**Reviewer’s Comments**

## 

## A REVIEW OF BREAST CANCER RISK FACTORS

## ABSTRACT

## Breast cancer is a commonly diagnosed neoplastic ailment in females particularly near menopause. This ailment signifies a substantial health problem as it has influenced a large number of women. Several risk factors are associated with breast cancer that cannot be altered, but certain can be modified. The existence of risk factors of breast carcinoma does not mean that cancer is unavoidable; numerous females having risk factors not ever developed the disease. The risk factors aid in identifying the females who may get help at maximum from screening or other precautionary measures. It is noteworthy that breast carcinoma can also ensue in females with no recognizable risk factors. The augmented occurrence of breast cancer worldwide revealed by several epidemiological investigations indicates the need of aiming multidirectional investigations so as to ascertain risk factors linked with the incidence of this disease.

**Keywords: cancer,** breast cancer, incidence, occurrence, risk factors

INTRODUCTION

Breast carcinoma incidence has been amplified than before universally1. Its existence has been rising in Asia and it is also recognized as the most widespread malignancy in Asian women2. Breast carcinoma in Pakistan is on top in Asia after Israel and it is also 2.5 times greater than that in various neighboring states3.In Pakistan, this cancer is among the topmost 20 reasons of deceases4. Breast carcinoma risk factors have been investigated and acknowledged in numerous researches5,6. It is probable that females surviving to 85 years of age would have a 1 in 9 lifetime chance of attaining this cancer but the amount of risk is inconsistent through the populace since some persons would not ever develop breast carcinoma while others would be at augmented risk7. Breast cancer is often diagnosed in females around menopause thereby reducing their capability to function normally in daily life. Researches done since over the years revealed that 20-30% of new cases of breast cancer might be related to the manifestation of different risk factors that actively start or modify the course of breast cells neoplastic transformation e.g. age above 40 years, family history in first-degree members, early menarche and late childbirth (after the age of 35 years), etc8.Even though various factors augmenting the risk of breast cancer incidence have been recognized, yet no risk factor is found in 75-80% of females8.

RISK FACTORS

If the risk factors of breast carcinoma are present in an individual, it does not ascertain that cancer is unavoidable; numerous females with risk factors not ever attained breast cancer. However, the risk factors aid in identifying the females who can get help from screenings or further preventive processes. It is should also be remembered that breast carcinoma can also develop in females having no identifiable risk elements9.

Types of Risk Factors:

Various risk factors linked with breast cancer cannot be changed, but certain can be modified.  
1. Non-modifiable risk factors are intrinsic; all of them institute independent factors and do not go through simple alteration in a person's life10.The ACS11 includes non-modifiable risk factors for breast cancer e.g. gender, progressing age, genetic features, race, ethnicity, family history, dense breast tissue, certain benign breast conditions, previous chest radiations tobacco smoke, and exposure to diethylstilbestrol4.

2. Modifiable risk factors are extrinsic factors; they may modify neoplastic course to a certain level. If modifiable factors are identified then they may be helpful in developing prevention schemes thereby reducing breast cancer occurrence10.Lifestyle-related risk factors take account of the birth control, number of children given birth to, breastfeeding, hormone therapy, overweight or obesity, alcohol use and physical activity.

3. Controversial risk factors have uncertain, debatable or unconfirmed effect on the risk of attaining breast carcinoma i.e. diet and vitamin intake, induced abortions, chemicals in the environment, etc.11,4

Different risk factors of breast cancer are discussed as follows:

STANDARD RISK FACTORS:

1. Gender:

 Breast cancer is very common in females and is 100 times as compared to the males9.

1. Age:

It is the primary, strongest risk factor and is proportional to risk4i.e its relationship with breast carcinoma is stated to be slighter in youngsters but then it surges as the age is more than 40 years12.Also, if the females of < 65 years of age are related with females having 65 years of age or more, the relative risk of breast carcinomalinked with increasing age is reported to be 5.87.

1. Education and Socio-Economic Status:

These are considered as important aspects concerning the occurrence of breast cancer. Due to poorer education level and low SES, there are patients’ deferments to seek medical support from the healthcare centers13. Those females who are educated and have a relatively higher SES, get more into contact and avail healthcare services and hence are recognized to be linked with breast cancer14,15. This leads to reduction in mortality rates of breast cancer due to timely identification of the ailment and prompt commencement of its management16. It has also been reported that the females of higher socio-economic status with early menarche, late menopause and those who conceived in 30 years of age are at a greater risk of developing breast cancer17; also, women with more than 40 years of age with higher social class have greater risk18. As revealed in various investigations, this association is linked with the point that females in developed nations have on average lesser children, and also partial and infrequent period of breastfeeding19.Those women who have increasing age with middle class family background, greater body mass index and an increased ratio of incomplete pregnancies are at considerably greater risk of developing breast cancer4.

