Midlife Clarity with Dr. Tracy Page

"Clarity Changes Everything"

Hosted by Dr. Tracy Page

Episode # 21 — My Mom Had Breast Cancer

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I want you to picture a theater. A big one, 1,000 seats, and every seat is filled with a woman in her 50s. Some of these ladies are your friends. One of them may even be you. So over the next five years, about 23 of those 1000 women will be diagnosed with breast cancer. That's the baseline. That's what happens. With no hormones at all. 23 women, 23 women out of 1,000. Will be diagnosed with breast cancer regardless of hormone therapy. Now, if every woman in that theater started a combined hormone therapy, estrogen plus [inaudible]. And I want to be careful when I say this part because it depends on the type of progesterone, but the research suggests about four more women would be diagnosed over those five years. And some of that research comes from progestin, not micronized progesterone, okay? But four more women. Over five years, four. If every woman in that theater now drank two or more glasses of wine at night, about five more would be diagnosed. So actually, how much alcohol they intake. Increases the number of women diagnosed with breast cancer. And if every woman in that theater were carrying significant excess weight,

after menopause, because remember they're 50, right? And we're talking excess weight. So their basic metabolic rate. And I would say their body fat percentage. Over 28%, okay, so they're carrying excess weight, so we're 28%. And that could be anywhere from 20-plus pounds of excess weight. The estimate is that about 24 more women will be diagnosed with breast cancer.

I'm not telling you that to scare you about wine, alcohol, weight. I'm telling you because I've watched a single sentence shut down one of the most important conversations, the most important health conversations a woman can have. And that sentence is, "My mom had breast cancer, so I can't take hormones". And the title of this podcast is My Mom Had Breast Cancer, Fear Is Not A Medical Decision. Okay. So if you've said that sentence or thought it, this episode is definitely for you. Your fear. It does make sense. It comes from love. It comes from watching someone you loved suffer. And I respect that deeply, but the story doesn't end there. And that's why I made this podcast. Fear is not a medical decision. Your family history is real, and it absolutely

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belongs in the conversation. It just shouldn't be the end of the conversation when it comes to your hormonal health. So today we're going to open the door. Together, I'm gonna explain what family history actually means in the numbers, and how those details change everything. The risk nobody mentions of not treating menopause because there's a risk of not making a decision to treat it.

And when caution really is the right answer, and exactly what to bring to your next appointment so you get the right answers if your mom had breast cancer. I'm Dr. Tracy Page. This is Midlife Clarity. Thanks for being here. When I create clarity, it makes everything simpler. So I'm trying to create that for you. I think this podcast is especially important. Sorry, it's taking a while for me to get it out here, but it's here, and let's talk about it. So. Let's start with the question you probably never had answered with an actual number. What does my mom's breast cancer mean for me? Your family history is a forecast. It's not a verdict. When the forecast says 40% chance of rain, you don't cancel your life, right? Sometimes I want to, but you don't, right? You bring an umbrella, you check the sky, you check your phone, you make a plan. And a family history is the same thing. A family history of breast cancer works in the same exact way. I know it sounds very simple, but it does. It tells us to screen more carefully and to have a more detailed conversation about what happens, right? It doesn't tell us that the storm is coming for certain.

and it doesn't tell us to stay inside forever. So here at the forecast, this is the approximate lifetime breast cancer risk. The average US woman, it's about 13%. Roughly one in eight women will be diagnosed with breast cancer. The approximate lifetime breast cancer risk with one first-degree relative- a mother, sister, or daughter who had breast cancer, Roughly double. Or roughly, I would say doubles the average. But I'm gonna come back to that word, doubles. So please keep listening. (static buzzing) Two first-degree relatives: roughly three times the average. Okay. And if you have a BRCA1 or BRCA2 mutation, about 60 to 72% by age 80 is your lifetime risk of breast cancer. Now let's flip one of those numbers around and let's talk about a different way. If your lifetime risk is about 13%, regardless of anything, that means one in eight women will have breast cancer. That means 87% of women never develop breast cancer, almost 90%,

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87%, okay? And for a woman with one affected first-degree relative, the large majority will still... Never develop breast cancer. Most women with a family history of breast cancer never get breast cancer.

