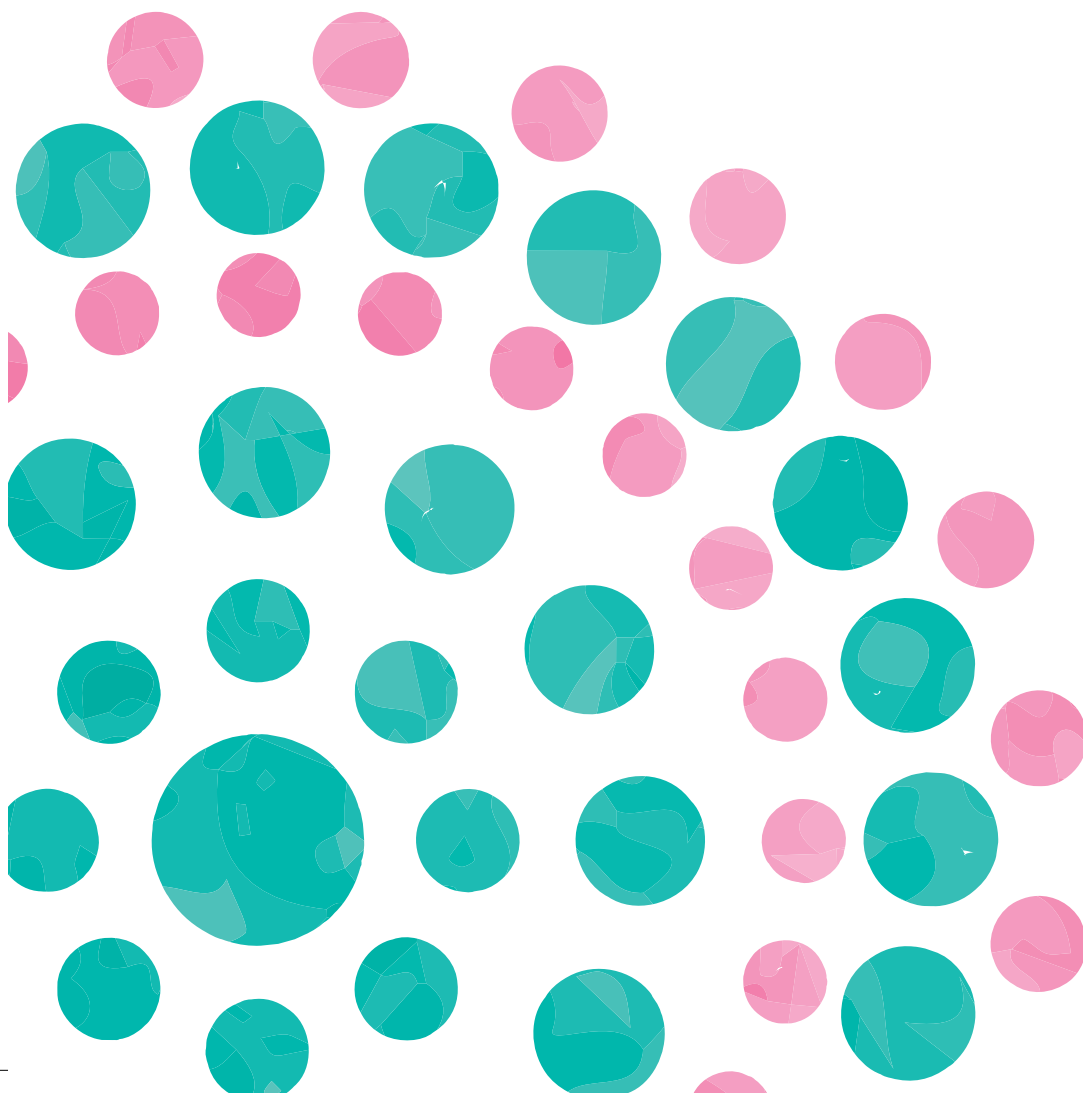


Ductal carcinoma in situ (DCIS)

Breast
Cancer
Network
Australia

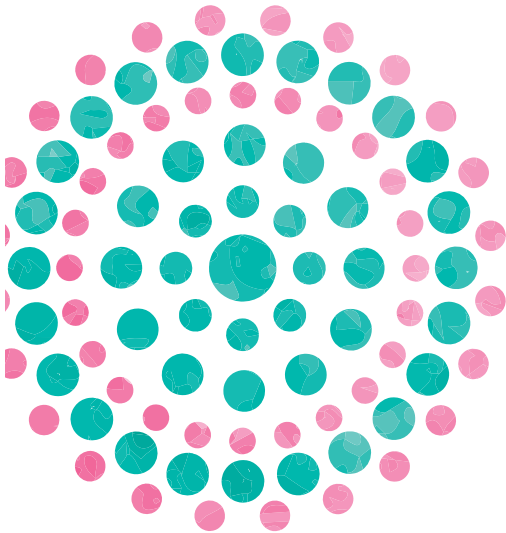


Breast Cancer Network Australia (BCNA) is the peak national organisation for Australians affected by breast cancer. We work to ensure that people receive the very best support, information, treatment and care appropriate to their individual needs.

At BCNA, we want to make sure that you and your family have access to as much information about ductal carcinoma in situ (DCIS) and its treatment as you need. Being involved in your treatment and care will help you make the decisions that are best for you, right from the start.

To do that you will want different information at different times. This DCIS booklet is designed to give you information in a way that is easy for you to understand.

However, if you use a smartphone, computer or the internet, you might prefer to use the *My Journey* online tool that is available from **bcna.org.au/myjourney**. The online tool provides a way for you to access information that is tailored specifically for you and your needs.



This resource is a Cancer Australia *Supporting Women in Rural Areas Diagnosed With Breast Cancer* Program initiative, funded by the Australian Government.



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Ductal carcinoma in situ (DCIS)

Ductal carcinoma in situ (DCIS) is the name for abnormal changes in the cells that line the milk ducts of the breast. While the abnormal cells may look similar to cancer cells, they are precancerous cells that are contained within the ducts (in situ) and have not spread into surrounding breast tissue or to other parts of the body.

The abnormal cells remain in the milk ducts as they have not yet developed the ability to spread outside the ducts. As a result of being confined to the ducts DCIS has a very good chance of cure.

DCIS is often referred to as stage 0 breast cancer and like any breast abnormality can be a confusing and scary diagnosis, so it is important to understand the facts. This includes understanding any risks associated with your individual diagnosis of DCIS so you can make the decisions that are right for you.

DCIS - the facts

DCIS is **not** invasive breast cancer. It is when precancerous cell changes are seen in the breast. DCIS is called non-invasive breast cancer because the abnormal cells are still contained inside the milk duct and have not grown into, or invaded, the normal breast tissue.

DCIS is not life-threatening, but it can mean you are at higher risk of developing invasive breast cancer at a later time.

If DCIS is left untreated, it can spread outside the ducts into surrounding breast tissue and then potentially to other parts of the body. When this happens, it is called invasive breast cancer.

In Australia, it is estimated more than 2,000 women are diagnosed with DCIS every year with most cases of DCIS being detected through screening mammograms.

