Stephen Calabria: [00:00:00] From the Mount Sinai Health System in New York City. This is Road to Resilience, a podcast about facing adversity. I'm your host, Stephen Calabria, Mount Sinai's, director of podcasting.

On this episode and with this month designated as mammogram, may we welcome Laurie Margolies, MD FACR. Dr. Margolies is the Vice Chair of Breast Imaging for the Mount Sinai Health System.

She's also the chief of breast imaging at the Mount Sinai. She's also the chief of breast Imaging at Mount Sinai's Dubin Breast Center, which provides state-of-the-art facilities, technology, diagnostics, and research to Mount Sinai's breast cancer patients.

In this conversation, Dr. Margolis discusses the many ways that current and prospective patients may detect breast cancer, the medical interventions necessary for when breast cancer is detected.

The technological advancements driven by AI that are already making a [00:01:00] difference in patient outcomes. And how breast cancer itself offers innumerable opportunities to witness and cultivate resilience. We're honored to welcome Dr. Laurie Margolies to the show.

Dr. Laurie Margolies, welcome to Road to Resilience.

Dr. Laurie Margolies: Thank you so much.

Stephen Calabria: Our pleasure.

So you are the director of the Breast imaging for, excuse me, you are the director of breast imaging for the Mount Sinai Health System. Can you describe the role of a breast radiologist and how that fits into the larger ecosystem of breast cancer prevention and care?

Dr. Laurie Margolies: So the breast radiologist is the person you want to find your breast cancer if you are unfortunate to get breast cancer. So what we do is educate people on the importance of screening for breast cancer.

We perform and interpret screening mammograms, screening breast ultrasounds, screening breast [00:02:00] MRIs, as well as all the diagnostic exams that come about when a screening exam is abnormal or somebody has a sign or a symptom or some kind of a breast problem.

And then of course, we do the biopsies for the majority of people. So we're the people who find the early breast cancers.

Stephen Calabria: What does resilience mean to you in the context of breast cancer?

Dr. Laurie Margolies: So when somebody learns they have breast cancer, it's very typically a person like myself will call and say, unfortunately, the results of your biopsy came back abnormal, and show that there is some cancer.

So people get upset, obviously. So what does resilience mean? It means getting angry, getting upset, but then turning around and getting to work on fighting that breast cancer.

It means finding your care team, finding your surgeon, finding your oncologist, finding your friends and relatives that are gonna support you [00:03:00] through this journey. That's what resilience is.

Stephen Calabria: Are there stages to how breast cancer develops?

Dr. Laurie Margolies: Sure there's this very early breast cancer, what we call stage zero breast cancer, and then cancer goes all the way from stage zero to stage four when it unfortunately has gone far away from the breast into the liver or bones or brain or elsewhere.

So you wanna find breast cancer in as earliest stage as possible. So research that we've done here at Sinai by Doctors Port, myself and others, has shown that if we detect your cancer by screening, you're less likely to need a mastectomy. You're less likely to need chemotherapy. You're less likely to need all the lymph nodes under your arm removed.

So finding it by screening gives you lots of benefits.

Stephen Calabria: At what age should a person seek help and at what age are people most at risk of breast cancer?

Dr. Laurie Margolies: So that, that's a [00:04:00] very interesting question. So typically, if you have a no or minimal family history of breast cancer, you should start screening mammography when you hit 40.

So you hit 40, you start screening mammograms. If, however, you have a family history of breast cancer. In a mother or a sister, or lots of family members, even

a dad, then you should start screening 10 years younger than that person. So if, for example, your mom got breast cancer at 38, you should start screening at 28, and then the screening is different.

So the help we give you, the assistance we give you in looking for breast cancer is different depending upon your risk factors. So if you're an average risk woman with. Fatty breasts, screening mammograms might be all you need. If, however, you are a high risk patient with dense breasts, you may be getting [00:05:00] mammograms and MRIs.

