

A practical guide to understanding cancer

WE ARE MACMILLAN. CANCER SUPPORT

UNDERSTANDING BREAST CANCER IN WOMEN



About this booklet

This booklet is about breast cancer in women. It is written for women who are having tests for breast cancer and women who have been diagnosed with breast cancer.

We hope it answers your questions and helps you deal with some of the feelings you may have. We can't advise you about the best treatment for you. This information can only come from your own doctor, who knows your full medical history.

This information is about breast cancer that has not spread to other parts of the body. Breast cancer that has spread to other parts of the body is called secondary breast cancer. We have a separate booklet **Understanding secondary breast cancer**.

Rarely, men get breast cancer. Our booklet **Understanding breast cancer in men** is about early and advanced breast cancer in men.

If you'd like to discuss this information, call the Macmillan Support Line free on **0808 808 00 00**, Monday–Friday, 9am–8pm. If you're hard of hearing, you can use textphone **0808 808 0121**, or Text Relay. For non-English speakers, interpreters are available. Alternatively, visit **macmillan.org.uk** At the end of this booklet are details of some other useful organisations (see pages 125–131).

We've included some quotes from women who have had breast cancer, which you might find helpful. They are from women who have chosen to share their story with us, including Rocio, who is on the cover of this booklet. Some names have been changed.

We have a video about breast cancer that you may find helpful. You can watch it at [macmillan.org.uk/livingwithbreastcancer](https://www.macmillan.org.uk/livingwithbreastcancer)

We also have an online community where people share their experience. Visit community.macmillan.org.uk

How to use this booklet

To help you find the information you need, we have divided this booklet into sections. This is because some information may not be relevant to you. It depends on the treatment you are having. You may also decide to leave some parts of the booklet and read them later, when you feel ready.

You may also like to make notes and think of questions to ask your doctor or nurse. You could use the space on pages 132–133 to do this.

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What is cancer?

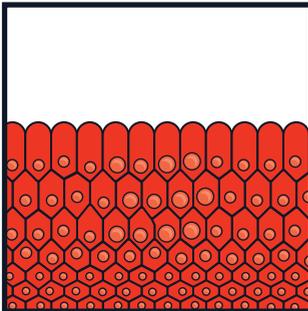
Cancer starts in cells in our body. Cells are tiny building blocks that make up the organs and tissues in our bodies. They divide to make new cells in a controlled way. This is how our bodies grow, heal and repair.

Cells receive signals from the body telling them when to divide and grow, and when to stop growing. When a cell is no longer needed or can't be repaired, it gets a signal to stop working and dies.

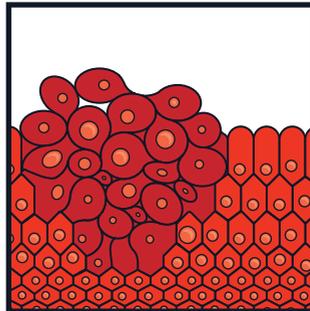
Cancer develops when the normal workings of a cell go wrong and the cell becomes abnormal. The abnormal cell keeps dividing, making more and more abnormal cells. These eventually form a lump (tumour).

Not all lumps are cancer. Doctors can tell if a lump is cancer by removing a small sample of tissue or cells from it. This is called a biopsy. The doctors examine the sample under a microscope to look for cancer cells.

Normal cells



Cells forming a tumour



A lump that is not cancer (benign) may grow but cannot spread to anywhere else in the body. It usually only causes problems if it puts pressure on nearby organs.

A lump that is cancer (malignant) can grow into nearby tissue. Sometimes, cancer cells spread from where the cancer first started (the primary site) to other parts of the body. They can travel through the blood or lymphatic system (see page 9).

When the cells reach another part of the body, they may begin to grow and form another tumour. This is called a secondary cancer or a metastasis.

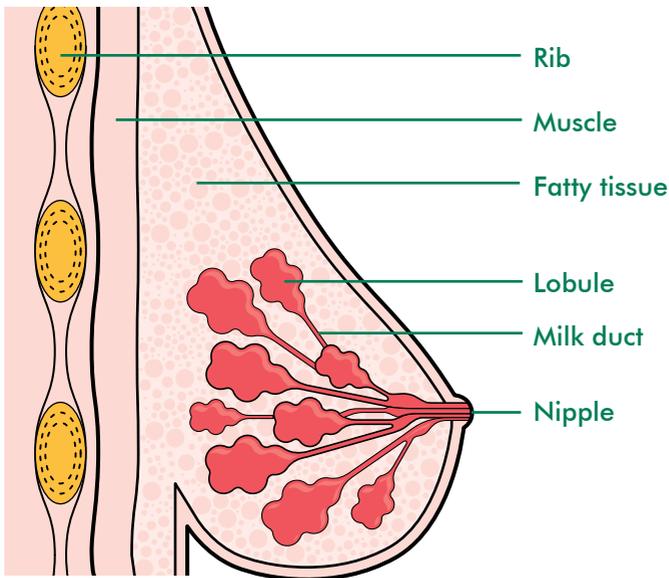
We have a video on our website that explains how cancer develops. You can watch it on our website at [macmillan.org.uk/information-and-support](https://www.macmillan.org.uk/information-and-support)

The breasts

Breasts are made up of fat, supportive (connective) tissue and glandular tissue containing lobes. The lobes (milk glands) are where breast milk is made. They connect to the nipple by a network of fine tubes called milk ducts.

It is common for a woman's breasts to be a different size or shape from each other. They also feel different at different times of the month. For example, just before a woman's period, her breasts may feel lumpy. As a woman gets older, her breasts may become smaller and feel softer.

Side view of the breast



The lymphatic system

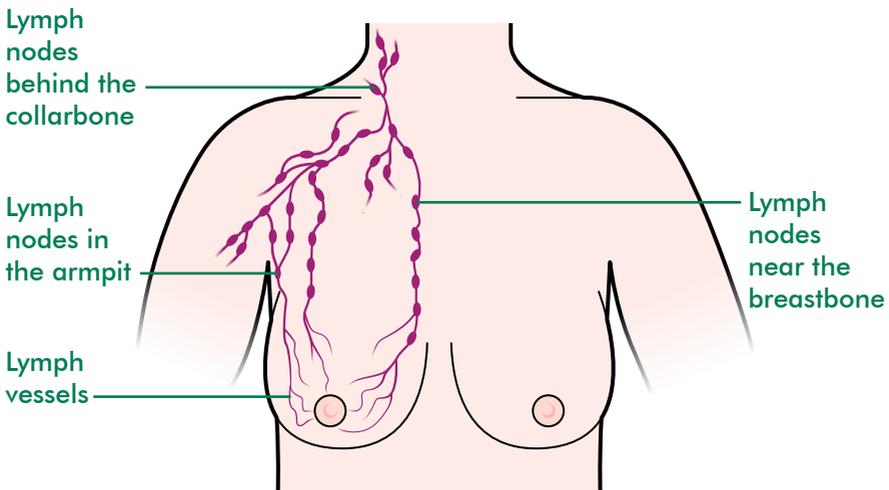
The lymphatic system helps to protect us from infection and disease. It is made up of fine tubes called lymphatic vessels. These connect to groups of bean-shaped lymph nodes (sometimes called lymph glands) all over the body.

The lymph nodes filter bacteria (germs) and disease from a liquid called lymph, which travels around the body in the blood.

Once the lymph is filtered, it is returned to the blood. If you have an infection, for example a sore throat, the lymph nodes close by often swell while they fight it.

Sometimes, cancer can spread through the lymphatic system. If the cancer cells spread outside the breast, they are most likely to go to lymph nodes in the armpit. You will usually have tests on the lymph nodes to look for cancer cells. There are also lymph nodes near the breastbone and behind the collarbone.

The lymph nodes near the breasts



Risk factors and causes

Each year, about 50,000 women are diagnosed with breast cancer in the UK. It is more common in women who are aged 50 and over, but it can also affect younger women. Improvements in treatment mean more women are surviving breast cancer

The exact cause of breast cancer is unknown. But certain things called risk factors can increase your chance of developing it. Having one or more risk factors doesn't mean you will definitely get cancer. Equally, if you don't have any risk factors, it doesn't mean you won't get breast cancer.

Breast cancer is likely to be caused by a combination of different risk factors, rather than just one.

Age

The strongest risk factor for breast cancer is increasing age. About 8 out of 10 (80%) women diagnosed are over the age of 50.

Breast cancer and some breast conditions

Your risk is increased if you have had breast cancer before. This includes ductal carcinoma in situ (see page 26). Having the following breast conditions can also increase your risk:

- **Lobular carcinoma in situ (LCIS)** – see page 26.
- **Atypical ductal hyperplasia** – there are slightly abnormal cells in the milk ducts in a small area of the breast.
- **Dense breast tissue** – when the breast is mostly made up of glandular and connective tissue and has very little fatty tissue.

Radiotherapy to the chest at a young age

Women who have had radiotherapy to the chest at an early age (for example to treat Hodgkin lymphoma) have an increased risk of breast cancer.

Hormonal factors

The female hormones oestrogen and progesterone can affect your breast cancer risk. Factors that can increase your risk include:

- Taking hormone replacement therapy (HRT) – particularly if you are taking combined HRT (oestrogen and progesterone). When you stop HRT, your risk reduces again.
- Not having children.
- Having children after the age of 30.
- Not breastfeeding your children, or breastfeeding for less than a year in total.
- Starting your periods early (under the age of 12) or having a late menopause (after the age of 50).
- Taking the contraceptive pill, although the risk reduces if you stop taking it.

Lifestyle factors

The following lifestyle factors may slightly increase your breast cancer risk:

Alcohol

Drinking alcohol increases your risk of developing breast cancer. But the risk is small for women who drink within the recommended guidelines.

Being overweight

The risk of breast cancer is higher in women who are overweight, particularly after the menopause. This is because it may change hormone levels in the body.

Smoking

Smoking may cause a slight increase in breast cancer risk. The younger you are when you start smoking and the longer you smoke for, the greater the risk.

Family history and risk

Most women who get breast cancer don't have a family history of it. If you have only one female relative diagnosed with breast cancer over the age of 40, your risk is unlikely to be very different from other women the same age as you.

But sometimes breast cancer can run in families. The chance of there being a family link is greater when:

- a number of family members have been diagnosed with breast cancer or related cancers, such as ovarian cancer
- the family members are closely related
- the family members were diagnosed at a younger age.

Less than 1 in 10 breast cancers are thought to be caused by a change (alteration) in a gene running through the family. In hereditary breast cancer, BRCA1 and BRCA2 are the two genes most often found to have change in them. Our leaflet **Are you worried about breast cancer?** explains more about family history and breast cancer. You may also be interested in our booklet **Cancer genetics – how cancer sometimes runs in families**. Call our cancer support specialists on **0808 808 00 00** or visit **be.macmillan.org.uk** to order a free copy.

Symptoms

Some of the signs and symptoms of breast cancer include:

- a lump in the breast
- a change in the size or shape of the breast
- dimpling of the skin or thickening in the breast tissue
- a nipple that's turned in (inverted)
- a rash (like eczema) on the nipple
- discharge from the nipple
- swelling or a lump in the armpit
- pain or discomfort in the breast that doesn't go away.

A lump in the breast is the most common symptom of breast cancer.

Most breast lumps are not cancer. They are usually fluid-filled lumps (cysts) or a fibroadenoma, made up of fibrous and glandular tissue.

But it is important to get anything that is unusual for you checked by your GP. The earlier breast cancer is treated, the more successful treatment is likely to be.

'I was aware of a lump in my breast, but at the time I had housing issues so I ignored it.'

Rocio





'I went to the hospital alone for an examination, but they did a biopsy on the same day. I didn't really stop and think that cancer could be the end result.'

Rocio

DIAGNOSING BREAST CANCER

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How breast cancer is diagnosed

You usually start by seeing your GP, who will examine you and refer you to a breast clinic to see a specialist. You should receive an appointment for the breast clinic within two weeks.

Some women are referred through national breast screening programmes because there are changes on their mammogram (see next page). Breast screening is a way of picking up breast cancer at an early stage when it's too small to be felt or seen.

Our booklet **Understanding breast screening** has more information. Call us on **0808 808 00 00** or visit **be.macmillan.org.uk** to order a free copy.

At the breast clinic

Most hospitals have a special breast clinic. At the clinic, you will see a specialist breast doctor. You may also see a breast care nurse or advanced nurse practitioner. They usually ask you if you have had any other breast problems and if anyone in your family has had breast cancer.

The doctor will examine your breast, and the lymph nodes in your armpits and around your neck. After this, they will explain the tests you need.

You may have all the tests on the same day, as well as the results. Although you might have to wait up to a week for some results. You may also need to come back to the hospital afterwards for further tests.

Mammogram

A mammogram (see below) is a low-dose x-ray of the breast. You will need to take off your top and bra for the mammogram.

The radiographer will position you so your breast is against the x-ray machine and gently but firmly compressed with a flat, clear, plastic plate. You'll have mammograms of each breast taken from different angles.

The breast tissue needs to be pressed down to keep the breast still and to get a clear picture. Most women find this uncomfortable, and for some women it's painful for a short time.



'For me it wasn't painful, just slightly uncomfortable. I was surprised because some people had said, "Ooh, it hurts".'

Norma

Mammograms to detect breast cancer are usually only used for women over the age of 35. In younger women, the breast tissue is more dense (has less fat), which makes it difficult to detect any changes on the mammogram. Women under 35 are usually offered an ultrasound of the breast.

But if you are under the age of 35 and are diagnosed with breast cancer, your specialist will arrange for you to have a mammogram.

Breast ultrasound

An ultrasound uses sound waves to build up a picture of the breast. It can show if a lump is solid (made of cells) or if it's a fluid-filled cyst.

You will be asked to take off your top and bra, and lie down on a couch, often with your arm above your head. The person doing the scan puts a gel on to your breast and moves a small hand-held device around the area. A picture of the inside of the breast shows up on a screen. An ultrasound only takes a few minutes and is painless.

Ultrasound of the lymph nodes

You will also have an ultrasound of the lymph nodes in the armpit. If any of the nodes feel swollen or look abnormal on the ultrasound, the doctor will take a biopsy (see next page) of the node or nodes.

Breast biopsy

This is when the doctor removes a small piece of tissue or a sample of cells from the lump or abnormal area. A pathologist (a doctor who specialises in studying cells) looks at the tissue or cells under a microscope to check for cancer cells.

There are different ways of taking a biopsy. Your doctor or nurse will explain the type you will have.

For a few days after the biopsy, your breast may feel sore and bruised. Taking painkillers and wearing a supportive bra will help with this. Any bruising will go away in a couple of weeks.

