The Mammogram Myth: What Breast Cancer Screening Isn’t Telling You Transcript

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Introduction and guest background

This is Doctor Talks, real talk from real doctors on the issues that matter to you most. Hello ladies. Welcome back to Mastering Your Menopause Transition Summit 4.0. We're on our fourth year of helping you have hormonal happiness.

I do a lot of new interviews, but there are some colleagues who I just got to bring on again because the information you're going to hear is like, it doesn't get old.

It only gets newer. It only gets better. And it's only so, so important for you. And so we've got fan fave Dr. Jennifer Simmons in the house. Hello, my friend.

I'm missing your red lipstick today. You're throwing me off. It's a little there. I'm on day one of my Prolon five-day. I'm a little subdued and as I'm ready to cleanse.

But Dr. Jen is an integrative oncologist. For those of you that don't know her, she's the founder of Perfection. How do you say it? Perfection. Perfection.

But it's like Perfection QT because we're going to talk about the QT scan. imaging, she's in Philadelphia, she's rocking and rolling, she's impacting so many women's lives and helping so many women on this.

These are the questions I get continually, continually, continually. She hosts her own podcast, Keeping a Breast with Dr. Jen. I don't know. She has a best-selling book.

There's nothing this woman has not done to help me understand breast health. Well, I haven't slept much. And she comes, she is a breast surgeon. So we're getting the real, real deal here.

And we are going to talk about What you need to know right now in the next 30 minutes, you're going to walk out of here understanding how to screen for breast health.

Is estrogen safe? And all the things that I know she hears, I hear. You want to know the answers too. So we're going to do this. So happy to have you here.

Well, I am delighted to be here and to cap off my day with you and your beautiful smile. so let's just let's just dive in because yeah where should we start because we're speed dating today right well let's start let's start with screening right because we've had it's a great place to start our heads that mammographies are mandatory so let's just start with there how should we be screening It's a great question, especially because we've had drilled into our head that mammograms save lives, right?

It's been said so many times that people actually believe it's true. It's been said so many times that people actually believe that it's preventative.

I can't tell you the amount of times and you must have heard this too. I don't know how I got breast cancer. I get my mammogram every year, right? Like people, even the ones that know and understand that it is at best early detection, they still don't know and understand that it has nothing to do and has never been proven to impact survival.

And I will argue that that is the only thing that matters.

Why mammogram screening is questioned

So when we look at the mammographic screening program and the foundation that it was built on, it was started in the 1970s and built on this foundational understanding that breast cancer growth is both linear and predictable.

So it starts as something very small like maybe atypia and then it turns into DCIS and then it turns into invasive cancer, but it's no negative invasive cancer and then it's no positive invasive cancer and then it metastasizes, right?

So if you are able to find it before it gets to the node positive part, you will save lives and save breasts, right? And it's a really logical explanation, seems really reasonable.

It just doesn't happen to be true. And breast cancer growth is neither linear nor predictable. So it just doesn't happen like that. As much as we would like to believe that it happens like that, it doesn't.

Breast cancer is what it is from the very beginning. So even if you find something small, if it's an aggressive process, because breast cancer is all about biology, if it's an aggressive process, it's an aggressive process from the very beginning.

And this is why mammogram does not impact survival because it doesn't matter where you find this. If it's going to be aggressive, it's going to be aggressive, and it's not going to be aggressive, it's not going to be aggressive, and everything in between.

So no matter how many mammograms we do every year, the same exact number of women die of breast cancer. No matter how many mammograms we do every year, the same exact number of women present with aggressive disease.

And the only thing that mammogram has done, and this has been borne out in multiple studies over multiple countries, over hundreds of thousands of women, right?

These are not small studies. This is not disputable information. This is indisputable information. When we look at the Swedish trials, 600,000 women, half of them screen with mammogram, half of them don't.

They all have the same access to care because it's universal health care in Sweden. So they all have the same access, they all have the same kind of care.

And when you look at the two groups, the exact same number of women die of breast cancer in each group. And the only difference between them is if you screen with mammogram, you're going to diagnose 20 to 30 percent more cancers.

