A diagnosis of breast cancer can cause a lifechanging ripple effect of impact, affecting those we love the most and those upon whom we lean, for comfort and strength in the most challenging of times. My name is Aisling Hurley and I'm the CEO of Breast Cancer Ireland and you're listening to More Than A Lump, a podcast that talks openly and honestly to a selection of guests about their very personal connections to breast cancer – be it through their career choice, their own first-hand experience of the disease, or through sharing the experience of close family members. My conversations will centre on how breast cancer has informed their perspective on life, love, family, health, their goals, and aspirations. Although each story is utterly unique, the one common thread that runs through each one, is that breast cancer is more than a lump.

Rhonda Richardson's grandmother and her three aunts all had breast cancer, and so she had been attending the breast screening clinic since the age of 33, but sadly, at the age of 45, Rhonda herself was diagnosed with breast cancer. In today's podcast, I speak with Rhonda about her diagnosis and treatment and the decisions she and her sisters have taken following their positive screening for the BRACA 2 gene. I'm joined by Dr. Reem Salman, consultant breast surgeon, and a member of the Family Risk Assessment Clinic at Beaumont Hospital. Rhonda and Reem, you're both very welcome to our More Than a Lump podcast, and I'm delighted to have you both here in our studio to talk about this very important subject of breast cancer, genetics and family history.

(01:55):

I know for many women that I've spoken to over the years that a big concern once they come to terms with their own diagnosis is around the likelihood of their siblings or indeed children being diagnosed in the future. As well as that they often find the whole area of going to be tested for the BRCA gene very traumatic, and I've come across many women diagnosed who put this off for quite a time. But before we go into this area in more detail, can I first talk to you, Rhonda, and ask you to explain to our listeners about your own breast cancer journey and that of your family history?

Speaker 2 (02:23):

Thanks very much for inviting me. Um, I was, as you said I was visiting the breast clinic in The Mater since I was 33. But when I was at the age of 39, my consultant asked me would I meet with the genetics team. So I met with the genetics team and we went through the whole family history and he called me back. Then about three weeks later, I went back in to see him and he said, We've decided we won't genetically test you because my mother didn't have the, the breast cancer. So he put me on the extra screening and it was through screenings that they found my cancer where I was very, very lucky.

Speaker 1 (03:01):

Okay. And so tell me a little bit about your family history. So your grandmother?

Speaker 2 (03:05):

My maternal grandmother and my maternal aunt had breast cancer. Okay. And my paternal three aunts had breast cancer. Ah. So it's on my mother's side and my father's side.

Speaker 1 (03:16):

Okay. Okay. And when you were diagnosed at the age of 45, that was from just your regular routine mammogram?

Speaker 2 (03:23):

I had the mammogram in December and it was clear, and then I had my MRI in May, and that's when the cancer showed up.

Speaker 1 (03:30):

Okay. Okay. Okay. Um, and you were, you were, you were saying that you screening, So they were screening you, were you triaged, possibly were triaged as a higher risk given the family history? Yeah. So you would be triaged every, what, six months?

Speaker 2 (03:43):

Yeah, you'd have a screen and then you'd have a clinic visit. Okay. So every six months.

Speaker 1 (03:48):

Okay. Yeah. Okay. Um, and can you tell us a little bit about the, your treatment plan that you were given after you were diagnosed?

Speaker 2 (03:55):

Um, I was given radiation, uh, 15 sessions of radiation. Okay. And, um, that was it. I had two surgeries. My four surgery when they went into second, when they went in the first time they realized I had to come back in. I was gone a little bit deeper. Okay. So they brought me back in again to do another surgery, and a week later I got an infection in the breast. So that kind of delayed on me treatment plan. So I was supposed to start me treatment in September, so I couldn't start, uh, the radiation until November.

Speaker 1 (04:25):

Okay. Okay. And, um, I suppose following your diagnosis then with your siblings Yeah. When were you advised that you should have the genetic test?