So it's all tailored to the individual and their risk and their age.

Stephen Calabria: Let's talk genetics. Are they the dominant factor in whether a patient develops breast cancer?

Dr. Laurie Margolies: No, that's a myth. It's a myth that most people that get breast cancer have a family history. In fact, most people that get breast cancer do not have a family history of breast cancer.

They become essentially their family history. So what's the main risk for bringing, for getting breast cancer? The main risk is being a woman and getting older. So who typically gets breast cancer? A woman who has little or no family history and who is in their fifties, sixties, seventies, even eighties and beyond.

So the average age for a woman to get breast cancer in the United States is about 60. And again, most of those people do not have a significant [00:06:00] family history of breast cancer.

Stephen Calabria: How could that be? There are so many things out there, or so many illnesses that we trace back to our family history. Is this kind of the exception to what we are told is the rule?

Dr. Laurie Margolies: No, it's just that most women who get breast cancer don't have a mother with breast cancer, don't have a sister with breast cancer. They may have a distant cousin with breast cancer or an aunt with breast cancer, but not a close relative, not somebody who would make them think that they are at major increased risk.

So sometimes people come and they say, wait a second, I've done everything right. My whole life I jogged every day. I ate only lettuce. I bought only organic food. How in the world can I get breast cancer? Nobody knows why any one person gets breast cancer.

Stephen Calabria: Is diet also a factor in breast cancer's development [00:07:00] and could it be a factor in its prevention?

Dr. Laurie Margolies: It's a very interesting question and people would love to know the answer to that. Clearly, obesity is a risk factor for breast cancer as well as other cancers and other diseases. We would love to know do what role does the environment play in breast cancer? Do plastics play a role? Do the chemicals in food, play a role, do the chemicals in our water supply.

Play a role. We don't really know. We do know, however, that people that come from parts of the world where there is little to no breast cancer and move to the United States within a generation or two, they get to the one and eight American women who get breast cancer. So there has to be some environmental factors that are at play.

What those are, we don't really know what you can do to prevent them. Are the obvious. Use less plastic, eat [00:08:00] more fruits and vegetables, eat less processed food. All those things can help. Will they prevent it? Absolutely. No guarantees.

Stephen Calabria: Why is early detection through mammography so critical for patient outcomes? And what trends have you seen in detection over the years?

Dr. Laurie Margolies: So what's critical is early detection decreases the chance that you're gonna die from breast cancer. If we detect your cancer by screening, it's less likely that you'll die from breast cancer. If we detect your cancer by screening, it is less likely that you will need a mastectomy.

You may still choose one, but less likely that you will need one. If we detect your. Breast cancer Through screening, it is less likely that you will need chemotherapy. If we detect your breast cancer through screening, it is less likely that you will need all the lymph nodes under your arm removed. Now, why I say less likely, it doesn't mean you won't need it, but it's just decreases your chances that will be recommended.[00:09:00]

Stephen Calabria: We've already covered some of the myths associated with breast cancer, but what are some of the most common myths and misconceptions you encounter about mammograms and breast cancer generally?

Dr. Laurie Margolies: So I think that the very main one that I encounter is a mammogram is so painful, I'm not gonna have it. So I would like to flip that

switch and say, you should love your mammogram because that few minutes of pain.

Might save your life. So if somebody said you could be uncomfortable for two minutes or one minute or three minutes or five minutes, but you're gonna live 20 more years, that's a pretty good deal. I think most of us would sign up for it. Another commonly another myth that I hear a lot. Radiation. Oh my goodness.

There's so much radiation in a mammogram. There is so little radiation in a mammogram. Our [00:10:00] mammograms have gotten to be so low dose that you'll actually get more radiation by living in Denver for a year compared to living in New York City or flying in an airplane across the country, then you will from getting a mammogram.

