

ACS NBCRT Post-Webinar Q&A

A Provider's Guide to Breast Density & Optimal Screening Webinar

Session: September 30, 2026

Watch the recording: www.nbcrt.org/webinar

Thank you for your thoughtful questions! We apologize that we could not respond to them all during the session. Please see below for follow up responses from Dr. Wendie Berg, Professor at University of Pittsburgh School of Medicine and Chief Scientific Advisor to DenseBreast-info.org; Dr. Tracy Battaglia, Professor of Medicine at Yale School of Medicine and Associate Director of Community Outreach and Engagement at Yale Cancer Center; Dr. Amy K. Patel, Medical Director of the Breast Care Center at Liberty Hospital, Associate Professor of Radiology at KU School of Medicine, and Steering Committee Member and Chair Membership Committee of the ACS NBCRT. If you have any additional questions, please email nbcrt@cancer.org.

1. Do you have materials showing the anatomy of the breast and explaining breast density in languages other than English? Specifically looking for Spanish and Somali.

SenosDensos.org is part of DenseBreast-info.org and provides content in Spanish.

2. We talk about screening younger women, but how effective is mammography?

Younger women are more likely to have dense breasts and there are fewer cancers to be found. Together, these factors reduce the benefits of mammography, but there is still benefit to annual screening mammography starting at age 40. For women at high risk because of disease-causing genetic variant, or prior chest radiation therapy before age 30 and at least 8 years prior, we start with screening MRI as early as age 25, and only add mammography beyond age 30. If there is family history of mother or sister diagnosed with breast cancer before age 50, screening mammography should start 10 years earlier (e.g. mother diagnosed at age 45, then the woman should start at age 35). It is especially important for Black, Hispanic, and Asian women to start screening at least by age 40 as their peak age at diagnosis is younger, in the late 40s.

If the breasts are extremely dense on mammography, additional screening is recommended beyond mammography.

For women with heterogeneously dense breasts, other risk factors should be considered when deciding to have more screening, such as family history, prior atypical or cancerous biopsy, but additional screening is still an option even without other risk factors.

What type of additional screening is recommended? Adding a screening MRI is the best test to find breast cancer. If MRI is not an option, some centers can do contrast-enhanced mammography (off label, as it is not FDA approved for screening), or screening ultrasound can be considered. Beyond age 70, we do not typically do screening MRI as it is such a limited resource, so screening ultrasound can be considered in that situation. MRI is also not used in pregnant patients. For more about additional screening tests, see <https://densebreast-info.org/for-patients/screening-tests-after-a-mammogram/>. The woman will also want to confirm her insurance will cover the additional screening. The additional screening should be done within about 6 months, and is recommended every year or two, in addition to yearly mammography.

3. Is there a difference in screening effectiveness relative to tumor type?

Invasive lobular carcinoma (ILC) can be particularly difficult to see on mammograms as it grows as single-file columns of cells and may not form a discrete mass on mammography or even ultrasound. ILC also

usually does not have calcifications, and calcifications are well seen on mammograms even in dense breasts. ILC is better seen on ultrasound, contrast-enhanced mammography, and MRI than on standard mammograms. We do recommend additional screening in women with a history of ILC. Triple negative invasive breast cancer can sometimes have a rather benign appearance and even sometimes mimic a benign cyst, but it is usually easily detected. All noncalcified cancers are harder to see in dense breasts, including some estrogen- and progesterone-receptor negative high-grade ductal carcinoma in situ (DCIS).

