Rad to Rad Learning: Male Breast Cancer

The Radiology Partners (RP) Breast Imaging National Subspecialty Division (NSD) presents our newest Rad to Rad Learning case.

Peer Learning Opportunity

While male breast cancer is rare, it is often diagnosed at a later stage with poorer outcomes.

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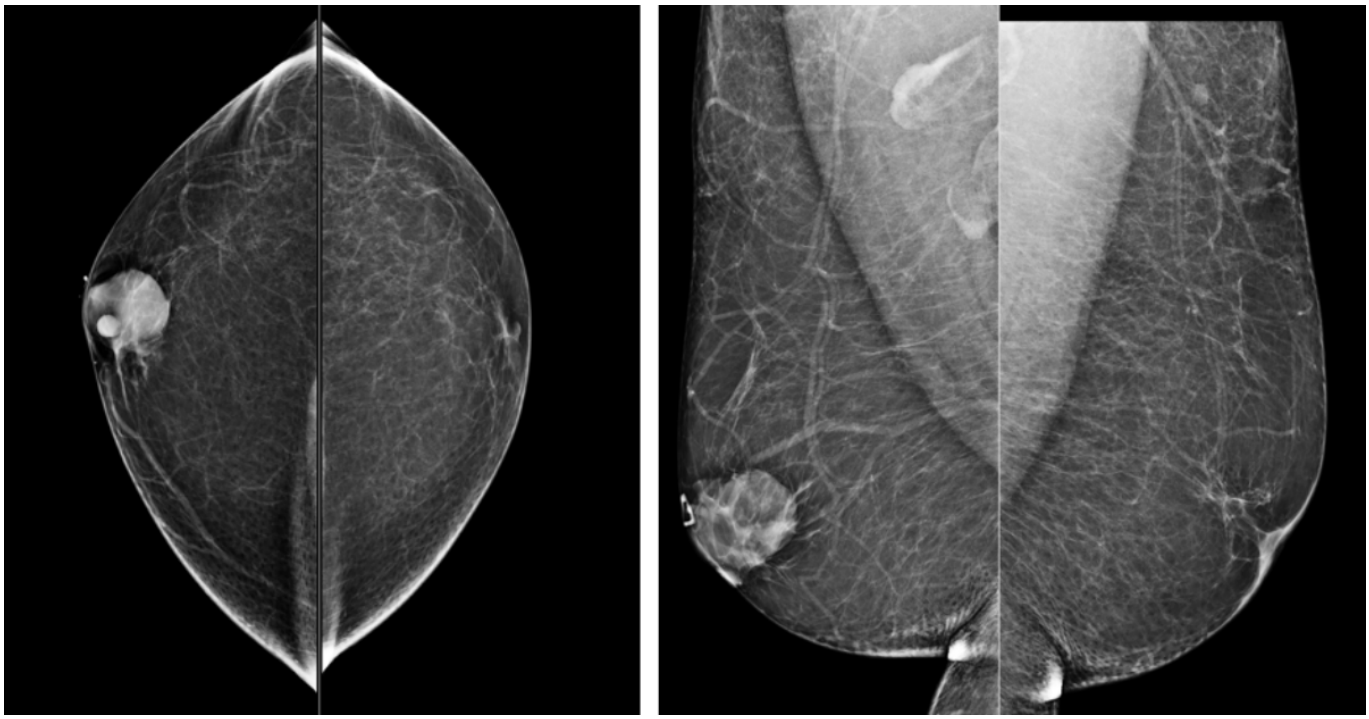

Male Breast Cancer

Most commonly found in the subareolar region, frequently with secondary signs including nipple retraction or thickening.