Speaker 2 (04:34):

When I came back after, um, me radiation, I came back to the consultant and it was actually one of my aunts and my, my dad's sister said that she'd go and get the test done. Okay. So when I come back and said to, to the consultant, he said, No, that I was a candidate because I had had the breast cancer. So he decided then it would've been around the December that I'd go and get it done. So they sent everything over to James Hospital, and then they contacted me and I went into St. James' Hospital on, um, April. It was a good Friday. Mm-hmm. <affirmative>. And they done my genetic testing and I waited six months for the results to come back. But when I went in that day to get it, get the, the blood test done and see everybody, I kind of, when I went down to the labs to get the blood done, I kind of changed my mind.

(05:23):

I didn't know whether I wanted to do it. And I said, I think I let me auntie do it. I don't think I could do it. Mm-hmm. <affirmative>, and then like, when you think of it, I said, I have to do it because I have sisters and I have brothers. Yeah. And they have children. Yes. And I said, and like it was my partner said to me like, this was all come the build up to it. And he said like five years down the line, if you end up getting ovarian cancer and your consultant tells you like, we give you an option five years ago to get BRACA tested, we've no screening for ovarian cancer. And like, so I just bit the bullet and went straight in and done the blood state then mm-hmm.

Speaker 1 (05:58):

<affirmative> mm-hmm. <affirmative> and finding out that you carried the gene

Speaker 2 (06:01):

At that it was traumatic. Mm. Yeah. It was like, like when I found out I had cancer, I knew a lot about cancer because I would've, from the age of 18, I would've been attend in St. Luke's with my grandmother. Mm-hmm. <affirmative> and my aunt had an auntie had no children, and if my mother couldn't go where her, I'd go with her for our treatment and our appointments to St. Vincent's Hospital. So I kind of knew enough a lot about cancer. So when I was given the diagnosis I'm, today, the first thing I asked was, Am I getting chemo? Yeah. And when she said no, well, I said, I'm happy. Yeah. I said, I'm happy. I said, What will be me treatment plan? She said it'd be lumpectomy and radiation. Yeah. So that, that I was happy. Then I didn't worry. They go, you know, the worst thing I was worried about was going under the anesthetic <laugh>. Yeah.

Speaker 1 (06:49):

A lot of people that

Speaker 2 (06:51):

That's the only thing. And then the second time when I had to go in and I was going under it again, but yeah. Other than that, yeah.

Speaker 1 (06:57):

That. Yeah. And then being told you have the brca, how did you and your family come to terms with that? Obviously your sisters were then going to be tested.

Speaker 2 (07:06):

They were going to be tested, and like they were, as they said, Randy, you got cancer to save us. Mm-hmm. <affirmative>, that's the way they looked at it. So, and if they said, if comes back positive, we'll all deal with it then. So when I came back, I said, at the, you went to bed thinking about it, you woke up thinking about it. As I said, it was like a death sentence. But as you grow and you learn about it and you research it and you look into everything, you realize it's lifesaving. Yeah. It really saves your life. Mm-hmm.

Speaker 1 (07:37):

<affirmative> and they, have they been tested now

Speaker 2 (07:39):

Also? They've been tested. They're positive too. Yeah.

Speaker 1 (07:41):

Okay. Okay.

Speaker 2 (07:42):

So in I was the force to go in to have the surgery, the removal of the Philippian tube and the ovaries. And then last year my two sisters went in and they had theirs done as well.

Speaker 1 (07:52):

Okay. Which is the preventative surgery. That's

Speaker 2 (07:54):

The preventative surgery.

Speaker 1 (07:55):

Yeah. Yeah. Yeah. And ream, if I move on to you, um, first and foremost, I suppose I'd love to know how come surgery, how come breast cancer areas specialty? What brought you to that road in life?