Because first of all, if you use mammogram as your screening tool, because it is radiation, it's an x-ray at the end of the day, right? If you use a test that causes cancer to screen for cancer, you're going to cause some cancers, right?

And beyond that, The harder you look for cancer, the more you're going to find. And this is not just in the area of breast. This is in the area of prostate cancer.

It's everything. The harder you look, the more you're going to find. So if you look harder for breast cancer, you're going to find more. But that doesn't mean you're impacting survival.

Because if you are diagnosing people who would have never developed clinical disease, then you're not helping these women because all of a sudden they now have a diagnosis and they are obligated.

First of all, they're scared. They're scared to death, right? And they feel obligated or otherwise to then get treated. And our treatments are not benign.

Our treatments cause a lot of problems. So we know when we look at the general population, there's no benefit to screening, right? The women who are eligible to screen 40 and over, there's no benefit to screening.

But there was some postulation that maybe a subset would benefit, right? Maybe the younger women would benefit from screening. And so let's look at the data.

The Canadian breast cancer screening study, 90,000 women, ages 40 to 59, which I consider young women. Thank you very much. Me too. So age 40 to 59, 45,000 screen with mammogram, 45,000 have physical examination.

The same exact number of women die of breast cancer in each group. And the only difference between them is if you screen with mammogram, you are 23% times more likely to diagnose breast cancer.

There's an additional 23% of breast cancers in the group that screens with mammogram. We are not saving lives. Okay, so you know if we're not saving lives, but we're saving breasts because that was one of the other foundational understandings of breast cancer screening is that if we found things earlier It would lead to less treatment, less severity of treatment, and we could save breasts.

Well, that's a noble cause, right? Like if we're not saving lives, but we are saving breasts, that might be a worthwhile endeavor. So look at the data.

What happened when we started to screen for breast cancer with mammogram? The mastectomy rate increased by 20%. by 20%. And I will tell you, having been a breast cancer surgeon for two decades, There is no way, no matter what you say, no matter what you do, there is no way to prepare a woman for mastectomy.

Those scars run so deep. And there will never come a day for the rest of her life that she will not remember that she had breast cancer. No matter how good that reconstruction is, there will never come another day for the rest of her life where she won't remember that she had breast cancer.

which incidentally, you know, if you need a mastectomy because you have a significant amount of tumor burden in your breast and there is no other way to get rid of it, sometimes you need a mastectomy.

But mastectomies are being done with great frequency for something called DCIS or Dr. Carson, I'm inside you, a condition that would have never threatened a woman's life, never affected the length of her life.

And yet, we treat DCIS like it's breast cancer. And what I was saying before, breast cancer treatment is not benign. When we treat women for breast cancer and we treat DCIS like it's breast cancer, just like it's invasive breast cancer, we treat them all the same.

Once you have that sign, Once you get that diagnosis, once you get that designation, everyone is treated the same. So now we're giving them systemic treatments, we're doing surgery, we're doing radiation, and these things have serious long-term consequences.

Because when you treat a woman for breast cancer, you are accelerating a lot of systemic disease. You are virtually putting everyone in menopause. And when you do that, and when you take away a woman's estrogen, which is the molecule of life, you accelerate heart disease, by far exponentially the number one threat to a woman's life.

You accelerate brain disease, which we are on the verge of an epidemic. with neurodegenerative disease. We are going to see more Alzheimer's in our lifetime than has ever seen before and that our system is able to care for.

You accelerate bone loss. Everyone's worried about bone density and they should be because, lest we forget, the same exact number of women that die of breast cancer every year die of a complication of a fracture.

So for many of these women, We are trading in a diagnosis that would have never affected them in their lifetime,

and we're giving them a worse disease.

And this is a huge problem. We currently have four million breast cancer survivors in this country now. And these women are not living well. They are not living well at all.

I call these women the forgotten women. This is the title to my next book. Because we tell these women, we treat them for breast cancer, and we tell them that they should be grateful to be alive.

And they are grateful. Don't get me wrong. They're grateful to be alive. But it is very hard to feel grateful when you can't think. You can't remember your words.

You can't sleep. You're anxious. You're depressed. You gained weight. Your breasts are deformed or absent. You don't recognize your body. Everything hurts.

