

UNCLASSIFIED

AD NUMBER
ADB267647
NEW LIMITATION CHANGE
TO Approved for public release, distribution unlimited
FROM Distribution authorized to U.S. Gov't. agencies only; Proprietary Info.; Dec 2000. Other requests shall be referred to U.S. Army Medical Research and Materiel Command, 504 Scott St., Fort Detrick, MD 21702-5012.
AUTHORITY
U.S. Army Medical Research and Materiel Command and Fort Detrick ltr., dtd October 17, 2001.

THIS PAGE IS UNCLASSIFIED

AD _____

Award Number: DAMD17-95-1-5006

TITLE: Genetic Epidemiology of In Situ Breast Cancer

PRINCIPAL INVESTIGATOR: Elizabeth Claus, M.D., Ph.D.

CONTRACTING ORGANIZATION: Yale University
New Haven, Connecticut 06520-8047

REPORT DATE: December 2000

TYPE OF REPORT: Final

PREPARED FOR: U.S. Army Medical Research and Materiel Command
Fort Detrick, Maryland 21702-5012

DISTRIBUTION STATEMENT: DISTRIBUTION STATEMENT: Distribution authorized to U.S. Government agencies only (proprietary information, Dec 00). Other requests for this document shall be referred to U.S. Army Medical Research and Materiel Command, 504 Scott Street, Fort Detrick, Maryland 21702-5012.

The views, opinions and/or findings contained in this report are those of the author(s) and should not be construed as an official Department of the Army position, policy or decision unless so designated by other documentation.

20010620 116

NOTICE

USING GOVERNMENT DRAWINGS, SPECIFICATIONS, OR OTHER DATA INCLUDED IN THIS DOCUMENT FOR ANY PURPOSE OTHER THAN GOVERNMENT PROCUREMENT DOES NOT IN ANY WAY OBLIGATE THE U.S. GOVERNMENT. THE FACT THAT THE GOVERNMENT FORMULATED OR SUPPLIED THE DRAWINGS, SPECIFICATIONS, OR OTHER DATA DOES NOT LICENSE THE HOLDER OR ANY OTHER PERSON OR CORPORATION; OR CONVEY ANY RIGHTS OR PERMISSION TO MANUFACTURE, USE, OR SELL ANY PATENTED INVENTION THAT MAY RELATE TO THEM.

LIMITED RIGHTS LEGEND

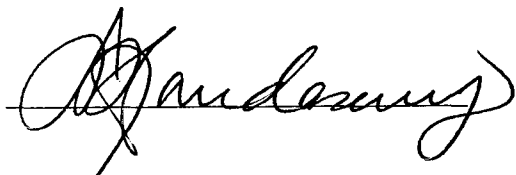
Award Number: DAMD17-95-1-5006

Organization: Elizabeth Claus, M.D., Ph.D.

Location of Limited Rights Data (Pages):

Those portions of the technical data contained in this report marked as limited rights data shall not, without the written permission of the above contractor, be (a) released or disclosed outside the government, (b) used by the Government for manufacture or, in the case of computer software documentation, for preparing the same or similar computer software, or (c) used by a party other than the Government, except that the Government may release or disclose technical data to persons outside the Government, or permit the use of technical data by such persons, if (i) such release, disclosure, or use is necessary for emergency repair or overhaul or (ii) is a release or disclosure of technical data (other than detailed manufacturing or process data) to, or use of such data by, a foreign government that is in the interest of the Government and is required for evaluational or informational purposes, provided in either case that such release, disclosure or use is made subject to a prohibition that the person to whom the data is released or disclosed may not further use, release or disclose such data, and the contractor or subcontractor or subcontractor asserting the restriction is notified of such release, disclosure or use. This legend, together with the indications of the portions of this data which are subject to such limitations, shall be included on any reproduction hereof which includes any part of the portions subject to such limitations.

THIS TECHNICAL REPORT HAS BEEN REVIEWED AND IS APPROVED FOR PUBLICATION.



REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 074-0188

*Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing this collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0188), Washington, DC 20503

1. AGENCY USE ONLY (Leave blank)		2. REPORT DATE December 2000	3. REPORT TYPE AND DATES COVERED Final (15 Nov 94 - 14 Nov 00)	
4. TITLE AND SUBTITLE Genetic Epidemiology of In Situ Breast Cancer			5. FUNDING NUMBERS DAMD17-95-1-5006	
6. AUTHOR(S) Elizabeth Claus, M.D., Ph.D.				
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) Yale University New Haven, Connecticut 06520-8047 E-MAIL: claus@biomed.med.yale.edu			8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES) U.S. Army Medical Research and Materiel Command Fort Detrick, Maryland 21702-5012			10. SPONSORING / MONITORING AGENCY REPORT NUMBER	
11. SUPPLEMENTARY NOTES				
12a. DISTRIBUTION / AVAILABILITY STATEMENT DISTRIBUTION STATEMENT: Distribution authorized to U.S. Government agencies only (proprietary information, Dec 00). Other requests for this document shall be referred to U.S. Army Medical Research and Materiel Command, 504 Scott Street, Fort Detrick, Maryland 21702-5012.				12b. DISTRIBUTION CODE
13. ABSTRACT (Maximum 200 Words) BACKGROUND: No study has reported the risk factors and cancer screening practices associated with a diagnosis of breast carcinoma in-situ (BCIS), across all categories of age and histology. METHODS: The data are from a population-based case/control study which includes all female cases of BCIS diagnosed among residents of the state of Connecticut from 9/15/94 to 3/14/98 as well as a series of random-digit-dial (RDD) controls. Cases (n=1068) were between the ages of 20 and 79 years at time of diagnosis while controls (n=999) were frequency matched to the cases by five-year age intervals. RESULTS: Cases with ductal carcinoma in-situ (DCIS) were more likely than controls to be older at age of first full-term pregnancy and at menopause, to have had a previous breast biopsy as well as fewer full-term pregnancies. In addition, DCIS cases were more likely to report a family history of breast cancer particularly at a young age. With respect to cancer screening, DCIS cases were more likely than controls to have had at least one screening mammogram and to be receiving yearly breast exams by a physician. Cases with lobular carcinoma in-situ (LCIS) were more likely than controls to be older at menopause, to have had at least one breast biopsy and yearly physician-performed breast exams. No association was found between oral contraceptive use or hormone replacement therapy (HRT) and BCIS risk nor was there an association seen between diagnosis and use of breast self examination (BSE). Screening was significantly associated with a number of breast cancer risk factors including race, family history, HRT use and a previous breast biopsy. CONCLUSIONS: The risk factors for BCIS are similar to many of those associated with invasive breast cancer. The diagnosis of BCIS is associated with the use of mammography and yearly physician-performed breast examinations but not with BSE. In these data, utilization of these three screening methodologies varies significantly with race, a family history of breast cancer, HRT, and a previous breast biopsy.				
14. SUBJECT TERMS Family History, In-Situ, Genetic Epidemiology, Case/Control, Population-Based, Breast Cancer Risk, Breast Neoplasms, Paraffin Blocks, Ductal carcinoma in-situ, Lobular carcinoma in-situ			15. NUMBER OF PAGES 58	
			16. PRICE CODE	
17. SECURITY CLASSIFICATION OF REPORT Unclassified	18. SECURITY CLASSIFICATION OF THIS PAGE Unclassified	19. SECURITY CLASSIFICATION OF ABSTRACT Unclassified	20. LIMITATION OF ABSTRACT Unlimited	

NSN 7540-01-280-5500

Standard Form 298 (Rev. 2-89)
Prescribed by ANSI Std. Z39-18
298-102

TABLE OF CONTENTS

	Page
Front Cover	1
SF 298, Report Documentation Page	2
Foreword	3
Table of Contents	4
Introduction	5
Body	6
Key Research Accomplishments/Reportable Outcomes/Conclusions	7
Appendices A and B	

THE GENETIC EPIDEMIOLOGY OF BREAST CARCINOMA IN SITU

4. INTRODUCTION

Breast cancer remains one of the most important health care issues of the 20th century. Despite a wealth of studies on the topic, the current literature provides little information regarding the nature of the epidemiologic risk factors or clinical characteristics of breast tumors which are classified as non-invasive, i.e., breast carcinoma in situ (BCIS). As screening efforts throughout the United States have increased, so has the number of women diagnosed with BCIS, with up to 20% of screened patients diagnosed with this lesion. The identification of risk factors associated with the development of BCIS is especially important, particularly in light of the fact that in the coming century up to one in fifty women in the United States will be diagnosed with this tumor during her lifetime. This project will define risk factors associated with BCIS through the mechanism of a case/control study. The study population includes 1068 cases of female breast carcinoma in situ and 999 age-matched female controls selected from the population of the state of Connecticut over a 3.5 year data collection period. Cases are between the age of 20 and 79 years at time of diagnosis. The controls are frequency matched to the cases by five year age intervals. Telephone interviews were conducted with the study subjects and collected information concerning family history of cancer, pregnancy and menstrual history, hormone replacement therapy, oral contraceptive use, fertility drug use, as well as sociodemographic variables. The expression of estrogen and progesterone receptors (ER and PR) as well as two of the most frequently reported oncogenes associated with invasive breast cancer, p53 and c-erbB-2, will be examined in these BCIS cases for the first time in a population-based series.

The goals of this study are as follows:

1. To determine whether there is an association between a family history of breast and/or ovarian cancer and the development of breast carcinoma in situ (BCIS).
2. To determine whether there is an association between additional epidemiologic risk factors, including those traditionally associated with invasive breast carcinoma such as age at menarche, age at first birth, and oral contraceptive use and the development of BCIS.
3. To collect paraffin-embedded tumor tissue for a subset of the BCIS cases.
4. To test for the presence of p53 and c-erbB-2 protein expression as well as estrogen and progesterone receptor expression using the methods of immunohistochemistry in the paraffin-

embedded tumor tissue.

5. To examine the association between p53, ER, PR and/or c-erbB-2 expression in BCIS tumors with clinical and epidemiologic variables including grade and family history of breast cancer.
6. To develop risk prediction models to be used in defining screening guidelines for women not yet diagnosed with BCIS.

Specific Location of Study

Drs. Claus and Holford have offices located in the Department of Epidemiology and Public Health. Dr. Carter has an office and laboratory located within the Pathology Department. Dr. Badve, who now works with the project as a consultant, is located in the Department of Pathology at Northwestern University in Chicago. The offices of the project director and the director of the Rapid Case Ascertainment Shared Resource are located at 200 College Street, New Haven, CT.

5. BODY

RESEARCH PLAN

The cases were ascertained through the Rapid Case Ascertainment (RCA) Shared Resource of the Yale Cancer Center. The physicians of each eligible case were identified by the RCA. The names of patients and physicians were given to the project director by RCA staff. A letter signed by Dr. Claus and the project director was sent to the physicians requesting permission to send a letter of introduction to the case.