How DCIS develops

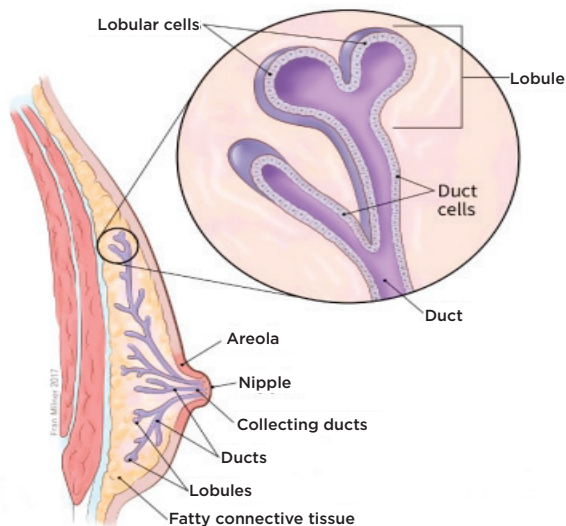
To understand how DCIS develops it is helpful to understand what the breast looks like on the inside.

Women's breasts are made up of a type of tissue called 'glandular tissue'. This tissue has ducts and lobules supported by fibrous and fatty connective tissue (Figure 1). There are around 12-15 major ducts in each breast that come together to drain into the nipple. Ducts and lobules are lined by two layers of cells:

- The inside layer of cells called luminal epithelial cells, make milk during pregnancy.
- The outer layer of cells, called myoepithelial cells, help push milk to the nipple during breast feeding.

Hormones produced by the body such as oestrogen and progesterone stimulate the glandular cells in the breast to grow at different times during a woman's hormonal cycle, to prepare the breast cells for a possible pregnancy.

Figure 1: View of a woman's breast from the inside



Non-cancerous changes in the breast

Over many hormonal cycles benign (non-cancerous) changes can develop. These are called fibrocystic changes. The medical names for such changes are cystic change, hyperplasia and metaplasia. During a mammogram, these changes might be picked up as cysts and can appear as white spots/shadows. The cysts are often surrounded by fibrous tissue and the fluid in the cyst can harden due to deposits of calcium (calcification). These cysts can occasionally be felt by women as a lump. Fibrocystic changes are common and do not need any treatment.

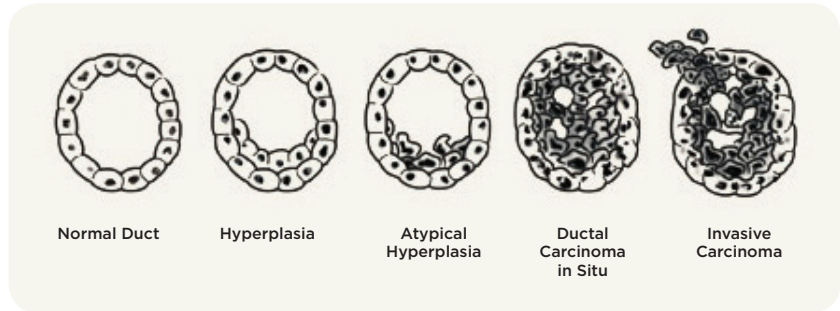
Abnormal changes in the breast

Sometimes cells lining the milk ducts in the breast can change into abnormal cells. This is a complex process that is not fully understood.

Over time, hormones being released in the body during women's monthly cycles can lead to proliferative (growth) non-cancerous changes in the cells that line the breast ducts. These cell changes are called 'hyperplasia' (an increase in the number of normal cells). Some of these changes may go on to become 'atypical hyperplasia' (an excessive growth of cells that now have an abnormal appearance) and DCIS (an excessive growth of cells that look like cancer cells, confined to the inside of the duct).

When DCIS breaks through the ducts into the surrounding tissue, it is called invasive carcinoma (commonly referred to as invasive breast cancer). It is only then that it can spread to other parts of the body. Figure 2 (next page) shows how the cells of the milk ducts change from normal cells to cancer cells.

Figure 2: Drawing of cells progressing from normal to invasive breast cancer



As Figure 2 shows there are a spectrum of changes from benign (non-cancerous) to malignant (cancerous) cells in the breast. The timing, and rate, of how this change progresses differs from person to person. In any one person, different ducts may be at different stages of change. There may be no invasive cancer present, or there may be a mixture of DCIS and invasive breast cancer.

Depending on the timing and type of procedure performed (e.g. mammography followed by biopsy), it is sometimes hard to say accurately at what stage the cells are. Surgery to remove the area of DCIS is often needed, and this, combined with the pathology report, will determine the extent and level of disease present and provide a clear diagnosis.

How DCIS is found

I was diagnosed with DCIS after being recalled to BreastScreen for further investigation after a routine mammogram. When I went to receive my diagnosis, I was told I had DCIS and would require surgery to remove the small area of concern, but to not think I had breast cancer, I didn't.

DCIS is usually found through a mammogram, most often done as part of the BreastScreen Program. The mammogram may show tiny white dots called calcification (these are calcium salts). They are common. Some calcification is benign (non-cancerous) and will not require removal or treatment, while others are abnormal and will require surgery. As a result of better screening mammograms, more breast abnormalities like DCIS are being detected early.

Although calcification is the most common presentation, not all DCIS will calcify and occasionally other abnormal changes such as a mass-like appearance may also be seen on a mammogram or ultrasound. Some DCIS cannot be seen at all on a mammogram.


Most women with DCIS have no symptoms. Occasionally, a lump can be felt or seen by the woman herself, or there may be a nipple discharge. It is important to discuss any changes in your breasts with your doctor.

Confirming a diagnosis of DCIS

Having the biopsy was not at all threatening, as the staff at that point were just so lovely, putting on music of my choice and making me feel quite at ease. All the doctors I saw that day were also amazing, leaving me with no unanswered queries.

On our return the following day to get the result of the biopsy and the diagnosis, we were totally impressed with the doctor who spoke to us. She spent a long time explaining everything and made an appointment for me to see a surgeon the very next week ...

My advice to newly diagnosed women is to stay calm, have someone with you, as there is a lot to take in [and] know that all the staff are there to assist you through this process.



If a mammogram shows changes that may be an indication of DCIS, the diagnosis will need to be confirmed and the extent of the disease determined. This will be done using a combination of procedures.

These procedures may include:

- Further mammograms to see the area of calcification in more detail. Sometimes an ultrasound is also used. On occasions an MRI may be useful to confirm the extent of DCIS and/or rule out the presence of any invasive breast cancer.
- A biopsy - a tissue sample is taken using a core needle biopsy (CNB) or vacuum-assisted biopsy needle (VAB). This is where samples of affected breast tissue are taken guided by a mammogram to help locate the exact area of calcifications or breast abnormality.

The diagnosis of DCIS on the biopsy is not always straightforward. This is because of:

- the range of changes of cell changes that may be present in the breast (Figure 2)
- the types/range of DCIS that can exist.

It may be hard to accurately classify DCIS on a small amount of biopsy tissue and more procedures (biopsy, surgery) may be needed, to make a final diagnosis.

In addition, even when a biopsy gives a definite diagnosis of DCIS, the surgery (to remove the DCIS) may produce unexpected findings. Since the biopsy sample takes only a small amount of tissue, there is a possibility that other grades of DCIS or an unsuspected invasive cancer may show up on the tissue removed during surgery. The area of DCIS may also be larger than what the tests have shown prior to surgery. All these possibilities underline that a final diagnosis may take a little while as more test results come in and the puzzle pieces are slowly put into place.

I was diagnosed with DCIS after I had a lumpectomy to remove a part of my breast. The initial biopsy showed atypical hyperplasia. I was told that there was a 15 to 20 per cent chance that it was going to be something 'more' than that. When I was told it was DCIS, it was initially confusing. I knew the cells were cancerous but I wasn't sure if I had 'real' breast cancer, although the treatment options were nearly the same.


Other procedures you may have to locate the DCIS

If you have a biopsy, sometimes a small procedure to mark the borders or margins of the DCIS may be planned to make it easier for the surgeon to locate and find the right spot when they are operating. This can be done using a number of procedures, including placing markers within the breast to allow the surgeon to remove the area of breast tissue with DCIS.

