**Risk Categories**

Women ages ≥ 35 years old, and one of the following:

- History of lobular carcinoma in situ (LCIS)
- Atypical hyperplasia (AH) (ductal and lobular)
- Gail model 5 year breast cancer risk ≥ 1.7%
- Tyrer-Cuzick model 10 year breast cancer risk ≥ 5%
- Prior thoracic radiation therapy (XRT) at age 10-30 years old
- Life expectancy ≥ 10 years
- No contraindications to risk reduction therapy

**RISK ASSESSMENT**

Does patient meet criteria?

- Yes
- Post-menopausal
- Any of the following:
  - LCIS
  - AH
  - Lifetime risk ≥ 20% by Gail or Tyrer-Cuzick models
  - Prior thoracic XRT at age 10-30 years old

- No
- Patient not a candidate for risk reduction treatment

- Tamoxifen
- Raloxifene
- Aromatase inhibitors (AI) (exemestane or anastrozole)

**TREATMENT**

Assess balance of benefits and harms:

- Tamoxifen
- Raloxifene
- Aromatase inhibitors (AI) (exemestane or anastrozole)

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1. Patients without breast prophylactic mastectomy (BPM)
2. Primary benefit is seen in patients up to age 70 years old and may not be as great for those who are older
3. Limited data regarding risk reduction therapies in women with prior thoracic XRT
4. Prior history of a thromboembolic event is an absolute contraindication. Adequately treated endometrial hyperplasia or early-stage endometrial cancer is not a contraindication to the use of tamoxifen.
5. Starting dose of tamoxifen is 20 mg by mouth once daily; may reduce to 5 mg once daily (or 10 mg every other day) if needed for patient tolerance
6. Lower risk of uterine cancer but less long-term benefit
7. Limited data regarding AIs in women with proliferative breast lesions
8. Off-label (Not FDA approved)


This risk reduction algorithm is based on majority expert opinion of the Breast Cancer Risk Reduction Therapy workgroup at the University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

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