Proto-controls were identified by Northeast Research in Orono, Maine through the mechanism of random-digit dialing. Female residents of the state of Connecticut aged 20-79 who were served by a telephone were eligible.

Those cases approved for contact by their physicians were sent a letter of introduction from Dr. Claus and the project director explaining the project. Controls received a similar letter. Informed consent forms accompanied the letter of introduction and study subjects were asked to return them via the stamped, addressed envelope provided. Approximately 1-2 weeks later an interviewer (either Ms. Sheila Griffin or Ms. Marjorie Jasmin) contacted the potential study subject by telephone. If the potential study subject decided to participate, the interviewer administered the questionnaire over the telephone at the patient's convenience after verbal consent had been given for the interview. Subjects who agreed to be interviewed were sent an oral

contraceptive picture booklet with an accompanying letter. Subjects were interviewed for an average of 43 minutes. The questionnaire included questions on family history of cancer, pregnancy and menstrual history, oral contraceptive and other exogenous hormone history, medical history, socioeconomic status, as well as alcohol and tobacco use.

Pathology slides and histologic specimens were collected in the form of paraffin-embedded tumor tissue. Cases who agreed to allow us to retrieve paraffin-embedded blocks were sent an authorization of health information form that we then asked them to return via mail. RCA requests and couriers slides and paraffin-blocks from each of the pathology departments as well as returns the slides and blocks after the laboratory analyses are completed. The blocks are returned to the various hospitals after sufficient material has been removed from them. Alternatively, hospitals may choose to cut material from the blocks rather than send the block itself. The slides are quickly returned after our pathologists have reviewed them to confirm the diagnosis.

Medical records were reviewed to provide details requested in the questionnaire regarding dates of diagnoses or pathologic details of diagnosis. In particular, pathology data are useful in identifying tumor blocks most likely to contain tumor. A stamped, addressed envelope is provided for study subjects so that they may return the authorization for release of health information (for review of medical records and retrieval of paraffin-blocks) via mail. The project director telephoned study participants who did not return the form to encourage them to do so. Replacement forms were sent to women who misplace the original form.

YEARLY REPORT

The personnel on the project remained stable with the sole change being the identification of a new project director, Ms. Lisa McKay. Our previous project director, Mr. Thy Do, graduated and Ms. McKay has been hired to finish the work on this grant as well as continue as the project director on our new grant. This new grant, from the NIH, will fund a five-year followup study of the cases and controls in this data set and allow us to continue to collect paraffin blocks for immunohistochemical studies.

Over the study period, 1606 proto-cases and 1445 proto-controls were identified. One hundred and eleven cases were ineligible due to out-of-state residency (8), language (21), a history of previous breast cancer/biopsy of unknown outcome (51), and age-group (31). Ninety-one percent of eligible cases had a consenting physician. Among eligible cases who were contacted by our study, 83 % participated in the interview portion of the study. Two hundred and four controls were ineligible due to out-of-state residency (3), language (18), a history of previous breast cancer/biopsy of unknown outcome (181), and age-group (2). Among eligible controls who were contacted by our study, 81 % agreed to be interviewed. The final sample included 1068 case and 999 control subjects.

In addition to the interview portion of the study, we completed the histologic slide/pathology review portion of the study. Slides were obtained and reviewed for approximately 83% of interviewed cases. Among cases, 83.6% were diagnosed with DCIS, 11.7% with LCIS, and 4.7% with mixed or other pathology.

We are continuing to retrieve blocks for those women who have given permission. This portion of the study has proved to be very time-consuming as many of the hospitals in the state have put a hold on the release of biologic specimens. In fact, just last month, Hartford Hospital finally agreed to release blocks to us after two years of negotiations by RCA. At present we have received and/or stained approximately 350 blocks and will continue to collect and stain them during our five-year followup.

Data analysis continued this year with two manuscripts under review (copies are enclosed): "Breast carcinoma in-situ: Risk factors and screening patterns" and "Family history of breast and ovarian cancer and the risk of breast carcinoma-in situ". Results from the first manuscript were presented at the DOD meeting in Atlanta in June 2000. Two additional manuscripts are near completion: "Oral contraceptive use and the risk of breast carcinoma in-situ" and "Segregation analysis of breast carcinoma in-situ". In addition, we are happy to report that the work done on this Army grant has helped us to receive an NIH grant to continue our work and follow the study subjects for five years.

HUMAN SUBJECTS

Subject Population

All female Connecticut residents between the ages of 20 and 79 years at time of diagnosis and diagnosed with breast carcinoma in situ from 9/15/94 to 3/14/98 were eligible. Cases with a previous history of breast cancer and/or a breast biopsy of unknown outcome were excluded. In this time period, 1606 women were diagnosed with BCIS in the state of Connecticut within the age-group of interest. From this group, we interviewed 1068 women. Proto-controls were randomly selected by an external firm (Northeast Research) and consist of age-matched Connecticut female residents. We identified 1445 proto-controls and interviewed 1048 as controls. (Of note, upon interview, 49 controls reported a history of breast cancer and were not included in the final count as study controls. The final count is therefore 999 controls.)

Risks/Benefits

As this is primarily an interview study, we anticipate no physical risk to study subjects. However, given the serious nature of breast cancer, it is conceivable that some patients will experience some degree of psychological distress as a result of being interviewed concerning their health status. In order to minimize the occurrence of such distress, interviewers are trained to conduct interviews in a relaxed, friendly, and professional manner. Swift corrective action will be taken concerning any interviewer whose demeanor seems to have a negative effect on study participants.

There are no monetary inducements to participants in this study. The primary inducement for participants is the ability of the study to contribute to our understanding of breast cancer. This research has the potential to define modifiable risk factors associated with the development of breast cancer as well as the potential to identify currently healthy women at increased risk of this disease who might benefit from increased screening for breast cancer.

At present no adverse effects have been reported in this study. A number of positive effects have been reported, particularly to our interviewers, including the improvement of family relationships in association with the gathering of family history information. In addition, among cases, the discussion of a breast cancer diagnosis with an independent observer has proved to be helpful to a number of women.

Protection of Subjects

Each study subject is assigned a code number. The interview cover sheet containing identifying information is removed from the interview booklet and stored separately. All staff members are informed prior to employment and at regular intervals as to the necessity for keeping all data confidential. All written study material is stored in locked file cabinets. All histologic specimens will be stored in the laboratory of Dr. Carter.

The opinion of Dr. Carter, the study pathologist, concerning histologic specimens may in some instances differ from that of the original pathologist. If Dr. Carter interprets the woman's cancer to be invasive rather than solely in-situ, the original pathologist and surgeon will be contacted and informed of the opinion of the study pathologist. If the original pathologist is not available, we will inform the Chair of Pathology at the appropriate hospital.

No information that identifies an individual subject will be given to third parties, including family members, unless that subject has given consent to do so. Information obtained during the study will not be placed in a subject's medical record. Publication and presentation of results will contain only aggregate data.

No laboratory test results on specimens will be released to the participant or her physician. This current work is in the realm of research and any results should be regarded as preliminary findings and not definitive. None of the materials collected on these patients will be used to do research unrelated to their breast cancer diagnosis.

Human Investigation Committee Approvals

We have had great success in obtaining the approval and participation of the state's hospitals. At present, all but four of the state's 32 hospitals are active participants. We are able to identify cases diagnosed and treated at these four hospitals via the Connecticut Tumor Registry. Overall, the response of the state's hospitals and medical personnel has been extremely positive. Most of the hospitals are now in their sixth year of participation with our study.

6. KEY RESEARCH ACCOMPLISHMENTS/REPORTABLE OUTCOMES/CONCLUSIONS

The study represents the first large population-based case/control study of breast carcinoma in-situ with data collected across all age-categories and histologic subtypes, and with information on screening variables such as mammography. Data from the project were presented at the DOD meetings in both 1998 and 2000. There are two manuscripts under review at present (see Appendices A and B) and two in preparation (listed above). We have applied for and received funding from the National Institutes of Health to continue our work on these study subjects in the form of a five-year R01 grant. The goal of the new grant is to provide five-year follow-up for these women to describe the outcomes of women with BCIS and to define possible risk factors associated with morbidity and mortality in these women. We are also applying for additional funding to study mammographic risk factors and the development of BCIS.

Appendix A

BREAST CARCINOMA IN-SITU:

RISK FACTORS AND SCREENING PATTERNS

Elizabeth B. Claus, Ph.D., M.D., Meredith Stowe, Ph.D.,

Darryl Carter, M.D.

From the Departments of Epidemiology and Public Health (E.B.C., M.S.) and Pathology (D.C.), Yale University School of Medicine, P.O. Box 3333, New Haven, CT 06510. Address reprint requests to Dr. Claus at Department of Epidemiology and Public Health, Yale University, 60 College St., P.O. Box 208034, New Haven, CT 06520-8034.

This work was supported by the U.S. Army Medical Research and Material Command under DAMD-17-95-1-5006.

ABSTRACT

BACKGROUND

Although numerous studies have defined risk factors for invasive breast carcinoma, no study has reported the risk factors and cancer screening practices associated with a diagnosis of breast carcinoma in-situ, across all categories of age and histology.

METHODS

The data are from a large, population-based case/control study which includes all female cases of breast carcinoma in-situ (BCIS) diagnosed among residents of the state of Connecticut from September 15, 1994 to March 14, 1998 as well as a series of random-digit-dial (RDD) controls selected from the state of Connecticut. Cases (n=1068) were between the ages of 20 and 79 years at time of diagnosis while controls (n=999) were frequency matched to the cases by five-year age intervals. Telephone interviews were used to collect information on family history of cancer, pregnancy and menstrual history, exogenous hormone use, as well as socio-demographic variables and cancer screening history.

RESULTS

Cases with ductal carcinoma in-situ (DCIS) were more likely than controls to be older at age of first full-term pregnancy and at menopause, to have had a previous breast biopsy (odds ratio (OR): 3.34, 95 percent confidence interval (95CI): 2.70 to 4.15) as well as fewer full-term pregnancies. In addition, DCIS cases were more likely to report a family history of breast cancer particularly at a young age; results for women aged 49 years or younger (OR: 2.36; 95CI, 1.47 to 3.77) versus for women older than 49 years (OR: 1.36, 95CI: 1.01 to 1.85). With respect to cancer screening, DCIS cases were more likely than controls to have had at least one screening mammogram (OR: 2.46,

95CI: 1.78 to 3.40) and to be receiving yearly breast exams by a physician (OR: 1.83, 95CI: 1.48 to 2.26). Cases with lobular carcinoma in-situ (LCIS) were more likely than controls to be older at menopause, to have had at least one breast biopsy (OR: 4.12, 95CI: 2.33 to 7.29) and yearly physician-performed breast exams (OR: 2.37, 95CI: 1.44 to 3.90). An association between family history of breast cancer and a diagnosis of LCIS was suggested but did not reach statistical significance (OR: 1.69, 95CI: 0.97, 2.96). No association was found between oral contraceptive use or hormone replacement therapy (HRT) and BCIS risk nor was there an association seen between diagnosis and use of breast self examination (BSE). Screening was significantly associated with a number of breast cancer risk factors including race, family history, HRT use and a previous breast biopsy.

