Talking With Your Oncologist

A patient-centered mini-med school — guided by *your* questions

PICK A TOPIC. ANY TOPIC. LET'S TALK.

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Today's Topics

Jump to whatever matters most to you. No order required.

1. **Cancer Treatments**
   Chemo vs. immunotherapy vs. hormone vs. targeted therapy
2. **Osteoporosis**
   Why your oncologist won't stop talking about your bones
3. **Menopause & Hormones**
   What we know, what changed, what's right for you
4. **Dense Breasts**
   What it means and what to do about it
5. **Tests & Scans**
   Which ones do you actually need?
6. **Reading Your Results**
   Making sense of scan reports

Don't see your question? Bring it up — you probably won't be the first to ask.

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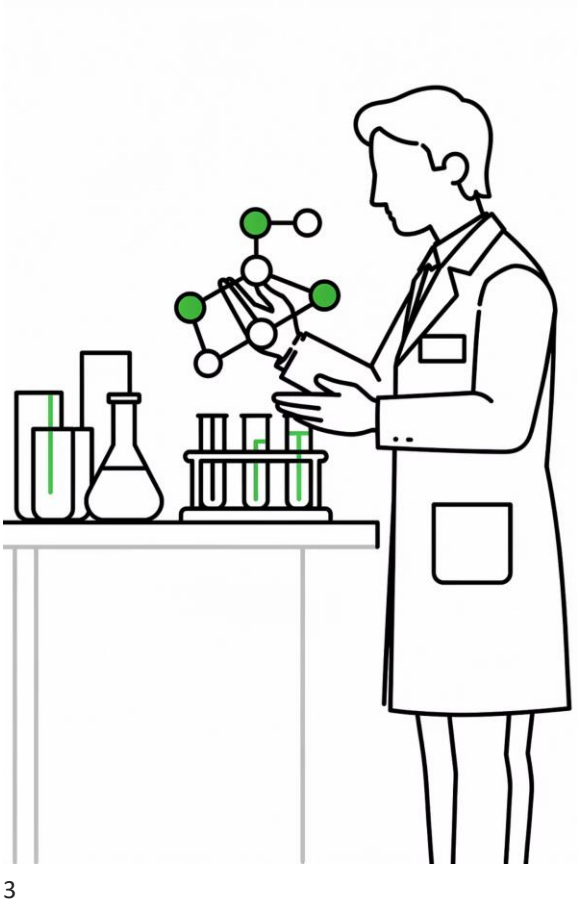

What Even Is Chemotherapy?

The word gets used loosely. Let's be precise.

Chemotherapy

Disrupts cell division — affects any fast-dividing cell

Immunotherapy

Unlocks your immune system to find and destroy cancer

Hormone Therapy

Cuts off the hormonal fuel certain cancers depend on

Targeted Therapy

Flips a very specific off-switch — only works with the right match

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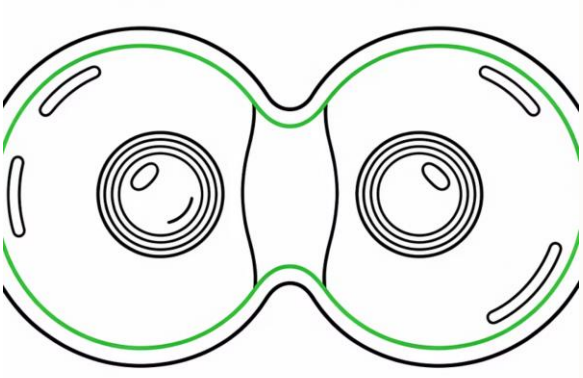

Chemotherapy

Cancers divide fast. Chemo attacks dividing cells — cancer and otherwise. Normal cells recover. Cancers often don't.

