Ethnic and age differences in right-left breast asymmetry in a large population-based screening population

Sue Hudson[1], Louise Wilkinson[2], Rachel Denholm[3], Bianca L De Stavola[4] ,

Isabel dos-Santos-Silva[1]

Author Details:

Sue Hudson, Department of Non-Communicable Disease Epidemiology, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK. (Corresponding author).

Susan.Hudson@lshtm.ac.uk

Louise S. Wilkinson, Oxford Breast Imaging Centre, Oxford University Hospitals NHS Foundation Trust, Oxford, UK

Louise.wilkinson1@ouh.nhs.uk

Rachel Denholm, Centre for Academic Primary Care, Bristol Medical School, University of Bristol, Bristol, UK.

r.denholm@bristol.ac.uk

Bianca L. De Stavola, Faculty of Pop Health Sciences, Institute of Child Health, University College London, UK.

b.destavola@ucl.ac.uk

Isabel dos-Santos-Silva, Department of Non-Communicable Disease Epidemiology, London School of Hygiene and Tropical Medicine, London, UK.

Isabel.Silva@lshtm.ac.uk

Author details

[1]Department of Non-Communicable Disease Epidemiology, London School of Hygiene and Tropical Medicine, London, UK. [2]Oxford Breast Imaging Centre, University of Oxford Hospitals NHS Foundation Trust, Oxford, UK, [3]Centre for Academic Primary Care, Bristol Medical School, University of Bristol, Bristol, UK. [4]Population, Policy and Practice Programme, Great Ormond Street Institute of Child Health, University College London, UK.

Authors' information

LSW was previously Director of the South West London Breast Screening Service, SWLBSS, UK

1 **ABSTRACT**

2 **Objectives:**

3 Exposure to sex hormones is important in the pathogenesis of breast cancer (BC) and inability to

4 tolerate such exposure may be reflected in increased asymmetrical growth of the breasts. This study

5 aims to characterise, for the first time, asymmetry in breast volume (BV) and radio-dense volume

6 (DV) in a large ethnically-diverse population.

7 **Methods:**

8 Automated measurements from digital raw mammographic images of 54,591 cancer-free

9 participants (aged 47-73) in a UK breast screening programme were used to calculate absolute (cm^3)

10 and relative asymmetry in BV and DV. Logistic regression models were fitted to assess asymmetry

11 associations with age and ethnicity.

12 **Results:**

13 BV and DV absolute asymmetry were positively correlated with the corresponding volumetric

14 dimension (BV or DV). BV absolute asymmetry increased, whilst DV absolute asymmetry decreased,

15 with increasing age (P-for-linear-trend<0.001 for both). Relative to Whites, Blacks had statistically

16 significantly higher, and Chinese lower, BV and DV absolute asymmetries. However, after adjustment

17 for the corresponding underlying volumetric dimension the age and ethnic differences were greatly

18 attenuated. Median relative (fluctuating) BV and DV asymmetry were 2.34% and 3.28% respectively.

19 **Conclusions:**

20 After adjusting for the relevant volumetric dimension (BV or DV), age and ethnic differences in

21 absolute breast asymmetry were largely resolved.

22 **Advances in knowledge:**

23   Previous small studies have reported breast asymmetry – BC associations. Automated

24   measurements of asymmetry allow the conduct of large-scale studies to further investigate these

25   associations.

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INTRODUCTION

Exposure to endogenous and exogenous sex hormones are recognized to be important in breast development and in the pathogenesis of breast cancer [1-5], with the effect of many reproductive factors on breast cancer risk, e.g. early age at menarche and late age at menopause, being mediated by circulating levels of these hormones [6].There is also some evidence that pre-natal exposure to high levels of sex hormones may increase the risk of breast cancer. Breast cancer risk is elevated in women who were exposed in utero to diethylstilboestrol (DES) given to their mothers to prevent pregnancy complications [7] and some studies have reported positive associations between breast cancer risk and birth size, pre-eclampsia and multiple births, all possible markers of raised, in-utero, exposure to oestrogens [8]. It is also thought that an individual's ability to tolerate exposure to oestrogens, particularly during periods of growth, may be reflected in a higher degree of homeostasis and thus bilateral symmetrical development of paired organs such as the breasts [9]. Increased 'fluctuating asymmetry', i.e. increased anthropometrical asymmetry in paired features, is a common response to increased stress during development [10] and is related to both fecundity and general health [11-14]. For example, studies of dermatoglyphics have shown that increased asymmetry in hand patterns is associated with increased risk of several diseases including breast cancer [15]. Also, women with high 2nd digit to 4th digit ratio (2D:4D) (thought to be associated with lower exposure or sensitivity to prenatal testosterone and/or higher levels in utero oestrogen levels) had increased risk of breast cancer [16] and they presented with breast cancer at a younger age [17, 18]. An association between left-handedness and increased risk of breast cancer has also been reported [19, 20]. Manning et al showed that increased breast FA was correlated not only with age, height and parenchymal type but also with reproductive factors such as parity, age at first birth and age at menopause [9].

Only a few small-sized studies, mainly among Caucasians, have so far examined the association between breast size asymmetry and breast cancer risk. Their findings are consistent with asymmetry being associated with the presence of a breast cancer [21-24] as well as with a higher risk of having a breast cancer diagnosed in the short- and medium-term (mean interval between mammography and diagnosis 6.44 years) [25]. Mammographic density captures the amount of radio-dense tissue in the breast, and there is also some evidence that asymmetry in density might be associated with higher short-term likelihood of being diagnosed with breast cancer [26-28]. It has also been suggested that a slightly larger left breast, with a higher volume of radio-dense tissue, may account for the slightly larger frequency of cancers in the left than the right breast although the mechanisms for this are poorly understood [29-31]. Overall, the findings from these studies suggest that asymmetry in breast size and density may reflect underlying biological mechanisms linked to the pathogenesis of breast cancer or may be early consequences of the presence of a tumour. Hence, asymmetry measurements have the potential to be used as risk predictors or diagnostic markers. To our knowledge there is, as yet, no large-scale study of the prevalence of breast volume asymmetry and breast density asymmetry from large population-based studies.

The recent introduction of full-field digital mammography (FFDM) has led to the development of automated algorithms which allow volumetric assessments of both breast size and mammographic density from 2-dimensional digital mammographic images. Such automated methods make it feasible to conduct large-scale studies based on objective measurements of bilateral asymmetry in breast size and mammographic density. This study aims to quantify bilateral asymmetry in breast

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71 size and mammographic density volume in a very large, and ethnically-diverse sample of over 54,000

72 women who participated in a population-based breast screening programme in England. The

73 findings will provide the first population-based data on the distribution of breast asymmetry, and

74 potential age and ethnic variations.