So the MAM mammograms do not. Cause significant radiation, they do not cause cancer. Squeezing the breast doesn't cause cancer. Another myth I hear is trauma causes breast cancer. If I get breast cancer, that must mean that my husband or significant other or somebody must have beat me at some time. Not true.

Stephen Calabria: Now that just relates to myths that people have that make them uncomfortable or frightened even. But getting called back after a screening can no doubt be frightening for many patients. How do you help patients navigate the emotional side of mammogram results? [00:11:00]

Dr. Laurie Margolies: So getting called back definitely makes people very anxious.

They always assume the worst, and that's normal. So what can you do if you get called back? So think about this in this way. Roughly 10% of women who have a screening mammogram will get called back with artificial intelligence ai, and with 3D mammography, were calling back fewer and fewer people. If, however you do get called back very often some additional views or an ultrasound will clear up a spot and make it that nothing else is needed or maybe a, just a ju double check in six months.

But if you need a biopsy, even then the majority of the biopsies we do come back benign. So more than two out of three biopsies we do are benign. We are much better at finding things than we are at determining, which is cancer and which is benign with artificial intelligence. [00:12:00] That may change over time, but today, even if we do a biopsy, there's a very good chance it's gonna come back benign.

Stephen Calabria: Now, you've talked about some of the interventions already, but after you've determined that. One given case is cancerous versus benign. What are the most common interventions when it comes to breast cancer?

Dr. Laurie Margolies: So the most common treatment for breast cancer is called the lumpectomy. Which means a small part of the breast is removed, not the whole breast, but a small part of the breast is removed.

Typically, that's followed by radiation therapy, and depending upon the type of breast cancer it is, may be followed either by chemotherapy or by endocrine therapy, and that's all determined by pathology. So it's very important to get that surgery to know exactly what the pathology is so that the medical oncologist can therefore determine if you need chemotherapy or [00:13:00] endocrine therapy, or perhaps even both.

Stephen Calabria: Perhaps it depends on the particular case, but what are the factors usually you'd use to determine whether counseling a patient to go the chemotherapy route versus the surgical route?

Dr. Laurie Margolies: So very often people give both. Sometimes they get one first or the other. Sometimes, for example, chemotherapy is given first for some types of cancers or some of the larger cancers and it's, that's very helpful sometimes 'cause then we know that chemotherapy works or doesn't work, so we know if that's the chemotherapy we might give after surgery.

Sometimes the cancers are such that we can do the surgery first. And do the chemotherapy and radiation afterwards, and it depends on the receptors. So receptors are molecules that are within the breast cancer. So some cancers have estrogen receptors, some have progesterone receptors, some have other kinds of receptors.

It all depends on what [00:14:00] those receptors show. And then there's all kind of other tests that we can do to show how aggressive a cancer is. And then there's even more tests we can do to show how likely a. Particular person's breast cancer is to metastasize how much they will benefit from chemotherapy. So there's a lot of testing that goes on the tissue that is taken out.

Stephen Calabria: You as a doctor have to, I imagine, maintain a certain level of emotional distance from your patients. How do you balance that distance with providing the kind of empathy required when someone's sick?

Dr. Laurie Margolies: So it's very hard. It's a real privilege to be involved with somebody's life on their most difficult days.

And what I teach our trainees is what is a good day for us? Finding that small, early breast cancer is the patient's worst day. It's their worst nightmare. Come [00:15:00] to pass and understanding that and giving the patient time just to cry, time to be angry, time to say, why me?

But then helping them get to the next steps of getting to a surgeon, getting their significant others, getting friends or relatives on the phone with them who can be there and support them.

All those things help and help us. Remember that at the end of the day, this is why we went into medicine. We met, we went into medicine to help people. To really help them through these really dark times so they can get to those times 5, 10, 15, 20 years from now when they're going to children or grandchildren's graduations and weddings and other celebrations and enjoying life.