Examples: paclitaxel, carboplatin, doxorubicin

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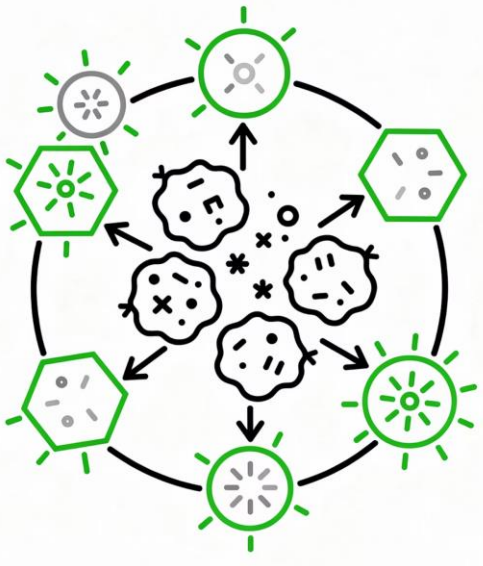

Immunotherapy

Cancer fakes an ID badge to fool your immune system. Checkpoint inhibitors say: *we're checking everyone*. Won the Nobel Prize in 2018.

Examples: pembrolizumab, nivolumab, durvalumab

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Hormone Therapy

Breast and prostate cancers run on estrogen or testosterone. Hormone therapy cuts the supply or blocks the pump.

Examples: tamoxifen, letrozole, leuprolide, abiraterone

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Targeted Therapy

Like a shellfish allergy — dramatic effect only if you have the right mutation. Useless without it. Very powerful with it.

Examples: osimertinib, imatinib, olaparib

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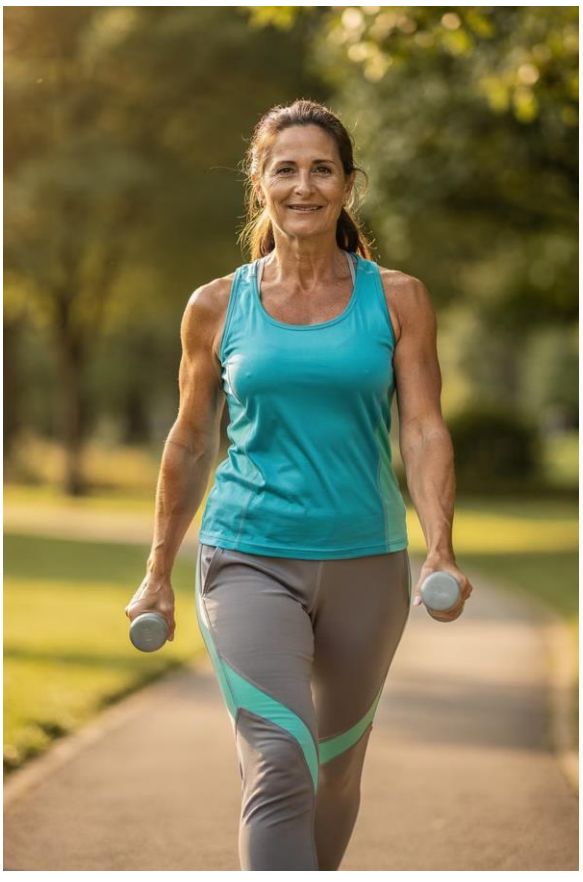

Osteoporosis: Why Your Oncologist Won't Let It Go

Chemo

Lowers bone density, may trigger early menopause

Hormone Therapy

Estrogen-lowering meds contribute to bone loss

Steroids

Important for cancer treatment — but accelerate bone loss

⚠ Cancer treatment can caus increase risk of osteoporosis. That's why your oncologist keeps bringing it up.

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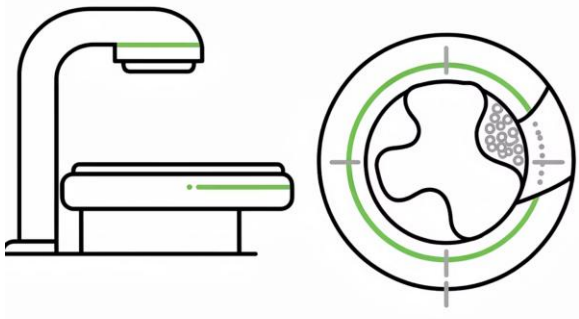

What Is Osteoporosis?