The markers may include a fine wire (called a hookwire), low-dose radioactive injection or seed, metal marker or magnetic bead. Occasionally a tract of carbon (trail of carbon leading to the skin) will be placed at the time of your biopsy. This can be used by the surgeon to locate the abnormal area of the breast to be removed.

Hookwire localisation is a common procedure that may be used just before surgery to help the surgeon locate the area of DCIS to be removed. The wire is called a hookwire because there is a tiny hook at the end, which keeps it in position. Hookwire localisation is guided by either mammography or ultrasound, and is done in an X-ray department or private radiology clinic. Mammographic guidance is common for DCIS as it is usually difficult or not possible to see on ultrasound.

A small metal clip (or marker) is often placed in the breast where the biopsy samples are taken so that the area can be found again if another biopsy or surgery is needed. It can be safely left in the breast and does not need to be removed, even if no further procedures are needed.



Some hospitals insert a tiny, very low-dose radioactive seed or a magnetic seed into the breast tissue instead of using a fine wire. This can be done up to two weeks before your surgery. During surgery, a special probe locates the seed and guides the surgeon to the tissue that needs to be removed along with the seed.

Understanding your pathology report

DCIS is made up of a broad range of conditions. Even when the cell changes can be accurately identified as DCIS, there are different kinds of DCIS, and these can progress at different speeds and in different areas of the breast.

When the suspicious area in your breast is biopsied, the samples taken are studied under the microscope by a pathologist. The pathologist sends your doctor a report that gives a diagnosis for each sample taken.

The pathology report provides information about the type and grade (see below) of your DCIS. In some cases it may also state whether or not the cancer cells have receptors for the hormones oestrogen and/or progesterone. If oestrogen and/or progesterone receptors are present this means that the cancer cells to some extent rely on these hormones to grow. Hormone-blocking therapies might be recommended to block the effects of oestrogen or lower oestrogen levels in the body. The benefits of hormone-blocking therapies vary. This is an area of ongoing research. For more information on hormone-blocking treatment see page 40.

The information in the pathology report will help you and your doctors decide what treatment will be best for you.

Grading of DCIS

The term 'grade' is used to describe the three different types of DCIS. The DCIS cells will be given a grade according to how different and variable they are to normal breast cells and how quickly they are growing.

DCIS is graded as low, intermediate or high-grade:

1. Low (Grade I) – cells are like normal cells and are slow growing.
2. Intermediate (Grade II) – cells grow faster than normal cells and look less like them.
3. High (Grade III) – cells grow quickly and look very different from normal cells.

If some of the abnormal cells have died (called necrosis), this can mean the cells are turning over more quickly, and is considered an adverse feature. Cell necrosis happens when cancer cells grow quickly and some cells don't get enough nourishment and die. The presence of necrosis is an important indicator of how aggressive and fast growing the DCIS is and may influence treatment decisions.

DCIS and the risk of invasive breast cancer

Initially confusion was my overriding feeling. I was diagnosed with DCIS after a routine breast screen and recall, which included a biopsy ... My surgeon was determined to explain that DCIS is not cancer, and he reinforced that on several subsequent visits, as did my radiation oncologist later.

At the moment, it is not currently possible to tell for sure which women with DCIS will go on to develop invasive breast cancer. In some cases, DCIS will never develop further, or will grow so slowly that it would never cause harm during a person's lifetime. However, the grade and features of DCIS are important in determining the risk (likelihood) of DCIS developing into invasive breast cancer. This will influence treatment decisions.

The risk of invasive breast cancer may be **higher** in women who:

- are younger (under 40 years of age) at diagnosis
- have a large area of DCIS (e.g. greater than 4 cm)
- have high-grade (fast-growing) DCIS or a pathological change called comedo necrosis

- have close or involved (positive) margins found in the tissue removed during surgery (this means that abnormal cells have been found at the edge of the tissue removed)
- have DCIS in more than one area of the breast (called multifocal disease).

The risk of invasive breast cancer may be **lower** in women who:

- are older at diagnosis (over 60 years of age)
- have a small area of DCIS (e.g. less than 1.5 cm)
- have low-grade DCIS (slow growing)
- have clear margins (DCIS is removed along with enough healthy tissue around it to ensure that all DCIS has been completely removed)
- have DCIS in only one area of the breast.

Although these factors can help predict if DCIS will become invasive, there is currently no way that is 100 per cent accurate to predict how, when and if DCIS will turn into invasive cancer for individual women. Treatment for DCIS is recommended in order to minimise the chance of the DCIS coming back and the chance of developing invasive breast cancer.

In the instances where 'untreated' DCIS goes on to become invasive cancer, the time it takes to progress varies. For those with:

- low-grade DCIS, it may take, on average, 15 years or more
- high-grade DCIS, it may take, on average, around five years or less.

Untreated high-grade DCIS is more likely to become invasive breast cancer than low-grade DCIS, and do so more quickly. If you have high-grade DCIS the possibility exists that you may already have invasive cancer present.

Studies have shown that DCIS is usually (but not always) in a single segment of the breast. In most cases, if invasive carcinoma develops, it will be in the same area as the original DCIS was found.

Why treatment is needed for DCIS

The main thing I remember was being told I was 'lucky', as if I was going to get breast cancer this was best one to have. I understand the logic behind this, but honestly I definitely did not feel lucky!


Women with DCIS are recommended treatment because DCIS has the potential to become invasive breast cancer. Currently, it is not reliably known for certain which women with DCIS will develop invasive breast cancer if they are not treated. While some women may never develop invasive breast cancer if not treated, others may. Research is currently being undertaken internationally to help health professionals better predict which women with DCIS are more likely to develop invasive breast cancer and how long after their diagnosis of DCIS this would be likely to occur.

How treatment decisions are made

I recall that when I was in hospital I felt mixed emotions, and because I didn't feel sick or need further treatment, I couldn't get my head around what DCIS actually was. My advice for other women diagnosed with DCIS is to ask questions and don't be afraid to ask again if anything is unclear.

I found that researching and reading everything I could was helpful. I somehow felt a little more in control and certainly more informed about what would be the right options for me. The reading and researching helped inform me about what I should and could be asking questions about – and I asked lots of questions. I even had questions I asked my partner and mum to ask for me if I felt a little intimidated asking them myself.

It is important that you are able to be as involved as you would like to be in making decisions about your treatment. Often, women say their fear about DCIS returning or becoming invasive breast cancer has the strongest influence on their treatment decisions. So too are



the potential effects of treatment on their quality of life. It is important that you discuss any concerns you may have with your treating team.

The treatment recommended for you will take into account your individual situation and the recommendations of the specialists who are part of your multidisciplinary team. Your doctors will use your pathology report and imaging tests (scan results) to recommend the best treatment for you. They will also consider your risk factors (see page 44), whether you have a family history of breast cancer, your general health and personal preferences.

Treatment for DCIS is based on the following features:

- where in the breast the DCIS is located, and how much of the breast is affected
- the degree of abnormality of the cells (e.g. grade and cell features).

You should not feel rushed into making treatment decisions for DCIS. It is okay to take a few weeks to decide about what treatment you would prefer so that you have time to talk with your family, friends or other important people in your life to help you decide what is most appropriate for you. If you feel unsure, you may also like to get a second opinion from another doctor who has experience with DCIS. This may help you feel more confident with your choice of treatment.

The treating team

My advice for others diagnosed with DCIS is just to listen to the experts ... Ask as many questions as you like and talk about your concerns. The surgeons and the hospital staff are there to support you and answer any questions/concerns you have.