Hear that, okay? Let's talk about lottery tickets and how they relate to the word double. Here's why the word double can mislead you quite a bit. That's a relative risk. What you need is an absolute risk number. Imagine a raffle with a thousand tickets. Okay, remember those thousand women in the chairs in the theater? If I give you two tickets instead of one, I've doubled your chance of winning. But you're still only holding two out of a thousand. Okay, doubled sounds enormous, but two in a thousand doesn't sound quite so enormous, right? So it's really a lot more, right? It's your absolute risk, okay?

When a headline or even a well-meaning clinician says, "Hormones increase your risk." Your very next question should always be by how much? Out of how many? And for how long? And I'm gonna summarize this at the end, 'cause this is important. By how much does it increase my risk? By how many, out of how many, does it increase my risk? And over how long of a time does it increase my risk? The one question changes the entire conversation. Here's something that surprises many women. When researchers have looked at whether hormone therapy raises breast cancer risk, I would say more in women with a family history. Than in women without one. Several large analyses, including data from the Women's Health Initiative, have not found that it does. So let me repeat that. Something that surprises many women. When researchers looked at whether hormone therapy raises breast cancer risk more in a woman with a family history than a woman who doesn't have one. Several large analyses, including data from the Women's Health Initiative, have not found that it increases their risk. In other words, family history raises your starting point, but it doesn't appear to make hormones act differently in your body.

That's still something to discuss individually, of course, but it's not an automatic stop sign most women are led to believe. Okay? Family history tells us where your starting line is. It doesn't tell us where your finish line is. And that's super important for a woman in menopause, okay? Or perimenopause. When a woman tells me My mom had breast cancer, my next questions are always the same, not because I doubt her, not because

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those four words hold, I would say, different stories for different women. It's because I need to know these four questions. So kind of think of it this way: a hurricane and a summer thunderstorm are both storms, but you would never prepare for them the same way. Breast cancer is similar. The details of your relative's diagnosis tell us which kind of storm we're forecasting, right? Is it a thunderstorm or is it a hurricane? So the details matter most. How old was she? So these are the four things that you're gonna wanna know. How old was she when she was diagnosed? A diagnosis before 50 of breast cancer, before menopause, sends a stronger hereditary signal than a diagnosis at 72, okay, or at 60. Breast cancer becomes more common with age. A diagnosis in a woman in her 70s or 60s often reflects age more than inherited genes.

So therefore, if that's your mother at 60 or 70, I'm not gonna worry about you as much about hormone therapy, okay? What type of breast cancer was it? About 70 to 80% of breast cancers are hormone receptor positive, meaning they are fueled by estrogen or progesterone. Others, such as triple-negative breast cancer, aren't driven by hormones at all. And a triple-negative diagnosis in a young relative can be a clue to a possible BRCA mutation. So that detail is super important for a different reason. It tells us to think about genetic testing. Number three, who else in the family? Multiple relatives on the same side, a male relative with breast cancer, ovarian cancer, pancreatic cancer, aggressive prostate cancer in the family. Even if you're of a certain Jewish ancestry, it raises questions of inherited mutations. You need to answer that at your appointment. And number four, has anyone been genetically tested? BRCA1 and BRCA2 are the best known genes, but modern panels now test for many, many more. A BRCA mutation is a genetically different clinical picture. It changes screening, prevention options, and the hormone conversation itself.

And here's something many women are never told. For BRCA carriers who have their ovaries removed early to lower. Well, let me say it. For BRCA carriers who have their ovaries removed early to lower their cancer risk. So they get their ovaries removed early to lower their cancer risk. Guidelines often support using hormone therapy until around the natural age of menopause. So they have BRCA; they get their ovaries removed. The guidelines are actually supporting using hormone therapy until they're actually, like, let's

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say they get their ovaries removed at age 35. They're actually supporting hormone therapy until the age of menopause, right? That's because an abrupt surgical menopause at 40 or 30 carries its own serious risk to the heart, bone, and brain. So that decision belongs with the specialist and with the patient, but it shows you how far from automatic no. Reality really is, right? Just because you have something doesn't mean automatically no form of. Kind of think about it like a family album. So your family history isn't one photo; it's an album. One photo of your mom at 74 tells me something. The whole album tells me what I need to know. Your job before your next appointment is to gather the album and tell exactly how the episode ends based on all the information that you give to your provider.