Needle (core) biopsy

This is the most common type of biopsy. It's a quick test where the doctor uses a needle to take small pieces of tissue from the lump or abnormal area. Before taking the biopsy, they inject some local anaesthetic into the area to numb it. You may feel uncomfortable and have a feeling of pressure for a short time during the biopsy.

Fine needle aspiration (FNA)

This is a quick, simple test. The doctor puts a very fine needle into the area and withdraws a sample of cells into a syringe.

The following tests aren't usually done at your first visit to the breast clinic. You usually have to go back to have them done.

Vacuum-assisted biopsy (VAB)

This is a way of taking needle biopsies using a vacuum-assisted method. The doctor gives you an injection of local anaesthetic into the skin to numb the area. They then make a small cut and put a needle through it into the breast. A mammogram or ultrasound picture helps them guide the needle to the right area. The doctor uses the vacuum to gently withdraw a piece of breast tissue into a small container. They can take several biopsies without needing to remove the needle and put it in again.

Excision biopsy

Occasionally, the doctor makes a cut in the skin of the breast and removes the lump or abnormal area. This is usually done under a general anaesthetic but can sometimes be done using local anaesthetic.

Usually, you have stitches that dissolve and don't need to be removed.

Wire localisation

Sometimes, an x-ray or ultrasound is used to guide a fine wire into the breast to mark exactly where the surgeon should take the biopsy. This is usually done when a mammogram or ultrasound shows an abnormal area, or when a lump is too small for the doctor to feel. The surgeon removes the wire when the excision biopsy is done.

Sometimes the surgeon leaves a tiny metal marker clip in place, which is permanent. The clip shows up in mammograms and marks the area where the biopsy was taken. This helps the surgeon find the exact area if you need to have more breast tissue removed later on. We have more information on this on page 45. The clip doesn't cause you any harm or discomfort.

Further tests

If the biopsy results show there are breast cancer cells, you may need more tests before you start treatment.

MRI (magnetic resonance imaging) scan

An MRI scan uses magnetism to build up cross-sectional pictures of your body. If you have invasive lobular cancer (see pages 26–27), it may be done to find out the size of the cancer and help doctors decide which operation you should have. The scan is painless and takes about 30 minutes.

The scanner is a powerful magnet, so you'll be asked to remove any metal belongings, including jewellery, before entering the scanning room. If you have any metal implants or have worked with metal or in the metal industry, tell your doctor.

Before the scan you may be given an injection of dye into a vein in your arm. This is called a contrast medium and can help the images from the scan to show up more clearly.

You'll be asked to lie very still on a couch, inside a metal cylinder. The scan is noisy, so you'll be given earplugs or headphones.

Blood tests

You'll have blood taken to check your general health and how well your kidneys and liver are working.

Waiting for test results

Waiting for test results can be a difficult time. You may find it helpful to talk with your partner, family or a close friend. Your specialist nurse or one of the organisations listed on pages 125–131 can also provide support. You can also talk things over with us on **0808 808 00 00**.

Other tests

Some women may have scans to check if the cancer has spread to other parts of the body. You may hear these referred to as staging scans.

Bone scan

This test shows up abnormal areas of bone. You have a small amount of radioactive substance injected into a vein. You will need to wait for 2 to 3 hours between having the injection and the scan. The scan may take an hour. Abnormal bone absorbs more radioactivity than normal bone and shows up on the scan pictures.

The amount of radioactive substance used is small. But you will be advised not to have close contact with pregnant women, babies and young children for up to 24 hours after the scan. After this, your body will have got rid of the radioactivity in your urine. If you are pregnant or breastfeeding, it's important to phone the scanning department before the test for advice.

If you are travelling through an airport in the days following your scan, you could take your appointment letter with you. Some airport scanners may detect the small amounts of radiation in your body.

CT (computerised tomography) scan

A CT scan takes a series of x-rays, which build up a three-dimensional picture of the inside of the body. The scan takes 10–30 minutes and is painless. It uses a small amount of radiation, which is very unlikely to harm you and will not harm anyone you come into contact with. You will be asked not to eat or drink for at least four hours before the scan.

You may be given a drink or injection of a dye, which allows particular areas to be seen more clearly. This may make you feel hot all over for a few minutes. It's important to let your doctor know if you are allergic to iodine or have asthma, because you could have a more serious reaction to the injection.

You'll probably be able to go home as soon as the scan is over.

Types of breast cancer

There are different types of breast cancer. Knowing the type you have allows your doctor to plan the best treatment for you.

Ductal carcinoma in situ (DCIS) is the earliest form of breast cancer and we have a separate booklet about DCIS. DCIS is when there are cancer cells in the ducts (see page 8) of the breast. But these cells are contained (in situ) and have not spread into normal breast tissue. DCIS may show on a mammogram and is usually diagnosed when women have breast screening.

Lobular carcinoma in situ (LCIS) is not breast cancer, although it's name can be misleading. There are changes in the cells lining the lobes (see page 8) that show a woman has an increased risk of developing breast cancer later in life. But most women with LCIS don't get breast cancer. They have regular check ups with breast examinations and mammograms. We have a fact sheet about LCIS that we can send you.

Invasive breast cancer

Invasive breast cancer means the cancer cells have spread outside the lining of the ducts or lobes into the surrounding breast tissue.

Invasive ductal breast cancer

Most invasive breast cancers (80%) start in the ducts of the breast.

Invasive lobular breast cancer

About 1 in 10 invasive breast cancers (10%) start in the lobes of the breast. This type can sometimes be difficult to diagnose on a mammogram because of the way it grows. Some women may need an MRI scan (see page 23).

Doctors test the cancer cells to decide which treatments are best for you. They look at whether the cells have receptors (proteins) for hormones like oestrogen or a protein called HER2 (HER2 positive breast cancer).

Breast cancer that has no receptors is called triple negative breast cancer. There is more information about receptors on pages 34–35.

Uncommon types of breast cancer

Inflammatory breast cancer

This is when cancer cells grow along and block the tiny channels (lymph vessels) in the skin of the breast. The breast then becomes inflamed and swollen.

Paget's disease of the breast

This shows as a red, scaly rash (like eczema) on the skin of the nipple. Women with Paget's disease may have DCIS or invasive breast cancer.

We have fact sheets about different types of breast cancer, including information about tubular breast cancer and malignant phyllodes tumour. If you have a type of breast cancer we haven't mentioned here, call the Macmillan Support Line on **0808 808 00 00**.



Staging

The stage of a cancer describes its size and if it has spread from where it started. This information affects the decisions you and your doctor make about your treatment. They won't know the exact stage of the cancer until after your operation and any scans you may have had.

TNM staging

The TNM staging system gives the complete stage of the cancer:

T describes the size of the tumour.

N describes whether the cancer has spread to the lymph nodes and which nodes are involved. For example, N0 is no lymph nodes affected. N1 means there are cancer cells in 1–3 of the lymph nodes.

M describes if the cancer has spread to another part of the body. For example, M0 means the cancer has not spread (metastasised) to other parts of the body.

The number stage

Breast cancer can also be divided into four number stages. We have put these into a table to make them easier to understand.

This booklet is about stage 1 to 3 breast cancer.

Stage 1 or 2 breast cancer is often called 'early breast cancer'.	
Stage 1	<ul style="list-style-type: none"> The cancer (lump) is 2cm or smaller and has not spread to the lymph nodes in the armpit.
Stage 2 is divided into two stages	
Stage 2A	<ul style="list-style-type: none"> The cancer is smaller than 2cm and has spread to the lymph nodes in the armpit. <p>or</p> <ul style="list-style-type: none"> The cancer is bigger than 2cm and has not spread to the lymph nodes. <p>or</p> <ul style="list-style-type: none"> The cancer can't be found in the breast but is in the lymph nodes close to the breast.
Stage 2B	<ul style="list-style-type: none"> The cancer is smaller than 5cm and has spread to the lymph nodes in the armpit. <p>or</p> <ul style="list-style-type: none"> The cancer is bigger than 5cm but has not spread to the lymph nodes.

Stage 3 is divided into three stages. Stage 3 breast cancer is sometimes called 'locally advanced' breast cancer.

Stage 3A	<ul style="list-style-type: none"> • The cancer can't be found in the breast but has spread to the lymph nodes in the armpit (which are found close together). <p>or</p> <ul style="list-style-type: none"> • The cancer is under 5cm and has spread to the lymph nodes in the armpit. <p>or</p> <ul style="list-style-type: none"> • The cancer is bigger than 5cm and has spread to the lymph nodes.
Stage 3B	<ul style="list-style-type: none"> • The cancer has spread to tissue near the breast. • It may be attached to skin or muscles and has usually spread to the lymph nodes in the armpit.
Stage 3C	<ul style="list-style-type: none"> • The cancer has spread to 10 or more lymph nodes: <ul style="list-style-type: none"> • in the armpit • or below the breast bone, near or under the collar bone.

Stage 4 breast cancer is also called 'secondary' or 'metastatic' breast cancer.

Stage 4	<ul style="list-style-type: none"> • The cancer has spread to other parts of the body such as the bones, liver or lungs.
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If you have stage 4 breast cancer, you may find our booklet **Understanding secondary breast cancer** helpful.

Grading

The grade of a cancer gives an idea of how quickly it might grow. The grade is decided based on what the cancer cells look like under a microscope compared with normal cells. Knowing the grade helps your doctor decide which other treatments you need after surgery.

Grade 1

The cancer cells look similar to normal cells (are well differentiated) and usually grow slowly. The cancer cells are less likely to spread.

Grade 2

The cancer cells look more abnormal and grow slightly faster than grade 1 cells.

Grade 3

The cancer cells look very different from normal cells (are poorly differentiated) and may grow faster than grade 1 or 2 cells.



Receptors

Breast cancer cells may have receptors (proteins) that hormones or other proteins can attach to and encourage the cancer to grow. A pathologist (see page 40) will test the cancer cells to find out if they have receptors and what type they are.

The results help you and your doctor to decide on the most effective treatment for you.

Hormone receptors

Breast cancers with receptors for the hormone oestrogen are called oestrogen-receptor positive (ER positive) breast cancer. About 70% of breast cancers are ER positive. Hormonal therapies (see pages 75–81) work well for ER positive breast cancer.

Oestrogen-receptor negative (ER negative) breast cancers don't have hormone receptors.

These receptors are called ER because the American spelling of oestrogen is estrogen.

Breast cancer cells may also have receptors for the hormone progesterone (PR). This may be called PR positive breast cancer.

Protein receptors

Some breast cancers have a high number of receptors for the protein HER2 (human epidermal growth factor 2). They are called HER2 positive breast cancers. About 1 in 7 women (15%) with early breast cancer have HER2 positive cancer. A drug called trastuzumab (Herceptin®) is an effective treatment for this type of breast cancer (see pages 82–83). We can send you a fact sheet about HER2 positive cancer.

Triple negative breast cancer

Cancer that does not have receptors for either HER2 or the hormones oestrogen and progesterone is called triple negative breast cancer. It affects up to 1 in 5 women (15 to 20%) with breast cancer and is more common in younger women. We can send you a fact sheet about triple negative breast cancer.



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Treatment overview

For most women, the first treatment for breast cancer is surgery to remove it. This is usually combined with additional treatments to reduce the risk of the cancer coming back. Treatment given after surgery is called adjuvant treatment. These treatments may include radiotherapy, hormonal therapy, chemotherapy and targeted therapy with a drug called trastuzumab (Herceptin®).

Sometimes doctors give treatments before surgery to shrink the cancer, making it easier to remove. This is called neo-adjuvant treatment.

Your doctor and breast care nurse will explain the treatments they think are best for you. They will ask about your preferences, explain the options available and can help you if you need to make decisions about treatment.

Surgery

Surgery is one of the main treatments for breast cancer. Your surgeon may advise you to have either one of the following operations:

- **Breast-conserving surgery** – an operation to remove the cancer and some surrounding normal breast tissue.
- A **mastectomy** – an operation to remove the whole breast.

With both operations, you will usually need some or all of the lymph nodes in your armpit removed. Some women also have breast reconstruction (see pages 46–47) at the same time as surgery. Reconstruction can also be done at a later time.

Adjuvant treatments

You are usually offered one or more of the following treatments after surgery to reduce the risk of the cancer coming back.

Radiotherapy

After breast-conserving surgery, your doctor will usually advise you to have radiotherapy (see pages 60–66) to the rest of the breast. This reduces the risk of the cancer coming back in that area. After a mastectomy, some women need radiotherapy to the chest.

Some women will need radiotherapy to the lymph nodes near the breast.

Chemotherapy

If the cancer is large, is in the lymph nodes or is grade 3, your doctor will usually talk to you about having chemotherapy (see page 67–75). Women with triple negative or HER2 positive breast cancer are also likely to have chemotherapy.

Hormonal therapy

If the cancer is oestrogen-receptor positive, your doctor will ask you to take hormonal therapy for a number of years (see pages 76–81).

Targeted therapy

If you have HER2 positive breast cancer, you will usually have treatment with trastuzumab (see pages 82–83) and chemotherapy.

Research into breast cancer is going on all the time. Better treatments mean more women are cured or living for longer. Your breast specialist may ask you if you would like to take part in a clinical trial. You can read more about this on pages 84–85.

How treatment is planned

A team of specialists will meet to discuss and decide on the best treatment for you. This multidisciplinary team (MDT) will include:

- a surgeon, who specialises in breast surgery and may also specialise in breast reconstruction
- a plastic surgeon, who specialises in breast reconstruction
- an oncologist (cancer specialist), who specialises in chemotherapy, radiotherapy, hormonal therapy and targeted therapy
- a specialist breast care nurse, who gives information and support
- a radiologist, who specialises in x-rays and scans
- a pathologist, who specialises in studying tissue samples and cells.

It may also include other healthcare professionals, such as a research nurse, physiotherapist, psychologist, social worker or counsellor.

Your cancer team looks at different factors to help decide which treatments are likely to work best for you.

These include:

- the stage and grade of the cancer
- if the cancer cells have hormone (oestrogen) receptors or HER2 receptors.

They will also assess the chance of your cancer coming back when planning how much treatment to offer you.

After the MDT meeting, your cancer specialist or specialist nurse will talk to you about the best treatment for you.

Specialist doctors or nurses may sometimes use an online tool such as PREDICT or Adjuvant! Online. These can help to show how much some treatments may reduce the risk of the cancer coming back. You might find this helpful, especially if your doctor has asked you to make a decision about whether to have chemotherapy.

