

A practical guide to understanding cancer

UNDERSTANDING INVASIVE AND ADVANCED BLADDER CANCER



About this booklet

This booklet is for people who have invasive or advanced bladder cancer. We hope it answers some of your questions and helps you deal with some of the feelings you may have.

Invasive bladder cancer is cancer that has spread from the inner lining of the bladder where it started, into the muscle layer. Doctors may call this muscle-invasive bladder cancer or MIBC. In this booklet, we call it invasive bladder cancer.

Advanced bladder cancer is cancer that has spread into tissues or organs close to the bladder. It is also cancer that has spread to another part of the body, such as the lungs or liver. Doctors usually call this metastatic bladder cancer.

Bladder cancer that is only in the inner lining of the bladder is called non-invasive bladder cancer. It is treated differently to invasive bladder cancer. You can read more in our booklet **Understanding non-invasive bladder cancer**.

In this booklet, we've included quotes from people affected by invasive bladder cancer. They are members of our Online Community – [macmillan.org.uk/community](https://www.macmillan.org.uk/community) You can visit the community to read more experiences or share yours.

We can't advise you about the best treatment for you. This information can only come from your doctor, who knows your full medical history.

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. Or you can visit **macmillan.org.uk**

Turn to pages 117–124 for some useful addresses and websites. On page 125, there is space to write down any notes or questions you have.

If you find this booklet helpful, you could pass it on to your family and friends. They may also want information to help them support you.

How to use this booklet

We've divided the booklet into parts to help you find the information you need. You can go to any section or chapter in the booklet and start reading from there. For example, if you are only having chemotherapy, it's fine to skip the other treatment sections that aren't relevant to you.

Finding out you have cancer can be a very emotional time. There is information on taking care of yourself and getting the support you need on pages 92–95.

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ABOUT INVASIVE AND ADVANCED BLADDER CANCER

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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 of 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 die.

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 cancerous. Doctors can tell if a lump is cancerous 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.

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

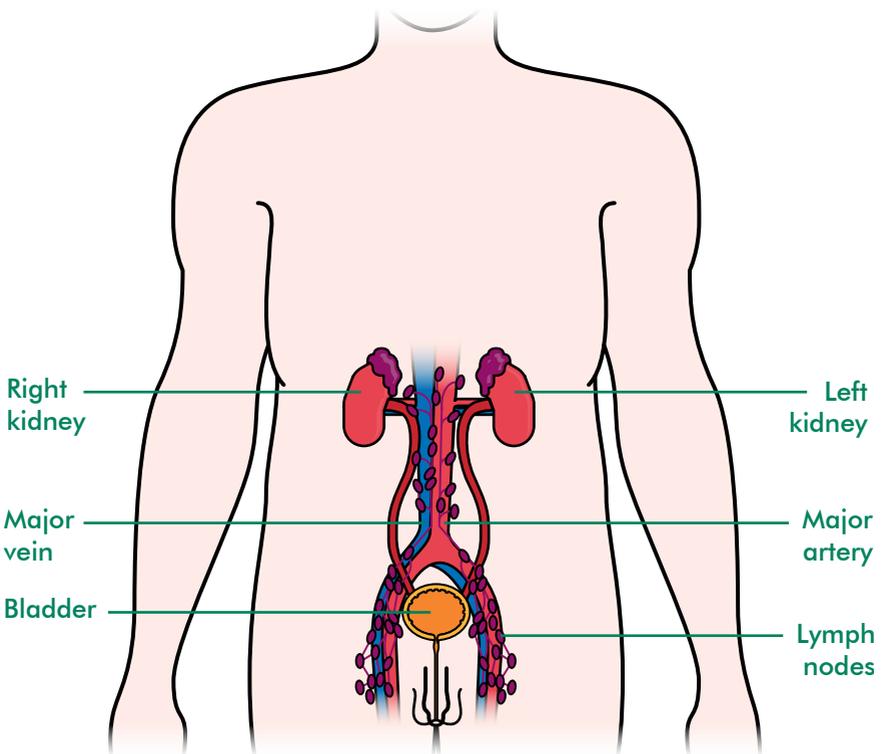
A lump that is cancer (**malignant**) can grow into nearby tissue. Sometimes, cancer cells spread from where the cancer first started (the primary site) to other parts of the body. They can travel through the blood or lymphatic system (see opposite page). When the cells reach another part of the body, they may begin to grow and form another tumour. This is called a **secondary cancer** or a **metastasis**.

The lymphatic system

The lymphatic system helps to protect us from infection and disease. It also drains lymph fluid from the tissues of the body before returning it to the blood. The lymphatic system is made up of fine tubes called lymphatic vessels that connect to groups of **lymph nodes** throughout the body.

Lymph nodes (sometimes called lymph glands) are small and bean-shaped. They filter bacteria (germs) and disease from the lymph fluid. When you have an infection lymph nodes often swell as they fight the infection.

The lymphatic system



The bladder

The bladder is a hollow, muscular, balloon-like organ that collects and stores urine. It sits in the lower part of the tummy (abdomen), called the pelvis.

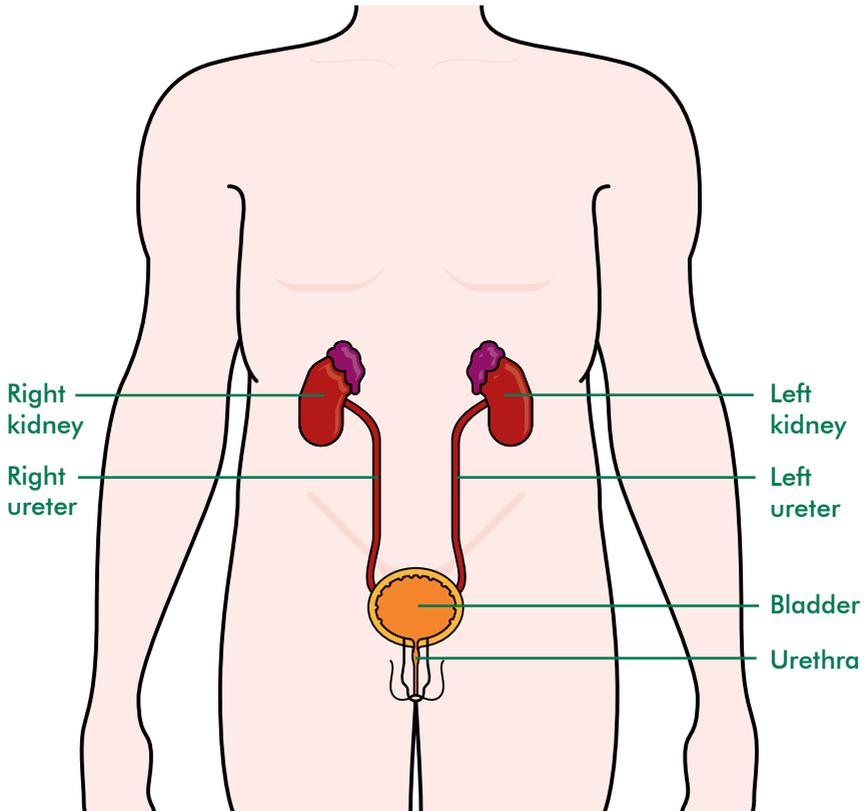
The inside of the bladder is covered with a urine-proof lining called the **urothelium**. This stops urine from being absorbed back into the body. The cells that make up this lining are called **urothelial cells** or **transitional cells**.

Urine is made in the kidneys. It travels to the bladder through tubes called **ureters** (see diagram on the next page). Urine is made up of water and waste products that the body doesn't need.

When the bladder is full, it sends messages (nerve signals) to the brain. This makes you feel like you need to empty your bladder.

The bladder muscle contracts and squeezes the urine out of the body through the **urethra**. In women, the urethra is a short tube that lies in front of the vagina. In men, the urethra is longer and passes through the prostate gland to the tip of the penis.

Position of the bladder in the body



Causes and risk factors

Each year, over 10,000 people in the UK are diagnosed with bladder cancer.

There are certain things that can affect the chances of developing bladder cancer. These are called risk factors. But having a risk factor doesn't necessarily mean a person will get bladder cancer. And people without risk factors can also develop bladder cancer.

Age

Bladder cancer is more common in people over 60. A few people under the age of 40 get bladder cancer.

Smoking

Smoking may cause about 4 in 10 (40%) of bladder cancers. Chemicals that can cause bladder cancer are present in cigarette smoke. These chemicals eventually pass into the urine through the blood. They can damage the cells that line the bladder. Over many years, this could cause bladder cancer.

The longer a person smokes and the more cigarettes they smoke, the greater the risk.

There is more information about smoking and your health on page 93. We also have tips and advice in our booklet

Giving up smoking.

Gender

Bladder cancer is more common in men than in women.

Exposure to chemicals at work

These include chemicals previously used in dye factories and industries such as rubber, leather, textile, printing, hairdressing, gasworks, plastic and paint. Many of these chemicals are now banned. But it can take more than 25 years after exposure to them for bladder cancer to develop.

If you think chemicals at your work may have caused the cancer, you may be able to claim Industrial Injuries Disablement Benefit. The Department for Work and Pensions (visit [gov.uk](https://www.gov.uk)) has more information about this benefit. If you live in Northern Ireland, NI direct (see [nidirect.gov.uk](https://www.nidirect.gov.uk)) has more information.

Infection

Repeated urinary infections and untreated bladder stones are linked with a less common type of bladder cancer, called squamous cell cancer.

People who are paralysed because of an injury to their spinal cord can have more bladder infections. This may be why they have a higher risk of bladder cancer.

Previous treatment for cancer

People who have had radiotherapy to the pelvis have an increased risk of bladder cancer. People who have had the chemotherapy drug cyclophosphamide also have an increased risk. But the benefits of cyclophosphamide treatment far outweigh the risk of bladder cancer.

Diabetes

Diabetes has been linked with an increased risk of bladder cancer. A drug called pioglitazone is likely to be the cause of this. Other medicines for diabetes are not linked with an increased risk of bladder cancer.

Family history

If you have a close relative who has had bladder cancer, your risk of developing it increases slightly. This may be due to sharing certain risk factors, such as smoking.

Rarely, an inherited gene may increase the risk of bladder cancer. But having a close relative who has also had bladder cancer does not mean an inherited gene has caused it. If you are worried about this, talk to your doctor or specialist nurse.

Bladder cancer isn't infectious and can't be passed on to other people.

Types of bladder cancer

Urothelial bladder cancer

This is the most common type of bladder cancer. It's also known as **transitional cell carcinoma** or **TCC**. It starts in cells in the bladder lining (urothelial or transitional cells). This cancer may be non-invasive or invasive (see pages 27–29).

In non-invasive bladder cancer, the cancer cells are only in the inner lining of the bladder. There's more information in our booklet **Understanding non-invasive bladder cancer**.

This information is about invasive or advanced bladder cancer. This is when the cancer has spread into the muscle, through the muscle, or to other parts of the body.

Less common types of bladder cancer

Less common types of bladder cancer include squamous cell cancer and adenocarcinoma. They start from different types of cells in the bladder lining and are usually invasive.

You can call our support line on **0808 808 00 00** for more information about these types of bladder cancer.

Symptoms

Blood in the urine (haematuria)

This is the most common symptom of bladder cancer. It can happen suddenly and may come and go. Your urine may look pink, red or sometimes brown. Or you may see streaks or clots of blood in it. If you see blood in your urine, it is important to get it checked by your GP straight away.

Sometimes blood in the urine can't be seen and is found during a urine test. This is called non-visible or microscopic haematuria. If you have urinary symptoms (see below), your doctor will ask you to provide a sample of urine. They test this for non-visible blood.

Urinary symptoms

Some people have a burning feeling when they pass urine. Or, they feel the need to pass urine more often or urgently. These symptoms are usually caused by infection rather than cancer. Some people may need more tests to find out the cause of their urinary symptoms.

Pain in the lower part of the tummy or back

This is less common, but it may happen in some people.

There are different causes for these symptoms, such as an infection, kidney stones or bladder stones. But if you have any of these symptoms, it's important to get them checked by your GP. The earlier bladder cancer is diagnosed, the more likely it is to be cured.

'I would suddenly need to go to the toilet and that had to happen straight away. Then it would just go away. I went to see the GP and told them that something was definitely wrong. I just didn't know what it was.'