In most major treatment centres a multidisciplinary team will be managing your treatment. The term 'multidisciplinary team' is used to describe the group of specialists who will be involved in your treatment and care. This team may include:

- **breast surgeon** – performs breast surgery
- **radiologist** – examines imaging such as mammograms, ultrasound and MRI
- **pathologist** – examines the cells/tissue removed from your breast to determine your diagnosis
- **breast care nurse** – provides ongoing information and support to you, often working alongside the breast surgeon
- **radiation oncologist** – plans and manages radiotherapy treatment
- **general practitioner (GP)** – provides ongoing supportive care and referral to specialists.

You can also be referred to other health professionals as required. These may include:

- **breast reconstructive surgeon** – to restore the shape of the breast, particularly if you have a mastectomy (removal of the whole breast)
- **physiotherapist** – to provide information about post-operative exercises
- **social worker** – for practical or financial assistance
- **counsellor, psychologist or psychiatrist** – for emotional support.

The management of DCIS can be complex, so bringing together all specialists in a multidisciplinary team is very important. Your multidisciplinary team will meet at regular intervals and your breast surgeon is usually the one who will relay their findings to you, while your breast care nurse remains your key point of contact throughout your diagnosis and treatment. If your team members are not based in the same treatment centre, which is often the case in rural areas, they may attend multidisciplinary team meetings using videoconferencing or teleconferencing facilities.

Once you complete treatment, your GP will become an important part of your follow-up care. If you don't already have a regular GP, now would be a good time to establish a relationship with one you feel comfortable with.

Treatment for DCIS

I was diagnosed with DCIS at age 44. My surgeon advised surgery and radiotherapy. I was given a booklet, but it was still confusing, was it 'cancer' as we know it? - 'It's cancer, but it's not.' I went ahead with treatment as advised.

The aim of treatment for DCIS is complete cure. Women diagnosed with DCIS have excellent outcomes, with survival rates exceeding 98 per cent 10 years after treatment is completed.

Most women diagnosed with DCIS who undergo treatment for DCIS do not have a recurrence of their disease or develop invasive breast cancer.

Treatment for DCIS is designed to remove all DCIS from the breast. It may involve:

Surgery

Surgery is nearly always the first treatment for DCIS. The aim of surgery is to remove the area of DCIS. Surgery involves either breast conserving surgery (also called wide local excision or lumpectomy) or mastectomy. Breast conserving surgery is the removal of the area of DCIS along with a small amount of healthy surrounding tissue called the surgical margin, while mastectomy is the removal of the whole breast.

Breast surgery also provides the DCIS tissue for pathology testing which will determine whether surgery has been successful in removing all the DCIS in the breast. This is referred to as clear margins which means that the margins surrounding the tissue removed are clear of all DCIS. If the margins are not clear, further breast conserving surgery or mastectomy may be advised. (See Table 1 on page 31 for a summary of the advantages and disadvantages of breast conserving surgery and mastectomy).

Radiotherapy

Following breast conserving surgery most women will be recommended radiotherapy (treatment for cancer using X-rays and other forms of radiation) to destroy any abnormal cells that may be left in the breast after surgery. These residual cells often do not show up on any scans, but may still exist. In order to reduce the chance of DCIS coming back or developing into invasive breast cancer, radiotherapy is required. Radiotherapy is not usually recommended after mastectomy for women with DCIS.

Hormone-blocking treatment

Hormone-blocking treatment, also referred to as endocrine treatment, might be considered after surgery for DCIS that is hormone receptor positive although this is not recommended for everyone. Hormone-blocking treatment usually consists of a tablet taken every day for up to five years.

1. Surgery

Surgery for DCIS involves:

- breast conserving surgery (usually followed by radiotherapy), or
- mastectomy.

You may be offered a choice between these types of surgery depending on the size and location of the breast area affected and the size of the area affected in comparison to your breast size. Your breast surgeon will discuss this with you.

In some women with DCIS which has a higher risk for containing invasive breast cancer, a sentinel lymph node biopsy is done at the time of the surgery. This includes when the DCIS can be felt or is extensive. It is usually done when a mastectomy is performed to remove extensive disease.

A sentinel lymph node biopsy means that lymph nodes under your arm are checked to see whether any invasive cancer that may exist in the DCIS has spread to the lymph nodes under your arm, which is the first area invasive breast cancer spreads to. For more information on sentinel lymph node biopsy see page 32.

Breast conserving surgery

Breast conserving surgery, also known as a wide local excision or lumpectomy, involves removal of the area of DCIS along with a small amount of healthy surrounding tissue called the surgical margin.

Breast conserving surgery may be recommended if:

- the area of DCIS is small and can be completely removed with clear margins of healthy tissue
- the DCIS is in only one area of the breast.

The surgeon will leave as much breast tissue as possible behind so that the breast can stay as close as possible to its original size. Occasionally, the breast may need to be reshaped or nearby body tissue used to replace the tissue removed from the breast using techniques of oncoplastic surgery.

Sometimes after breast conserving surgery, further surgery may be necessary if:

- there are abnormal cells in the edge of breast tissue removed (surgical margin)
- the amount or grade of DCIS found was more than suspected, and a bigger operation is needed to remove all of the abnormal area within the breast
- an unsuspected invasive breast cancer is identified in the tissue and removed during surgery.

If you are having breast conserving surgery, you will probably be asked to arrive at the hospital on the day of surgery. The operation is done under a general anaesthetic.

The operation itself usually takes up to one-and-a-half hours. However, there will also be preparation time, possibly insertion of a hookwire for localisation prior to the surgery and you will need time to recover from the anaesthetic. The length of time you will need to stay in hospital depends on the surgery you have, and how well you recover, but it is often a day procedure.

What to expect following breast conserving surgery

After breast conserving surgery, you will have a dressing over the surgery site. Most women who have breast conserving surgery do not have drainage tubes. After breast conserving surgery, you will have a scar on your breast where the DCIS was removed. The scar will become less obvious with time. After surgery, the pathologist will examine the removed breast tissue. The pathologist will check for clear surgical margins, examine the stage and grade of the area again, and may conduct receptor tests on the sample. Results of receptor tests may mean hormone-blocking treatments or other treatments are recommended. The pathologist's report will help you and your doctors decide what other treatments, if any, are best for you. If there are abnormal cells at the edges of the breast tissue removed (positive surgical margins), this means that the DCIS could not be removed completely and you may need more surgery to remove the remaining DCIS. Sometimes further breast conserving surgery will be performed, while other times a mastectomy is required.

The size and shape of your breast may change following breast conserving surgery depending on how much breast tissue is removed. If your breast size and shape change a lot, you can use a partial external breast prosthesis in your bra to make your breasts look equal or have further surgery to improve the symmetry of your breasts (e.g. surgery to reduce the size of the other breast).

Ask your surgeon or breast care nurse for more information about BCNA's *My Care Kit*, which includes a Berlei post-surgery bra and a soft form prosthesis (if needed) which may help your bra fit better.

It is a good idea to ask your surgeon to show you some pictures of women who have had breast conserving surgery before you have your surgery so you know what to expect.

Side effects of breast conserving surgery

Everyone responds differently to breast conserving surgery. Some side effects happen to most women, and others happen only occasionally. Side effects can happen straight after surgery, or take longer to develop.

Always talk to your doctors about any side effects that you are worried about or think you are developing. Most side effects can be reduced or managed with the right care.

Common side effects of breast conserving surgery include:

- pain, discomfort or numbness in the breast while wounds are healing
- bruising or swelling around the wound in your breast
- stiffness in your arm or shoulder

Bleeding or wound infection are uncommon after breast conserving surgery.