Speaker 3 (08:09):

Well, I have to say surgery was not my first choice when I started medicine. Um, the reason I went to surgery, because I love how you can influence people, uh, decision and you give them a treatment that has an immediate effect. Um, the, the reason I went for a breast surgery because I worked as intern, a surgical intern in, uh, one of the country hospitals and, uh, in their women in their seventies and eighties, they were attending here in Ireland with a cancer. And I was the intern of the team and the female of <laugh> in the team. And I was called to see these ladies because they won't allow, you know, male surgeon to examine them. And that made me think is like, God, this need to be changed. Mm-hmm. <affirmative> women need to be able to show their disease treated as much earlier than leaving it because of embarrassment.

(09:15):

And, uh, that's how I went into surgery and breast surgery was chosen for that reason. I was privileged that I attended here, graduated from U C D and went through the higher basic surgical training on higher surgical training in Ireland. Also, I worked in a fantastic unit in Galway, um, with a professor Karen, whom encouraged me to consider the breast reconstruction, which is the new trend that breast surgeon need to do the breast reconstruction. Mm-hmm. <affirmative>, and this is how I went on to do breast reconstruction, which is made a difference, uh, in a woman diagnosis of breast cancer. And certainly plays a big role now with, uh, risk reducing surgery and immediate

Speaker 1 (10:04):

Reconstruction. Absolutely. And I mean, breast reconstructive surgery has come on so much in the last couple of years, you know, with new techniques and new options available to people. And I, you know, we've spoken to a number of people who have sometimes decided to go straight away and have their reconstruction done when they're having their mastectomy so that they wake up and have the reconstruction, they're in place and others have chosen not to. And it is very much a personal

Speaker 3 (10:27):

Choice by a hundred percent agree that it is a personal choice. Um, w I look at it as you do what's right for you at the time, it's enough that you have the breast cancer diagnosis at that time, and your head is a hundred percent thinking, Should I have, should I not? Um, at least at these days, we can offer it as immediate reconstruction. While when I was started, and that was more than 20 years ago, there was no discussion about reconstruction. Mm. Um, now we see younger and younger women get diagnosed and certainly it affect their lifestyle. Um, and at least when a breast reconstruction is offered is something that women might avail of. Um, it's not the choice of everyone, as I agree, and not everybody is fit for it on immediately at time of the diagnosis. Mm-hmm. <affirmative>. So, um, there are option to be discussed, and I'm glad we moved into this is an option, you know, for women to choose a from mm-hmm. <affirmative>. Not to say if you don't have the immediate depress reconstruction, you always can have an option, uh, to discuss aela

Speaker 1 (11:44):

Reconstruction.

Speaker 3 (11:46):

You just some, uh, I have to say about 20% of my patient do not want to think about reconstruction after a mastectomy. That's it. Despite, I discuss it with them on every review. Sure. But it is a personal choice. And then people by the image and how they see it, you

Speaker 1 (12:06):

Know? That's right. Yeah. A lot of times people, you know, emotionally, they're psychologically, they're just thinking, Get the cancer out of my body and I let me heal and I'll worry about that at a later stage. Yeah. Others have a feeling of, look, when you're getting it out, make me feel, you know, feminine again, I don't wanna wake up, you know, with a mastectomy scar.

Speaker 3 (12:24):

Not to say pre, uh, breast reconstruction is not a risk of free procedure. Sure. Um, like every other surgical procedure, it carries a risk, but people, once they are fully informed about what's the outcome, you know, uh, what do they expect? Uh, because everybody thinks they gonna have a wonderful breast, quite natural looking, yet it might be artificial, uh, a breast because it's a reconstructed breasts. Yet now we are moving more towards, uh, your own tissue reconstruction and we have involvement quite a big center, which they do the DA reconstruction. Yeah. And that is something available and it's quite good aesthetic result.