Alex



DIAGNOSING INVASIVE AND ADVANCED BLADDER CANCER

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How it is diagnosed

Most people are diagnosed after going to see their GP when they notice symptoms. Your GP will talk to you about your symptoms and ask you for a sample of your urine. They can do a quick test to find out if there is any blood in your urine (haematuria). The sample is then sent to a laboratory to check for infection.

If you have blood in your urine, your GP will make sure there is no obvious reason for this, such as an infection.

Your GP should arrange for you to see a specialist if:

- you can see blood in your urine which can't be explained
- you can still see blood in your urine after having treatment for a urine infection
- a urine test finds blood in your urine and you have urinary symptoms but don't have a urine infection.

Most people are referred to a haematuria clinic for tests and to see a specialist. You can usually have most of the tests done on the same day.

Some people are referred to hospital to see a specialist. You may see a doctor who specialises in diagnosing and treating urinary, bladder and kidney problems (a urologist). Or you may see a nurse called a urology nurse specialist.

At the hospital

The urologist or urology nurse specialist will ask you about your symptoms and your general health. They will examine you by feeling your tummy (abdomen) and bladder. Then they will talk to you about the tests you need.

Having tests to diagnose bladder cancer can take a while and some may need to be repeated. This can be frustrating, but it's important your doctor has all the information they need to make the diagnosis. You'll usually have some of the following tests:

Blood tests

You will have samples of your blood taken. These are used to check your general health and number of blood cells in your blood (blood count). They can also show how well your kidneys are working.

Urine tests

A sample of your urine can be tested to look for cancer cells.

Some people may have a test which looks for substances in the urine that are present in bladder cancer. This is called molecular testing and is only occasionally done.

Flexible cystoscopy

This is the main test used to diagnose bladder cancer. A cystoscope is a thin tube with a camera and light on the end. A doctor or specialist nurse uses it to look at the inside of your bladder.

A cystoscopy to check for bladder abnormalities is usually done under local anaesthetic using a flexible cystoscope. You may be asked to drink lots of fluids before the cystoscopy and to provide a sample of urine, which will be checked for infection.

The doctor or nurse will squeeze a jelly containing anaesthetic into the opening of your urethra (see the information on page 8). This is to make the procedure less uncomfortable. The anaesthetic starts to work after a few minutes.

The doctor gently passes the cystoscope through your urethra and into the bladder. They look at the whole lining of the bladder and urethra. The test takes a few minutes and you can usually go home after it's finished.

You may have some burning or mild pain when you pass urine for a couple of days after the test. You may also notice blood in your urine. This should clear up after a day or two. You'll be asked to drink lots of fluids to help flush out your bladder.

'The procedure is nothing to worry about. It's slightly uncomfortable for a few seconds as the camera goes in, but then it's painless.'

Richard

If these symptoms don't go away or you have a high temperature, tell your doctor straight away. They can check to make sure you don't have an infection.

After the cystoscopy, the doctor will usually be able to tell you if they have seen a bladder tumour. If they have, they will arrange for you to come into hospital to have a rigid cystoscopy. This is done under general anaesthetic.

During this test, the doctor will pass instruments through the cystoscope to remove the tumour. Or they may take a small piece of tissue (biopsy). See page 42 for more information.

Blue light cystoscopy

During a cystoscopy, the doctor uses light to see inside the bladder. Sometimes the doctor uses a technique called blue light cystoscopy or photodynamic diagnosis (PDD). This is usually done under general anaesthetic as part of a rigid cystoscopy.

A light-sensitive drug is put into the bladder through the catheter. It is absorbed by cancer cells. During the cystoscopy, a blue light is used to show the inside of the bladder. The blue light makes areas of cancer glow pink. It can pick up small bladder tumours and carcinoma in situ (CIS).

Narrow-band imaging (NBI)

Some people may have a newer type of cystoscopy called narrow-band imaging (NBI). Your doctor or specialist nurse can give you more information.

A healthcare professional in blue scrubs is adjusting a Siemens CT scanner. A patient is lying on the table, ready for a scan. The machine is white and has a Siemens logo on top. The patient is wearing a white hospital gown with a pattern. The healthcare professional is looking at the patient and adjusting the table. The machine has a small screen on top and a control panel on the right side. The background is a plain white wall with a ceiling vent.

Someone having a CT scan

Visit [macmillan.org.uk/ct-scan](https://www.macmillan.org.uk/ct-scan) to watch our video of someone having a CT scan.

Ultrasound scan

This scan can show up anything unusual in your urinary system. It uses sound waves to build up a picture of the inside of the body. You'll be asked to drink plenty of fluids before the test, so that your bladder is full and can be seen clearly.

Once you're lying comfortably on your back, a gel is spread over your tummy (abdomen). A small device that gives out sound waves is passed over the area. It picks the sound waves up again when they bounce back as echoes from the organs inside your body. The echoes are made into a picture by a computer. The scan is painless and takes about 15–20 minutes. Once it's over, you can empty your bladder.

CT (computerised tomography) scan

A CT scan (see picture on opposite page) 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 may be asked not to eat or drink for at least four hours before the scan.

You may be given an 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 should also tell your doctor if you have kidney problems or diabetes. You will need a blood test before the scan to check how well your kidneys are working.

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

MRI (magnetic resonance imaging) scan

This test uses magnetism to build up a detailed picture of areas of your body. The scanner is a powerful magnet so you may be asked to complete and sign a checklist to make sure it's safe for you. The checklist asks about any metal implants you may have, such as a pacemaker, surgical clips or bone pins, etc. You should also tell your doctor if you've ever worked with metal or in the metal industry as very tiny fragments of metal can sometimes lodge in the body. If you do have any metal in your body, it's likely that you won't be able to have an MRI scan. In this situation, another type of scan can be used. Before the scan, you'll be asked to remove any metal belongings including jewellery.

Some people are given an injection of dye into a vein in the arm, which doesn't usually cause discomfort. This is called a contrast medium and can help the images from the scan to show up more clearly.

During the test, you'll lie very still on a couch inside a long cylinder (tube) for about 30 minutes. It's painless but can be slightly uncomfortable, and some people feel a bit claustrophobic. It's also noisy, but you'll be given earplugs or headphones. You can hear, and speak to, the person operating the scanner.

PET-CT scan

This is a combination of a CT scan, which takes a series of x-rays to build up a three-dimensional picture (see page 23), and a positron emission tomography (PET) scan. A PET scan uses low-dose radiation to measure the activity of cells in different parts of the body. PET-CT scans give more detailed information about the part of the body being scanned. You may have to travel to a specialist centre to have one. You can't eat for six hours before the scan, although you may be able to drink.

A mildly radioactive substance is injected into a vein, usually in your arm. The radiation dose used is very small. The scan is done after at least an hour's wait. It usually takes 30–90 minutes. You should be able to go home after the scan.

Bone scan

A bone scan can show any abnormal areas of bone. It may be done to find out if the cancer has spread to the bones. A small amount of a mildly radioactive liquid is injected into a vein, usually in your arm. The level of radioactivity used doesn't cause any harm. Abnormal bone absorbs more of the radioactive substance than normal bone. These areas show up as highlighted on the scan. They are known as hot spots.

After having the injection, you will have to wait for up to three hours before you have a scan of your whole body. This gives time for the bone to absorb the radioactive substance. You may want to read a book or magazine to help pass the time.

A bone scan can show conditions other than cancer, such as arthritis. In this case, you may need to have further tests, such as an x-ray of the abnormal area.

Waiting for test results

Waiting for test results can be a difficult time. It may take from a few days to a couple of weeks for the results of your tests to be ready. You may find it helpful to talk with your partner, your family or a close friend. Your specialist nurse or one of the organisations listed on pages 117–124 can provide support. You can also talk things over with one of our cancer support specialists on **0808 808 00 00**.

Your data and the cancer registry

When you are diagnosed with cancer in the UK, some information about you and your health is collected in a cancer registry. This is used to plan and improve health and care services. Your hospital will usually give this information to the registry automatically. There are strict rules to make sure the information is kept safely and securely. It will only be used for your direct care or for health and social care planning and research.

Talk to your doctor or nurse if you have any questions. If you do not want your information included in the registry, you can contact the cancer registry in your country. You can find more information at **[macmillan.org.uk/cancerregistry](https://www.macmillan.org.uk/cancerregistry)**

Staging and grading

Staging

The stage of a cancer describes how far it has grown from where it started and whether it has spread. Test results provide a lot of information, but the exact stage of the cancer won't be known until after surgery to remove it. Knowing the stage of the cancer helps your doctor decide on the best treatment for you.

Doctors often use the TNM system to stage bladder cancer. This system combines the following to give the overall stage of the cancer:

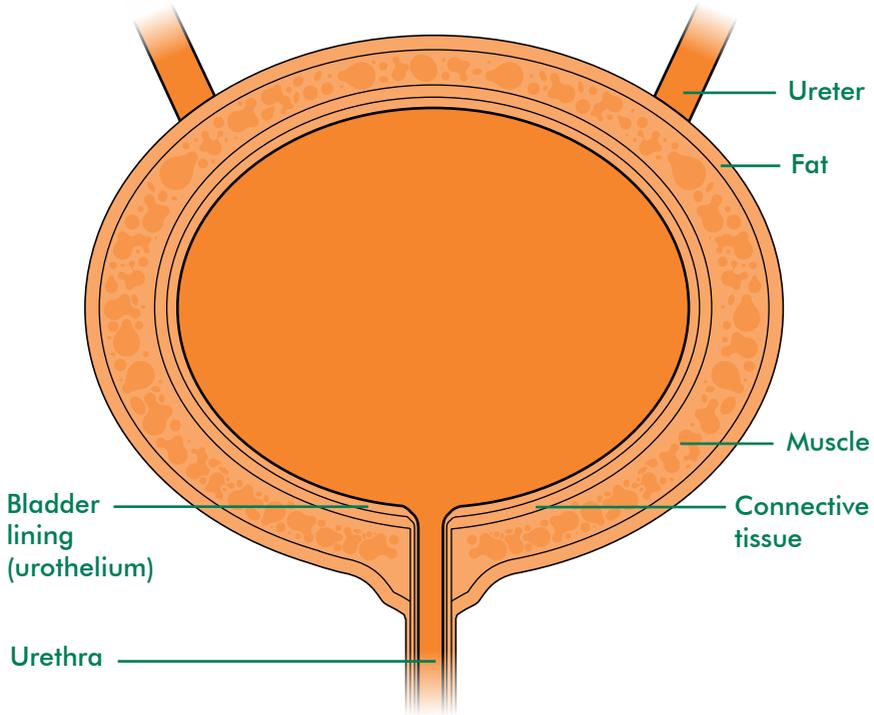
- **T** is how far the tumour has grown into the bladder and how far it has spread into the surrounding tissues.
- **N** is whether the cancer has spread to nearby lymph nodes (see page 7).
- **M** is whether the cancer has spread to other parts of the body. This is called **secondary** or **metastatic** cancer.

Tumour

Invasive and advanced bladder cancer is staged as T2–T4. Your doctor or specialist nurse can tell you more about your stage of bladder cancer:

- **T2** – the cancer has grown into the muscle of the bladder wall.
- **T3** – the cancer has grown through the muscle of the bladder and into the fat layer surrounding it.
- **T4** – the cancer has spread into the prostate (in men), or the womb or vagina (in women). It is also when the cancer has spread into the wall of the tummy (abdomen) or pelvis.

The bladder and bladder wall



Nodes

- **N0** – there is no cancer in the lymph nodes.
- **N1** – the cancer is in one of the lymph nodes near the bladder in the pelvis.
- **N2** – the cancer is in more than one lymph node in the pelvis.
- **N3** – there is cancer in one or more of the lymph nodes further from the bladder but within the tummy.

Metastases

- **M0** – the cancer has not spread to other parts of the body.
- **M1** – the cancer has spread to other parts of the body, such as the bones, the lungs, the liver, or lymph nodes outside the tummy.

Doctors may use other terms to describe bladder cancer:

- **Invasive** – the cancer is in the muscle layer of the bladder or has spread into the fat layer. But it has not spread outside the bladder.
- **Locally advanced** – the cancer has spread outside the bladder into the nearby tissues, prostate, vagina, ovaries, womb or back passage.
- **Advanced** – the cancer has spread to other parts of the body, such as the lymph nodes, liver, lungs and bones.

