Enhancing early detection: the latest in breast cancer screening

This webinar will start shortly.

Enhancing early detection: the latest in breast cancer screening

Zoom webinar – Tuesday, 17th June 2025 from 6:30pm to 8pm

Acknowledgement Of Country

We acknowledge the Traditional Custodians of the Country throughout Australia and their continued connection to land, sea and community.

We pay our respects to Elders, past and present and extend that respect to any Aboriginal People here today.

KARADI ABORIGINAL CORPORATION

Learning outcomes

After this session, I will be able to:

1. Describe how breast density influences breast cancer risk and mammographic sensitivity.
2. Recommend an appropriate pathway for a patient with dense breasts.
3. Identify specific opportunities for cancer screening in the LGBTQ+ community.
4. Identify culturally-safe cancer screening practices for Aboriginal and Torres Strait Islander people.

Some housekeeping

- Tonight's webinar is being recorded
- Please use the Zoom Q&A feature to ask questions
- At the end of the webinar, your browser will automatically open an evaluation survey. We appreciate you taking the time to complete this to help us improve our events programme
- Please don't forget to register for your next webinar at: https://www.primaryhealthtas.com.au/for-health-professionals/events/

Presenter:

Dr David Speakman

BreastScreen Victoria

Breast density reporting

Dr David Speakman

Acknowledgement of Country

In the spirit of unity and respect, BreastScreen Victoria acknowledges the First Peoples of these lands and waterways.

We recognise their deep connection to the earth and the importance of holistic wellbeing as we embark on our shared journey of breast health.

Title: Regenerating our Wellbeing

Artist: Kedeasha Jackson, *Wemba Wemba, Ngiyampaa and Wiradjuri*

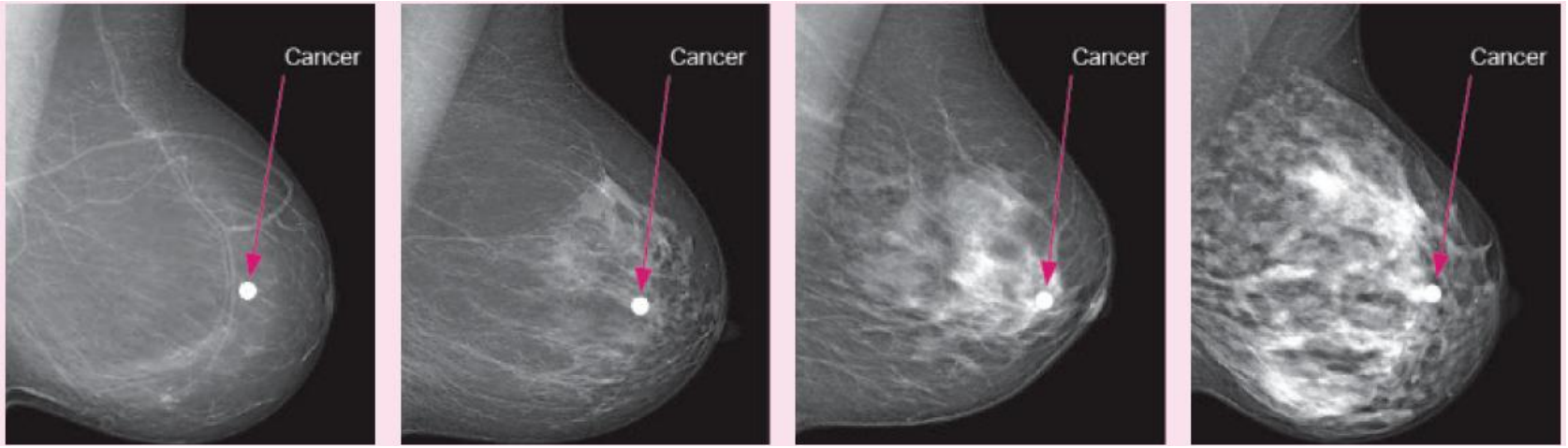
BreastScreen Victoria

About breast density

What is breast density?

- Breasts are made up of a combination of tissue:
  - Fatty tissue
  - Glandular tissue
  - Connective/fibrous tissue
- Women with high breast density have more fibroglandular tissue and less fatty tissue
- Breast density is commonly classified into four categories (A, B, C & D)
- Dense breasts are common, most women fall into categories B & C

Fatty ⟷ Dense



Category A	Category B	Category C	Category D
10% of women	40% of women	40% of women	10% of women
Almost entirely fatty	Scattered areas of fibroglandular density	Heterogeneously dense	Extremely dense

Breast imaging reporting and data systems (5th edition)

BreastScreen Victoria

Why is breast density important?

Masking effect

- Dense breast tissue can mask the appearance of cancers in a mammogram, making them harder to detect

Risk

- High breast density can increase a person's risk of developing breast cancer
    - Risk should be considered in the context of other risk factors

How is breast density measured?

- Not related to how breasts look or feel
- Can only be measured from a mammogram
- Can be measured either subjectively (usually by a radiologist) or objectively using software
- BreastScreen Victoria measures breast density using Volpara software, producing a measurement in a standardised, reproducible system without human variability

What influences breast density?

- Age, particularly after menopause
- Genetics
- BMI
- Hormone therapy
- Having had children

BreastScreen Victoria

What are the recommended options for patients with dense breasts?