4. **How is everyone addressing high risk need in the uninsured population? Sage only goes so far, and it does not include MRI, genetic testing, or high-risk consults in a high-risk breast clinic. And I should have included the dense breast population not at high risk who are not insured?**

Agree this is a challenge. Your state BCCEDP programs may support some of these patients in your community. <https://www.cdc.gov/breast-cervical-cancer-screening/index.html>

5. **Are women offered Risk profiling routinely in the USA?**

Formal risk assessment is not routinely performed at this time, and a visit to a high-risk program may not be fully covered by insurance. There is no reimbursement to primary care providers or breast imaging centers to perform risk assessment. Informally, breast imaging centers routinely consider breast density, family history, and prior atypical or cancerous biopsy results when making recommendations. If not routinely available via their providers, patients can access patient-facing websites to estimate their own risk: <https://www.komen.org/breast-cancer/risk-factor/understanding-risks/gail-method/> or <https://magview.com/ibis-risk-calculator/>. Results should be reviewed and interpreted with a provider. Some centers are routinely using AI review of mammograms for risk assessment (see below) or are offering this as a self-payment option.

6. **Are there recognized imaging pathways for different densities?**

Yes. The American College of Radiology, National Comprehensive Cancer Network, and other organizations endorse adding screening MRI for women with extremely dense breasts. For women with heterogeneously dense breasts, other risk factors should be considered and may prompt MRI, <https://www.ncbi.nlm.nih.gov/pubmed/38141231>, though even without other risks, MRI can be considered. The simplest summary available, emphasizing supplemental screening and based on consensus opinion, is: <https://densebreast-info.org/for-providers/who-needs-more-screening/>.

7. **When utilizing CEM for high-risk screening, do those patients also need noncontrast mammogram yearly as well or is just the one CEM yearly sufficient?**

CEM is not currently FDA approved for screening, but in centers doing this off label or as part of research programs, the low-energy image that is part of the CEM examination serves as the standard mammogram, so just the one CEM yearly is sufficient, yes. [Note: A CEM examination is performed after injection of iodinated contrast and includes a low-energy and a high-energy image, the latter more absorbed by areas containing more iodine. Computer processing is used to essentially subtract one from the other to show areas of enhancement (“recombined image”), and we review both the low-energy image and the recombined image.]

8. **Would a woman with a history of BrCa and heterogeneously dense breasts warrant an automatic supplemental screening?**

“Automatic” is not the right word, but yes, up to age 70 or 75, if a woman is very healthy, additional screening with MRI is recommended by the American College of Radiology (ACR), or CEM if that is available. If neither MRI nor CEM can be performed, ultrasound can be considered. The frequency of

added MRI or CEM can be every one to two years, in addition to yearly 3D mammography (tomosynthesis). Women diagnosed with breast cancer before age 50 are also recommended to have supplemental screening MRI even if their breasts are not dense, <https://www.ncbi.nlm.nih.gov/pubmed/37150275>.

9. How has AI analytics changed detection and determining risk?

There are (mostly commercially) available AI tools to quantify breast density, estimate 5-year risk for breast cancer from the mammogram alone, and to detect cancer. At present, these are only being used in a few facilities. AI can improve cancer detection by about another 1 per 1000 (similar to the benefit of 3D mammography vs. 2D) and is being used to replace the second radiologist for double reading in Europe.

10. I frequently see that radiologists recommend mammography prior to breast MRI.

Over the age of 30, women who are eligible for screening MRI should also have screening mammography. It is helpful to correlate the two, so we do often prefer that the mammogram is available when interpreting the MRI. There are modeling studies that suggest that alternating the mammogram and the MRI by 6 months provides a slight advantage in earlier cancer detection. For high-risk women who are screened by MRI starting at age 25, we do not do mammography unless there is a suspicious finding on MRI or after ultrasound for a suspicious clinical finding.

11. Are there risk assessment tools that are preferred for AA or Indigenous communities, or you would still recommend Tyrer-Cuzick?

This is an excellent question, and this is a limitation of the most widely used tools. Tyrer Cuzick was developed in a largely white European population. And the Gail Model, which takes into consideration race/ethnicity, is thought to underestimate risk for Non-White populations. There is a model developed by the Black Women's Health Study but it has not been widely utilized in practice. You may choose to complete the Gail model with Race/ethnicity "unknown" and see how that changes your patient's risk – and use the higher of the two outputs.

12. New BIRADS regarding breast density has changed from amount of tissue to masking. If a woman has a dense patch of tissue but the rest is scattered, do we now say the breasts are heterogeneous dense?