Speaker 1 (13:08):

Yeah, exactly. Exactly. And I suppose talking take us through now, um, and talk a little bit about the, your work with the Family Risk Assessment Clinic. Um, I know that, uh, lots of GPS and medics know that it, it's there and it's available, but I have often talked to people who didn't know that there was, that's such a facility around. And I suppose it's more for people, and I know hereditary wise the risk of breast cancer. You know, it's like 5% of patients have a, have a registry link, whereas the other 95 who get breast cancer and whether they get it young, um, or middle aged, you know, there is that sense of, well, I'm, I'm so young, you know, if I was 30, 35, should I be worried about my sisters having it or is there somebody in the background that I didn't realize in my, in my aunts and uncle, in my aunts and grandmothers, et cetera, who had it. So I just think that understanding that this facility is there, um, that people should be aware of.

Speaker 3 (14:02):

So we have, I have to make it very clear to everybody and all the audience that breast cancer is more common to be as sporadic cancer than a genetic risk cancer. Yes. If you are diagnosed at a younger age, which is under age of 50 certain type of a breast cancer, like the triple negative of breast cancer, if there is a woman in your family who might had a bilateral breast cancer, certainly influence more. If you have a first degree and the number of people affected on one side of the family, this is all a place role. Also, a contribution of other cancer that might contribute such as the ovarian cancer is sometimes the thyroid, the pancreatic, uh, cancer. That might play a role in your genetic risk because it might be associated with another gene in the family that might have a breast cancer risk.

(15:04):

Mm-hmm. <affirmative>, one of the thing, um, uh, people need to be aware of, basically it's a breast awareness. It's important to examine yourself and be breast aware regardless of your family history. Mm-hmm. <affirmative>, you know, go for your screening mammogram when you are over age of 50 regardless of your family history. And also is important to be aware to find out about your family history. Because sometimes people hear about maybe five cousins affected with the breast cancer, they never met them, they never heard about it. Mm-hmm. <affirmative> also, then they find out their grandmother died from breast cancer at age of 35 and they never heard of it. It's important that when you attend these weddings or you, you know, family occasion mm-hmm. <affirmative>, you might identify if there is somebody mm-hmm. <affirmative>, not everybody who diagnosed with the breast cancer, share it with a family.

(16:05):

Sure. And also not everybody who might carry the gene, uh, you know, and get diagnosed unknown to carry the gene, share it with the family. Mm-hmm. <affirmative>, I've noticed sometimes that some people are ashamed or the guilt of being the first person diagnosed in the family. Hold it a little bit. I see it in family history clinic, uh, involvement. When people you try to open with them, would you, you are a high risk, would you go for genetic testing? And they always pull back and say, Maybe I'll consider it, I'll talk about it with my family and come back. Um, it, it is just, it's become now more we are having genetic testing available. There is genetic centers where you can refer, uh, patient, Uh, the test used to take two years and you know, on the waiting list is two years. Now. There is availability of a fast tracking of certain group of people who are high risk, but also we went into certain diagnosis of breast cancer get, uh, to have their chemotherapy up front, such as the triple negative of breast cancer. Mm-hmm. <affirmative>. And these ladies might want to think if they carry the gene when they are due to have their surgery, might consider a more risk reducing surgery on the other side. Okay. So these things, technology has improved. These tests are becoming more available mm-hmm. <affirmative>, you know, and uh, uh, fast forward with the result. Mm-hmm.

Speaker 1 (17:48):

<affirmative>, <affirmative>. And just walk me through the process. So supposing somebody is at home, they've been, they've gone through a breast cancer diagnosis, they're not sure they're quite young, so they're in their forties. Um, should they, and they have say sisters and supposing they're not sure whether they carry the gene and it's been suggested that they go for genetic testing. Who do they contact?