75 **METHODS**

76 **Study participants**

77 The study participants were women resident in one of five London boroughs – Wandsworth,

78 Merton, Croydon, Sutton, Richmond and Kingston – who underwent routine 3-yearly screening

79 mammography as part of the England and Wales National Health Service Breast Screening

80 Programme (NHSBSP) at the South West London Breast Screening Service (SWLBSS) based in the St

81 George's University Hospitals National Health Service (NHS) Foundation Trust. The NHSBSP is an

82 organised population-based mammographic screening programme, with a call-recall system, which

83 targets women aged 50-70 years and has a coverage of ~75% [32]. Also included were a small

84 number of younger women (aged 29-45) who had been identified as having a higher risk of breast

85 cancer and therefore were invited for screening on an annual basis [33], plus any women over 73

86 years who had optionally contacted the service for a self-referred screening appointment. All

87 women were asymptomatic at the time of screening. Participants were screened during the period

88 01/03/2013 to 18/08/2016. Data on ethnicity were collected as part of the standard screening

89 protocol via a self-completed screening questionnaire. Ethnicity was categorised according to the

90 Census classification and summarised as, "Asian" (Indian, Pakistani or Bangladeshi or other), "Black-

91 African", "Black-British or Caribbean or other", "Chinese", "Mixed" (White and Black, White and

92 Asian or any other mixed), "White" (British or Irish or other) and "Other" [34]. Data for other known

93 breast cancer risk factors (e.g. parity, duration of breast feeding, age at menarche, body mass index

94 (BMI), family-history of breast cancer) are not collected in a systematic way across the NHSBSP

95 screening programme and thus were unavailable.

96

97 Each woman underwent the NHSBSP standard 2-view (cranio-caudal (CC) and medio-lateral-oblique

98 views (MLO)) mammography of each breast [35], with the set of four digital raw images being stored

99 on the SWLBSS Picture Archiving and Communication system (PACS). The images were double read

100 with arbitration by consensus. When women had multiple screening episodes during the study

101 period, only images from the earliest screen episode were included in the analysis. Raw digital

102 mammographic images were processed via the automated algorithm Volpara® Density^{TM} version

103 1.5.11 (Volpara), (Matakina Technology Limited, Wellington, New Zealand) [36]; this algorithm

104 provided fully-automated estimates (in cm^3) of the volume of the breast (BV) and the volume of the

105 radio-dense tissue (DV) separately for each of the four (left (L) and right (R) breasts / CC and MLO

106 views) images. The screening programme does not use mammographic density as a diagnostic aid,

107 and participants are not informed on whether they have dense breasts.

108 In all, 66,176 women were screened during the study period. Women were excluded from this

109 analysis if cancer was detected by the current screen (N=530); if they had a previous history of

110 breast cancer (N=438); if their screen images were classified as "technical recall", i.e. were

111 considered by the reader not to be of high enough quality for diagnosis (N=26); if they had breast

112 implants; if their standard set of four images (i.e. L/R CC and MLO images) was incomplete

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113 (N=9,823); and if at least one of the two CC images was rejected by Volpara based on its internal

114 consistency checks (N=7,338). Exclusions were not mutually exclusive, leaving a total of 54,591

115 women who were eligible for inclusion in the analysis.

Ethical approval

117 This retrospective study was carried out on fully anonymous, routinely collected data only, held in

118 accordance with the NHS Cancer Screening Programmes Confidentiality and Disclosure Policy 2011.

119 The NHSBSP has section 251 support under the NHS Act 2006. The study was approved by all

120 relevant ethics committees (Research Ethics Committees from St George's University Hospitals NHS

121 Foundation Trust, and the London School of Hygiene and Tropical Medicine).

Statistical Methods

123 For each participant the volume of each breast (BV), and the volume of radio-dense tissue (DV), was

124 calculated as the average of the readings obtained from the same side CC and MLO images (i.e. CC

125 and MLO views were used to obtain an overall average). Both absolute and relative measures of left-

126 right asymmetry were calculated: *absolute* asymmetry (in cm^3), i.e. the unsigned difference between

127 left BV (or DV) and right BV (or DV), and *relative* asymmetry as $(|L-R|)/(L+R)/2$ expressed as a

128 percentage. Absolute and relative asymmetry were estimated from the CC images only because this

129 view is likely to capture the whole of the breast whilst being less affected than the MLO view by the

130 inclusion of variable amounts of retro-glandular fat tissue near the chest wall [36]. (For comparison

131 the equivalent asymmetry measures were also calculated using the MLO views only).

132 The distributions of absolute and relative asymmetry values were plotted. Natural-log

133 transformations were applied to normalise the distributions of absolute and relative BV and DV

134 asymmetry and quintiles were used to categorise BV and DV into five equally sized categories.

135 To examine whether age-related variations in breast volume and breast asymmetry differ across the

136 various ethnic groups, medians, 25th and 75th centiles of the distributions of untransformed BV, DV

137 and absolute asymmetry measures were also calculated and plotted separately by 5-year age

138 categories and ethnicity. These were also calculated for each single year of age and plotted after

139 smoothing using a Lowess function (values based on fewer than 20 observations were omitted from

140 the plots). Scatter plots and Spearman correlation coefficients were used to examine the

141 correlations between asymmetry measures and the corresponding volumetric dimension. In order to

142 assess whether allometry is a feature of this relationship (as identified by Manning et al [9]) we

143 regressed log of asymmetry on log of the corresponding volumetric measure.

144 Linear regression models were used to examine the strength of the associations between each

145 exposure variable – age and ethnicity – and the outcome variables, BV or DV absolute asymmetry,

146 controlling for their respective average volume (BV or DV). Because of the log-transformation,

147 regression coefficients represent the relative change (RC) in absolute asymmetry per one unit

148 change in the exposure category. In all the analyses, we considered statistical significance (2-sided)

149 at p-value<0.05. All analyses were conducted in Stata (IC 14) [37].

5

RESULTS

Study participants

The characteristics of the 54,591 participants are shown in Table 1. The majority (~87%) of women were within the ages of 50 to 70 years, the age-group targeted by the NHSBSP. Among the 85% of the participants who reported their ethnicity, ~76% were White but there were also high numbers of women of Black and Asian ethnicity.