Gene expression tests

A test called Oncotype DX can give more information about the risk of early breast cancer coming back. The National Institute for Health and Care Excellence (NICE) has recommended Oncotype DX for women with ER positive cancer that hasn't spread to the lymph nodes. The results can help women and their doctors make a more informed decision about whether or not to have chemotherapy after surgery. If the results show a low risk of the cancer coming back, it means you can avoid unnecessary chemotherapy and side effects.

NICE guidance only covers England and Wales. If you live in Scotland or Northern Ireland, your cancer specialist will be able to tell you if this test is likely to be available. NICE recommends that other gene expression tests called MammaPrint, IHC4 and Mammostrat are still only used in research trials.

Ask your cancer specialist or specialist nurse if you would benefit from this test. Oncotype DX may be covered by some private health insurance companies.

Fertility

Some treatments for breast cancer can affect your fertility. This may be temporary but for some women it can be permanent. Before treatment starts, your doctors and nurses will talk to you about this. If any of the treatments you are having could affect your fertility, they will explain what may be done to help preserve it. We have more information about fertility on page 92.

Giving your consent

Before you have any treatment, your doctor will explain its aims. They will ask you to sign a form saying that you give permission (consent) for the hospital staff to give you the treatment.

No medical treatment can be given without your consent.

Before you are asked to sign the form, you should be given full information about:

- the type and extent of the treatment
- its advantages and disadvantages
- any significant risks or side effects
- any other treatments that may be available.

If you don't understand what you've been told, let the staff know straight away, so they can explain again. Some cancer treatments are complex, so it's not unusual to need repeated explanations.

It's a good idea to have a relative or friend with you when the treatment is explained, to help you remember the discussion.

You may also find it useful to write a list of questions before your appointment.

People sometimes feel that hospital staff are too busy to answer their questions, but it's important for you to know how the treatment is likely to affect you. The staff should be willing to make time for your questions.

You can always ask for more time if you feel that you can't make a decision when your treatment is first explained to you.

You are also free to choose not to have the treatment. The staff can explain what may happen if you don't have it. It's essential to tell a doctor or the nurse in charge, so they can record your decision in your medical notes. You don't have to give a reason for not wanting treatment, but it can help to let the staff know your concerns so they can give you the best advice.

Second opinion

Your multidisciplinary team uses national treatment guidelines to decide the most suitable treatment for you. Even so, you may want another medical opinion. If you feel it will be helpful, you can ask either your specialist or GP to refer you to another specialist for a second opinion.

Getting a second opinion may delay the start of your treatment, so you and your doctor need to be confident that it will give you useful information.

If you do go for a second opinion, it may be a good idea to take a relative or friend with you, and have a list of questions ready, so that you can make sure your concerns are covered during the discussion.

Surgery

Surgery is one of the main treatments for breast cancer. The operation you have depends on:

- the size of the cancer
- the position of the cancer
- your own preference.

Your surgeon and breast care nurse will talk to you about your options. You may be asked to decide which operation you have (see pages 47–49).

Your surgeon will usually recommend breast-conserving surgery. This keeps as much of the breast tissue and the shape of the breast as possible. In some situations, they may recommend having the whole breast removed (mastectomy). Your surgery will usually include removing some or all of the lymph nodes in your armpit (see pages 50–51).

Some women have hormonal therapy or chemotherapy before their operation. The aim is to shrink the cancer to avoid a mastectomy.

Wide local excision (breast-conserving surgery)

The surgeon removes the cancer and some normal looking tissue around it (the margin). This is called a wide local excision (WLE).

In early breast cancer, having a WLE followed by radiotherapy is as effective as a mastectomy. Having radiotherapy after a WLE reduces the risk of the cancer coming back in the breast.

If the cancer is very small, you may need a fine wire to mark the area so the surgeon can find it more easily. This is called wire localisation (see pages 22–23).

After a WLE, most women are pleased with the appearance of their breast.

Removing a larger area of breast tissue

Some women need to have a larger area of breast tissue removed. Surgeons can use different ways to help improve the appearance of your breast if you need a lot of tissue removed. They may reshape the breast by moving the breast tissue around and making it smaller. Sometimes, they take tissue from somewhere else in the body to help reshape the breast.

Or, they may suggest you have the other breast made smaller so both breasts are the same size. This can be done at the same time as surgery or at a later time.

You will still need radiotherapy as part of your treatment.

Our booklet **Understanding breast reconstruction** has information for women having breast-conserving surgery and surgery to reshape the breast.

Clear margins

After breast-conserving surgery, the pathologist examines the tissue that has been removed. They check the area (margin) around the cancer. If there are cancer or pre-cancer cells (DCIS) at the edges, you will need another operation to remove more tissue. Making sure the margins are clear reduces the risk of the cancer coming back in the breast.

If your surgeon doesn't think another breast-conserving operation is likely to be successful, they usually recommend a mastectomy.

Removing the breast (mastectomy)

Breast surgeons usually try to do an operation that means you can keep your breast (breast conserving surgery). But there are situations when they may recommend a mastectomy. This may be when:

- the lump is large in proportion to the rest of your breast
- there is cancer in different parts of the breast
- there is widespread DCIS in the breast (see page 26)
- you have had radiotherapy to the chest before to treat another cancer, such as Hodgkin lymphoma.

Breast reconstruction

If you are having a mastectomy, your surgeon will usually ask if you want a new breast shape made at the same time. This is called immediate breast reconstruction. You can choose to delay reconstruction until after you have completed radiotherapy or chemotherapy.

You may decide not to have immediate reconstruction. But if you want reconstruction in the future, it's best to mention this before you have a mastectomy. You don't have to make a definite decision at this stage, but it will help the surgeon to plan your initial surgery.

Breast reconstruction is specialised surgery carried out by a plastic surgeon or oncoplastic surgeon. There are different types of reconstruction. A new breast shape can be made using:

- a silicone implant
- tissue taken from another part of your body.

You may be able to talk to a plastic surgeon before surgery about your options for reconstruction.

We have more information in our booklet **Understanding breast reconstruction**. Call us on **0808 808 00 00** or visit **be.macmillan.org.uk** to order a free copy.

Treatment decisions

The chances of surviving early breast cancer are similar whether you have breast-conserving surgery and radiotherapy or a mastectomy. Your surgeon and specialist nurse may ask you to choose the treatment you feel suits you best.

Making treatment decisions can be difficult. It's important to talk it over carefully with your surgeon and breast care nurse. Make sure you take your time and have the information you need to make the right decision for you. You may also want to talk it over with someone close to you, such as a partner, family or friends.

We have a booklet called **Making treatment decisions**, which you may find helpful. You can also get support by calling the Macmillan Support Line on **0808 808 00 00**.

It's helpful to think about the possible advantages and disadvantages before making a decision. On pages 48–49, we explain some of the advantages and disadvantages of having breast-conserving surgery and radiotherapy and having a mastectomy.

Breast-conserving surgery and radiotherapy

+ Advantages

- It keeps the appearance and sensation of the breast.
- Recovery is shorter and easier than with a mastectomy.
- It may be less likely to affect your sex life and relationships.

- Disadvantages

- You may need more than one operation to get clear margins.
- You need three or more weeks of radiotherapy after the surgery (some women will also need radiotherapy after a mastectomy).
- Radiotherapy has short-term side effects, and some women may have long-term side effects.

'I thought, "Mastectomy. That's really drastic. To take my breast away for this little lump?"'

Helen

Mastectomy

+ Advantages

- You may not need radiotherapy after a mastectomy. But some women will need it. Ask your cancer specialist about this.
- You may feel less anxious.

- Disadvantages

- You lose your breast permanently.
- It takes longer to recover after having a mastectomy.
- It changes your appearance, which may affect your confidence, sex life and relationships.
- You will need a longer operation and possibly further surgery if you want breast reconstruction afterwards. However, reconstruction may help to reduce other disadvantages for some women.

'It was a hard decision to accept as I really didn't want a breast removed. But I have a young family and didn't want to leave any doubt.'

Asma

Surgery to the lymph nodes

Your surgeon may remove some or all of the lymph nodes in your armpit to check them for cancer cells. This can:

- get rid of any lymph nodes that contained cancer cells (you may need more treatment if only some nodes were removed).
- give information about the stage of the cancer, which helps when making decisions about having other treatments.

There are different types of lymph node surgery.

Sentinel lymph node biopsy (SLNB)

A sentinel lymph node biopsy is a way of checking lymph nodes in the armpit. SLNB isn't suitable for everyone. It may be done if:

- you had a small cancer
- the ultrasound of your armpit was normal.

Surgeons remove the smallest number of lymph nodes possible (usually 1–3) to see if there are any cancer cells. Removing only a small number of lymph nodes reduces the risk of side effects that can occur after lymph node surgery. These include swelling of the arm known as lymphoedema and stiffness of the arm (see page 54).

The lymph nodes that are the most likely to have cancer cells are called the sentinel lymph nodes. These are the first ones that lymph fluid drains to from the breast.

If there are no cancer cells in the sentinel nodes you won't need surgery to remove more lymph nodes.

If any nodes from the SLNB contain cancer cells, your cancer specialist will talk to you about further treatment.

You may be offered another operation to remove the remaining lymph nodes. Some women have radiotherapy to the rest of the lymph nodes instead of more surgery.

Your surgeon will explain if SLNB is an option for you.

How an SLNB is done

Before the sentinel lymph nodes can be removed, the surgeon needs to check which nodes are the sentinel lymph nodes.

On the day of surgery, or sometimes the day before, the doctor injects a harmless amount of radioactive liquid into your breast. During the operation, the surgeon uses a handheld machine to find the lymph nodes that have picked up the radioactivity. The surgeon also injects a blue dye into your breast during the operation. This stains the lymph nodes blue. The lymph nodes that absorb the radioactivity or become blue first are the sentinel lymph nodes.

The surgeon can then remove blue or radioactive nodes (sentinel nodes). These are tested to see if there are any cancer cells.

Removing all the lymph nodes

In some cases, the surgeon will recommend removing all the lymph nodes in the armpit. This is called an axillary lymph node dissection (ALND). It aims to get rid of any nodes that contain cancer cells. An ALND is usually done when:

- there are cancer cells in the fine needle aspiration (FNA) of the lymph nodes
- the SLNB or sampling shows there are cancer cells in the nodes.

There is an increased risk of developing swelling of the arm called lymphoedema after having an ALND. You can read more about lymphoedema and taking care of your arm on pages 93–94.

Before your operation

Before your operation, you may be seen at a pre-assessment clinic. This is a good opportunity for you to ask questions and talk over any concerns about the operation. You may have tests to check your general health. These can include blood tests, a urine check, chest x-ray or a recording of your heart (ECG).

Most women who have breast cancer surgery can go home the same day or the following day. But if you have breast reconstruction at the same time as a mastectomy, you may be in hospital for longer (1 to 5 days). This will depend on the type of reconstruction operation you have.

Your surgeon or breast care nurse will talk to you about how your breast will look after your surgery. They may show you photographs of other women who have had breast surgery, or put you in touch with someone who has been through it. You could also contact a local support group or Breast Cancer Care (see page 125).

You will usually come into hospital on the day of your operation. You'll meet the doctor who gives you the anaesthetic (anaesthetist). The nurses may give you elastic stockings to wear during and after the operation to help prevent blood clots.

After your operation

You will be encouraged to start moving around as soon as possible after your operation.

Your wound

You will have a dressing covering your wound, which may not be removed for the first few days. The nurses will let you know how to look after it before you go home.

How long it takes to heal depends on the operation you had. If you only had a small area of tissue removed, your wound will usually heal quickly. If you don't have stitches that dissolve, you will probably have your stitches removed about 7 to 10 days after your operation.

Wound infection

This can be a complication of surgery. Signs of infection can include warmth, redness, swelling around the wound or discharge coming from it. You may also feel unwell with a fever. Tell your nurse or doctor if you get any of these symptoms, even after you go home.

Drains

You may have a long, thin plastic drainage tube attached to a bottle that fluid from the wound drains into. It is usually left in until it stops draining, which may take a few days. You can go home with the drain. A practice nurse or a district nurse may check it when you are at home. Or you might have it checked and removed at the hospital.

Fluid collecting around the wound (seroma)

Fluid can build up in the area around the wound. This is called a seroma. It usually goes away within a few weeks. Sometimes your nurse or doctor may need to drain it off with a needle and syringe.

Pain

You will probably have some pain around the wound and in your armpit if you had lymph nodes removed. This may last a few days. The nurses will give you painkillers to take regularly until it settles down. After a mastectomy, you may need to take them for a week or two. Let your doctor or nurse know if the painkillers are not helping. They can prescribe stronger ones for you to try.

Stiff shoulder or arm

After a mastectomy or having lymph nodes removed, your shoulder or arm may feel sore or stiff.

It's important to do the arm exercises that your physiotherapist or nurse shows you. This will help improve the movement in your shoulder and arm, and reduce the risk of long-term problems. You should start the exercises the day after your operation and gradually build up what you can do.

Breast Cancer Care (see page 125) have a leaflet about these exercises after breast cancer surgery.

Numbness and tingling in the upper arm

You may have this if nerves in your breast and armpit are injured during the operation. This is more likely if you had all the lymph nodes removed. It may slowly improve over some months but can sometimes be permanent.

How your breast looks

It is common to have swelling and bruising after your operation.

It should improve after a few weeks, but let your breast care nurse know if it doesn't. Wearing a crop top or sports bra might feel more comfortable until the swelling goes down. If you had an SLNB (see pages 50–51), you may see the blue dye in your skin for a while, but this is normal.

Scars

Before your operation, your surgeon or breast care nurse will explain where the scars will be. Scars from breast conserving surgery are usually small. Depending on where the surgeon makes the cut, the scar may be in the area where the cancer was, or a small distance away.

A mastectomy scar is across the skin of the chest and into the armpit. After surgery to the lymph nodes, the scar is in the armpit and shouldn't be noticeable from the front.

To begin with, your scar will be red if you have white skin, or darker if you have dark skin. It will also be firm and slightly raised. Over time, it will flatten and fade. Everyone's skin heals differently. If you have dark skin or fair, freckled skin, scars can take longer to settle and may be more noticeable for longer.

If you are worried about your scar, talk to your breast care nurse or surgeon. There is more information about scarring after breast reconstruction in our booklet **Understanding breast reconstruction**.

'I am able to view my scar as a positive sign that I survived. So I don't feel too upset about the loss of my breast, and still feel confident and able to dress exactly as I did before.'

Janet

Coping with a changed appearance

The first time you look at your breast or chest after surgery you may want to have someone with you, or you might prefer to be alone. Your breast care nurse will talk to about this and help support you.

At first, the area will look swollen and bruised, but this will settle in a few weeks. In time the scar becomes less obvious.

