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Correspondence

In response to Peshkin et al. "Genetic counseling and testing for hereditary cancer risk in young adult women: Facilitating autonomy and informed decision making is key"

Thank you to Professor Peshkin and colleagues for their thoughtful letter (Peshkin et al., 2015). They have provided a thorough outline for consideration of genetic testing of women ages 18–20. We completely agree that a one size fits all approach does not do justice to the particular needs of each individual. The specific gene, family history and the circumstances of each woman should be a factor. Some syndromes such as Lynch, Peutz Jeghers or ovarian small cell carcinoma can occur in younger women and testing may be appropriate at a younger age.

Our emphasis is on informed consent and that testing women for these genes should be offered in adulthood. We have used the recommendation of age of 21 as a time when women are transitioning to independent living and autonomy, and a time when the results would be delivered closer to an age where they will be actionable. Relevant management decisions in BRCA mutation carriers are unlikely to occur between age 18 and 21, but if these decisions were dependent on the knowledge of gene status then we would agree that testing would be appropriate. Such examples would be for prenatal diagnosis. We would presume that it is unlikely that an 18 year old would base a decision to use oral contraceptives on her gene status. Decisions regarding surveillance and risk reducing surgery for BRCA1 and BRCA2 are not recommended until age 25 unless in special circumstance of family history.

Studies on disclosing BRCA test results to adolescents suggest that communication is more robust in mothers who have received negative or uninformative results rather than positive results (Tercyak et al., 2013). Studies of psychological impact and distress caused by genetic testing have not looked at this young age group and we should be cautious not to extrapolate from studies of cohorts with the majority of women undergoing testing were over the age of 45 (Schwartz et al., 2002). The updated American Society of Clinical Oncology guidelines have emphasized informed consent over age (Robson et al., 2010). We agree that there is paucity of data on the impact of testing in very young women (ages 18–20) and in light of the lack of data, our intent was to recommend age 21 not as a strict cut off but as a reasonable age to consider testing given the lack of clinical relevance and impact of earlier testing.

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