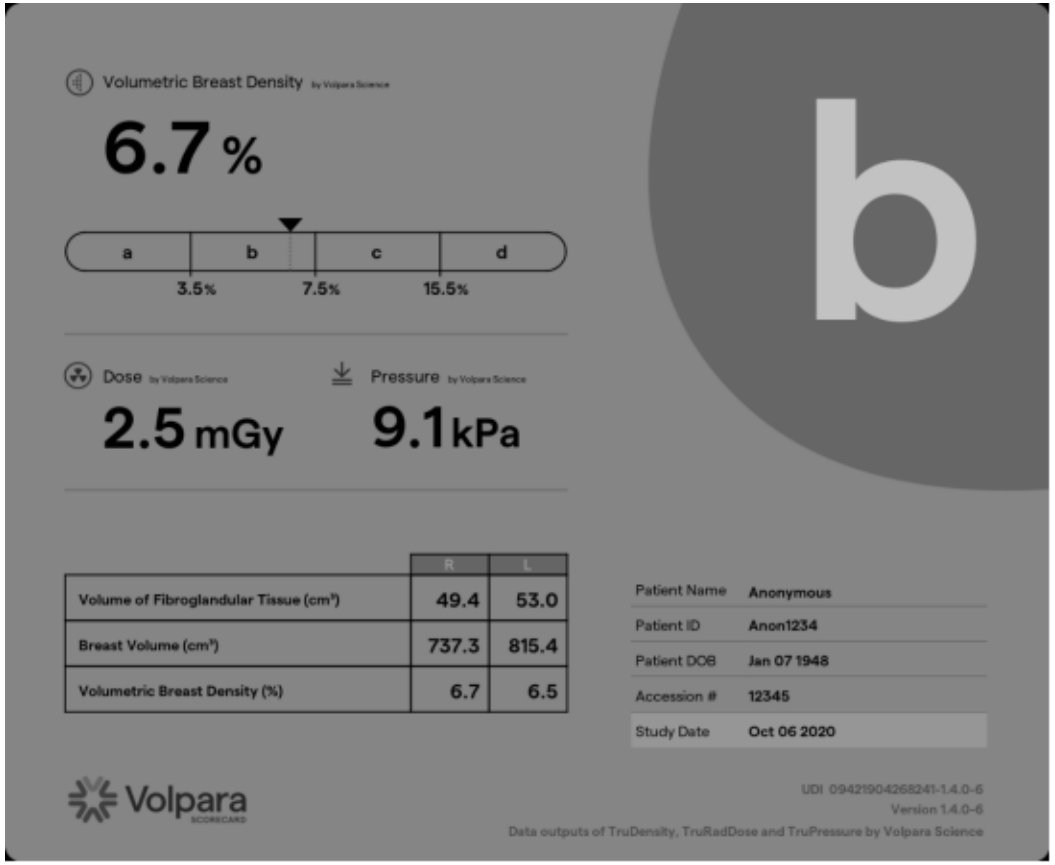
Key considerations

- Mammograms still detect the majority of breast cancers
- Breast density should be considered alongside other risk factors
- Encourage patients to reduce their risk with lifestyle modifications
- A risk tool such as iPrevent or the Tyrer-Cuzick risk model can be used to facilitate discussions with patients
- All patients, regardless of breast density, should be encouraged to stay breast aware and continue to regularly screen
- Options should be considered in the context of the patient's:
  - Other risk factors
  - Personal circumstances
  - Preferences

Supplementary tests

- Supplementary tests are not currently available as part of the BreastScreen program
- High breast density alone does not necessarily mean a patient needs additional imaging
- Can consider:
  - MRI
  - Ultrasound
  - Tomosynthesis
  - Contrast enhanced mammography

Volpara breast density measurement



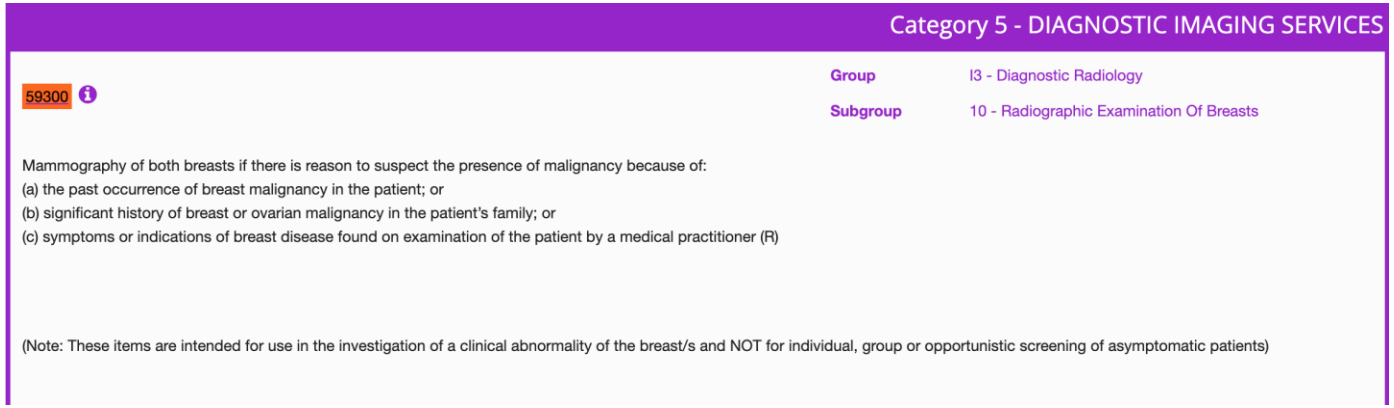
BreastScreen Victoria

Comparison of imaging modalities

	2D MMG	Tomosynthesis	CEM	MRI
Radiation	Yes	Yes	Yes	No
Compression	Yes	Yes	Yes	No
IV contrast	No	No	Yes	Yes
False negative	Current standard of care	Better	Better	Better
False positive	Low, current standard of care	Low	?Lower	Higher
Contraindication	N/A	N/A	Iodine allergy	Implanted metal e.g., pacemaker
Rebate for screening	Available free at BreastScreen	Maybe, see MBS item 59300	Maybe, see MBS item 59300	Sometimes, see MBS item 63464

MBS Items

Item 59300



Category 5 - DIAGNOSTIC IMAGING SERVICES

59300

Group I3 - Diagnostic Radiology

Subgroup 10 - Radiographic Examination Of Breasts

Mammography of both breasts if there is reason to suspect the presence of malignancy because of:
(a) the past occurrence of breast malignancy in the patient; or
(b) significant history of breast or ovarian malignancy in the patient's family; or
(c) symptoms or indications of breast disease found on examination of the patient by a medical practitioner (R)

(Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients)

Item 63464: MRI: Eligibility for MRI

- A lifetime risk estimation greater than 30% or a 10 year absolute risk estimation greater than 5% using a clinically relevant risk evaluation algorithm (accepted algorithm is the Tyrer-Cuzick algorithm version 8 or later – breast density is an input)
- Or use iPrevent

Screening MRI

Screening MRI increases sensitivity at the cost of increased false alarm in normal risk women with high breast density

	1st round	2nd round
Additional cancer	16.5 per 1000	5.8 per 1000
False positive rate	79.8 per 1000	26.3 per 1000

Interval cancers women having MRI	Interval cancers women not having MRI
0.8 per 1000	4.9 per 1000

Supplemental Breast MRI for Women with Extremely Dense Breasts: Results of the Second Screening Round of the DENSE Trial,Stefanie G. A. Veenhuizen et al,RadiologyVolume 299, Issue 2 Mar 16 2021

Contrast enhanced mammograms

- I-MED Radiology Monash (Clayton Rd, Clayton)
- Epworth Freemasons (Victoria Pde, East Melbourne)
- Breast Imaging Victoria (Victoria St, Melbourne)
- Geelong Breast Clinic (Myers St, Geelong)
- Cabrini Malvern
- Cabrini Brighton

Breast Density Category	RACGP family history risk category	Options for discussion
BI-RADS a or b	Average risk	Recommend mammography screening every 2 years
	Moderate risk	Recommend mammography screening at least every 2 years
	High risk	Refer to familial cancer services***
BI-RADS c	Average risk	Recommend mammography screening every 2 years
	Moderate risk	Recommend mammography screening at least every 2 years Review additional risk factors and consider using a risk assessment tool (e.g. iPrevent or Tyrer-Cuzick) to determine eligibility for MBS-funded MRI (Item 63464)** Consider additional imaging* with CEM or MRI where available (DBT or US if MRI and CEM are contraindicated or unavailable)
	High risk	Refer to familial cancer services***
BI-RADS d	Average risk	Recommend mammography screening every 2 years Consider additional imaging* with CEM or MRI where available (DBT or US if MRI and CEM are contraindicated or unavailable)
	Moderate risk	Recommend mammography screening Calculate breast cancer risk using a risk assessment tool (e.g. iPrevent or Tyrer-Cuzick) - If lifetime risk estimation >30% (or a 10-year absolute risk estimation >5%), offer additional MBS-funded MRI** - If lifetime risk estimation <30% (or a 10-year absolute risk estimation <5%), offer additional imaging* with CEM or MRI where available (DBT or US if MRI/ CEM are contraindicated or unavailable)
	High risk	Refer to familial cancer services***

* Additional imaging screening tests are associated with an increase in false positive results may incur out of pocket costs.