Changes to your appearance can cause concerns about your body image. This is the picture in your mind of how your body looks and works. These concerns can make you feel less confident or less feminine and may affect your sex life (see pages 90–91).

We have a booklet called **Body image and cancer** that explains how to get help and what you can do to improve your body image.

Some women find that breast reconstruction (see page 46) helps give them back their confidence and feelings of femininity.

Breast prosthesis

If you have a mastectomy and don't have breast reconstruction, your nurse will give you a soft, lightweight prosthesis (false breast) to wear inside your bra. It's often called a 'cumfie' or 'softie'. You can wear it straight after your operation.

When your wound has healed, you can choose a permanent prosthesis made of soft plastic (silicone). It will be matched to the size and shape of your other breast and your skin colour. Many women find their confidence gradually improves as they get used to it.

You can get different types of prosthesis from the NHS. Breast Cancer Care (see page 125) can also give you a list of suppliers.

'I was totally bowled over by how realistic prostheses are. I mean, they feel just like real flesh.'

Cheryl

When you get home

Your recovery will depend on the type of operation you have.

Try to get plenty of rest and eat well. Do some light exercise, such as walking, to help build up your energy. You can gradually increase the amount you do. Carry on with the exercises you were shown in hospital. Follow the advice you were given by your breast care nurse.

Depending on the operation you had, you may need to avoid lifting or carrying anything heavy for a few weeks.

Some insurance policies give specific time limits for not driving after surgery. Contact your insurance company to let them know you have had an operation. Most women are ready to drive about four weeks after their operation. Don't drive unless you feel in full control of the car.

You will be given a clinic appointment to see the surgeon and breast care nurse to check your wound is healing properly. They will also tell you about the tissue removed during surgery (pathology), the stage of the cancer and any further treatment you need.

Late effects of surgery

Some women may have problems with the effects of surgery for months or longer after their operation. Tell your breast care nurse if you develop any of these or if you are worried about them.

Cording

This feels like a tight cord running from your armpit down the inner arm, sometimes to the palm of your hand. It usually happens after surgery to remove one or more lymph nodes. You may notice it weeks or months after surgery. It usually gets better on its own over a few months. Some women may need physiotherapy and massage.

Pain and changes in sensation

Sometimes women continue to have numbness, tingling or pain in the upper arm because of injury to the nerves during surgery. Your doctor can prescribe low doses of a drug that treats nerve pain.

Changes to your arm or shoulder movement

Arm and shoulder movement and strength usually improve after surgery. Doing exercises helps reduce the risk of long-term problems. If you have problems, ask your doctor for a referral to a physiotherapist. If moving your shoulder or arm is painful, your doctor can prescribe you some painkillers.

Lymphoedema

Surgery or radiotherapy to the lymph nodes in the armpit can cause swelling of the arm (lymphoedema). If you notice any swelling, speak to your breast care nurse or doctor. Treatment can be more effective the earlier it begins. There is information on reducing the risk of lymphoedema on pages 93–94.

Our booklet **Managing the late effects of breast cancer treatment** has more information about lymphoedema.

Radiotherapy

You may be given radiotherapy to reduce the risk of breast cancer coming back in the breast, chest or lymph nodes.

Radiotherapy uses high-energy x-rays to destroy cancer cells. Normal cells can also be damaged by radiotherapy, which may cause side effects. But careful planning and newer ways of giving radiotherapy have reduced the risk of damage to healthy tissue and nearby organs. Cancer cells cannot repair themselves after radiotherapy, but normal cells usually can.

Radiotherapy after breast-conserving surgery

If you have breast-conserving surgery, your cancer specialist will recommend you have radiotherapy to the breast afterwards.

You usually start radiotherapy four weeks after surgery unless you are having chemotherapy. Radiotherapy is given after chemotherapy.

Radiotherapy after a mastectomy

Some women have radiotherapy after a mastectomy. This depends on the risk of the cancer coming back in the chest area. Your cancer specialist may recommend radiotherapy after a mastectomy if:

- the cancer was large
- there were cancer cells in some lymph nodes in the armpit.

Radiotherapy to the lymph nodes

If the surgeon removed some lymph nodes from your armpit and they contained cancer, you may have radiotherapy to the rest of the nodes.

Some women also have radiotherapy to the lymph nodes above the collarbone and by the breastbone – see the diagram on page 9.

We can send you a booklet called **Understanding radiotherapy**, which has more detailed information about this treatment.

How radiotherapy is given

You usually have a course of radiotherapy for three weeks. Some women may need up to five weeks.

You have the treatment in the hospital radiotherapy department. Each treatment takes 10 to 15 minutes and they are usually given from Monday to Friday with a rest at the weekend. Women who have had breast conserving surgery also have an extra dose to the area where the cancer was (a booster dose).

Your cancer specialist or nurse will talk to you about the treatment and possible side effects.

Some women may have radiotherapy as part of a clinical trial (see pages 84–85).

External radiotherapy does not make you radioactive and it is safe for you to be with other people, including children, after your treatment.



Someone being positioned for radiotherapy

Planning radiotherapy

Radiotherapy has to be carefully planned to make sure it works as well as possible.

It is planned by a cancer specialist (oncologist) and it may take a few visits. On your first visit to the radiotherapy department, you will be asked to have a planning CT scan (see page 25). Or you may lie under a machine called a simulator, which takes x-rays of the area to be treated.

You will be given your treatment by radiographers. They make tiny permanent markings (tattoos) the size of a pinpoint on your skin to show the exact place to aim the radiotherapy beams. It can feel a little uncomfortable at the time. This is only done with your permission.

Positioning

The radiographer helps you put your arm into the best position for the radiotherapy to work (see the photograph on the opposite page). If your muscles and shoulder feel stiff or painful, a physiotherapist can show you exercises that can help.

Treatment sessions

At the beginning of each session, the radiographer positions you carefully on the couch and makes sure you are comfortable. You will be alone in the room during treatment. But you can talk to the radiographer who is watching from the next room. Radiotherapy is not painful, but you need to lie still for a few minutes while it's given.

Side effects of radiotherapy

You may develop side effects over the course of your treatment. These usually disappear gradually over a few weeks or months after treatment finishes. Your doctor, nurse or radiographer will discuss this with you so you know what to expect. Let them know about any side effects you have during or after treatment. There are usually things that can be done to help.

Skin irritation

Your skin in the treated area may get red, dry and itchy. Dark skin may get darker or have a blue or black tinge. Your nurse or radiographer will give you advice on looking after your skin. If it becomes sore and flaky, your doctor can prescribe creams or dressings to help this.

Skin irritation usually goes away 2 to 4 weeks after radiotherapy.

Here are some tips to help:

- Don't put anything on your skin in the treated area without checking with your nurse or radiographer first.
- Have a warm shower rather than a bath if you can. Turn away from the spray to protect your breast.
- Gently pat the area dry with a soft towel. Don't rub the area.
- Wear loose clothing that is less likely to irritate your skin.

You need to avoid exposing the treated area to sunshine for at least a year after treatment finishes. Use sunscreen with a high sun protection factor (SPF) of at least 30 to protect your skin if it's exposed.

Tiredness

This is a common side effect that may last for up to a month or two after treatment. Try to get plenty of rest and pace yourself. Balance this with some physical activity, such as short walks, which will give you more energy.

Aches and swelling

You may have a dull ache or shooting pains in the breast that last for a few seconds or minutes. Some women may also notice that their breast becomes swollen. These effects usually improve quickly after treatment. Some women still have occasional aches and pains in the breast area after radiotherapy.

Late effects

Radiotherapy to the breast may cause side effects that happen months or years after radiotherapy. If you are worried about any side effects, talk to your cancer specialist.

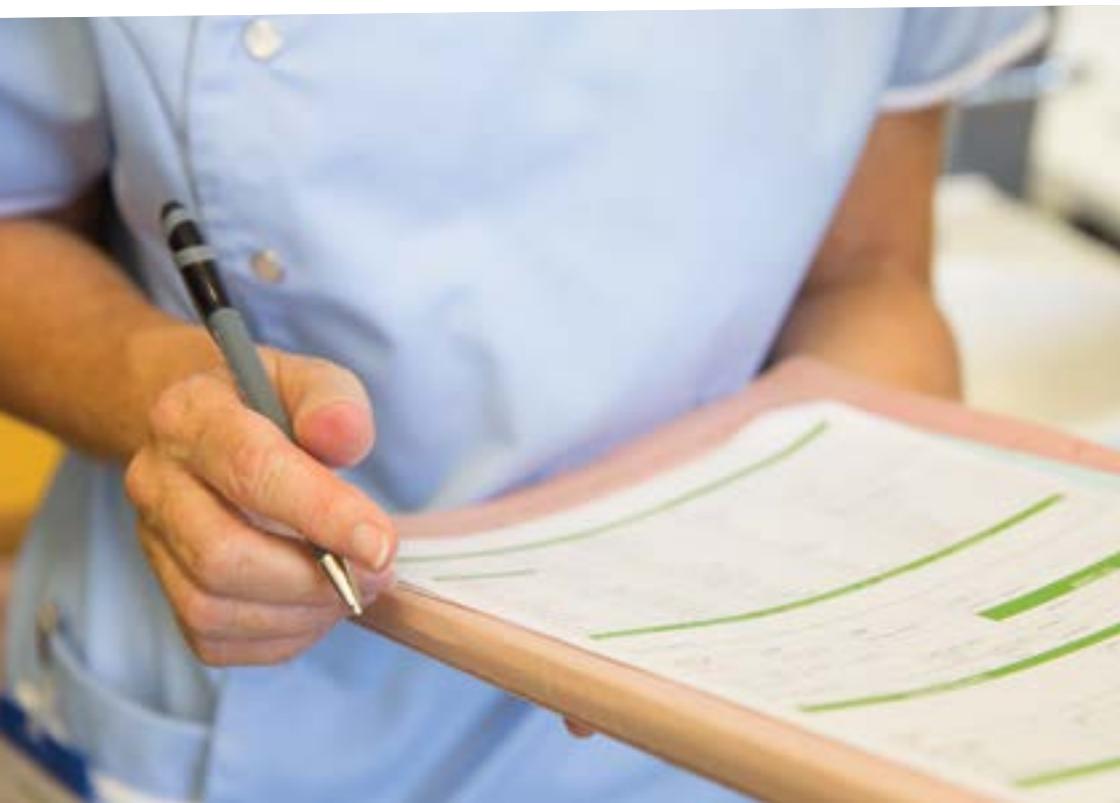
The most common late effect is a change in how the breast looks and feels.

Small blood vessels in the skin can be damaged by radiotherapy. This can cause red 'spidery' marks (telangiectasia) to show.

After radiotherapy your breast may feel firmer, and shrink slightly in size. If your breast is noticeably smaller you can have surgery to reduce the size of your other breast. If you had breast reconstruction using an implant before radiotherapy, you may need to have the implant replaced.

Rarely, radiotherapy can cause heart or lung problems, or problems with the ribs in the treated area. Newer ways of giving radiotherapy help reduce the risk of these late effects.

Our booklets **Coping with fatigue** and **Managing the late effects of breast cancer treatment** have more information. Visit be.macmillan.org.uk or call **0808 808 00 00** to order these free resources.



Chemotherapy

Chemotherapy uses anti-cancer (cytotoxic) drugs to destroy cancer cells. Cytotoxic means toxic to cells.

These drugs disrupt the way cancer cells grow and divide but they also affect normal cells.

When you have chemotherapy

Your cancer specialist may recommend you have chemotherapy after surgery to reduce the risk of breast cancer coming back. This is called adjuvant chemotherapy. Your doctor or nurse will explain the benefits of this to you and the likely side effects.

You are usually offered chemotherapy if the cancer is:

- large
- grade 3
- in the lymph nodes
- triple negative (see page 35)
- HER2 positive (see page 35).

Some women have chemotherapy before surgery to shrink a large cancer (neo-adjuvant treatment). If it works well, you may only need part of the breast removed instead of a mastectomy.

Women with inflammatory breast cancer (see page 27) usually have chemotherapy before surgery.

Your cancer specialist may ask you to take part in a research trial that compares different types of chemotherapy (see pages 84–85).

How chemotherapy is given

You usually have chemotherapy in the chemotherapy day unit and go home after it. The drugs are usually given into a vein (intravenously).

When you have intravenous chemotherapy, the nurse will give you the drugs as an injection into a vein or as a drip (infusion).

You usually have them through a small tube (cannula) in your hand or arm. Sometimes they are given through a soft plastic tube called a central line or PICC line. These lines go into a large vein in your chest. Chemotherapy can also be given into a thin, soft plastic tube, with a rubber disc (port) under the skin on your upper chest.

You can read more about lines and ports in our booklet **Understanding chemotherapy**.

'I wrote my chemo appointments in a diary, and then crossed them off when they were done. It was another way of gaining control.'

Rocio

Chemotherapy is given into the vein as one or more sessions of treatment. Each session takes a few hours. After the session, you will have a rest period of a few weeks. The chemotherapy session and the rest period is called a cycle of treatment.

The length of a cycle depends on the chemotherapy drugs you are taking, but most cycles are between 1 and 3 weeks long. Your doctor or nurse will explain more about this. Most courses of chemotherapy are made up of six cycles.



The drugs used

You have a combination of different chemotherapy drugs. Some commonly used combinations include:

- **FEC** – fluorouracil (5FU), epirubicin and cyclophosphamide
- **FEC-T** – FEC followed by docetaxel (Taxotere®)
- **AC** or **EC** – doxorubicin (Adriamycin®) and cyclophosphamide or epirubicin and cyclophosphamide
- **TC** – docetaxel and cyclophosphamide
- **EC-T** – epirubicin and cyclophosphamide followed by docetaxel (Taxotere®)
- **EC-P** – epirubicin and cyclophosphamide followed by paclitaxol (Taxol®)
- **FEC-P** – fluorouracil (5FU), epirubicin and cyclophosphamide followed by paclitaxol (Taxol®).

Your doctor may offer you a choice of chemotherapy treatments. If so, you will be given more information to help you make a decision.

If you have HER2 breast cancer, you may have a targeted therapy called trastuzumab (Herceptin®) along with your chemotherapy (see pages 82–83).

We can send you information about individual chemotherapy drugs and combinations. Call us on **0808 808 00 00**.

Side effects of chemotherapy

Chemotherapy drugs can cause side effects. Many of these can be controlled well with medicines and will usually go away when your treatment finishes. Your doctor or nurse will tell you what to expect. Always let them know about your side effects, as there are usually ways to control them.