Stephen Calabria: To that point, looking at down the road to those sorts of life milestones that folks wouldn't be able to have reached without your interventions, what are some of the [00:16:00] stories that most stick out for you when it comes to patients' resilience?

Dr. Laurie Margolies: So I think what sticks out the most are those patients who really end up turning their breast cancer into a positive.

That may be those patients who say, you know what? I'm gonna make sure that all my friends, all the parents in my kids' school, all the parents in my grandchildren's school are getting their screening. I'm going to use this as a teaching moment.

I'm going to use this as a mechanism for change. Maybe I'll go on a breast cancer walk and raise money for research. Maybe I'll raise money for Mount Sinai to do research. Maybe I'll raise money for Mount Sinai's mobile mammography van.

But I'm gonna do something to give back and to make sure that more people can get the early detection that I got. And what we're very lucky in the United States that we have this.

[00:17:00] If you look at some parts of the world, there is no screening and people come to the medical centers when breast cancers are huge, when they're

going through the skin, when they're in their bones, and it's really too late to do just about anything.

So we're really privileged to be able to find breast cancer early. And so those people who. Wake up one morning and say, oh, it's my screening mammogram day. I am gonna go and use that as an instrument for change.

Stephen Calabria: In your mind, what makes breast cancer different from other cancers? Both biologically and as far as how patients have to navigate it?

Dr. Laurie Margolies: So, breast cancer is different in many ways. One is it's more emotionally charged. It affects how a woman perceives herself. Women are afraid that it might perceive how their significant others or their friends perceive them.

It [00:18:00] affects clothing, it affects how people dress, how they might put on a bathing suit. It affects all facets of somebody's life beyond the immediate, and also if it's different in that we give people more choices. Do you want a lumpectomy?

Do you want a mastectomy? Do you want one mastectomy? Do you want two mastectomies? We typically, for example, don't say to a colon cancer patient, would you like six inches of your colon removed?

Or would you like 12 inches of your colon removed? The surgeon does whatever they are going to do. They don't have that shared decision making that we have with our patients, so it's very different in that regard.

And you can't take away the emotional aspect of how a woman looks and how she feels and how she thinks others might perceive her. And the fear of how others might perceive her is real.

I've known women, men who have just said, I don't want anybody but you and my husband to know. I'm not [00:19:00] telling my friends, I'm not telling my mother, I'm not telling anybody else. And that becomes very difficult. It becomes very difficult for the husband 'cause they don't have anybody to support them.

Whereas the people that talk about their breast cancer, they're on their phone to 20 people and all of a sudden they've got a major support system. Everybody's there driving them, going with them, making food, take, picking up their children from school or doing whatever.

It's very helpful. That kind of resilience in getting that support system can really make a big difference.

Stephen Calabria: Do you encourage people in those situations to push past their reluctance and to cultivate a support system? We know that people having a social support network, a community can make differences, huge differences in people's lives. What do you say to those folks?

Dr. Laurie Margolies: I absolutely say there's no shame in having breast cancer. It is nothing to be [00:20:00] embarrassed about If somebody doesn't like the way you look. They don't belong in your friend circle because how would you feel if somebody lost their finger?

You wouldn't cut them out of your life if somebody became bald because your husband lost all his hair when he started turning 40. You wouldn't say That's it out it, it matters. So if people don't accept that you're having a problem.

It reflects more on them than on you. Nobody gets their life without a problem. Everybody has a problem. Nobody's children are perfect. Nobody's parents are perfect, nobody's life is perfect. And I think maybe with social media today, we think everything is perfect, but it's not.

So when you talk to your friends, all of a sudden you'll say, I didn't wanna tell you, but three years ago I had a breast biopsy and I was scared. Or five years ago my sister had breast cancer and she's fine now.

You'll be [00:21:00] fine too. Those kind of support systems are invaluable. We can't bottle them. They're not in a pill. You need to create them yourselves if you're the breast cancer patient, but they really help.