** Patient may be eligible for a Medicare rebate (Item 63464), but this requires referral from a breast specialist, which may incur additional out of pocket costs

*** Refer to eviQ General practitioner referral guidelines for cancer genetics assessment, which includes a list of Genetic Services by state and type of service https://www.eviq.org.au/cancer-genetics/referral-guidelines/1147-general-practitioner-referral-guidelines-for#website-resources

Case study

- Female patient
- Age 54
- **Category D breast density**
- Mother diagnosed with breast cancer when 55
- Overweight
- Smoker

- Discuss the patient's risk factors with them
  - Consider using a tool such as iPrevent
- Encourage patient to modify lifestyle – diet, exercise, smoking
- Discuss supplementary testing with patient

Case study

- Female patient
- Age 72
- **Category C breast density**
- No family history
- Non-drinker
- Very active

- Discuss the patient's risk factors with them
  - Consider using a tool such as iPrevent
- Encourage patient to maintain lifestyle
- Unless indicated otherwise by other risk factors, supplementary testing unlikely to be warranted

Case study

- Female patient
- Age 63
- **Category B breast density**
- Two aunts diagnosed with breast cancer in their 60s
- BMI 26
- Drinks 1-2 days/week

- Discuss the patient's risk factors with them
  - Consider using a tool such as iPrevent
- Encourage patient to modify lifestyle – diet, exercise, alcohol
- Encourage patient to stay breast aware and continue to have a regular mammogram

BreastScreen Victoria

Breast density reporting in BreastScreen Victoria

What is reported

- Breast density category (A-D) is sent to clients in their result letter
  - Clients receive a breast density fact sheet and information about what to do
  - Clients with Category D breast density are advised to see a doctor for a risk assessment
  - Clients with Category C breast density are advised to see a doctor if they are concerned about their breast density
- Breast density category (A-D) is also included in GP result communication

Information for GPs

breastscreen.org.au/breastdensitygp

Breast density information for GPs

We are now reporting breast density to our clients and their nominated doctors.

Here you can find answers to commonly asked questions about breast density.

We continue to recommend women aged 50 to 74 have a breast screen (mammogram) every two years as it is still considered the most effective way to detect breast cancer early.

- What is breast density? +
- How is breast density classified? +
- Why is breast density important? +
- What influences breast density, and can it change? +
- How is breast density measured? +
- Can everyone's breast density be measured? +
- What should I do if my patient has dense breasts? +
- WEBINAR RECORDING | Breast density reporting in BreastScreen Victoria's program +
- Where can I get more information? +

BreastScreen Victoria

Breast density enquiry line

- 8843 0029
- Available to clients and GPs

Presenter(s):

Dr Gausihi Sivarajah and Dr Virginia Baird

Breast Density

Resources in Tasmania

Dr Gausihi Sivarajah
Dr Virginia Baird

Breast Screen Tasmania

Presenter:

