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

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Introduction and Guest Welcome

Hello, ladies. Welcome back to mess during your Menopause Transition Summit 4.0, or on our fourth year of helping you have hormonal happiness. And I have a 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 favorite Jennifer Simmons in the house and at my friend I'm missing your red lipstick today. You're throwing me off. It's a little bare I'm on a Monday.

One of my parole on five day I gotcha okay I'm a little subdued and. Yeah. And as I'm. Yeah. Ready to cleanse. But Doctor Jen is an integrative oncologist.

For those of you that don't know her, she's the founder of perfect. How do you say perfection? Perfection. But it's like perfection. Cutesy. You're talking about the cutest scan imaging.

She's in Philadelphia. She's she's rocking and rolling. She's impacting so many women's lives and helping so many women on this. You know, these are the questions I get continually, continually, continually.

She hosts her own podcast, Keeping Abreast with Doctor Jen. I don't I don't know. She has a bestselling book like, there's nothing this woman has not done to help you understand.

Breast. Well, I haven't slept much and she comes, you know, she is a breast surgeon, so, like, 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.

Why Mammogram Screening Is Controversial

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 to. So we're going to do this.

So 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. This, 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 to our heads that mammography is are mandatory.

So let's just start with there. How should we be screening for breast. It's a 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 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.

So when we look at the Mammographic screening program and the foundation that it was built on, it was 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 a tibia, and then it turns into DCIs, and then it turns into invasive cancer. But it's no negative and it invasive cancer.

And then it's not 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 screened 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% 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 in the area of prostate cancer.

It's it is 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 this woman 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 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 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. Screened 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's screened with mammogram.

We are not saving lives. Okay, so, you know, if we're not saving lives, but we're saving breast because that was one of the other foundational understanding 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 breast, 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 ductal carcinoma in situ, 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 its 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, the 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 treating 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 4 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, you know, 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. I'm not talking about exceptions.

I'm talking about this is how most people are after breast cancer treatment. 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 un sophisticated, needed to decide who should and who should not get biopsied, who should and who should not get treated.

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

So let's let's jump into that right now because. Yeah, but I do want I do want to talk about what people should do for screening because I hate to leave them.

Self-Exam and Tear-Based Breast Risk Testing

I hate to leave them with that. So I'm just going to tell you what 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 a meaningful because, you know, all of these subclinical cancers that we're 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 are 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 post-menopausal, you can examine them whenever you want.

Feel them on the first feel. I'm on the 15th. I don't care when you feel I'm just be all 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? Crying the tears. Yeah, yeah. So this is this is an amazing tool. It's not exactly a screening tool for breast cancer.

What it's looking for are two proteins, the S 188 and S 189 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 going to pick it up. And that other 7% of the time what the company has found. And I'm I don't own the company.

I have nothing to do with the company. I 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 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 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 as 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 the 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 should 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 talks all about the wise 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 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 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 quite an acute 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 has. 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 what 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 quality.

Now, if you're I would just want to ask, so are you saying if the aura, the aura is negative, you don't recommend the CT? No, I don't, and I know that that's hard to hear because we're so we're 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 people. Our clinic is going to have to be one of the 50 who has the CT, 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 in their tears makes total sense.

So but if you're not near acuity 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 CT because they think that it doesn't see everything.

Mammograms see it. So let's just talk about what she sees and what it doesn't because she sees calcifications MRI doesn't see calcifications. Mammogram sees calcifications.

But she does everything mammogram does and more. They people radiologists and and people who are not informed about CT say that is only good for seeing if things are cystic or solid.

That is absolutely not true. She is far more like an MRI than it is like an ultrasound. So don't let the word ultrasound or sound wave technology for you, because it's so much more than ultrasound. And and the one thing that is so unique about T 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 she 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 CT, 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. Right.

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 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 overdiagnosis and therefore avoiding the overtreatment. 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.

But if you're not near a cut 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.

And then exactly. It can be difficult to get a doctor to give you an ultrasound without a mammography, for it's very difficult, I understand I know it's very difficult, but I'm I'm hopeful and optimistic that the world is changing and that, that the tone deafness that has been so pervasive for the last 50 years is going away a little bit.

Safer Imaging Options and Follow-Up

And, you know, whenever I, I, I've plenty of trolls on my Instagram page and, you know, doctors or mammo attacks that, that are so critical of me and that, you know, I'm a snake oil salesman or a chiropractor or like, they call me crazy things.