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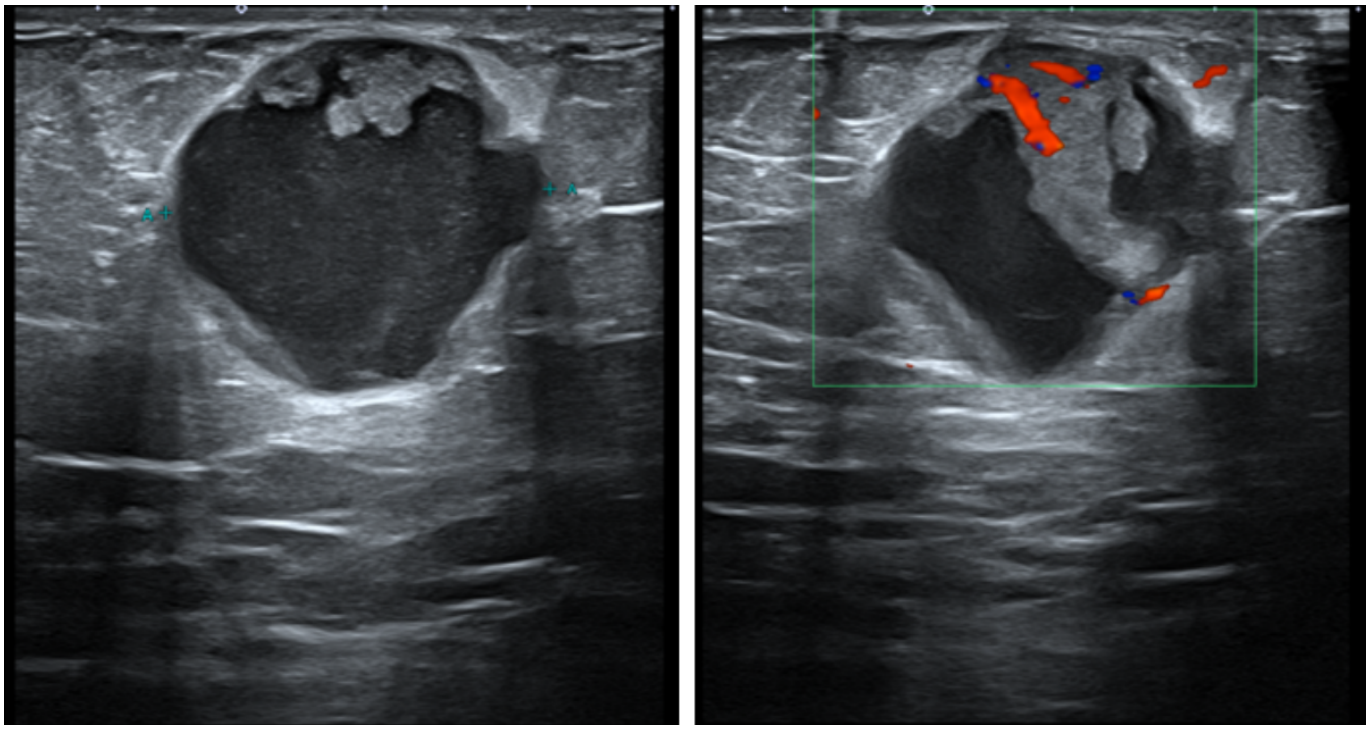

Shared to improve patient safety and healthcare delivery in the provision of radiology services. The circumstances and facts are changed, altered, or deidentified to preserve confidentiality. Privileges have not been waived.

Practical Insights

- **Gynecomastia often presents as a retroareolar, flame-shaped density that gradually blends into the surrounding fat.**
- **Can present with classic malignant features like spiculation or indistinct margins, but also as more benign-appearing oval or round shapes.**
- **Any calcification should be considered suspicious.**

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US typically shows a hypoechoic solid mass with variable posterior acoustic properties and often increased vascularity on Doppler.

Always suspect malignancy if there is an irregular or spiculated retroareolar mass.

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Visit the Clinical Resources page for more cases and to see what we've developed to enhance best practice recommendations, elevate image quality and patient care and update current standards throughout RP's network of practices, all to deliver excellent radiology services to patients, referring clinicians and client partners.