Associate Professor
Dr. Ruth McNair

Cancer screening for LGBTQ+ people

Dr Ruth McNair AM

Webinar with the

Primary Health Tasmania

June 2025

THE UNIVERSITY OF MELBOURNE
FACULTY OF MEDICINE DENTISTRY & HEALTH SCIENCES
DEPARTMENT OF GENERAL PRACTICE

Outline

Who – LGBTIQ diversity

Cancer burden for LGBT people

Cancer screening- cervix, breast, prostate, anal

Health promotion and inclusive practice

Who

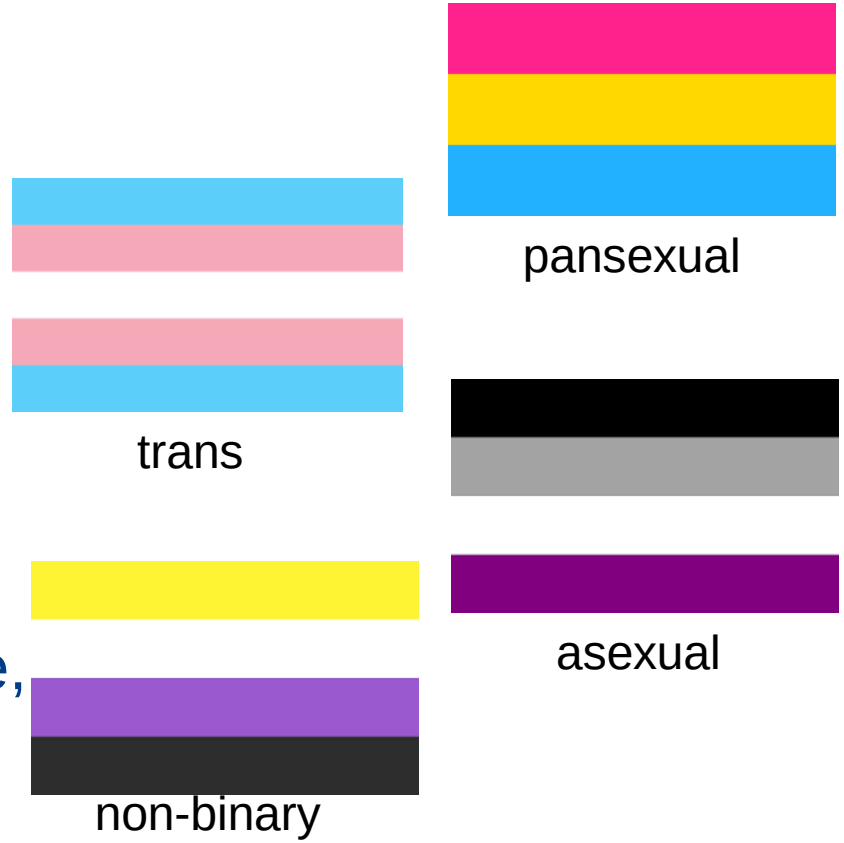
LGBTQ+

- Diverse sexual identities

  Lesbian, (gay), bisexual, pansexual, queer, asexual, other

- Diverse gender identities

  Trans, non-binary, gender diverse, gender queer, other



Cancer burden for LGBTQ populations

Quinn et al Cancer Journal for clinicians 2015

More risk factors

- Smoking
- Alcohol
- Obesity
- Stress
- HPV infection

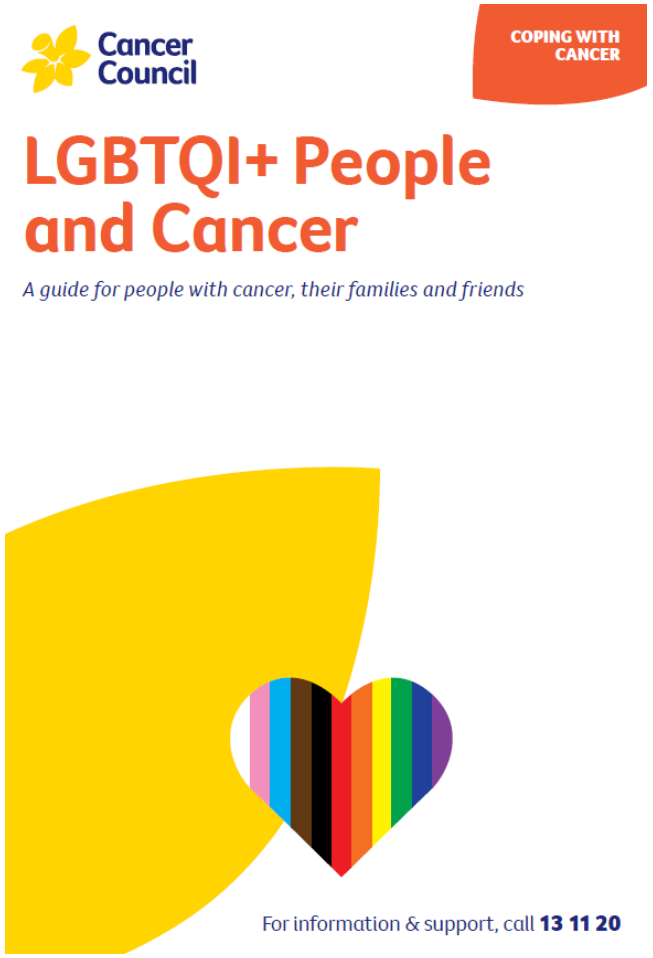
Less screening

- Fear of discrimination
- Less HC access- less opportunistic screening
- Poor HCP knowledge

7 cancers needing attention

- **Cervical**
- **Breast**
- **Prostate**
- **Anal**
- Uterine
- Colorectal
- Lung

Higher risk of certain cancers



- Smoking and alcohol related
  - Breast, mouth, bowel, lung, cervical
- HPV infection
  - Cervical, anal, throat, penile, vulvar
- HIV/AIDS infection
  - Kaposi sarcoma, non Hodgkin lymphoma, cervical

www.cancercouncil.com.au/wp-content/uploads/2023/02/LGBTQI-People-and-Cancer-2023.pdf

International review on LGBTQ+ cancer screening rates

50 studies

- LBQ women lower screening rates – cervical and breast ca
- GBQ men higher rates – anal and colorectal ca
- Trans – lower rates than cisgender for all screening

Emily Heer et al. Prev Med. 2023 May;170:107478

Australian data – Private Lives 3, 2020, n=6,835

Any cancer diagnosed past year	Cervical screening up to date	Most likely to be screened	Least likely to be screened
• 1.7% • Vs 1.8% gen pop • Types – skin, prostate, leukemia	• Cisgender women 58.3% • Trans people with cervix 38.3% • National 2018–2022 68.3%	• Attended regular GP • Out to GP • Postgrad degree • Attended LGBTQA+ inclusive service	• Lesbian or asexual • Living with disability • Not inner urban

Screening for other cancers – not asked

LBTQ Cervical cancer prevalence – very little data

1. The Women's Health Initiative USA, 93,311 post-menopausal women aged 50-79 (Valanis 2000)

   lesbians 2.2%

   bisexual women 2.1%

   heterosexual women 1.3%

2. Australian Longitudinal study of Women's Health, n=10,451, aged 65-69 (Brown et al 2015)

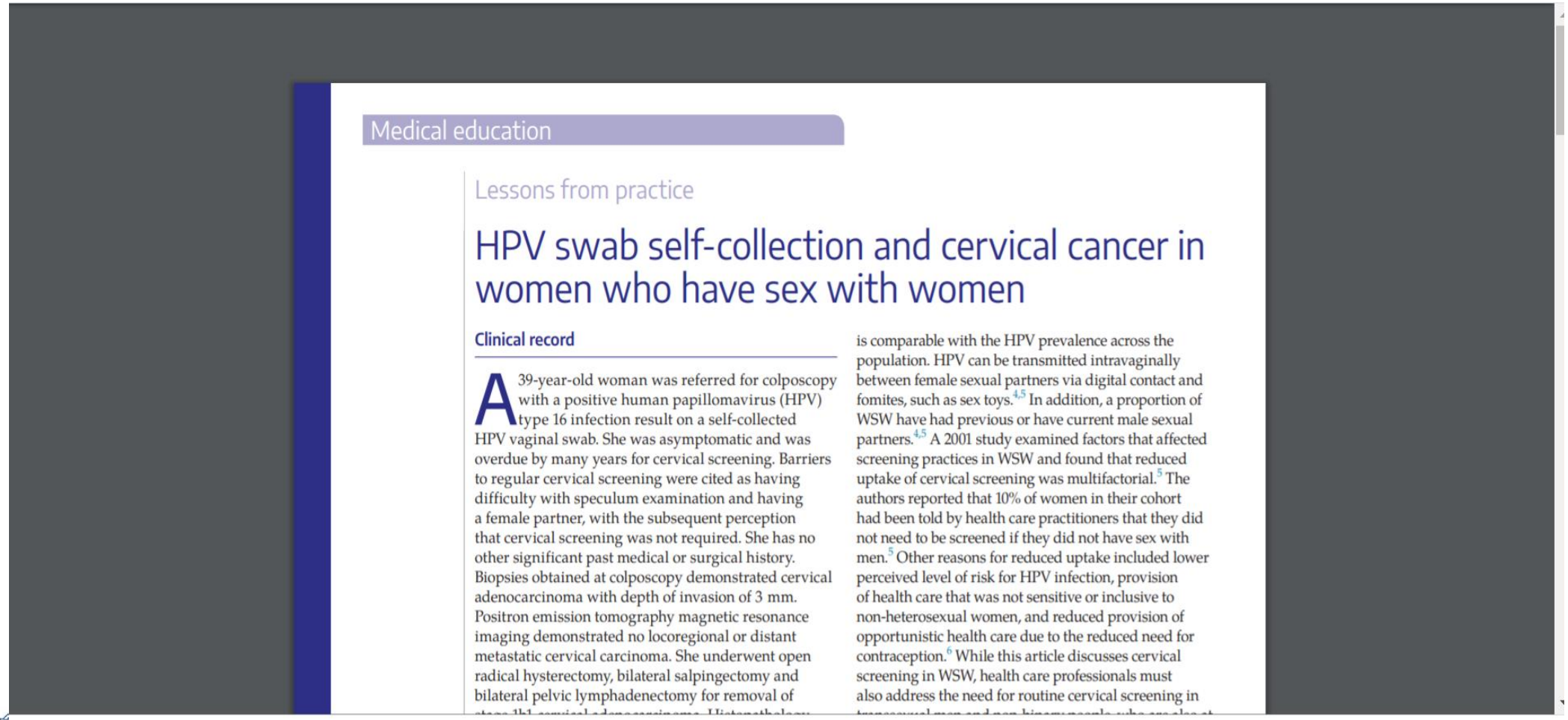
   no difference in cancer prevalence

3. Trans men and cervical cancer – unknown

   higher burden of cancer generally, often late diagnosis

   (The Lancet Editorial 2015)