Yes, but this was true also in the BI-RADS 5th edition, since 2013.

13. At what age should women stop getting mammograms if they are not high risk?

To observe a benefit of screening mammography in terms of reduced deaths from breast cancer, it takes a 9- to 10-year horizon. Therefore, when life expectancy is less than 10 years, it is reasonable to stop screening. However, the earlier a cancer is found, the less invasive the treatment can be, so there are benefits to mammography beyond reduced deaths from breast cancer. Many estrogen-receptor positive tumors can be treated effectively with oral aromatase inhibitors. The decision to continue screening beyond age 85 or sometimes younger should be based on overall health and patient preference, i.e. shared decision making with her health care provider.

14. If a woman is high risk at 35 but would not be at 40 what is recommendation?

I would recommend you reassess risk at 40 rather than make future recommendations based on current risk assessment. There are some high-risk patients at age 35 who should have screening mammography and MRI (e.g. family member with early onset cancer and dense breasts or woman with certain disease-causing genetic variants).

15. Would you recommend a 6-month interval for supplemental screening ABUS for density? Or would you recommend the ABUS/Complete breast US at time of mammogram?

There are modeling studies that suggest that alternating the mammogram and the MRI by 6 months provides a slight advantage in earlier cancer detection, and the same could be true of screening ABUS. For either MRI or ABUS, it is important to correlate with the patient's mammogram and for the facility performing screening MRI or screening ultrasound to also see the patient for diagnostic testing and possible biopsy. There are some companies doing only screening ultrasound without comparison to other breast imaging or performing diagnostic testing or biopsies, and that is not good patient care.

16. What do you think of mammogram based 5 yr risk such as Clarity?

The American Cancer Society in 2007 first recommended supplemental annual screening MRI in high-risk women, with one of the definitions being women with an estimated 20-25% lifetime risk of breast cancer, http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=17392385, and these guidelines are in the process of being updated. The ACS recommended against using the Gail model to determine risk for purposes of MRI screening eligibility as the Gail model does not consider paternal family history (which should be included).

Clarity is an AI tool being direct marketed to patients. Women can send in their mammogram images and receive an estimate of their chances of developing breast cancer in the next five years. The United States Preventive Services Task Force suggests a 3% five-year risk as the threshold for "high-risk". The National Comprehensive Cancer Network now suggests a 1.7% five-year risk as a threshold to consider screening MRI, and suggests the Gail model or AI tools can be used to estimate that risk. The problem is that five-year risk increases with increasing age, and nearly every woman over age 58 has a five-year risk exceeding 1.7%, and we do not recommend screening MRI in all women over age 58. Colditz et al have a nice paper in the Journal of Breast Imaging that compares appropriate five-year risk thresholds with a 20% lifetime risk threshold (which is widely accepted to decide to recommend MRI), <https://www.ncbi.nlm.nih.gov/pubmed/42054113>. Lifetime risk decreases with age as there are fewer years left to develop breast cancer. At age 40-44, a five-year risk >1.3% is similar to a 20% lifetime risk; at ages 55-59, a 3.3% 5-year risk is similar; and by age 70-74, five-year risk should exceed 10.9% to equate with a 20% lifetime risk. Providers and breast imaging centers are generally not clear on what 5-year risk thresholds are appropriate for recommending MRI.

17. Do you recommend Tyrer Cuzick risk assessment be completed and documented by nurse or provider?

Other team members can definitely be trained in completing risk assessment. Our genetic counselors are great at it, for example.

18. How can someone have access to the flyer? (DR Patel's flyer)

The flyer is not available online – but you can find an image of it linked here: https://nbcrt.org/wp-content/uploads/2026/10/Density-Flyer_Web.pdf. Additional patient-facing materials that can be helpful are https://densebreast-info.org/wp-content/uploads/2026/07/English_PatientBrochure072026.pdf (brochure) and the patient fact sheet: <https://densebreast-info.org/wp-content/uploads/2025/12/Patient-Fact-Sheet-English122825.pdf>.