CONCLUSIONS

The risk factors for BCIS are similar to many of those associated with invasive breast cancer. The diagnosis of BCIS is associated with the use of mammography and yearly physician-performed breast examinations but not with BSE. In these data, utilization of these three screening methodologies varies significantly with race, a family history of breast cancer, HRT, and a previous breast biopsy.

Word Count: 2781

Keywords: Breast carcinoma in situ, risk factors, epidemiology, ductal carcinoma in situ, lobular carcinoma in situ

INTRODUCTION

As mammographic screening efforts have increased, so has the number of breast tumors which are classified as non-invasive, i.e. breast carcinoma in situ (BCIS), with up to 20% of screened breast cancer patients diagnosed with

this lesion. Few studies have examined the epidemiology of BCIS.²⁻¹⁵ Previous attempts to define risk factors have focused on small subsets of BCIS cases nested within larger invasive breast cancer (IBC) case/control^{3,4,13} studies or screened cohorts.^{6,9,14} A recent population-based study of 1616 breast cancer cases aged under 45 years and which included 228 BCIS cases, reported that both ductal (DCIS) and lobular (LCIS) in situ cancer were positively associated with many established IBC risk factors including a family history of breast cancer, previous breast biopsy, and nulliparity.³ A second population-based case/control study which included 233 in-situ cases aged 40 and younger or between 55-64 years, also reported an increased risk of BCIS with family history and benign breast disease.⁴ However, in premenopausal women, the risk of in-situ lesions relative to invasive disease decreased with increasing body mass index while in postmenopausal women, use of unopposed estrogen replacement was associated with increased risk of in-situ cancer relative to women with invasive disease. Data from additional case-control analyses obtained from cohorts of screened women report increased risk associated with age^{9,14}, a positive family history of breast cancer^{6,9}, race¹⁴, nulliparity⁹, a previous breast biopsy⁶, and increased age at first livebirth^{6,9}

The above mentioned studies provide evidence that many risk factors associated with IBC may also play a role in the development of BCIS. The results, however, are not consistent across studies. In many instances, small sample size does not allow for precise estimates of risk. In general, information on screening variables is not available;^{4,6,8,9} in the one study that did collect such information, no data are available for cases over 45 years of age.³ Furthermore, only one study has presented separate analyses by histologic subtype and again, only for women under the age of 45 years.³ The data presented here represent the first large, population-based study specifically designed to examine the association between risk factor history and BCIS diagnosis across the full spectrum of age and histology, while

incorporating data on cancer screening.

METHODS

The study population includes all cases of female BCIS diagnosed among residents of the state of Connecticut from September 15, 1994 to March 14, 1998 as well as a series of age-matched controls. Cases were identified through the Rapid Case Ascertainment (RCA) Shared Resource of the Yale Cancer Center and were between the ages of 20 and 79 years at time of diagnosis. Controls were female Connecticut residents selected by random-digit dialing methods and were frequency matched by five-year age intervals to the cases. Study subjects with a previous history of breast cancer and/or a breast biopsy of unknown outcome were excluded. The study, consent forms and questionnaire were approved by the Yale University School of Medicine Human Investigation Committee.

The physicians of each eligible case were contacted to request permission to approach the case. Cases approved for contact by their physicians and controls were sent a letter of introduction. Approximately 1-2 weeks later a trained interviewer contacted the potential study subject by telephone. If a woman decided to participate, the interviewer administered the questionnaire over the telephone at the subject's convenience. Women who consented to be interviewed were sent an oral contraceptive picture booklet developed for the Harvard University Nurses' Health Study¹⁶ to allow them to review products used in the past. Subjects were interviewed for an average of 43 minutes. The questionnaire included detailed questions on family history of cancer, pregnancy and menstrual history, exogenous hormone history, demographics, medical and screening history, and smoking and alcohol consumption.

Over the study period, 1606 proto-cases and 1445 proto-controls were identified. Eighty cases were ineligible due to out-of-state residency (8),

language (21), or a history of previous breast cancer/biopsy of unknown outcome (51), and age-group (31). Ninety-one percent of eligible cases had a consenting physician. Among eligible cases who were contacted by our study, 83% participated in the interview portion of the study. Two hundred and four controls were ineligible due to out-of-state residency (3), language (18), a history of previous breast cancer/biopsy of unknown outcome (181), and age-group (2). Among eligible controls who were contacted by our study, 81% agreed to be interviewed. The final sample included 1068 case and 999 control subjects.

Cases were defined as in-situ, either ductal (DCIS) or lobular (LCIS), if they were non-infiltrating. All cases were confirmed by pathology report. Cases with mixed or other pathology were not included in any analyses. Risk factor information was truncated at the date of diagnosis for cases and the date of interview for controls. Data on screening variables consisted of five questions which asked for the commencing age, frequency, and date of most recent routine checkup, breast exam by a physician, breast self-exam (BSE), pap smear, and mammogram one year prior to the diagnosis/interview.

Statistical Analysis

The initial portion of the statistical analysis included descriptive statistics. T-tests and chi-square tests were used to examine the association between the risk of BCIS and independent covariates. To assess the relative risk of BCIS associated with risk factors, logistic regression was used to provide maximum likelihood estimates of the odds ratios (ORs) (adjusted and unadjusted) with 95% confidence intervals (CIs) using the statistical package PC-SAS version 6.11.¹⁷

RESULTS

Approximately 92 percent of the cases and controls were white with the

remaining eight percent representing primarily women of African-American background (6.5%). Thirty-four percent of cases were college-educated versus 28% of controls. Cases were older on average than controls (57.4 versus 55.9 years). Because of the statistically significant differences in education and age, all risk estimates were adjusted for both of these variables. Among cases, 83.6% were diagnosed with DCIS, 11.7% with LCIS, and 4.7% with mixed or other pathology. Among women diagnosed with DCIS, 66% had their lesion discovered by mammogram versus 8% by self-exam, 11% by accident, and 10% by a physician. LCIS cases reported discovery rates of 17%, 16%, 34%, and 20%, respectively.

The proportions of women who participated in various cancer screening procedures is presented by case/control status in Table 1. DCIS cases were more likely than controls to have received at least one screening mammogram one year prior to interview (OR: 2.46, 95CI: 1.78, 3.40) as well as yearly physician breast exams (OR: 1.83, 95CI: 1.48, 2.26) but were as likely as controls to be performing BSE (OR: 1.01, 95CI: 0.84, 1.21). When examining the percentages of women under 45 years, 78% of DCIS cases and 62% of controls reported ever having had a mammogram. Cases with LCIS were more likely to report having a yearly physician performed breast exam (OR: 2.37, 95CI: 1.44, 3.90) but no more likely to report use of mammography (OR: 1.81, 95CI: 0.92, 3.55) or BSE (OR: 0.89, 95CI: 0.61, 1.31).

The age-adjusted proportion of study subjects participating in mammography, yearly physical exam, and monthly BSE one year prior to interview is presented by breast cancer risk factor profile in Table 2. Women with a first degree family history of breast cancer were more likely to have had a mammogram (OR= 2.4, 95% CI: 1.5, 3.9), a yearly breast exam by a physician (OR = 1.5, 95% CI: 1.2, 1.8), and have practiced monthly BSE (OR = 1.2, 95% CI: 1.1, 1.5) than were women who did not report such a history. Among women with a family history, those with an affected mother (OR 3.20, 95CI: 1.55, 6.60) were almost twice as likely to have undergone at least one mammogram relative

to those with an affected sister (OR 1.47, 95CI: 0.76, 2.86). HRT users were four times as likely to undergo mammography and over twice as likely to be undergoing yearly physician breast exams relative to women who did not receive HRT. White women were more likely than non-white women to have received a mammogram, equally likely to report a yearly physician breast exam and less likely to report doing BSE. Study subjects who reported having had at least one breast biopsy also reported a higher rate of all three screening modalities relative to women without such a history, while college-educated women were more likely to have had a yearly physician breast exam ($p = 0.05$) but equally likely to have had a mammogram or practiced BSE relative to women without such an education.

Multivariate adjusted odds ratios of BCIS are presented, by histologic subtype, in Table 3. Among women diagnosed with DCIS, cases were significantly more likely than controls to be older at age of first full-term pregnancy and at menopause (borderline significance). In addition, DCIS cases were more likely to report a first degree family history of breast cancer, to be nulliparous, to have fewer full-term pregnancies, and to have had at least one breast biopsy. An inverse association was seen between age at onset and family history with respect to risk; cases diagnosed prior to age 50 were 2.34 (95CI: 1.47, 3.77) times more likely than controls to report having an affected first degree relative versus an odds ratio of 1.36 (95CI: 1.01, 1.85) for cases diagnosed at 50 years or older. No significant differences were appreciated between DCIS cases and controls with respect to race, age at first menstrual period, oral contraceptive (OC) or HRT or by history of smoking or alcohol use. Because of the association between case/control status and mammography utilization, all odds ratios are adjusted for mammogram history. Additional adjustment for other breast cancer screening methods did not significantly alter the odds ratios (primarily due to correlation between the screening variables) and hence were not included in the final model. The analyses were also performed retaining the original frequency-matched study design (five-

year age strata); the results obtained were essentially unchanged from those presented in Table 3.

Women diagnosed with LCIS were more likely than controls to be older at menopause, to have had at least one breast biopsy and to be undergoing yearly physician-performed breast exams. An association between family history of breast cancer and a diagnosis of LCIS was suggested but did not reach statistical significance ($p = 0.07$). The data were too sparse to examine the role of age at onset in this relationship. As can be seen from Table 3, the magnitude and direction of many risk factors were the same for the two histologic subtypes, although in several instances the risk factor reached statistical significance for DCIS but not LCIS cases, likely due in part to the much smaller number of LCIS cases relative to DCIS cases.