Case report 39yo lesbian with HPV 16, adeno ca cervix, MJA 2020. 'Overdue by many years for cervical screening'



Medical education

Lessons from practice

HPV swab self-collection and cervical cancer in women who have sex with women

Clinical record

A 39-year-old woman was referred for colposcopy with a positive human papillomavirus (HPV) type 16 infection result on a self-collected HPV vaginal swab. She was asymptomatic and was overdue by many years for cervical screening. Barriers to regular cervical screening were cited as having difficulty with speculum examination and having a female partner, with the subsequent perception that cervical screening was not required. She has no other significant past medical or surgical history. Biopsies obtained at colposcopy demonstrated cervical adenocarcinoma with depth of invasion of 3 mm. Positron emission tomography magnetic resonance imaging demonstrated no locoregional or distant metastatic cervical carcinoma. She underwent open radical hysterectomy, bilateral salpingectomy and bilateral pelvic lymphadenectomy for removal of

is comparable with the HPV prevalence across the population. HPV can be transmitted intravaginally between female sexual partners via digital contact and fomites, such as sex toys.[4,5] In addition, a proportion of WSW have had previous or have current male sexual partners.[4,5] A 2001 study examined factors that affected screening practices in WSW and found that reduced uptake of cervical screening was multifactorial.[5] The authors reported that 10% of women in their cohort had been told by health care practitioners that they did not need to be screened if they did not have sex with men.[5] Other reasons for reduced uptake included lower perceived level of risk for HPV infection, provision of health care that was not sensitive or inclusive to non-heterosexual women, and reduced provision of opportunistic health care due to the reduced need for contraception.[6] While this article discusses cervical screening in WSW, health care professionals must also address the need for routine cervical screening in

Barriers to cervical screening WSW

- Lower risk perception for STIs, especially among women never had sex with men
- Adverse experiences of health care, compounded for people with disabilities, First Nations people, refugees, multi-cultural
- Dissuaded from screening by provider
- Reduced attendance – less opportunistic screening
- Non-disclosure

Barriers to cervical screening- gender diverse and trans men
(Johnson 2016)

More androgynous, gender diverse people and trans males than cis LB women are under-screened

- Less likely to have gynaecological examination due to gender dysphoria
- Speculum examination painful
- Experience more discrimination in health care
- Less likely to be offered screening

Oliver Kensit and TJ Sweet: Trans men on You Can't Ask That, ABC

Trans men have more unsatisfactory cervical screening

Pap tests performed on 233 trans men and 3,625 female patients at an urban community health centre, USA

- Inadequate samples (adjusted odds ratio = 10.77)

  Trans male -10.8%

  Female -1.3%

- Trans patients more likely than females to have had multiple inadequate tests, and had longer latency to follow-up testing.

Testosterone-mediated atrophic cervicovaginitis

- ? Increases effects of HPV on the cervical cells
- Increases discomfort of speculum examination
- Smoking rates can be higher

Peitzmeier, J Gen Intern Med. 2014

National Cervical Screening Program

"Can Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) people also get the virus?

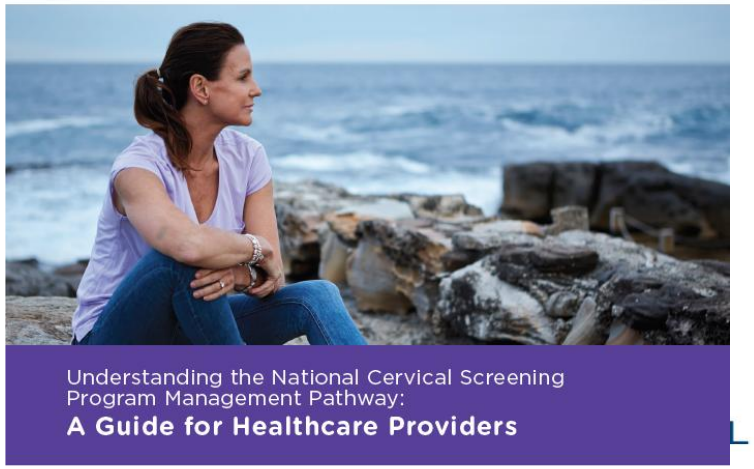
Yes, anyone who engages in genital skin-to-skin contact with a person of any gender can get a HPV infection."

http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/about-HPV-and-cervical-cancer#7

High risk groups:

- LGBTI
- CALD
- Disability
- ATSI
- Sexual trauma
- Domestic violence

NATIONAL CERVICAL SCREENING PROGRAM
A joint Australian, State and Territory Government Program



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L PRACTICE

Self-collected samples

- Never screened WSW and trans men need to be specifically targeted
- More acceptable to do self-testing, particularly some trans men, young LBQ women, and older LBQ women

Reiter PL, McRee AL. Cervical cáncer screening behaviours and acceptability of human papillomavirus self-testing among lesbian and bisexual women aged 21-26 years in the USA 2014. J Fam Plann Reprod Health Care.

Anal cancer and GBTQ+ men

- General prevalence – rare about 0.2% population
- Increased among GB men
  - related to coexistence of other STIs, smoking, multiple partners/multiple HPV strains
- Much higher among HIV positive GB men
  - related to immuno-suppression, even on antiretrovirals
- HPV immunisation is recommended for MSM (RACGP)
- Currently no anal HPV screening program ‘chap smears’

Anal cancer screening

ASHM recommendations for HIV positive MSM https://www.ashm.org.au/hiv/hiv-management/anal-cancer/

- MSM living with HIV aged 50 and above should have a digital ano-rectal examination (DARE) annually as part of their routine HIV care.

- Digital ano-rectal examination (DARE) should be offered to all people living with HIV aged 45 and over

- The 'screening test' will also involve looking or feeling for any abnormalities in the perianal skin (i.e. within 5 cm diameter of the anal verge).

Breast cancer for LGBTQ+ people

LB Cis women - Prevalence data – very limited

- some evidence of increased among LB women

Trans people – extremely limited evidence

- Trans women on oestrogen >5 years likely same prevalence as cis women
- Trans men on testosterone likely same prevalence as cis men (lower oestrogen)

Breast screening –no nationally agreed LGBTQ+ guidelines or promotion

Breast cancer risk factors

LB women

- Alcohol excess
- Smoking
- Overweight
- Less likely to have biological children
- Being under-screened