Osteoporosis is a disease of the bones that makes them fragile and likely to break easily. The most common way to diagnose it is with a DEXA scan — which looks at two key sites: your lumbar spine (lower back) and left femoral neck (top of your left thigh bone). These sites are chosen because weakness there is most strongly linked to serious, life-altering fractures.

Understanding Your T-Score

A T-score compares your bone density to a healthy 30-year-old. The more negative the number, the more fragile your bones.

Above -1
Normal
Bone density is healthy

-1 to -2.5
Osteopenia
Weaker than normal, but not yet at high fracture risk

Below -2.5
Osteoporosis
Significantly increased risk of a serious broken bone

ⓘ A T-score of -1 means your bones are more fragile than 84 out of 100 healthy 30-year-olds. A T-score of -2.5 means more fragile than 99 out of 100.

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Who Should Consider Osteoporosis Treatment?

High FRAX Score

The FRAX score combines your T-score with other risk factors — smoking, alcohol use, previous fractures, family history. If your 10-year risk of a hip fracture is >3%, or any fragility fracture is >20%, treatment is worth strong consideration.

T-Score of -2.5 or Worse

This is the classic definition of osteoporosis. At this level, your bones are more fragile than 99 out of 100 healthy 30-year-olds.

A Fragility Fracture

Breaking a bone from minimal trauma — falling in your kitchen, sitting down too hard — is exactly what we're trying to prevent. If it's already happened, treatment is urgent.

ⓘ Ask your oncologist: What is my T-score? Do I need a FRAX score? Should I be on bone medication?

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How Serious Is a Broken Hip, Really?

It's not like breaking your leg as a kid. For adults with osteoporosis, it's often life-changing.

1 in 3

Die Within a Year

After a hip fracture from osteoporosis

1 in 2

Don't Regain Independence

Among those who survive the fracture

5×

Higher Risk

Of living in a nursing facility after an osteoporotic hip fracture

The death risk in the year after a hip fracture is more than twice that of a new metastatic estrogen receptor positive breast cancer diagnosis.

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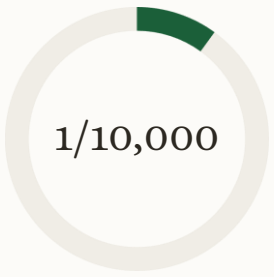
Osteoporosis Treatment: Are the Risks Overstated?

The Fear: Osteonecrosis of the Jaw (ONJ)

A wound in the jaw bone that won't heal. Real, and serious.



Risk per year

For people with healthy teeth on osteoporosis medication

Key: Coordinate any tooth extractions or major dental work carefully with your doctor first.

The Other Fear: Atypical Femur Fractures

A rare unusual fracture caused by the medication itself.

But for every **1** atypical fracture caused by bisphosphonates over 3 years:

- **75** hip fractures prevented
- **270** total fractures prevented

Source: NEJM, 2020

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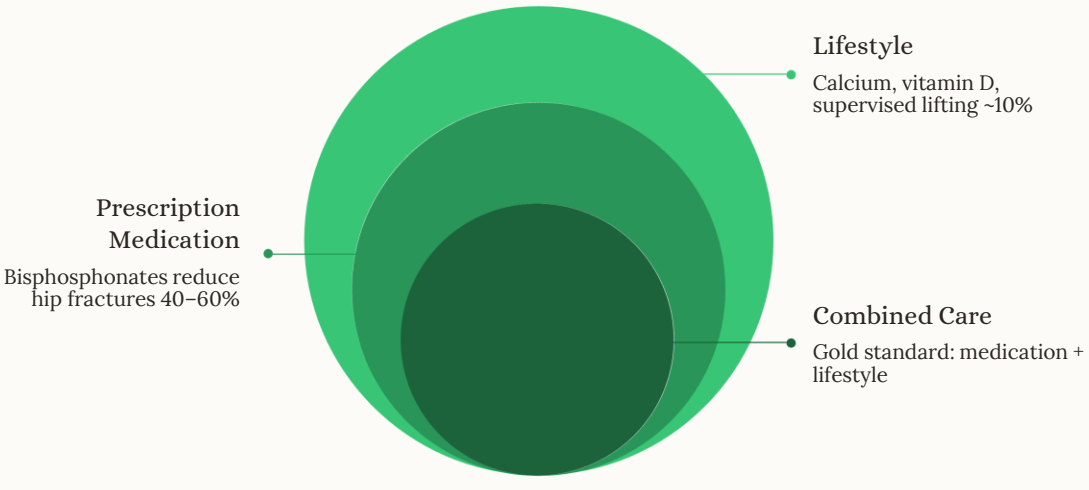
What Actually Helps Bones?