Risk of infection

Chemotherapy can reduce your number of white blood cells, which help fight infection. If the number of white blood cells is low, you will be more likely to get infections. A low white blood cell count is called neutropenia.

Always contact the hospital immediately on the 24-hour contact number you have been given and speak to a nurse or doctor if:

- you develop a high temperature, which may be over 37.5°C (99.5°F) or over 38°C (100.4°F) depending on the hospital's policy – follow the advice that you have been given by your chemotherapy team
- you suddenly feel unwell, even with a normal temperature
- you feel shivery and shaky
- you have any symptoms of an infection such as a cold, sore throat, cough, passing urine frequently (urine infection) or diarrhoea.

If necessary, you will be given antibiotics to treat an infection. You will have a blood test before each cycle of chemotherapy to make sure your white blood cells have recovered. Occasionally, your treatment may need to be delayed if your number of white blood cells is still low.

You may have a drug called G-CSF. This is given as a small injection under the skin. It encourages the bone marrow (where blood cells are made) to make more white blood cells. The nurses in the chemotherapy department can teach you how to give this to yourself at home or arrange for a practice nurse to do it.

Bruising and bleeding

Chemotherapy can reduce the number of platelets in your blood. Platelets are cells that help the blood to clot. If you develop any unexplained bruising or bleeding such as nosebleeds, bleeding gums, blood spots or rashes on the skin, contact your doctor or the hospital straight away.

Anaemia (low number of red blood cells)

Chemotherapy may reduce the number of red blood cells (haemoglobin) in your blood. A low level of red blood cells is known as anaemia, which can make you feel very tired and lethargic. You may also become breathless. Let your doctor know if you get these effects.

Feeling sick (nausea)

Some chemotherapy drugs can make you feel sick (nauseated) or possibly be sick (vomit). Your cancer specialist will prescribe anti-sickness (anti-emetic) drugs to prevent this. Let your doctor or nurse know if your anti-sickness drugs are not helping, as there are several different types you can try. We can send you more information about nausea and vomiting.

Tiredness (fatigue)

You are likely to become tired and have to take things more slowly. Try to pace yourself and save your energy for things that you want to do or that need doing. Balance rest with some physical activity. Even just going for a short walk will help increase your energy levels. Our booklet **Coping with fatigue** has more helpful tips.

Hair loss

This is a common side effect of the drugs used to treat breast cancer. Ask your nurse what you should expect. Some women may lose all their body hair, including eyelashes and eyebrows.

If you do experience hair loss, your hair should start to grow back about 3 to 6 months after treatment. Your nurse can give you advice about coping with hair loss and how to look after your scalp. You can also get helpful information from our booklet, **Coping with hair loss**.

Your nurse will let you know if scalp cooling – a way of reducing hair loss during chemotherapy – would be appropriate.

Sore mouth

Your mouth may become sore (or dry), or you may notice small ulcers during treatment.

Drinking plenty of fluids and cleaning your teeth regularly and gently with a soft toothbrush, can help to reduce the risk of this happening. Tell your nurse or doctor if you have any of these problems. They can prescribe mouthwashes and medicine to prevent or clear mouth infections.

Diarrhoea

Some chemotherapy drugs can cause diarrhoea. This often starts several days after treatment. If you are taking chemotherapy tablets or capsules at home, it's important to let your doctor or nurse know if you have diarrhoea, as your treatment may need to be interrupted. Medicine can be prescribed to help. It's important to drink plenty of fluids if you have diarrhoea.

Effects on the nerves

Some chemotherapy drugs can affect the nerves in your hands or feet. This can cause tingling or numbness, a sensation of pins and needles or muscle weakness (peripheral neuropathy).

It's important to let your doctor know if this happens. They may need to change the chemotherapy drug if it gets worse. Usually, peripheral neuropathy gradually gets better when chemotherapy is over, but sometimes it's permanent. We can send you more information about peripheral neuropathy.

Side effects can be hard to deal with, but they usually disappear gradually when your treatment finishes.

Contraception

Your doctor will advise you not to get pregnant while having chemotherapy. This is because the drugs may harm an unborn baby. It's important to use effective contraception during your treatment (see page 91).

Sex

You are usually advised to use condoms if you have sex within the first 48 hours after chemotherapy. This is to protect your partner from the drugs in case they are present in the vaginal fluid.

Early menopause

Younger women may find chemotherapy brings on an early menopause, which can be difficult to cope with. We have more information about early menopause on page 95.

Infertility

If you are worried about the effect chemotherapy may have on your fertility, it's important to talk this over with your cancer specialist before treatment starts. You can read more about infertility on page 92.



Hormonal therapy

Hormones help to control how cells grow and what they do in the body. The hormones oestrogen and progesterone can encourage some breast cancers to grow, particularly oestrogen.

Hormonal therapies reduce the amount of oestrogen in the body or stop it attaching to the cancer cells. They only work for women with oestrogen-receptor positive cancers (see page 34).

You may have hormonal therapy to reduce the risk of breast cancer coming back and to protect your other breast. You usually start taking it after surgery or chemotherapy. You take hormonal therapy for a number of years. Sometimes doctors prescribe it before surgery to shrink a large cancer.

The type of hormonal therapy you have depends on:

- whether you have been through the menopause or not
- the risk of the cancer coming back
- how the side effects are likely to affect you.

We can send you information about individual hormonal therapy drugs. Call us on **0808 808 00 00** to order this for free.

Taking your hormonal therapy

Hormonal therapy reduces the risk of breast cancer coming back.

It's very important to take hormonal therapy for as long as your cancer specialist prescribes it. It may help to make taking it part of your daily routine so it becomes a habit.

Most women cope well with the side effects of hormonal therapy. They may be more of a problem in the first few months, but usually get better over time. If the side effects don't improve or are difficult to cope with, talk to your breast care nurse or doctor. They can prescribe drugs to help and advise you on ways of coping. If you are still having problems after this then your cancer specialist may suggest changing to a different type of hormonal therapy.

Hormonal therapy after the menopause

After the menopause, the ovaries no longer produce oestrogen. But women still make some oestrogen in their fatty tissue.

If you have been through the menopause, your doctor may prescribe one of the following:

- an aromatase inhibitor such as anastrozole (Arimidex[®]), letrozole (Femara[®]) or exemestane (Aromasin[®])
- the anti-oestrogen drug tamoxifen and an aromatase inhibitor (one type is given after the other)
- tamoxifen on its own.

Aromatase inhibitors (AIs)

Aromatase inhibitors (AIs) are the main hormonal therapy used for post-menopausal women. They stop oestrogen being made in the fatty tissue after the menopause. Your doctor may prescribe an aromatase inhibitor such as anastrozole, letrozole or exemestane.

These drugs are taken daily as a tablet. Side effects can include:

- hot flushes
- joint and muscle pain
- tiredness.

If taken over a long period of time, AIs can cause bone thinning (osteoporosis). Before you start an AI, you will have a scan called a DEXA (dual-energy x-ray absorptiometry) scan, to check your bone health (density).

If you are at risk of osteoporosis, your cancer specialist may prescribe drugs called bisphosphonates to protect your bones. They will probably also advise you to take calcium and vitamin D supplements to help strengthen your bones.

Tamoxifen

Tamoxifen is a drug that stops oestrogen attaching to breast cancer cells and encouraging them to grow. It is occasionally used for post-menopausal women. Some women take it for a few years and then go on to take an aromatase inhibitor. Doctors sometimes prescribe tamoxifen if you have problems with your bones or if you have troublesome side effects with AIs.

Tamoxifen doesn't cause bone thinning in post-menopausal women, but it can slightly increase the risk of womb cancer. It's important to tell your doctor if you have any vaginal bleeding. The general side effects of tamoxifen are described on page 79.

Hormonal therapy before the menopause

Before the menopause, the ovaries produce oestrogen. If you haven't been through the menopause (pre-menopausal), your doctor may recommend one or more of the following:

- the anti-oestrogen drug tamoxifen
- a drug, such as goserelin (Zoladex[®]), that stops the ovaries producing oestrogen (ovarian suppression)
- a combination of tamoxifen with either Zoladex[®] or ovarian ablation
- a combination of an AI with either Zoladex[®] or ovarian ablation
- surgery to remove the ovaries (ovarian ablation).

Some hormonal therapies bring on a temporary or permanent menopause. If you have an early menopause, you may have a DEXA (dual-energy x-ray absorptiometry) scan to check your bone health. If you are at risk of bone thinning (osteoporosis) you may be prescribed drugs called bisphosphonates to protect your bones. You may also be advised to take calcium and vitamin D supplements to strengthen your bones.

Tamoxifen

Tamoxifen is the main hormonal therapy for women who have not been through menopause. It is taken daily as a tablet.

The side effects are similar to the effects of the menopause and may include:

- hot flushes and sweats
- weight gain
- tiredness.

Tamoxifen can slightly increase your risk of a blood clot. We can send you more information about tamoxifen and its effects.

You will usually take tamoxifen for at least five to ten years. You can talk to your doctor about this. It won't be suitable for everyone, especially if you have side effects or if there is a time when you want to try to get pregnant. If you are close to your natural menopause when you start tamoxifen, your doctor may change your treatment to an aromatase inhibitor (see page 78) after a few years.

Drugs that stop the ovaries producing oestrogen

Zoladex[®] stops the production of oestrogen in the body and causes a temporary menopause. It does this by stopping the pituitary gland in the brain from sending messages to the ovaries to produce oestrogen. The side effects are similar to menopausal symptoms and include:

- hot flushes and sweats
- joint pain
- low sex drive.

Your nurse will give you Zoladex[®] as a monthly injection under the skin of the tummy (abdomen). When you finish treatment, your ovaries usually start to produce oestrogen again. This means your periods will come back. If you were close to your natural menopause when you started Zoladex[®], this may not happen.

We can send you more information about Zoladex[®].

Permanently stopping the ovaries from working (ovarian ablation)

Other ways of lowering oestrogen levels include stopping the ovaries from working. Doctors sometimes call this ovarian ablation. It can be done with a small operation to remove the ovaries or, rarely, with a short course of radiotherapy to the ovaries. Your doctor may ask you to choose between taking Zoladex® or having ovarian ablation.

The operation can often be done during a short stay in hospital using keyhole surgery. The surgeon makes a small cut in the tummy area and inserts a thin tube with a tiny light and camera on the end (laparoscope). The surgeon removes the ovaries through the cut using the laparoscope, which has small surgical instrument attached to it. Women usually recover quickly from this type of operation.

If you have this surgery, your periods will stop straight away. After radiotherapy, women usually have one more period before their periods stop completely. It's important to use contraception for three months after radiotherapy.

Both methods of ovarian ablation (surgery and radiotherapy) cause a permanent menopause. Becoming infertile because of cancer treatment can be very hard to cope with. There is more information about the support that's available on page 92.

We can send you more information about ovarian ablation and coping with menopausal effects. Call us on **0808 808 00 00**.

Targeted therapy

Targeted therapies (sometimes called biological therapies) are new drugs that work differently from chemotherapy. The main targeted therapy used in breast cancer treatment is trastuzumab (usually called Herceptin®). It reduces the risk of breast cancer coming back in women with HER2 positive breast cancer.

Trastuzumab attaches to the HER2 receptors on the surface of breast cancer cells and stops them from dividing and growing. You will usually have trastuzumab every three weeks for a year. It is given with chemotherapy, or on its own.

How trastuzumab is given

Trastuzumab can be given as a drip (infusion) into a vein (intravenously) or as an injection under the skin (subcutaneously).

When it's given as a drip, you have it slowly the first time (over an hour and a half) and the nurse will check you for signs of a reaction. You can then have future infusions over about 30 minutes.

It only takes a few minutes to have it as an injection under the skin. But you will still need to wait for an hour and a half so the nurse can check you for any reaction.

Side effects

The side effects of trastuzumab are usually mild. You may have some while having the drip or up to four hours after, particularly with the first dose. These include flu-like symptoms such as a headache, high temperature (fever) and chills, or feeling sick. They generally get better within a few hours of the drip finishing. Another possible side effect is an allergic reaction, but this is rare. The nurses will check for signs of a reaction. If it happens, they can treat it quickly with drugs.

You may get other side effects after treatment. These include diarrhoea, headaches and feeling sick.

Effects on the heart

Trastuzumab may lead to changes in the way your heart works and can cause problems in some women. Usually, any effect is mild and reversible. You may be given heart medicines to help with this side effect.

You will have tests to check your heart before and during treatment to make sure the drug isn't causing any damage. Trastuzumab isn't usually given to women who already have heart problems.

We have more information about trastuzumab (Herceptin®) that we can send you.

Research – clinical trials

Cancer research trials are carried out to try to find new and better treatments for cancer. Trials that are carried out on patients are known as clinical trials. These may be carried out to:

- test new treatments, such as new chemotherapy drugs, hormonal therapies or targeted therapies
- look at new combinations of existing treatments, or change the way they are given to make them more effective or reduce side effects
- compare the effectiveness of drugs used to control symptoms
- find out how cancer treatments work
- find out which treatments are the most cost-effective.

Trials are the only reliable way to find out if a different type of surgery, chemotherapy, hormone therapy, radiotherapy, or other treatment is better than what is already available.

Taking part in a trial

You may be asked to take part in a treatment research trial. There can be many benefits in doing this. Trials help to improve knowledge about cancer and develop new treatments. You will be carefully monitored during and after the study.

Usually, several hospitals around the country take part in these trials. It's important to bear in mind that some treatments that look promising at first are often later found not to be as good as existing treatments or to have side effects that outweigh the benefits.

If you decide not to take part in a trial, your decision will be respected and you don't have to give a reason. However, it can help to let the staff know your concerns so that they can give you the best advice. There will be no change in the way that you're treated by the hospital staff, and you'll be offered the standard treatment for your situation.

Blood and tumour samples

Blood and/or tumour samples may be taken to help make the right diagnosis. You may be asked for your permission to use some of your samples for research into cancer. If you are taking part in a trial, you may also be asked to give other samples, which may be frozen and stored for future use when new research techniques become available. These samples will have your name removed from them so you can't be identified.

The research may be carried out at the hospital where you are treated or at another one. This type of research takes a long time, and results may not be available for many years. The samples will, however, be used to increase knowledge about the causes of cancer and its treatment. This research will hopefully improve the outlook for future patients.

Our booklet **Understanding cancer research trials (clinical trials)** describes clinical trials in more detail.



AFTER YOUR TREATMENT

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Follow-up

After treatment, you may have regular check-ups and yearly mammograms. At first your appointments may be every few months, but eventually they may be once a year. If you notice any new symptoms between appointments, it's important to contact your doctor or nurse for advice. You will be given contact numbers so that you don't have to wait until your next appointment to do this.