Recovering from breast conserving surgery

Your wounds should be fairly well healed after about a week, although during the first few weeks after surgery they will be sensitive and need extra care. You may feel tired and need a lot of rest, even after your wounds have healed. You may feel ready to go back to work or normal activities after a week or two or you may need longer to recover.

Your physical recovery after surgery is important, but is only part of the recovery process. You will also need time to recover emotionally. It can take time to adjust to how you may feel about your body, sexuality or self-esteem after breast conserving surgery. Although it is not always easy, talking to a member of your treating team about how you are feeling can help.

Mastectomy


The roller-coaster ride began. It was very confusing. I had the surgery the next week to remove the area, and further pathology showed that DCIS was in more areas of the specimen than appeared on the mammogram. To cut a long story short, I decided to have a mastectomy and reconstruction surgery.

Mastectomy usually involves removal of the entire breast, including the nipple. If you are having a mastectomy, you will probably be asked to arrive at the hospital on the day of surgery. The operation is done under a general anaesthetic and usually takes a few hours.

Mastectomy may be recommended if:

- the area of DCIS is large compared to the size of your breast
- the DCIS is in more than one area of your breast (although if the areas are small, it may be possible to have two wide local excisions instead of mastectomy)
- it hasn't been possible to get a clear margin around the DCIS using wide local excision
- you have a strong family history of breast cancer, or you have tested positive for a hereditary genetic mutation that increases your risk of developing breast cancer
- you have had radiotherapy to the breast previously (radiotherapy cannot be used again to treat the same breast)
- you are pregnant and radiotherapy is not recommended.

After many years of monitoring, I was diagnosed with DCIS in the left breast. My mother and her sister both had breast cancer - both survived. Because I had been to a seminar on breast cancer I was aware that my diagnosis was the 'best' one, as it was not invasive. As I was informed and being treated by an excellent specialist who was very informative and fully supported by my family, I made the decision to have both breasts removed as my breast tissue was very dense and it was difficult to see any problems in the other breast. I have never regretted my decision for one minute.



If you are thinking about mastectomy for DCIS, you may also want to consider breast reconstruction options when planning for surgery.

Mastectomy can include breast reconstruction to restore the shape of your breast. This could be an immediate reconstruction (done at the same time as the mastectomy) or a delayed reconstruction (done some time later after other treatment is finished). Waiting times for delayed breast reconstruction in the public system can vary from hospital to hospital, and across different states and territories.

Ask your breast surgeon about breast reconstruction options before you have a mastectomy, including timing and possible reconstruction techniques. If you are considering mastectomy and are interested in having a breast reconstruction, it is a good idea to ask for a referral to a specialist breast reconstructive surgeon **before** your surgery so that you can discuss your options. This will help you make the best choice for your individual circumstances.

If breast reconstruction is not available where you are being treated, you can ask for a referral to a specialist cancer centre where you can discuss your options with experts who are experienced in different breast reconstruction techniques.

You may decide you don't want a reconstruction now, or you may not be sure if you want one at all. Even if you think reconstruction is not for you, it is still a good idea to talk about what the options are so that you can be sure you have made the decision that is right for you.

Your preferences in relation to breast reconstruction will be taken into account at the time of your mastectomy. For example, if you have chosen to have an immediate reconstruction, your surgeon may save more of the skin and possibly the nipple to allow for a temporary tissue expander or more permanent implant, or the use of your own body tissue (called an autologous or 'flap' reconstruction). If you are planning a delayed reconstruction or you are not thinking of reconstruction, your surgery may be different.

There will be some preparation time before your surgery, and you will need time to recover from the anaesthetic afterwards. The length of time you will need to stay in hospital depends on the surgery you have and how well you recover. For example, if you choose to have a breast reconstruction at the same time as your mastectomy, the surgery is likely to take longer, and you may need to stay in hospital longer than if you have a mastectomy only.

It is a good idea to ask your surgeon to show you some other pictures of women who have had mastectomies and/or reconstruction before your surgery so that you are prepared for your surgery. More information about breast reconstruction is on page 33.

Best practice in breast cancer


The *Cancer Australia Statement – influencing best practice in breast cancer* is a summary of 12 practices that have been identified as appropriate or inappropriate for the provision of breast cancer care in Australia.

Practice 11 states: It is **not appropriate** to perform a mastectomy without first discussing with the patient the options of immediate or delayed breast reconstruction.

More information about the statement can be found at canceraustralia.gov.au/statement.

Nipple-sparing mastectomy

If the DCIS is located some distance away from your nipple, you may be able to have a nipple-sparing mastectomy. A nipple-sparing mastectomy involves removing all of the breast tissue, leaving the skin including the nipple. This nipple-sparing procedure can usually only be used if you are having an immediate reconstruction.



The procedure generally involves the surgeon making an incision underneath the breast or on the outer side of the breast. The space created from removing the breast tissue is then filled with a temporary expander or implant generally placed underneath the chest muscle (pectoralis major).

The advantage of a nipple-sparing mastectomy is that your own nipple is preserved, although it is common to lose sensation in the nipple.

The major risks of this surgery are:


- whether the nipple and surrounding skin will have enough blood supply to survive (up to 10 per cent of surgeries of this type may have some complications, which can affect the overall result)
- the loss of nipple sensation.

If keeping your nipple is important to you, you can ask your surgeon if nipple-sparing mastectomy is a safe option for you. The alternative to preserving the nipple at the time of mastectomy is to have a nipple reconstruction following mastectomy. There are a number of ways this can be done and your surgeon can talk to you about this.

What to expect following mastectomy

After a mastectomy, you will have a dressing over the operation site. You may have a plastic tube (called a drain) in your chest wall area. This drain removes blood and fluid that collects during the healing process, and will usually be removed after a few days. Sometimes the fluid continues to build up, meaning that the drain will stay in for longer.

If you haven't had an immediate reconstruction, you can wear a soft temporary external breast prosthesis (soft breast form) while your wounds are healing. Once your wounds have healed, you can be fitted for a permanent prosthesis (an insert for your bra). This will usually be six to eight weeks post-surgery depending on how quickly the swelling and discomfort goes away.



You may be given a soft temporary prosthesis while you are in hospital. BCNA's *My Care Kit* includes a Berlei post-mastectomy bra and soft forms. Ask your surgeon or breast care nurse for more information.

Side effects of mastectomy

Everyone responds differently to mastectomy. Some side effects happen to most women, and others happen only occasionally. Side effects can happen straight after surgery, or take longer to develop. Talk to your treating team about any side effects that you are worried about or think you are developing. Most side effects can be reduced or managed with the right care.


Common side effects of mastectomy include:

- pain, discomfort or numbness in the chest while wounds are healing
- fluid that may collect around the scar in your chest (called a seroma) and may need to be drained using a needle and syringe
- stiffness in your arm or shoulder – you may find it helpful to do some approved exercises after surgery; talk to your surgeon, physiotherapist, nurse or breast care nurse for advice.

Less common side effects after mastectomy are swelling or bruising around the wound in the chest. Bleeding or wound infection are uncommon after mastectomy.

Recovering from mastectomy

The wound from your surgery should be well healed after about a week. After a mastectomy, you will have a scar that runs across or down your chest that will become less obvious with time. During the first few weeks after surgery, the wound will be sensitive and need extra care. You may feel tired and need extra rest, even after your wound has healed. You may feel ready to go back to work or normal activities after a couple of weeks, or you may need longer to



recover. If you have a breast reconstruction at the same time as your mastectomy, you will probably take longer to recover than if you have a mastectomy only.