Exercise matters — especially lifting heavy weights with good training. But for people who already have osteoporosis, prescription medication is by far the most powerful tool. Use both together for best results.

ⓘ Ask your oncologist: Have I had a DEXA scan? What is my T-score? Do I need a FRAX score? Should I be on bone medication?

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Menopause & Hormones After Cancer

A topic full of misinformation. Here's an honest, simplified map.

Early Menopause from Cancer Treatment (Not Breast Cancer)

Increased risk of fractures, heart disease, dementia. **MHT should be strongly considered** — at least until age 52.

Breast Cancer Survivors

Systemic MHT is not currently considered safe. **Vaginal estrogen is the exception** — effective for dryness and UTIs without raising systemic estrogen. Talk to your team.

Natural Menopause, Cancer History (Not Breast)

Your cancer likely doesn't change the conversation. Talk to your gynecologist about your personal risks and benefits.

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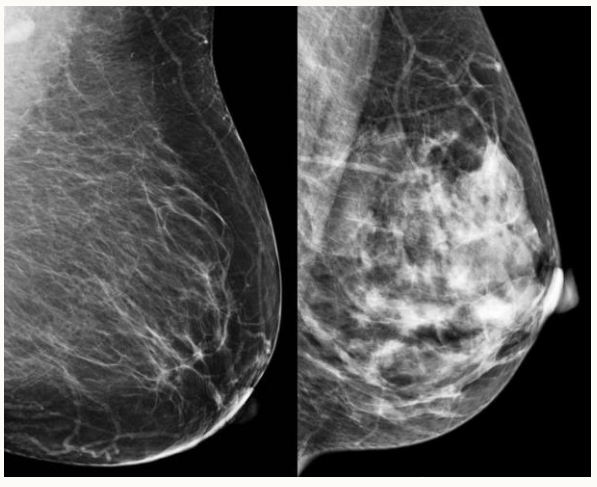
Dense Breasts: A Two-Part Problem

Problem 1: Mammograms Are Harder to Read

Cancer looks white. Fatty breasts look black — white stands out clearly. Dense breasts look like storm clouds — white on white. Easy to miss.



Problem 2: Higher Biological Risk

Dense breast tissue is biologically different. Even setting the mammogram challenge aside, women with dense breasts are **nearly twice as likely** to develop breast cancer.

Ask: Are my breasts dense? Do I need additional screening? Should we calculate my overall risk and consider a risk-reducing medication?

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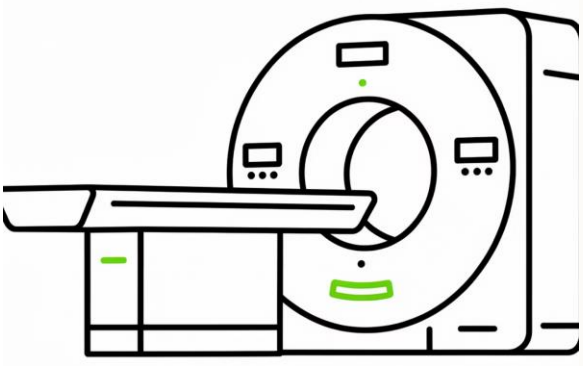

Tests & Scans: Which Ones Do You Actually Need?

