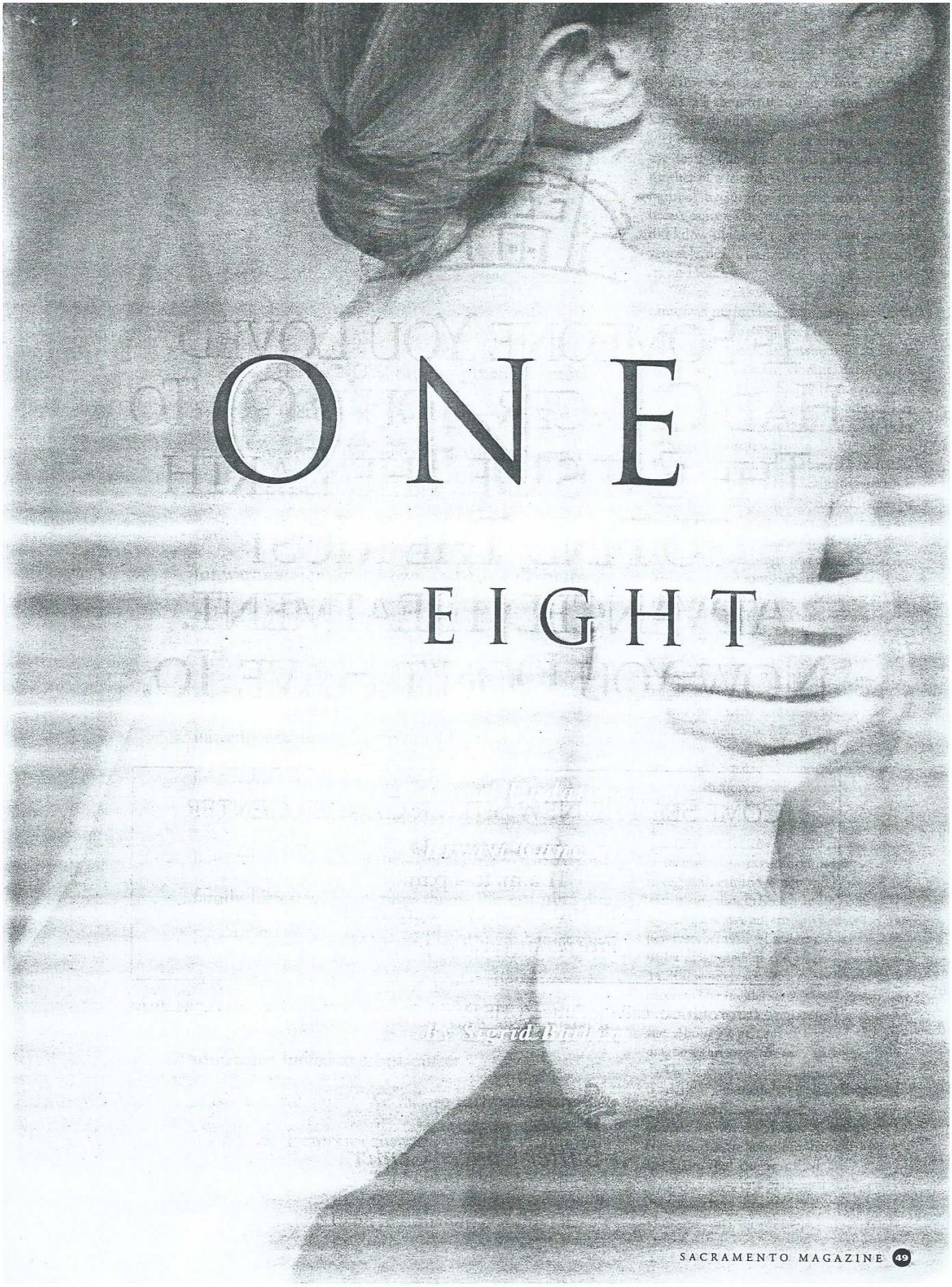

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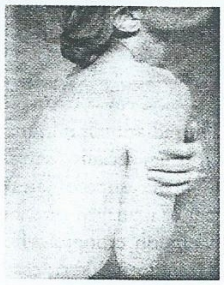

ALL WOMEN KNOW other women—a mother, a sister, a friend, even a daughter—who have been scarred, or even killed, usually slowly, by breast cancer. We recall the stories, the pain, the incredible courage of these women, and we are mostly vigilant for warning signs in our own bodies—a slight thickening, a tiny lump, an unusual discharge.

