ovarian cancer, or multiple cases of the same or related cancers on one side of the family in multiple generations," Farmer said.



Is it for you?

"People should know that it is important to meet with a genetic counselor or other genetic specialist before undergoing testing to help sort through all of the possible gene panels available to choose the one that best matches their personal and family history," Daly said.

"We are most likely to find a hereditary cause for cancer in a family if testing is performed in someone that has had cancer. Testing of several genes through next-generation sequencing is most appropriate for someone that has had thorough pre-test counseling by a cancer genetics expert and is comfortable with the potential ambiguities related to many of the newer genes that can be tested," Farmer said.

The science is always improving.

"These tests are good, but no genetic test is perfect. A negative test result does not rule out a hereditary contribution to someone's personal/family history of cancer. If this history is suspicious, it may be appropriate for a person to undergo earlier or additional screening for the types of cancers seen in his/her family, even after a negative test result," Farmer said.

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Dr. Mary B. Daly

GOAL: \$160,000

WE'RE HALF WAY THERE!

50%

50%

RRH Development Foundation is diligently working to promote early detection of breast cancer. You can be a part of this incredible effort by supporting our fundraising efforts to purchase an Automated Breast Ultrasound System or ABUS.

Be a part of the good things happening at Ridgecrest Regional Hospital. Donate today at <http://rrh.org/about-rrh/rrh-development-foundation/> or call us at (760) 499-3955.

TAMARA TILLEY
RRH DEVELOPMENT
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