Rad to Rad Learning
Focused tips from our experts

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Rad to Rad Learning: Hyperechoic Breast Lesions

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Hyperechogenicity is typically associated with benign breast lesions, including hamartoma, lipoma, angiolipoma, hemangioma, hematoma, fat necrosis, fibrosis, and galactocele. However, some rare malignant lesions may also appear hyperechoic.

Presents with palpable mass

Presents with new bruise

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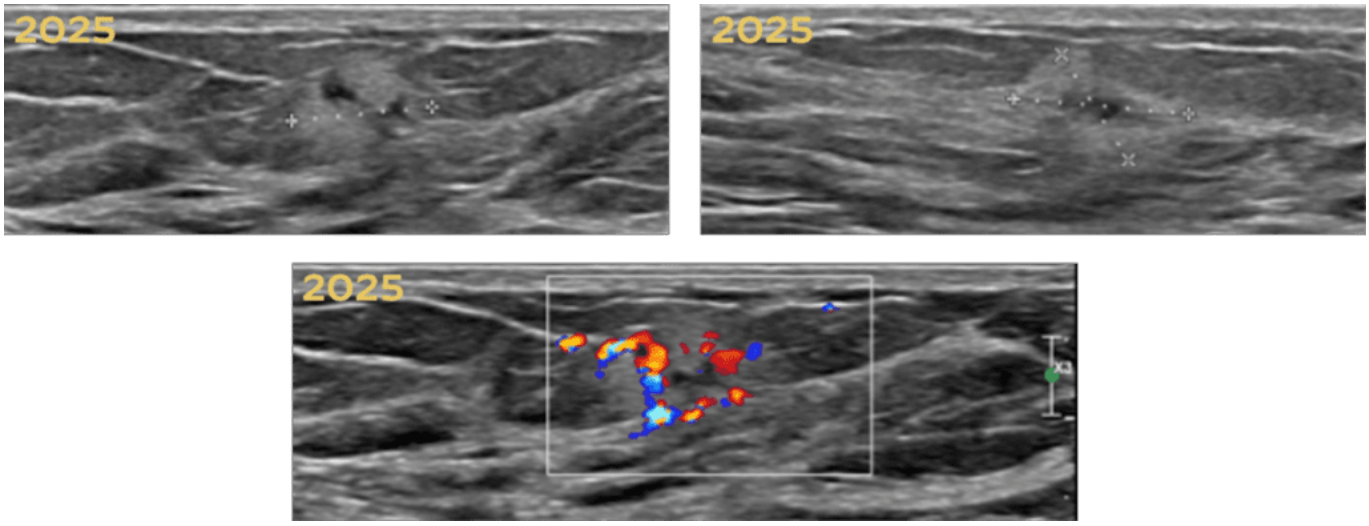
Hyperechoic Breast Lesions

Presents with persistent palpable concern

Biopsy-proven Invasive Lobular Carcinoma



Watch for subtle, suspicious features like irregular shape, non-circumscribed margins, non-parallel orientation, or posterior acoustic shadow.

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Practical Insights

- **Don’t dismiss a lesion simply because it is hyperechoic. Correlate US findings with other modalities and the patient’s clinical history.**

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Consider specific histologies, not only invasive ductal or lobular carcinomas.

- **Rare cancers like angiosarcoma, lymphoma, and metastases can also present.**
- **Don’t hesitate to recommend a biopsy for suspicious lesions. Do not rely solely on the hyperechoic appearance to rule out malignancy.**
- **Contrast-enhanced mammography is a promising alternative for dense breasts.**

Hyperechoic breast lesions are not always benign.

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Why RP? A Q&A with Dr. Jean Weigert, Breast Radiologist

In honor of Breast Cancer Awareness Month, we spoke with Dr. Jean Weigert about the path that led her to become a breast radiologist, advocate for dense breast legislation and champion patient-centered care through decades of innovation.