You may not be able to drive for a couple of weeks after mastectomy surgery. Your surgeon or treating team will be able to provide advice.

After a mastectomy, you may be aware of a difference in weight between the two sides of your body, particularly if your unaffected breast is large. A breast prosthesis or breast reconstruction can help balance the weight and improve your posture.

Your physical recovery after surgery is important, but is only part of the recovery process. You will also need time to recover emotionally. Many women feel a sense of grief about losing their breast and trepidation about waking up after surgery. Some women tell us that they find it hard to reconcile why they had to lose their breast when they did not have an invasive breast cancer. Everyone is different. Adjusting to how you feel about your body, your sexuality and self-esteem can take time. Although it is not always easy, talking to your doctor or breast care nurse about your feelings can help.

Table 1: Breast conserving surgery and mastectomy for treatment of DCIS - the advantages and disadvantages

Breast conserving surgery		Mastectomy	
Advantages	Disadvantages	Advantages	Disadvantages
<ul style="list-style-type: none"> • The breast is not removed. • A good cosmetic result is possible. • Radiotherapy reduces the risk of a recurrence of DCIS or the development of an invasive breast cancer in the same breast. 	<ul style="list-style-type: none"> • Some DCIS may be left behind at the time of surgery requiring further surgery to remove. • Radiotherapy may be given five days a week over a period of five to six weeks. • Radiotherapy can cause side effects to the skin and nearby tissues. • There is still a small risk of DCIS recurring or an invasive breast cancer developing in the future. • Yearly mammograms are needed on both the affected and unaffected breasts. 	<ul style="list-style-type: none"> • Radiotherapy is not usually required after mastectomy. • The risk of DCIS returning or an invasive breast cancer developing is small. • Mammograms are not needed on the mastectomy side but are still recommended for the unaffected breast. 	<ul style="list-style-type: none"> • The breast is removed • The operation is more extensive than breast conserving surgery • Recovery takes longer, especially if combined with breast reconstruction. • There is still a very small risk of recurrence of DCIS or invasive cancer in the future.

Surgery to the lymph nodes in the armpit (axilla)

Most women with DCIS will not have surgery to remove the lymph nodes. Lymph node removal is not usually recommended for women with DCIS because the abnormal cells have not developed the ability to spread outside the ducts and therefore cannot have spread to the lymph nodes in the armpit (axilla) and subsequently to other parts of the body.


However, if you are having a mastectomy your breast surgeon may discuss having a sentinel lymph node biopsy at the same time, as it is difficult to assess the sentinel node later if an invasive cancer is found.

Occasionally, a sentinel node biopsy may be recommended at the time of surgery if the surgeon considers there is a reasonable chance that there may be invasive breast cancer present, even though the biopsy did not indicate invasive breast cancer. Situations where this is more likely include palpable DCIS (felt as a lump) and larger areas of DCIS (typically more than 4–5 cm) especially if the biopsy indicates the DCIS is high-grade and has comedo necrosis.

Sentinel lymph node biopsy is the removal of the 'gatekeeper node(s)' (the first lymph node(s) to which the cancer would spread) to assess if invasive breast cancer has spread beyond the breast into the axillary lymph nodes. Sentinel node biopsy identifies whether the first lymph node(s) are clear of cancer cells.

Sentinel lymph node biopsy requires a small amount of radioactive fluid to be injected into the breast. This helps the surgeon to find the sentinel node using a special type of scanner during your surgery. This can mean your urine and faeces may be blue or green for a few days after surgery. A blue stain can be left on the breast that may last a long time. Once the sentinel node(s) have been removed, a pathologist will check whether any cancer cells are present.

If the sentinel lymph node biopsy is clear of cancer cells, no further surgery to remove axillary lymph nodes is needed. If the sentinel lymph node biopsy shows that the first node/s are affected by cancer cells, more surgery to the remaining axillary lymph nodes may be recommended.



Sometimes an area of invasive breast cancer is found as well as DCIS. If this is the case, it will affect the treatments you are offered, and you may need surgery to the lymph nodes under the arm to check if they contain cancer cells.

Possible side effects of sentinel lymph node biopsy

Some women will experience some mild numbness, stiffness of the arm and shoulder, and swelling after sentinel node biopsy. Ask your treating team for information about your personal situation.

There is a small risk of allergic reaction to the radioactive fluid or blue dye used to find the sentinel node. Allergic reactions are usually mild and easily treatable. As with any surgery, infection is a possible risk of sentinel node biopsy, although the risk is low.


Breast reconstruction after mastectomy

Breast reconstruction re-creates the shape of the breast in an attempt to create a natural shape. Breast reconstruction can sometimes be done at the same time as mastectomy (immediate reconstruction), or it may be done later (delayed reconstruction). It may also involve more than one operation to achieve the final result.

Deciding about breast reconstruction

If you are recommended to have a mastectomy, it is important to talk to your surgeon about the options for breast reconstruction surgery before you have your surgery. Your breast surgeon will be able to explain the different breast reconstruction options, and together you can decide what is best for you.

BCNA's website provides access to a free decision-making tool - BRECONDA - which may help you decide if a reconstruction is right for you. It guides you through a series of questions that cover considerations such as the different surgery available, risks and benefits, possible complications, stress management and communicating your decision.



Breast reconstruction can take several procedures over many months to achieve the final result. Your surgeon will be able to tell you if this is possible for you. Depending on the size and shape of your breasts, you may need to have surgery to your unaffected breast at some point to achieve symmetry (similar shape and size).

When deciding about breast reconstruction, bear in mind that your new breast will not look and feel like the old one. Depending on the type of reconstruction you choose, you may have scars on your breast and on other parts of your body.

There are many types of breast reconstruction, with much to consider, and it can seem overwhelming. Talking to your breast reconstructive surgeon about your options and connecting with other women who have had a breast reconstruction may help you find all the information you need to make the decisions that are right for you.

You may find it helpful to ask the women you talk to, or your breast reconstructive surgeon, to show you photos of the types of reconstruction you are considering. Weigh up the risks, side effects and benefits of each type of operation and what is important for you.

BCNA's online network has a private breast reconstruction group where women share information about their surgery and photos of their reconstruction results. For more information or to join, visit **bcna.org.au/onlinenetwork**. If an online network doesn't suit you, you can contact Cancer Council's Cancer Connect program where you can speak by phone to a volunteer who has had breast reconstruction.

Types of breast reconstruction

Some of the different types of breast reconstruction include:

1. Reconstruction using tissue expanders and implants: a silicone or saline implant is inserted under the skin and muscle of the chest.
2. Reconstruction using your own tissue, also called autologous reconstruction.

- The deep inferior epigastric perforators (DIEP) flap is the most advanced form of autologous reconstruction. This procedure uses your own abdominal skin and fat to reconstruct a natural, warm, soft breast after mastectomy. Unlike the TRAM flap (see below), the DIEP preserves all the abdominal muscles. Only abdominal skin and fat are removed similar to a tummy tuck. Saving the abdominal muscles means you experience less pain, enjoy a faster recovery, maintain core strength long-term, and have a lower risk of complications.
- Back muscle transfer (latissimus dorsi flap) is when a flap of skin, fat and muscle from the back, is moved to the chest to create a new breast mound.
- The transverse rectus abdominis muscle (TRAM) flap is when a flap of skin, fat and muscle from the stomach is moved to the chest to create a new breast mound. This type of reconstruction can also be muscle sparing, maintaining the function of the abdominal wall.

Some types of reconstruction use tissue from other parts of the body. Sometimes an implant can also be used with an autologous reconstruction.