So my mom had breast cancer is the beginning of the story. But again, it's not the whole story is not the whole album, right? Okay, so. This I think, is the most important question in this entire episode. So I'm gonna say it slowly. The question is never just are our hormones risky? That's not the question. The question is: risky compared to what? All right, so. Let's use this analogy. Every time you drive your car, there's a risk. So you could decide never to get in a car again, but then you can't get to work. You can't see your friends can't get to the grocery store. Get to your doctor's appointment; you can't do much of anything that requires you to drive, right? Staying home isn't risk-free either. It just trades visible risks. For invisible ones, because let's say you can't eat because you can't get to the grocery store. So now you risk starving, right? So there is a risk with every decision, right? Untreated menopause is the same thing. So no hormones feels like it might be the safe choice because nothing is happening. I want to tell you a lot is happening. It's just happening quietly that no one's discussing with you. Okay.

Let's go back to our theater analogy. So looking back to our 1000 women in their 50s, these are estimates from the British Menopause Society patient information, and they're approximate, but they give you a sense of scale over five years. So again, baseline, no hormone therapy, the change in breast cancer cases per 1000 women was 23 cases, no hormone therapy, okay? This is the British Menopause Society's patient information. Combined estrogen and progestin therapy about four more cases. And again, I say that with caution because micronized progesterone has been shown to be less likely to

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cause breast cancer. Okay. Estrogen-only therapy in women without a uterus who chose just to go on estrogen about four fewer cases. Per thousand. Okay. Two or more alcoholic drinks a day, about five more cases per thousand. Overweight or obesity after menopause. 24 more cases. Per thousand that had breast cancer. Despite the 23 baseline, remember? And then two and a half hours of exercise a week, seven fewer cases of breast cancer. So look at the estrogen-only line again. So think about that. In the Women's Health Initiative, the very study that frightened the generation of women, the women who took estrogen alone actually had fewer breast cancers than the placebo group over the long-term follow-up.

The type of hormone and the formulation matter enormously. There's a conversation for you and your clinician to have, including the choice of whether or not you add progesterone and the type of progesterone since new data suggests bioidentical, micronized progesterone can carry less breast cancer risk than older synthetic versions like progestins, okay? Let's look at the ledger. So let's talk about the woman who rarely hears about doing nothing. Okay, so - Heart disease. Heart disease is the leading cause of death in women. You've heard me talk about it many times and it kills far more women than breast cancer ever will. I mean, far more. So there is more heart disease than all cancers combined, the number of women who pass because of heart disease. A woman's lifetime risk of dying from breast cancer is about one in 40. Cardiovascular disease causes about one in five women to die. One in five. Estrogen helps keep blood vessels flexible and cholesterol in check. And when it declines, heart risk begins to climb. For healthy women who start hormone therapy under 60, and we use 60 as kind of that cutoff if you're going through menopause at 50. And I don't, and I use the word cutoff very loosely.

or within 10 years of menopause, studies suggest a neutral to favorable effect on the heart. And I say that I use that term loosely because I have women in their sixties who I started on hormone therapy because they have no reason not to start on it. They have no risk involved. And it actually is the benefit I'll raise, raise any of their risk. So I don't use; I like to use a specific number as a cutoff. Bones. Women can lose up to 10 to 20% of their bone density in the first five to seven years after menopause. About half of women

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over 50 will break a bone due to osteoporosis. And that's not the worst thing. A hip fracture in an older woman isn't just a broken bone. Roughly one in five women who break a hip die within a year. And many never return to independent living. So, hormone therapy is proven to prevent bone loss and reduce fracture risk, including hip fractures, which ultimately could save your life and maintain your independence. Brain and sleep. Hot flashes and night sweats wreck sleep. And I just did a podcast on sleep. As we covered in the sleep episode, poor sleep affects everything from your weight to your mood to inflammation to your memory to your energy level. Perimenopause also is a window of higher risk for depression, even in women who have never had it before. And I've seen this as well in my practice.