Grading

Grading is how the cancer cells look when they are examined under a microscope. If you have invasive and advanced bladder cancer, grading will not affect what treatment you will have. Your doctor can tell you more about grading.



TREATING INVASIVE AND ADVANCED BLADDER CANCER

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Treatment overview

The type of treatment you are offered will depend on the stage of the cancer, its size and your general health. Treatment may be given to cure the cancer. If a cure isn't possible, you can have treatment with the aim of controlling the cancer and relieving your symptoms (see pages 33–34).

Treatment to cure the cancer

People with invasive bladder cancer that hasn't spread to other parts of the body usually have treatment that aims to cure the cancer.

The main treatments are:

- chemotherapy
- surgery to remove the bladder
- radiotherapy to the bladder and pelvis.

Most people have chemotherapy and either surgery or radiotherapy. You may be asked to choose between surgery and radiotherapy.

Your specialist doctor and nurse will talk to you about the different treatment options and how they may affect you. You can then decide together what treatment is best for you.

Treatments each have their own benefits and disadvantages. You can read more in our section on treatment decisions (see page 34).

Chemotherapy (see pages 77–83) uses anti-cancer drugs to destroy cancer cells. It is often used before surgery or radiotherapy to shrink the tumour. This is called neo-adjuvant chemotherapy.

Some people have chemotherapy after surgery. This is called adjuvant chemotherapy. It may reduce the risk of the cancer coming back.

Surgery (see pages 42–66) usually involves removing the whole bladder (cystectomy) and making a new way for you to pass urine (urinary diversion). Having your bladder removed is major surgery. It can take time to cope with and adjust to.

Sometimes, a bladder tumour may be removed without removing the bladder. There is more information about this on page 42.

Radiotherapy (see pages 68–75) uses high-energy rays to destroy cancer cells. It means you will keep your bladder, but some people may have permanent side effects to cope with. You may have chemotherapy at the same time as radiotherapy, to make treatment more effective. This is called **chemoradiation**.

Treatment to control the cancer and relieve symptoms

If the cancer has spread to other parts of the body (advanced or metastatic cancer), you'll usually be given treatment to control tumour growth and relieve your symptoms. This is called palliative treatment.

Chemotherapy can help to control the cancer in some people, but it can also cause side effects. Not everyone is fit enough to have chemotherapy. Your doctor will let you know if it is suitable for you. They will also discuss the risks and benefits of having chemotherapy.

Radiotherapy can be used to treat symptoms such as bleeding from a tumour in the bladder. It may also be used to relieve pain if cancer has spread to the bones.

There is more information about palliative treatment on page 74 and pages 84–85.

Treatment decisions

You may be offered the choice of having either surgery or radiotherapy as your main treatment. Chemotherapy is usually given before both of these treatments.

Surgery and radiotherapy may work as well as each other, but each has its own benefits and disadvantages. Deciding what treatment to have can be difficult. Your doctors, specialist nurse and stoma nurse (see page 38) will talk to you about the different treatments and their effects. They can answer any questions you have to help you reach a decision.

Make sure you have the information you need, so you feel confident about making the right decision for you. You may also want to talk it over with family and close friends.

We've included a table on the next few pages which shows the main differences between surgery and radiotherapy.

You may also find it helpful to read our booklet **Making treatment decisions**.

Table about surgery and radiotherapy

You may find it helps to look at this table again after you have read about surgery (see pages 42–66) and radiotherapy (see pages 68–75).

	Surgery	Radiotherapy
What does the treatment involve?	<p>You will be in hospital for 7–21 days.</p> <p>You'll need a general anaesthetic.</p> <p>You'll need surgery to make a new way for you to pass urine. This is called a urinary diversion (see pages 48–51).</p> <p>A urinary diversion can take time to get used to. It may affect your body image (page 63).</p> <p>It can take 3–6 months to return to full fitness.</p> <p>You may need chemotherapy too.</p>	<p>You will need to travel to the hospital each weekday, for 4–7 weeks for treatment.</p> <p>Common side effects during treatment include bladder irritation (passing urine more often and urgently) and diarrhoea – see pages 71–74.</p> <p>Radiotherapy is not usually as physically demanding as surgery.</p> <p>You may need chemotherapy too.</p> <p>Some people may need surgery to remove the bladder if the cancer comes back.</p>

	Surgery	Radiotherapy
Effects on bladder function	You will have a new way to pass urine, which will take time to get used to.	<p>You will be able to pass urine in the normal way.</p> <p>Some people find that their bladder reduces in size. This means they need to pass urine more often – see page 71.</p>
Effects on the bowel	Bowel complications may sometimes happen after surgery. But these usually get better with time.	<p>Sometimes, the bowel may be permanently affected by radiotherapy (late effects).</p> <p>This means you may have bowel motions more often and have diarrhoea – see page 74.</p>

	Surgery	Radiotherapy
Effects on sex life	<p>Men have a high risk of not being able to get or keep an erection after surgery.</p> <p>Women may have a shorter vagina due to surgery. This can make penetrative sex more difficult or uncomfortable, or cause changes in sexual sensation.</p> <p>There is more information about these side effects on pages 64–66.</p>	<p>Some men may find radiotherapy makes it more difficult to get an erection.</p> <p>Some women may find that radiotherapy narrows their vagina. This can make sex more difficult or uncomfortable.</p> <p>There is more information about these side effects on page 73.</p>

Planning your treatment

Your treatment will be planned by a team of specialists. They will discuss your treatment and agree on what they think is best for you.

This multidisciplinary team (MDT) may include:

- a **urologist**, who is a surgeon experienced in bladder surgery
- a **specialist urology nurse**, who gives information and support
- **oncologists**, who are doctors that have experience in bladder cancer treatment using chemotherapy, immunotherapy and radiotherapy
- a **specialist stoma nurse**, who supports people with stomas – see the information about urinary diversion on pages 46–61
- a **palliative care specialist**, who is a doctor or nurse who specialise in symptom control
- **pathologists**, who advise on the type of cancer and its extent
- **radiologists**, who analyse x-rays and scans.

Other staff are also available to help you if needed. They include dietitians, physiotherapists, occupational therapists, counsellors and psychologists.

Your doctor will talk to you about the best treatment for your situation. If you have any questions about your treatment, don't be afraid to ask the doctor or nurse looking after you.

The benefits and disadvantages of treatment

You may feel worried about having cancer treatment because of the side effects that can happen. If you're offered a choice of surgery or radiotherapy as your main treatment, you'll need to think about the benefits and disadvantages of each treatment before you decide which one to have. The table on pages 35–37 may help. Your doctor or specialist nurse can also answer any questions you have.

If a treatment aims to cure the cancer, you may want to know what the chances are of the cancer coming back. Your doctor can talk to you about this.

If the cancer is advanced and has spread to other parts of the body, you may be offered treatment to control it. This may improve your symptoms and quality of life. If you are having chemotherapy, you'll be checked for signs that it's working and to see if there are side effects.

If you choose not to have treatment to control it, treatments can be given to relieve symptoms caused by the cancer. For example, painkillers can be given to control pain.

Making a decision about treatment in these situations can be difficult. Your doctor or specialist nurse can answer any questions you have.

Giving your consent

Before you have any treatment, your doctor will explain its aims. They will usually 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, and 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 (MDT) 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.

'Everyone goes down different routes for various reasons. Keep positive, ask questions of your consultants, listen to everyone and then make your own decision.'

Ann

Surgery

Surgery usually involves removing your whole bladder. This is called a radical cystectomy.

Cystectomy is used to treat invasive or locally advanced bladder cancer (see page 43). It may also be used in advanced bladder cancer, when the cancer is only in a small number of lymph nodes close to the bladder.

When your whole bladder is removed, the surgeon will make a new way for you to pass urine. This is called a urinary diversion. It's done at the same time as the operation to remove your bladder. There are different types of operation to make a urinary diversion. You can read more about these on pages 46–51.

Other types of surgery

Some people may have the bladder tumour removed without removing the bladder. This is only suitable for invasive bladder cancer which is only in the muscle layer. This operation is called a transurethral resection of bladder tumour (TURBT). You will have chemotherapy and radiotherapy after surgery.

Some people may have part of their bladder removed. This is called a partial cystectomy. It is only suitable for a small number of people with rarer types of bladder cancer.

Your surgeon will explain if any of these operations are suitable for you.

Removing the bladder (cystectomy)

Your operation will usually involve removing some areas close to the bladder as well as the whole bladder. If you are having an operation to make a new bladder (bladder reconstruction), your urethra won't be removed.

Your surgeon or specialist nurse will explain what will be removed and how this will affect you. This includes possible effects on your sex life and fertility. If you are worried about your fertility, speak to your doctor or specialist nurse before your treatment starts.

Cystectomy is a major operation. Your doctor will check your general health to make sure you are fit enough for the operation.

Men

In men, the bladder, prostate gland, seminal vesicles (where semen is stored) and sometimes part or all of the urethra are removed. The lymph nodes (glands) close to the bladder are also taken away.

After a cystectomy, you may not be able to get or keep an erection (erectile dysfunction). This is because the prostate gland is removed and the surrounding nerves may be damaged.

Talk to your doctor or specialist nurse about this before surgery. They can explain about treatments that may help. There is more information about your sex life after surgery on pages 64–66.

After the operation, you won't be able to produce semen. This means you will be infertile. If you are worried about this, you may be able to store sperm before treatment starts.

Women

In women, the bladder, nearby lymph nodes and the urethra are removed. Usually the womb, ovaries, cervix and part of the vagina are also removed. In women who haven't had their menopause, the ovaries and womb may be left in place.

After surgery, women may find sexual sensation very different. Removing part of the vagina makes it shorter. This can sometimes mean penetrative sex is more difficult, uncomfortable or no longer possible. Speak to your doctor or specialist nurse if you are worried about this. There is more information about the effects of surgery on your sex life on pages 65–66.

Having your bladder removed is a major operation, and you may find the thought of it scary. If you would like to talk to someone, you can call our cancer support specialists on **0808 808 00 00**.

'I had bladder removal and reconstruction nearly two and a half years ago. It's certainly a major op, requiring months to fully regain former energy and fitness. However, I had no complications, started back at work after three months and am now managing fine.'

Tess

Laparoscopic (keyhole) surgery

Some people have laparoscopic (keyhole) surgery to remove their bladder. The surgeon makes several small cuts in your tummy (abdomen) rather than one large cut. This means that you recover from your surgery more quickly. Keyhole surgery is not suitable for everyone.

During keyhole surgery, the surgeon uses an instrument called a laparoscope to see and work inside the tummy. The laparoscope is a thin tube with a tiny camera on the end. It sends pictures of the inside of the tummy to a computer screen. The surgeon puts the laparoscope into the tummy through a small cut in the skin.

Sometimes the surgeon may use a machine (robot) during laparoscopic surgery. This is called robotically assisted surgery. The robot holds the instruments which are controlled by the surgeon. This makes the surgery very precise and may help reduce the risk of complications.

Laparoscopic (keyhole) surgery needs to be carried out by surgeons with specialist training. You may have to travel to a different hospital to have it.

Your surgeon will be able to discuss the benefits and disadvantages of this type of surgery with you.

Making a urinary diversion can also sometimes be done using keyhole surgery, but standard methods of surgery are usually used for this.

Types of urinary diversion operation

When your bladder is removed, your surgeon will make a new way for you to pass urine. This is called a urinary diversion.

There are different types of operation. Your surgeon and nurse will talk to you about what is involved. They can advise you which type of urinary diversion is most suitable for you.

These operations are only carried out by specialist surgeons. Some people may need to travel to a different hospital to have their operation.