We are often baffled by the plethora of reports and studies—some of them contradictory, critics even say flawed, or focusing on too small a group of women to be reliable. We try to eat low-fat, high-fiber diets because we have heard it helps prevent breast cancer. We have annual mammograms after age 40. We search our family histories if we know them. We examine our breasts. Because we are more likely to get breast cancer, those of us approaching or past menopause worry about the impact of hormone replacement therapy, sometimes linked to breast cancer.

Mainly, we worry. We talk to each other, and we badger our doctors for answers, which they cannot always easily provide in a field as fraught with conflict—and overwhelmed with information—as this one.

Time was, we worried some, but we didn't talk about it at all or get help when we knew we should.

I remember my mother telling me about the death of an older woman she knew, the mother of a friend, who refused to be "disfigured" by surgery after learning she had breast cancer. I didn't really know her, but I did know she died a horrible, perhaps preventable, death, hastened by equal parts vanity and fear.

When I was a senior in high school, a story came over the kitchen radio about the death of another of my mother's friends, the wife of a prominent businessman with three young sons. A smart, vibrant, dark-haired beauty who had graduated from college at the age of 19 and married the love of her life, she battled breast cancer for more than a decade. Before it was over, she had endured multiple surgeries, and the cancer had metastasized throughout her body. My mother wore a path walking through the field between her house and ours. Toward the end, my mother took her to the hospital to have fluid drained from her lungs. She was 43 when she died, six years younger than I am today. I remember her husband, who was known around town as a tough, ruthless businessman, coming for dinner one night and crying in the dining room.

Later, some of my own friends would be diagnosed with breast cancer. An aunt and great-aunt on my father's side had mastectomies in their 60s. My aunt is now 76, my great-aunt—who was later told she "probably" could have had a "lumpectomy" instead of the much more radical mastectomy—is 93. They are the lucky ones.

EXCEPT FOR SKIN CANCER, breast cancer is the most common cancer in women. One in eight American women will be diagnosed with it sometime in her life. In 1996, according to the American Cancer Society, some 184,300 new cases of invasive breast cancer are expected to be diagnosed in the United States, and 44,300 women are expected to die from the disease. The incidence of breast cancer and breast-cancer-related mortality increase with age. About 77 percent of women with new diagnoses are over the age of 50.

Genetic factors are clearly involved, particularly if a woman has a close female relative (mother, sister, daughter) with breast cancer. As women's health issues generally command more attention than ever, experts speculate that the so-called breast cancer "epidemic"—a one percent annual increase in breast cancer between 1940 and 1982, then a jump of four percent annually between 1982

and 1987, and a leveling off between 1987 and 1992—is attributable largely to better detection and diagnosis, including the widespread use of mammography to detect early breast cancer.

But questions about the cause of the increase remain. Environmental factors such as pesticide use have been raised as a possible precipitating factor, as has the aging of the Baby Boomers. Women who never have children—or have them later in life—are at somewhat higher risk. Also a possible factor: the widespread use of long-term hormone replacement therapy for pre- and post-menopausal women. While HRT is widely credited with reducing heart disease (which kills more women than breast cancer) and osteoporosis—not to mention the sometimes horrific symptoms of menopause—its long-term effect on breast cancer is less clear.

"Part of the increase in [diagnosed] breast cancer is the result of mammography and new techniques," says Dr. Gary Palmer, director of medical oncology for Mercy Health Systems. "But, clearly, some of the increase is real."