So for many women, symptoms... Like in daily life, they can last seven years or longer. So that's a long time to live with night sweats, joint pain, vaginal dryness, painful intimacy, recurrent UTIs, the risk of sepsis, infections, brain fog. Urinary, genitourinary symptoms, like all of those things, typically get worse when you don't treat hormones. Imagine a sheet of paper with a line down the middle; on the left, the risk of hormone therapy for you. Specifically, okay on the right the risk of not taking hormone therapy for you specifically. Most women have only ever been shown one side of hormone therapy risk. They've never been talked about the side of risk if you don't do therapy. Okay. You can't make a real decision if you're only looking at half a page, you have to look at both sides. You have to weigh the benefits versus the risks. And it's different for every woman, but it is real and it is a discussion that should happen. Doing nothing. Is a decision. It just doesn't feel like one, but you are deciding. So this series is built on honesty. So I want to be just as clear about the other side, the side of doing hormones and not doing hormones, okay?

There are real situations where hormone therapy isn't the right choice. And where it needs a specialist, extra care, or a deeper dive. Think about it like this. There's different lights on your dashboard, right, of your car. These cars nowadays have so many. Some mean, check this at your next oil change, no big deal, right? But some mean, pull over right now, this could be serious, right? And so we're gonna talk about the ones that are like the yellow to red, like, hmm, caution, or two, stop, this could be serious. So in a

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hormone conversation, family history is usually a yellow light. Slow down and get more information. But there are some red lights as well. So personal history of breast cancer is a red light, especially hormone receptor positive. Systemic estrogen is generally not recommended because it has a different effect on your body. There are, though, non-hormonal options and in some cases, I have even seen ladies who have receptor-positive get vaginal therapy because vaginal therapy doesn't work systemically. So they get that for their vaginal area. But again, it's a conversation with your oncologist and knowing what type of breast cancer you have. So this is a red light scenario. Stop caution.

Well, over now, don't make a decision to have all the answers, okay? Known BRCA1 or BRCA2 mutation, this needs a specialist; I would say a specialist to plan out what your treatment is. The answer depends on whether your ovaries and breasts are still in place, and it also depends on your age. It's not a simple yes or no. So that's a red light. History of blood clots like DVT or pulmonary embolism or history of a stroke. So. I never prescribe oral estrogen. Oral estrogen raises your clot risk because it goes to the liver and affects clotting factors. Transdermal estrogen, meaning a patch, gel or spray, doesn't appear to raise it in the same way and may be considered. With specialist input. So again, yellow light for transdermal, red light for oral estrogen. And then unexplained vaginal bleeding, active liver disease, or an active estrogen-sensitive cancer. Because there are some cancers like in the brain, that are hormonally receptive. So it's not just breast cancer. These need to be evaluated and addressed first and fall under the red light scenario. So we have to stop.

We have to assess; we have to make sure we have all the information before we move forward. And timing, it does matter, but it matters based on history and also the patient. So starting hormone therapy under 60 or within 10 years of menopause care is very favorable or more favorable, I say, balance of benefits than risk. Starting much later doesn't mean you're excluded if you're over 60. And I did a whole webinar on that. So please watch it. They watched over 10 million women over the age of 65 or up to 65 who are still on hormones, and they had less all-cause mortality in every single circumstance. So that's worth talking about because. If someone's gonna ask me, I'm

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going to my grave with my hormones as long as I don't have any reason not, like the benefit outweighs the risk, right? You are also allowed to decide hormones aren't right for you. So please hear that. I'm not here saying that hormones are for everyone. That's a completely valid choice. My only ask is that you make it with the whole (static) page of both sides of the information in front of you, not just the scary half of what happens if you go on hormones, but also you need to know what happens if you don't. And if you're not a candidate, you still have other options. So non-hormonal medications for hot flashes, bone-building medication, strength training, nutrition, sleep, sleep support, vaginal moisturizers- they're all real tools. And a no to hormone should never be a no to feeling better.