A very common question — and a very nuanced answer. The appeal of regular full-body scans is completely understandable. You've been through so much. The idea of checking and being reassured makes total sense. But the science tells a more complicated story.

The Intuition

Find it early, nip it in the bud. Regular scans = peace of mind and better outcomes.

The Evidence

Studies show intensive monitoring with whole-body scans and tumor markers does not improve survival compared to regular oncology visits. More testing → more expense and anxiety, not more cures.

When cancer recurs in distant organs, it is usually not curable — regardless of how early it's detected. This is why the calculus on scanning is different from initial diagno

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When Scanning Does Matter: Local Recurrence

There's an important exception. When cancer comes back near where it started — before spreading to other organs — we can sometimes cure it with surgery or radiation. This is why site-specific surveillance remains essential.

Breast Cancer

Annual mammograms and breast exams

Colon Cancer

Regular colonoscopies

Lung Cancer

CT scans of the lungs

Prostate Cancer

PSA monitoring

The goal of local surveillance is cure. The goal of whole-body scanning for distant recurrence is usually not — which is why the guidelines look so different.

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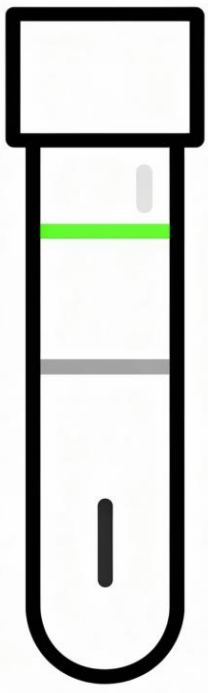

Tumor Markers: Useful, Unreliable, or Both?

A tumor marker is a lab test that looks for a chemical commonly secreted by a specific cancer. Some are well-validated. Others cause more harm than good.

Well-Validated Markers

PSA (prostate cancer), CEA (colon cancer), CA 19-9 (pancreatic cancer). Backed by science, useful because physical exams can't easily check a pancreas or colon.

Less Reliable Markers

CA 15-3 and CA 27-29 (breast cancer) are NOT recommended by national guidelines. Frequent false positives → fear, expensive testing, unnecessary procedures. Many breast cancers never secrete these chemicals → false reassurance.

A positive result that turns out to be nothing is not a free pass. It's a toll booth — paid in anxiety, time, and sometimes painful procedures.

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Circulating Tumor DNA (ctDNA): Promising, But Not Yet Ready

ctDNA tests search your blood for a genetic 'thumbprint' unique to your cancer — either from your own tumor or from a broad population sample. They're increasingly common and extensively studied.

What It Can Do

Detect recurrent cancer earlier than traditional scans or symptoms. Highly sensitive technology that is rapidly improving.

What It Can't Do (Yet)

Outside of one specific example in bladder cancer, detecting early recurrence with ctDNA has not yet been shown to save lives. We can find it sooner — but we don't yet have a way to cure it sooner.

ⓘ This may change. The technology and treatment options are evolving fast. Ask your oncologist whether ctDNA testing makes sense for your specific situation.

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Making a Surveillance Plan You Can Sleep With

Surveillance is not one-size-fits-all. National guidelines exist — and for some cancers they're very clear, for others there's broad leeway. Your oncologist's job is to be your guide and decision-making partner.

Understand the 'Why'

Know what each test is actually for — and what it can and can't tell you.

Weigh the Downsides

More testing means more anxiety, more false alarms, more procedures. That's a real cost.

Make a Plan Together

Some patients do CT scans twice a year for a few years. Some follow tumor markers. Some get ctDNA. All of that can be right — if it's an informed choice.

ⓘ My job is to help you make a plan you can sleep with at night. If minimal testing feels wrong to you, let's talk about why — and build something that feels sensible and safe.