Urostomy (ileal conduit)

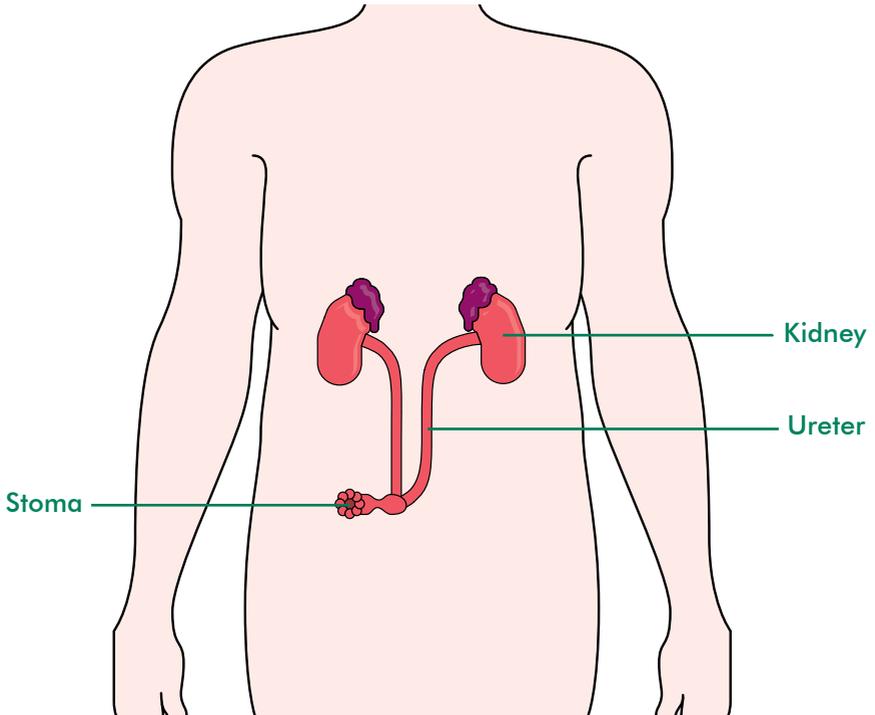
This is the most common type of operation. Your urine will be collected in an external bag, which you stick onto your tummy (abdomen).

During the operation, the surgeon removes a section of your small bowel (ileum) to use. They join the two ureters to one end of it. They bring the other open end of bowel out through a small opening in the skin of your tummy. This is called a stoma.

The ureters carry urine from your kidneys to the piece of bowel. The piece of bowel acts as a channel (conduit) to take the urine to the surface of your tummy. This is why this operation is sometimes called an ileal conduit.

You place a flat, watertight bag over the stoma to collect your urine. It's kept in place with adhesive. The bag will fill with urine, and you'll need to empty it regularly. A specialist nurse will show you how to take care of it. There is more information about living with a urostomy on pages 58–59.

Urostomy (ileal conduit)



Bladder reconstruction (neobladder)

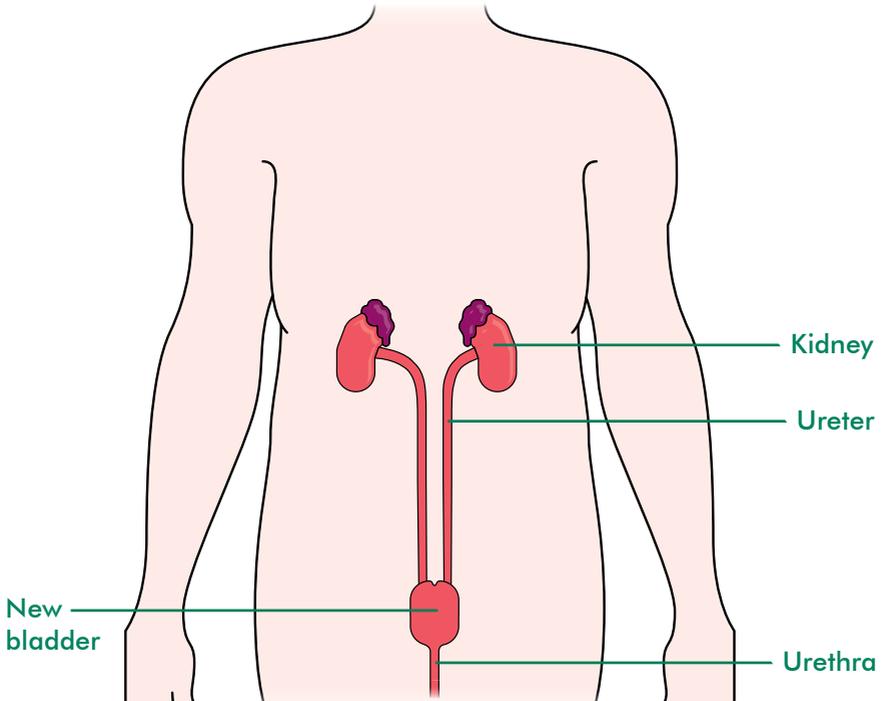
The surgeon makes a new (neo) bladder using a piece of your bowel which they connect to your urethra. The new bladder stores urine and you pass urine through your urethra as before.

To empty your new bladder, you need to flex your tummy muscles. You do this by holding your breath and pushing down into your tummy. You have to do this regularly, as you don't have the nerves that tell you when your bladder is full.

Some people may also need to pass a catheter into their urethra to completely empty their new bladder. This is called self-catheterisation. Your specialist nurse will teach you how to do this.

Sometimes the surgeon may not be able to make the new bladder during surgery. If this happens, they will form a urostomy instead. Your surgeon will explain the risk of this before surgery.

Neobladder (bladder reconstruction)

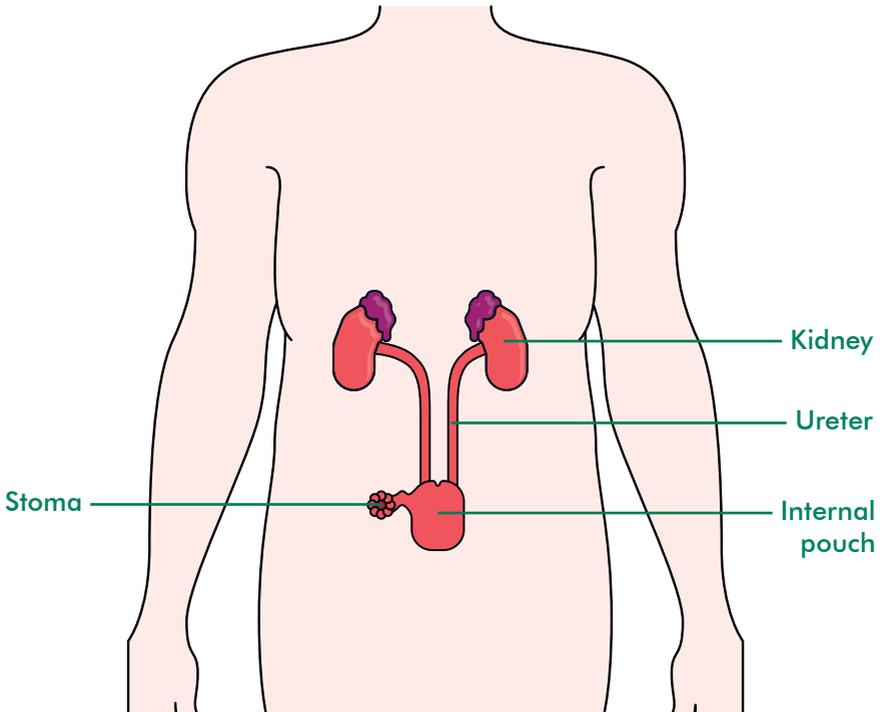


Continent urinary diversion

This is similar to a urostomy, but you don't need an external bag to collect your urine. Your surgeon uses a piece of your bowel to make an internal pouch that stores urine inside your tummy. They attach your ureters, which carry urine from your kidneys, to the pouch. The surgeon uses a piece of tissue, for example your appendix, to make a tube that connects the pouch to your tummy wall. They make a small opening (stoma) from this tube on the tummy wall. This type of stoma lies flat against the skin and isn't raised.

You empty urine from the pouch through the stoma using a tube (catheter). This is called self-catheterisation. You need to do it about five or six times a day. A specialist nurse will show you how to do this. We have more information about managing a continent urinary diversion on page 61.

Continent urinary diversion



Preparing for your urinary diversion

A specialist nurse will talk to you about managing your urinary diversion before you have surgery. They will also arrange to visit you after your surgery.

Before your operation, the nurse or doctor will carefully plan the position of the stoma. They will do this even if you are having a bladder reconstruction, just in case they need to create a urostomy. They make a mark on your tummy so that your surgeon knows the best position for the stoma.

A stoma is often on the right side of your belly button (navel). But it may be positioned on the left side if you are left-handed. Sometimes, the position can be suited to a person's needs. For example, a right-handed golfer may prefer a left-sided stoma so it doesn't interfere with playing golf.

For a continent urinary diversion (see pages 50–51), the stoma is positioned where you can see it and easily put a catheter into it.

The thought of urinary diversion surgery may seem overwhelming. Asking all the questions you want to before your operation can help. Your doctor or nurse may be able to arrange for you to meet someone who already has a urinary diversion before your surgery. You will have a specialist nurse who will help you learn to look after it.

With time and practice, looking after your urinary diversion will get easier. There is more information about living with a urinary diversion on pages 58–61.

Before your operation

Your surgeon or nurse will explain the operation and talk to you about what to expect afterwards. This is a good time to ask any questions you have about the operation.

Usually, you go to a pre-assessment clinic a few days before the operation. You will have a medical examination to check your general health. You will have a blood test and may also have a tracing of your heart (ECG) and a chest x-ray. Some people also have further tests to make sure they are fit enough to have the surgery. The anaesthetist will also see you to explain about the anaesthetic.

If you think that you might have problems when you go home (for example, if you live alone), tell your nurse or social worker. You should do this before your operation so that they have time to organise any help you will need.

You will usually be admitted to hospital the day before your surgery. This is so the doctors and nurses can do any further tests and prepare you for the surgery. Some hospitals make sure that all the tests and preparations for surgery are done beforehand. In this case, you will go into hospital on the day of your surgery.

Some hospitals use a programme called Enhanced Recovery. This helps to you prepare for surgery and recover sooner after surgery. Your surgeon or specialist nurse will explain more about this and if it is suitable for you.

Because part of your bowel is used for a urinary diversion, you may need a clear bowel for the surgery. Your doctor or nurse will give you any instructions you need about this before surgery. You may be asked to follow a special diet for a few days and take a laxative. Some people have an enema, where medicine is given into the back passage to help empty their bowel. This is usually given the evening before the operation.

After your operation

Most people are looked after in a high-dependency or intensive care unit for a day or two after their operation.

The nurses will encourage you to start moving about as soon as possible after your operation. This helps to prevent problems such as chest infections or blood clots. Usually, you are given stockings to wear to help prevent blood clots.

If you have to stay in bed, the nurses will encourage you to do regular leg movements and deep breathing exercises. A nurse or a physiotherapist can help you do the exercises.

Drips and drains

After the operation, you may have some of the following for a short time:

- A drip (intravenous infusion) to give you fluids until you are able to eat and drink again. It may also be used to give you painkillers.
- A drainage tube in your wound or wounds to prevent fluid building up. This allows them to heal properly and is usually removed after a few days.
- A nasogastric (NG) tube that goes down your nose and into your stomach or small bowel. This allows fluids to be removed so that you don't feel sick. It's usually taken out within 48 hours.
- A fine tube that goes into your back (epidural) or into your wound to give you painkillers.

You will have tubes in place to help drain urine from your body. The tubes will depend on the type of urinary diversion you have. Your doctor and nurse will be able to tell you more.

Pain

After your operation, you'll need painkilling drugs for a few days. You may have painkillers given into your blood, into your back or into the area around the wound.

To begin with, you may be given painkillers into a vein using an electronic pump. The pump is set to give you a continuous dose of painkiller. You have a hand control with a button you can press if you're in pain. This is called patient-controlled analgesia (PCA). The nurses set the pump so you can't have too much painkiller (overdose). So it's safe to press it whenever you are uncomfortable.

Some people are given painkillers into their back (called an epidural). The drugs numb the nerves in the operation area to control your pain. You usually have them through a drip (infusion) attached to an electronic pump.

You may be given painkillers into the area around your wound. The surgeon puts small tubes into the wound during your operation. Your nurse or doctor can give you regular injections of painkillers into the tubes. The drugs help to numb the nerves in the same way as an epidural.

If you're in pain, let your nurses and doctors know as soon as possible. You will be given painkiller tablets to take before you go home.

Going home

How long you're in hospital for will depend on the type of operation you've had and your general health. It can range from 7 to 21 days.

Your doctor will advise you about how soon you'll be able to get back to doing things such as work, driving, shopping, gardening or playing sport. This will depend on the operation you had and your recovery.