You're having hot flashes. You feel you feel depressed. You feel scared. You have no libido Sex is painful and unwanted your relationship is either suffering or absent and This is how we're leaving most women after breast cancer treatment.

Self-exams, ARIA tears test, and QT imaging

I'm not talking about exceptions I'm talking about this is how most people are after breast cancer treatment and And it's real hard to feel grateful when you're suffering.

And most of these women are suffering. And at least 30% of them are suffering totally unnecessarily because they were overdiagnosed because we are using a test that causes breast cancer to screen for breast cancer.

And we are trusting a tool which is very unsophisticated. to decide who should and who should not get biopsied, who should and who should not get treated.

Amen to that. I mean, there's so much reward when you work with patients, but when I see these women who've been suffering and help them turn their lives around, it's like, It's infuriating that they were, like you said, just left out, like, nope, nothing we can do.

So let's jump into that right now. Yeah. But I do want to talk about what people should do for screening. Because I hate to leave them with that. So I'm just going to tell you what I do for screening, which I think is pretty universally applicable.

So I think that everyone should be doing a self-breast examination. I think it's really meaningful. I think that you should know exactly what your breasts feel like when they're normal so that you can know what they feel like when they're abnormal.

And it is a fairly reliable test when you know your own body. And the number of women who who find their own cancers when they are meaningful because, you know, all of these subclinical cancers that were diagnosing with mammogram, many of them should never be diagnosed because they will never come to fruition.

And I do want to be clear, I'm not saying that breast cancer isn't a disease and isn't horrible and there aren't people that need treatment. There are.

There certainly are. But there are also a lot of people being treated who don't need it. So I think physical examination is a very important tool. Once a month, you don't have to walk around feeling your boobs every day, right?

Once a month, day seven of your cycle, if you're still menstruating, if you're postmenopausal, you can examine them whenever you want, feel them on the first, feel them on the 15th, I don't care when you feel them, just feel them, right?

So that's the first thing I do. The second thing I do which I think this technology is probably the most impressive to me because I think it will determine who does and does not need imaging in the future.

So I use something called the ARIA test. Have you heard of the ARIA tears test? Trying the tears, yeah. So this is an amazing tool. It's not exactly a screening tool for breast cancer.

What it's looking for are two proteins, the S100A8 and S100A9 proteins, which are abundant for whatever the reason, I don't know the reason why, in our tears.

And if they reach a certain threshold, there is a big correlation with breast cancer. So you take a little tiny piece of litmus paper and you fold down the corner and you put it right inside of your eyelid and close your eye for five minutes.

Send this piece of paper off to the company. A week and a half later, you get a result that is either normal or clinically significant. If you have a clinically significant result, this has a 93% sensitivity.

So 93% of the time, if you have breast cancer, this is gonna pick it up. And that other 7% of the time, what the company has found, and I don't own the company, I have nothing to do with the company, I don't work for the company, I'm just telling you that I love this technology.

What the company has found is that with the more advanced cancers, that protein tends to go away. So it's not a reliable indicator of late breast cancer, but it is a reliable indicator of early breast cancer.

And so, you know, late breast cancers shouldn't require this test, right? You should know. If you have, you know, a big tumor in your breast or nodal disease or anything like that, like, you should know.

And someone who's in touch with their body, they will know, right? The test has a 58% specificity, which means that 42% of the time you have a clinically positive result, but you don't have a breast cancer right now.

However, if you follow those people out who have a clinically significant result every six months, every six months another 11% of them will present with clinical disease.

Because if you have a clinically significant result, you have the inflammatory precursors of breast cancer. Which means that if you do nothing else, you're on the road to developing breast cancer.

So there are no false positives for this test. If you have a clinically significant result, you have the precursors to breast cancer and what you have is opportunity.

You have the opportunity to know that you have inflammation in your body that needs to be addressed. You need to think about where it's coming from. So that's why I started, I mean, of course you can read my book, The Smart Woman's Guide to Breast Cancer, which will get you well on your way to a much healthier version of you and talk all about the whys people get breast cancer.

But that's why I developed my breast cancer prevention program so that people had a place to go when they got a positive ARIA result so that they can take their health into their own hands and actually prevent a diagnosis.