Table 1 Characteristics of the study participants

| | No. | Percent | BV (cm³) [a] | DV (cm³) [a] | Median (25th and 75th centiles) | | | |
					BV Absolute CC Asymmetry [b] (cm³)	DV Absolute CC Asymmetry [b] (cm³)	BV Relative CC Asymmetry (%) [c]	DV Relative CC Asymmetry (%) [c]
Age at screening (yrs)								
<45-	234	0.4	563 (353, 950)	63.8 (47.4, 94.7)	56.7 (24.7, 105.6)	7.79 (3.86, 16.18)	2.87 (1.48, 4.56)	3.26 (1.87, 5.74)
45-49-	3,297	6.0	727 (450, 1135)	62.0 (45.4, 85.3)	57.5 (24.7, 112.8)	7.46 (3.39, 14.46)	2.42 (1.11, 4.06)	3.40 (1.62, 5.83)
50-54	15,40	28.2	762 (485, 1138)	54.3 (40.6, 75.5)	59.2 (25.8, 115.4)	6.45 (2.79, 12.69)	2.36 (1.12, 4.09)	3.33 (1.54, 5.87)
55-59	12,40	22.7	770 (498, 1148)	48.5 (36.6, 64.6)	61.8 (26.8, 120.4)	5.59 (2.45, 10.86)	2.43 (1.15, 4.21)	3.26 (1.53, 5.82)
60-64	10,44	19.1	767 (515, 1109)	46.1 (35.1, 61.0)	60.1 (26.9, 117.1)	5.21 (2.26, 10.24)	2.41 (1.14, 4.13)	3.18 (1.47, 5.65)
65-69	9,483	17.4	751 (506, 1063)	44.0 (33.9, 57.7)	62.5 (27.5, 120.9)	5.04 (2.19, 10.04)	2.50 (1.17, 4.33)	3.23 (1.47, 5.78)
70+	3,297	6.0	723 (499, 1014)	42.9 (33.5, 56.1)	63.6 (28.3, 118.9)	5.25 (2.27, 10.10)	2.66 (1.24, 4.52)	3.28 (1.52, 5.79)
Missing	27	0.1						
Ethnic group								
White - British, Irish, Other	35,44	64.9	747 (485, 1098)	47.9 (36.1, 64.9)	59.3 (25.8, 115.5)	5.60 (2.44, 11.13)	2.42 (1.13, 4.18)	3.30 (1.53, 5.84)
Asian [d]	4,829	8.9	718 (508, 1005)	44.8 (34.8, 59.6)	59.4 (27.2, 111.8)	5.02 (2.10, 9.91)	2.43 (1.19, 4.24)	3.17 (1.40, 5.52)
Black – British, Caribbean	2,705	5.0	956 (610, 1381)	58.3 (44.6, 77.8)	71.6 (31.1, 136.4)	6.59 (3.02, 12.17)	2.26 (1.04, 4.02)	3.17 (1.50, 5.49)
Black – African	1,999	3.7	960 (672, 1347)	56.0 (42.1, 74.0)	81.1 (35.7, 155.5)	6.39 (2.95, 12.65)	2.50 (1.20, 4.14)	3.23 (1.50, 5.64)
Mixed [e]	1,029	1.9	800 (535, 1176)	53.0 (39.4, 71.5)	64.5 (28.4, 124.5)	6.12 (2.71, 11.66)	2.36 (1.13, 4.21)	3.28 (1.50, 5.54)
Chinese	654	1.2	394 (258, 552)	41.0 (29.6, 60.7)	35.1 (16.2, 67.7)	5.03 (2.28, 9.67)	2.71 (1.38, 4.68)	3.38 (1.60, 6.52)
Missing or not reported	7,932	14.5	751 (499, 1121)	51.2 (38.5, 70.8)	61.6 (27.5, 119.5)	6.20 (2.71, 12.05)	2.48 (1.19, 4.21)	3.35 (1.56, 5.91)
All women	54,59		757 (496, 1112)	48.9 (36.8, 66.5)	60.6 (26.6, 117.8)	5.71 (2.49, 11.27)	2.43 (1.15, 4.19)	3.28 (1.52, 5.79)

Footnotes:

[a] Calculated from the average BV (or DV) value from the 4 images: left CC image, right CC image, left MLO image, right MLO image.

[b] Calculated as the absolute difference between the BV (or DV) value from the left CC image and the BV (or DV) value from the right CC image.

[c] Relative Asymmetry estimated as (|L-R|)/ (L+R)/2*100, where L and R are volumes from the left and right breasts estimates from the CC views.

[d] Asian includes: British Indian, Pakistani, Bangladeshi, Other Asian excluding Chinese

[e] Mixed includes: White and Black, White and Asian or any other mixed

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Breast volume, dense volume and absolute asymmetry by age and ethnicity

The median (25th, 75th centiles) BV and DV values for the whole study sample were 757 (496, 1112) cm^3 and 48.9 (36.8, 66.5) cm^3, respectively (Table 1). There was, however, evidence of bilateral asymmetry in BV and DV, with a median (25th, 75th centiles) absolute difference in BV and DV between the two breasts of 60.6 (26.6, 117.8) cm^3 and 5.71 (2.49, 11.27) cm^3, respectively, with the wide IQR indicating considerable between-woman variation in bilateral asymmetry (Table 1). This difference was seen in every age and ethnic group, albeit with some variations with the smallest median absolute differences seen among Chinese women.

The distributions of BV and DV absolute asymmetry estimates were right skewed and, hence, a log-normal transformation was used to normalise them (Figure 1). The transformed BV and DV asymmetry distributions approximated a normal distribution although both were leptokurtic (kurtosis coefficient: 5.60 and 4.76, respectively) and slightly skewed (skewness coefficient: -1.12 and -0.96, respectively).

Further analyses by age-group show that, on average, BV increased slightly with increasing age up to ages 55-59, declining thereafter (Figure 2). Ethnic variations in BV were much more marked than those observed with age (Figure 3), with BV being, on average, highest among Black Caribbean (median: 956 cm^3) and Black African (960 cm^3) women and lowest among Chinese women (394 cm^3) but with wide between-woman variability being present within each ethnic group. Absolute BV asymmetry showed similar age and ethnicity patterns to those observed for BV (Figures 2 and 3).

In contrast to BV, DV decreased, on average, with increasing age-group from <45 to 70+ years but, similarly to BV, DV was highest among Black Caribbean (median: 58.3 cm^3) and Black African women (56.0 cm^3) and lowest among Chinese women (41.0 cm^3). Absolute DV asymmetry followed a similar pattern to DV, i.e. lower values across successive age-groups, and higher among Black African and Black Caribbean women (Figures 2 and 3).

The observed absolute asymmetry in BV and DV reflected that fact that, on average, women had a larger left breast with a larger amount of radio-dense tissue. The only exception was that DV was higher in the right breast among Chinese women.

Figure 4, which depicts median single-year-of-age volumetric and asymmetry values by ethnicity, shows that age-related changes in BV varied across the different ethnic groups. Among Asian, Black African and White women, BV increased progressively up to age ~60 years but declined thereafter whilst among Black Caribbean women, BV continued to increase up to age 70 years. In contrast, DV decreased with age in all ethnic groups. There was, however, a marked levelling out after age ~55. BV and DV absolute asymmetry follow the same general pattern as their corresponding underlying volumetric dimension.

Relative asymmetry by age and ethnicity

The magnitude of relative BV asymmetry was similar across all age groups (median overall relative BV asymmetry for all study participants: 2.43% (25th, 75th centiles: (1.15%, 4.19%); Table 1) except that it was slightly higher in the youngest age band (median 2.87% (1.48%, 4.56%)). The magnitude of relative BV asymmetry was also similar irrespective of the ethnicity of the participants although slightly higher in the Chinese ethnic group (2.71% (1.38%, 4.68%)).