Before you leave hospital, you'll be given an outpatient appointment for a check-up. This will be a few weeks after your surgery. It is a good time to discuss any concerns you may have after your operation. But if you are worried about anything before this time, contact your hospital team for advice.

Some people may have loose bowel motions after their surgery. This is because part of the bowel is used to make a urinary diversion. It usually gets better over time. Tell your doctor or specialist nurse if it continues.

You will be given a lot of support to help you manage your urinary diversion. We explain this on pages 58–63.

We have a booklet called **Going home from hospital** that explains how care and support is arranged for you when you go home. It also talks about the different health professionals who may be involved.

Managing your urinary diversion

Getting used to a urinary diversion and learning to look after it takes time, but help is available. Like anything new, it gets easier with practice. Most people find that they soon get used to it.

Before you leave hospital, the nurse will make sure you have a supply of the equipment you need. When you're at home, you can get your supplies (urostomy bags or catheters) directly from a supplier or your chemist. Your stoma nurse will tell you more about this. The Urostomy Association (see page 118) can also give you details of suppliers.

When you get home, you will still be able to phone your specialist nurse for advice. You may also have contact with a community stoma nurse. The hospital staff will arrange for a district nurse to visit you when you first leave hospital. The nurse can help you if you have any problems with your urinary diversion.

Urostomy

A stoma nurse will show you how to look after your urostomy and can help you cope with any problems. You may also find it helpful to talk with someone who has already learned to live with a urostomy. Your stoma nurse or doctor may be able to arrange for someone to visit or phone you and tell you about how they coped. This can be very helpful, especially in the first few months after your operation.

Most people who have a urostomy can get back to a normal life. Many go back to work and take up their favourite activities again, including swimming. If you are worried about your life after surgery, you can talk to your stoma nurse.

The stoma

For the first few days after your operation, your nurse will look after your urostomy for you. They will make sure that the bag is emptied and changed as often as necessary.

At first your stoma will be slightly swollen. It may be several weeks before it settles down to its final size. The stoma will also produce mucus (a thick white substance), which might appear as pale 'threads' in the urine.

As soon as you feel ready, the nurse will show you how to clean your stoma and change the bag. It may be helpful for a close relative or friend to be shown as well, in case you ever need help.

There are different types of bags (appliances) available. Your nurse will help you choose one that suits you best. When you're changing your bag, allow yourself plenty of time and privacy so you can do it at your own pace and without interruptions.

Appearance

Urostomy bags are flat so they won't be noticed under your clothes. The size and position of the stoma is the most important factor in how noticeable the bag is through your clothes. Many people with a urostomy can wear their tightest clothes without anyone knowing they have a stoma bag. Although you may be very aware of your urostomy, people won't usually notice it unless you choose to tell them.

Bladder reconstruction

After your surgery, you will go home with a catheter to drain the urine from your new bladder (neobladder).

Your nurse will explain how to look after it before you go home. The bowel tissue used to make the new bladder continues to make mucus. This can block the catheter, so you will need to flush your catheter several times per day using fluid and a syringe. Your nurse will teach you how to do this or they can refer you to a district nurse who will help.

After a few weeks, you will return to hospital to have an x-ray called a **cystogram**. The catheter will also be removed. You may have to stay in hospital for a day or two after this, to make sure your bladder is emptying fully.

Emptying your new bladder

At first, you will have to empty your bladder every two to three hours. Over time, your new bladder will stretch and be able to hold more urine. But you may still have to empty it every four to six hours. Some people may also need to pass a catheter into their urethra (self-catheterise) to empty the new bladder completely.

Some people may leak urine at times to start with, but this usually improves over a few months. If this doesn't get better, talk to your specialist nurse or surgeon. They can suggest things to help and may refer you to a continence adviser.

Before your surgery, your nurse will show you how to do pelvic floor exercises. It's important to keep doing these as they can help with continence.

Continent urinary diversion

When you go home, you will have two catheters. One goes into the pouch through your tummy and the other through the stoma.

Once the pouch has healed, usually six weeks after your surgery, you will return to hospital. You will usually stay in hospital for a day or two for the catheters to be removed. You will also learn how to empty the pouch and wash it out. Your specialist nurse will teach you how to do this.

Emptying your pouch

To empty your pouch, you will put a fine tube (catheter) through the stoma into the pouch. At first, you will need to do this every couple of hours until your pouch stretches. In time, you may be able to leave the pouch for up to six hours without emptying it during the night.

Washing out your pouch

As well as emptying your pouch, you will need to wash it out. The bowel tissue used to make the pouch continues to make mucus, which could cause an infection if it isn't washed out.

You'll need to wash out your pouch several times a day. To do this, you put fluid through the catheter that you use to drain your pouch. Your specialist nurse will teach you how to do this.

Different surgeons may give slightly different instructions on how you should empty and flush out your pouch, and the equipment you should use. Follow the advice you are given. If you need more support, talk to your specialist nurse or doctor.

Just Can't Wait toilet card

These treatments for bladder cancer can mean you need to go to the toilet more often. Carrying a Just Can't Wait card may help you get access to a toilet more quickly when you're out. You can show it to staff in places like shops or pubs. The card allows you to use their toilets without them asking awkward questions. You can get the cards from the Bladder and Bowel Community – see page 118 for details.

Macmillan also has a toilet card that can help you access toilets. Call us on **0808 808 00 00** or visit **be.macmillan.org.uk** to request one.

The National Key Scheme (NKS) offers access to about 9,000 locked public toilets across the UK. You can buy a key from Disability Rights UK (see page 123). They can also send you details of where the toilets are located.

You can read other people's experiences of bladder cancer and urinary diversion on our Online Community. You can also talk with people who know what you're facing. Visit **macmillan.org.uk/community**

Support groups are another way to meet and talk with people going through a similar experience – visit **macmillan.org.uk/supportgroups**

Body image changes

You may be worried about adapting to changes in the way your body looks and works. This may affect how you think and feel about your body (body image). This is a normal reaction and it can take time to adjust.

Over the years, everyone develops an image in their minds of what their body looks like. Although someone may not be completely satisfied with that image, most people are used to the way they see themselves. It can be upsetting to have that changed permanently by surgery.

Many people find that they feel reassured once they've talked about their fears. You could talk to your partner or someone close to you about it. Talking also gives other people the chance to understand more about how you are feeling.

You can also talk to your doctor or nurse about your concerns, and the organisations on pages 117–124 can give you support.

You may find our booklet **Body image and cancer** helpful. It's been developed with the help of people who have experienced body changes and includes quotes about their experiences.

Sex after surgery

Your operation may have made changes to your body that can affect your sex life. Your surgeon and specialist nurse will talk this over with you before your surgery. They can tell you about things that may help.

Your doctors will do all they can to prevent nerve damage during the operation, but it may not be possible to avoid it. If nerves are damaged, there's a risk of erectile problems in men and changed sensation in women.

Men

There are different treatment options for men with erectile difficulties after surgery. Your surgeon or GP will be able to advise you on these.

Treatment may involve tablets, such as sildenafil (Viagra®), vardenafil (Levitra®) and tadalafil (Cialis®) to produce an erection, if the nerves are not damaged. They can't be taken by men who take nitrate-based medicines for heart problems. Your doctor can advise you about this.

Pellets put into the tip of the urethra or injections given into the penis with a small needle can also help to produce an erection.

Vacuum pumps may also be used to give an erection lasting for about 30 minutes. You put your penis into the pump. It has a handle that draws blood into the penis by creating a vacuum. You then put a rubber ring around the base of the penis. It traps the blood in the penis to give an erection. You take the ring off after sex and the blood flows normally again. Pumps may take a bit of practice before you get used to them.

Talk to your surgeon or specialist nurse about what might be best for you. They will be able to explain about the different treatments in more detail. Your surgeon may suggest using a combination of tablets and a vacuum pump soon after surgery.

The organisations listed on page 120 that can give you advice and information about sexual difficulties. Our booklet **Sexuality and cancer – information for men** has more information on treatments for erection difficulties.

Women

In some women, the vagina may have been shortened or narrowed during the operation. This can make sex difficult or uncomfortable at first. When you feel ready, having sex regularly and gently can help gradually stretch the vagina. This makes it more supple, which means sex will be easier and more enjoyable.

You may be advised to use a vaginal dilator. Your nurse or doctor can show you these and explain how to use them. Sometimes gels or creams that contain the female hormone oestrogen are prescribed to help ease discomfort in the vagina.

Some women find that they have different sensations during sex. It may be more difficult to have an orgasm. The organisations listed on page 120 that can give you advice and information about sexual difficulties.

Talk to your surgeon or specialist nurse if you are worried or need advice about sex after your surgery. Our booklet **Sexuality and cancer – information for women** has more details. It gives tips for coping with various sexual problems caused by cancer treatments.

Talking about sex

You may find it difficult or embarrassing to talk about sexual problems. Most doctors are understanding and can refer you to a specialist in sexual problems, or to a trained counsellor. These specialists can give emotional support and advice about coping with sexual difficulties.

If you have a partner, it may be helpful for them to see the specialist with you. See pages 120–121 for some useful organisations you can contact.

Sex is safe

One common fear is that cancer can be passed on during sex. You can't catch cancer by having sex. It is safe for you and your partner to have sex as soon as you feel ready.

Fertility after bladder surgery

A radical cystectomy will cause infertility in men. It will also cause infertility in pre-menopausal women, if their womb and ovaries are removed. If you have any worries about your fertility, talk to your surgeon before your treatment.

We can send you more information about cancer and fertility.



Radiotherapy

Radiotherapy treats cancer by using high-energy rays to destroy the cancer cells while doing as little harm as possible to normal cells. It is given using equipment similar to a large x-ray machine.

You can be given radiotherapy to try to cure bladder cancer (**radical radiotherapy**) or to relieve symptoms (**palliative radiotherapy**).

We have a booklet called **Understanding radiotherapy** that we can send you. You can also watch a video that explains the treatment and shows a radiotherapy machine at macmillan.org.uk/radiotherapy

Radiotherapy to cure the cancer (radical radiotherapy)

If the cancer has not spread outside of the pelvis, you may be offered radiotherapy to try to cure the cancer. Having radiotherapy instead of surgery means you'll still have your bladder.

Having other treatment with radiotherapy

Usually, you have other treatment with radiotherapy to help make it work better. This may be chemotherapy with the drugs mitomycin and 5FU. Chemotherapy makes the cancer cells more sensitive to the effects of radiotherapy. You usually have chemotherapy every day (Monday to Friday) in the first and fourth week of your radiotherapy. When chemotherapy is given with radiotherapy, it is called chemoradiation.

Instead of chemotherapy, some people have treatment with a gas called carbogen and tablets called nicotinamide. You breathe in carbogen for a few minutes before and during your radiotherapy. Nicotinamide tablets increase the supply of oxygen to the cancer cells. You take them before radiotherapy.

You may also have chemotherapy before your radiotherapy. This is to shrink the cancer and reduce the risk of it coming back after treatment.

There is more information about chemotherapy on pages 77–83.

How radiotherapy is given

Radiotherapy is given in the hospital radiotherapy department as a series of short daily treatments. You can usually have it as an outpatient. Each treatment takes 10–15 minutes.

The treatments are usually given Monday to Friday, with a rest at the weekend. A course of radiotherapy for bladder cancer may last for 4–7 weeks. Your doctor or nurse will tell you what to expect and explain the possible side effects. There are different ways of giving radiotherapy to treat bladder cancer:

- **Image guided radiotherapy (IGRT)** uses a radiotherapy machine that takes x-ray images of the bladder. This means that the radiotherapy treatment can be adjusted to the precise size and position of the bladder. It makes the treatment very accurate.
- **Intensity modulated radiotherapy (IMRT)** shapes the radiotherapy beams, allowing different doses of radiotherapy to be given to different parts of the bladder. It may be helpful for people who have large bladder tumours or if the cancer has spread to the lymph nodes in the pelvis.

Your radiotherapy team can tell you more about IGRT and IMRT. There is also more information about these treatments in our booklet **Understanding radiotherapy**.

Planning your radiotherapy

Radiotherapy has to be carefully planned to make sure it's as effective as possible. It's planned by a cancer specialist (clinical oncologist) and it may take a few visits.