Dr. Jean Weigert is a breast radiologist and breast imaging section chief at Jefferson Radiology, a Radiology Partners (RP)-affiliated practice. A Fellow of the American College of Radiology (FACR) and the Society of Breast Imaging (FSBI), she joined RP in 2017. Outside of work, Dr. Weigert's passions include singing and ballroom dancing.

We talked to Dr. Weigert about her experience in the continually transforming field of breast imaging, her part in passing legislature in her home state of Connecticut and how the role of women has changed drastically in medicine.

What inspired you to be a radiologist?

I went to medical school in the late 1970s, when medicine still had quotas for women. Only about 20%

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of the class could be female. Most of us assumed we'd go into fields like pediatrics, OB-GYN or internal medicine. We didn't think about surgery or what was then the "esoteric" field of radiology. I originally planned to pursue OB-GYN and took several electives, including one in radiology. During that rotation, I realized I could see anatomy in three dimensions. Not everyone can do that. The radiologists would show us images, and I could immediately recognize the structures. Everyone else was asking, "What are you seeing?"

Looking back, I think a lot of that came from my upbringing. I was raised in a very artistic home. My father was a physician who also painted, and we spent a lot of time in art museums. To me, the human body is beautiful, inside and out. Radiology let me appreciate it in a truly unique way. Unlike most people at the time, I went directly into radiology. I did a rotating internship and was fortunate to be accepted to some of the top residencies. I chose Columbia, and it was the right fit; their radiology department was excellent, and the experience shaped the rest of my career.

How did you become a breast radiologist?

Back when I trained, "breast imaging" didn't really exist. But during my abdominal imaging fellowship, I started spending more time in gynecologic imaging and with early mammography, which was still developing in the early 1980s. At that time, mammograms were done on standard X-ray machines, often for women who already had a suspicious lump, as there was no screening yet.

After my training, I moved to Connecticut for my husband's job. It was very hard to find a radiology position, especially as a woman. Ironically, I was hired by a group opening a mammography center, mainly because I was a woman and they thought it would be good for public relations. Reverse discrimination? Maybe. But I took the opportunity and ran with it, and that's how I carved out a niche in breast imaging. I started teaching residents at the University of Connecticut once a month, hauling in my mammograms in a bag. They called me the "bag lady." Over time, I built a reputation as a women's imager, doing research, lecturing and growing the practice in ways no one else was really doing.

What was mammography like for women in the 1980s?

It was a very different world. Women typically came in because they felt a lump. Cancers were larger and often already metastatic. We didn't have minimally invasive biopsies; surgeons would remove large pieces of tissue. If the pathology came back as cancer, the woman would often wake up having had a mastectomy. Lumpectomies weren't a thing yet. We've come a long way, but even today, we still see too many advanced cancers. We all hoped we'd catch every cancer early – under 1 cm – but that's not always the case. Still, with the tools we have now, we can detect more cancers earlier than ever before.

What do you wish more women knew about breast health today?

That they have power and control over their health. I say this to patients all the time: “You know your body better than anyone. If something doesn’t feel right, don’t ignore it.” Even if it turns out to be nothing, that’s still a win. We’re also seeing a troubling trend, with more aggressive breast cancers in younger women. I’ve seen women in their 20s with invasive disease. Since screening usually starts at 40, these cancers are often only found because the patient noticed a lump. That’s why self-awareness and risk-based screening are so important.

Speaking of guideline, what should women understand beyond “get a mammogram at 40”?

Guidelines are just that – guidelines. If you have a first-degree relative with breast cancer, you should start screening 10 years earlier than their age at diagnosis. And now we have genetic risk models and tools to assess a woman’s lifetime risk. But I also remind patients: “Don’t say you’re not at risk just because you have no family history. If you have breasts, you’re at risk.”