Speaker 3 (18:11):

Well, number one contacts is their gp. Sure. And I would recommend before they even contact their gp, try to draw their family tree, find out what cancers are there in the family, who's affected what age they were affected. If they can discover these things, it make the process much more faster. Mm-hmm. <affirmative> and prompt to get to where they need to be. The GP can have patient referred to be accurately categorized regard their family history risk to the family history clinic. Mm-hmm. <affirmative>. And this, we have one enrollment whom we triage people into low, medium, and high risk. And the high risk will be basically, um, divided into the group that need a screening with mammogram MRIs. Some of them might have the, uh, screening with mammogram only, but at least we have educate them to tell them what's their category and what's the recommendation of the current guidelines of their screening. And the GP can uh, go through, um, a quick assessment through denied guidelines and they can identify if those patients are eligible to be referred to the family history clinic. Also, GPS can have access of those very high risk people whom they might return because they identify the genetic communication in the family already to be referred directly to the genetics screening. Mm-hmm. <affirmative>, uh, service. Yeah.

Speaker 1 (19:49):

And I think what you say also is very important. You touched on it there earlier, you know, um, breast check and the breast screening is available for 50 for women who are 50 years and over every two years. However, it is very important for women, younger women, and you refer to it earlier with triple negative breast cancer, especially happening younger women that women, you know, from the age of 20 and onwards need to be breast aware. They need to understand what their normal is, check themselves every month and know the signs and symptoms that they're looking for. And I suppose this is where we came up with a breast aware app that's free to download. It shows you the eight signs and symptoms. It shows you on a simulated video guide how to perform your own self breast examination. And it sends you a monthly reminder to your phone to remind you to do, to be breast aware. If you know your base normal today, if any abnormality arises, you spot it quickly. You know, you contact your gp, your po, your outcome is a lot more positive with your treatment.

Speaker 3 (20:42):

A hundred percent. We seen it Ron, Ron as a story. She said she had had a mammogram in December, which was clear. So it's just, I'm trying also to emphasize to people, screening is not a hundred percent to prove tools. And it's important people, as you said, to know what's their normal, it's easy to figure out their abnormal. And sometimes people, I don't know what's the normal, what I should be looking for. Your apps is one, but also there is so many leaflets out there. People, they can go on Google. Um, yes.

Sometimes people might have no much symptoms on screening, identify their abnormality and that's what's the screening for, to pick it up before it becomes symptomatic. Mm-hmm. <affirmative>. But screening is not a hundred percent tool, but fair play that people sometimes if they are on the higher risk group, they might need extra tool, uh, on top of the mammogram. Sure. To identify and clearly, uh, assess their oppress.

Speaker 1 (21:54):

And I have had a lot of, um, people who've said to me, But you know, we need to have mammograms for younger women then, because if you look statistically there's, you know, 23% of the pop of the population of those diagnosed or under the age of 50, between 20 and 50. But I've always said to them, it's not necessarily accurate, as you say, you know, it's a 90% accuracy of an imaging, um, tool that we have. It's the best we have. But yet as women get older, your breast tissue is gray and it goes black. So cancer is easy to observe, but when you're young and it's active white, it's white, it's very difficult to detect white on white.

Speaker 3 (22:27):

Yeah. But also, um, if women, like screening is not a tool under age of 40 with a mammogram. And if women feels she wants to have a mammogram, she can definitely avail of it through referring to symptomatic clinic to the, some radiology departments might offer, uh, public mammograms, but also they can avail of our private mammograms. Exactly. But what's important is if you get to know what your breasts like, by all means, you'll pick up to changes. If you are have a higher risk group or a medium risk group, definitely when you get referred to the family history, you get assessed and you will be offered those screening tools. Mm-hmm. <affirmative> it, it is just that put us into the two prospects. Get to know your family history, get to know your body, and it try to be a proactive because prevention, you know, it's the best tool. Absolutely. You know, we've seen it, in your case, it's picked up as a DCI s which is, that's by definition of a breast cancer is a stage zero, you know, which is very

Speaker 1 (23:44):

Early, early.