Those are things that will help you feel better. Okay, so I want to talk about the fear itself for a moment because the fear is real. It's really real because when a woman says to me, my mom had breast cancer, I, so I can't take hormones. She's usually not making a statement about estrogen receptors. Like she doesn't think about that. What she's really saying is, I watched someone I love go through something terrible. I sat in the waiting room when my mom was having surgery. I saw what chemo and radiation did to her body, right? And I will do anything not to go through that myself. That's what she's saying when she comes in and says, "My mom had breast cancer; I can't do hormones, right?" She's saying, I don't want that life, right? I don't want that to happen to me. And that's not irrational. That actually is, I think, love. That's grief. And it deserves respect. It deserves respect; it deserves acknowledging. It's more important than a statistic, but it's not the only thing. The statistics still matter, right? The best way I can describe it is that when patients come in and they're very fearful is like having a flashlight on in a dark room.

So fear is like the flashlight in the dark room because it's very powerful and it's focused, and it points to the one thing that scares you the most, the reason you turn the flashlight on, right? So you can see that, let's say, corner in sharp detail, right? Like that's the one thing, but everything else in the room disappears. So you get to see where the flashlight is pointed, and everything else is dark. So the stuff that is dark in your body is the bone you're losing, the years of broken sleep and all the effects that has, the heart risk that

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climbs and increases your risk. There are one in five women will die of a cardiac event that could possibly be prevented by being on hormones. The intimacy that quietly goes out of your marriage because you lost your hormones, the version of you that used to feel sharp and sexy and strong. Is no longer there; that's a real loss, right? That goes on that column of no doing hormones. This is what happens. So the goal isn't to turn off the flashlight. That's not the goal. The goal is that your fear is telling you something that matters. The goal is to turn on the rest of the lights in the room. So you get to see all the options and all the risks and benefits. And I want to talk about quality of life because it too often gets treated as a luxury.

And as a woman who's 60, who feels amazing, has an amazing life. Because of my hormones, I truly believe that. Feeling good is not a luxury. Sleeping through the night is not a luxury. Being able to think clearly at work is not a luxury. Having a sex life that feels great and doesn't hurt and you have desire is not a luxury. Staying strong enough to pick up your grandkids or carry your groceries or travel anywhere you want and stay independent until you're 90 or 100. That is not a luxury. That is so important. And that's your life. And it counts when you're making these decisions. Really counts. So many women spent a decade or longer enduring symptoms because they believed the only choices they had were suffering. Or I'm gonna get breast cancer. But that's never always the real choice, right? For very few women, that's really comes down to those two things. It's not very often. So your mother's story is part of you, 100%. It belongs in the room. It should be discussed, but you get to write your own story too, and you deserve to write it with all the information, not just fear. So I don't want you to just feel better because you listen to this episode and now I get to go do hormones. I want you to do something and I want you to have a plan. So just like a GPS, it can't give you the directions until you put the starting point in and the destination in, right? So I can't tell you if you're eligible for hormones. We need information. We need a starting point. It's a general region and your specific numbers is basically all the...

History and stuff is the address that gets you to where you want to go. So this week, I want you to work on if this episode applies to you or someone you know, who's had their mother have breast cancer, and they're afraid to do hormones. I want you to put

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your family history in a folder. Call your mom if she's alive. If she's not asking aunt or sister or whoever holds the family story and write it down. Who had breast cancer or ovarian cancer. So breast cancer or ovarian cancer and which side of the family were they on? Number two: how old each person was at diagnosis. Number three, what type of cancer it was. If known, was it hormone receptor positive, estrogen positive, progesterone positive, both hormones? Was it HER2 negative? Was it... Triple negative cancer. And then number four, whether anyone had genetic testing and if they did, what were the results? And number five, what other cancers are in the family, including pancreatic, prostate, colon, ovarian, and any male breast cancers? If your mom's living, great conversation to have with her. And if she's not, look at medical records, talk to aunts and uncles, sisters, cousins, somebody will know.

Write down what you learned; even if the answer is unknown, you've still asked the question. And then at your next appointment, ask these five questions to your provider. What is my personal risk number? Ask your clinician to calculate your risk with a valid tool. There's one. It's Tyrer, T-Y-R-E-R, Cuzick, C-U-Z-I-C-K. And then it's in parentheses IBIS. It's a model. It takes detailed family history into account. A breast surgeon, a breast oncologist, they'll know about this tool.