1. Race/ethnicity:

It is a very significant intrinsic element that raises the risk of breast cancer occurrence10. The degree of breast cancer is lesser in black females i.e.113 per 100,000; American Indians/Alaska inhabitants i.e. 92 per 100,000; Hispanic females i.e. 90 per 100,000; and it is lowermost in Asian Americans/Pacific Islanders i.e. 82 per 100,0009.Ban *et al*.20 examined the data incorporated in database of SEER (Surveillance, Epidemiology, and End Results) in his study, and found breast cancer occurrence in Caucasian females to be approximately 127.4 in 100 000 persons.

1. Weight:

Body mass index has been linked to an augmented risk of breast carcinoma chiefly in postmenopausal femlaes21,22 while a higher body mass index (BMI) is related to a diminished premenopausal breast cancer risk, though the process behind this relationship is unclear. Those women who are more active than others are at 15-20% decreased risk23.To study the association between BMI and breast cancer, 570,000 Norwegian females (aged 30 to 69 years) were enrolled and studied. The follow up was taken for 6 to 18 years regarding occurrence and consequences of breast cancer24.BMI was not observed as a risk factor forpre-menopausal breast cancer but in case of postmenopausal females, the relative risk of occurrence of breast cancer in the highest versus the lowest BMI quintile was 1.1 (in females from 55 to 59 years of age) , 1.18 (in females from 60 to 64 yearsof age) and 1.22 (in females aged 65 to 69 years).Furthermore, a number of researches propose that greater BMI is linked with greater insulin and insulin-like growth factors levels that are related to enhanced breast cancer risk25-27. This is of exceptional significance in peri- and postmenopausal females since body fat accumulation in such ages is generally abdominal, and abdominal obesity is intensely linked with hyper-insulinemia which is a breast cancer risk factor28.

1. Increased exposure of estrogen:
2. Benign breast disease — Women may develop abnormal breast abnormalities due to proliferative lesions i.e. excessive progression of the glandular breast tissue or may have growths in fibrous tissue, ductal amplification, or non-proliferative lesions i.e. cyst formations. Females with a history of proliferative breast lesions have an enhanced risk for breast cancer, principally if there is atypical hyperplasia9.
3. Breast density— Breast density is established as a strong and an independent risk factor of breast cancer29.Women whose mammograms show less dense breast have nearly 5 times lesser breast cancer risk. Estrogen-progestin treatment is linked with a rise in % mammographic density (% PMD) i.e. the proportion of the total breast area covered by dense tissue. Histo-pathological examination have revealed that widespread PMD is related to a larger number of cells and total nuclear area (inclusive of epithelial and non-epithelial cells) and an elevated quantity of collagen and glandular structures30leading to widespread percent mammographic density.
4. High bone density — Bone has estrogen receptors and is sensitive to levels of circulating estrogen. So, BMD (bone mineral density) is taken as a surrogate marker to circulating estrogen levels. Different studies instituted that females with a greater BMD have an enhanced breast cancer risk9.
5. Other hormonal elements:
6. Androgens — High testosterone levels in females are related to a greater breast cancer risk; some investigations proposed an enhanced risk for hormone receptor-positive ailment specially9.
7. Insulin — High levels of insulin and growth factors related to the insulin pathway may affect breast cancer risk9.
8. Menopausal hormonal therapy — If combined oral estrogen-progestin (specifically conjugated equine estrogens – CEE and medroxyprogesterone acetate – MPA)31is used on long term basis i.e. for 5 years or more in females from 50 to 79 years of age then it escalates a female's risk of breast cancer and also stroke, heart diseaseand clots in legs. The risk of breast carcinoma on use of only estrogen for a short time does not appear to be increased9.
9. Endogenous Hormones:  
   The presence of high levels of endogenous estrogen is a distinctive risk factor leading to a greater breast carcinoma incidence10.Post-menopausal females who have greater levels of testosterone and oestrogen are 2-3 times more at risk as compared to those having lower levels32. This was also confirmed by prospective studies that there is a substantial relationship amid higher concentrations of sex hormones (total estradiol, estrone sulfate,free estradiol, estrone, dehydroepiandrosterone, androstenedione,dehydroepiandrosterone sulfate and testosterone) in postmenopausal females and greater risk of breast cancer33. Also, levels of circulating estrogens and androgens have been noticed in large cohorts of participants to play a significant part in the occurrence of breast cancer in premenopausal females34,35. A reduced risk of breast carcinomawas reported due to enhanced insulin levels in females who did not take hormone replacement therapy; likewise, insulin-like growth factor 1 is linked with risk of breast cancer positively36.
10. Oral Contraceptive Pills:

Oral contraception (OC) as breast cancer risk is controversial10; there is an insignificant rise in the risk of breast carcinomaowing to the usage of oral contraceptives37. The risk is greater for attaining breast cancer when HRT (combination of estrogens and progesterone) is used by females for ≥15 years38 as compared to those who take oral contraceptives39. Hormonereplacement therapy, whether estrogen or estrogen plus progestin, is found to be related to an increased risk of breast cancer40,41.By the use of hormonal oral contraceptives, risk of breast cancer was observed to be increased by 24% than in those females who have never used them42; the biggest incidence increase being seen during the use of contraception. On the contrary, a reanalysis of various investigations revealed almost no link between oral contraception and breast cancer risk43. The inconsistencies among analyses might be linked with formulation changes of oral contraceptives; besides, various formulations of oral contraceptives might be related to various breast cancer risks. It has been instituted that the risk of breast carcinoma falls considerably 10 years subsequent to discontinuation of hormonal treatment; it is independent of the length of their use44. The non-triphasic levonorgestrelpreparations were not related to augmenting breast cancer risk45.

1. Reproductive factors:

Reproductive factors are also considered as risk for breast carcinoma.

1. Age at time of menarche and at menopause — in the mid 19th century, the average age of menarche in developed states was from 16-17 years to 12-13 years which was constantly linked with high breast cancer risk46. A woman undergoing menopause at age of 55 years would have 30% greater breast cancer risk than the one who gets it at age of 45 years47.Hence, both younger menarche age and maturemenopausal age enhance breast cancer risk. This is probable in a woman's lifespan owing to the extended general estrogen exposure9. It was observed by by Brinton et al. that females having menarche before 12 years of age had relative risk of 1.3 in lieu of invasive breast malignancy than those after 15 years of age48. [27](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1514477/#r27-7) The females not experiencing menopause up to 55 years of age or later, presented a relative risk = 1.22 than those who had it at less than 45 years of age48. Based on these findings, Vogel proposed that breast malignancy risk from such gynecologic variables is a function of number of ovulatory menstrual cycles that a female experiences through her lifespan49.
2. Pregnancy and breastfeeding — Nulliparous females are more at risk to attain breast cancer than those who have given birth many times; the younger a female is at her first full-term pregnancy, the lesser her breast cancer risk9. This association is mostly concerned with postmenopausal females with hormone dependent (ER positive) breast cancer42.It has also been established that as compared to nulliparous females, the women having children have 30% reduced risk; with each full-term pregnancy, the risk falls overall by 7%50. Breastfeeding has been noted to be a protective factor against attaining breast9 cancer- the lengthier the period, the more will be the safety. It is considered as an uncertain protective factor due to indecisive results but it is considered as a modifiable risk factor51.It was also established by the Brinton studies that breast cancer risk augmented for nulliparous female or if the first live birth at or after 30 years of age; relative risk for nulliparous female was 1.67 in comparison with one having first live birth at less than 20 years of age and the risk for the female was 2.23 with live birth at or after 30 years of age52,53. Moreover, not any protective outcome due to early gravidity was observed if it was not conceded to full term52,53. Cell differentiation in breast may be the reason during last part of a female’s first full-term gravidity followed by breast feeding.
3. Personal history of breast malignancy:

Previous history of malignancy in single breast leads to an augmented risk of cancer in the other9.There is a significantly greater risk for developing invasive breast cancer in those persons having a former account of invasive carcinoma, carcinoma in situ, or atypical breast hyperplasia. Most doctors have a preference to cope such cases with conservative therapy and close observation, while a small number of females at elevated risk may go for prophylactic mastectomy54-58.