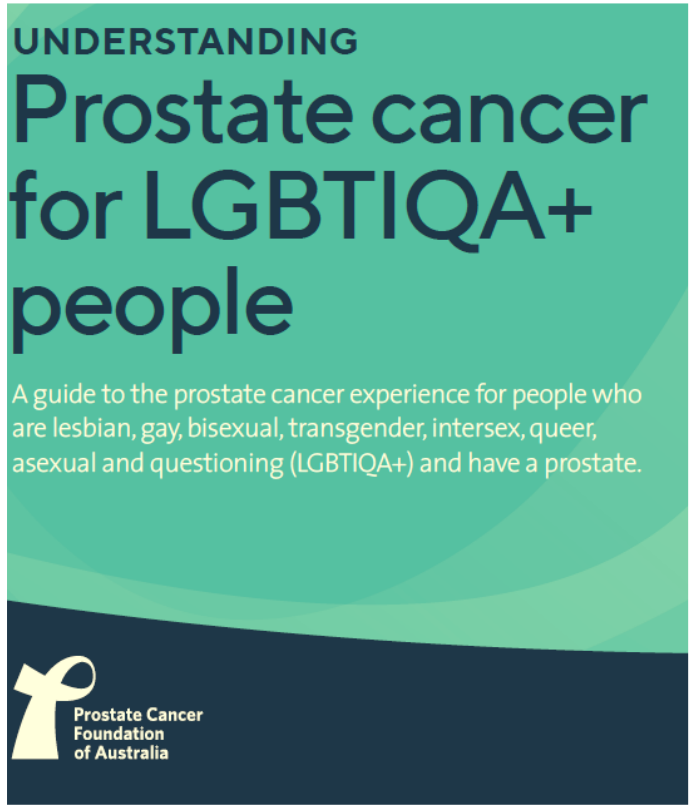
Trans men/non binary

- With breast tissue- same risks as LB women

Trans women

- Possible increased risk of being on relatively high dose oestrogen

Prostate cancer and GBTQ+ men



- Prevalence is not known in Australia
  - USA data- HIV positive men dx less advanced cancers, and had reduced risk of cancer
- Sexual practices change after treatment
  - more GB men bothered by loss of ejaculation, and effects on self esteem
- Screening practices not known
- No data at all for trans and non binary people with a prostate

Inclusive practice – in the consult

Use inclusive language for partners and sexual practices

Ask about preferred names for body parts

Don’t do a genital examination unless required/ offer privacy for swabs etc

Consider binary gender markers on forms – pathology/radiology

Be proactive – offer screening opportunistically

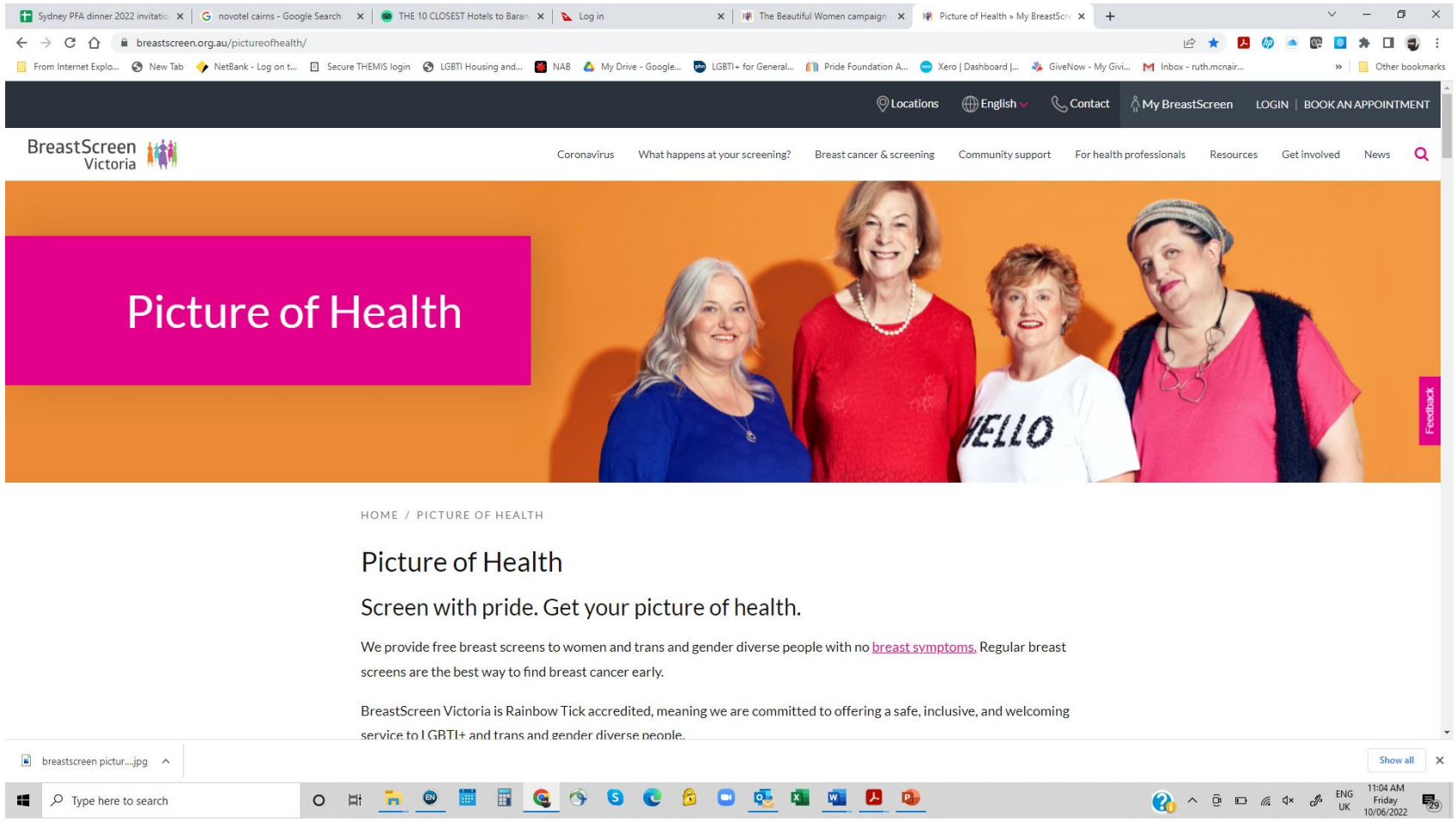
Health promotion needs to be LGBT targeted

