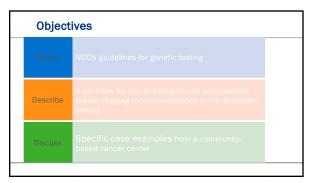
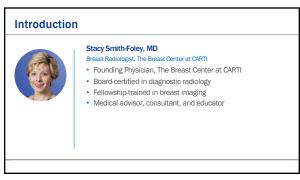


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Experience

The Breast Center of NWA, Fayetteville, AR – 2006-2016

• Independent breast center (MSG)

Hillcrest Medical Center Tulsa OK – 2016-2017

• First 3D Mammography program in Tulsa

• For-Profit Inner-City Hospital

Anderson Radiology, Greenville SC 2018 – 2019

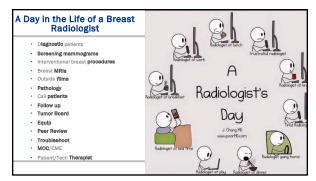
• MedQuest/Novant (IDTF)

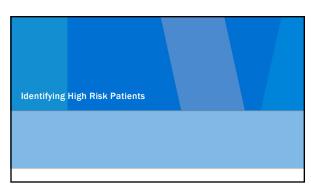
Launched The Breast Center at CARTI, Little Rock, AR – 2019

• Independent Non-Profit (CCC)

4 5







Factors that Contribute to Risk

Personal Factors

- Weight
- · Alcohol Consumption
- Tobacco Use
- Exogenous Hormones
- Parity
- Breastfeeding

Inherent Factors

- · Race/Ancestry
- Age
- Height
- · Breast Density
- · Age of Menarche/Menopause
- · History of High-Risk Histology
- · Family history

Identifying High-Risk Patients

Published Guidelines for Risk Assessment

- ACCC Association of Community Cancer Centers
- ACOG American College of Obstetricians and Gynecologists
- ASBS American Society of Breast Surgeons ASCO – American Society of Clinical
- Oncologists NCCN - National Comprehensive Cancer
- · NPWH Nurse Practitioners in Women's Health
- · NSGC National Society of Genetic Counselors
- ONS Oncology Nursing Society
- SGO Society of Gynecologic Oncologists
- SSO Society of Surgical Oncologists · USPSTF - U.S. Preventative Services Task Force
- ACR/SBI 2018 (NEW 2023 Guidelines)

Genetic Risk Assessment

- · Identify patients with significant risk factors for developing hereditary cancer
- · Multiple methods of performing risk assessment
- · Use test results for medical management for at risk patients



10

11

A patient's risk may be categorized differently based on the tools used



Tools to evaluate patient's risk today

- BI-RADs score
- Breast density
- Family history
- Risk models (Tyrer-Cuzick score, other risk tools: Gail, Claus, BCSC,

Opportunity to detect blind spot with genetics

- Comprehensive family
- Germline genetic testing
- Tyrer-Cuzick score*
- Polygenic risk score
- (PBS)*

Tyrer-Cuzick (Version 8)

Risk Factors Incorporated:

Age

14

- Height
- Weight
- · Age of menarche
- · Age of first childbirth
- Parity
- · Age at menopause HRT use

· Ovarian cancer

- · Ashkenazi descent
- · Age of diagnosis of first- and second-degree female relatives with breast or ovarian
- · Male relatives with breast cancer
- · Prior breast biopsy
- · Breast density

Criteria for Testing



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Personal history of:

- . Ovarian cancer at any age
- Metastatic or high-risk prostate cance at any age
 Pancreatic cancer at any age
- Colon or rectal cancer at any age
 Uterine/endometrial cancer at
- age 64 or younger
- Three or more breast cancers in relatives on the same side of the family at any age Ovarian, metastatic or high-risk prostate, pancreatic, or male breast cancer at any age

Family history of:

- Colon, rectal, uterine cancer at 49 or younger (1st degree relative)
- . A gene mutation found in a family member

. Two breast cancers in one relative at any age

Breast cancer at age 49 or younger

· Ashkenazi Jewish ancestry with breast cancer at any age

13

Red Flags for HBOC

- Ovarian cancer
- · Breast Cancer age 50 or younger
- •2 Primary Breast Cancers
- Male breast cancer
- Triple Negative Breast Cancer
- •2 or more HBOC associated cancers
- · Ashkenazi Jewish Ancestry with an HBOC associated cancer
- · Known mutation in a family member

The impact of a high-risk breast program

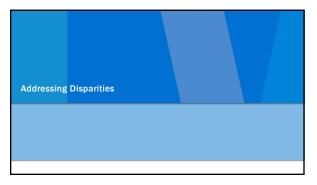


- Improve patient outcomes for increased population health
- · Enhance the patient experience for better quality and satisfaction
- · Reduce patient dropout
- Differentiate your breast cancer program from others in the region
- · Begin bridging the gap from volume to value based reimbursement models