1. Family history — is an intrinsic factor that increases breast cancer risk about double, chiefly in first-degree affected family member i.e. mother or sister. The risk further surges if two or more relatives are affected and also if the cancer is diagnosed below age of 50 years59.In general, < 10 % of all breast cancers are linked with inherited genetic mutations in one of two genes known as BRCA1 and BRCA29(breast cancer susceptibility 1 and 2) accomplishing the functioning of tumor suppressor genes in cells10.These two genes are established to be related to an inherited susceptibility to ovarian and breast cancers60.
2. Lifestyle characteristics:

Various modifiable risk factors linked with greater risk of breast cancer include:

1. Physical inactivity — is related to an enhanced breast cancer risk; physical exercise seems to be protective factor in both premenopausal and postmenopausal females though there is no direct confirmation9. More active females were reported to be at 15-20% reduced risk61.Further studies have demonstrated that regular physical activity (3-5 times a week) reduced 20-40% breast cancer risk, supported immunological system, improved health overall and also the quality of life62.
2. Smoking — particularly in premenopausal females, both passive and active tobacco smoking have been related to an enhanced breast cancer risk. This risk is connected with early start, extended period, and/or greater pack-years of smoking9.An in vitro study revealed that cigarette smoke initiated neoplastic changes in breast epithelial cells63. Due to partial combustion of organic materials, chemical agents causingcancer i.e. polycyclic aromatic hydrocarbons (PAHs) are formed. There is miscellany in structure and biological activity of PAHs, therefore, all PAHs cannot lead to same grade of cancer. The metabolites of PAH can be more toxic than the parent compounds64rather only a mild positive and substantiallink between second hand(passive) smoking and breast carcinoma risk was recognized68,69.
3. Diet:
4. Alcohol — Alcohol ingestion as little as 3 drinks a week has been related with a significant risk of breast cancer. The risk seems to rise with more alcohol ingestion and is additive with the usage of menopausal hormone treatment9.Several mechanisms have been suggested that might enhance breast cancer risk due to alcohol ingestion. These mechanisms range from stimulating the carcinogens’ metabolism such as acetaldehyde to declining DNA repair efficacy or decreasing consumption of protective nutrients49.In alcohol users, the level of sex hormones in the blood stream is more than in the non-users. More than 6% breast cancers have been found to be alcohol-linked in UK70.Breast cancer risk may rise by drinking even a minor quantity of alcohol since it influences the metabolism of estrogen in liver71.
5. Dietary habits — Studies have revealed conflicting results regarding the linkamid dietary patterns and risk of breast cancer4. There have been varying patterns of relation as risk for breast cancer due to use of dairy products. Cheese and milk are established to be linked with breast malignancy due to existence ofinsulin growth factor I and pesticides 72.
6. Intake of Dietary fat — An association has been seen in some researches between greater ingestion of dietary fat and breast cancer, even though the effect seems to be small on the whole9. There is convincing confirmation that high fat diet leads to obesity which is associated with breast cancer11. This may be an element stimulating the neoplastic transformation mechanism in breast cells73. This association leads to an augmented risk of breast cancer incidence deprived of overexpression of estrogen, progesterone or HER2 receptors, mainly observed in postmenopausal women in the period74. Saxe et al. also confirmed these observations75.
7. Red meat consumption — there may be an enhanced risk of hormone-positive breast cancer in premenopausal females if they consume more than 5 servings of red meat per week9.
8. Environmental factors:
9. Miscellaneous factors — There are certain compounds that are frail estrogens, very lipophilic, and having capability of persisting in body for ages i.e. organochlorines like dioxins, polychlorinated biphenyls and organochlorine pesticides like dichlorodiphenyltrichloroethane (DDT). However, their relation with breast cancer has not been significantly established9.

CONCLUSION:

Breast cancer has been established as a common malignancy among females globally. Major risk factors of breast cancer take account of age, family history, socio-economic status, BMI, age at menarche and menopause, use of hormonal therapy, alcohol use, smoking, etc. Positive full-term gravidities and lactation have found to be protective elements. In general, a healthy diet and lifestyle may diminish the risk of attaining this disease.The risk factors may foretell the probabilities of developing this disease to a certain level. Knowledge and research is required in different geographical zones from time to time about the susceptibility elements in the inhabitants in order to prevent or treat and decrease its occurrence since all the established risk factors of breast cancer are not applicable in every area of the world due to miscellany of various elements.

References:

1.Hery C, Ferlay J, Boniol M & Autier P. Changes in breast cancer incidence and mortality in middle-aged and elderly women in 28 countries with Caucasian majority populations. Annals of Oncology; 2008: 19: 1009-1018.

2.Kim H & Choi DH. Distribution of BRCA1 and BRCA2 Mutations in Asian Patients with Breast Cancer. Journal of breast cancer; 2013: 16: 357-365.

3.Shaukat U, Ismail M & Mehmood N. Epidemiology, major risk factors and genetic predisposition for breast cancer in the Pakistani population. Asian Pac J Cancer Prev;2013: 14: 5625-9.