What innovations have transformed breast imaging during your career?

When I started, mammograms were done on film and developed in dark rooms. Fast-forward to today, and we have:

- Digital mammography, which allows real-time manipulation of images.
- Tomosynthesis (3D mammography), which gives us millimeter-thin slices of breast tissue—like a CT scan of the breast.
- Advanced ultrasound, which can evaluate vascularity and tissue characteristics.
- MRI, now a powerful tool for high-risk women, with sequences that reveal solid vs. cystic lesions and vascular kinetics.
- Contrast-enhanced mammography and molecular imaging, which give us insight into metabolic activity—cancers are often hypermetabolic.
- AI, which helps us assess density, flag subtle findings and improve accuracy.

We’ve gone from “how did we even find cancers back then?” to having an array of incredible tools today. The challenge now is interpreting all that data responsibly and minimizing unnecessary biopsies while still catching early, aggressive cancers.

You played a role in passing Connecticut’s dense breast legislation. Can you tell us more about that?

In 2005, Connecticut passed a little-known law allowing ultrasounds for women with dense breasts, but no one was using it. Then a close colleague of mine was diagnosed with Stage III breast cancer shortly after receiving a “normal” mammogram. Her breasts were dense, and the mammogram had missed it. She became a tireless advocate. Together with the Connecticut Radiology Society, we

lobbied to make breast density reporting and supplemental screening the standard. In 2009, Governor Rell, herself a survivor, signed the first dense breast law in the U.S.

I also led some of the earliest studies on screening ultrasound, publishing papers that showed we could detect an additional 3–4 cancers per 1,000 women. That's huge. Now, 38 states have laws, and as of September 2024, every woman in the U.S. must be notified of her breast density on her mammogram results.

What's been the most meaningful part of working with patients?

It's the human part of radiology. When I can tell a woman, "This looks totally fine," and she hugs me in relief—it's amazing. When I have to tell a patient we need a biopsy, I'm honest and compassionate. I say, "I've been doing this long enough to know that when I don't know what something is, I need to find out." Then I lay out the plan. Patients appreciate that clarity.

You're now part of Jefferson Radiology and RP. How has that experience been?

What drew me to Jefferson Radiology was their subspecialty model, where I could focus on what I do best. The volume, the team and the technology elevated my skills. Honestly, it felt like a mini fellowship. I learned so much from my colleagues. Radiology has changed drastically over my career and so has the role of women in medicine.

As part of RP, I've gotten to participate in exciting national projects, like research on breast calcifications. That level of collaboration didn't happen in my smaller group before. I also appreciate RP's openness to innovation and the fact that they've created a platform for clinical voices like mine to be heard.

What honors have shaped your career?

In 2008, I became a Fellow of the American College of Radiology (FACR) an honor given to only 10% of radiologists, and even fewer women at the time. I was also appointed chair of the ACR Accreditation Committee for Mammography and continue to serve as a senior reviewer for MQSA.

In 2020, I was honored to become a Fellow of the Society of Breast Imaging (FSBI). Most SBI fellows are academics with dozens of publications. I've always been a clinician, a "closet academic." They actually adjusted the criteria to allow recognition of clinical excellence—and I was the first to be awarded through that path.

How do you spend your time outside of medicine?

I have five daughters—two of my own and three stepdaughters—and seven grandchildren. I'm not the

“babysitting grandma,” but I’m very involved. Some of my daughters now get mammograms, and I’m proud they take their health seriously—even if they sometimes forget to tell me!

Outside of family, I have two big passions: singing and competitive ballroom dancing. I’ve been dancing for 30 years. It’s great for my body and my brain and it forces me to let someone else lead, which isn’t easy for me! I also love history and genealogy. I come from a long line of scientists and physicians, including a Nobel Prize winner, in some ways, this path was always part of my DNA.