Speaker 3 (23:45):

It's a marker of maybe you are at a high risk, but it doesn't mean you have a, a big cancer. Yes, exactly. And I have to also say, um, people, uh, need to be, uh, more, um, what do you call it, uh, aware that breast screening, it's a good tool. Okay. But it's not a hundred percent. And people feel is if I have my mammogram in three months time, it's okay. My breast lump will be okay. It'll be looked af after. Or if I have my mammogram every year, why do I need to examine myself to be honest? Examination pick up way more than the screening.

Speaker 1 (24:34):

Absolutely. Absolutely. And we've seen it time and time again with different people who've reported, you know, they had a rash, um, on their breast, but you know, and they put PSD cream on it for months, avoiding going to the GP because the cost of going to a GP and only went subsequently because they were bringing a child and said, Oh, by the way, this rash hasn't gone. Could you have a look? And lo and behold, their stage of cancer has progressed, unfortunately. So that's why it is oftentimes we talk, it's more than a lump. It can be, you know, and oftentimes one breast bigger than the other, lower than the other, you know, nipple nipples changing the rash on the underside, which is the tumor and the inside pulling in, you know, and pain under your arm. So like there's lots, there's eight signs and symptoms that we need to be aware. And it is about empowering people. I say people more so than women because it does happen to men much lower percentage. But you know, you need to know your own body, know your baseline and work from there. You gotta take your own breast health seriously to, to allow your, you know, to understand. And so that if you do detect something, it's tripped up. Get. Absolutely.

Speaker 3 (25:35):

And also what we do in the family history, for example, involvement is more of education. How to reduce your risk. Even if you don't, if you qualify as being a low risk person, you need to look at reducing your risk. Uh, because as we earlier said, is not all your genetics. Okay. One of them is, um, your healthy lifestyle, the physical activity contribute a lot in reducing your risk. Your alcohol intake reduced, no smoking. Uh, people achieve a bmi, you know, a healthy bmi and also is important not, uh, to expose yourself to a hormonal therapy that it might not be necessary. Mm-hmm. <affirmative>. So that is important to consider it in all aspects. Mm-hmm.

Speaker 1 (26:32):

<affirmative>. Yeah. And I think, and it's in moderation. It's about living life in moderation. You know, it's not saying that we all have to be skinny minis running around the place and be ever so fantastic in our lifestyle, but it's about everything in moderation. And I think once that is in, in everybody's life plan, you know, we are helping to reduce ourselves from every serious illness that there is. I suppose one thing I I I, I remember hearing one of our patient ambassadors, um, she's a young girl. She was diagnosed at the age of 30, um, and had her treatment, et cetera. She did go for genetic testing only because I think further along the line, somebody had been diagnosed, she was diagnosed with the BRCA gene. Um, and at the time, um, Professor Hill, who she was seeing said to her not to worry initially she was panicked. She had had her double mastectomy through her own treatment for breast cancer. She then thought should she go ahead and have the, her ectomy, et cetera. So he said, No, you don't need to rush. You know that there isn't that same Oh, I have the BR gene, therefore I have to have everything out and everything often, you know, in order to increase my risk of survival.

Speaker 2 (27:36):

If you're over 40, isn't it 45? That's in the ovaries

Speaker 3 (27:40):

Now. Yeah. You had your I did. Yes. One of the things is we have to say is we recommend that you definitely have, if you tested the PRCA positive, you must go into your screening, high risk screening, have your mammograms, have your MRIs, you know the issue about when do I have to remove my breast to reduce my risk? Your risk will definitely reduce significantly. It will never be zero. Yeah. Okay. That's one thing. The other thing is sometimes is difficult for a woman to have all these changes done when she is a 25 or 28. And there is no right time for people. It is right time for that individual. Sure. Okay. Now, one of the things is we say try to finish your family. You know, you might avail the breastfeeding, which we encourage it to, you know, then you decide about, okay, I've done all these screening, I'm tired of keep doing the mammograms, the MRIs, and I would like to have, you know, risk reducing mastectomy.