Cancer Council Vic/THH 2019

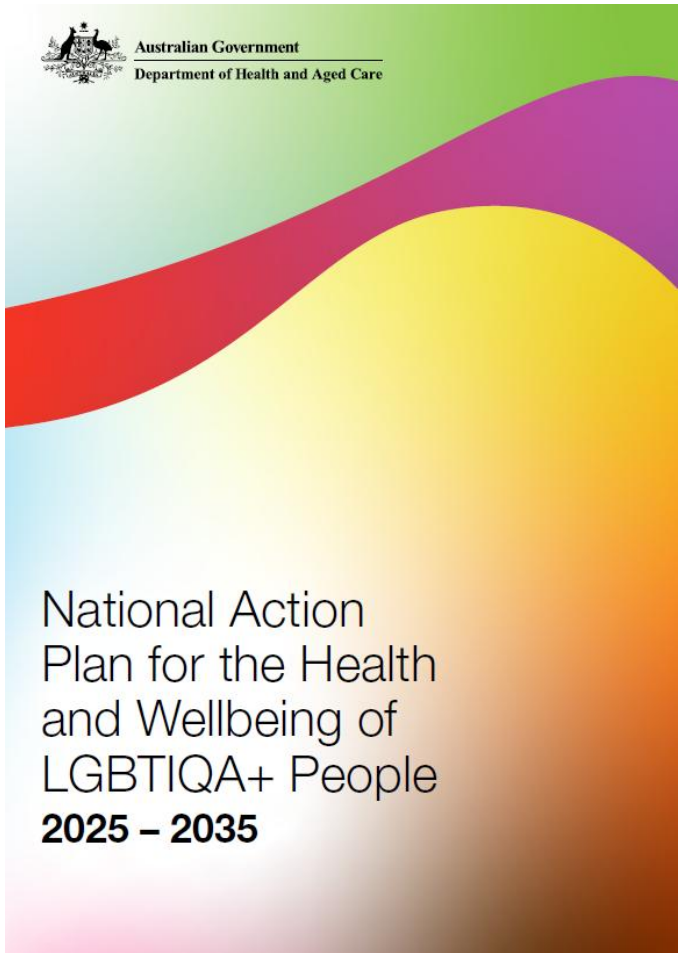
Melb Queer Film Festival 2016

Breastscreen Vic 2018

https://youtu.be/iDAaY5f0m70



Future opportunities LGBTIQA+ screening



10 year LGBTIQA+ health action plan

- Primary care training
- LGBTQ+ inclusion in national screening programs

Resources for health professionals

- CHECK May 2025 Case study –‘Daniel has received a reminder letter’ Ruth McNair, Rosemary McBain, Hannah Saunders

https://www.racgp.org.au/check/check-issues/2025/cervical-screening-and-follow-up-care

- GPSA LGBTIQ Health and Inclusive Healthcare: An introduction to teaching and learning, 2021.

https://gpsupervisorsaustralia.org.au/lgbtqia-inclusive-healthcare/

- BreastScreen WA, Stakeholder Communications Toolkit: Cancer Screening in LGBTIQ+ Communities, 2022, - Bowel, Breast, Cx

https://www.breastscreen.health.wa.gov.au/Breast-screening/LGBTQIA-plus/Screening-Saves-Lives-campaign/Stakeholder-Communications-Toolkit

- Cancer Council, LGBTQI+ People and Cancer: a guide for people with cancer, their families and friends, 2023

www.cancercouncil.com.au/wp-content/uploads/2023/02/LGBTQI-People-and-Cancer-2023.pdf

Thanks

r.mcnair@unimelb.edu.au

Presenter:

Emma Robertson

Improving Breast Cancer Screening in Aboriginal and Torres Strait Islander Communities

A Culturally Safe Approach to Health Promotion and Early Detection

Emma Robertson
Aboriginal Health Practitioner

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Acknowledgement Of Country

We acknowledge the Traditional Custodians of the Country throughout Australia and their continued connection to land, sea and community.

We pay our respects to Elders, past and present and extend that respect to any Aboriginal People here today.

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Who Are We?

Karadi Aboriginal Corporation

Image: Aunty Verna Nichols
Photographer: Jamie Langdon – Black Snow Images

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Background

- Lower Breast Cancer Screening Rates
- Prevalence of Cancer
- Barriers to Screening
- Limited Access to Healthcare Services
- Fear, Stigma, and Mistrust
- Lack of Culturally Appropriate Resources

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Importance of Breast Cancer Screening

- Improved Survival Rates
- Reduction in Mortality
- Culturally appropriate Screening information

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Role of Primary Health Professionals

- Raising Awareness
- Addressing Barriers through Culturally Safe Practices
- Providing Education and Support
- Building Trust and Rapport

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Culturally Safe Practices

- Respect for Culture
- Community Engagement
- Tailored Communication
- Cultural Competence Training

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Practical Strategies for Health Professionals

- Outreach Programs
- Health Promotion Materials
- Support Networks
- Feedback Mechanisms

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Karadi’s role in Breast Cancer Screening

- Removing Barriers
- Appointment Coordination
- Onsite Support
- Morning Tea
- Unique touches

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The Beautiful Things Project.

- Building on Successful Models: Beautiful Shawl and Deadly Choices Projects
- BreastScreen Tasmania and Karadi Aboriginal Corporation
- Community-Centered Artwork to Encourage Screening
- Launch Event: Morning Tea and First Nations-Specific BreastScreen Services
- Culturally Significant T-Shirts for Participants

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Resources for Health Professionals

- The Aboriginal and Torres Strait Islander Cancer Plan
- The National Agreeement on Closing the Gap
- National Abrogianl and Torres Strait Islander Health Plan 2021-2031
- Our Mob and Cancer
- Optimal Care pathways for Aboriginal and Torres Strait Islander People with Cancer
- Cultural Respect Framework

- National Aboriginal Community Controlled Health Organisation (NACCHO)
- Australian Indigenous Health Info Net
- Royal Australian College of General Practitioners (RACGP) and the National Safety
- Quality Health Service (NSQHS) Standards
- National Strategy for the elimination of cervical cancer
- Attend Cultural Competence Training

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Nayri Nina-tu – Thank you

If you have any questions or want to reach out and discuss anything in my presentation, please feel free to email me at erobertson@karadi.org.au

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Q&A

Facilitator: Michelle Cornelius
Speakers:
Dr. David Speakman
Associate Professor Ruth McNair

HealthPathways

HealthPathways is a web-based information portal. It is designed to help primary care clinicians plan local patient care through primary, community and secondary healthcare systems.

https://www.health.gov.au/resources/apps-and-tools/primary-health-network-locator

HealthPathways

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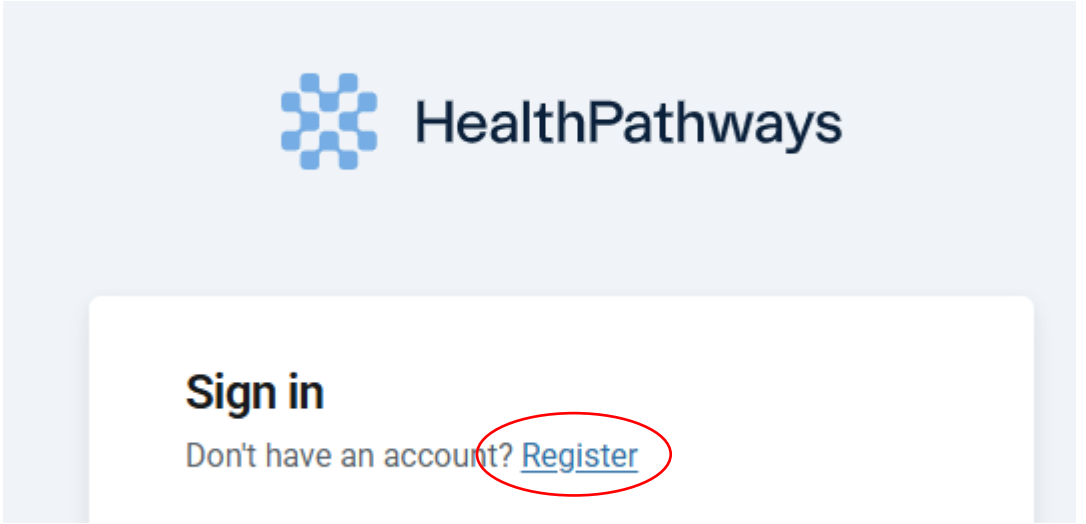