Part of the increase in diagnosed breast cancer is the result of mammography and new techniques.

"There is definitely an increase [in breast cancer] above just the early diagnosis," says Dr. Virginia Joyce, a surgeon and assistant clinical professor at UCD who specializes in breast cancer. "We're picking up more because of mammography, but if you account for that statistically, there [still] is an increase. That speaks to other processes, whether they be environmental or genetic." As for the impact of HRT, Joyce echoes the sentiments of many women's health experts. "There are benefits and detriments," she says. "There is conflicting data. We recommend that women who have had breast cancer not take estrogen. The reality is that it's not clear cut. As soon as somebody gives me the answer, I'll sleep more easily."

Dr. Karen Lindfors, associate professor of radiology and chief of breast imaging at UCD Medical Center, says more women "are coming for mammography and are being diagnosed with cancers that would otherwise not be found for several years. We don't really know if all of the non-invasive cancers would progress to invasive cancers if we didn't diagnose them mammographically, so some of the increase [in breast cancer diagnosis] is due to the increase in the utilization of mammography."

Heated debate over whether women should have mammograms annually after age 40 has further clouded the subject. Lindfors and other breast cancer specialists see little to argue about. "My recommendation is that women start at age 40 and have annual mammograms after that," says Lindfors. "The American Cancer Society recommends every one to two years after 40, then annually after 50. I think there is good evidence that women in their 40s should have it annually. But there is a great deal of controversy over that issue."

Joyce says she also recommends mammograms every year over age 40. "These are productive, salvageable women," she says bluntly. "We need to work hard to find early disease and treat it aggressively. It makes no sense to me to weigh it in the balance."

Mercy's Palmer, who also teaches in the UCD medical school, cites studies that show "improvement in survival for a mammographically screened population" and recommends annual mammograms for women after age 40. "It is a relatively minor procedure," he says. "The radiation is minimal." And it works, he and other cancer specialists say, to improve early detection and, hence, survival rates.

In the era of managed care, however, controversy remains. "Certainly economics have a great deal to do with it," says Lindfors. "It's very costly to screen women."

The quality of the mammography—especially the skill of the technologist who administers it and the radiologist who reads it—is absolutely critical, and many health facilities are adopting a team approach to breast cancer detection and treatment that includes experts in mammography, ultrasound, oncology, pathology and plastic surgery. Increasingly, many of those experts are women.

This month, Sutter Community Hospitals unveil their much-touted Cancer Center across the street from Sutter General Hospital on 28th and L streets, with state-of-the-art technology and a team approach to cancer treatment and recovery. It is also the site of clinical trials for the national Breast Cancer Preventon Trial to study the effects of the drug tamoxifen in preventing the spread of breast cancer. "Breast cancer in women is on the rise at an alarming rate," says Cancer Center director Dr. Vincent Caggiano, who adds that "the most important treatment is prevention."

And the key to prevention often begins with a mammogram. "The skill of the radiologist is extremely important," says Lindfors. The Mammography Quality Standards Act, which went into effect in 1994, imposed strict standards for the administration of mammograms. Lindfors says the legislation is "important in assuring the public that when they go in they are getting an exam of reasonable quality."

She says a "wide variety of quality" prior to the legislation resulted in "some inferior mammograms." Whether those "inferior" mammograms led to patient deaths is open to question, she says, although a delay in diagnosis may have resulted. "There certainly was a perception several years ago that there was a great disparity in quality, and that a woman had no assurance when she went to a particular facility that she would get a good exam."

More stringent professional standards for mammograms, combined with a cooperative medical approach to diagnosis and treatment, has resulted in more precise, and earlier, detection. Inconsistencies remain in the type of diagnostic tools and treatment utilized when a breast mass is found and/or cancer is suspected in the reading of the mammogram. Although the routine radical mastectomy is no longer the rule, surgeons say there is still wide variation in the type of biopsy performed and, if cancer is found, whether a "lumpectomy" can be performed instead of removing the entire breast and surrounding tissue.