Stephen Calabria: Is that kind of communal aspect a part of your practice? Do you provide those sorts of perhaps group settings for folks to talk about their diagnoses?

Dr. Laurie Margolies: Absolutely. So at the Dubin Breast Center, we have things like group yoga, we have group knitting sessions.

There are definitely different kinds of support groups for different age groups, different ethnic groups. There are lots of support groups throughout the Sinai system and throughout the city and throughout the country. There are major support groups for people with all different kinds of cancers.

There are invasive lobular support groups there. There's tons of support. If you don't have it intrinsically.

Stephen Calabria: After someone has received treatment for breast cancer, what does the typical [00:22:00] timeline look like? I assume we're monitoring them to see if the cancer has returned. What does it typically look like?

Dr. Laurie Margolies: So it depends on the age when somebody gets breast cancer. If you are 75 and get breast cancer, we are probably gonna go to yearly mammography. If you were 40 when you got breast cancer and you didn't have mastectomies, we are probably gonna go to yearly mammography and yearly MRI.

So it's a little bit age dependent and also depends upon one's breast density. So if you had dense breasts, we're more likely to add the MRI. If you're younger, we're more likely to add the MRI.

Stephen Calabria: Looking to the future, what kinds of innovations are we seeing in the field of breast cancer treatment, specifically relating to radiology, and how might they improve resilience in patient care?

Dr. Laurie Margolies: So I think we're looking at a lot of changes in artificial intelligence. So now we're using artificial intelligence to detect breast cancer. [00:23:00] And for decision support, meaning if we're suspicious about something, we can essentially phone a friend and say, what do you computer think about this? In the future, the computer will look at the image and say, okay, this person is unlikely to get breast cancer in the next five years.

Maybe they don't. Maybe they can skip next year. Conversely. This person is, has an 80% chance that they're gonna get breast cancer in the next five years. Maybe they should get breast MRIs twice a year. Now that's not ready today, but perhaps in the future we'll get to such a spot. And then that brings up a whole other set of questions.

If you're in that group that's told you have a high risk of getting breast cancer. How do you live with that? How do you deal with that on a day-to-day basis? If the computer says, you've got a really high chance in the next five years, you're gonna have breast cancer, but the radiologist doesn't see anything, you don't feel anything, [00:24:00] the doctor doesn't feel anything.

How? How do you deal with resilience in that setting to be determined? Tough situation for people to, to navigate as we move forward.

Stephen Calabria: I imagine that's it's easy for someone like myself who's sitting on the sidelines to say, oh, this is better than this, or This might be worse than this.

But I imagine it is better from both a patient standpoint and the physician standpoint to, to know that someone might have a better. Or to know that someone might have a higher likelihood of getting breast cancer because that means they're more likely to beat it. Would that be the case?

Dr. Laurie Margolies: It's more likely that we can add in extra screening. So if we know that you're more likely to get breast cancer and we're not seeing it on a mammogram, or if we know you have dense breasts, then maybe we can get your insurance company to pay for MRIs. [00:25:00] We can keep doing MRIs maybe every six months if we know you're at super high risk according to this new AI algorithm.

So we find that breast cancer really early because we don't know if it's the left breast, the right breast, top, bottom, inside, outside. We don't know where in the breast it might show up, and maybe it's wrong 'cause it's not saying a hundred percent chance you're gonna get breast cancer. It's saying 70%, 80% maybe you're in the lucky 20%.

That doesn't get it. And now you've been aggravated for all this time for nothing. So there's a lot of work being done. We don't have anything magic on the horizon that is going to say, here it is. We don't have a blood test. We don't have any great new technology that's here today. Everybody is working on it.

Rest assured, everybody is working on all different kind of things to look for MRIs without contrast, for mammograms, with contrast [00:26:00] for ultrasounds that have more artificial intelligence for robots to do ultrasounds. There's a zillion things being worked on, almost as more than you can even imagine.