DISCUSSION

The epidemiology of IBC has been extensively studied.¹⁸⁻²⁶ Among those variables that have been shown to bear a relationship with IBC, the greatest increase in risk (2-3 fold), after controlling for age, has generally been associated with the presence of a positive family history.¹⁸⁻²⁶ Individuals with multiple first degree family members diagnosed with ovarian or breast cancer, particularly at young ages, are at even greater risk. Examination of such families has led to the identification of several breast/ovarian cancer susceptibility alleles (BRCA1, BRCA2).^{27,28} Little work has specifically examined the effect of a family history on the risk of BCIS with existing data hampered by limitations of sample size, age at onset or pathology. Despite these caveats, the existing studies uniformly report an increased risk associated with family history with odds ratios ranging from 1.6 to 2.7^{3,4,6,9,10} similar to those observed for IBC. The current study confirms this finding in a large sample, with odds ratios of 1.6 and 1.7 for women diagnosed with DCIS and LCIS, respectively. These values generally match well to studies which include women of similar age range⁶ but are somewhat lower than studies

which include relatively younger women.^{3,4,9} However, when risk is dichotomized by age in these data, an inverse relationship is seen between age at onset and risk associated with family history with cases diagnosed by age 49 reporting a risk of 2.4, similar to other reports which include young cases^{3,4,9} versus a risk of 1.4 for cases diagnosed over the age of 49 years. This association between age at onset, family history and breast cancer risk is well documented for IBC; it is likely that this relationship also exists for BCIS and may suggest a role for breast cancer susceptibility alleles such as BRCA1 and BRCA2, although there is currently little data to suggest that mutations in these alleles occur with any frequency in women with BCIS.²⁹ A positive association between family history and LCIS risk was also suggested here as has been reported elsewhere.^{3,13} As with previous reports, it is likely that limitations of sample size may have reduced the power to obtain a significant result in these data.

Additional variables associated with IBC risk include those with endogenous or exogenous hormonal components such as nulliparity, age at first livebirth, age at menarche and menopause, as well as (in some subgroups) OC and HRT use. In general, these risk factors have been associated with 1.5-2 fold increases in breast cancer risk. In these data risk was associated with several of the same factors. In particular, DCIS cases were more likely than controls to be older at first full-term pregnancy and at last menstrual period and to have fewer full-term pregnancies. The data also suggest a reduction in risk with a later age at first menstrual period, however this effect did not reach statistical significance. The results from this analysis as well as previous examination of such variables appear to confirm an association between in-situ risk and later age at first full term pregnancy^{4,6,9,10,11}, nulliparity^{3,9,10,11}, and later age at menopause⁴. No association was seen in these data between either OC or HRT use and in-situ risk. To our knowledge, this is the first estimate of the relative risk associated with OC use and

BCIS. The role of HRT in BCIS has been previously explored although the results are not uniform and the sample sizes are small; several^{4,30,31} but not all³² of the few previous studies report an increase in risk.^{4,30,31} Although it is possible that some of this effect may be the result of increased screening among HRT users versus non-users, the studies mentioned all made some attempt to adjust for screening history. To further explore the relationship between exogenous hormones and the development of BCIS, detailed analyses will be presented elsewhere to define the role of age, duration, frequency, composition, and potency on this relationship.

As has been reported in a number of studies^{3,4,6,9,10}, a history of breast biopsy is strongly correlated with a diagnosis of both DCIS and LCIS in these data. The association between benign breast disease and IBC is well known. The correlation reported here between BCIS diagnosis and biopsy is likely due to a combination of factors, including the likelihood that some benign breast disease is associated with the eventual development of BCIS. This observed correlation is also likely a function of increased surveillance and hence early detection; it is not possible at present to quantify the extent to which each of these possibilities plays a role in this significant association.

There were a number of significant associations between screening patterns and risk factors. At least within the state of Connecticut, women with either a family history of breast cancer or a previous breast biopsy appear to be receiving more intensive screening than those without such a history. Race was also significantly associated with screening frequency; in these data, white women were twice as likely as non-white women to report having had a screening mammogram but 30% less likely to practice BSE. This is of note given the increased rates of BCIS diagnosis associated with mammography use but not with BSE. The risk factor most strongly associated with screening in these data was use of HRT. The magnitude of this association is large (fourfold); it is notable that women with this risk factor were almost twice as likely as women with a first degree family history to receive

a mammogram.

This study provides evidence that many of the risk factors for BCIS are similar in nature and magnitude to those for IBC, lending support to the hypothesis that some in-situ lesions may be a part of the causal pathway leading to invasive disease. These data represent the largest examination to date of the epidemiology of BCIS across all categories of age and histology. Furthermore, as information on screening was included in all analyses, the estimates of risk presented here should be relatively free of screening bias, particularly important in the analysis of non-invasive tumors which are more likely to be diagnosed at an early stage using screening procedures such as mammograms.

REFERENCES

1. Claus EB, McKay L, Holford T: The risk of a contralateral breast cancer among women diagnosed with ductal and lobular breast carcinoma in-situ: Data from the Connecticut Tumor Registry. *Am J Epidemiol* 1997;145:A108.
2. Bodian CA. Benign breast disease, carcinoma in-situ and breast cancer risk. *Epidemiol Rev* 1993;15:177-87.
3. Weiss HA, Brinton LA, Brogan D, Coates RJ, Gammon MD, Malone KE, Schoenberg JB, Swanson CA. Epidemiology of in situ and invasive breast cancer in women aged under 45. *Brit J Cancer* 1996;73(10):1298-305.
4. Longnecker MP, Bernstein L, Paganini-Hill A, Enger SM, Ross RK. Risk factors for in situ breast cancer. *Cancer Epidemiol, Biomarkers Prev* 1996;5:961-5.
5. Millikan R, Dressler L, Geradts J, Graham M. The need for epidemiologic studies of in situ carcinoma of the breast. *Breast Cancer Res Treat* 1995;35:65-77.
6. Brinton LA, Hoover R, Fraumeni JF Jr. Epidemiology of minimal breast cancer. *JAMA* 1983;249:483-7.
7. Ernster EL, Barclay J, Kerlikowske K, Grady D, Henderson C. Incidence of and treatment for ductal carcinoma in-situ of the breast. *JAMA* 1996;275:913-8.
8. Saltzstein SL. An epidemiologic study of differences between mammary ductal and lobular carcinoma in situ: analysis of 11,436 cases from the California

Cancer Registry. Anat Pathol 1996;1:193-203.

9. Kerlikowske K, Barclay J, Grady D, Sickles EA, Ernster V. Comparison of risk factors for ductal carcinoma in situ and invasive breast cancer. JNCI 1997;89:77-82.

10. Newcomb P, Storer BE, Marcus PM. Risk factors for carcinoma in situ of the breast. Abstract, American Society of Preventive Oncology, Bethesda, Maryland, 1994.

11. Lambe M, Hsieh CC, Tsaih SW, Ekblom A, Trichopoulos D, Adami HO. Parity, age at first birth and the risk of carcinoma in situ of the breast. Intl J Cancer 1998;77:330-332.

12. Claus EB, Stowe M, Holford T, Carter D. The genetic epidemiology of breast carcinoma in-situ. US Army Medical Research and Material Command's 1997 Meeting-DOD Breast Cancer Research Program: An Era of Hope. Washington, D.C. 1997 Proceedings.

13. Claus EB, Risch NR, Thompson WD, Carter D: Relationship between breast histopathology and family history of breast cancer. Cancer 1993;71:147-153.

14. Dubin N, Hutter RVP, Strax P, Fazzini E, Schinella RA, Batang E et al. Epidemiology of minimal breast cancer among women screened in New York City. J Natl Cancer Inst 1984;73:1273-9.

15. Press MF, Bernstein L. Molecular epidemiology of breast carcinoma in situ. The U.S. Army Medical Research and Material Command Annual Meeting, Atlanta 2000.

16. Colditz GA, Manson JE, Hankinson SE. The Nurses= Health Study: 20-year contribution to the understanding of health among women. J Womens Health 1997;6:49-62.
17. SAS Institute Inc., SAS/STAT User=s Guide, Version 6, Fourth Edition, Volume 1, Cary, NC: SAS Institute Inc., 1989.
18. Claus EB, Risch N, Thompson WD. Age at onset as an indicator of familial risk of breast cancer. Am J Epidemiol 1990;131:961-972.
19. Lynch HT, ed. Genetics and Breast Cancer. New York: Van Nostrand Co., Inc 1981.
20. Ottman R, Pike MC, King MC, Casagrande JT, Henderson BE. Familial breast cancer in a population based series. Am J Epidemiol 1986;123:15-21.
21. Sattin RW, Rubin GL, Webster LA, Huezo CM, Wingo PA, Ory HW, Layde PM, and the Cancer and Steroid Hormone Study. Family history and risk of breast cancer. JAMA 1985;253:1908-13.
22. Schwartz AG, King MC, Belle SH et al. Risk of breast cancer to relatives of young breast cancer patients. J Natl Cancer Inst 1985;75:665-668.
23. Kelsey JL, Gammon MD. Epidemiology of breast cancer. Am J Epidemiol 1990;12:228-240.
24. Slattery ML, Kerber RA. A comprehensive evaluation of family history and breast cancer risk: the Utah Population Database. JAMA 1994;270:1563-1568.
25. Colditz GA, Willett WC, Hunter DJ, Stampfer MJ, Manson JE, Hennekens CH,

et al. Family history, age, and risk of breast cancer. JAMA 1993;270:338-343;1548.

26. Claus EB, Risch N, Thompson WD. Genetic analysis of breast cancer in the Cancer and Steroid Hormone Study. Am J Hum Genet 1991;48:232-42.

27. Miki Y, Swensen J, Shattuck-Eidens D, et al: A strong candidate for the breast and ovarian cancer susceptibility gene BRCA1. Science 266:66-71,1994

28. Wooster R, Neuhausen SL, Mangion J, et al: Localization of a breast cancer susceptibility gene, BRCA2, to chromosome 13q12-13.Science 1994;265:2088-2090.

29. Marcus JN, Watson P, Page DL, et al: Hereditary breast cancer. Pathobiology, prognosis, and BRCA1 and BRCA2 gene linkage. Cancer 77:697-709,

30. Brinton LA, Hoover R, and Fraumeni JF Jr. Menopausal estrogens and breast cancer risk: an expanded case-control study. Br J Cancer 1986;54:825-832.

31. Schairer C, Byrne C, Keyl PM, Brinton LA, Sturgeon SR, Hoover RN. Menopausal estrogen and estrogen-progestin replacement therapy and risk of breast cancer (United States). Cancer Causes Control 1994;5:491-500.

32. Stanford JL, Weiss NS, Voigt LF, Daling JR, Habel LA, Rossing MA. Combined estrogen and progestin hormone replacement therapy in relation to risk of breast cancer in middle-aged women. J Am Med Assoc 1995;274:137-142.

Acknowledgements

The authors would like to acknowledge Sheila Griffin and Marjorie Jasmin

for their work as interviewers on the study.