4.R Tariq, S Huma, MZ. Butt, et al. Risk factors and prevalence of breast cancer� a review. J Pak Med Assoc; 2013:63: 1075-78.

5.Thomsen A & Kolesar JM. Chemoprevention of breast cancer. American Journal of Health-System Pharmacy;2008: 65: 2221-2228.

6.Lee SM, Park JH & Park HJ. Breast cancer risk factors in Korean women: a literature review. International nursing review;2008: 55: 355-359.

7.Eva Singletary. Rating the Risk Factors for Breast Cancer.[Ann Surg](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1514477/); 2003: 237: 474–482. doi:  [10.1097/01.SLA.0000059969.64262.87](https://dx.doi.org/10.1097%2F01.SLA.0000059969.64262.87).

8.Bucholc M, Lepecka-Klusek C, Pilewska A, et al. Ryzyko zachorowania na raka piersi w opinii kobiet. Ginekol Pol;2001:72:1460–1456. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/11883297)]

9.[Wendy Y Chen, MD, MPH](http://www.uptodate.com/contents/factors-that-modify-breast-cancer-risk-in-women-beyond-the-basics/contributors) ; [Section EditorDaniel F Hayes, MD](http://www.uptodate.com/contents/factors-that-modify-breast-cancer-risk-in-women-beyond-the-basics/contributors) ; [Deputy EditorSadhna R Vora, MD](http://www.uptodate.com/contents/factors-that-modify-breast-cancer-risk-in-women-beyond-the-basics/contributors). Patient information: Factors that modify breast cancer risk in women (Beyond the Basics). Literature review current through: Jul 2017. | This topic last updated: Aug 21, 2017.UpToDate.

10.[Marzena Kamińska](https://www.ncbi.nlm.nih.gov/pubmed/?term=Kami%26%23x00144%3Bska%20M%5BAuthor%5D&cauthor=true&cauthor_uid=26528110), [Tomasz Ciszewski](https://www.ncbi.nlm.nih.gov/pubmed/?term=Ciszewski%20T%5BAuthor%5D&cauthor=true&cauthor_uid=26528110), [Karolina Łopacka-Szatan](https://www.ncbi.nlm.nih.gov/pubmed/?term=%26%23x00141%3Bopacka-Szatan%20K%5BAuthor%5D&cauthor=true&cauthor_uid=26528110), [Paweł Miotła](https://www.ncbi.nlm.nih.gov/pubmed/?term=Miot%26%23x00142%3Ba%20P%5BAuthor%5D&cauthor=true&cauthor_uid=26528110), and [Elżbieta Starosławska](https://www.ncbi.nlm.nih.gov/pubmed/?term=Staros%26%23x00142%3Bawska%20E%5BAuthor%5D&cauthor=true&cauthor_uid=26528110). Breast cancer risk factors**.** [Prz Menopauzalny](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4612558/); 2015: 14: 196–202.

doi:  [10.5114/pm.2015.54346](https://dx.doi.org/10.5114%2Fpm.2015.54346)

11.American Cancer Society: Cancer facts and figures. 1992, Atlanta, American Cancer Society.  
12.Mcpherson K, Steel C & Dixon J. ABC of breast diseases: breast cancer—epidemiology, risk factors, and genetics. British Medical Journal;2000a: 321, 624.

13.Sharma K, Costa A, Shulman LN & meara JG. A systematic review of barriers to breast cancer care in developing countries resulting in delayed patient presentation. Journal of oncology; 2012.

14.Matson S, Andersson I, Berglund G, Janzon L& Manjer J. Nonattendance in mammographic screening: a study of intraurban differences in Malmo, Sweden, 1990-1994. Cancer detection and prevention; 2000: 25: 132-137.

15.Zackrisson S, Andersson I, Manjer J & Janzon L. Non‐attendance in breast cancer screening is associated with unfavourable socio‐economic circumstances and advanced carcinoma. International journal of cancer;2004: 108: 754-760.

16.Vona-Davis L. & Rose D. P. The influence of socioeconomic disparities on breast cancer tumor biology and prognosis: a review. Journal of Women's Health; 2009: 18: 883-893.