But nothing beats what we have today 'cause we know that yearly screening mammography saves lives. It's been proven with super old technology from the sixties and seventies. It saves lives and it's only getting better.

Our chemotherapy is getting better, our surgery is getting better. We're learning that we can even do less surgery and less chemotherapy to make it easier for people.

We're learning that we can do things to prevent the hair loss from chemotherapy, so we're learning that we can make the whole breast cancer experience much less invasive for patients.

Now in sticking with the conversation around advancements in screening and care mutation in two specific genes, BRCA one and BRCA two can increase the risk of [00:27:00] developing certain cancers, especially breast cancer.

Stephen Calabria: Are there any advancements being made in mitigating their mutations or even reversing the trajectories?

Dr. Laurie Margolies: So you can't really do much once you have that mutation. Except for a very few specific things. So we all know about the Angelina Jolie effect when she had bilateral mastectomies and it was all over the news.

So obviously, having bilateral mastectomies and bilateral ectomies mean taking out the ovaries significantly reduces your risk of breast cancer. Never makes it zero, but makes it way, way lower than it was.

You can do some really interesting things, however, with in vitro fertilization. So in other words, you one can take their eggs and look at them and say, okay, these have the BRCA mutation, or these sperm have the BRCA mutation, so those we're not going to use, those.

We're not going to [00:28:00] allow to develop into embryos, and we're going to select. The ones that are free of this mutation. Now we don't know what other mutations they may have. Maybe they're gonna get a heart attacks when they're 45.

We don't know. But science today can separate out. Embryo goes with BRCA mutations and without BRCA mutations, so that theoretically, in a family that knows they have the mutation, they could stop that mutation from getting to the next generation.

Stephen Calabria: How have technological advancements, you've discussed AI, but things like AI, 3D mammography, how have they changed the way that you practice and help patients?

Dr. Laurie Margolies: I think it, it makes us happier radiologists. It makes us more confident radiologists because I know that if I believe the mammogram is normal.

The computer also thinks it's normal. So now you've got two reads. You've got the artificial intelligence and you [00:29:00] have me. So you've got two people, not two people, one person, one computer, or one computer algorithm saying this mammogram is fine. So before you talked about how does the physician feel, so it's a wellness tool.

We talk a lot about physician wellness and physician burnout. It really helps the physicians. So if I'm looking at something and I'm thinking, oh my goodness, I think it's worrisome and I think it's worrisome, and then the computer says it's worrisome, then I don't feel bad calling back that person. 'cause I know if I call back that person I'm ruining their day.

I'm ruining their week. But now I say, okay, the computer also thinks it's worrisome. I think it's worrisome. The computer thinks it's worrisome. We have to go ruin this person's day. So it really helps, it helps us make, it makes us more confident and patients ask lots of questions. They wanna ask, what's in this black box of ai?

And obviously the AI companies don't wanna tell you [00:30:00] exactly what's in the black box, but we know that it works because here at Sinai, we've looked at all our cancers that we've biopsied over years, and we've seen how they work with ai and we've seen that the AI is pretty good. Is it perfect? Absolutely not.

Are there breast cancers that we have found that the computer hasn't? Absolutely. Are there breast cancers that maybe we wouldn't have seen if we didn't have the computer? Probably. Are there things that we find that the computer is not designed to see? Absolutely. For example, I can think of a couple of patients who've had lymphoma.

Now that's not breast cancer. So the AI is not designed to pick up lymphoma in the breast, but our eyes can see it so the radiologist can find that lymphoma in the breast. So the computer isn't wrong. There was no breast cancer, but if I was that patient, I would wanna know that I had lymphoma so I could get my lymphoma treated.[00:31:00]

Stephen Calabria: That actually relates to my next question as to why the radiologist has the final say and not the AI assisted computer in determining whether a patient might have breast cancer. And I imagine it's because the radiologist is not just looking for this very specific thing that the computer is trained to look for, but you are an actually trained physician who knows all the other potential problems.