So I use who should and who should not get imaging based on the result of the ARIA test. So if you have a negative ARIA test, I personally don't think that you need imaging.

I think that physical examination suffices. But if you have a clinically positive ARIA result, I think you need imaging. So I opened up the first Perfection Imaging on the East Coast in August of 2024. We are using a QT imaging device which uses sound waves transmitted through a warm water bath to create a true 3D reconstruction of the breast without pain, without compression, without radiation, 100% safe.

And it collects 200,000 times more data points than MRI and has 40 times the resolution of MRI. So this without

question is going to forever change how we screen for breast cancer because who wants to be compressed and radiated?

when you can have a beautiful spa-like experience to screen for breast cancer, right? So I'm opening up 50 in the next five years. So, you know, not much sleep in my future, but I think is really important.

And my goal is to make sure that everyone who wants access to this imaging gets access to this imaging. And when I get those 50 open, I am 100% certain that insurance coverage will exist for it.

And this will be a test that everyone can get. If you don't have access to QT now, if you're… I would just want to ask, so are you saying if the Aurea is negative, you don't recommend the QT?

No, I don't. And I know that that's hard to hear because we're so, we're so trained to get imaging every year, right? Like that has been ingrained on us, but it's actually not necessary if you don't have the inflammatory precursors to breast cancer.

Interesting, good, because I'm going to be one of those, our clinic is going to be one of the 50 who has the QT and that is good to know. Now on the flip side of it is that for people who have a clinically positive result, I'm imaging them more frequently.

because those are the people that you know are at risk. That is the at-risk population. So, you know, those people really should be imaged every six months until that converts and they no longer have a clinically positive result because they've eliminated whatever the inflammatory triggers were that are triggering the release of those inflammatory proteins in their tears.

Makes total sense. So, but if you're not near a QT center, I mean, there are several centers around the United States. If you're not near one of them, then an ultrasound absolutely positively suffices.

I know the radiologists are up in arms that ultrasound doesn't see everything that mammogram sees. They're also up in arms about QT because they think that it doesn't see everything mammogram sees.

So let's just talk about what QT sees and what it doesn't. Because QT sees calcifications, MRI doesn't see calcifications, mammogram sees calcifications, but QT does everything mammogram does and more.

They, people, radiologists and people who are not informed about QT say that QT is only good for seeing if things are cystic or solid. That is absolutely not true.

QT is far more like an MRI than it is like an ultrasound. So don't let the word ultrasound or sound wave technology fool you because it's so much more than ultrasound.

And the one thing that is so unique about QT that none of the other modalities have is volumetric measuring. So the other modalities are measuring the size of lesions by calipers and saying like it's this long and this tall and this wide and giving you a size based on averages.

What QT does is volumetric measuring. So it is measuring the actual volume of the lesion because it sees it in a three-dimensional way. And so if we see a lesion on QT, If it's an obvious cancer, we are sending people to have their obvious cancer worked up.

And they are having conventional workups. Because if you have an obvious cancer, you need to speak the language of the people that are going to take care of you.

And they speak mammogram, ultrasound, and MRI. That's all they speak. Right? But if you have something that appears to be benign, we bring someone back in two months, and we re-image them, and we measure the volume, and then we compare the two volumes and get a doubling time.

So cancers have a doubling time of 100 days or less, and so if the doubling time is 80 days, we know that that's something that needs attention, and we send you to go get the attention that you need.

If the doubling time is greater than 100 days, this is either not cancer or not meaningful, and we tell you to come back in a year. So what we accomplish with QT that is not happening with any of the other modalities is that we're avoiding a lot of unnecessary biopsies, and 80% of the biopsies are done in this country for benign changes.

80% so we're avoiding a lot of the unnecessary biopsies. We're also avoiding the over diagnosis and therefore avoiding the over treatment and Ultimately, this is going to have a profoundly positive effect on on the future because women have suffered enough and they don't need to suffer anymore and But if you're not near a QT center, ultrasound will suffice.

You do not need to find calcifications in the breast. It's not important. If that develops into a mass, the ultrasound will see it. Exactly. It can be difficult to get a doctor to give you an ultrasound without a mammography.