On your first visit to the radiotherapy department, you'll be asked to have a CT scan or lie under a machine called a simulator, which takes x-rays of the area to be treated.

You may need some small marks made on your skin to help the radiographer (who gives you your treatment) position you accurately and to show where the rays will be directed. These marks must stay visible throughout your treatment, and permanent marks (like tiny tattoos) are usually used. They are extremely small, and will only be done with your permission. It may be a little uncomfortable while they are done.

Treatment sessions

At the beginning of each session of radiotherapy, the radiographer will position you carefully on the couch and make sure you are comfortable. During your treatment you'll be alone in the room, but you can talk to the radiographer who will watch you from the next room. Radiotherapy is not painful, but you will have to lie still for a few minutes during the treatment.

Side effects of radiotherapy

Your doctor, nurse or radiographer will discuss side effects with you so you know what to expect. Let them know about any side effects you have during or after treatment, as there are often things that can be done to help. Side effects usually disappear gradually over a few weeks or months after treatment finishes.

There's more information about side effects in our booklets **Pelvic radiotherapy in men – managing side effects during treatment** and **Pelvic radiotherapy in women – managing side effects during treatment**.

Bowel symptoms

You may have diarrhoea and sore skin around the back passage. Your specialist will prescribe anti-diarrhoea tablets to reduce it. Some people may be advised to cut down on fibre in their diet. It's important to drink at least two litres (three and a half pints) of fluids a day.

Bladder symptoms

You may need to pass urine more often and have a burning feeling when you pass urine. Your doctor can prescribe medicines to reduce these symptoms.

Drinking plenty of fluids will also help. Try to drink about two litres (three and a half pints) a day. Some fluids can irritate the bladder and make symptoms worse. These include drinks with caffeine, such as tea, green tea and coffee, alcohol, fizzy drinks and drinks containing artificial sweeteners.

These effects usually disappear gradually a few weeks after the treatment has ended.

Effects on the skin

Your skin in the treatment area may redden or get darker and become dry or sore. The radiographer will give you advice on looking after your skin.

Tiredness (fatigue)

Radiotherapy makes you tired and this may continue for several months after treatment. During treatment, you'll need to get plenty of rest. Try to balance this with some gentle exercise, such as short walks, which will give you more energy. You can gradually build up the amount you do after treatment.

We can send you our booklet **Coping with fatigue**. You can also watch a video at macmillan.org.uk/fatigue

'After treatment finished, the fatigue kicked in. A wave came over me and drained all my energy. I had to curl up on the couch until it passed.'

Richard

Hair loss

You may lose some of your pubic hair. The hair will usually grow back, but may be thinner than it was.

Possible long-term side effects

Some effects of radiotherapy can appear after your treatment ends. These are called late effects and there are things you can do that help reduce the risk.

There is more information in our booklets **Managing the late effects of pelvic radiotherapy in men** and **Managing the late effects of pelvic radiotherapy in women**.

Effects on the vagina

Radiotherapy to the pelvis can make the vagina narrower, which can make sex difficult or uncomfortable. You may be advised to use a vaginal dilator to try to help prevent this happening. Your specialist nurse or radiographer will give you more advice and explain how to use them. Hormone creams applied to the vagina can also help. These can be prescribed by your doctor.

Effects on erections

For men, radiotherapy to the pelvis can make it more difficult to have an erection. There are treatments that can help with this (see pages 64–65).

Infertility

Radiotherapy to the pelvic area is likely to cause infertility in men and women. If you are worried about your fertility, talk to your doctor before your treatment starts.

There is more information about some of these side effects, in our booklets **Sexuality and cancer – information for men** and **Sexuality and cancer – information for women**.

You may also find our booklets **Cancer treatment and fertility – information for men** and **Cancer treatment and fertility – information for women** helpful.

Effects on the bowel or bladder

Occasionally, the bowel or bladder may be permanently affected by the radiotherapy. Certain side effects may not improve or side effects may develop years after radiotherapy treatment.

If your bowel is affected, you may have bowel motions more often and have diarrhoea. If your bladder is affected, it may shrink. This means it can't hold as much and you need to pass urine more often.

The blood vessels in the bowel and bladder can become more fragile. If this happens, blood appears in urine or bowel motions. If you notice blood in your urine or bowel motions, tell your doctor straight away so that tests can be done and the right treatment given.

If you have bladder or bowel problems, there is more information about getting access to toilets on page 62.

Radiotherapy for symptom control (palliative radiotherapy)

You may be given radiotherapy to control symptoms if the cancer has spread to other parts of your body. Usually, one to five radiotherapy treatments are given over a week. Side effects are uncommon and often mild if they do happen.

Treating bladder symptoms

Radiotherapy may be used to relieve bladder symptoms, such as pain or bleeding. It may be given as three treatments over a week, usually on alternate days. For example, you may have the radiotherapy to relieve bladder symptoms on Monday, Wednesday and Friday.

Each treatment takes around 10–15 minutes. Sometimes you will only have one treatment.

Treating bone symptoms

Radiotherapy can also treat symptoms caused by cancer that has spread to the bones. Often, just one radiotherapy treatment is needed, but sometimes up to five treatments are given over five days.

It can take up to four to six weeks for the full benefits of the radiotherapy to be felt, but you may notice improvements in your pain much sooner than this.

We can send you our booklet **Understanding secondary cancer in the bone**. We also have a booklet called **Coping with advanced cancer** that you may find helpful.

A photograph of an elderly man with a full, light-colored beard and hair, sitting in a hospital bed. He is wearing a light-colored, short-sleeved button-down shirt. He is looking off to the right of the frame. In the background, there is a medical monitor on a stand, a yellow bin, and other hospital equipment. The scene is brightly lit, likely from a window. A green banner is at the top, and another green banner with text is at the bottom right.

Someone having chemotherapy

Visit [macmillan.org.uk/chemotherapy](https://www.macmillan.org.uk/chemotherapy) to watch our videos about chemotherapy.

Chemotherapy

Chemotherapy uses anti-cancer (cytotoxic) drugs to destroy cancer cells. Cytotoxic means toxic to cells. The drugs disrupt the way cancer cells grow and divide but they also affect normal cells.

There is more information about chemotherapy in our booklet **Understanding chemotherapy**.

Chemotherapy may be given:

- before surgery or radiotherapy, to shrink the cancer and reduce the risk of it coming back (neo-adjuvant chemotherapy)
- at the same time as treatment with radiotherapy (chemoradiation), to make treatment more effective
- sometimes after surgery (adjuvant chemotherapy), if there's a high risk of the cancer coming back. It's not known how effective this is, so it's usually given as part of a clinical trial (see pages 86–87)
- on its own for bladder cancer that has spread to other parts of the body (palliative chemotherapy).

Drugs are often given in combination to treat bladder cancer. Some commonly used combinations are:

- gemcitabine and cisplatin (GC)
- methotrexate, vinblastine, doxorubicin and cisplatin (MVAC)
- 5-FU and mitomycin – usually given when chemotherapy is given at the same time as radiotherapy (chemoradiation)
- carboplatin and paclitaxel
- gemcitabine and carboplatin.

Other drug combinations or a single drug may also be given.

We have more information about individual chemotherapy drugs and different combinations at [macmillan.org.uk](https://www.macmillan.org.uk) Or call our cancer support specialists on **0808 808 00 00**.

Chemotherapy for advanced or metastatic bladder cancer

Chemotherapy may be given when the cancer has spread outside the bladder to other parts of the body. It can help shrink or slow down the growth of the cancer and reduce your symptoms.

The type of chemotherapy you have will depend on how advanced your cancer is and how physically well you are. You may be given a combination of chemotherapy drugs or one drug on its own.

Many people worry about having chemotherapy because of the possible side effects, but these side effects can usually be well controlled with medicines.

Deciding whether to have treatment when you have metastatic cancer can be difficult. You can talk to your doctor and specialist nurse about the advantages and disadvantages of treatment in your situation. Talking to your family and close friends may also help.

If you decide not to have chemotherapy, there are other medicines available and ways of controlling cancer symptoms such as pain. Your doctor will discuss these with you.

We have a booklet called **Making treatment decisions** that you may find helpful.

How chemotherapy is given

You have your treatment in the chemotherapy day unit or during a short stay in hospital. Chemotherapy is usually given as a course of several sessions (or cycles) over a few months. One cycle often takes a few weeks. A cycle includes having the treatment and having a break with no treatment. Your doctor or nurse will explain more about this.

If you have chemotherapy at the same time as radiotherapy (chemoradiation), your doctor or nurse will tell you how the chemotherapy will be given.

Usually, the chemotherapy drugs are given into a vein (intravenously). This can be by injection or as a drip (infusion). The drugs are given through a small tube (cannula) in your arm or a soft plastic tube, called a central line or PICC line. A central line goes into a vein in your chest. A PICC line is put into a vein above the bend in your arm.

We have more information about PICC and central lines that we can send you.

Side effects of chemotherapy

Chemotherapy drugs can cause side effects, but these can usually be well controlled with medicines. We describe some below. Your doctor or specialist nurse will give you more information about the specific side effects of the chemotherapy drugs you are having.

Risk of infection

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

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

- you develop a high temperature – this 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'll be given antibiotics to treat any infection. You'll have a blood test before each cycle of chemotherapy to make sure your white blood cells have recovered. Sometimes your treatment may need to be delayed if the number of your white blood cells is still low.

Visit [macmillan.org.uk/avoidinginfection](https://www.macmillan.org.uk/avoidinginfection) to watch a slideshow about things you can do to avoid infection.

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 (reduced 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.

Anaemia can be treated with blood transfusions. This should help you to feel more energetic and ease the breathlessness.

Feeling sick

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 take. We have more information about nausea and vomiting that you may find helpful.

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, as they can prescribe mouthwashes and medicine to prevent or clear mouth infections.

There is a slideshow on our website about looking after your mouth during chemotherapy. Visit [macmillan.org.uk/mouthcare](https://www.macmillan.org.uk/mouthcare)

Hair loss

Some chemotherapy drugs may cause hair loss. Some people may have complete hair loss including eyelashes and eyebrows. Others may only experience partial hair loss or thinning. It depends on what chemotherapy drugs you are having (your doctor or nurse can tell you more about what to expect). If you do experience hair loss your hair should start to grow back within about three to six months of the end of treatment. It may grow back straighter, curlier, finer, or a slightly different colour than it was before. Your nurse can give you advice about coping with hair loss and how to look after your scalp.

Visit [macmillan.org.uk/hairloss](https://www.macmillan.org.uk/hairloss) to watch a video of someone talking about their experience of hair loss and the things that helped.

Tiredness (fatigue)

You're likely to become tired and have to take things 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 going for short walks will help increase your energy levels. Our booklet **Coping with fatigue** has more helpful tips.

Fertility

Some chemotherapy drugs can affect your ability to become pregnant or to father a child. If this is a concern for you it's important to talk this over with your cancer doctor before you start chemotherapy.

Early menopause

Younger women may find that chemotherapy causes an early menopause. This can cause menopausal symptoms like hot flushes and sweats. Your doctor can prescribe hormone replacement therapy (HRT) to replace the hormones that are no longer being produced. You can talk this over with your cancer doctor or specialist nurse.

Contraception

Your doctor will recommend you don't become pregnant or father a child while having chemotherapy for bladder cancer. This is because the drugs may harm a developing baby. You should use effective contraception during your treatment and for up to a year afterwards. Talk to your doctor or specialist nurse if you are worried about this.

Condoms should be used during sex within the first 48 hours after chemotherapy, to protect your partner from any drugs that may be present in semen or vaginal fluid. Your doctor or specialist nurse can give you more information about this.

We can send you information about all of these side effects, including our booklets **Eating problems and cancer**, **Coping with hair loss** and **Coping with fatigue**. Or you can read it at [macmillan.org.uk/cancerinformation](https://www.macmillan.org.uk/cancerinformation)

Supportive treatments

If you have a cancer that has spread to other parts of the body (advanced or metastatic cancer), you may have treatment to help your symptoms. This may be chemotherapy (see pages 77–83) or radiotherapy (pages 68–75).

Your doctor may also refer you to a palliative care team. This is a team of health professionals who are experts in helping with symptoms caused by cancer.

We have information about how different symptoms can be controlled in our booklet **Controlling the symptoms of cancer**. We also have more information about different symptoms.