Dr. Laurie Margolies: And we know lots of things that the computer doesn't know.

We might know that there is something palpable in an area. We might know family history, we might know what the mammogram looked like before we might know their patient's genetics. We might know all sorts of things that go into whether we're going to proceed or not. And those things make it important.

So I think what the best radiologists. The best patient care is going to be those radiologists who use [00:32:00] AI and who use it well. So you can't just turn AI on and say, okay, it's on, it's running. It's like your GPS in your car. If you're a, if you're a driver, you sometimes the GPS is wrong. It takes you on a strange route.

And sometimes it takes you on a route that you don't wanna go on, or sometimes it tells you to take an extra, make six more turns to save 30 seconds. So if you think of it in that way, it doesn't replace the radiologist, it's a tool. Just let, I might use a magnifying glass or I might ask a friend an opinion.

It's a tool and the best radiologist will use that tool well and efficiently. And work with it and not afraid of it.

Stephen Calabria: We've done over a hundred thousand mammograms using the AI overlay. How have patients reacted to its use?

Dr. Laurie Margolies: It's very interesting. I was talking with a gynecologist [00:33:00] recently who said that her patients ask her a lot of questions about it and she tells them what she knows, but very few patients ask me. It's very interesting how they, even though it's in every mammogram report we put on there, that we've used it and the actual AI results are available to the patient.

Nobody calls, nobody asks about those results, but they are asking the referring providers, how does this work? Why does it work? I think patients are generally very happy to know that they have this extra. Extra pair of computer generated eyes looking at their images and makes them more confident.

I think they're happy that here at Mount Sinai we use it on every single mammogram. We don't just use it on those who can pay. There are some places in the tri-state area throughout the country actually [00:34:00] who will say, if you want AI, give us $50.

If you don't have that $50, no AI for you. Here at Sinai, it's every single mammogram, whether it's a screening mammogram, whether it's a diagnostic mammogram, whether it's a mammogram performed as part of a biopsy, every single mammogram gets ai.

Whether your mammogram is done in a facility of ours, way out on Long Island or in Manhattan, AI is running on all our mammograms.

Stephen Calabria: How do we see AI evolving over the next few years in helping us get to more precise diagnoses?

Dr. Laurie Margolies: So I think there are several important things that are gonna happen with AI. Some are real easy. AI will get to the point where it's comparing with prior mammograms. That's coming really soon.

Also coming very soon is the ability of AI to look at the arteries that supply blood to the rest looking for [00:35:00] cardiovascular disease. We also know that AI will continually get smarter as people feed at cases.

You miss this great call. Good job. Bad job. Good job. Bad. It will learn. Part of artificial intelligence is learning just like a radiologist learns when they're a medical student. You know something.

And then when you're a resident, you know something. When you, it's the first day of being an attending, something. When you've been an attending for 20 years, a lot more. So the artificial intelligence will evolve.

So I think it will get more sensitive, meaning it, it's going to find more smaller earlier breast cancers. It will find more. High risk saying this tissue looks like it may be heading towards a breast cancer.

It will also be better at saying, this is good, meaning it'll be more specific. So it's the false positives, the false scars will go down. So I think overall it's going to continue to make the mammogram experience a better experience for the [00:36:00] patient.

Stephen Calabria: What advice do you give to patients, particularly women who are anxious about getting their first mammogram?

Dr. Laurie Margolies: Don't look at Google. Don't look at the internet. Don't talk to every single friend of yours. I. Go to a place that where you feel comfortable, that might be the mobile van that's coming to your healthcare

facility, your mobile van, coming to your church, or other religious organization. It may be your local hospital or maybe you wanna go with friends.