17. Paffenbarger RS, Kampert JB, Chang HG. Characteristics that predict risk of breast cancer before and after the menopause. Am J Epidemiol; 1980: 112: 258-68.  
18. Kreiger N. Social class and the black/white crossover in the age-specific incidence of breast cancer: a study linking census-derived data to population-based registry records. Am J Epidemiol; 1990: 131: 804-14.  
19. Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and breast feeding: collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50302 women with breast cancer and 96973 women without the disease. Lancet; 2002: 360: 187-95.  
20. Ban KA, Godellas CV. Epidemiology of breast cancer. Surg Oncol Clin N Am;2014: 23:409–422. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/24882341)]

21.Yoo KY, Tajima K, Park SK, Kang D, Kim SU, Hirose K, Takeuchi T & Miura S. Postmenopausal obesity as a breast cancer risk factor according to estrogen and progesterone receptor status (Japan). Cancer letters; 2001: 167: 57-63.

22.Yang XR, Sherman ME, Rimm DL, Lissowska J, Brinton LA, Peplonska B, Hewitt SM, Anderson WF, Szeszenia-Dąbrowska N & Bardin-Mikolajcza K A. Differences in risk factors for breast cancer molecular subtypes in a population-based study. Cancer Epidemiology Biomarkers & Prevention; 2007: 16: 439-443.

23. Monninkhof EM, Elias SG, Vlems FA, van der Tweel I, Schuit AJ, Voskuil DW, et al. Physical activity and breast cancer: a systematic review. Epidemiology 2007; 18: 137-57.  
24. Tretli S. Height and weight in relation to breast cancer morbidity and mortality. A prospective study of 570,000 women in Norway. Int J Cancer; 1989: 44: 23–30. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/2744893)]

25. Goodwin PJ, Ennis M, Pritchard KI, et al. Fasting insulin and outcome in early-stage breast cancer: results of a prospective cohort study. J Clin Oncol; 2002: 20: 42–51. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/11773152)]

26. Del Giudice ME, Fantus IG, Ezzat S, et al. Insulin and related factors in premenopausal breast cancer risk. Breast Cancer Res Treat; 1998: 47: 111–120. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/9497099)]

27. Suga K, Imai K, Eguchi H, et al. Molecular significance of excess body weight in postmenopausal breast cancer patients in relation to expression of insulin-like growth factor I receptor and insulin-like growth factor II genes. Jpn J Cancer Res; 2001: 92: 127–134. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/11223541)]

28. Stoll BA. Perimenopausal weight gain and progression of breast cancer precursors. Cancer Detect Prev; 1999: 23: 31–36. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/9892988" \t "pmc_ext)]

29. Tamimi RM, Byrne C, Colditz GA, Hankinson SE. Endogenous hormone levels, mammographic density, and subsequent risk of breast cancer in postmenopausal women. J Natl Cancer Inst; 2007: 99: 1178-87.  
30. Martin LJ, Minkin S, Boyd NF. Hormone therapy, mammographic density, and breast cancer risk. Maturitas;2009: 64:20–26. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/19709825" \t "pmc_ext)]

31. Prentice RL, Chlebowski RT, Stefanick ML, et al. Conjugated equine estrogens and breast cancer risk in the Women's Health Initiative clinical trial and observational study. Am J Epidemiol;2008:167:1407–1415. [[PMC free article](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2703736/)][[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/18448442)]

32. Key T, Appleby P, Barnes I, Reeves G, Endogenous Hormones and Breast Cancer Collaborative Group. Endogenous sex hormones and breast cancer in postmenopausal women: reanalysis of nine prospective studies. J Natl Cancer Inst; 2002: 94: 606-16.  
33. Key T, Appleby P, Barnes I, et al. Endogenous sex hormones and breast cancer in postmenopausal women: reanalysis of nine prospective studies. J Natl Cancer Inst;2002: 94:606–616. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/11959894" \t "pmc_ext)]

34. Eliassen AH, Missmer SA, Tworoger SS, et al. Endogenous steroid hormone concentrations and risk of breast cancer among premenopausal women. J Natl Cancer Inst;2006: 98:1406–1415. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/17018787" \t "pmc_ext)]

35. Kaaks R, Berrino F, Key T, et al. Serum sex steroids in premenopausal women and breast cancer risk within the European Prospective Investigation into Cancer and Nutrition (EPIC) J Natl Cancer Inst;2005: 97:755–765. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/15900045" \t "pmc_ext)]

36. Endogenous Hormones and Breast Cancer Collaborative Group, Key TJ, Appleby PN, Reeves GK, Roddam AW. Insulin-like growth factor 1 (IGF1), IGF binding protein 3 (IGFBP3), and breast cancer risk: pooled individual data analysis of 17 prospective studies. Lancet Oncol; 2010: 11: 530-42.  
37. Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and hormonal contraceptives: collaborative reanalysis of individual data on 53 297 women with breast cancer and 100 239 women without breast cancer from 54 epidemiological studies. Lancet; 1996: 347: 1713-27.