Should I have genetic counseling or testing? If you have a close relative that's diagnosed, that was young, Multiple affected relatives or ovarian cancer in the family asked to get genetic counseling or testing. And three, based on my history, what are the risks of hormone therapy for me? Ask for absolute numbers, how many out of a thousand over how many years? Just like that example I said in the beginning. And number four what are the risks to me if I don't treat my menopause. So get a DEXA scan, know what your bone health is. Get your cardiac work up. Do that cardiac cue where you know your particle numbers, your Lp(a), your ApoB. Sleep and mood, quality of life. Those are all conversations that you should be having. If hormone, and number five, if hormones aren't right for me, what are my other options should also be a question. If your clinician says no based on family history alone and can't explain why your specific history leads to that answer, it's okay to seek a second opinion from a clinician who specializes in menopause. These are common questions that we are

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answering and uncovering every single day. And you deserve good reasoning, good answers.

These are things also too that you can do to start to lower your risk regardless of your choice. Because remember, I gave you some pretty interesting statistics. in the beginning. So here's the empowering part. Some of the biggest breast cancer risk factors are ones you can influence whether or not you ever take a single hormone. And that's really gets under my skin sometimes because patients come in and they're so adamant like I can't do hormones. They're going to cause me to have cancer. And I'm like, well, that alcohol that you're drinking five nights a week is definitely going to also cause you to have cancer. But let's talk about that. Right. So. Move, aim for at least 150 minutes of activity, plus strength training two times a week. For your bones and your metabolism, okay? Because remember when we decrease insulin, we decrease inflammation, the disease comes from inflammation. Rethink your alcohol. Breast cancer risk rises with every daily drink. So if you drink, consider cutting back or try 30 days without alcohol and just even see how you sleep. It's pretty amazing. Weight goes down like a lot of things change when you give up alcohol.

Remember, two drinks increases the risk, right? Protect your body composition. After menopause, that tissue becomes a major source of inflammation. It can even, at high weights, can be a source of estrogen, too much estrogen. So keeping muscle and reducing excess body fat is one of the most powerful moves you can make. To decrease your risk of breast cancer. And stay on top of your screenings. Keep up with your mammograms, ask whether your breast density or risk level means you'd benefit from additional imaging. Usually they'll tell you such as a breast MRI or an ultrasound. So. The mammograms have been shown in population studies to be the number one tool to detect early cancer or early detection, I should say. So I have some women out there who want to do mammograms, they want to do thermograms, but if you look at the studies, mammogram is the most therapeutic diagnostic tool we have, okay? Besides actually checking your own breasts. And then get your bone density checked. If you're postmenopausal and you have a risk of fracture. Risk of fractures and you've

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had family history of people who have osteoporosis, then you need to make sure you're getting a DEXA.

Let's go back to the theater one more time of the thousand women. Every one of them deserves to know her own numbers. Everyone deserves to see both columns. What happens if you go on hormone therapy and what happens if you don't? And everyone deserves a clinician who takes fear seriously, but helps you see past it and turns on all the lights, right? So you're looking at the whole picture. Family history as a variable is not a veto. Fear is a signal. It's definitely not a decision. And doing nothing is a choice, right? So here's your homework. This week, build your family history folder, then bring it and your five questions to your next appointment with your provider. And don't leave until you have the whole conversation. If you want a practice, if you can't find that and you need a practice that will walk you through your personal risk with you, both sides of the ledger talks to you about with and without hormones. We do this every day at WIFM. You can call us, you can visit our website. We'd be happy to help you. We have amazing providers here who take care of women every day. And if you know a woman who has said, my mom had breast cancer so I can't have hormones.

Please share this episode with her. It might be the conversation that she needs to hear in order to help her move to the next level. I'm Dr. Tracy Page. This is Midlife Clarity and I truly do believe when you have clarity, it makes everything simpler because it helps you to make the best decisions with a clear view. You deserve the full picture, so go out there and get it. Remember, this is for educational purposes only, and make sure you talk to your provider about your personal risk and make sure that you're getting the care that you need. Until next time, I wish you happiness and hormonal good health.

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