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202 The magnitude of relative DV asymmetry was similar across all age groups and ethnicities (median
203 overall relative DV asymmetry for all study participants: 3.28% (1.52%, 5.79%)). Overall age and
204 ethnic variations in relative BV and DV asymmetry were much less marked than those observed for
205 absolute BV asymmetry and absolute DV asymmetry (Figures 2 and 3).

Correlations between absolute asymmetry and volumetric measures

207 BV and DV absolute asymmetry were moderately positively associated with their corresponding
208 underlying volumetric measure (Spearman correlation coefficient (r): 0.45 and 0.43, respectively;
209 P<0.0001 for both). Regressing log BV asymmetry on log BV revealed negative allometry (coefficient:
210 0.84; 95% CI 0.83, 0.85)) whilst regressing log DV on log DV revealed slight positive allometry (1.09;
211 1.07, 1.12). There were no statistically significant differences in the magnitude of these allometry
212 coefficients across the different ethnic groups (data not shown).

Associations between absolute asymmetry and age and ethnicity

214 The fitted linear regression models showed that BV absolute asymmetry increased with increasing
215 age (in 5-year categories, P for trend (Pt)<0.001; Table 2), and that this trend persisted after
216 adjustment for BV (Pt<0.001). In contrast, DV absolute asymmetry decreased with increasing age
217 (Pt<0.001), but this trend was attenuated upon adjustment for DV (Pt=0.14; Table 2). Further
218 adjustment for ethnicity affected little the magnitude of the BV or DV absolute asymmetry
219 associations with age (Table 2).

220 When considering ethnicity on its own, relative to White women (reference group) those of Black
221 Caribbean, Black African and Mixed ethnicity had statistically significantly higher, whilst those of
222 Chinese ethnicity had statistically significant lower, BV absolute asymmetry (Table 2). However, upon
223 adjustment for BV the magnitude of these ethnic differentials was markedly reduced, remaining
224 statistically significant only in Black African women (RC 1.13; 95% CI 1.07, 1.19), while there was
225 borderline evidence of higher BV absolute asymmetry for Asian women (1.04; 1.00, 1.07; Table 2).
226 Similarly, and still relative to White women, DV absolute asymmetry was found to be significantly
227 higher among Black Caribbean and Black African women and significantly lower among Asian and
228 Chinese women in unadjusted analyses. However, these differences remained significant after,
229 adjustment for DV, only for Asian women (0.94; 0.91, 0.98; Table 2). There was no evidence of
230 interaction between age and ethnicity in their effects on BV or DV absolute symmetry (p=0.69 and
231 p=0.53, respectively).

DISCUSSION

Main findings

234 This study of >54,000 women clarifies the associations between absolute breast asymmetry and
235 breast volume, with the findings being broadly consistent with those from a smaller study (n=500
236 younger women) by Manning et al. which showed that simple linear regression of BV absolute
237 asymmetry (log transformed) on BV gives a significant positive association (our study r^2= 0.15,
238 p<0.001; Manning r^2 = 0.13, p<0.001) [9]. We also found that absolute DV asymmetry is strongly
239 positively associated with DV. Thus, the larger the volume of the breast (or the volume of the radio-
240 dense tissue) the higher the magnitude of BV (or DV) absolute asymmetry. This explained, at least in
241 part, the higher levels of BV and DV asymmetry observed in women of Black ancestry as they also

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242 had, on average, higher BV and DV. After adjusting for the relevant breast volumetric measure (i.e.
243 BV for BV asymmetry, DV for DV asymmetry), the ethnic differences in absolute breast asymmetry
244 observed in the unadjusted analysis were attenuated, indicating that they were largely driven by
245 ethnic differences in breast and dense tissue volumes.

246 Similar to the findings of Manning et al. [9], our findings showed that the BV absolute asymmetry/BV
247 relationship was negatively allometric across all main ethnic groups, indicating that women with
248 large breasts had a smaller fluctuating asymmetry than expected for their volume. There was,
249 however, evidence that the DV absolute asymmetry/DV relationship was positively allometric.

250 Like Manning et al. we found, using simple linear regression, that BV asymmetry is only weakly
251 positively associated with age (our study r^2= 0.004, p<0.001, Manning r^2=0.019, p=0.02) [9]. The
252 differences in the strength of the association might be explained by the fact that the women in our
253 study were considerably older than those in the study by Manning et al.[9] (mean ages 58.57 and
254 39.85 respectively). We found that DV absolute asymmetry is weakly but negatively associated with
255 age, with these associations being attenuated upon adjustment for DV, indicating that these
256 associations are largely driven by decreasing DV with age.

257 Two earlier studies, one in the USA (n=980) [38] and the other in Switzerland (n=87) [39], focused on
258 the left:right ratio (L:R) in BV. Although such L:R ratio cannot be regarded as a measure of relative
259 asymmetry, it is nevertheless worth noting that their findings are consistent with our finding that, on
260 average, the left BV exceed the right BV by ~4% across the whole breast screening population
261 irrespective of ethnicity and age. There was, however, marked between-woman variability in breast
262 asymmetry among cancer-free, screened women.

263 Literature on the prevalence of DV asymmetry is limited. Consistent with our findings Lee et al., in a
264 study of 860 South Korean women, found that the L:R ratio in DV was less than 1 indicating a greater
265 volume of radio-dense tissue in the right breast, thus challenging the view that the laterality of DV
266 ratio is similar across all ethnic groups. Chen et al. [40] on a small sample of 24 Taiwanese women
267 also found that DV, as measured by magnetic resonance imaging (MRI), was higher in the right than
268 in the left breast.

Strengths and limitations
270 Strengths of this study include its population-based design, the very large sample size relative to
271 previous studies, and the wide ethnic mix. As the images for both breasts were collected at the same
272 point in time, and under similar technical conditions, within-woman L:R breast comparisons are
273 unlikely to have been biased by anthropometric, reproductive and lifestyle characteristics (e.g. BMI,
274 menopausal status) or by differences in image acquisition (e.g. differences in mammographic
275 equipment) as these would have affected both breasts similarly. This does not exclude, however, the
276 possibility that the findings may have been affected by within-woman differences in the way the left
277 and right breasts were examined (e.g. differences in a woman's positioning during mammography).
278 The study relied on an automated method to estimate the volumes of the left and right breasts and
279 the amounts of their radio-dense tissues, and thus such objective measurements were not
280 influenced by subject or observer biases. Although the volumetric estimates were derived from 2-
281 dimensional images and, hence, may have been affected by errors, these would have affected both
282 breasts similarly.

