



Breast Cancer

Breast cancer is the most common cancer in women in the United States and second to lung cancer as cause of cancer deaths. The National Cancer Institute estimates that the risk of a woman developing breast cancer in her lifetime is 1 in 8 (*more than half of the lifetime risk is after age 65*). Some cancers are discovered when the woman finds a palpable mass in her breast. Other cases are diagnosed by screening mammography (*breast x-ray*). The diagnosis of breast cancer is made by biopsy.

Staging is done to determine the prognosis, to direct therapies, and for reporting results in treatment research studies. The staging system of the American Joint Committee on Cancer Staging uses TNM (tumor, node, metastasis) classification. The primary tumor is evaluated by size, involvement of other tissues, status node, and presence or absence of distant metastasis.

Non-invasive cancer (aka in-situ) has a better prognosis than invasive tumors. Tumor size is an independent prognostic factor. Each involved node worsens the prognosis. There is risk of recurrence if no treatment is given beyond excisional biopsy. The risk is less for DCIS (ductal cancer in-situ) than for (LCIS) lobular cancer in-situ.

For breast cancer, the mortality risk varies with the stage of the cancer.

Stage	Tumor Size	Lymph Node Involvement	Metastasis	Rating
0	in-situ	no	no	Tumor Table D
I	≤ 2 cm	no	no	age <45 at diagnosis PP 5 yrs then enter Tumor Table A, 6 th yr. age 45-65 at diagnosis use Tumor Table B age > 65 at diagnosis use Tumor Table D
II	> 2 cm ≤ 5 cm	no moveable axillary LN	no	some cases may be considered if size >2 cm but no LN or if size ≤ 2 cm and only 1-2 LNs involved
III	chestwall or skin involvement	fixed axillary LN or internal mammary LN	no	decline
IV	any size	yes/no	any distant metastasis	decline

Lifelong follow-up is required to detect recurrences which can occur as late as 30 years after the initial diagnosis of cancer.

This handout shows our malignant tumor rating schedule absent other significant health problems for individual policies. Other prognostic factors besides lymph node involvement and tumor size which can affect the underwriting rating include: adequate follow-up care, hormone receptor status, grade, vascular or lymphatic invasion, menopausal status and DNA ploidy.

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Malignant Tumor Rating Schedule

	A	B	C	D
Within 1st year	R	R	R	\$5x3
2nd year	R	R	\$7.50x5	\$5x2
3rd year	R	\$10x6	\$7.50x4	\$5x1
4th year	\$15x6	\$10x5	\$7.50x3	0
5th year	\$15x5	\$10x4	\$7.50x2	0
6th year	\$15x4	\$10x3	\$7.50x1	0
7th year	\$15x3	\$10x2	0	0
8th year	\$15x2	\$10x1	0	0
9th year	\$15x1	0	0	0

For example, Stage I breast cancer diagnosed in a woman age 60 who is now in the third year following treatment would be rated under Tumor Table B: \$10x6

To get an idea of how a client with a history of breast cancer would be viewed in the underwriting process, feel free to use the attached *Ask "Rx"pert underwriter* for an informal quote

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751 Broad Street, Newark, NJ 07102-3777
Rx025 IFS-A005004 Ed. 09/05 Exp. 03/07

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