Instead of routine appointments, some women are given information on what to look out for by their breast care nurse. They are asked to contact their nurse or cancer specialist if there is anything they are worried about. Some women may have their follow-up appointments at a nurse-led clinic and only see their cancer specialist if something needs to be checked further.

Many women find they feel anxious for a while once treatment ends. This is natural. It can help to get support from family, friends or one of the organisations listed on pages 125–131. You can also contact the Macmillan Support Line on **0808 808 00 00**.

Breast awareness

Although you will have yearly mammograms, it's still a good idea to be aware of what's now normal for you. Your treated breast will look and feel different depending on the treatment you have had.

Your breast care nurse can tell you what you should expect and what to look out for. It's also important to be aware of what to look out for in your untreated breast.

If you notice anything unusual between appointments, contact your cancer specialist or breast care nurse straight away.



Sex and fertility

This section is about the effects cancer and its treatments can have on your sex life or your ability to have children (fertility). There is also information about contraception and future pregnancy.

Sexuality

Breast cancer, its treatments and side effects may affect your sex life and your feelings about yourself as a woman.

Our booklet **Body image** has information about body image and cancer that you may find helpful. Visit be.macmillan.org.uk or call us on **0808 808 00 00** to order a free copy.

Difficulties often gradually improve after treatment, although for some women, it may take longer. You may feel insecure and worry whether your partner or a future partner will find you sexually attractive. Talking openly with your partner about how you feel can help. You may both need some time to adjust.

Cuddles, kisses and massages can show how much you care for someone, even if you don't feel like having sex. You can wait until you and your partner feel ready – there's no right or wrong time.

Our booklet **Sexuality and cancer** has more information and tips that may help you.

Let your doctor or nurse know if you have any difficulties with your sex life that don't improve. They may be able to reassure you and can offer further help and support. If you feel uncomfortable talking to your doctor or nurse, you can call us on **0808 808 00 00**.

Some people may find it helpful to talk to a sex therapist. You can contact a therapist through the College of Sexual and Relationship Therapists (see page 130).

Contraception

Your doctor will advise you not to use contraception containing hormones, such as the pill, or coils (intra-uterine devices) that release hormones. Coils that don't contain hormones or barrier contraception methods, such as condoms or the cap, are usually the most suitable. Your breast care nurse can give you advice.

Pregnancy

Having a family can be an important part of life after cancer. Some women, particularly if they are under the age of 35, don't have difficulties getting pregnant naturally after treatment.

Doctors sometimes advise women to wait for two years. This is because breast cancer is most likely to come back during this time. But waiting also gives women time to recover from treatment. Studies show that getting pregnant after breast cancer does not increase the risk of it coming back.

If you are taking hormone therapy and thinking of getting pregnant it's important to talk to your cancer specialist first. It is not advisable to get pregnant while taking tamoxifen as it may harm a developing baby. Talk to your specialist before you stop taking any medicines.

Effects on fertility

Some breast cancer treatments may affect your ability to have children (fertility). Chemotherapy can bring on an early menopause, especially in women who are closer to the menopause. But if you are a younger woman, even though your periods may stop during treatment, they may start again after it has finished.

It's important to talk to your cancer specialist about your fertility before treatment starts. Sometimes it may be possible to remove eggs from your ovaries before your treatment. These can be fertilised with a partner's sperm, and the embryos (fertilised eggs) frozen and stored to use later. Women without a partner may have their eggs frozen and stored.

Becoming infertile can be very hard to live with, whether or not you already have children. Some women find it helpful to talk through their feelings with a trained counsellor. If you need more specialist help, ask your doctor or nurse to arrange this for you.

There is more information in our leaflet **Cancer treatment and fertility – information for women**. Call our cancer support specialists on **0808 808 00 00** or visit **[be.macmillan.org.uk](https://www.be.macmillan.org.uk)** to order a free copy.

Effects after treatment

After treatment, you will probably be keen to get back to doing the day-to-day things you did before. But you may still be coping with some side effects of treatment and some difficult emotions (see pages 104–107). It takes time to recover, often several months, so try not to expect too much of yourself.

Our booklet **Life after cancer treatment** discusses ways of coping after treatment.

Lymphoedema

Lymphoedema is a swelling of the arm that sometimes happens after surgery or radiotherapy to the lymph nodes in the armpit. It can develop months or years after treatment. If you only had a sentinel lymph node biopsy (see pages 50–51), your risk of lymphoedema is small. Women who had all or a large number of lymph nodes removed are more at risk.

Women who have had radiotherapy to the armpit as well as surgery are more likely to get lymphoedema.

There are things you can do to help reduce the chances of developing lymphoedema. It's important to protect your arm and hand, and look after the skin in that area. Here are some tips:

- Keep your skin clean and moisturise it every day with unperfumed cream or oil to keep it in good condition.
- Wash small grazes and cuts straight away, put on antiseptic cream and cover if necessary.
- See your GP immediately if you get signs of infection around a cut, for example if it becomes red, hot or swollen.
- Where possible avoid needles such as blood tests, injections, drips or acupuncture. Avoid having your blood pressure taken in the arm on the same side as the treated breast. Your specialist nurse or doctor can give you advice on what is safe.
- Wear gloves and long sleeves when doing household tasks, DIY, gardening or when handling animals or pets.
- Use nail clippers to cut your nails and don't push back or cut the cuticles – use cuticle cream instead.
- Use an electric razor if you shave under your arms.
- Cover up in the sun and use a suncream with a high sun protection factor (SPF) of at least 30.

If you notice any swelling in your arm, hand or chest, always get it checked by your doctor or nurse. The earlier lymphoedema is diagnosed, the easier it is to manage and treat successfully.

Our booklet **Understanding lymphoedema** has more information. Call our cancer support specialists on **0808 808 00 00** or visit **be.macmillan.org.uk** to order a free copy.

Early menopause or menopausal symptoms

Some treatments can cause an early or temporary menopause. Hormonal therapies can cause side effects that are the same as menopausal symptoms.

Doctors don't recommend hormone replacement therapy (HRT) because it contains oestrogen, which could encourage breast cancer cells to grow. If your menopausal symptoms are severe and nothing else has helped, some doctors may occasionally prescribe HRT. You will need to talk this over with your doctor to make sure you know the possible risks.

There are different ways to treat menopausal symptoms. We have a fact sheet about breast cancer and menopausal symptoms that has more information.

Hot flushes and sweats

Low doses of antidepressant tablets, such as paroxetine and fluoxetine, help to reduce flushes. Doctors don't prescribe these if you are taking tamoxifen, as they can interfere with how it works.

They can prescribe other antidepressants called citalopram or venlafaxine instead. Some women find that yoga and other breathing methods can also help with hot flushes.

Vaginal dryness

Non-hormonal creams and water-based lubricants can help to reduce dryness and any discomfort during sex.

Emotional symptoms

These can include mood swings, feeling anxious, and problems with concentration and memory. Talking about how you feel with your doctor, nurse, family or friends can help. Some women find it helps to talk things through with a counsellor.

Early menopause can increase the risk of bone thinning (osteoporosis). We have more information about looking after your bones on page 98, including helpful tips on keeping them healthy.

A number of organisations, including The Daisy Network (see page 126), provide support to women going through the menopause.

We also have a video on our website about coping with menopausal symptoms. You can watch it at [macmillan.org.uk/breast/menopausalsymptoms](https://www.macmillan.org.uk/breast/menopausalsymptoms)

Well-being and recovery

After breast cancer treatment, some women choose to make some positive lifestyle changes. Or you may already have a healthy lifestyle and now feel you want to make the most of your health.

Eat well and keep to a healthy weight

After treatment, it's quite common for women to find they have put on some weight. This can happen with chemotherapy and hormonal therapy. When you are feeling up to it, you can check with your GP if your weight is within the normal range for your height. Our booklet **Managing weight gain after cancer treatment** has some helpful tips.

There is some evidence that keeping to a healthy weight after the menopause may help reduce the risk of breast cancer coming back. We already know it reduces the risk of heart problems, diabetes and developing some other cancers.

Here are some tips for keeping to a healthy weight:

- Try not to over eat.
- Eat a balanced diet with lots of fruit and vegetables.
- Eat less saturated fat and sugar.
- Be more active.

There is information about healthy eating in our booklet **Healthy eating and cancer**. Call us on **0808 808 00 00** or visit **be.macmillan.org.uk** to order a free copy.

Be physically active

Being physically active helps to keep your weight healthy and can reduce stress and tiredness. It helps to keep your bones strong and your heart healthy. There is some evidence that regular physical activity may help to reduce the risk of breast cancer coming back.

We have a booklet called **Physical activity and cancer treatment**, which has more information.

Look after your bones

Aromatase inhibitors (see page 78) and treatments that cause an early or temporary menopause increase the risk of bone thinning (osteoporosis). This is because oestrogen helps keep bones healthy and strong. Keeping physically active, such as walking, eating a healthy diet with enough calcium and vitamin D, and not smoking, keeps bones healthy.

Our booklet **Bone health** has more information.

Look after your heart

Some treatments may increase the risk of getting heart problems later in life. Look after yourself by keeping physically active, eating healthily, not smoking and sticking to sensible drinking guidelines. British Heart Foundation (see page 125) has helpful information and advice.

Give up smoking

If you smoke, giving up is the single most important thing you can do for your health. Smoking increases your risk of bone thinning (osteoporosis), some cancers and heart disease. Our leaflet **Giving up smoking** has more information and tips to help you quit. Call us on **0808 808 00 00** or visit **be.macmillan.org.uk** to order a free copy.

Limit how much alcohol you drink

Stick to sensible drinking guidelines. NHS guidelines recommend that women should:

- not regularly drink more than 14 units of alcohol in a week
- spread the alcohol units they drink in a week over three or more days
- try to have several alcohol-free days every week.

Getting help and support

Different people can help you during and after treatment.

Practical help

If you need help at home during or after treatment, a nurse or hospital social worker may be able to arrange this. If you have children, the social worker may arrange some help with childcare. We have a fact sheet about childcare that has more information.

A social worker or benefits adviser can tell you about benefits you may be able to claim and help with other costs.

Emotional help

It's common to have different, and sometimes difficult, feelings after cancer treatment (see pages 104–107). But as you recover and get back to your everyday life, these usually get easier to deal with. Talking to family and friends often helps. If you think you may be depressed, or feel helpless or anxious a lot of the time, talk to your cancer specialist or specialist nurse. They can refer you to a psychologist or counsellor who specialises in the emotional problems of people with cancer.

Our cancer support specialists can tell you more about counselling and let you know about services in your area. Call them on **0808 808 00 00**.

'My advice is to definitely treat yourself well. Make yourself feel as good as you possibly can. And there are many ways to make yourself feel good, if you have the energy and you're able to physically and mentally.'

Rocio

Complementary therapies

Some women find that using complementary therapies helps them to relax or cope with treatment side effects. Some hospitals or support groups may offer therapies such as relaxation or aromatherapy. Our booklet **Cancer and complementary therapies** has more information.

Support groups

Self-help or support groups offer a chance to talk to other women who understand what you are going through. You can call us or visit our website ([macmillan.org.uk/supportgroups](https://www.macmillan.org.uk/supportgroups)) for information about support groups in the UK.

Online support

Many people get support on the internet. There are online support groups, social networking sites, forums, chat rooms and blogs for people affected by cancer. You can use these to share your experience and to ask questions, get and give advice based on your breast cancer experience.

Our online community ([macmillan.org.uk/community](https://www.macmillan.org.uk/community)) is a social networking site where you can talk to people, write blogs, make friends and join support groups.



YOUR FEELINGS AND RELATIONSHIPS

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Your feelings

It's common to feel overwhelmed by different feelings when you're told you have cancer. We talk about some of these here. Partners, family and friends may also have some of the same feelings.

You might have different reactions to the ones we describe here. There is no right or wrong way to feel. You'll cope with things in your own way. Talking to people close to you or other people affected by cancer can often help.

Shock and disbelief

You may find it hard to believe when your doctor tells you that you have cancer. It's common to feel shocked and numb.

You may not be able to take in much information and find that you keep asking the same questions again and again.

At first, you might find it hard to talk to family and friends about the cancer. This usually gets easier as the shock wears off and it becomes more real to you.

You may find you can't think or talk about anything but the cancer. This is because your mind is trying to process what you're going through.

Fear and anxiety

People can be very anxious or frightened about whether treatment will work and what will happen in the future. This uncertainty can be one of the hardest things to cope with.

It can help to try to focus on what you can control. You may want to find out more about the cancer, its treatment and how to manage side effects. It can also help to talk about your feelings and to take time to do things that are important to you and that you enjoy.

Doctors often know roughly how many people can benefit from a type of treatment. But they can't be sure what will happen to an individual person. Although they may not be able to answer your questions fully, they can usually talk through any problems with you and give you some guidance.

Avoidance

Some people cope by not wanting to know very much about the cancer and by not talking about it. If you feel like this, let your family and friends know that you don't want to talk about it now. You can also tell your doctor if there are things you don't want to know or talk about yet.

Occasionally, this avoidance can be extreme. Some people may not believe that they have cancer. This is sometimes called being in denial. It may stop them making decisions about treatment. If this happens, it's very important for them to get help from their doctor.

Sometimes, avoidance is the other way around. Family and friends may seem to avoid you and the fact that you have cancer. They may not want to talk about it or they might change the subject. This is usually because they are also finding the cancer difficult to cope with, and they may need support too. Try to let them know how this makes you feel and that talking openly with them about your illness will help you.

Anger

You may feel angry about your illness and sometimes resent other people for being well. These are normal reactions, especially when you feel frightened, stressed, out of control or unwell.

You may get angry with the people close to you. Let them know that you are angry at your illness and not at them. Finding ways to help you relax and reduce stress can help with anger. This can include talking about or writing down how you feel, gentle exercise, breathing or relaxation therapy, yoga or meditation.

Guilt and blame

Some people feel guilty or blame themselves or others for the cancer. You may try to find reasons for why it has happened to you. Most of the time, it's impossible to know exactly what has caused a person's cancer. Over time, several different factors may act together to cause a cancer. Doctors don't fully understand all of these factors yet.

Instead, try to focus on looking after yourself and getting the help and support you need.

Feeling alone

Some people feel alone because they don't have enough support. Family and friends may live far away, have other commitments or feel uncomfortable because of their own fears about cancer.

Try to let your family and friends know how you feel and how they could support you more.