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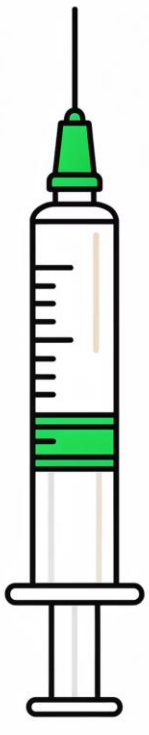

Can I Take a GLP-1?

Short answer: Yes.

> "Evidence is lacking with regard to an increased frequency of neoplasms, cancer, or death from the use of GLP-1 receptor agonists. In fact, reduction in body weight may ultimately lead to reduced risks of certain cancers associated with obesity." — Rosen & Ingelfinger, NEJM, April 2026

Some Positive Signals

Reduced Cancer Risk

Large trials show reduced overall cancer risk, including endometrial cancer, ovarian cancer, and meningiomas.

Reduced Mortality

GLP-1 use in cancer patients associated with reduced all-cause mortality and hospitalization.

Small Caveats (Still Being Studied)

- Possible small increase in kidney cancer risk — needs more research
- Possible small increase in certain thyroid cancers — needs more research
- Theoretical concern about rare neuroendocrine tumors — has not materialized in human data

ⓘ For people with obesity that is negatively impacting their health, these medications are more likely to provide health benefits than harms. There is no current science to support withholding GLP-1s from cancer survivors.

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GLP-1 & Cancer: References

Selected peer-reviewed literature supporting the safety and potential benefits of GLP-1 receptor agonists in cancer survivors.

1. Ko A, Chang YC, Bahar F, et al. "Risk for Cancer With Glucagon-Like Peptide-1 Receptor Agonists and Dual Agonists: A Systematic Review and Meta-Analysis." Annals of Internal Medicine. 2025.
2. Dai H, Li Y, Lee YA, et al. "GLP-1 Receptor Agonists and Cancer Risk in Adults With Obesity." JAMA Oncology. 2025.
3. Ateiwi YA, Mahmood R, Wong HJ, et al. "Glucagon-Like Peptide-1 Receptor Agonists and the Risk of Obesity-Related Cancers: A Systematic Review and Meta-Analysis." Diabetes Research and Clinical Practice. 2026.
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8. Wawrzak-Pienkowska K, Pienkowski T, Golonko A, et al. "Incretin Signaling at the Crossroads of Metabolism, Inflammation, and Tumorigenesis: Implications for Obesity Patients." European Journal of Pharmacology. 2025.
9. Mahadevan A, Vosooghi A, Arora JS, et al. "GLP-1 Receptor Agonists in Patients With Cancer Are Associated With Reduced All-Cause Mortality and Hospitalization." Journal of Clinical Endocrinology and Metabolism. 2026.
10. Radwan RM, Lu Y, Dai H, et al. "GLP-1 RA Use and Survival Among Older Adults With Cancer and Type 2 Diabetes." JAMA Network Open. 2025.
11. Kim C, Dinan MA, Robinson TJ, et al. "Semaglutide and Tirzepatide Prescribing for Obesity in Patients With Preexisting Comorbid Cancers." JAMA Oncology. 2025.

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Reading Your Scan Report: A Field Guide

You're going to see your results before your doctor does. Here's how to make sense of what you're reading.

01

Indication

The reason for the scan. Sometimes detailed, sometimes a click-box. Tells the radiologist what to focus on.

02

Comparison

Lists whether a previous scan was used for comparison, and which one. If the report seems off, check this — radiologists sometimes miss that a prior scan exists, especially across health systems.

03

Technical Details

Contrast used, machine details. Usually not important for patients.

04

Findings

The detailed description of everything seen. Some radiologists describe every detail (the 'mom' version). Others only mention things of concern (the 'dad' version). Both are fine — silence usually means normal.

05

Impression

The most important section. Usually at the bottom. Better or worse? Anything new? Anything needing follow-up? If it's not here, it probably doesn't need your attention.

If something worries you, call us. Don't spend the night or weekend fretting. You'll get results before we do — that's how portals work. We hate that you're anxious. Call.