38.Borgquist S, Anagnostaki L, Jirström K, Landberg G& Manjer J. Breast tumours following combined hormone replacement therapy express favourable prognostic factors. International journal of cancer; 2007: 120: 2202-2207.

39.Mcpherson K, Steel C & Dixon J. ABC of breast diseases: breast cancer—epidemiology, risk factors, and genetics. BMJ: British Medical Journal; 2000a: 321, 624.

40.Colditz GA. Relationship between estrogen levels, use of hormone replacement therapy, and breast cancer. Journal of the National Cancer Institute; 1998: 90: 814-823.

41.Chlebowski RT, Chen Z, Anderson GL, Rohan T, Aragaki A, Lane D, Dolan NC, Paskett ED, Mctiernan A & Hubbell FA. Ethnicity and breast cancer: factors influencing differences in incidence and outcome. Journal of the National Cancer Institute; 2005: 97: 439-448.

42. Ban KA, Godellas CV. Epidemiology of breast cancer. Surg Oncol Clin N Am;2014: 23:409–422. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/24882341" \t "pmc_ext)]

43. Westhoff CL. Breast cancer risk: perception versus reality. Contraception;1999: 59(1 Suppl):25S–28. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/10342093" \t "pmc_ext)]

44. Marchbanks PA, McDonald JA, Wilson HG, et al. Oral contraceptives and the risk of breast cancer. N Engl J Med;2002: 346:2025–2032. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/12087137" \t "pmc_ext)]

45. Hunter DJ, Colditz GA, Hankinson SE, et al. Oral contraceptive use and breast cancer: a prospective study of young women. Cancer Epidemiol Biomarkers Prev;2010: 19:2496–2502. [[PMC free article](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3055790/)][[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/20802021)]

46. Tanner JM. Trend towards earlier menarche in London, Oslo, Copenhagen, Netherlands and Hungary. Nature; 1973: 243: 95-6.  
47. Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and hormone replacement therapy: collaborative reanalysis of data from 51 epidemiological studies of 52,705 women with breast cancer and 108,411 women without breast cancer. Lancet; 1997: 350: 1047-59.  
48. Brinton LA, Schaiere C, Hoover RN, et al. Menstrual factors and risk of breast cancer. Cancer Invest; 1988: 6: 145–154. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/3167610" \t "pmc_ext)]

49. Vogel VG. Breast cancer risk factors and preventive approaches to breast cancer. In: Kavanagh JJ, Singletary SE, Einhorn N, et al. (eds). Cancer in women. Malden, MA: Blackwell Science; 1998: 58–91.

50. Ewertz M., Duffy SW, Adami HO, Kvale G, Lund E, Meirik O, et al. Age at first birth, parity and risk of breast cancer: a meta-analysis of 8 studies from the Nordic countries. Int J Cancer; 1990: 46: 597-603.  
51. Tworoger SS, Eliassen AH, Sluss P, Hankinson SE. A prospective study of plasma prolactin concentrations and risk of premenopausal and postmenopausal breast cancer. J Clin Oncol; 2007: 25: 1482-8  
52. Brinton LA, Hoover R, Fraumeni JF Jr. Reproductive factors in the aetiology of breast cancer. Br J Cancer; 1983: 47: 757–762. [[PMC free article](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2011348/)][[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/6860545)]

53. Brinton LA, Hoover R, Fraumeni JF Jr. Epidemiology of minimal breast cancer. JAMA; 1983: 249: 483–487. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/6848848" \t "pmc_ext)]

54. Hankey BG, Curtis RE, Naughton MD, et al. A retrospective cohort analysis of second breast cancer risk for primary breast cancer patients with an assessment of the effect of radiation therapy. J Natl Cancer Inst; 1983: 70: 797–804. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/6573525" \t "pmc_ext)]

55. Rosen PP, Groshen S, Dinne DW, et al. Contralateral breast carcinoma: an assessment of risk and prognosis in stage I (T1N0M0) and stage II (T1N1M0) patients with 20-year follow-up. Surgery; 1989: 106: 904–910. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/2814824" \t "pmc_ext)]

56. Bellamy CO, McDonald C, Salter DM, et al. Noninvasive ductal carcinoma of the breast: the relevance of histologic categorization. Hum Pathol; 1993: 24: 16–23. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/8380275" \t "pmc_ext)]