"There is so much inconsistency nationwide," says Joyce. "Lumpectomy is preferred in some areas, and there are other areas where more mastectomies are done, and it isn't clear for what reason. In other areas, the reverse is true." The general rule, she says, should be that "there is no reason to do more extensive surgery [than is] appropriate to the patient."

When a mammogram reveals that a biopsy is necessary, a woman has more options available to her. Physicians—with the help of highly sophisticated mammography or ultrasound—can recommend a considerably less invasive "core" or "stereotactic" needle biopsy instead of the traditional surgical biopsy.

Most breast masses or lesions detected in mammograms are benign. Traditional surgical biopsies involve cutting tissue out of the breast and can be disfiguring. In the core biopsies, a needle is used to remove tissue from the affected area of the breast, with ultrasound or X-ray guidance.

"In the stereotactic biopsy in our particular unit, a woman lies on her stomach, and her breast goes down in a hole in the table," explains Lindfors. "The computer calculates the exact coordinates of the lesion, pinpointing where the lesion is in the breast." The needle is used to withdraw tissue from several areas of the lesion for further testing.

"A lot of women aren't aware of these techniques," says Lindfors. "Many women have undergone numerous [surgical] biopsies, which may leave scars." The stereotactic procedure is also much cheaper than a surgical biopsy, which costs about $2,500. "This can be done for half of that," says Lindfors. "No surgical stitches are necessary. You don't have to go without food. You don't have to be off work a whole day." The procedure takes about an hour under local anesthetic.

Not available in all facilities, the new stereotactic biopsies require sophisticated equipment and a multidisciplinary approach. And they are not for everyone. "Not all lesions can be approached with this technique," says Joyce. "Then you need to do an open [surgical] biopsy and get to it. If we do get the diagnosis of cancer on a core biopsy, we can go to the operating room only once."

CAROL-LYNN HARRIS, 53, of Sacramento has become something of an expert on breast lumps. Every couple of years since 1983, Harris, who is prone to breast cysts, would have to have the fluid-filled cysts drained. In 1991, her mammogram prompted the surgeon to perform a surgical biopsy. The cysts were benign, but she was distressed by the resulting scar tissue from the procedure.

"I'm five feet tall and small-breasted, and I'd had a lot of biopsies through a needle," she says about her state of mind when the surgeon recommended a surgical biopsy. "I went ahead and did it and was very disappointed in the results. There was discomfort, and scar tissue, which makes future mammograms more difficult to read. It basically ended up being a lumpectomy. I had been told I could see while they did it. I couldn't. I was told the amount [of tissue] they take out would be a small amount. It wasn't."

Last fall, another mammogram revealed "indeterminate calcifications" in one breast. This time, the surgeon offered her the option of the new stereotactic biopsy. She got

ROY M. COX

Support For Survivors

At 55, Valorie Phillips of Sacramento has been a cancer survivor for eight years. She is a volunteer for Reach to Recovery, a support/visitation program designed to offer support and advice to women with breast cancer. Her history is daunting, her relentless good humor awesome.

Plagued for years by uterine fibroid tumors, which are rarely malignant, she suffered from anemia and heavy bleeding, and in 1988 had a hysterectomy. Six weeks before the surgery, she also had a benign lump in her breast removed. Twelve days before, a routine Pap smear to detect cervical cancer had been negative. "Although the hysterectomy had been put off for years," she recalls, "it saved my life."

It was discovered that she had cervical cancer, undetected by the Pap smear because "the cells were way up high in the cervix."

"It was a very aggressive cancer, and it was breast tissue cancer. They couldn't understand why it was in the cervix."

Doctors from several area institutions converged on her case—a radiologist from Sutter Health, a gynecologist and surgeon at Kaiser, and Dr. Walter Kinney, a noted gynecologic oncologist then at UCD Medical Center who is now at Kaiser.