Dr. Jean Weigert earned her medical degree from State University of New York Upstate Medical Center, and she completed both her fellowship in abdominal imaging and residency in diagnostic radiology at Columbia-Presbyterian Medical Center.

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Rad to Rad Learning: False Negative in Dense Breast

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Mammographic sensitivity can drop to as low as 50% in extremely dense breasts (Category D), compared to nearly 90% in fatty breasts (Category A).

Top: Screening 2021, Bottom: Screening 2024

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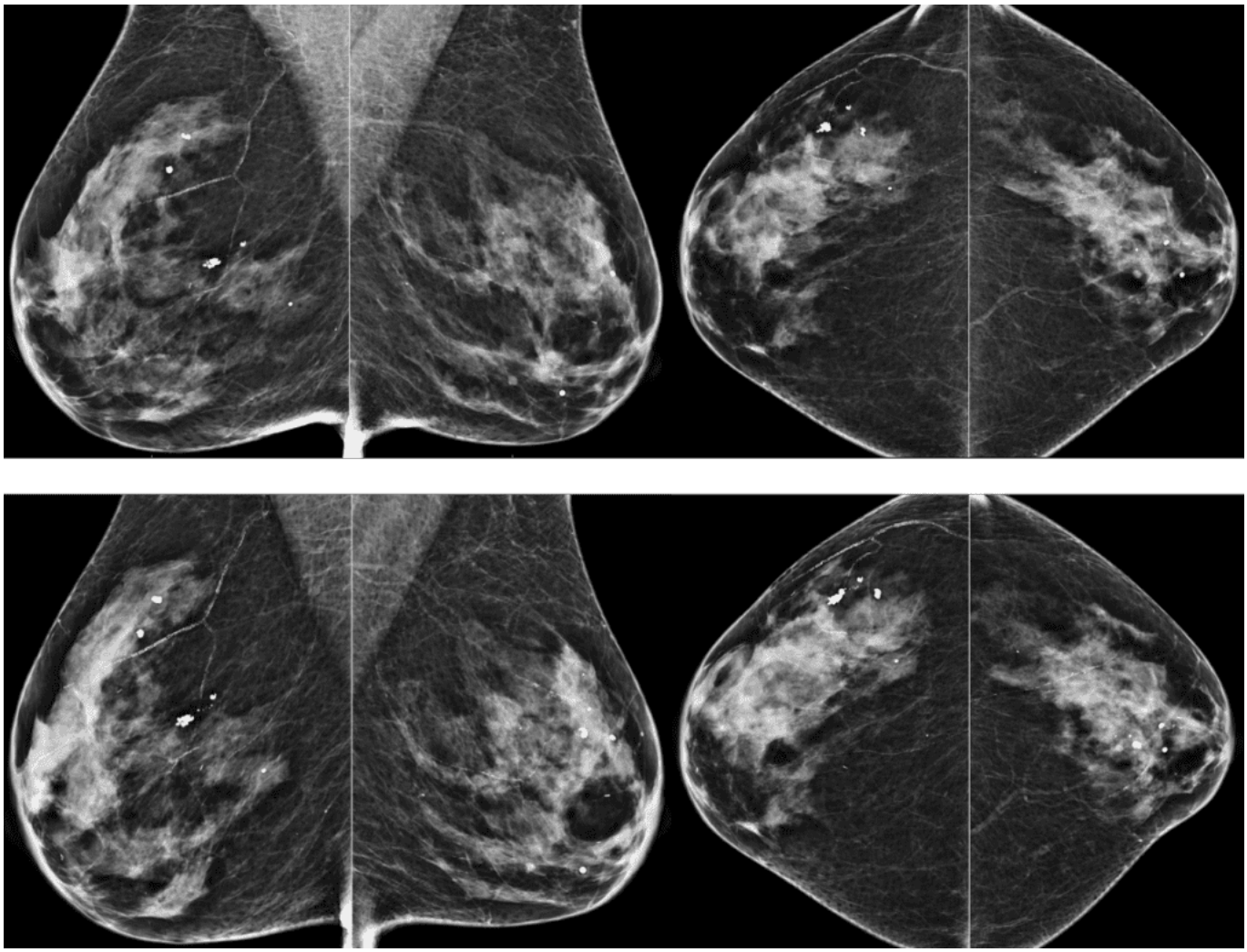

False Negative in Dense Breast

Cancers detected by supplemental screening whole-breast ultrasound are often invasive, however small and node negative, indicating they are found at an early, more treatable stage.