57. Page DL, Dupont WD, Rogers LW, et al. Intraductal carcinoma of the breast: follow-up after biopsy only. Cancer; 1982: 49: 751–758. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/6275978" \t "pmc_ext)]

58. Dupont WD, Park FF, Hartmann WH, et al. Breast cancer risk associated with proliferative breast disease and atypical hyperplasia. Cancer; 1993: 71: 1258–1265. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/8435803)]

59. Pharoah PD, Day NE, Duffy S, Easton DF, Ponder BA. Family history and the risk of breast cancer: a systematic review and meta-analysis. Int J Cancer; 1997: 71: 800-9.  
60. Brody L, Biesecker BB. Breast cancer susceptibility genes: BRCA1 and BRCA2. Medicine; 1998: 77: 208–226. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/9653432" \t "pmc_ext)]

61. Monninkhof EM, Elias SG, Vlems FA, van der Tweel I, Schuit AJ, Voskuil DW, et al. Physical activity and breast cancer: a systematic review. Epidemiology; 2007: 18: 137-57.  
62. Lynch BM, Neilson HK, Friedenreich CM. Physical activity and breast cancer prevention. Recent Results Cancer Res;2011:186:13–42. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/21113759" \t "pmc_ext)]

63.Russo J, Tahin Q, Lareef MH, Hu YF & Russo IH. Neoplastic transformation of human breast epithelial cells by estrogens and chemical carcinogens. Environmental and molecular mutagenesis; 2002: 39: 254-263.

64.Strickland P &Kang D. Urinary 1-hydroxypyrene and other PAH metabolites as biomarkers of exposure to environmental PAH in air particulate matter. Toxicology letters; 1999: 108: 191-199.

65.Terry PD & Rohan TE. Cigarette Smoking and the Risk of Breast Cancer in Women A Review of the Literature. Cancer Epidemiology Biomarkers & Prevention; 2002: 11: 953-971.

66.Terrry PD & Goodman M. Is the association between cigarette smoking and breast cancer modified by genotype? A review of epidemiologic studies and meta-analysis. Cancer Epidemiology Biomarkers & Prevention; 2006: 15: 602-611.

67.Ambrosone CB, Kropp S, Yang J, Yao S, Shields PG & Chang-Claude J. Cigarette smoking, N-acetyltransferase 2 genotypes, and breast cancer risk: pooled analysis and meta-analysis. Cancer Epidemiology Biomarkers& Prevention; 2008: 17: 15-26.

68.Conway K, Edmiston SN, Cui L, Drouin SS, Pang J, He M, Tse CK, Geradts J, Dressler L & Liu ET. Prevalence and spectrum of p53 mutations associated with smoking in breast cancer. Cancer research; 2002: 62: 1987-1995.

69.Shantakumar S, Gammon MD, Eng SM, Sagiv SK, Gaudet MM, Teitelbaum SL, Britton JA, Terry MB, Paykin A & Young TL. Residential environmental exposures and other characteristics associated with detectable PAH-DNA adducts in peripheral mononuclear cells in a population-based sample of adult females. Journal of Exposure Science and Environmental Epidemiology; 2005: 15: 482-490.

70. Rinaldi S, Peeters PH, Bezemer ID, Dossus L, Biessy C, Sacerdote C, et al. Relationship of alcohol intake and sex steroid concentrations in blood in pre- and post-menopausal women: the European Prospective Investigation into Cancer and Nutrition. Cancer Causes Control; 2006: 17: 1033-43.

71. Bagnardi V, Rota M, Botteri E, et al. Light alcohol drinking and cancer: a meta-analysis. Ann Oncol;2013: 24:301–308. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/22910838" \t "pmc_ext)]

72.Moorman PG & Terry PD. Consumption of dairy products and the risk of breast cancer: a review of the literature. The American journal of clinical nutrition; 2004: 80: 5-14.

73. Konopka P. Poradnik dla pacjentów. Wrocław: MedPharm; 2009. Rak, układ odpornościowy a odżywianie.

74. Thiébaut AC, Kipnis V, Chang SC, et al. Dietary fat and postmenopausal invasive breast cancer in the National Institutes of Health-AARP Diet and Health Study cohort. J Natl Cancer Inst;2007: 99:451. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/17374835" \t "pmc_ext)]

75. Saxe GA, Rock CL, Wicha MS, et al. Diet and risk for breast cancer recurrence and survival. Breast Cancer Res Treat;1999: 53:241–253. [[PubMed](https://www.ncbi.nlm.nih.gov/pubmed/10369070)]