Recommended Surveillance for Female BRCA Carriers

	Procedure	Age to Begin	Frequency
Breast Cancer Surveillance	Breast Awareness	18 years	
	CBE	25 years	Every 6-12 months
	MRI/Mammography	25 years MRI with contrast (preferred) or mammography 30 for both MRI and Mammography Individualized to younger ages based on the earliest diagnosis in the family	Annually
Ovarian Cancer Surveillance	TVUS/CA-125 may be considered	30-35 years	Individualized

Source: NCCN Genetic/Familial High-Risk Assessment: Breast, Ovarian, and Pancreatic Guidelines. V2.2022





ACR/SBI Call to Action

"Since 1990, breast cancer death rates dropped 23 percent in African-American women — approximately half that in whites. We changed our approach to help save more African-American women and others at higher risk from this deadly disease,"

Wendy B. DeMartini, MD, FSBI

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The Why

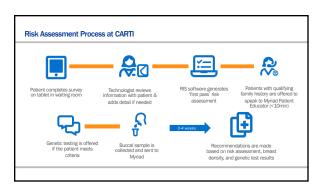
Factors that contributed to the ACR/SBI reclassification of African-American women include:

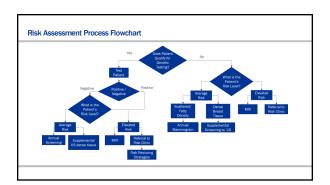
- African-American women are 42 percent more likely to die from breast cancer than non-Hispanic white women despite roughly equal incidence rates.
- African-American women have a two-fold higher risk of aggressive "triple-negative" — breast tumors.
- African-American women are less likely to be diagnosed with stage I breast cancer, but twice as likely to die of early breast cancers.
- African-American women have a higher risk of BRCA1 and BRCA2 genetic mutations than those of Western European ancestry.

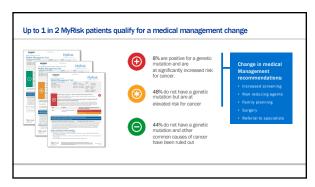
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Genetic Testing Results and Recommendations

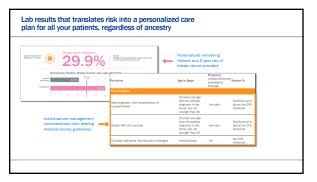
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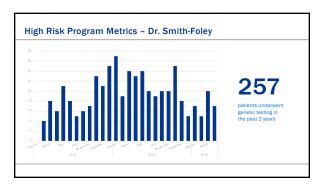


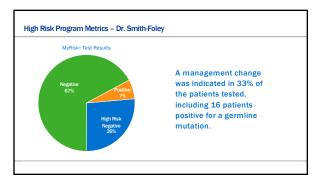




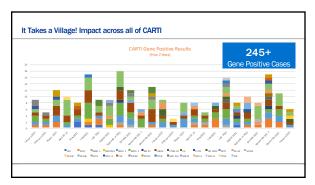
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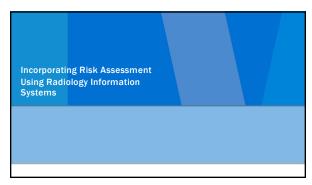


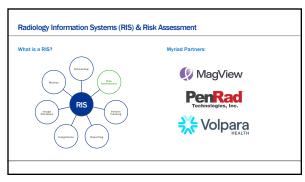




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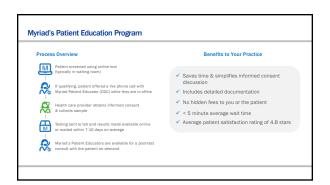


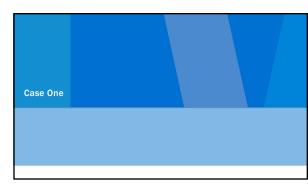


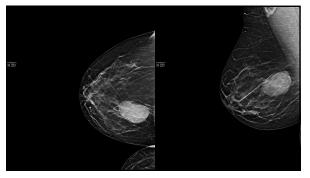


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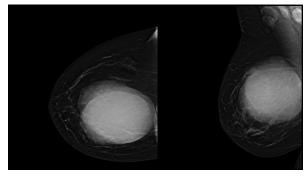