If there is a blockage in the ureters or kidneys

Sometimes, bladder tumours can block the drainage of urine from the kidneys into the bladder through the ureters. If this happens you may have pain or discomfort in your back or side, or you may feel sick. Tell your doctor or specialist nurse if you notice any of these symptoms.

If a ureter is blocked, your doctor may suggest an operation to put a stent into one or both of your ureters. Stents allow urine to drain from the kidney.

This operation is done under general anaesthetic using a cystoscope (see pages 20–21). The doctor passes the cystoscope through your urethra and into your bladder. Using a thin wire, they position the stent into the ureter.

If it is not possible to put in the stent using a cystoscopy, you may have a tube put directly into your kidney. This is called a nephrostomy. A nephrostomy drains urine directly from your kidneys into a bag.

Under a local anaesthetic in the x-ray department, the doctor uses an x-ray or scan to help them position the tube in your kidney. Once the nephrostomy is in position, it can be used to put in the stent.

We can send you more information about having a nephrostomy.

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 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.

Clinical trials are described in more detail in our booklet **Understanding cancer research trials (clinical trials)**. We can send you a free copy.

Blood and tumour samples

Blood and 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 take part in a trial you may also give other samples, which may be frozen and stored for future use when new research techniques become available. Your name will be removed from the samples 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 be used to increase knowledge about the causes of cancer and its treatment, which will hopefully improve the outlook for future patients.

Our booklet **Understanding cancer research trials (clinical trials)** describes clinical trials in more detail. We can send you a copy. You can also visit [macmillan.org.uk/clinicaltrials](https://www.macmillan.org.uk/clinicaltrials) for links to current trial databases.

After treatment

Follow-up

After treatment, you'll have regular follow-up appointments. Your kidneys and ureters will be checked, and your doctor will look for any signs of the cancer returning (recurrence). You will also have scans to check for any sign of the cancer coming back.

If you've had a urinary diversion, you will have regular scans to check your kidneys are working well. You will also have blood tests.

If you've had radiotherapy, you will have regular cystoscopies (see pages 20–21). These will be every three months at first but this will lessen over time. You will continue to have them for at least five years.

If your urethra wasn't removed during surgery, there is a small risk that the cancer could come back in this area. You will have regular tests each year to check the urethra (urethrosopies). This usually continues for five years.

Many people find that for a while they get anxious before appointments. This is natural. It may help to get support from family, friends or one of the organisations listed on pages 117–124 during this time. If you have any problems, or notice any new symptoms in between check-ups, let your doctor know as soon as possible.

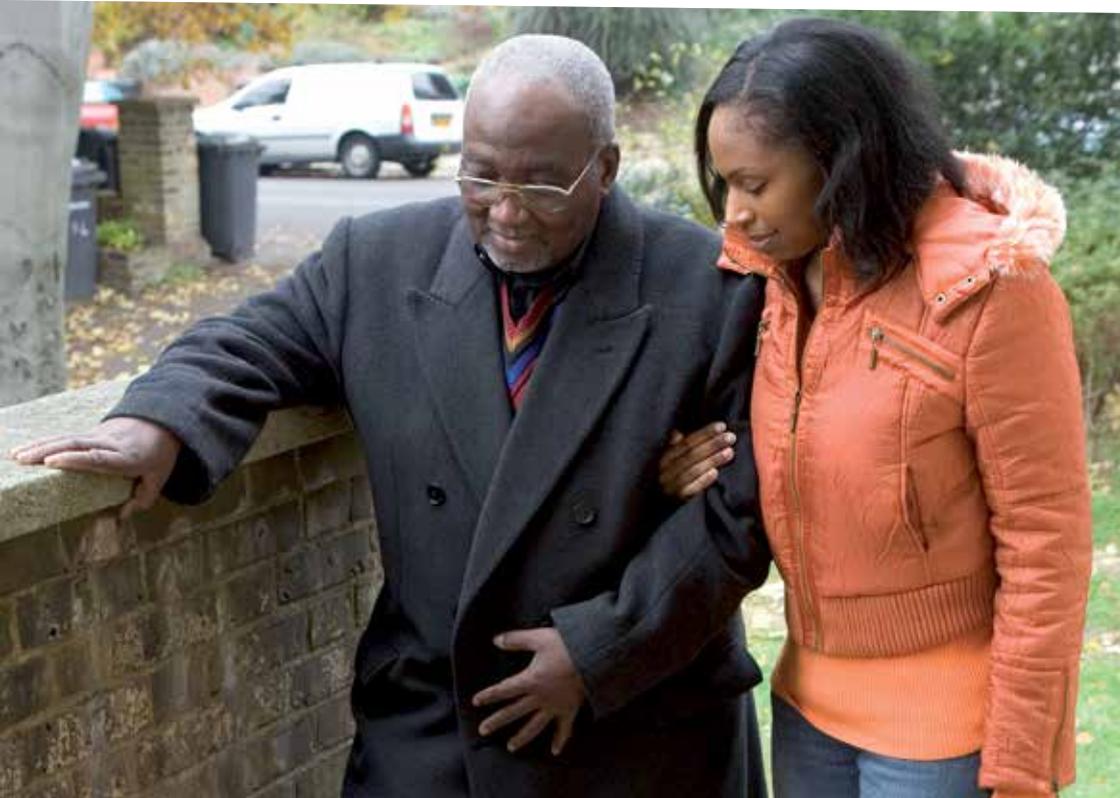
If you have finished cancer treatment except for regular check-ups, it can feel like you've suddenly been left on your own. Our booklet **Life after cancer treatment** or our leaflet **What to do after cancer treatment ends: 10 top tips** may help.

If the cancer comes back

If the cancer comes back, you can have further treatment. If it comes back after radiotherapy, you may need to have your bladder removed (cystectomy).

You may be offered chemotherapy. There is more information about chemotherapy on pages 77–83.

If you have already had your bladder removed, chemotherapy or radiotherapy may be suggested.





COPING DURING AND AFTER TREATMENT

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Well-being and recovery

What you can do

One of the hardest things to cope with can be the feeling that the cancer and its treatment have taken over your life. This is a common feeling, but there are lots of things you can do.

There may be days when you feel too tired to even think about what could help. You'll have good and bad days, but if you're overwhelmed by these feelings let your doctor or nurse know. It may be that you have depression, which is treatable. They should be able to help.

Finding ways to cope

You may find it helps to try to carry on with life as normally as possible. You may do this by staying in contact with friends and doing your usual activities. Or you may want to decide on new priorities in your life. This could mean spending more time with family, going on the holiday you've dreamed about, or taking up a new hobby. Just thinking about these things and making plans can help you realise that you still have choices.

Some people want to improve their general health by eating a more healthy diet, getting fitter or finding a relaxing complementary therapy. We have more booklets and leaflets about these things.

Understanding the cancer and its treatment helps many people cope. It means they can discuss plans for treatment, tests and check-ups with their doctors and nurses. Being involved in these choices can help give you back control of your life.

Looking after yourself and making positive choices

After cancer treatment, you need time to recover. Looking after yourself is an important part of this. You may have had a healthy lifestyle before cancer, but some people might choose to make lifestyle changes. You may feel you want to focus more on making the most of your health.

We've included some information on the next couple of pages that may help you.

Give up smoking

If you're a smoker, giving up is one of the healthiest decisions you can make. Smoking is a major risk factor for bladder cancer and other cancers such as lung cancer. It also increases the risk of heart disease. Our booklet **Giving up smoking** has more information and tips to help you quit.

Keep to a healthy weight

If you feel you need to lose weight, you can ask your GP for advice and find out what your ideal weight is. Keeping to a healthy weight reduces the risk of some other cancers, heart problems and illnesses such as diabetes.

Here are some tips to help you lose weight:

- only eat as much food as you need
- eat a balanced diet with lots of fruit and vegetables
- eat less fat and sugar
- be more physically active.

Our booklet **Managing weight gain after cancer treatment** has some helpful tips.

Eat healthily

Eating healthily will give you more energy and help you recover. Try to eat plenty of fresh fruit and vegetables (five portions a day). If you eat meat, reduce the amount of red meat and eat more chicken and fish.

There's more information in our booklet **Healthy eating and cancer**.

Get physically active

Being physically active helps you feel less stressed and will give you more energy. It also keeps your weight healthy and reduces the risk of other health conditions.

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

Stick to sensible drinking guidelines

Current guidelines recommend that men and women should drink no more than 14 units of alcohol in a week. They also suggest you should spread any alcohol units you drink over three or more days. It's a good idea to have a several alcohol-free days each week.

Who can help?

Many people are available to help you and your family.

District nurses work closely with GPs and make regular visits to patients and their families at home if needed.

The **hospital social worker** can give you information about social services and benefits you may be able to claim, such as meals on wheels, a home helper or hospital fares. They may also be able to arrange childcare for you during and after treatment.

In many areas of the country, there are also specialist nurses called **palliative care nurses**. They are experienced in assessing and treating symptoms of advanced cancer. Palliative care nurses are sometimes known as **Macmillan nurses**. However, many Macmillan professionals are nurses who have specialist knowledge in a particular type of cancer. You may meet them when you're at a clinic or in hospital.

Marie Curie nurses help care for people who are approaching the end of their lives in their own homes. Your GP or hospital specialist nurse can usually arrange a visit by a palliative care or Marie Curie nurse.

There's also specialist help available to help you cope with the emotional impact of cancer and its treatment. You can ask your hospital doctor or GP to refer you to a doctor or counsellor who specialises in supporting people with cancer and their families.

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



YOUR FEELINGS

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Your feelings

It's common to feel overwhelmed by different feelings when you're told that 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 it 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 right 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](https://www.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](https://www.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, then 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.

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

Deciding what to tell your children or grandchildren about your cancer is difficult. An open, honest approach is usually best. 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 only small amounts of information, and gradually tell them more to build up a picture of your illness.

Teenagers

Teenagers can have an especially hard time. At a stage when they want more freedom, they may be asked to take on new responsibilities and they may feel over-burdened. It's important that they can go on with their normal lives as much as possible and still get the support they need.

If they find it hard to talk to you, you could encourage them to talk to someone close who can support and listen to them, such as a grandparent, family friend, teacher or counsellor. They may also find it useful to look at the website **riprap.org.uk** which has been developed especially for teenagers who have a parent with cancer.



WORK AND FINANCIAL SUPPORT

Financial help and benefits

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Work

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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:

- **contributory** – you can get this if you have made enough national insurance contributions
- **income-related** – you can get this if your income and savings are below a certain level.

Since October 2013, a new benefit called **Universal Credit** has started replacing income-related ESA in England, Scotland and Wales. This benefit is for people who are looking for work or on a low income.

Personal Independence Payment (PIP) is a new benefit for people under 65 who find it difficult to walk or look after themselves (or both). You must have had these difficulties for at least three months, and they should be expected to last for the next nine months. Since April 2013, PIP has started to replace a similar older benefit called **Disability Living Allowance** (DLA) in England, Scotland and Wales.

Attendance Allowance (AA) is for people aged 65 or over who find it difficult to look after themselves. You may qualify if you need help with things like getting out of bed, having a bath or dressing yourself. You don't need to have a carer, but you must have needed care for at least six months.

If you are terminally ill, you can apply for PIP, DLA or AA under the 'special rules'. 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, Scotland and Wales) 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 (see page 122) or Citizens Advice (see page 121). In Northern Ireland, you can call the Benefit Enquiry Line Northern Ireland on **0800 220 674**.

Our booklet **Help with the cost of cancer** has more detailed information. You might also find our video at **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 pages 122–123.

Our booklets **Insurance** and **Getting travel insurance** may also be helpful.

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 that may be helpful. There's also lots more information at macmillan.org.uk/work



GETTING TRAVEL INSURANCE



PENDING



HOW ARE YOU FEELING?

WORK AND CANCER

HOW CAN WE HELP?

HOW CAN WE HELP?

Journey

Cancer Focus

CAN YOU HELP?