(28:53):

Then you are right in the set of mind to get the journey of mastectomy and breast reconstruction if you wish to. But then there are people up to their age of 70 and they don't want, or maybe they discover their BRCA gene when they are in their fifties and they said, You know what? I'm now in my 50. I'll continue. If I develop cancer, you know, I'll deal with it. And in fairness, I won't be worried so much about the people who are BRCA positive because they will beed and they will be looked after and cancer will be picked up at a, uh, smaller size and good outcome. I will be more cautious about the people who might test BRCA negative, but they still have a higher risk group, which they need to continue with their, you know, screening. Because sometimes they get so much confident, I don't have the gene, I don't need to continue with these mammograms and MRIs.

(29:56):

Okay. But we still recommend it for them. If you don't carry that gene, it doesn't mean you are not a high risk. And that is important. Also, we emphasize here so much about the bracket gene, but there are other genes in the, you know, out there that it might increase the high risk of a breast cancer with them. Some of, uh, the moderate risk and people need to be aware of it. And some of them are the higher risk, um, also is important to understand sometimes, uh, other risk that can increase your breast cancer. Not necessary. Your family history risk. And we know, and we see them in our higher risk clinic in Beaumont, is the people who might have HS wall radiation as some at a younger age for treatment. Uh, um, majority of them is for lymphoma at younger age. And those people will be a higher risk group. They need to be watched on screen at uh, a younger age than the 50 mm. So that's another group. But I, I really look at, people need to be aware family history contribute a a smaller risk, but if you don't have a family history, it doesn't mean you don't get cancer. Absolutely. And that's what sometimes people, when you assured them you are a low risk group, they nearly thought, that's it. I'm never gonna get cancer. Yeah. You know, and that is not, we all need to be

Speaker 1 (31:35):

Just be vigilant and be aware of, you know, understanding good breast health. And Rhonda, looking at you now, and I know our listeners can't see you, but I met you last Sunday and the at the great pink run you did in Lepers Town in horrendous Rather, You and a Tribe of Women with you <laugh>, which was fantastic to see. How did you get on?

Speaker 2 (31:55):

Oh, we had a great time. Um, um, me self and my cousins, we all walked. Yeah. But my aunt, she's Indian city running group, so a group of four and I think it was about 15 of them, they all done the 10 K. Yeah. So it was brilliant. Yeah, it was great.

Speaker 1 (32:11):

It was fantastic. It's fantastic to see.

Speaker 2 (32:12):

Very emotional at the end of it. It's

Speaker 1 (32:14):

Very emotional, very emotional to see the amount of men, women, children, buggies out there. Everybody like over 4,000 were in leopard stand last Sunday. Um, it's just phenomenal. Yeah. And then as

I stood on the finish line to see the amount of faces that are so determined, but so like tears Yeah. Of joy coming across the line, whether it's for themselves, cuz they've been through it definitely. Or they're doing it for somebody else. I mean it's just, just amazing to see everybody there. At

Speaker 2 (32:40):

One stage when we were doing it, there was a girl and our dog and it was just like, you know, it was hard wrenching looking at them doing it and she'd done it and she got through it. It was brilliant.

Speaker 1 (32:49):

Yeah. No, it's fantastic. There's a, there was a lady who came in, uh, a lady you called Allie, she's a young girl, she's only in her twenties. She's currently going through chemo and she walked it with her mom and her family had come in ahead of her and they were just waiting for her to cross the line. Yeah. So it was just fantastic.

Speaker 2 (33:04):

My aunt now who she ran a and um, my cousin's, they, they went through before I got there and they were at the finish line waiting. It's brilliant. It is. Ah, it is for

Speaker 1 (33:13):

Me. It's obviously, it's a real community of a pink tribe. Um, and I suppose, look, we go on to kill Kenny next week. We have another two and a half thousand there. There's about 2000 who have done it virtually. Um, which is fantastic because what we see is that, you know, with over 8,000 people taking part in this event annually, and now that we're back in a physical sense with a hybrid model of physical and virtual, I mean we will raise over a half a million euros for our research because through the sponsorship that we get with Gambia and U P M C and others, we cover our costs. So all the entry fees and individual sponsorship comes in and goes directly to to, to fund our research, which is phenomenal. And the research we're doing at the moment, which is one of the challenging areas that we see is that area of metastatic disease progression to the brain.