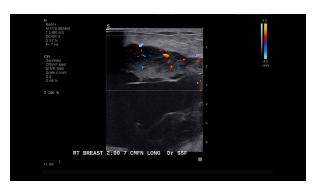


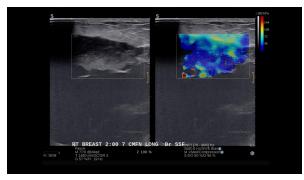




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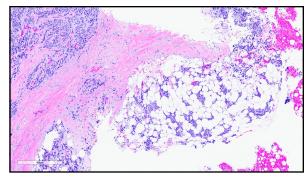




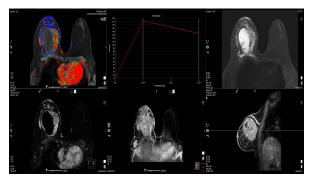
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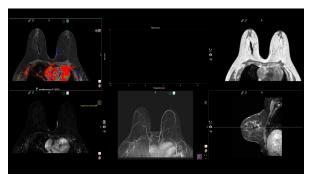


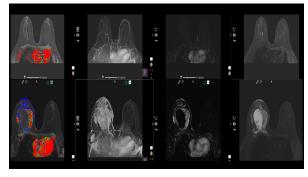




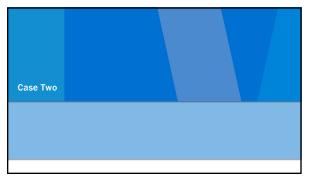
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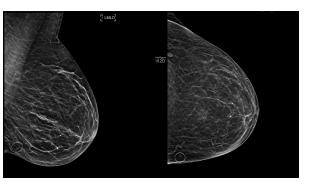






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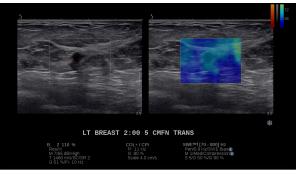


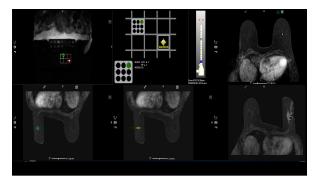


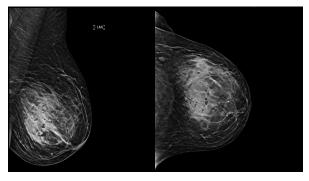


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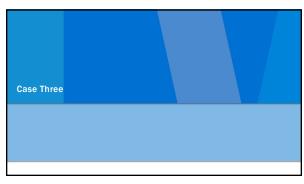


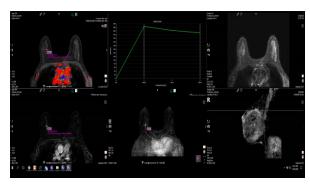
CLINICAL INFORMATION
Clinical history: 74-year-old female BRCA 1 mutation, 7 mm mass left breast UOQ 1-2:00 8 cm from the nipple Pre-opdiagnosis: Fibroadenoma versus infiltrating ductal carcinoma
DIAGNOSIS:
AMENDMENT FOR AMENDMENT COMMENT ON 7/22/2020:
Left breast, 1 to 2:00 and 6 cm from nipple, core needle biopsy:
Poorly differentiated carcinoma, compatible with infiltrating mammary carcinoma, ductal type, Nottingham grade 3, see comment.



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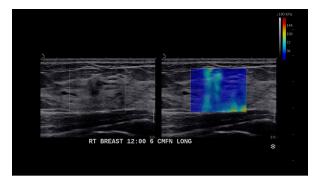
CLINICAL INFORMATION
Clinical history: 76-year-old Caucasian female with BRCA1 gene mutation. Diagnosed with left IDC in 4/2020 status post bilateral mastectomy without reconstruction. Recent CT demonstrated left axillary adenopathy.
Differential diagnosis: Metastatic versus reactive adenopathy.
DIAGNOSIS:
Lymph node, left axilla, needle core biopsy:
- Metastatic mammary (ductal) carcinoma, poorly differentiated (see comment).





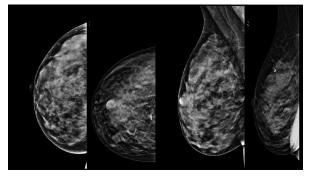
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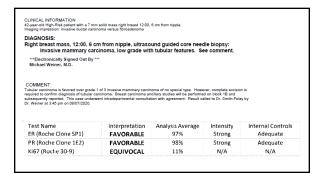


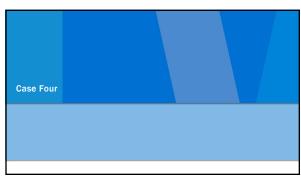




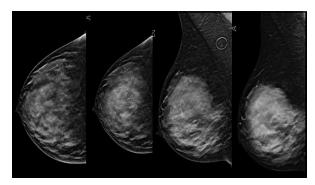
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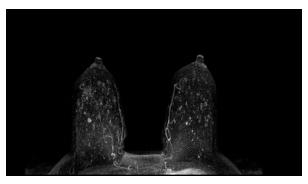