It's very difficult. I understand. I know it's very difficult. But I'm hopeful and optimistic that the world is changing and that the tone deafness that has been so pervasive for the last 50 years is going away a little bit.

And whenever I have plenty of trolls on my Instagram page, and doctors or mammotechs that are so critical of me and that I'm a snake oil salesman or a chiropractor.

They call me crazy things. I'm like, really? I thought I went to medical school and I'm a surgical oncologist. Whatever. But, you know, all I say to them is, listen, if you want to go have a mammogram, go have a mammogram, like no one's stopping you.

But there's a hundred thousand people here who don't want to have a mammogram. Read the room. Read the room. Right. There's a reason why I post about this and 10 million people watch it.

Read the room. Right? So I think the world is changing. I think the world will be forced to change because 40% of the population that is eligible to screen doesn't screen because they won't have mammogram.

They want safe options. They want painless options. And I don't think anyone should have to sacrifice their health for the purposes of screening. It's so Looney Tune.

I mean, it just is like, and if it was like something that we were recommending in the alternative world that we live in, then we would be, we're insane.

But because it's in the mainstream and because we've been indoctrinated and because it's about money and insurance, it's overlooked that you're gonna screen for cancer with ionizing radiation that is known to cause cancer.

Yeah, I especially love the people that want the data on mammograms causing cancer. And I'm like, you want the data on radiation causing cancer? Like, is that a joke?

Even if I started to send it to you, I would never finish. It would take me the rest of my life to furnish you with all of that information. Me personally, I'm 57. I have never had a mammography, and I don't ever plan to have one.

Well, you're lucky. I wish I could say that. But I'll never have another one. Never have another one, though. So yeah. And I made my mom stop when she was still alive.

I was like, absolutely not. Yeah. So OK. You know, when you know better, you do better.

Estrogen, breast cancer, and hormone therapy

Exactly. And so yeah, don't beat yourselves up. Do not beat yourselves up. self-flagellation around here, you're getting educated, you're making, you know, we're doctors, we're probably not your doctor unless you're patient

watching, but you know, you're getting information, you're gonna ingest this and digest this for yourself, you're gonna talk to your doctor and make a good choice for you, but we're just on you.

Exactly. We're just telling you what we're doing. So let's talk about, we've got that, that's a really great overview. Thank you. So now let's talk about the other monkey in the room, the other big pink gorilla, the other 800 pound gorilla that I have, that I have chosen to wrestle with.

Let's talk about. So, you know, The belief that estrogen causes breast cancer is, again, very logical. This narrative was told in a way that people can really understand it, right?

It's digestible as the word that you used. It, again, just doesn't happen to be true. But this narrative was very intentionally created Because if you take away a woman's estrogen, you really open up the treatment field.

Because taking away estrogen leads to a whole host of opportunities for pharmaceuticals. So, and unfortunately, what our conventional medical system is built on is failure, disease, dysfunction.

I mean, there is no benefit to the conventional medical system for you to be healthy. None. They have no way of getting paid. The doctors don't get paid.

The hospitals don't get paid. No one gets paid if you're healthy. So they are so disincentivized. Is that a word? I think it's a word. They're so disincentivized for you to be healthy that not only do they not Do they not pursue it?

But they don't even know how to pursue it. It's not part of their language. So with regard to hormones, I mean, most of what we know about hormones is born out of the Women's Health Initiative from 2003. So it just so happened that that's when I finished my fellowship training in 2003. And in 2003, I was trained by a world-renowned breast surgeon, like really an international thought leader.

And in 2003, he taught me three things. He taught me hormones cause breast cancer. And the only person that should be on hormones is someone who absolutely, positively cannot live without it.

And said person who needs hormones should go on the smallest dose for the shortest amount of time, right? And all of that was really born out of the findings of the Women's Health Initiative, which was the biggest study that we had on hormone replacement, which was halted early due to a belief that hormones cause breast cancer, even though that data was not validated and was released without the consensus of the study investigators.

And it was released to the New York Times. It was not published in a peer-reviewed journal. So it was kind of like, stop the presses, hormones cause breast cancer.