Table 1. Percentage of women undergoing screening^a stratified by case/control status.

Screening Modality	Study Subject		
	DCIS	LCIS	Controls
Mammogram (Ever/Never)	93.3% ^b	91.2%	85.4%
No. Mammograms			
None	6.3%	8.1%	14.8%
One	5.0%	8.1%	0.8%
Two or more	88.7%	74.8%	84.4%
Breast Self Examination	43.5%	40.6%	43.3%
Physician Breast Exam	79.9% ^b	83.7% ^b	68.5%
Pap Smear	97.6%	96.8%	97.3%

a. One year prior to diagnosis for cases/interview for controls.

b. Significantly different from controls at $p = 0.05$.

c. Significantly different from LCIS cases at $p = 0.05$.

Table 2. Percentage of women undergoing screening^a stratified by breast cancer risk factors.

Risk Factor	Screening Method		
	Mammogram	Physician Exam	Breast Self Examination
First Degree Family History			
Yes	94.8%	79.2%	46.2%
No	88.5%	74.8%	42.8%
OR (95% CI)	2.4 (1.5, 3.9) ^b	1.3 (0.9, 1.7)	1.1 (0.9, 1.4)
Race (White)			
Yes	90.3%	75.7%	42.7%
No	82.2%	74.6%	50.3%
OR (95% CI)	2.0 (1.3, 3.1) ^b	1.1 (0.7, 1.5)	0.7 (0.5, 1.0)
Previous Breast Biopsy			
Yes	95.3%	80.5%	46.4%
No	86.1%	72.4%	41.4%
OR (95% CI)	3.2 (2.2, 4.6) ^b	1.6 (1.3, 1.9)	1.2 (1.0, 1.5)
Hormone Replacement^c Therapy			
Yes	95.3%	82.3%	44.8%
No	83.3%	67.1%	42.2%
OR (95% CI)	4.0 (2.8, 5.8) ^b	2.3 (1.8, 2.8)	1.1 (0.9, 1.3)
College Education			
Yes	89.4%	77.9%	43.6%
No	89.8%	74.1%	43.2%
OR (95% CI)	1.0 (0.7, 1.3) ^b	1.2 (1.0, 1.5)	1.0 (0.8, 1.2)

a. One year prior to diagnosis for cases/interview for controls.

b. Adjusted for age (continuous).

c. Ever/Never

Table 3. Multivariate-adjusted Odds Ratios (OR) for breast cancer according to the level of risk factors, stratified by case histology.*

	Number of			OR (95% CI)		
	DCIS	LCIS	Controls	DCIS	LCIS	LCIS vs DCIS ^b
Age at menarche (yr)						
#11	173	31	187	1	1	1
12	232	32	240	1.03 (0.76, 1.39)	1.47 (0.67, 3.21)	1.74 (0.80, 3.79)
13	253	29	292	0.88 (0.66, 1.17)	0.66 (0.28, 1.60)	0.80 (0.34, 1.91)
≥14	203	29	260	0.80 (0.59, 1.09)	1.01 (0.44, 2.30)	1.42 (0.62, 3.26)
χ^2 for trend				0.96 (0.90, 1.02)	0.96 (0.82, 1.14)	1.03 (0.87, 1.23)
Previous breast biopsy						
No	420	31	788	1	1	1
Yes	455	92	211	3.34 (2.70, 4.15)	4.12 (2.33, 7.29)	1.20 (0.69, 1.71)
Family history						
No	553	73	721	1	1	
Yes	322	50	278	1.56 (1.19, 2.03)	1.69 (0.97, 2.96)	1.14 (0.66, 1.99)
Number full-term pregnancies						
No	166	23	127	1	1	1
Yes (per FTP)	709	100	872	0.86 (0.80, 0.93)	0.99 (0.80, 1.23)	1.14 (0.94, 1.39)
Age at first live birth (yr)^c						
<20	86	8	144	1	1	1
20-29	515	82	604	1.60 (1.12, 2.30)	1.53 (0.54, 4.32)	0.96 (0.33, 2.81)
30+	108	10	124	1.79 (1.14, 2.81)	0.74 (0.17, 3.17)	0.46 (0.10, 2.01)
χ^2 for trend				1.03 (1.00, 1.05)	0.99 (0.92, 1.06)	0.97 (0.90, 1.04)
Age at menopause (yr)^d						
<45	186	23	209	1	1	1
45-49	184	19	164	1.31 (0.95, 1.82)	1.09 (0.39, 3.05)	0.60 (0.21, 1.67)
50-54	196	26	191	1.09 (0.79, 1.51)	2.05 (0.85, 4.96)	1.59 (0.67, 3.79)
55+	63	6	50	1.55 (0.97, 2.48)	2.35 (0.65, 8.54)	1.39 (0.40, 4.81)
per yr				1.01 (0.99, 1.03)	1.06 (1.01, 1.12)	1.04 (0.98, 1.09)
Ever use of OC						
No	471	62	477	1	1	1
Yes	404	61	522	0.94 (0.74, 1.21)	0.55 (0.29, 1.04)	0.55 (0.39, 1.02)
Ever use of HRT						
No	431	55	563	1	1	
Yes	430	65	423	1.17 (0.94, 1.44)	1.34 (0.74, 2.40)	1.29 (0.72, 2.30)

Ever smoke						
No	388	58	434	1	1	1
Yes	485	65	562	1.02 (0.82, 1.25)	1.03 (0.58, 1.81)	0.94 (0.54, 1.65)
Ever Drink						
No	335	37	346	1	1	1
Yes	537	85	650	0.93 (0.74, 1.16)	1.07 (0.58, 1.98)	1.22 (0.66, 2.23)

- a. Adjusted for age (continuous), college education (yes/no), history of at least one screening mammogram one year prior to interview, quetelet index, race (white/other) and mutually adjusted for the other variables in the table.
- b. Odds of LCIS relative to DCIS for a given risk factor
- c. Results for age at first birth are for parous women only
- d. Results for age at menopause are for post-menopausal women only and include both surgical and natural menopause

Appendix B =

**FAMILY HISTORY OF BREAST AND OVARIAN CANCER
AND THE RISK OF BREAST CARCINOMA IN-SITU**

Elizabeth B. Claus, Ph.D., M.D., Meredith Stowe, Ph.D.,
Darryl Carter, M.D.

From the Departments of Epidemiology and Public Health (E.B.C., M.S.) and Pathology (D.C.), Yale University School of Medicine, P.O. Box 3333, New Haven, CT 06510. Address reprint requests to Dr. Claus at Department of Epidemiology and Public Health, Yale University, 60 College St., P.O. Box 208034, New Haven, CT 06520-8034.

This work was supported by the U.S. Army Medical Research and Material Command under DAMD-17-95-1-5006.

ABSTRACT

CONTEXT

A family history of breast cancer is an important risk factor for in-situ breast carcinoma (BCIS), however there are no detailed analyses of its variation in effect by number, type, laterality or age at onset of affected relatives nor by association with ovarian cancer. In addition, the role of the breast cancer susceptibility genes, BRCA1 and BRCA2, in the development of BCIS is unclear.

OBJECTIVE

To better define the role of 1) a family history of breast and ovarian cancer and 2) the cancer susceptibility genes, BRCA1 and BRCA2, in the development of BCIS.

DESIGN, SETTING, AND PARTICIPANTS

The data are from a large, population-based case/control study of BCIS and includes all female cases of BCIS diagnosed among residents of the state of Connecticut from September 15, 1994 to March 14, 1998 as well as a series of random-digit-dial (RDD) controls selected from the state of Connecticut. Cases (n=1068) were between the age of 20 and 79 years at time of diagnosis while controls (n=999) were frequency matched to the cases by five-year age intervals. Telephone interviews were used to collect information on family history of cancer, pregnancy and menstrual history, hormone replacement therapy, oral contraceptive use, as well as socio-demographic variables and cancer screening history.

MAIN OUTCOME MEASURE

To assess the relative risk of BCIS associated with breast and ovarian cancer family history, logistic regression was used to provide maximum likelihood estimates of the odds ratios (OR) with 95% confidence intervals (95CI). The probability of being a BRCA1 and/or BRCA2 gene carrier is calculated for each case and control, using family history of breast and ovarian cancer, age/age at diagnosis for relatives, prevalence and penetrance data for BRCA1/BRCA2, and self-report of Jewish heritage.

RESULTS

Cases with ductal carcinoma in-situ (DCIS) or lobular carcinoma in-situ (LCIS) were significantly more likely to report a first degree family history of breast cancer (OR: 1.7, 95CI: 1.3, 2.1 for DCIS versus OR: 1.8, 95CI: 1.2, 2.9 for LCIS cases) than were controls. In addition, DCIS cases were 2.6 (95CI: 0.9, 7.3) times more likely than controls to report both an affected mother and sister. An inverse association was suggested between age at onset and DCIS risk with cases aged 49 years or younger at 2.4 (95CI: 1.5, 3.8) times the risk of controls (95CI) versus 1.5 (95CI: 1.1, 2.0) for cases older than 49 years. Cases and controls did not differ significantly with respect to the proportion of family members affected with ovarian cancer (OR: 1.2, 95CI: 0.8, 1.8).

The predicted probability that a woman represents a carrier of either BRCA1 or BRCA2 differed significantly by case/control status as well as (for BRCA1) by age at onset. In these data, approximately 0.1% of DCIS cases were predicted to carry a mutation in BRCA1.

CONCLUSIONS

A family history of breast cancer is associated with an increased risk of BCIS. Furthermore, as is true for invasive breast cancer, women with multiple family members affected with breast cancer, particularly at a young age, are at increased risk of BCIS. These data suggest the possibility that breast cancer susceptibility alleles such as BRCA1 and BRCA2 may also play a role in the development of BCIS, however, the results indicate that mutations in such alleles may occur less frequently in BCIS than is currently reported for invasive breast cancer.

INTRODUCTION

The association between a family history of breast cancer and invasive breast cancer (IBD) is well established¹⁻⁹ and there is compelling evidence to suggest that a similar association exists for breast carcinoma in-situ (BCIS)¹⁰⁻¹⁷. In general, a family history of breast cancer has been associated with a two- to three-fold increase in the risk of IBD.¹⁻⁹ Results from BCIS studies report a similarly increased risk with odds ratios ranging from 1.5 to 2.7.¹⁰⁻¹⁷ In more detailed analyses of family history in studies of IBD, researchers have found that individuals with multiple first degree family members diagnosed with ovarian cancer or breast cancer, particularly at young ages, are at even greater risk. Examination of such families with multiple members affected with early onset breast cancer as well as with ovarian cancer has led to the identification of several breast cancer susceptibility alleles (BRCA1, BRCA2).^{18,19} The results from studies of invasive disease coupled with the observed increased risk of BCIS associated with a family history of breast cancer suggest that further analyses of BCIS risk by type, number, age at onset, and disease laterality of affected relatives are necessary to determine whether a similar genetic mechanism may play a role in BCIS risk. To our knowledge no existing study includes information on breast cancer history on any relative other than a mother and/or sister(s). In addition, no published data exist which incorporate information on the age at onset or laterality of any relatives affected with breast cancer nor any information on ovarian cancer among any relatives in the calculation of BCIS risk. The data presented here therefore represent the first large, population-based effort to examine in detail the association between a family history of either breast or ovarian cancer and a diagnosis of BCIS across the full spectrum of age and histologic

subtype, while incorporating data on cancer screening history.