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283 The study included mostly women of screening age and reflected a mix of ethnic groups living in
284 England. The proportion (15%) of women for whom ethnicity data were missing was relatively low
285 and typical for NHSBSP screening services where collection of self-reported ethnicity data is
286 undertaken [42]. Women with a previous history of breast cancer, or who were diagnosed with
287 cancer at the time of screening, as well as those with breasts implants, were excluded from the
288 study; however, women with other conditions that might have affected their breast size (e.g. surgery
289 for non-malignant conditions) could not be excluded as information on these conditions is not
290 routinely collected by the NHSBSP.

291 A limitation of this study was the lack of data on potential confounders or mediators (e.g. BMI,
292 reproductive history) of the age/ethnicity associations with BV and DV asymmetry. Menstrual cyclic
293 variations in breast width asymmetry (measured from CC mammograms) were reported by Manning
294 et al [43], based on mammograms from 280 premenopausal women, with lowest breast asymmetry
295 occurring around the middle of the cycle (which Scutt & Manning later attributed to ovulation [44]).
296 Although the present study was unable to consider cyclical changes in asymmetry as information on
297 the day of menstrual cycle when the mammogram was taken is not routinely collected by the
298 NSHBSP, the large majority of women screened by the NHSBSP are of postmenopausal age.
299 Nevertheless, future studies of pre-menopausal women should examine cyclic variations in
300 asymmetry and, in particular, whether such variations should be taken into account when assessing
301 asymmetry – breast cancer risk associations.

302 The study was conducted using one specific algorithm for estimating volumetric breast size and
303 volumetric density. There is no published data specifically on the reliability of asymmetry measures
304 derived from the Volpara volumetric measurements, but the latter have been found to be reliable
305 and repeatable [45-47]. Nevertheless, it would be worthwhile to assess breast asymmetry using
306 other automated methods. Our estimates of BV and DV asymmetry were derived from the CC views
307 of the left and right breasts; however, MLO views produced similar breast asymmetry estimates (e.g.
308 median (IQR) for BV and DV absolute asymmetry for all participants was 60.6 (26.6, 117.8) cm^3 and
309 5.71 (2.5, 11.3) cm^3, respectively, if derived from the CC views and 65.1 (28.7, 127.0) cm^3 and 7.2
310 (3.2, 14.1) cm^3, respectively, if derived from the MLO views). Similar associations of these measures
311 with age and ethnicity were also found (data not shown).

Implications

313 So far, only a few small, studies have examined the relation of breast asymmetry measures with
314 breast cancer. Scutt et al. used area-based mammographic breast size (BV) asymmetry
315 measurements from ~250 breast cancer cases and ~250 matched controls, while adjusting for known
316 risk factors and absolute breast size, to show that absolute BV asymmetry at baseline screen was
317 associated, with cancer diagnosis at the baseline screen [21] and also medium-term risk [22]. In a
318 preliminary study, Eltonsy et al. examined data from 280 breast cancer cases and 82 controls and
319 found that the mean absolute BV asymmetry, adjusting for BV, was significantly higher in cancer
320 patients [19]. Kayar et al. used non-mammographic breast measurements (from Grossman-
321 Rounder Discs) on 251 breast cancer cases and 466 controls from a Turkish outpatient clinic, to
322 propose a 'pathological breast asymmetry ratio', suggesting that a L:R BV ratio of >±20% was
323 associated with an increased risk of breast cancer being diagnosed within one year of the
324 examination [20].

11

325 Zheng et al. investigated the relationship between mammographic density percentage (%MD)
326 asymmetry and breast cancer using a bespoke algorithm on mammograms from 230 women with
327 interval cancers (cancers diagnosed between screens) and 230 controls and suggested that as
328 percent mammographic density (i.e. volume of radio-dense tissue measured as percent of the total
329 breast volume) asymmetry increases there was an increased risk of cancer at both current screen
330 and in the medium term (1-3 years). These models adjusted for subjective breast density category
331 (BIRADS), but not for absolute breast density [23, 24].

332 The limited available literature suggests that BV and DV asymmetry may have potential value as
333 markers of either the presence of a cancer (diagnostic marker) or the risk of developing cancer in the
334 future (risk predictor). Proper examination of the potential value of these breast asymmetry
335 measures as diagnostic or predictor markers will require the conduct of large-scale and longitudinal
336 studies with objective measurements of breast asymmetry.   Objective breast tissue asymmetry
337 estimates can now be obtained using existing fully-automated mammographic volumetric analysis
338 tools and thus can be provided, without additional investigations, for all women attending screening.
339 The availability of such data will facilitate further research into the association between asymmetry
340 and breast cancer, both at the current screen and subsequently, and may potentially provide a
341 practical additional tool for stratifying the screening population in terms of likelihood of having, or
342 risk of developing, breast cancer.

343 **LIST OF ABBREVIATIONS**
344 BV: breast volume; CC: cranio-caudal view; SWLBSS: South West London breast screening service;
345 DV: dense volume i.e. absolute volume of dense tissue; IMD Index of Multiple Deprivation; IQR:
346 Interquartile Range; MLO: mediolateral oblique mammogram view; %MD: percentage
347 mammographic breast density; MRI: magnetic resonance imaging; NHS: National Health Service;
348 NHSBSP: England and Wales NHS Breast Screening Programme; SD: standard deviation; Volpara:
349 Volpara density algorithm.

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14
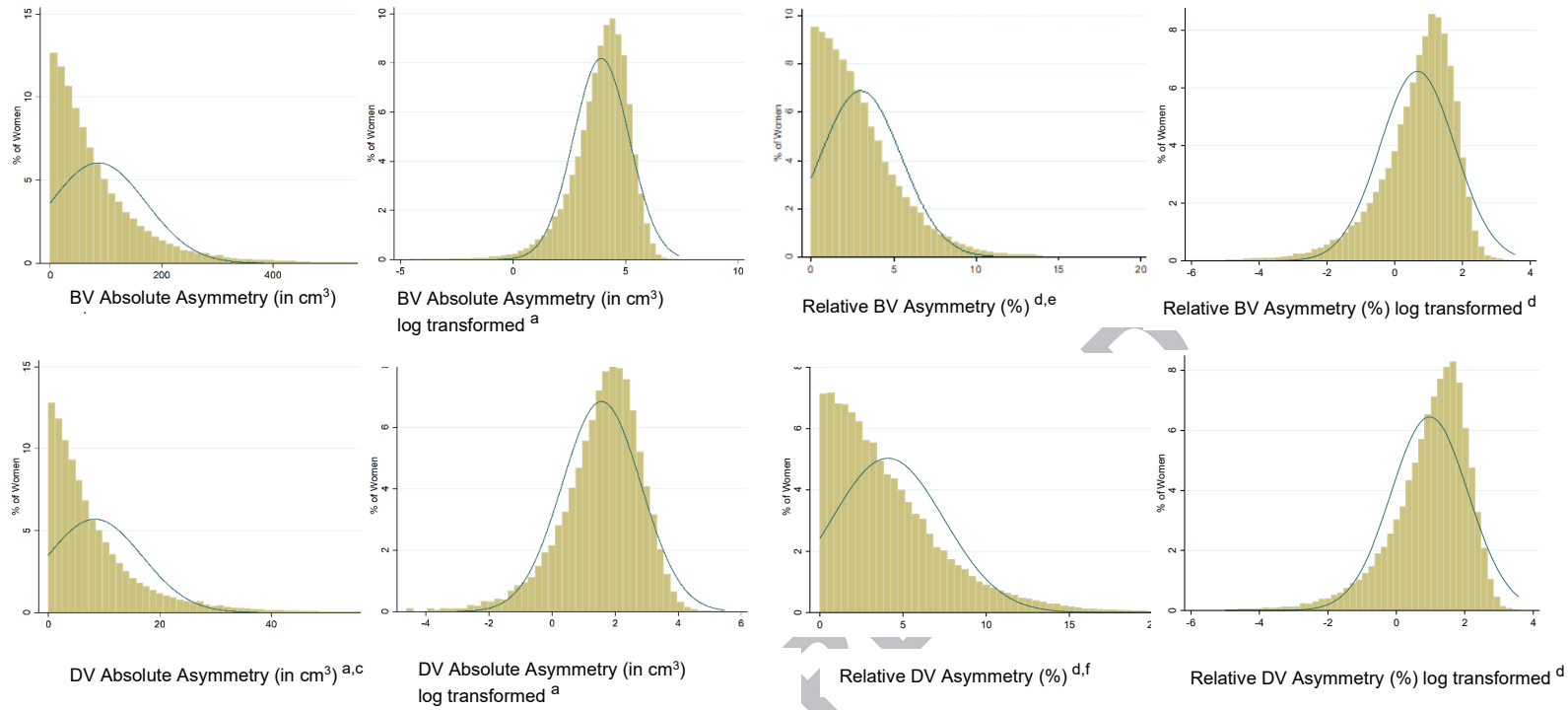
Figure 1