And since then, the study has been completely debunked. It was retracted, and there has actually been a retraction paper printed. But by the time that retraction was released, the damage was done.

And we had two decades of physicians trained to believe that hormones cause breast cancer. and two decades of women suffering because they believed that hormones cause breast cancer.

But when we really look at the data and we dig down into that data, the most profound thing is the women on estrogen alone therapy actually had a reduction in breast cancer.

Estrogen is protective. Now, the reason that narrative caught on so well is because a majority of breast cancers, when you look at them, they actually have estrogen receptors on them, right?

But, spoiler alert, so do normal breast cancer cells, right? So it's just a version of normal. And when we look at the population of women that get breast cancer, this is not the estrogen-rich population.

Breast cancer is far more a disease of estrogen deficiency than it is of estrogen excess. And when we look at the times in a woman's life where she has estrogen excess, and there are those times, right, teenagers, pregnancy,

breast cancer is exceedingly rare in those populations of estrogen excess and very very common in women who have estrogen deficiency.

We have to remember that association is not causation. Estrogen absolutely, positively does not cause breast cancer. And there are actually, because we use estrogen as like this catch-all term, but there are three primary estrogens in a woman's body.

And one of them, estriol, is actually quite protective. against breast cancer and estradiol which is our strongest of estrogens sometimes has affinity for the alpha receptor which is proliferative and does stimulate growth but sometimes it has affinity for the beta receptor and it just happens to be like the time of the month or what's happening in the body or the you know surrounding environment and so telling that estrogen story like was so easy for people to believe but it was mostly a narrative created by the pharmaceutical industry because if you took away a woman's estrogen it became you remember the Apple commercial we have an app for that Right?

Do you remember that whole ad campaign? We have an app for that. That's what the estrogen story became. Like, you don't need estrogen. Because we've got a pill for that.

Right? Like, losing your memory? Okay, we have memory drugs. Depressed? We have antidepressants. Do you have palpitations? We can give you beta blockers.

Your lipids are crazy? Great. We'll put you on statins. You're gaining weight? Hey, we've got lots of drugs for that. Your bones ache? Your joints ache?

Terrific. We'll put you on non-steroidal anti-inflammatories. you're leaking urine okay we've got we've got bladder drugs and vaginal dryness here's some lube and on and on and on so before you know it you can have a woman on three, four, five, six, seven, eight, nine, ten pharmaceuticals.

Right? Like, just look at the bisphosphonates alone. Everyone has profound bone density loss when you lose your estrogen. Profound. Really accelerated.

So, you know, we have all of these women on these bisphosphonates. Have we improved the fracture rate? No. All we're doing is making the bones thicker and more brittle.

And so now, instead of having the fractures that we had before because we had bones that had flexibility, Now we have all these atypical fractures and we're not helping people.

We're not helping people with the statins. We're not helping people with the antidepressants. But what we are is feeding the beast because every time you go on a new drug, you create a need for another drug.

And that's where this narrative came from. And that's why it continues to exist because this beast doesn't want to go away. This beast does not want to go to bed.

But when we look at the data, and we do have data on hormone replacement both before and after breast cancer, and for women who go on hormone replacement and get breast cancer, because let's face it, women who take hormone replacement get breast cancer, and women who don't take hormone replacement get breast cancer.

And we know that breast cancer incidence has only increased since 2003, but in 2003 when the Women's Health Initiative was released, like 80% of hormone replacement dropped off overnight.

And yet breast cancer rates just continued to rise. So the women who take hormone replacement and get breast cancer actually have better outcomes than the women that don't.

And on the flip side of it is, if you get breast cancer and you take hormone replacement afterwards, there's no increased risk of recurrence. In fact, there are a lot of studies that point to a decreased risk of recurrence.

And these women have better long-term outcomes because It's not just the breast cancer. It also protects against heart disease, which is by far and away the number one threat to a woman's life, whether you have breast cancer or not.

Because most women who have breast cancer don't die of breast cancer. Most women with breast cancer die of cardiovascular disease. Right? So, protects against heart disease, protects against brain disease, protects against bone disease, protects your vagina, your mood.