I know a group of ladies that come every year. All three of them, they come together every single year. They make a day out of it. They come, they have their mammograms, then they go to lunch, and then they do something else. They go to a show or something. They do something. They make it a nice day and they're there to support each other in case somebody didn't have a good result.

I would say don't be afraid. Don't listen to all the negative stories. Learn to love your mammogram. [00:37:00] It's not gonna be as bad as all those stories you've heard. Yes, it might be uncomfortable for. A few seconds. The compression that everybody talks about is good for you. It decreases the radiation. It gives the radiologist a clearer picture so it's not blurry, and that compression only lasts a few seconds and then it's gone.

So don't be afraid of it. Just come and come back every year.

Stephen Calabria: For those who've skipped a few years, maybe due to fear the pandemic or just life circumstances, what would you say to encourage them to come back in?

Dr. Laurie Margolies: Come back. We won't be angry. We won't judge, but come back. It's time to take care of yourself your children, your grandchildren, your friends want you to be around.

They want you here for the next 20, 30, 40, 50 years. You would feel very badly if you missed a few years, [00:38:00] and then all of a sudden you felt something in the shower that was big and you found something that was the size of a lemon. And then you're gonna hit yourself upside the head and say, you know what?

I shouldn't have been afraid. I should have just gone. So whether it's your first mammogram, 'cause you're turning 40, whether it's your 10th mammogram, but you've missed five years because of the pandemic or other reasons, or you missed a few years because you were caring for a sick family member.

Just come back. We want you back. There's no judgment. Nobody's gonna look at you and say, what the heck, where were you? Just come back. We're very happy to have you.

Stephen Calabria: Finally, what message would you like listeners to take away this Mammogram May, And how can the average listener to this show best observe Mammogram May?

Dr. Laurie Margolies: The best way you can observe mammogram May is to think about your mom. Mother's Day is in May. What would your mother tell you to do? What would you want your mom to do? [00:39:00] Make an appointment for your mom. Come with your mom.

If your mom is not here, come with a friend. Come with an aunt, come together, celebrate your mom by having a mammogram in May, or make your appointment in May and come in June, come in July, whenever it's convenient for you.

We work 12 months out of the year. But think about it. It's mother's. It's been Mother's Day. Think about your mom. Think about what she would want you to do. Think about what you want your mother to do. Would you like your mom? If you're, lucky enough to have a mom, would you like your mom to be here in 10, 20, 30 or 40 years?

So if your mom were to get breast cancer, would you want her to find it small? Sure. Encourage your mom to get a mammogram.

Stephen Calabria: That's it for my questions. Was there anything else you wanted to say?

Dr. Laurie Margolies: So there's a lot of artificial intelligence in the radiology department at Mount Sinai. So in breast imaging we use artificial intelligence in many [00:40:00] ways. So not only do we use it for detection of breast cancer on our mammograms, but we will use it for breast density.

We'll also use it to ensure the quality of mammograms. And by that to be sure that we've imaged all the breast, we've gotten all the folds out, and all our mammograms are well positioned. Mount Sinai is committed to providing high quality mammography throughout the Mount Sinai health system. From Staten Island to Manhattan, to Brooklyn, Queens, and Long Island.

Wherever you see a Mount Sinai logo, you can be sure that you're getting ai, that you're getting AI for positioning. You're getting AI for breast density, you're getting AI for detection. Those are all either here or coming. Detection is here, density is coming, and positioning is coming very soon.

Stephen Calabria: Dr. Laurie Margolies, thank you so [00:41:00] much for coming on Road to Resilience.

Thanks again to Dr. Laurie Margolies for her time and expertise. To schedule your mammogram at Mount Sinai, you can reach us at 2 1 2 2 4 1 8 3 3 3, or schedule it online at mychart.mountsinai.org.

Road to Resilience is a production of the Mount Sinai Health System. It's produced by me, Stephen Calabria, and our Executive Producer Lucia Lee.

From all of us here at Mount Sinai, thanks for listening and we'll catch you next time