The type of reconstruction recommended for you will depend on your body shape, general health and your preference. Not all types of reconstruction are suitable for all women (for example, if you do not have enough tissue on your stomach, it may not be possible for you to have a DIEP reconstruction). Breast reconstruction is a significant operation requiring a substantial recovery. Ask your treating team any questions that you may have.

Tips from women who have considered breast reconstruction

- Ask for referrals to more than one breast reconstructive surgeon so you can find one with whom you feel comfortable and confident.
- Consider all reconstruction techniques that may be right for you.
- Ask whether an immediate reconstruction (i.e. at the time of your breast surgery) may be right for you.
- If there is no reconstruction service at the hospital you are having surgery at, ask for a referral to one that does.
- Get more than one quote – out-of-pocket costs can vary considerably from surgeon to surgeon if you are having your surgery in the private system.
- Ask lots of questions and ask to see photos of the surgeon's previous breast reconstruction surgeries.
- BCNA's free breast reconstruction decision aid – BRECONDA – can help you decide whether (and what type of) reconstruction is right for you. Visit **bcna.org.au**.
- Talk to other women who have had the type of breast reconstruction you are considering. BCNA's online network has some private groups where women have shared their breast reconstruction experience through words and pictures. Visit **bcna.org.au/onlinenetwork**.
- Talk to other health professionals, such as a breast care nurse, about breast reconstruction and any concerns you have.

2. Radiotherapy

Radiotherapy is sometimes referred to as radiation therapy. It involves the use of X-rays to destroy abnormal cells that may be left in the breast after surgery. Radiotherapy is a localised treatment, which means it only treats the area of the body it is aimed at.

If your specialist is considering radiotherapy, you will be referred to a radiation oncologist who will talk to you about the plan for your treatment, including timing, how it will be delivered and the side effects that you are likely to experience.

Radiotherapy is usually recommended after breast conserving surgery. Radiotherapy is not usually needed after mastectomy.

It aims to:


- lower the risk of DCIS coming back
- reduce the risk of invasive breast cancer by treating any abnormal cells that may remain in the breast after surgery.

Having no radiotherapy after breast conserving surgery may be recommended if the benefit of radiotherapy is considered to be minimal and your risk of recurrence is low.

The benefit of radiotherapy is low if:

- your DCIS is small (just a few millimetres) and low-grade
- the DCIS is removed with enough healthy tissue around the DCIS (clear margins)
- you are at an older age (over 70) at diagnosis.

The definition of low risk is not always clear. If you decide on surgery only, close follow-up and monitoring is important. This may include regular breast examinations and imaging tests such as mammograms, ultrasound or in special circumstances, a MRI. The decision not to have radiotherapy must be considered carefully with your medical team. A second opinion can also be helpful.



Radiotherapy given every week day for five weeks (usually not on weekends) is the standard of care for DCIS. The addition of a boost is being studied in the clinical trial setting but long-term outcome results of these trials are still awaited. External radiation is usually given to the entire breast and can decrease the risk of developing DCIS again or invasive breast cancer by at least half.

Side effects of radiotherapy

Radiotherapy doesn't involve any painful or invasive procedures such as injections. However, you may have some side effects during or after treatment. Some side effects might develop months after treatment is over.

Your radiation oncologist will take care to reduce the chances of serious side effects, but some less serious ones are quite common.

Common side effects of radiotherapy include:

- tiredness or fatigue
- tenderness or swelling in the breast and/or chest
- skin changes.

Tiredness or fatigue may persist after treatment for up to four weeks. Exercise has been shown to reduce fatigue associated with radiotherapy.

Skin may become darker, dry, red or itchy. Sometimes blistering or peeling towards the end of radiotherapy can occur. Your radiation oncologist and nurse will help you with this, and the skin normally heals within a few weeks after treatment ends.

Rare side effects of radiotherapy include:

- Damage to the heart – When treating the left breast, a very small amount of the heart receives a very low dose of radiation. This is minimised by techniques such as deep inspiration breath-hold (DIBH) and technical modifications at the time of treatment planning. The evolution of treatment planning technology has allowed the radiation oncologist to minimise the dose to the heart.

- Damage to the lungs – This is a rare complication (occurring in less than 1 per cent of patients). Modern radiotherapy equipment allows your radiation oncologist to measure exactly how much radiation dose is delivered to the lungs and there are international guidelines that stipulate the maximum amount of radiation to the lungs that is safe.
- Development of a second cancer – This is an even rarer complication, and occurs in less than one in 2,000 patients and is the rarest of all of the side effects.

More information about the possible side effects of radiotherapy is available on the eviQ website in the radiation oncology section (eviq.org.au/radiation-oncology/breast).

Things you can do to reduce the chances of side effects

It is important to care for your skin during radiotherapy treatment. Ask your medical team for advice about how to best do this before, during and after radiotherapy. Tell the radiotherapy or nursing staff if you develop a skin reaction or if your skin reaction gets worse during treatment.

Here are some tips that have been shared by others that may help prevent or manage damage to the skin that happens as a result of radiotherapy.

- Apply moisturising cream (e.g. pure sorbolene, to unbroken skin after each radiotherapy session).
- When showering, avoid soap-based products, hot water, and rubbing or shaving the area. Gently pat your skin dry afterwards. As much as possible, keep skin folds dry.
- Wear loose-fitting cotton clothes and avoid tight clothes that can rub. Avoid wearing underwire bras as they put unnecessary pressure on breast tissue during treatment and the recovery period.
- Don't apply any tape or adhesive dressings to the treated skin.
- Avoid exposing the treated skin to direct sunlight by wearing sun-protective clothes.

- Avoid irritants – protect the skin in the treated area from damage by abrasion (be careful shaving, or use an electric razor), chemicals (e.g. perfumes or deodorants) and temperature extremes during your course of radiotherapy.

Make sure you know who to call after hours if you have any radiotherapy-related problems.

3. Hormone-blocking therapy

Some DCIS cells have hormone receptors on them (hormone receptor positive), which means they use female hormones to divide and grow. There are two types of hormone receptors – oestrogen receptors (ER) and progesterone receptors (PR).

Hormone-blocking therapy (sometimes called endocrine therapy) blocks or lowers the amount of oestrogen in the body, inhibiting the growth of DCIS and might be used if the DCIS tests positive for hormone receptors. Some studies have found taking hormone-blocking therapy after surgery reduces the risk of DCIS coming back and the risk of invasive cancer developing, but the women taking it did not live longer than those who didn't take it. Currently, there is no consensus on the use of hormone-blocking agents such as Tamoxifen, as there does not appear to be a survival benefit that outweighs the harm of long-term treatment with hormone-blocking therapies. Most women with hormone receptor positive DCIS do not receive hormone-blocking treatment.

Research is ongoing to determine which group of women with DCIS might benefit more from hormone-blocking therapy. It is important to discuss any questions you have about this with your treating team.

Not all treating centres test DCIS for hormone receptors as the benefits of hormone-blocking therapies are not clearly defined. Ask your surgeon about whether testing for hormone receptors on your DCIS will be carried out and whether hormone-blocking therapy should be part of your treatment.

Hormone-blocking therapy is used to treat oestrogen receptor positive invasive breast cancer. However, its benefits in DCIS are less clear and may not outweigh the possible side effects. The benefits of hormone-blocking therapy for women with oestrogen receptor positive DCIS vary depending on what treatment is given and it is not recommended for everyone.

For more information about hormone-blocking therapy, BCNA's *Hormone therapy and breast cancer* booklet outlines what hormone-blocking therapy is and how it works, and gives practical advice from other women about managing side effects. You can download it from bcna.org.au or phone **1800 500 258** for more information.