I mean, like, there's almost nothing it doesn't do because we have estrogen receptors everywhere in our body. Now, some of those improved outcomes are going to be because it does self-select a little bit.

Because the woman who's going to take hormone replacement is the woman who has more health conscience in general. But you know what? I'm OK with that.

I'm OK with that. It is long past time that we need to let that rumor go and start treating women with the dignity and the attention that they deserve.

So my practice does not discriminate. And just because you had hormone-positive breast cancer does not mean that you are not a candidate for hormone replacement.

You absolutely are. But you're a candidate based on your own personal story and your own merits in that You know, I'm not giving hormone replacement to women who are still smoking.

I'm not giving hormone replacement to women who are still drinking. I'm selecting who it's appropriate for. And it's very much a partnership. Like I say, you have to take care of yourself.

And if you continue to take care of yourself, I'll continue to support you. Yes, yes, yes. I mean, I love interviewing you because I can just say anything because you're just saying everything I think and say.

And I mean, I've been working with women with breast cancer since I started practicing in 2002 using bioidentical hormones since 2002 and everything. But did you find that most people would not?

Well, I think most people are terrified they would find me and be, you know, they would hear about me and then, and you know, and you know, it changes their life.

Cause like you said, they're the forgotten women who are left to suffer and without a good reason, you know, even today with this resurgence of hormone replacement and you know, what I call the menopause.

the Mary-Claire Havers of the world who are out there talking about it, they are still saying no to the breast cancer population. So it's going to take an army of people like us who stand up for these forgotten women because they are being left out of the conversation.

In fact, I wrote Oprah and her team and I said a little bit like, shame on you. Shame on you for having this big conversation about menopause and leaving breast cancer out of it.

It's so wrong. It's so wrong. I agree. I didn't watch the Oprah special because I was upset I wasn't on it telling the truth because yes, it's good that they're bringing out and helping menopause get more airtime, but they're giving a lot of wrong information and this is one of those areas.

And so Thank you for being you. Thank you for being on Team Estrogen. Team, we serve women. Team, we understand physiology. Team, we do what's right for you.

Team, we don't live in fear. We do things wisely. And we do things that help you. At the same time, we are as scientific as anyone and everyone else. And I would argue that this side that says no to hormones is being anti-scientific.

Oh, yeah. They are very much, you know, creating a narrative that is simply untrue and hiding behind pseudoscience. Yeah, I know. I know. Well, you've heard it here at the menopause summit with Dr.

Jen Simmons. So where can the ladies learn more? Yeah, so there's lots of places to find me. My medical practice is called realhealthmd.com. If you want to learn more about the perfection imaging, it's P-E-R-F-E-Q-T-I-O-N imaging.

My book for anyone on a breast cancer journey or if you're looking to prevent having to go on a breast cancer journey, my book is called The Smart Woman's Guide to Breast Cancer.

I do, as Dr. Stills said, have my own podcast. It's called Keeping a Breast with Dr. Jenn, and we release a new episode every week. Dr. Stills was on that podcast, so you can dig out her episode because God knows I can't remember which one it was.

And then I'm on all the social channels at Dr.

Closing remarks and resources

Jenn Simmons, and my Jenn has two N's. Well deserved two ends. Well, thank you. Thank you. Thank you for being my sister in breast health and hormone health and all the things.

And I just adore you and adore the work you're doing. You're making a huge impact and a huge difference. And women are feeling better because of it. So go, go, go check her out.

Check her out. Thank you so much, my friend. So good to be with you today. You too, and thanks everyone for being here. So yes, you didn't miss here. You heard it.

Estrogen is safe. It's safe. It's safe. It just has to be done appropriately. So keep learning. We didn't even say, but it's like the estrogen from the arm where they had less cancer.

They weren't even using bioidentical hormones, right? they're using I know that's like a whole other conversation that it doesn't even matter what you use if you're using something that is estrogenic it will lead to a decreased incidence of breast cancer so crazy all right sending you all love and thanks for being here and thanks for getting educated and thank you dr jen bye for now Thank you for tuning in to Doctor Talks.

We hope today's episode has enlightened and inspired you on your path to optimal health. Each day is a new opportunity to make choices that empower your well-being.

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