Figure 1 Distribution of breast tissue absolute and relative asymmetry measurements

Footnotes :

[a] Absolute asymmetry derived from absolute difference left and right CC views.

[b] Outliers where absolute BV asymmetry > 610cm^3 (10 *mean value) have been omitted to aid clarity (n=109)

[c] Outliers where absolute DV asymmetry > 57cm^3 (10 * mean value) have been omitted to aid clarity (n=252)

[d] Relative symmetry % derived from (|L-R|)/ (L+R)/2*100, where L and R represent the volumes of the left and right breasts as estimated from the CC views.
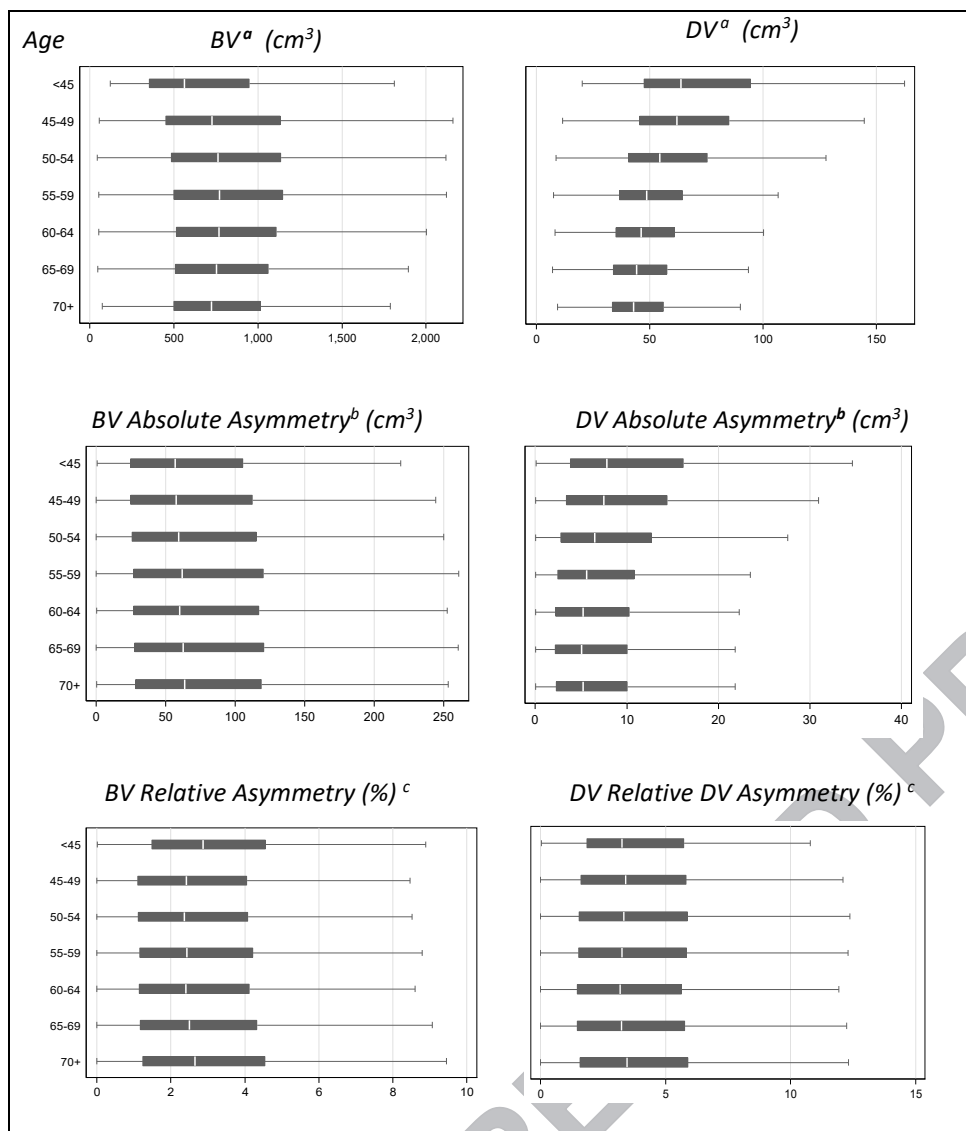
[e] Outliers where relative BV asymmetry > 20% have been omitted to aid clarity (n=51)

[f] Outliers where relative DV asymmetry >20% have been omitted to aid clarity (n=139)
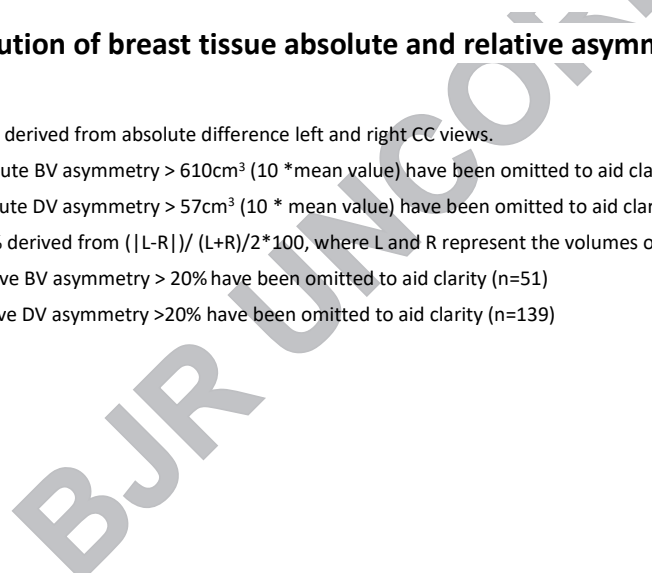
Figure 2