METHODS

The study population includes all cases of female BCIS diagnosed among residents of the state of Connecticut from September 15, 1994 to March 14, 1998 as well as a series of age-matched controls. Cases were identified through the Rapid Case Ascertainment (RCA) Shared Resource of the Yale Cancer Center and were between the ages of 20 and 79 years at time of diagnosis. Coverage of cancer cases by this service is considered essentially complete within the state of Connecticut. Controls were female Connecticut residents selected by random-digit dialing methods and were frequency matched by five-year age intervals to the cases. Study subjects with a previous history of breast cancer and/or a breast biopsy of unknown outcome were excluded. The study, consent forms and questionnaire were approved by the Yale University School of Medicine Human Investigation Committee.

The physicians of each eligible case were contacted to request permission to approach the case. Those cases approved for contact by their physicians were sent a letter of introduction explaining the project. Controls received a similar letter. Approximately 1-2 weeks later a trained interviewer telephoned the potential study subject. If a woman decided to participate, the interviewer administered the questionnaire over the telephone at the patient's convenience after verbal consent was given for the interview. Prior to the telephone interview, study subjects who had consented to be interviewed were sent an oral contraceptive picture booklet developed for the Harvard University Nurses' Health Study²⁰ to allow them to review products used in the past. Subjects were interviewed for an average of 43 minutes. The

questionnaire included detailed questions on family history of cancer, pregnancy and menstrual history, contraceptive and exogenous hormone history, demographic information, medical and screening history, and smoking and alcohol consumption.

Over the study period, 1606 proto-cases and 1445 proto-controls were identified. One hundred and eleven cases were ineligible due to out-of-state residency (8), language (21), a history of previous breast cancer/biopsy of unknown outcome (51), and age-group (31). Ninety-one percent of eligible cases had a consenting physician. Among eligible cases who were contacted by our study, 83% participated in the interview portion of the study. Two hundred and four controls were ineligible due to out-of-state residency (3), language (18), a history of previous breast cancer/biopsy of unknown outcome (181), and age-group (2). Among eligible controls who were contacted by our study, 81% agreed to be interviewed. The final sample included 1068 case and 999 control subjects.

Cases were defined as in-situ, either ductal (DCIS) or lobular (LCIS), if they were non-infiltrating. All cases were confirmed by pathology report. Cases with mixed or other pathology were not included in any analyses. Risk factor information was truncated at the date of diagnosis for cases and the date of interview for controls. Data on screening variables consisted of five questions which asked for the commencing age, frequency, and date of most recent routine checkup, breast exam by a physician, breast self-exam (BSE), pap smear, and mammogram one year prior to the diagnosis/interview. With respect to family history, study subjects were asked to provide the type, age at onset, and laterality (as appropriate) of up to three cancers for all male and female first degree (mother, father, sisters, brothers, daughters, and

sons) and second degree relatives (maternal and paternal grandmothers and grandfathers, as well as aunts and uncles).

Statistical Analysis

The initial portion of the statistical analysis included descriptive statistics. T-tests and chi-square tests were used to examine the association between the risk of BCIS and independent covariates. To assess the relative risk of BCIS associated with risk factors, logistic regression was used to provide maximum likelihood estimates of the odds ratios (ORs) (adjusted and unadjusted) with 95% confidence intervals (CIs) using the statistical package PC-SAS version 6.12.²¹

The probability of carrying a mutation in BRCA1 or BRCA2 or both is calculated for each case and control (i.e. proband) using BRCAPRO.²² The program employs a model which uses Bayes theorem and Mendelian genetics and assumes an autosomal dominant transmission for both BRCA1 and BRCA2.^{23,24} In each instance, a woman's probability of being a gene carrier is calculated conditional upon the breast and ovarian cancer status of her first and second degree female relatives and the age at onset of any affected female relatives as well as the current age/age at death of any unaffected female relatives. The calculation of carrier probability also takes into account whether or not the proband was herself affected and whether she identified herself as Jewish in the questionnaire. The model uses BRCA1/BRCA2 prevalence estimates from Ford et al. (1995)²⁵ as well as penetrance estimates from Easton et al. (1995)²⁶ for women who did not identify themselves as Jewish and from Struwing et al. (1997) for women who did identify themselves as Jewish.²⁷ Differences in the mean carrier probability were examined by case/control status and 10-year

age categories using analysis of variance.

To estimate the proportion of cases and controls who would be predicted to carry mutations in BRCA1, BRCA2 or either, study subjects were divided into two groups (carrier or non-carrier) by carrier probability, using 0.5 as the cutpoint. This cutpoint was selected based on sensitivity and specificity data collected on a sample of 125 patients with both BRCAPRO estimates and laboratory testing for BRCA1 and BRCA2²⁸ and on the fact that, in some instances, depending on available family history, the maximum possible predicted carrier value is 0.5 (i.e., for an individual with no offspring and no paternal data whose mother is a presumed carrier).

Standardized incidence ratios (SIR) and 95% Confidence Intervals were calculated for breast and ovarian cancer. In each instance, the number of affected mothers and sisters reported by controls was compared to the age- and site-specific incidences from the 1993-1997 Surveillance, Epidemiology, and End Results (SEER) centers.

RESULTS

The general makeup of the case and control subjects matched well to that of the state of Connecticut. Approximately 91% percent of cases and 92% of controls were white with the remaining sample representing primarily women of African-American background. The mean age for cases was not statistically different from that for controls (56.8 versus 55.9 years).

Unadjusted odds-ratios for a family history of breast and ovarian cancer in first and second degree relatives is presented by histologic subtype in Table 1. Both DCIS and LCIS cases were significantly more likely than controls to report at least one first degree female relative affected with breast

cancer (OR: 1.68, 95CI: 1.31, 2.14 and OR: 1.85, 95CI: 1.17, 2.93) for DCIS and LCIS, respectively. A higher proportion of DCIS cases than controls reported a mother (OR: 1.30, 95CI: 0.97, 1.75) or sister (OR: 2.54, 95CI: 1.73, 3.74), but not a daughter (OR: 0.59, 95CI: 0.15, 2.36) affected with breast cancer. LCIS cases reported a significantly increased risk for mothers and an elevated (but not significantly so) risk for sisters. DCIS cases with both an affected mother and sister were at 2.62 times (95CI: 0.94, 7.27) the risk of controls without such a history. Both DCIS and LCIS cases with at least one second degree relative affected with breast cancer were at increased risk for DCIS (OR: 1.20, 95CI: 0.95, 1.50 and OR: 1.45, 95CI: 0.93, 2.25) for DCIS and LCIS, respectively. Although many of the point estimates for second degree relatives were elevated, none of the odds ratios for individual second degree relatives differed significantly from one, with the exception of maternal aunts among DCIS cases. There were no male relatives reported to have breast cancer among any of the study subjects.

The risks associated with a family history of ovarian cancer are also presented in Table 1. DCIS cases were 1.30 (95CI: 0.72, 2.34) times more likely than controls to report a first degree relative affected with ovarian cancer. A higher proportion of DCIS cases than controls reported a mother (OR: 1.34, 95CI: 0.67, 2.71) or sister (OR: 1.18, 95CI: 0.41, 3.38) affected with ovarian cancer although neither estimate differed significantly from one. No study subject reported a daughter or more than one first degree relative affected with ovarian cancer. The estimates for women with second degree family members affected with ovarian cancer as well as family members affected with both breast and ovarian cancer are also presented; in general, the number

of affected relatives among these individuals is extremely small, making interpretation of these values difficult.

Table 2 provides data on the risk of DCIS stratified by the age at onset and the laterality of first degree relatives affected with breast cancer. In general, as is true for IBD, increased risk was associated with early age at onset and bilateral disease. Table 3 presents data which examines the effect of a family history by age at onset of the DCIS cases themselves. An inverse association between age at onset and DCIS risk is suggested with women aged 49 years or younger at 2.36 (95CI: 1.47, 3.77) times the risk of controls versus 1.47 (95CI: 1.10, 1.96) for women older than 49 years. In general, this pattern is seen throughout the table.

To help assess the quality of family history reporting in these data, SIRs were calculated for mothers and sisters of controls. Although the value for both breast and ovarian cancer (0.77 and 0.87, respectively) indicate that there is some under-reporting of both breast and ovarian cancer among first degree relatives of controls, neither estimate differed significantly from one and both are similar to reports from other large case/control studies which collected family history data.²⁹ In addition, further analysis of the data indicated that cases and controls were equally likely to report cancer at an unknown site in a first degree relative, suggesting that elevations in BCIS risk associated with a family history do not appear to be a result of less knowledge of family history of cancer among controls as compared to cases.

In addition to examining unadjusted odds ratios, the association between BCIS risk and family history was also calculated while controlling for potential confounders such as age, parity, age at first full-term pregnancy,

age at first menstrual period, history of breast biopsy, use of oral contraceptives (ever/never), use of hormone replacement therapy (ever/never), race (white/other), and mammographic screening history one year prior to interview. In general, the risk estimates were little changed in the adjusted analyses.

The distribution of predicted BRCA1 and BRCA2 carrier probabilities among DCIS cases and controls are presented by ten-year age groupings in Table 4. The mean BRCA1 carrier probability differed significantly by both age at onset and case/control status while the BRCA2 probability differed significantly by case/control status. When "carriers" are defined as individuals with calculated probabilities of 0.5 or greater, 0.1%, 0%, and 0.8% of the DCIS cases would be predicted to carry mutations in BRCA1, BRCA2, or either of the two, respectively. Regardless of the criteria used, no control subject was predicted to carry a deleterious allele in either BRCA1 or BRCA2.

