Our meeting was called to order by Director Lynda Dyer at 7:00 PM. Bettye Haynes introduced our speaker for the evening, Dr. Jenevieve Hughes, MD. Dr. Hughes is a breast specialist and is Director of the Breast Center at Methodist Richardson Hospital. The center provides all types of care relating to breast disease including diagnostic procedures, radiology, pathology, surgery and rehab following surgery. They also offer High Risk Clinics with the focus being prevention or early diagnosis for patients with a strong family history of breast cancer. Dr. Hughes has visited our support group on a few previous occasions and always brings very relevant and current information to share with us.

Dr. Hughes asked each of us to introduce ourselves, tell a little bit about our cancer story and something surprising about us that the group would have no knowledge of. She also wanted us to be thinking about things we had learned while going through our cancer walk, things we might wish to have changed and some advice we would want to share with a newly diagnosed patient. These responses would be shared after each one told their personal story. It was a very interesting and bonding time, drawing us in closer to one another, and was a wonderful way for her to know us a bit better. She picked up key words and phrases as we spoke which she used as her focus later to explain certain aspects of the disease and treatment, all of which were very helpful.

Following our introductory time, Dr. Hughes reviewed basic breast anatomy and explained that breast cancer names were determined by where they are found in the breast, either ductal found in the ducts and comprising 75% of all breast cancers) or lobular (found in the lobular breast tissue outside the ducts and comprises 10% of breast cancers). She explained that when cancer begins, one cell changes within the duct and continues to divide, filling the duct, diagnosed as DCIS. When the cells grow through the ductal walls, it becomes invasive cancer, either ductal or lobular.

Pathology is a very important key, and early in diagnosis tissue is tested to see if it is estrogen or progesterone receptive (fed from these hormones) When these test positive, endocrine therapy is indicated to prevent the binding of estrogen or the prevention of estrogen in the body. When estrogen/progesterone positive, Evista or Tomoxifen are given for 5-10 years. Aromadace inhibitors, which block the production of estrogen include Femora and Aromasin. These are considered targeted therapies, and there are many more being studied that will likely soon be available. HER2 positive tumors, which make up 16-209% of breast cancers, are due to a gene mutation. When present they influence the treatment plan, and immunotherapy is often given with the chemotherapy. Oncotype testing is done on ER/PR positive tumors and is a genetic test on the cancer itself. The pathology test looks at 21 genes, check their level of aggressiveness and a score is given which is divided into ranges. For example scores of 0-18 is considered low,
18-31 moderate and above 31 is high risk for a recurrence in 10 years. These test results help to determine when and if chemo therapy is indicated on each individual patient.

Dr. Hughes spoke about a fairly new targeted breast radiation treatment called internal radiation. A catheter is inserted into the surgical site following a lumpectomy where the tumor has been removed. For five days, twice a day, a radiation seed is blown into the catheter, stays a designated amount of time and then is removed. The outcome is equal to traditional radiation (usually 36 treatments), is completed in a much shorter time, and does affect surrounding tissues nearly as much as traditional radiation might. However, it is not available to all patients, and never to those with mastectomies. In discussing tissue margins at time of surgery, Dr. Hughes said that current criteria is that the space beyond any cancer cells is 2 mm but that this criteria is a changing measurement and is not a constant, depending on the situation. When a surgeon is required to go in to take additional tissue it is because the pathology reports showed that the margins were “not clear”.

The final discussion was regarding the use of expanders versus implants at the time of surgery. Factors that must be considered include how much skin conservation can be done, how good the blood flow to the tissue is, whether or not the patient has had previous implants and also future treatments that may be needed, such as radiation. When radiation is needed, expanders are needed first, with implants at a later time. Dr. Hughes generously stayed to answer the final questions from some of the members who had other concerns, and our meeting concluded at 8:45 PM.

Respectfully submitted,

Nancy Zucker, Board Member