Figure 2 Breast tissue volumes and asymmetry measurements by age, medians and IQR
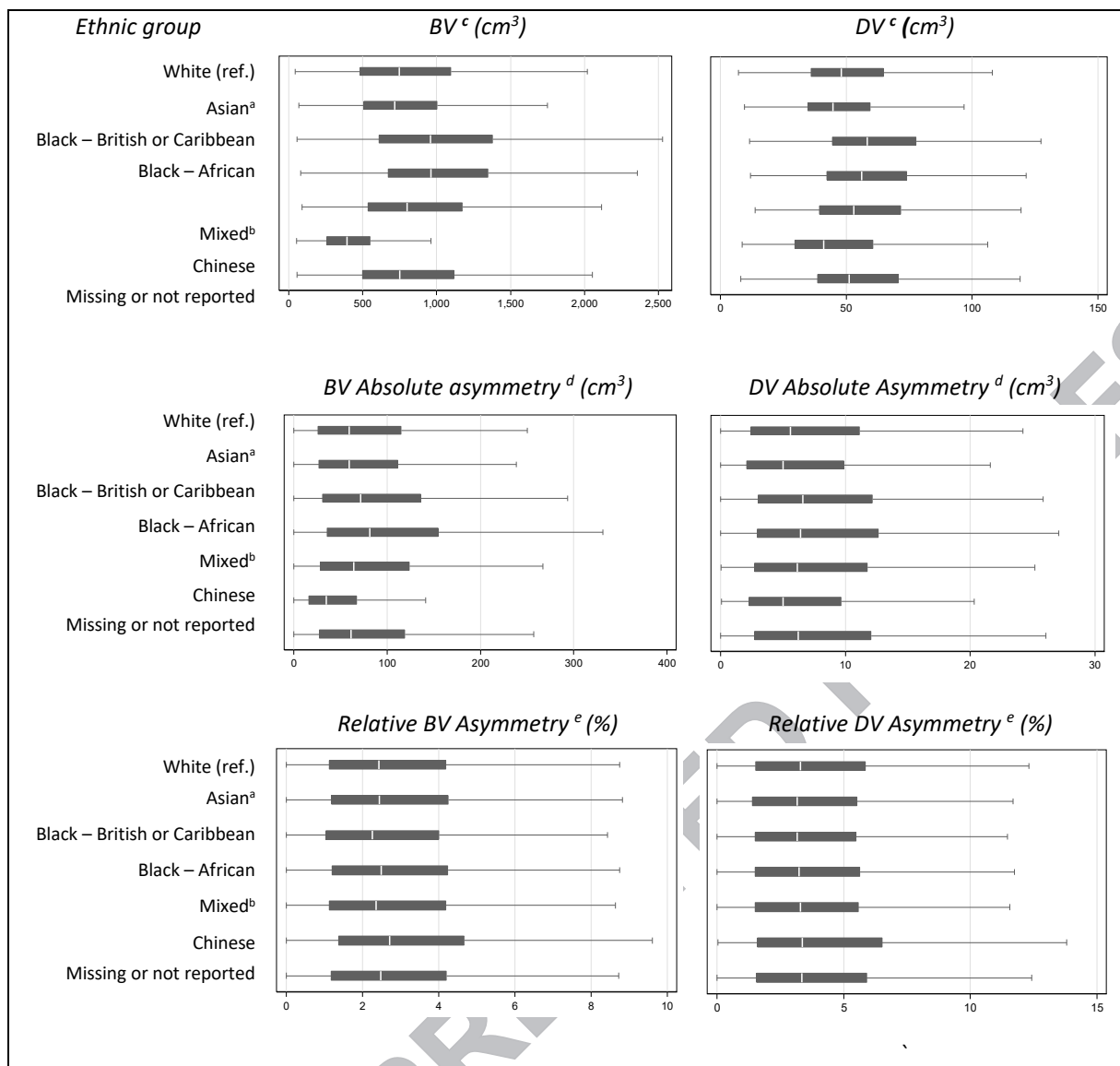
Footnotes :

[a] BV and DV are average values estimated from the 4 mammographic images: left CC image, right CC image, left MLO image, right MLO image.

[b] Absolute Asymmetry estimated from absolute difference between volume estimates derived from the left and right CC views.

[c] Relative Asymmetry estimated as $(|L-R|)/(L+R)/2*100$, where L and R are volume estimates derived from the left and right CC views.

Whiskers are calculated as lower adjacent value (i.e. smallest observed value >=lower quartile + 1.5 IQR) and upper adjacent value (i.e. largest observed value <=upper quartile + 1.5 IQR)

Figure 3

Figure 3 Breast tissue volumes and asymmetry measurements by ethnicity, medians and IQR

[a] Asian = British Indian, Pakistani, Bangladeshi or other Asian excluding Chinese

[b] Mixed = Mixed White and Black, White and Asian and any other Mixed.

[c] BV and DV are average values estimated from the 4 mammographic images: left CC image, right CC image, left MLO image, right MLO image.

[d] Absolute asymmetry estimated from absolute difference between volume estimates derived from the left and right CC views.

[e] Relative Asymmetry derived from (|L-R|)/ (L+R)/2*100, where L and R are volumes from Left and Right CC views.

