



ASK DR. BOB . . .

with Dr. Bob Frank

BREAST CANCER

Almost on a daily basis I am asked questions about the insurability of women with breast cancer. This is not surprising given the large number of women with this cancer. I felt this would be a good topic to discuss. Breast cancer is by far the most common female cancer, with a lifetime risk of approximately one in nine developing it. Although the incidence also seems to be increasing, there is good news in the fact that the death rate from cancer has decreased, owing mostly to early detection and cure. Most cancers develop in women older than age 50, although 15% are present in women less than this age. Although there are many risk factors, including the use of hormone therapy, birth control pills, and alcohol usage, by far the two most important risk factors are increasing age and a positive family history. If there are two or more first-degree relatives who have breast cancer, a woman experiences a fourfold increase in her risk. In addition, there is a primary genetic component present in approximately 5-10% of cancers. The two most common genetic abnormalities are the BRCA-1 and BRCA-2 mutations, and if present, this means at least a 60% chance of developing cancer by age 60. Genetic testing for this mutation is widely available in clinical medicine, and an increasing number of women are opting to have this test performed.

The most important factor in breast cancer cure is early detection. Although self-breast examination is somewhat helpful, early detection is best accomplished by routine mammography. It has been recommended that all women 50 years of age and older have routine mammograms, and some experts have argued that the testing should begin at age 40. If a woman is at high-risk because of genetic mutations or strong family history, the early testing should begin as early as age 25. With mammography, there is a better chance of finding the cancer in a stage referred to as "in-situ" disease (which means cancer is present but is confined to the cellular level). Currently 20% of all cancers are diagnosed in this stage, and are readily curable with surgery.

In terms of long-term prognosis, the two most important factors are the size of the tumor and whether or not there has been any metastatic spread to lymph nodes. Once a tumor is bigger than 2cm, the risk of positive nodes and occult metastases increases. Obviously, if nodes are already positive, then the cancer has spread. Even in node negative women, up to 20% of women will some time later on develop distant metastases. This is the reason that breast cancer can have an increased mortality even at 10 years after the cancer is found.

Newer modalities being used in the diagnosis are ultrasound of the breast and MRI mammography. It has definitely been shown that in high-risk individuals MRI mammography is superior to regular mammography in finding small cancers. However, it has an increased rate of false positives, and because it is more expensive, is not routinely used in normal screening programs. All high-risk women should consider having MRI mammography done in addition to routine mammography.

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The treatment of breast cancer has undergone a major transformation. The old standard radical mastectomy is seldom performed at the present time. Since tumors are being found at an early stage, it has now been shown that breast conserving surgery such as lumpectomy gives equivalent results compared to total mastectomy. This lumpectomy is usually followed with adjuvant radiation, which is radiation given to the breast and axillary lymph node area as a precautionary measure. Women at higher risk for distant micro-metastatic spread may also be treated with adjuvant chemotherapy for a period of six months. In addition, it is now routine to have hormonal manipulation done as part of the treatment. In women whose tumors are estrogen/progesterone positive, they can take the drug tamoxifen (an anti-estrogen) and this will decrease the risk of recurrent cancer. It has also been shown that tamoxifen can actually reduce the incidence of cancer itself in high-risk individuals.

From the underwriting standpoint, breast cancer is considered to be a slow growing cancer that has increased mortality even at 10 years and beyond from

the time of diagnosis. To assess the proper risk, the stage of the disease and the grade of the cancer are important to know. This requires a pathology report from the time of surgery. It is also important to look at their long-term follow up. Are they taking tamoxifen? Are they continuing to get regular mammograms, as the risk of cancer is much greater in a person who has already had one cancer? Since many cancers are diagnosed at a very early stage, many women can be taken at standard risk if they are having appropriate follow up.

Lastly, I would encourage all of our agents and brokers to make certain that they themselves or their spouses are getting their routine mammograms. Although mammograms aren't perfect, and can miss up to 15% of cancers, most women should never have to die from breast cancer if it is found early enough. If you think that you are a very high-risk person, consider talking with your physician about adding MRI mammography to your preventative protocol. I would be happy to answer any questions if you have them.