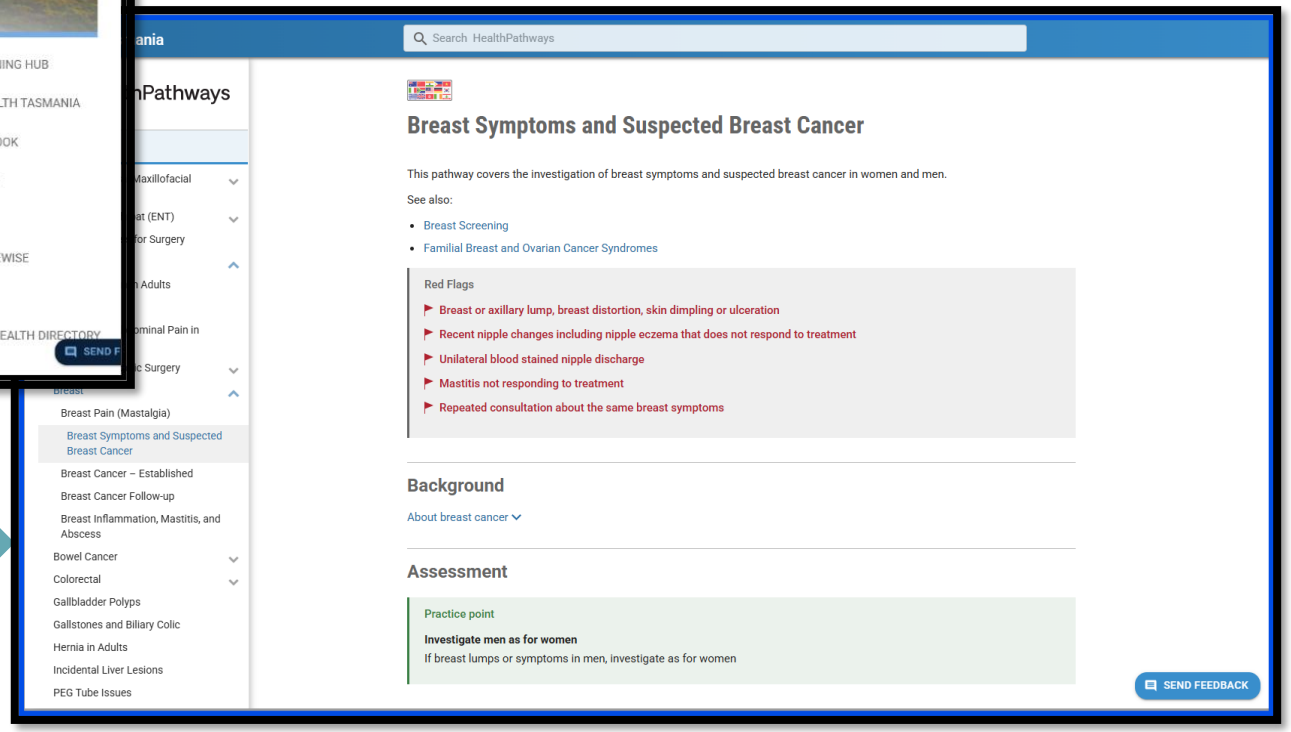

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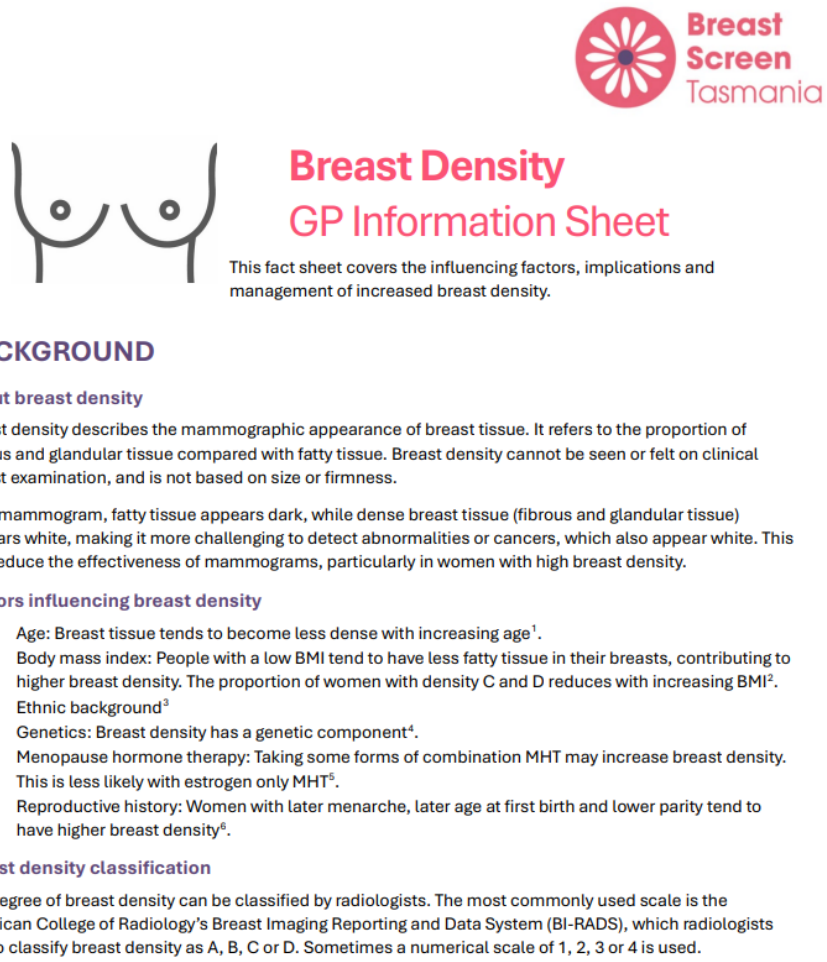
New breast density resource



Breast Screen Tasmania

Breast Density
GP Information Sheet

This fact sheet covers the influencing factors, implications and management of increased breast density.

BACKGROUND

About breast density

Breast density describes the mammographic appearance of breast tissue. It refers to the proportion of fibrous and glandular tissue compared with fatty tissue. Breast density cannot be seen or felt on clinical breast examination, and is not based on size or firmness.

On a mammogram, fatty tissue appears dark, while dense breast tissue (fibrous and glandular tissue) appears white, making it more challenging to detect abnormalities or cancers, which also appear white. This can reduce the effectiveness of mammograms, particularly in women with high breast density.

Factors influencing breast density

- Age: Breast tissue tends to become less dense with increasing age[1].
- Body mass index: People with a low BMI tend to have less fatty tissue in their breasts, contributing to higher breast density. The proportion of women with density C and D reduces with increasing BMI[2].
- Ethnic background[3]
- Genetics: Breast density has a genetic component[4].
- Menopause hormone therapy: Taking some forms of combination MHT may increase breast density. This is less likely with estrogen only MHT[5].
- Reproductive history: Women with later menarche, later age at first birth and lower parity tend to have higher breast density[6].

Breast density classification

The degree of breast density can be classified by radiologists. The most commonly used scale is the American College of Radiology's Breast Imaging Reporting and Data System (BI-RADS), which radiologists use to classify breast density as A, B, C or D. Sometimes a numerical scale of 1, 2, 3 or 4 is used.

- Available on the Tasmanian HealthPathways
  - Breast Imaging - Screening

Some final words

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