If you need more support, you can call the Macmillan Support Line free on **0808 808 00 00** and talk to one of our cancer support specialists. Our website can help you find out about local support groups – visit **macmillan.org.uk/supportgroups**

You can also talk to other people going through the same thing on our online community at **macmillan.org.uk/community**

It's normal to have times when you want to be left alone to sort out your feelings. But if you find you're avoiding people a lot of the time, try to talk to your doctor or nurse.

If you need more help

These feelings can be very difficult to cope with and sometimes people need more help. This happens to lots of people and doesn't mean you're not coping.

If you feel anxious, panicky or sad a lot of the time, or think you may be depressed, talk to your doctor or nurse. They can refer you to a doctor or counsellor who can help. They may also prescribe medicine to help with anxiety or an antidepressant drug.

Our booklet **How are you feeling? The emotional effects of cancer** discusses the feelings you may have in more detail, and has suggestions for coping with them. Call us on **0808 808 00 00** or visit **be.macmillan.org.uk** to order a free copy.

Relationships

Your cancer experience may have improved your relationships with people close to you. Support from family and friends may have helped you cope. But cancer is stressful and can affect your relationships.

Your partner

Some couples become closer when one partner has cancer. However, cancer can put a lot of strain on a relationship. Problems can develop, even between couples who have been together for a long time. If a relationship was already difficult, the stress of a major illness may make things worse.

Even couples who are close may not always know how their partner is feeling. Talking openly about your feelings and listening to each other can help you understand each other.

Our booklets **Cancer, you and your partner** and **Sexuality and cancer** have more information that may help.

Family and friends

Your family and friends may not always understand if you are not feeling positive. They may not know how much your treatment is affecting your life. Talking about how you feel will help them give you the support you need. Our booklet **Talking about cancer – a guide for people with cancer** has some more useful tips.

If you are a relative or friend

Some people find it hard to talk about cancer or share their feelings. You might think it's best to pretend everything is fine, and carry on as normal. You might not want to worry the person with cancer, or you might feel you're letting them down if you admit to being afraid. Unfortunately, denying strong emotions can make it even harder to talk, and may lead to the person with cancer feeling very isolated.

Partners, relatives and friends can help by listening carefully to what the person with cancer wants to say. It may be best not to rush into talking about the illness. Often it's enough just to listen and let the person with cancer talk when they are ready.

You may find some of the courses on our Learn Zone website helpful. There are courses to help with listening and talking, to help friends and family support their loved ones affected by cancer. Visit [macmillan.org.uk/learnzone](https://www.macmillan.org.uk/learnzone) to find out more.

Our booklet **Talking with someone who has cancer** has more suggestions if you have a friend or relative with cancer.

If you're looking after a family member or friend with cancer, you may find our booklet **Looking after someone with cancer** helpful. It's based on carers' experiences and has lots of practical tips and information.

We have more information about supporting someone with cancer at [macmillan.org.uk/carers](https://www.macmillan.org.uk/carers)

Talking to children

It can be hard to know what to tell your children or grandchildren about your cancer. It is usually best to be open and honest.

Even very young children can sense when something is wrong, and their fears can sometimes be worse than the reality.

How much you tell your children will depend on their age and how mature they are. It may be best to start by giving them a small amount of information and gradually tell them more.

Teenagers can have a very hard time. If they find it hard to talk to you, you could suggest they talk to someone close who can support and listen to them. This could be a grandparent, family friend, teacher or counsellor. They may also find the website **riprap.org.uk** helpful. This is for teenagers who have a parent with cancer.

Our booklet **Talking to children and teenagers when an adult has cancer** has more information. There is also a video on our website that may help at **macmillan.org.uk/talkingtochildren**





WORK AND FINANCIAL SUPPORT

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Work

You may need to take time off work during your treatment and for a while afterwards. It can be hard to judge the best time to go back to work, and this will depend mainly on the type of work you do and how much your income is affected. It's important to do what's right for you.

Getting back into your normal routine can be very helpful, and you may want to go back to work as soon as possible. It can be helpful to talk to your employer about the situation – it may be possible for you to work part-time or job share.

On the other hand, it can take a long time to recover fully from cancer treatment, and it may be many months before you feel ready to return to work. It's important not to take on too much, too soon. Your consultant, GP or specialist nurse can help you decide when and if you should go back to work.

Employment rights

The Equality Act 2010 protects anyone who has, or has had, cancer. Even if a person who had cancer in the past has been successfully treated and is now cured, they are still covered by the act. This means their employer must not discriminate against them for any reason, including their past cancer. The Disability Discrimination Act protects people in Northern Ireland.

Our booklets **Work and cancer**, **Working while caring for someone with cancer** and **Self-employment and cancer** have more information. There's also lots more information at macmillan.org.uk/work

Financial help and benefits

If you are struggling to cope with the financial effects of cancer, help is available.

If you cannot work because you are ill, you may be able to get Statutory Sick Pay. Your employer will pay this for up to 28 weeks of sickness. If you qualify for it, they cannot pay you less.

Before your Statutory Sick Pay ends, or if you do not qualify for it, check whether you can get Employment and Support Allowance (ESA). This benefit is for people who cannot work because they are ill or disabled. There are two different types of ESA:

- contribution-based (contributory) – you can get this if you have paid enough national insurance
- income-related (means tested) – you can get this if you don't qualify for contribution based ESA or if your income is low.

ESA is gradually being replaced by a new benefit called Universal Credit. This benefit is for people below retirement age in England, Scotland and Wales who are out of work or on a low income.

Personal Independence Payment (PIP) is a new benefit for people aged between 16 and 64. It is for people who have problems moving around and looking after themselves. You must have had these difficulties for at least three months and expect them to last for at least nine months. PIP replaces an older benefit called Disability Living Allowance (DLA) for adults in England, Scotland and Wales.

Attendance Allowance (AA) is for people aged 65 or over who have problems looking after themselves. You may qualify if you have problems with personal care, for example getting out of bed, having a bath or dressing yourself. You don't need to have a carer, but you must have had these problems for at least six months.

If you are terminally ill, and may be expected to live for less than six months, you can apply for PIP, DLA or AA under the special rules. It does not have to be certain and it does not matter if you live longer than six months. This means your claim will be dealt with quickly and you will get the benefit you applied for at the highest rate.

Help for carers

Carer's Allowance is a weekly benefit that helps people who look after someone with a lot of care needs. If you don't qualify for it, you can apply for Carer's Credit. This helps you to build up qualifying years for a State Pension.

More information

The benefits system can be hard to understand, so it's a good idea to talk to an experienced welfare rights adviser. You can speak to one by calling the Macmillan Support Line on **0808 808 00 00**.

We've just listed some benefits here, but there may be others you can get. You can find out about state benefits and apply for them online at **gov.uk** (England, Wales and Scotland) and **nidirect.gov.uk** (Northern Ireland). These websites have information about financial support, your rights, employment and independent living.

You can also get information about these issues from the relevant Department for Work and Pensions helplines or Citizens Advice (see page 131).

Our booklet **Help with the cost of cancer** has more detailed information. You might also find our video at [macmillan.org.uk/gettingfinancialhelp](https://www.macmillan.org.uk/gettingfinancialhelp) useful.

Insurance

People who have, or have had, cancer may find it hard to get certain types of insurance, including life and travel insurance. A financial adviser can help you look at your needs and find the best deal for you. You can find a financial adviser by contacting one of the organisations on page 131.

Our booklets **Insurance** and **Getting travel insurance** may also be helpful. Call us on **0808 808 00 00** or visit [be.macmillan.org.uk](https://www.be.macmillan.org.uk) to order a free copy.

**WE ARE
MACMILLAN.
CANCER SUPPORT**

At Macmillan:

we care about you and your family, and we'll support you through every step of your cancer journey.

From our specialist nurses to our support groups, we're here for you every step of the way.

Call us on 0800 011 2222 or visit www.maccmillan.org.uk

or email info@macmillan.org.uk

or visit www.maccmillan.org.uk

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About our information

We provide expert, up-to-date information about cancer. And all our information is free for everyone.

Order what you need

You may want to order more leaflets or booklets like this one. Visit [be.macmillan.org.uk](https://www.be.macmillan.org.uk) or call us on **0808 808 00 00**.

We have booklets on different cancer types, treatments and side effects. We also have information about work, financial issues, diet, life after cancer and information for carers, family and friends.

All of our information is also available online at [macmillan.org.uk/cancerinformation](https://www.macmillan.org.uk/cancerinformation). There you'll also find videos featuring real-life stories from people affected by cancer, and information from health and social care professionals.

Other formats

We also provide information in different languages and formats, including:

- audiobooks
- Braille
- British Sign Language
- Easy Read booklets
- ebooks
- large print
- translations.

Find out more at [macmillan.org.uk/otherformats](https://www.macmillan.org.uk/otherformats)

If you'd like us to produce information in a different format for you, email us at cancerinformationteam@macmillan.org.uk or call us on **0808 808 00 00**.

Help us improve our information

We know that the people who use our information are the real experts. That's why we always involve them in our work. If you've been affected by cancer, you can help us improve our information.

We give you the chance to comment on a variety of information including booklets, leaflets and fact sheets.

If you'd like to hear more about becoming a reviewer, email [**reviewing@macmillan.org.uk**](mailto:reviewing@macmillan.org.uk) You can get involved from home whenever you like, and we don't ask for any special skills – just an interest in our cancer information.



Other ways we can help you

At Macmillan, we know how a cancer diagnosis can affect everything, and we're here to support you. No one should face cancer alone.

Talk to us

If you or someone you know is affected by cancer, talking about how you feel and sharing your concerns can really help.

Macmillan Support Line

Our free, confidential phone line is open Monday–Friday, 9am–8pm. Our cancer support specialists can:

- help with any medical questions you have about your cancer or treatment
- help you access benefits and give you financial advice
- be there to listen if you need someone to talk to
- tell you about services that can help you in your area.

Call us on **0808 808 00 00** or email us via our website, **macmillan.org.uk/talktous**

Information centres

Our information and support centres are based in hospitals, libraries and mobile centres. There, you can speak with someone face to face. Visit one to get the information you need, or if you'd like a private chat, most centres have a room where you can speak with someone alone and in confidence. Find your nearest centre at **macmillan.org.uk/informationcentres** or call us on **0808 808 00 00**.

Talk to others

No one knows more about the impact cancer can have on your life than those who have been through it themselves. That's why we help to bring people together in their communities and online.

Support groups

Whether you are someone living with cancer or a carer, we can help you find support in your local area, so you can speak face to face with people who understand. Find out about support groups in your area by calling us or by visiting [macmillan.org.uk/selfhelpandsupport](https://www.macmillan.org.uk/selfhelpandsupport)

Online community

Thousands of people use our online community to make friends, blog about their experiences and join groups to meet other people going through the same things. You can access it any time of day or night. Share your experiences, ask questions, or just read through people's posts at [macmillan.org.uk/community](https://www.macmillan.org.uk/community)

The Macmillan healthcare team

Our nurses, doctors and other health and social care professionals give expert care and support to individuals and their families. Call us or ask your GP, consultant, district nurse or hospital ward sister if there are any Macmillan professionals near you.

'Everyone is so supportive on the online community, they know exactly what you're going through.'

Mal

Help with money worries

Having cancer can bring extra costs such as hospital parking, travel fares and higher heating bills. If you've been affected in this way, we can help.

Financial guidance

Our financial guidance team can give you advice on mortgages, pensions, insurance, borrowing and savings.

Help accessing benefits

Our benefits advisers can offer advice and information on benefits, tax credits, grants and loans. They can help you work out what financial help you could be entitled to. They can also help you complete your forms and apply for benefits.

Macmillan Grants

Macmillan offers one-off payments to people with cancer. A grant can be for anything from heating bills or extra clothing to a much-needed break.

Call us on **0808 808 00 00** to speak to a financial guide or benefits adviser, or to find out more about Macmillan Grants. We can also tell you about benefits advisers in your area. Visit [macmillan.org.uk/financialsupport](https://www.macmillan.org.uk/financialsupport) to find out more about how we can help you with your finances.

Help with work and cancer

Whether you're an employee, a carer, an employer or are self-employed, we can provide support and information to help you manage cancer at work. Visit [macmillan.org.uk/work](https://www.macmillan.org.uk/work)



Macmillan's My Organiser app

This free mobile app can help you manage your treatment, from appointment times and contact details, to reminders for when to take your medication. Search 'My Organiser' on the Apple App Store or Google Play on your phone.

Other useful organisations

There are lots of other organisations that can give you information or support.

Breast cancer support organisations

Breast Cancer Care

5–13 Great Suffolk Street,
London SE1 0NS

Helpline 0808 800 6000

Email info@

breastcancercare.org.uk

www.breastcancercare.org.uk

Provides information, practical and emotional support to people affected by breast cancer.

Breast Cancer Now

5th Floor Ibex House, 42–47
Minories, London EC3N 1DY

Tel 0333 20 70 300

Email supporterengagement@breastcancernow.org

www.breastcancernow.org

Breast Cancer Now is the UK's largest breast cancer charity, created by the merger of Breast Cancer Campaign and Breakthrough Breast Cancer.

Breast Cancer Now – Scotland

38 Thistle Street,
Edinburgh EH2 1EN

Tel 0131 226 0763

Email scotland@

breastcancernow.org

Support with symptoms and side effects

British Heart Foundation

Lyndon Place,
2096 Coventry Road,
Sheldon, Birmingham
B26 3YU

Helpline 0300 330 3311

www.bhf.org.uk

Provides information and advice to people with heart and circulatory problems. Also offers helpful tips on keeping your heart healthy.

The Daisy Network

PO BOX 71432,
London SW6 9HJ

Email daisy@

daisynetwork.org.uk

www.daisynetwork.org.uk

A support group for women who have an early menopause.

The Haven

www.thehaven.org.uk

The Haven is a national charity providing personalised care and support for people with breast cancer, helping them to achieve the best possible quality of life.

The Haven – Hereford

37 St Owen Street,
Hereford HR1 2JB

Tel 01432 361 061

Email herefordreception@
thehaven.org.uk

The Haven – London

Effie Road, London
SW6 1TB

Tel 020 7384 0099

Email londonreception@
thehaven.org.uk

The Haven – Wessex

35 The Square,
Titchfield, Hampshire
PO14 4RT

Tel 01329 559 290

Email wessexreception@
thehaven.org.uk

The Haven – Worcestershire Breast Unit

The Worcester Royal Hospital,
The Worcester Breast Cancer
Unit, Charles Hastings Way,
Worcester WR5 1DD

Tel 01905 677 862

Email worcesterreception@
thehaven.org.uk

The Haven – Yorkshire

4–5 The Gateway West,
East Street, Leeds
LS9 8DA

Tel 0113 284 7829

Email leedsreception@
thehaven.org.uk

National Osteoporosis Society

Camerton, Bath
BA2 0PJ

Helpline **0800 800 0035**

(Mon–Fri, 9am–5pm, excluding bank holidays)

Email nurses@nos.org.uk
www.nos.org.uk

A UK charity dedicated to improving the diagnosis, prevention and treatment of osteoporosis.