DISCUSSION

The present study is the largest case-control study to date to examine the relationship of a family history of breast and ovarian cancer with BCIS risk. The results confirm the importance of a positive family history of breast cancer and seem to suggest, as is true for IBD, that individuals with multiple first degree family members diagnosed with breast cancer, particularly at young ages, are at even greater risk. A number of previous analyses have examined the association between a history of breast cancer in at least one first degree relative and BCIS and reported odds ratios ranging from 1.6 to 2.7.¹⁰⁻¹⁴ The current study supports this finding in a large sample

including women of all ages and with correction for screening, with odds ratios of 1.7 and 1.8 for women diagnosed with DCIS and LCIS, respectively. Women with multiple first degree relatives affected with breast cancer, in particular, a mother and sister affected with breast cancer, were at even greater risk (OR = 2.6). The one previous study able to examine risk for women with both an affected mother and sister also reported an increased risk,¹⁰ however, the magnitude of that risk (OR: 6.93, 95% CI: 1.1-44) is much greater than that seen here although the confidence interval is quite wide. It is notable that the risk estimates for first degree relatives presented here generally match well to studies which include women of similar age range¹² but are somewhat lower than studies which include relatively younger women.^{10,11,13} However, when risk is dichotomized by age in these data, an inverse relationship is seen between age at onset and risk associated with family history with cases diagnosed by age 49 reporting a risk of 2.4, similar to other reports which include young cases^{10,11,13} versus a risk of 1.4 for cases diagnosed over the age of 49 years. A positive association between family history and LCIS risk was also suggested in these data as has been reported elsewhere.^{10,16} In general, the overall results for LCIS cases match those of the DCIS cases; however, extensive sub-analyses of LCIS cases by age at onset and laterality of relatives was not possible given the relatively small number of LCIS cases.

Among first degree relatives, the risk associated with an affected sister was greater than that associated with an affected mother, although not significantly so. Other studies also indicate that risk does not differ by the type of first degree relative affected^{3,6} although the point estimates vary in

whether the mother or sister is associated with higher risk. As has been shown for IBD, one possible model suggested by an equal risk to mothers and sisters and a small proportion of genetic cases is a model incorporating a rare autosomal dominant allele(s).

The role of ovarian cancer in the prediction of BCIS is less clear in these data. Although increased odds ratios were observed among DCIS cases with affected first degree relatives, none of the estimates differed significantly from one. The data associated with second degree relatives was difficult to interpret given the small numbers of affected relatives. This lack of association may represent a true finding but is likely due in part to an insufficient level of statistical power to detect a significant effect despite the relatively large size of the sample.

Given the findings here, at least with respect to breast cancer family history, it is of interest to attempt to assess the role that BRCA1 and BRCA2 may play in the development of BCIS. A review^{10-13,16} of stage-specific risk estimates associated with a breast cancer family history (used as a proxy variable for BRCA1 and BRCA2 status) provides no convincing evidence that the magnitude of risk associated with family history differs significantly by stage with some studies reporting a greater^{11,16} association with BCIS or "early" stage lesions while others report the opposite.¹² While there are extensive laboratory data³⁰⁻⁴⁰ which estimate the prevalence of mutations in BRCA1 and BRCA2 for women with as well as without a current diagnosis of breast and/or ovarian cancer, there is currently little such data collected for women diagnosed with "pure" BCIS (although researchers have noted BCIS associated with IBD in BRCA1/BRCA2 carriers).⁴¹ In this report, an attempt was

made to estimate the extent to which BRCA1 and BRCA2 might be involved in BCIS via the use of statistical modeling. The results obtained indicate that while there does appear to be some evidence that cancer susceptibility alleles play a role in the development of BCIS, the prevalence of such mutations may be decreased relative to that found in invasive cases.³⁰⁻⁴⁰

As is true of all statistical models of risk, accurate calculation of carrier probability depends upon a correctly specified statistical model as well as correct estimates of penetrance and prevalence. Two^{28,42} groups of independent investigators have undertaken validation studies of the carrier probability model used here. Both have reported a good overall predictive ability in identifying the presence of a mutation at either gene. Efforts are under way for a systematic multicenter validation of the model based on tested families. Statistical methodology and preliminary results are discussed by Iversen et al (1998).⁴³ Additional caveats apply; there are initial indications that the currently used values of penetrances and prevalences may lead to underestimating carrier probabilities for weak family histories. This is consistent with the belief that the penetrance functions currently utilized may be too high for families with weak histories. Although the women in this analysis were defined as carriers and non-carriers based on a generalized statistical model, these assignments may not hold true at the individual level. Women with low to moderate risk based on family history and ethnic background may still test positive for BRCA1 and BRCA2 mutations. The final determination of carrier status and the remaining role of family history will thus be a continually changing process as the collection of laboratory data proceeds.

Few studies have examined any aspect of the genetic epidemiology of BCIS; to our knowledge, the current study is the largest done to date. The data here provide evidence that mechanisms similar to those involved in the development of IBD may be at work here, although perhaps to a lesser extent. Whether this is evidence that BRCA1 and BRCA2 are more likely to be associated with a diagnosis of IBD versus BCIS remains to be confirmed using laboratory data. One advantage of the data presented here is that the full spectrum of age at onset and histology was included as was information on screening; the estimates of risk presented here should be relatively free of screening bias, particularly important in the analysis of non-invasive tumors which are more likely to be diagnosed at an early stage using screening procedures such as mammograms.

REFERENCES

1. Claus EB, Risch N, Thompson WD. Age at onset as an indicator of familial risk of breast cancer. *Am J Epidemiol* 1990;131:961-972.
2. Lynch HT, Watson P, Conway T, Fitzsimmons SL, Lynch J: Breast cancer family history as a risk factor for early onset breast cancer. *Br Cancer Res Treat* 1988;11:263-7.
3. Ottman R, Pike MC, King MC, Casagrande JT, Henderson BE. Familial breast cancer in a population based series. *Am J Epidemiol* 1986;123:15-21.

4. Sattin RW, Rubin GL, Webster LA, Huezo CM, Wingo PA, Ory HW, Layde PM, and the Cancer and Steroid Hormone Study. Family history and risk of breast cancer. JAMA 1985;253:1908-13.
5. Schwartz AG, King MC, Belle SH et al. Risk of breast cancer to relatives of young breast cancer patients. J Natl Cancer Inst 1985;75:665-668.
6. Kelsey JL, Gammon MD. Epidemiology of breast cancer. Am J Epidemiol 1990;12:228-240.
7. Slattery ML, Kerber RA. A comprehensive evaluation of family history and breast cancer risk: the Utah Population Database. JAMA 1994;270:1563-1568.
8. Colditz GA, Willett WC, Hunter DJ, Stampfer MJ, Manson JE, Hennekens CH, et al. Family history, age, and risk of breast cancer. JAMA 1993;270:338-343;1548.
9. Claus EB, Risch N, Thompson WD. Genetic analysis of breast cancer in the Cancer and Steroid Hormone Study. Am J Hum Genet 1991;48:232-42.
10. Weiss HA, Brinton LA, Brogan D, Coates RJ, Gammon MD, Malone KE, Schoenberg JB, Swanson CA. Epidemiology of in situ and invasive breast cancer in women aged under 45. Brit J Cancer 1996;73(10):1298-305.
11. Longnecker MP, Bernstein L, Paganini-Hill A, Enger SM, Ross RK. Risk

factors for in situ breast cancer. Cancer Epidemiol, Biomarkers Prev 1996;5:961-5.

12. Brinton LA, Hoover R, Fraumeni JF Jr. Epidemiology of minimal breast cancer. JAMA 1983;249:483-7.

13. Kerlikowske K, Barclay J, Grady D, Sickles EA, Ernster V. Comparison of risk factors for ductal carcinoma in situ and invasive breast cancer. JNCI 1997;89:77-82.

14. Newcomb P, Storer BE, Marcus PM. Risk factors for carcinoma in situ of the breast. Abstract, American Society of Preventive Oncology, Bethesda, Maryland, 1994.

15. Claus EB, Stowe M, Holford T, Carter D. The genetic epidemiology of breast carcinoma in-situ. US Army Medical Research and Material Command's 1997 Meeting-DOD Breast Cancer Research Program: An Era of Hope. Washington, D.C. 1997 Proceedings.

16. Claus EB, Risch NR, Thompson WD, Carter D: Relationship between breast histopathology and family history of breast cancer. Cancer 1993;71:147-153.

17. Claus EB, Stowe M, Carter D. Breast carcinoma in-situ: Risk factors and screening patterns (In review).

18. Miki Y, Swensen J, Shattuck-Eidens D, et al: A strong candidate for the breast and ovarian cancer susceptibility gene BRCA1. Science 266:66-71,1994
19. Wooster R, Neuhausen SL, Mangion J, et al: Localization of a breast cancer susceptibility gene, BRCA2, to chromosome 13q12-13.Science 1994;265:2088-2090.
20. Colditz GA, Manson JE, Hankinson SE. The Nurses' Health Study: 20-year contribution to the understanding of health among women. J Womens Health 1997;6:49-62.
21. SAS Institute Inc., SAS/STAT User's Guide, Version 6, Fourth Edition, Volume 1, Cary, NC: SAS Institute Inc., 1989.
22. Euhus D, Berry D, Parmigiani G, Iversen E, Frawley W. Cancer gene with BRCA1. University of Texas, 1998.
23. Berry DA, Parmigiani G, Sanchez J, Schildkraut J, Winer E. Probability of carrying a mutation of breast-ovarian cancer gene BRCA1 based on family history. J Nat Cancer Inst 1997;89:227-38.
24. Parmigiani G, Berry DA, Aguilar O. Determining carrier probabilities for breast cancer-susceptibility genes BRCA1 and BRCA2. Am J Hum Genet 1998;62:145-58.
25. Ford D, Easton DF, Peto J. Estimates of the gene frequency of BRCA1 and

its contribution to breast and ovarian cancer incidence. Am J Hum Genet 1995;57:1457-62.

26. Easton D, Ford D, Bishop DT, and the Breast Cancer Linkage Consortium. Breast and ovarian cancer incidence in BRCA1 mutation carriers. Am J Hum Genet 1995;56:265-71.

27. Struewing JP, Hartge P, Wacholder S, Baker SM, Berlin M, McAdams M, et al. The risk of cancer associated with specific mutations of BRCA1 and BRCA2 among Ashkenazi Jews. N Engl J Med 1997;336:1401-8.

28. Hiller EH, G Parmigiani, DA Berry, AB Chittenden, E Fox, SA Kieffer, KE Mahoney, KA Schneider, D Schrag, JE Garber. Validity testing of a computer model for calculating carrier probabilities of BRCA1 and BRCA2 mutations. Abstract presented at the 1997 meeting of the ASHG.

29. Schildkraut JM. Family history of cancer as a risk factor for epithelial carcinoma of the ovary. Ph.D. Dissertation. Yale University Press. 1987

30. Shattuck-Eidens D, McClure M, Simard J, Labrie F, Narod S, Couch F, et al. A collaborative study of 80 mutations in the BRCA1 breast and ovarian cancer susceptibility gene. Implications for presymptomatic testing and screening. JAMA 1995;273:535-41.