Post-biopsy reflector. Right breast, 7:00.

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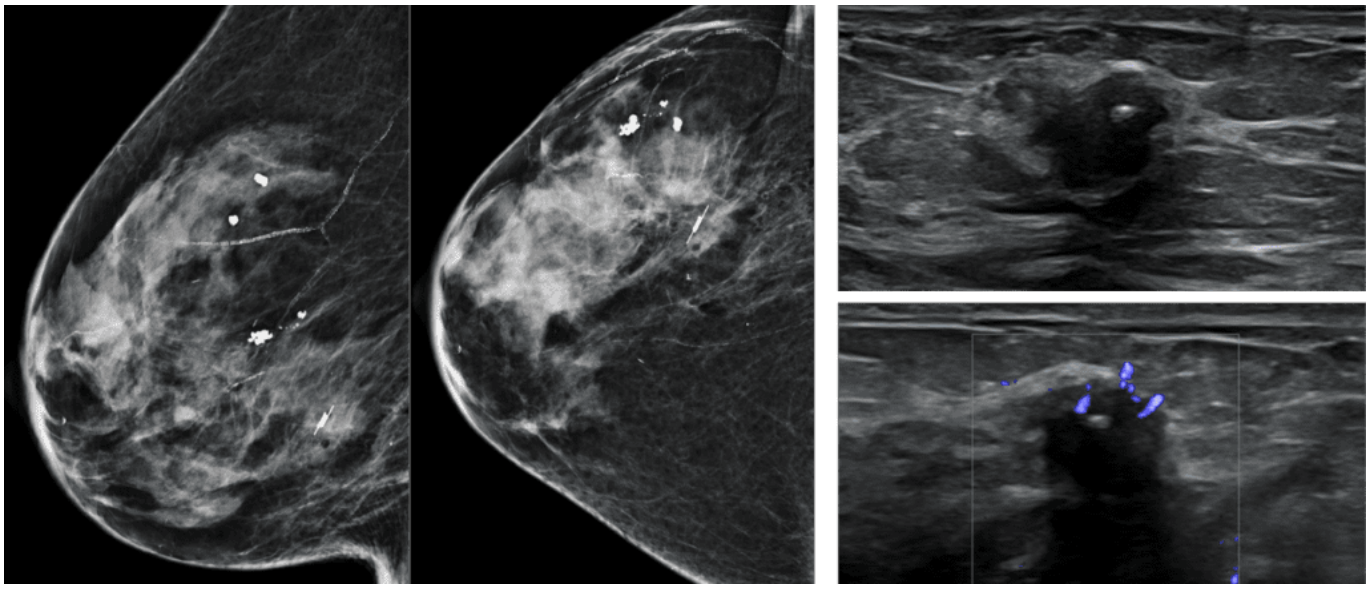

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Practical Insights

- **Breast density is an interdependent risk factor for breast cancer.**
- **Supplemental breast ultrasound can detect an additional 2-4 cancers per 1,000 women screened with dense breasts.**
- **Ultrasounds have a high false positive rate. The positive predictive value is 5-10% (compared to 25-40% for mammography).**
- **Women with dense breasts and other risk factors (e.g., strong family history, genetic mutations) may benefit most from supplemental MRI.**

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- **Contrast-enhanced mammography is a promising alternative for dense breasts.**

In dense breasts, US can find additional clinically significant cancers.