(33:56):

Um, you know, we, we have supported triple negative and we continue to do that, but this particular form of breast cancer is what is the most challenging and causes fatality. So we're really, we're doing a big collaboration, our, our research team in Ireland with a team in in the states, um, looking into brain metastasis and seeing can we flip that switch where we prevent the tumor from traveling to the brain. If we do that, I'm confident that you know what, we really will transform this disease into a, a long term treatable illness and that's what we want. Yeah.

Speaker 2 (34:27):

It's just progress all the time, isn't it?

Speaker 1 (34:28):

It is, it is. And it's

Speaker 2 (34:29):

Constant about the the surgery. Yeah. It's just your memories come back. My grandmother, like she would've had the prosthetic and we used to play <laugh>, but we really gotten it into it, you know, like for children. Yeah,

Speaker 3 (34:42):

Yeah. Things has changed so much, you know, from surgery was the only option. And then maybe radiotherapy and a hormone tablets. It's just a treatment had changed so much when I started is mainly the surgery, the radiotherapy, the hormone tablets. Now it's mainly breast conserving surgery. Our aim in the surgery modules and also the immunotherapy, the chemotherapy, the shorter course of radiotherapy and there is so much treatment even for metastatic disease. Before people when they were diagnosed, they were told maybe you have a year or two years mm-hmm. <affirmative> and now you can live with the bone metastasis for years. You know, so that's how things has changed. And it's only changed because of two reason. First, the patient who volunteered to be part of research and second because of the research that funded on the trial that made all these progress mm-hmm. <affirmative> mm-hmm <affirmative>. So I think we are gonna reach one day, hopefully in our lifetime when uh, breast cancer will be treated with the tablets and certainly you will be identified

Speaker 1 (35:58):

And I think that's what we all really want. You know, we're seeing clinical trial and it's one of the REITs of breast cancer Ireland, is to invest a lot more in clinical trial. We have been in the past investing in scientific discover in the labs to get to a point where they make these fantastic discoveries. But now we want to accelerate the discoveries in the lab into clinical trial. If we get it into clinical trial, we get new, new new therapeutics and new therapies that are available to treat different aspects and different subtypes of breast cancer. And that's where we need to go. And, and it's, it's a, I think it's a really bright future. You know, we looked and we talked in a previous podcast with people who are 20 years out and who, where their treatment was very, very different. Today's treatment, again, is really, really different. And it is moving in a positive direction, which is great.

Speaker 3 (36:42):

I have to say, uh, one thing I, I'm proud to be part of the family history clinic in moment. Uh, we have uh, set it as a separate clinic and is working uh, in a progress with all other specialty. Also, I have to acknowledge that, uh, I think the whole country and the N C C P has identified that there is a difference in family history screening in d in all over the country. And that's why they are now setting a national guidelines with regards setting family history clinic, uh, and assessing patient with equality and basically identified patient risk, uh, with the same tool. Mm-hmm. <affirmative>. So it'll be a no discrepancy around.

Speaker 1 (37:34):

Absolutely. And just so that our listeners understand, N CCP is the National Cancer Control program. So, um, for anyone that's interested, but that's really good cuz it is important to have governance and guidelines and one set of guidelines that everybody adheres to because it gives you a standard of care. That's excellent. Um, which is fantastic. So Rhonda and Dr. Ream, thank you so much for joining me today on our podcast, More than a Lump. The information in this podcast is based on the personal stories of those we have chatted to. If you are concerned in any way, please contact your GP immediately or you can contact us@breastcancerireland.com.