I'm like, really? I thought I went to medical school and I'm a surgical ecologist, but 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 100,000 people here who don't want to have a mammogram. Read the room. Read the room right there. 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 Tunes.

I mean, it just is like, you know, and if it was like something that we were recommending in the, you know, alternative world that we live in, then, you know, it 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 and it's overlooked that you're going to screen for cancer with ionizing radiation that is known to cause cancer.

Like, yeah, yeah, yeah, I love 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. You'd be, you'd be. It would take me the rest of my life to furnish you with all of that information.

I mean, I'm, you know, me personally, I'm 57. I have never had an the mega fee, and I don't ever plan. Well, you're lucky. I wish I could say that, but I'll never have another one.

I have another one, though, so. Yeah. And I, I made my mom stopped when she was still alive. I was like, absolutely not. Yeah. So. Okay, you know, when you know better, you do better.

Exactly. And so, you know. Yeah. Don't beat yourself up. Do not beat yourselves up. There's no 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 a patient watching. But, you know, you're getting information. You're going to ingest this and digest this for yourself.

You're going to talk to your doctor and make a good choice for you. But not just following 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 picture, the other 800. Yeah. That I have that I have chosen to wrestle with.

Let's talk about that for Virgin and so, you know, the the belief that estrogen causes breast cancer is again very logical. All this narrative was told in a way that people can really understand it.

Right. It's it's it's it's it's digestible as the, the word that you use 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 there's they are so disincentivize.

It's not a word. Yeah I think it's a word there. So dis incentivized 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 they said person who needs hormones should go on the smallest dose for the shortest amount of time, right. And all of that was really borne 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 caused breast cancer, even though that data was not validated and was not and was released without the consensus of the study investigators, and it was released to The New York Times, it was not popular 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 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, these are this is not the estrogen rich population.

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

Teenagers pregnancy, breast cancer is exceedingly rare in those populations of estrogen access and very, very common in women who have estrogen deficiency.

And so we have to remember that association is not causation, but 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 is shrill, is actually quite protective against breast cancer.

Estrogen, Menopause, and Breast Cancer Risk

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 that's what 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. All 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 have we improved the fracture rate. Now 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 of 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 piece 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 the 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 that the women there 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 is there 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 a woman who's going to take hormone replacement is the woman who is more health conscious in general.

But you know what? I'm okay with that. I'm okay 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 women hormone replacement to women who are still drinking. Like 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 anything because you're just saying everything I think and say and I've been, I mean, I've been working with women with breast cancer since I started practicing in 2002 using bioidentical hormone since 202 and everything.

But did you find that most people would not? Well, I think most people are terrified they would find me and, you know, they would hear about me and then and you know, and, you know, it changes their life because like you said, they're the forgotten women who are left to suffer and without a good reason, you know?

Yeah. Never even even today with this resurgence of hormone replacement. And you know what I call the menopause? The Mary Clare haters of the world who are out there talking about it, they are still saying no to the

breast cancer population.

So it it's going to take an army of people like us who, who stand up for, for these forgotten women because they are being left out of the conversation.

In fact, I wrote Oprah and her team and I said I 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 and it is so wrong. I agree, I, 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 are 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 but you and at the same time we 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.

Resources and Closing Remarks

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 doctor Gene Simmons, but what?

So where can the ladies learn more? Yeah. So there's lots of places to find me. My medical practice is called Real Health md.com. If you want to learn more about the perfection imaging, it's perfect.

Ion 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 is Doctor Still Said have my own podcast. It's called Keeping Abreast with Doctor Jan and we release a new episode every week. Doctor stills was on that podcast, so you can dig out her episode because God knows I can't remember which one it was.

And, and then I'm on all the social channels at Doctor Jen Simmons, and my Jen has two ends. Well deserved to ends well. Thank you, thank you, thank you for being my 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 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. And 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 like you didn't mishear. You heard it. Estrogen is safe.

It's safe, it's safe. It just has to be done appropriately. So exactly. Deep learning. And we didn't even say it. But it's like the estrogen, you know, from the arm where they had less cancer.

We weren't it they weren't even using bioidentical hormones. They're using, you 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, Doctor Jen. Bye for now.