31. Langston AA, Malone KE, Thompson JD, Daling JR, Ostrander EA. BRCA1

mutations in a population-based sample of young women with breast cancer. N Engl J Med 1996;334:137-42.

32. Fitzgerald MG, MacDonald DJ, Krainer M, Hoover I, O'Neil E, Unsal H, et al. Germ-line BRCA1 mutations in Jewish and non-Jewish women with early onset breast cancer. N Engl J Med 1996;334:143-9.

33. Struwing JP, Abeliovich D, Peretz T, Avishai N, Kaback MM, Collins FS, et al. The carrier frequency of the BRCA1 185delAG mutation is approximately 1 percent in Ashkenazi Jewish individuals. Nat Genet 1995;11:198-200.

34. Roa BB, Boyd AA, Volcik K, Richards CS, Ashkenazi Jewish population frequencies for common mutations in BRCA1 and BRCA2. Nat Genet 1996;14:185-7.

35. Oddoux C, Struwing JP, Clayton CM, Neuhausen S, Brody LC, Kaback, et al. The carrier frequency of the BRCA2 6174delT mutation among Ashkenazi Jewish individuals is approximately 1%. Nat Genet 1996;14:188-90.

36. Neuhausen S et al. Recurrent BRCA2 617delT mutations in Ashkenazi Jewish women affected by breast cancer. Nat Genet 1996;13:126-8.

37. Tavigan SV et al. The complete BRCA2 gene and mutations in chromosome 13q-linked kindreds. Nature Genet 1996;12:333-337.

38. Rebbeck TR, Couch FJ, Kant J, Calzone K, DeShano M, Peng Y et al. Genetic

heterogeneity in hereditary breast cancer: Role of BRCA1 and BRCA2.

39. Couch FJ, DeShano ML, Blackwood MA, Calzone K, Stopfer J, Campeau L, et al. BRCA1 mutations in women attending clinics that evaluate the risk of breast cancer. *N Engl J Med* 1997;336:1409-15.

40. Krainer M, Silva-Arrieta S, Fitzgerald MG, Shimada A, Ishioka C, Kanamaru R et al. Differential contributions of BRCA1 and BRCA2 to early onset breast cancer. *N Engl J Med* 1997;336:1416-21.

41. Marcus JN, Watson P, Page DL, et al: Hereditary breast cancer. Pathobiology, prognosis, and BRCA1 and BRCA2 gene linkage. *Cancer* 77:697-709,

42. Hilsenbeck SG, Wenger CR, Reynolds LP, Rojas LC, and Osborne CK (1997). Early results of genetic testing for breast cancer susceptibility. *Breast Cancer Research and Treatment*, 46:38.

43. Iversen E Jr., Parmigiani G, Berry DA. Validating bayesian prediction models: a case study in genetic susceptibility to breast cancer. In: C. Gatsonis, editor. *Case Studies in Bayesian Statistics*. Volume VI. Springer, New York, 1998: In press.

Acknowledgements

The authors would like to acknowledge Sheila Griffin and Marjorie Jasmin for their work as interviewers on the study and Edwin S. Iversen, Jr, Ph.D.

and Giovanni Parmigiani, Ph.D. for their assistance with the use of BRCA PRO.

Table 1. Unadjusted Odds Ratios (OR) for BCIS according to family history, stratified by case histology.

	Number of			OR (95% CI)	
	DCIS	LCIS	Controls	DCIS	LCIS
Breast Cancer Family History					
None	536	73	720	1	1
First Degree	178	28	137	1.68 (1.31, 2.14)	1.85 (1.17, 2.93)
Mother	103	21	96	1.30 (0.97, 1.75)	1.93 (1.16, 3.24)
Sister	83	7	41	2.54 (1.73, 3.74)	1.41 (0.62, 3.21)
Daughter	3	0	6	0.59 (0.15, 2.36)	N.A.
Mother and Sister	11	0	5	2.62 (0.94, 7.27)	N.A.
Second Degree	178	30	182	1.20 (0.95, 1.50)	1.45 (0.93, 2.25)
Maternal Grandmother	35	4	40	1.03 (0.65, 1.64)	0.81 (0.28, 2.29)
Paternal Grandmother	17	5	28	0.71 (0.39, 1.31)	1.47 (0.56, 3.87)
Maternal Aunt	88	9	62	1.75 (1.25, 2.45)	1.19 (0.58, 2.46)
Paternal Aunt	64	13	67	1.14 (0.80, 1.62)	1.64 (0.88, 3.07)
Ovarian Cancer Family History					
None	805	121	957	1	1
First Degree	24	2	22	1.30 (0.72, 2.34)	0.73 (0.17, 3.18)
Mother	17	1	15	1.34 (0.67, 2.71)	0.54 (0.70, 4.10)
Sister	7	1	7	1.18 (0.41, 3.38)	1.16 (0.14, 9.51)
Daughter	0	0	0	N.A.	N.A.
Mother and Sister	0	0	0	N.A.	N.A.
Second Degree	17	1	22	0.91 (0.48, 1.72)	0.36 (0.49, 2.72)
Maternal Grandmother	3	0	9	0.39 (0.11, 1.45)	N.A.
Paternal Grandmother	0	0	2	N.A.	N.A.
Maternal Aunt	8	0	4	2.37 (0.71, 7.91)	N.A.
Paternal Aunt	6	1	7	1.01 (0.34, 3.02)	1.16 (0.14, 9.51)
Breast and Ovarian Family History					
First Degree	6	0	4	1.78 (0.50, 6.31)	N.A.
Second Degree	4	0	7	0.67 (0.20, 2.30)	N.A.
Any Combination	16	1	14	1.35 (0.68, 2.79)	0.58 (0.7, 4.42)

Table 2. Unadjusted Odds Ratios (OR) for DCIS according to age and laterality of relative's breast cancer.

	OR (95% CI)	
	Relative age ≤ 49	Relative age >49
Breast Cancer Family History		
First Degree	1.93 (1.25, 2.98)	1.58 (1.19, 2.10)
Mother	1.36 (0.70, 2.63)	1.29 (0.94, 1.78)
Sister	2.74 (1.51, 5.00)	2.41 (1.47, 3.94)
	Bilateral	Unilateral
First Degree	2.12 (1.08, 4.15)	1.62 (1.26, 2.10)
Mother	1.75 (0.74, 4.12)	1.26 (0.92, 1.71)
Sister	2.26 (0.75, 6.76)	2.58 (1.71, 3.88)

Table 3. Unadjusted Odds Ratios (OR) for DCIS according to family history, stratified by age at onset^a.

	OR (95% CI)	
	DCIS ≤ 49	DCIS >49
Breast Cancer Family History		
Any	1.60 (1.14, 2.24)	1.45 (1.14, 1.85)
First Degree	2.36 (1.47, 3.77)	1.47 (1.10, 1.96)
≤ 49	2.54 (1.24, 5.22)	1.64 (0.95, 2.83)
> 49	2.24 (1.24, 4.04)	1.42 (1.03, 1.96)
Mother	1.68 (0.98, 2.86)	1.16 (0.82, 1.66)
Sister	4.62 (1.85, 11.5)	0.59 (0.15, 2.35)
Mother and Sister	2.38 (0.22, 26.4)	2.67 (0.82, 8.73)
Second Degree	1.13 (0.77, 1.65)	1.24 (0.93, 1.65)
Ovarian Cancer Family History		
First Degree	1.19 (0.41, 3.40)	1.34 (0.67, 2.72)
Second Degree	0.78 (0.32, 1.95)	1.06 (0.43, 2.63)
Breast and Ovarian Cancer Family History		
First Degree	2.38 (0.22, 26.4)	1.57 (0.35, 7.06)
Second Degree	1.19 (0.24, 5.93)	0.29 (0.03, 2.63)
Any Combination	2.10 (0.61, 7.25)	1.06 (0.43, 2.63)

a. Cases are matched to controls by control age at interview

Table 4. Age-specific estimates of BRCA1 and BRCA2 carrier probability

BRCA1						
	DCIS cases			Controls		
	Mean (S.D.)	Minimum	Maximum	Mean (S.D.)	Minimum	Maximum
Age Group						
<=39	0.0512 (0.0958)	0.0011	0.452	0.0012 (0.0039)	0.000032	0.0307
40-49	0.0233 (0.0534)	0.0005	0.345	0.0008 (0.0046)	0.000013	0.0585
50-59	0.0145 (0.0529)	0.0002	0.618	0.0003 (0.0009)	3E-6	0.0082
60-69	0.0109 (0.0552)	2E-5	0.195	0.0004 (0.0029)	3E-6	0.0390
70-79	0.0017 (0.0124)	4E-5	0.139	0.0002 (0.0005)	3E-6	0.0037
BRCA2						
	Mean (S.D.)	Minimum	Maximum	Mean (S.D.)	Minimum	Maximum
Age Group						
<=39	0.0105 (0.0252)	0.0007	0.153	0.0006 (0.0020)	0.000019	0.0155
40-49	0.0110 (0.0336)	0.0002	0.265	0.0008 (0.0068)	9E-6	0.1144
50-59	0.0132 (0.0483)	0.0001	0.475	0.0004 (0.0015)	2E-6	0.0158
60-69	0.0109 (0.0552)	4E-5	0.491	0.0004 (0.0029)	2E-6	0.0427
70-79	0.0058 (0.0396)	1E-6	0.394	0.0002 (0.0005)	1E-6	0.0057



DEPARTMENT OF THE ARMY

US ARMY MEDICAL RESEARCH AND MATERIEL COMMAND AND FORT DETRICK
810 SCHRIEDER STREET, SUITE 218
FORT DETRICK, MARYLAND 21702-5000

10/29/2001

REPLY TO
ATTENTION OF:

MCMR-RMI-S (70-1y)

17 Oct 01

MEMORANDUM FOR Administrator, Defense Technical Information
Center (DTIC-OCA), 8725 John J. Kingman Road, Fort Belvoir,
VA 22060-6218

SUBJECT: Request Change in Distribution Statement

1. The U.S. Army Medical Research and Materiel Command has reexamined the need for the limitation assigned to technical reports written for grants. Request the limited distribution statements for the Accession Document Numbers listed at enclosure be changed to "Approved for public release; distribution unlimited." These reports should be released to the National Technical Information Service.

2. Point of contact for this request is Ms. Judy Pawlus at DSN 343-7322 or by e-mail at judy.pawlus@det.amedd.army.mil.

FOR THE COMMANDER:

PHYLIS M. RINEHART
Deputy Chief of Staff for
Information Management

Enclosure