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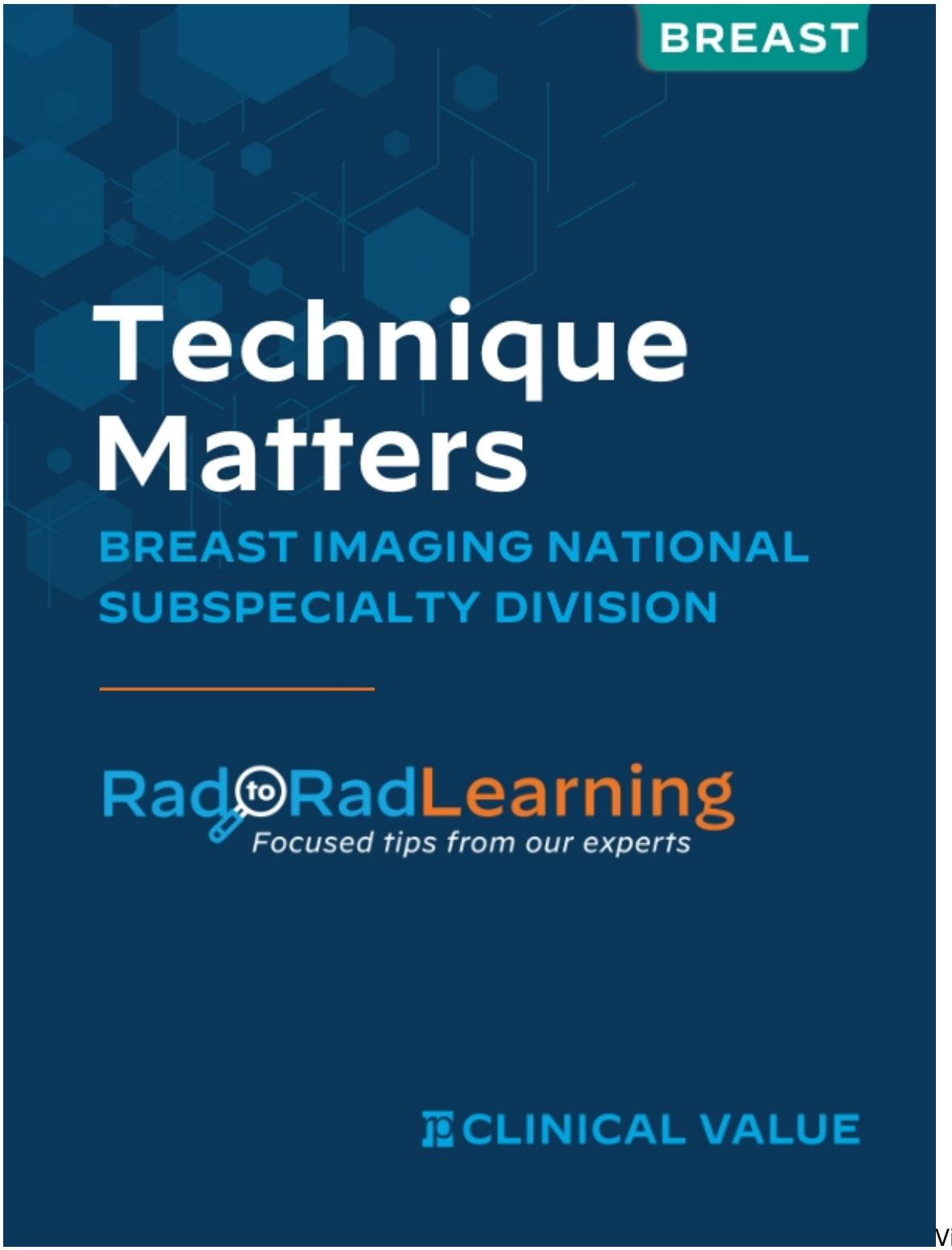

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