General cancer support organisations

Cancer Black Care

79 Acton Lane,
London NW10 8UT

Tel 020 8961 4151

Email info@cancerblackcare.org.uk

www.cancerblackcare.org.uk

Offers information and support for people with cancer from ethnic communities, their friends, carers and families.

Cancer Focus Northern Ireland

40–44 Eglantine Avenue,
Belfast BT9 6DX

Helpline 0800 783 3339

(Mon–Fri, 9am–1pm)

Email hello@cancerfocusni.org

www.cancerfocusni.org

Offers a variety of services to people affected by cancer, including a free helpline, counselling and links to local support groups.

Cancer Research UK

Angel Building,
407 St John Street,
London EC1V 4AD

Tel 0300 123 1022

www.cancerhelp.org.uk

Has patient information on all types of cancer and has a clinical trials database.

Cancer Support Scotland

The Calman Centre,
75 Shelley Road,
Glasgow G12 0ZE

Tel 0800 652 4531

Email info@cancersupportscotland.org

cancersupportscotland.org

www.cancersupportscotland.org

Runs cancer support groups throughout Scotland. Also offers free complementary therapies and counselling to anyone affected by cancer.

Maggie's Centres

The Gatehouse, 10 Dumbarton Road, Glasgow, G11 6PA

Tel 0300 123 1801

Email enquiries@maggiescentres.org

maggiescentres.org

www.maggiescentres.org

Provides information about cancer, benefits advice, and emotional or psychological support.

Riprap

Maggie's, The Stables,
Western General Hospital,
Crewe Road,
Edinburgh EH4 2XU

www.riprap.org.uk

Developed especially for teenagers who have a parent with cancer.

Tenovus

Head Office,
Gleider House,
Ty Glas Road,
Cardiff CF14 5BD

Helpline 0808 808 1010

(Mon–Sun, 8am–8pm)

Email info@tenovuscancercare.org.uk

tenovuscancercare.org.uk

www.tenovus.org.uk

Aims to help everyone get equal access to cancer treatment and support. Funds research and provides support such as mobile cancer support units, a free helpline, an 'Ask the nurse' service on the website and benefits advice

General health information

Health and Social Care in Northern Ireland

www.hscni.net

Provides information about health and social care services in Northern Ireland.

Healthtalk**Email**

info@healthtalkonline.org

www.healthtalk.org

www.youthhealthtalk.org

(site for young people)

Has information about cancer, and videos and audio clips of people's experiences.

NHS Choices

www.nhs.uk

The UK's biggest health information website.

Has service information for England.

NHS Direct Wales

www.nhsdirect.wales.nhs.uk

NHS health information site for Wales.

NHS Inform

www.nhsinform.co.uk

NHS health information site for Scotland.

Patient UK

www.patient.info

Provides people in the UK with information about health and disease. Includes evidence-based information leaflets on a wide variety of medical and health topics. Also reviews and links to many health- and illness-related websites.

Counselling and emotional support**British Association for Counselling and Psychotherapy (BACP)**

BACP House,
15 St John's Business Park,
Lutterworth,
Leicestershire LE17 4HB

Tel 01455 883 300

Email bacp@bacp.co.uk

www.bacp.co.uk

Promotes awareness of counselling and signposts people to appropriate services. You can search for a qualified counsellor at www.itsgoodtotalk.org.uk

College of Sexual and Relationship Therapists (COSRT)

PO Box 13686,

London SW20 9ZH

Tel 020 8543 2707

Email info@cosrt.org.uk

www.cosrt.org.uk

Provides information and support on sexual problems.

Relate

Premier House,

Carolina Court, Lakeside,

Doncaster DN4 5RA

Tel 0300 100 1234

www.relate.org.uk

Offers advice, relationship counselling, sex therapy, workshops, mediation, consultations and support face to face, by phone and online.

Support for carers

Carers Trust

Email support@carers.org

www.carers.org

Provides support, information, advice and services for people caring at home for a family member or friend. You can find details for UK offices and search for local support on the website.

Support for young people

Riprap

www.riprap.org.uk

Developed especially for teenagers who have a parent with cancer.

Teenage Cancer Trust

3rd Floor, 93 Newman Street,

London W1T 3EZ

Tel 020 7612 0370

Email [hello@](mailto:hello@teenagecancertrust.org)

teenagecancertrust.org

www.teenagecancertrust.org

A charity devoted to improving the lives of teenagers and young adults with cancer. Runs a support network for young people with cancer, their friends and families.

Support for older people

Age UK

Tavis House,

1–6 Tavistock Square,

London WC1H 9NA

Helpline (England and

Wales) 0800 169 2081

Helpline (Scotland)

0800 470 8090

Helpline (Northern Ireland)

0808 808 7575

(Daily, 8am–7pm)

www.ageuk.org.uk

Provides information and advice for older people across the UK via the website and advice line. Also publishes impartial and informative fact sheets and advice guides.

Financial or legal advice and information**Citizens Advice**

Provides advice on a variety of issues including financial, legal, housing and employment issues. Find details for your local office in the phone book or on one of these websites:

England and Wales

www.citizensadvice.org.uk

Scotland

www.cas.org.uk

Northern Ireland

www.citizensadvice.co.uk

Department for Work and Pensions (DWP) Personal Independence Payment Helpline

0345 850 3322

Textphone 0345 601 6677

Carer's Allowance Unit

0345 608 4321

Textphone 0345 604 5312

www.gov.uk/browse/benefits

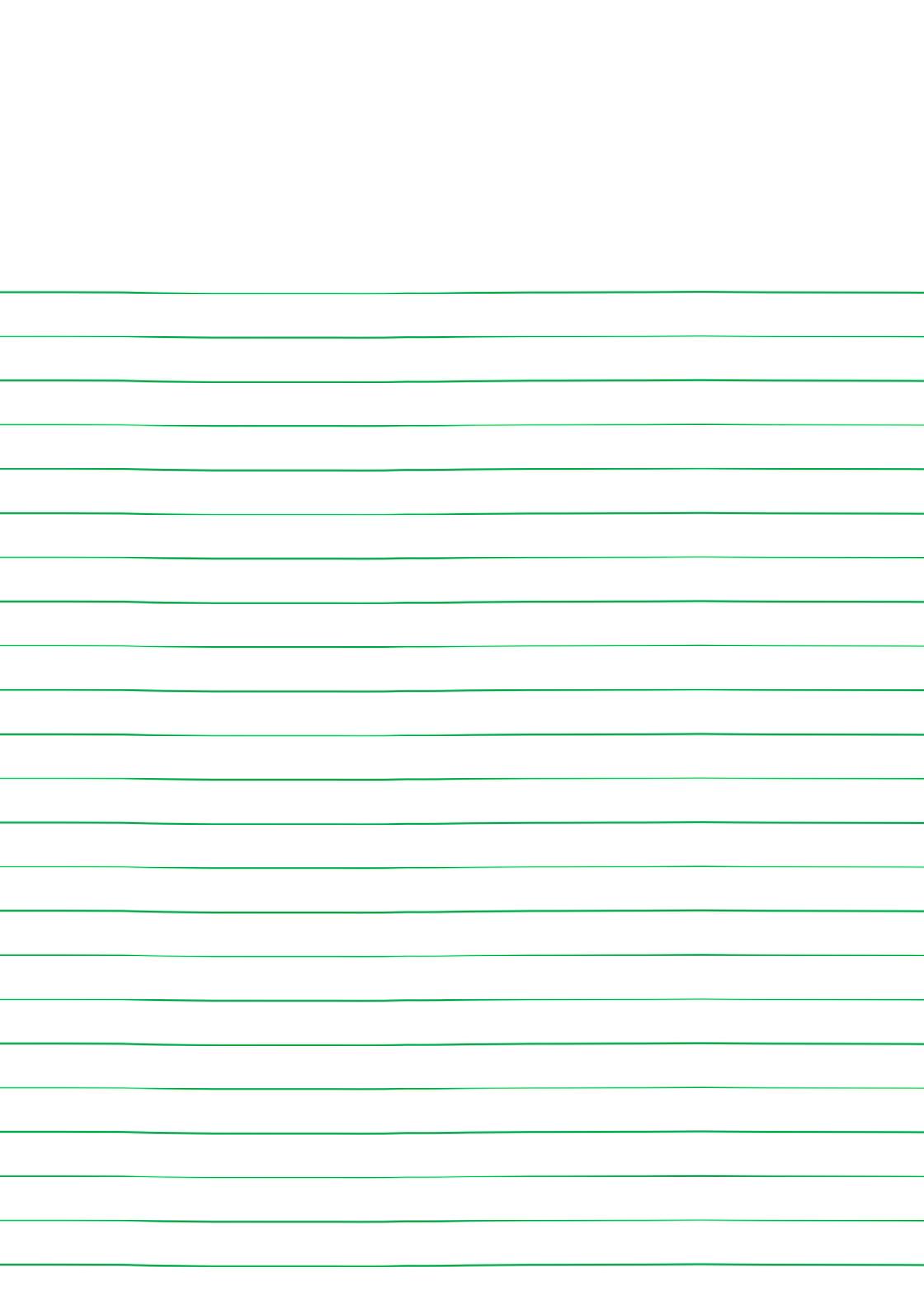
Manages state benefits in England, Scotland and Wales. You can apply for benefits and find information online or through its helplines.

GOV.UK**www.gov.uk**

Has information about social security benefits and public services in England, Scotland and Wales.



You can search for more organisations on our website at **macmillan.org.uk/organisations** or call us on **0808 808 00 00**.



Disclaimer

We make every effort to ensure that the information we provide is accurate and up to date but it should not be relied upon as a substitute for specialist professional advice tailored to your situation. So far as is permitted by law, Macmillan does not accept liability in relation to the use of any information contained in this publication, or third-party information or websites included or referred to in it. Some photos are of models.

Thanks

This booklet has been written, revised and edited by Macmillan Cancer Support's Cancer Information Development team. It has been approved by our Senior Medical Editor, Dr Rebecca Roylance, Consultant Medical Oncologist, and by our Chief Medical Editor, Dr Tim Iveson, Macmillan Consultant Medical Oncologist.

With thanks to: Dr Anne Armstrong, Consultant Clinical Oncologist; Rosemary Burch, Clinical Nurse Specialist in Breast Care and Miss Joanna Franks, Consultant Breast Surgeon. Thanks also to the people affected by cancer who reviewed this edition, and to those who shared their stories.

Sources

We've listed a sample of the sources used in this publication below. If you'd like further information about the sources we use, please contact us at [**bookletfeedback@macmillan.org.uk**](mailto:bookletfeedback@macmillan.org.uk)

Association of Breast Surgery at BASO 2009. Surgical guidelines for the management of breast cancer. *European Journal of Surgical Oncology*. 2009. S1–S22.

Early and localised breast cancer: diagnosis and treatment. February 2009.

National Institute for Health and Care Excellence (NICE).

Primary breast cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. ESMO Guidelines Working Group. *Annals of Oncology*. 2015. 26 Supplement 5.

SIGN 134: Treatment of primary breast cancer. September 2013.

Scottish SIGN guidelines.

Can you do something to help?

We hope this booklet has been useful to you. It's just one of our many publications that are available free to anyone affected by cancer. They're produced by our cancer information specialists who, along with our nurses, benefits advisers, campaigners and volunteers, are part of the Macmillan team. When people are facing the toughest fight of their lives, we're there to support them every step of the way.

We want to make sure no one has to go through cancer alone, so we need more people to help us. When the time is right for you, here are some ways in which you can become a part of our team.



Share your cancer experience

Support people living with cancer by telling your story, online, in the media or face to face.

Campaign for change

We need your help to make sure everyone gets the right support. Take an action, big or small, for better cancer care.

Help someone in your community

A lift to an appointment. Help with the shopping. Or just a cup of tea and a chat. Could you lend a hand?

Raise money

Whatever you like doing you can raise money to help. Take part in one of our events or create your own.

Give money

Big or small, every penny helps. To make a one-off donation see over.

Call us to find out more

0300 1000 200

macmillan.org.uk/getinvolved

Please fill in your personal details

Mr/Mrs/Miss/Other

Name

Surname

Address

Postcode

Phone

Email

Please accept my gift of £

(Please delete as appropriate)

I enclose a cheque / postal order /
Charity Voucher made payable to
Macmillan Cancer Support

OR debit my:

Visa / MasterCard / CAF Charity
Card / Switch / Maestro

Card number

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Security number

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Signature

Date / /

Don't let the taxman keep your money

Do you pay tax? If so, your gift will be worth 25% more to us – at no extra cost to you. All you have to do is tick the box below, and the tax office will give 25p for every pound you give.

- I am a UK tax payer and I would like Macmillan Cancer Support to treat all donations I make or have made to Macmillan Cancer Support in the last 4 years as Gift Aid donations, until I notify you otherwise.

I understand that if I pay less Income Tax and/or Capital Gains Tax than the amount of Gift Aid claimed on all my donations in that tax year it is my responsibility to pay any difference. I understand Macmillan Cancer Support will reclaim 25p of tax on every £1 that I give.

Macmillan Cancer Support and our trading companies would like to hold your details in order to contact you about our fundraising, campaigning and services for people affected by cancer. If you would prefer us not to use your details in this way please tick this box.

In order to carry out our work we may need to pass your details to agents or partners who act on our behalf.



If you'd rather donate online go to macmillan.org.uk/donate

Please cut out this form and return it in an envelope (no stamp required) to:
Supporter Donations, Macmillan Cancer Support, FREEPOST LON15851,
89 Albert Embankment, London SE1 7UQ

More than one in three of us will get cancer. For most of us it will be the toughest fight we ever face. And the feelings of isolation and loneliness that so many people experience make it even harder. But you don't have to go through it alone. The Macmillan team is with you every step of the way.

We are the nurses and therapists helping you through treatment. The experts on the end of the phone. The advisers telling you which benefits you're entitled to. The volunteers giving you a hand with the everyday things. The campaigners improving cancer care. The community there for you online, any time. The supporters who make it all possible.

Together, we are all Macmillan Cancer Support.

For cancer support every step of the way, call Macmillan on 0808 808 00 00 (Mon–Fri, 9am–8pm) or visit macmillan.org.uk

Hard of hearing? Use textphone 0808 808 0121, or Text Relay.
Non-English speaker? Interpreters available.
Braille and large print versions on request.

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