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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** 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**. 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**

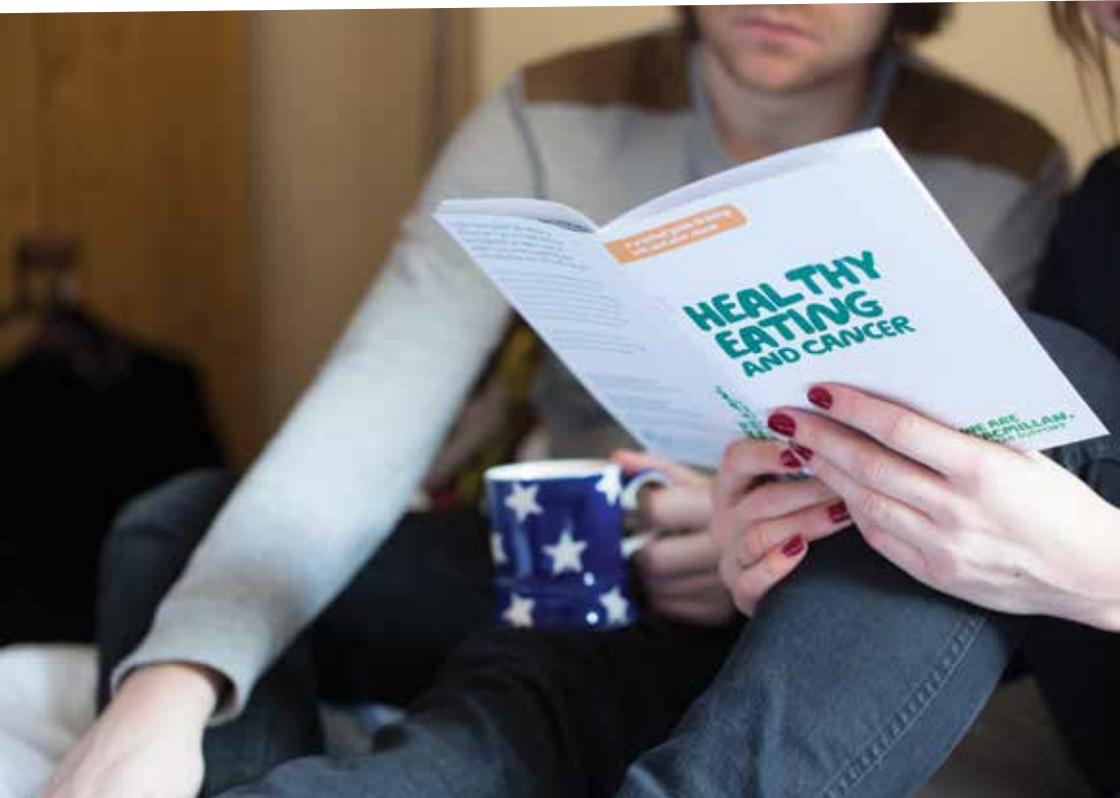
If you'd like us to produce information in a different format for you, email us at **cancerinformationteam@macmillan.org.uk** or call us on **0808 808 00 00**.

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 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 guidance
- 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. It can be fun too. It's not all just chats about cancer.'

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 team can give you guidance 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.

Bladder cancer support organisations

Action on Bladder Cancer (ABC)

6 Trull Farm Buildings,
Tetbury,
Gloucestershire GL8 8SQ

Email

info@actiononbladder
cancer.org

www.

actiononbladdercancer.org

Works with healthcare professionals, patients, carers and the general public to help improve the care of people with bladder cancers.

Fight Bladder Cancer

The Loft,
Robert House,
19 Station Road,
Chinnor,
Oxfordshire OX39 4PU

Email

info@fightbladdercancer.co.uk

www.

fightbladdercancer.co.uk

A national charity providing information and support to all people affected by bladder cancer. Also supports research into causes, treatments and better patient aftercare.

Organisations that help with bladder problems

Bladder and Bowel Community

SATRA Innovation Park,
Rockingham Road,
Kettering NN16 9JH

Tel 0845 345 0165

Email [info@bladderandbowel
foundation.org](mailto:info@bladderandbowelfoundation.org)

**[www.bladderandbowel
foundation.org](http://www.bladderandbowelfoundation.org)**

A UK-wide charity that provides information, advice and support for a range of symptoms and conditions related to the bladder and bowel.

Urostomy Association

4 Demontfort Way,
Uttoxeter ST14 8XY

Tel 01889 563191

Email

secretary.ua@classmail.co.uk

www.

urostomyassociation.org.uk

Supports people who are about to have, or have had, a urinary diversion, and their carers.

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 to people with cancer from ethnic communities, their friends, carers and families.

Cancer Focus

Northern Ireland

40–44 Eglantine Avenue,
Belfast BT9 6DX

Tel 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 Support Scotland

Calman Cancer
Support Centre,
75 Shelley Road,
Glasgow G12 0ZE
Tel 0800 652 4531

Email info@cancersupportscotland.org

www.

cancersupportscotland.org

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

Irish Cancer Society

43–45 Northumberland Road,
Dublin 4,
Ireland

Tel 1800 200 700
(Mon–Thu, 9am–7pm,
Fri, 9am–5pm)

Email helpline@irishcancer.ie

www.cancer.ie

National cancer charity offering information, support and care to people affected by cancer. Has a helpline staffed by specialist cancer nurses. You can also chat to a nurse online and use the site's message board.

Maggie's Centres

1st Floor,
One Waterloo Street,
Glasgow G2 6AY

Tel 0300 123 1801

Email

enquiries@maggiescentres.org

www.maggiescentres.org

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

Penny Brohn Cancer Care

Chapel Pill Lane,
Pill,

Bristol BS20 0HH

Tel 0845 123 2310
(Mon–Fri, 9.30am–5pm)

Email

helpline@pennybrohn.org

www.

pennybrohncancercare.org

Offers a combination of physical, emotional and spiritual support, using complementary therapies and self-help techniques.

Tenovus

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

Tel 0808 808 1010

(Mon–Sun, 8am–8pm)

www.tenovus.org.uk

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.

Organisations that help with sexual difficulties

College of Sexual and Relationship Therapists

PO Box 13686,
London SW20 9ZH

Tel 020 8543 2707

Email info@cosrt.org.uk

www.cosrt.org.uk

The national specialist charity for sex and relationship therapy. Previously known as the British Association for Sexual and Relationship Therapy.

The Institute of Psychosexual Medicine

Building 3,
Chiswick Park,
566 Chiswick High Road,
Chiswick,
London W4 5YA

Tel 020 7580 0631

Email admin@ipm.org.uk

www.ipm.org.uk

Has a comprehensive list of doctors throughout the country who are trained in psychosexual medicine.

The Sexual Advice Association

Tel 020 7486 7262

Email info@sexualadvice
association.co.uk

www.sda.uk.net

Aims to help improve the sexual health and well-being of men and women.

Counselling and emotional support

British Association for Counselling and Psychotherapy (BACP)

BACP House,
15 St John's Business Park,
Lutterworth 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 itsgoodtotalk.org.uk

UK Council for Psychotherapy (UKCP)

2nd Floor, Edward House,
2 Wakley Street,
London EC1V 7LT

Tel 020 7014 9955

Email info@ukcp.org.uk

www.psychotherapy.org.uk

Holds the national register of psychotherapists and psychotherapeutic counsellors, listing practitioners who meet exacting standards and training requirements.

Financial or legal advice and information

Benefit Enquiry Line Northern Ireland

Tel 0800 220 674

(Mon–Wed and Fri, 9am–5pm,
Thu, 10am–5pm)

Textphone 028 9031 1092

www.nidirect.gov.uk/contacts/contacts-az/benefit-enquiry-line

Provides information and advice about disability benefits and carers' benefits in Northern Ireland.

Citizens Advice

Gives advice on financial, legal, housing and employment issues. Find details for your local office in the phone book or on one of the following websites:

England and Wales

www.citizensadvice.org.uk

Scotland

www.cas.org.uk

Northern Ireland

www.citizensadvice.co.uk

**Department for Work
and Pensions
Disability Benefits Helpline**

08457 123 456

(Textphone 0845 722 4433)

**Personal Independence
Payment Helpline**

0845 850 332

(Textphone 0845 601 6677)

Carer's Allowance Unit

0845 608 432

(Textphone 0845 604 5312)

**[www.gov.uk/browse/
benefits](http://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 comprehensive information
about social security benefits
and public services.

Law Society

113 Chancery Lane,
London WC2A 1PL

Tel 020 7242 1222

www.lawsociety.org.uk

Can provide details of solicitors
in England and Wales.

Law Society of Scotland

26 Drumsheugh Gardens,
Edinburgh EH3 7YR

Tel 0131 226 7411

Email lawscot@lawscot.org.uk

www.lawscot.org.uk

Can provide details of
solicitors in Scotland.

**Law Society of
Northern Ireland**

96 Victoria Street,
Belfast BT1 3GN

Tel 028 9023 1614

www.lawsoc-ni.org

Can provide details of solicitors
in Northern Ireland.

Money Advice Scotland

Tel 0141 572 0237

**[www.moneyadvicescotland.
org.uk](http://www.moneyadvicescotland.org.uk)**

Offers independent debt
advice and can help you find
a financial adviser in your area.

The Money Advice Service**Tel** 0300 500 5000(Mon–Fri, 8am–8pm,
Sat, 9am–1pm)**Typetalk**

18001 0300 500 5000

**www.moneyadvice
service.org.uk**

Runs a free financial health check service and gives advice about all types of financial matters. Has an online chat service for instant money advice.

**Personal Finance Society –
‘Find an Adviser’ service****www.findanadviser.org**

Use the website to find qualified financial advisers in your area.

Unbiased.co.uk**Email**

contact@unbiased.co.uk

www.unbiased.co.uk

On the website you can search for qualified advisers who specialise in giving financial advice, mortgage, accounting or legal advice.

**Equipment and advice
on living with a disability****British Red Cross**UK Office,
44 Moorfields,
London EC2Y 9AL
Tel 0844 871 11 11**Email**

information@redcross.org.uk

www.redcross.org.uk

Offers a range of health and social services such as care in the home, a medical equipment loan service and transport.

Disability Rights UK12 City Forum,
250 City Road,
London EC1V 8AF
Tel 020 7250 3222**Email**

enquiries@disabilityrightsuk.org

www.disabilityrightsuk.org

Provides information on social security benefits and disability rights.

Disabled Living Foundation (DLF)

380–384 Harrow Road,
London W9 2HU

Tel 0845 130 9177

(Mon–Fri, 10am–4pm)

Email helpline@dlf.org.uk

www.dlf.org.uk

Provides free, impartial advice about all types of disability equipment and mobility products.

Support for older people

Age UK

Tavis House,
1–6 Tavistock Square,
London WC1H 9NA

Tel (England and Wales)

0800 169 6565

(Scotland)

0845 125 9732

(Northern Ireland)

0808 808 7575

(Mon–Sun, 8am–7pm)

www.ageuk.org.uk

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

Support for carers

Carers Trust (Princess Royal Trust for Carers in Scotland)

Tel (Scotland) 0141 221 5066

Tel (Wales) 0292 009 0087

Email support@carers.org

www.carers.org and

www.youngcarers.net

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.

Carers UK

Tel (England, Scotland, Wales)
0808 808 7777

Tel (Northern Ireland)

028 9043 9843

(Wed–Thu, 10am–12pm
and 2–4pm)

Email advice@carersuk.org

www.carersuk.org

Offers information and support to carers across the UK. Can put people in contact with support groups in their area.



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 Lisa Pickering, Consultant Medical Oncologist, and by our Chief Medical Editor, Dr Tim Iveson, Macmillan Consultant Medical Oncologist.

With thanks to Paula Allchorne, Uro-Oncology Nurse Specialist; Dr Alison Birtle, Consultant Oncologist; Professor Vinod Nargund, Consultant Urological Surgeon. Thanks also to the people affected by cancer who reviewed this edition, and those who shared their stories.

Sources

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

British Uro-oncology Group (BUG), British Association of Urological Surgeons (BAUS) Section of Oncology, Action on Bladder Cancer (ABC). *Multi-disciplinary Team (MDT) Guidance for Managing Bladder Cancer*. January 2013.

European Association of Urology. *Guidelines on muscle-invasive and metastatic bladder cancer*. 2015.

Nargund et al. *Urology Oncology*. Springer. 2008.

National Institute for Health and Care Excellence (NICE). *Bladder Cancer: diagnosis and management*. NG2. February 2015.

National Institute for Health and Care Excellence (NICE). *Suspected cancer: recognition and referral*. NG12. June 2015.

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

27530

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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**WE ARE
MACMILLAN.
CANCER SUPPORT**