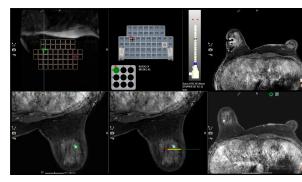




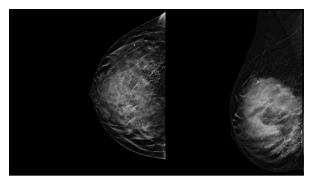
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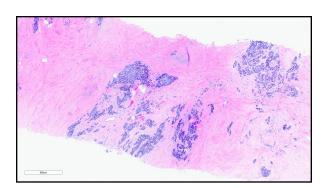






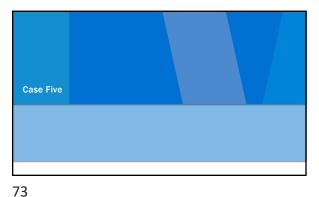
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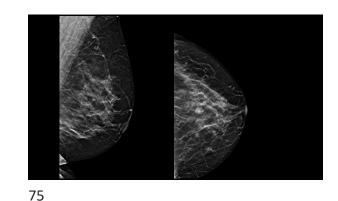
NOSIS:				
st, right, 6:00, MRI-qu	ided core biops	v: Infiltrating ma	ammary car	cinoma, no sp
ductal, NOS), low co				
ritumoral lymphovas				
mamoral lymphovas	Journal IIIVasion S	cen. occ comm	ciic.	
			,	
Test Name	Interpretation	Analysis Average	Intensity	Internal Controls
Test Name ER (Roche Clone SP1)	Interpretation FAVORABLE	Analysis Average 63%	Intensity Strong	Adequate
ER (Roche Clone SP1)				
	FAVORABLE	63%	Strong	Adequate
ER (Roche Clone SP1) PR (Roche Clone 1E2)	FAVORABLE FAVORABLE FAVORABLE	63% 57%	Strong Moderate N/A	Adequate Adequate

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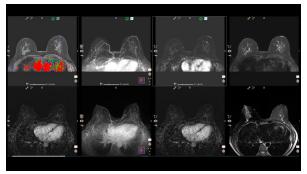


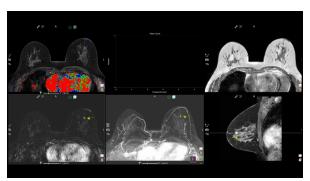


- Family Breast Hx: mother, at age 88, breast cancer and paternal aunt, at age 56, breast cancer
- Family Cancer Hx: father at age 65, colon cancer; brother at age 75, bladder cancer; paternal grandfather at age 45, colon cancer and paternal uncle at age 57, colon cancer
- Genetic Tested: Y+ MUTYH
- Patient qualifies for High Risk Imaging based on NCCN and Genetic Counseling based on NCCN, USPSTF, and ASBrS.
- Tyrer-Cuzick Lifetime (Last Density: C): 22.7%



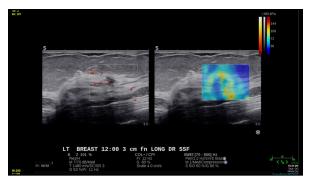
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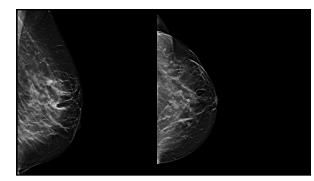


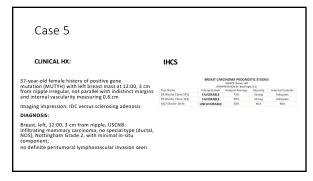


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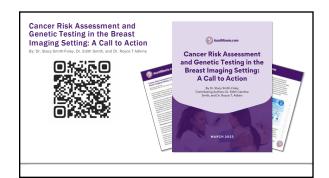


29 radiology societies met to discuss the specialty's most pressing problems: 8 takeaways

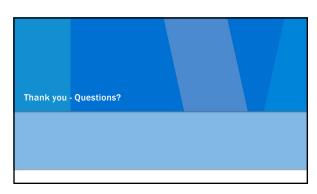
4) Increasing the visibility of radiology:

"Radiologists must take every opportunity to improve their visibility," the authors advised. "Our specialty should emphasize that radiology 'touches' every medical specialty—and nearly every patient—and we risk making ourselves and our profession vulnerable to commoditization if we purely focus on productivity."

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