Whiskers are calculated as lower adjacent value (i.e. smallest observed value >=lower quartile + 1.5 IQR) and upper adjacent value (i.e. largest observed value <=upper quartile + 1.5 IQR)
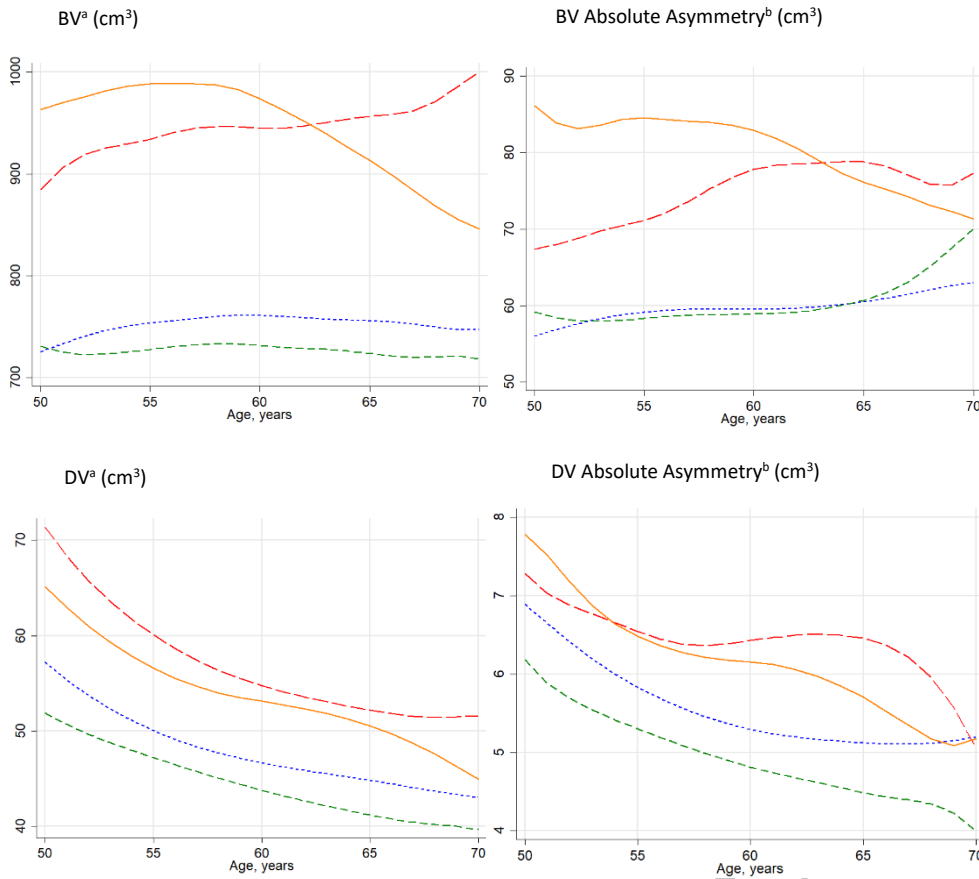
Figure 4

Figure 4 Breast composition and breast composition asymmetry by age and ethnicity.

Median volume, absolute asymmetry in cm^3 in each year band smoothed using Stata Lowess function

Footnotes :

[a] BV and DV are average values from the 4 images: left CC image, right CC image, left MLO image, right MLO image.

[b] Asymmetry derived from absolute difference Left and Right CC views.

Year group excluded if fewer than 20 observations in that age group

Asian = British Indian, Pakistani, Bangladeshi or other Asian excluding Chinese

Chinese ethnicity omitted due to sparsity of data in older women.

Ethnic Groups

- - - - - - White
- - - - Black Caribbean
- - - - - Asian
——— Black African

Table 2

Table 2. Linear Regression analysis of associations between BC risk factors and asymmetry measures

Variable	BV absolute asymmetry [a] (N=54,591)			DV absolute asymmetry [a] (N=54,591)		
	Unadjusted	Adjusted for BV[b]	Mutually-adjusted [c]	Unadjusted	Adjusted for DV [b]	Mutually-adjusted [c]
	RC (95% CI)	RC (95% CI)	RC (95% CI)	RC (95% CI)	RC (95% CI)	RC (95% CI)
BV / DV (per quintile)	1.41 (1.40, 1.42)		1.41 (1.40, 1.42)	1.40 (1.39, 141)		1.39 (1.38, 1.40)
	p<0.001		*<0.001*	*<0.001*		*<0.001*
	r^2 = 0.15			*r^2 = 0.14*		
Age[d] (years)						
<45	0.90 (0.76, 1.05)	1.07 (0.92, 1.24)	1.08 (0.93, 1.25)	1.32 (1.12, 1.55)	1.13 (0.97, 1.31)	1.13 (0.91, 1.31)
45-49	0.98 (0.94, 1.03)	1.01 (0.97,1.06)	1.01 (0.93, 1.06)	1.16 (1.10, 1.21)	1.04 (0.99,1.08)	1.03 (0.99,1.08)
50-54 (ref)	1.00	1.00	1.00	1.00	1.00	1.00
55-59	1.04 (1.01, 1.07)	1.03 (1.00,1.05)	1.03 (1.00,1.06)	0.87 (0.84, 0.89)	0.98 (0.95,1.00)	0.98 (0.95,1.01)
60-64	1.04 (1.01, 1.08)	1.03 (1.00,1.06)	1.04 (1.00,1.07)	0.80 (0.78, 0.83)	0.95 (0.93,0.98)	0.96 (0.93,0.99)
65-69	1.04 (1.01, 1.08)	1.06 (1.03,1.09)	1.06 (1.03,1.10)	0.78 (0.76, 0.81)	0.98 (0.05,1.00)	0.98 (0.95,1.01)
70+	1.08 (1.03, 1.13)	1.12 (1.08,1.17)	1.14 (1.09,1.19)	0.82 (0.79, 0.86)	1.05 (1.01,1.10)	1.05 (1.01,1.10)
P for homogeneity	*0.01*	*0.01*	*<0.001*	*<0.001*	*<0.001*	*<0.001*
P trend	*<0.001*	*<0.001*	*<0.001*	*<0.001*	*0.14*	0.20
	r^2=0.004			r^2=0.009		
Ethnicity						
White (ref.)	1	1	1	1	1	1
Asian[e]	1.01 (0.97, 1.05)	1.04 (1.00, 1.07)	1.04 (1.01, 1.08)	0.89 (0.85, 0.92)	0.94 (0.91, 0.98)	0.95 (0.91, 0.98)
Black – British/Caribbean	1.20 (1.14, 1.26)	1.00 (0.96,1.05)	1.01 (0.97, 1.06)	1.16(1.11, 1.22)	0.95 (0.91,1.00)	0.95 (0.91, 1.00)
Black – African	1.39 (1.31, 1.47)	1.13 (1.07,1.19)	1.14 (1.08,1.20)	1.14 (1.08,1.21)	0.98 (0.93,1.03)	0.98 (0.93, 1.03)
Mixed[f]	1.01 (1.02, 1.19)	1.04 (0.97,1.12)	1.04 (0.97,1.12)	1.05 (0.97, 1.14)	0.96 (0.89,1.03)	0.96 (0.89, 1.03)
Chinese	0.60 (0.55, 0.66)	0.94 (0.86,1.03)	0.95 (0.87, 1.04)	0.90 (0.81, 0.99)	1.01 (0.93,1.11)	1.02 (0.93, 1.11)
P for homogeneity	*<0.001*	*<0.01*	*<0.01*	*<0.001*	*0.54*	*0.55*

Footnotes:

[a] Absolute breast asymmetry measures are absolute CC asymmetry volumes log transformed.

[b] Adjusted associations: BV asymmetry adjusted by BV category, FG asymmetry by FGV category. Volumetric categories are quintiles of respective volumes.

[c] Mutually adjusted also adjusted for either Age or Ethnicity as appropriate.

[d] Age in 5-year age bands

[e] Asian = British Indian, Pakistani, Bangladeshi

[f] Mixed = mixed White and Black, White and Asian or any other mixed