Kinney performed a six-hour exploratory abdominal surgery in which he examined virtually all of her internal organs and took tissue samples. "It was a modified pelvic dissection," says Phillips, who works as a court reporter as well as an American Cancer Society volunteer. "He examined every bit of me abdominally." The nerves controlling bladder sensations were removed in the surgery, and "to this day, I have no bladder sensations. I never know when to empty my bladder. I just watch the clock and remember to go."

After the surgery, she spent 11 days in the hospital. "They said most people couldn't go through the surgery physically and emotionally."

But she survived. Three years later, in 1991, an annual mammogram revealed two masses in her right breast. "The recommendation then was every other year for a mammogram," recalls Phillips. "I had one in 1990 and nothing showed up. I could have gone another year, but I didn't. Just from one year to the next, it changed."

After the 1988 hysterectomy, Phillips had been placed on estrogen, which is commonly prescribed for women whose ovaries have been removed. The two breast masses, which turned out to be malignant, were described as "estrogen reactive." After undergoing a modified radical mastectomy for removal of her breast and lymph nodes, she was taken off the estrogen and placed on tamoxifen, a drug that is believed to retard the growth of estrogen-dependent tumors.

"No one can tell what contributed," she says. "At conception, we're female. And from that point on, we're at risk."

As a volunteer for Reach to Recovery, Phillips stresses monthly self-examination and knows that most breast lumps are found by women themselves, and most are benign. "Mine were very deep," she recalls. "I'm a C-cup. Even the surgeon had difficulty feeling them. He had to go by the mammogram."

After the surgery, she still felt "something" in her armpit. She was told by her doctor that it was scar tissue, not to worry. "He said it would thin out. It didn't."

In October 1994, three years after the mastectomy, a malignant egg-shaped tumor was finally removed from her right armpit. "It shows the importance of knowing our own bodies. You look for a change, something that wasn't there before. We have to be responsible for our own health. We have to persist. I should have been more aggressive."

For further information on Reach to Recovery, call 446-7933.

an appointment with Dr. Joyce at UCD, who consulted with Dr. Lindfors. A stereotactic biopsy March 15 revealed no cancer.

Before the procedure, she asked a lot of questions. "I was very, very careful. I wanted to know what was going on. I wanted more control. I started reading like crazy. I quizzed her [Lindfors] on the phone. I called back and quizzed her some more. When I got to her, I quizzed her again."

The result, says Harris, was "a much different experience" than her 1991 surgical biopsy. There was some bruising, she says, but no surgical scarring or disfigurement.

AT 50, WITH no family history of breast cancer, Martha Wheeland of Fair Oaks was shocked when her mammogram revealed a possible tumor. A core needle biopsy, guided by ultrasound, revealed she did indeed have cancer. She underwent a mastectomy Feb. 14. "It was two weeks to the day from the mammogram," she recalls. "During that two weeks, I was in a fog."

Before the surgery, she and her husband, Sacramento dermatologist Dr. Ronald Wheeland, spent a lot of time together. "I felt like everything was whirling around me. I'd just as soon have it diagnosed and done. But it actually gave my husband and me some time. We went down to see our son in Santa Cruz and took a hike. It gave us time to cry and to worry and to have some real quality time together."

Her three sons were all in school—two out of the area. "The distance was hard for them," she says. "They talked a lot with their dad."

The 1.5-centimeter tumor was "well-defined, and the margins were clear. My lymph nodes were clear. My prognosis is very good." She has had chemotherapy, and she no longer takes hormones for the symptoms of menopause. "I often ask myself how I would feel if the prognosis had not been good," she says. "It's easier to be positive when I have a lot going for me."

With the increasing volume of information available to women about breast cancer detection and treatment, confusion reigns. Women are more likely to question their physicians, sometimes in excruciating detail.

"The message I try to get out to my patients is that breast cancer is a very individual disease," says Joyce. "What is recommended to their mother or their sister or their aunt may not be what is recommended to them. Breast cancer treatment should be very tailored to the individual.

"Patients are scared and want to know and understand. Physicians want the same thing. We can only do the best we know." ■