Pregnancy and DCIS

If you are pregnant when diagnosed with DCIS, you may feel anxious, overwhelmed and concerned about how the diagnosis and treatment will impact your pregnancy and your overall health and wellbeing. It is important to know that there are various options available to you.

Breast surgery after the first trimester is considered safe, and the risk of miscarriage is low. Radiotherapy is not usually recommended because it carries some risk for the baby. Some pregnant women choose to have a mastectomy rather than breast conserving surgery in order to avoid radiotherapy.

You don't have to make any decisions about your treatment alone. Your obstetric and treating team should include health professionals with experience in caring for women diagnosed with DCIS while pregnant. They can help you to make the best choices for you and your baby.

Pregnancy and treatment

It is recommended that you do not become pregnant during treatment for DCIS. Contraception choices can be limited, especially if your DCIS is hormone positive. Non-hormonal contraception such as a diaphragm or condoms is recommended while you are having treatment. If you are unsure of what contraception to use, ask your doctor.

Pregnancy after treatment

Once you have completed treatment for DCIS, there is no evidence that pregnancy will affect your risk of DCIS returning or developing an invasive breast cancer.

Clinical trials

Depending on your type of DCIS, your doctor may ask whether you are interested in joining a clinical trial.

Clinical trials are studies carried out to help find new ways to prevent, diagnose or treat diseases. The improvements in breast disease outcomes over the last few decades have been as a result of clinical trials.

Some clinical trials test drugs, while others test refinements of treatments such as radiotherapy and surgery. Some trials aim to find out if some women may safely be able to be spared certain treatments without compromising their cancer outcomes. Clinical trials can also investigate the emotional and physical side effects of DCIS and its treatment, and explore ways to improve quality of life.

You may be offered an opportunity to take part in a clinical trial, although many factors are taken into account, so not everyone is eligible. Clinical trials are run through public and private hospitals.

All clinical trial protocols (documentation and processes) have been through a rigorous ethics review process, which includes consumer input to ensure the safety of patients.

If you are interested in participating in a clinical trial, talk to your doctor about whether there is a trial that may be suitable for you. For more information and listing of current trials visit canceraustralia.gov.au or australianclinicaltrials.gov.au.

Is it ever safe to avoid treatment for DCIS?

DCIS can be treated successfully and most women diagnosed and treated for DCIS will be cured of their condition.

Throughout this booklet we have talked about the spectrum of DCIS and some of the features that make it a more risky or more serious diagnosis.

There are currently a number of international trials investigating whether it is safe to avoid treatment in women with 'very low-risk' DCIS. The trials are looking at whether closely monitoring a woman's low-grade DCIS with regular physical examinations and imaging tests (mammograms) leads to the same survival outcomes as those for women who have treatments such as surgery and radiotherapy. This approach is called 'active surveillance' and sometimes referred to as a 'watch and wait' approach.

These trials are not currently available in Australia and this approach is not recommended outside of clinical trials. If you have been diagnosed with low-grade DCIS and have questions around whether it is ever safe to avoid treatment, it is important to understand that there are no national or international guidelines that recommend this approach at this time. Results of these trials will take time to help answer this question. Speak to your breast surgeon if you have any questions about this topic.

To find out more about the international trials investigating the management of low-grade DCIS visit canceraustralia.gov.au.

The risk of recurrence of DCIS or developing invasive breast cancer after treatment

At age 36 years on a routine GP visit a lump the size of a pea was discovered in my left breast. In consultation with my GP I decided to have surgery to remove the lump. I was told it was DCIS. At no stage did I feel worried either before or after surgery - no one in the medical team was worried, so neither was I. And now 30 years later I have not had a day's worry about it over all those years and am in fine health.


Most women treated for DCIS never have DCIS again or develop invasive breast cancer. The chance of DCIS coming back or developing invasive breast cancer depends on a variety of factors. After mastectomy, DCIS rarely comes back. For women who have breast conserving surgery, the chance is increased and is dependent on the grade and type of DCIS.

In general you may have a 'lower' risk of developing DCIS or invasive breast cancer after treatment if:

- you have a small area (e.g. less than 1.5 cm) of DCIS in only one area of the breast
- the DCIS is low-grade
- you have clear margins
- you have been diagnosed at an older age.

In general you may have a 'higher' risk of developing DCIS or invasive breast cancer after treatment if:

- you have a larger area (e.g. greater than 4 cm) of DCIS
- DCIS is in more than one area of the breast
- the DCIS is high-grade
- you have unclear margins
- you have been diagnosed at a younger age.



There is also still a very small risk of developing DCIS or invasive breast cancer in the small amount of tissue left after a mastectomy.

Your doctor can give you more information about the chance of DCIS coming back or developing invasive breast cancer in your circumstances.

Follow-up screening and care

Your doctors (surgeon, radiation oncologist or GP) will undertake routine follow-up appointments so that any abnormal changes can be found and treated early. They will also keep an eye on any side effects of the treatments you have had and help you manage them, and provide practical and emotional support. Regular check-ups involves clinical examinations and annual imaging tests such as mammograms.

Your follow-up care plan will be based on your individual circumstances. Your follow-up care may be shared between your GP and your treating team (often referred to as 'shared care'). A basic care plan will usually include:

- a summary of your treatment
- contact details for the health professionals involved in your treatment
- a schedule of follow-up tests (including mammograms)
- a list of any symptoms to watch out for, and possible long-term side effects that may have been discussed with you
- suggested ways to adopt a healthier lifestyle.

Talk to your specialist about your individual follow-up care plan. Five years after your treatment you can re-attend BreastScreen if you wish.

Complementary therapies

Complementary therapies are used alongside the standard treatments that doctors use to treat cancer (surgery, radiotherapy, chemotherapy and hormone-blocking therapies). They are generally used to enhance quality of life, and may include treatments like massage or vitamins and supplements, or practices like yoga, tai chi and meditation.

Complementary therapies can be used as a way of nurturing the mind, body and spirit. Most complementary therapies and complementary medicines can be safely used alongside conventional treatment (such as surgery and radiotherapy) to help with stress, reduce the side effects of treatment and enhance your sense of wellbeing.


Before starting any complementary therapy it is important to speak to your treating team so you can be sure it will not have an adverse impact on your conventional treatment.

Memorial Sloan Kettering Hospital in the USA has developed a website with information about complementary therapies. The website describes what is currently known about a range of herbal products and supplements and their interactions with cancer medicines. For more information go to the website: mskcc.org/mskcc/html/11570.cfm. There is also an app that you can download to your smartphone or tablet. (Note: this is an American website and not all information may be relevant for Australia. Ask your treating team if you are unsure what information might be right for you).

Healthy lifestyles

After a diagnosis of DCIS, many women feel motivated to look at their lifestyle and make improvements where they can. While this can help you get as much enjoyment as possible from life, it also helps to reduce the side effects of treatment.

Establishing a healthy lifestyle includes maintaining a healthy body weight, drinking less alcohol, having a balanced diet including eating less red and processed meat and eating more fruit and vegetables, and doing more exercise.



Healthy eating, maintaining a healthy body weight and being physically active/exercising may help to:

- relieve fatigue and other side effects of treatment
- improve appetite and help with re-establishing a healthy weight
- improve sleep
- strengthen bones and muscles
- improve confidence
- reduce depression and anxiety
- prevent illnesses such as cancer, diabetes and heart disease.

Research has shown significant survival benefits from moderate, sustained exercise both during and after treatment, so exercise is now often prescribed as an integral part of treatment for women with DCIS, in the same way that medicines are. Exercise after breast surgery is also an important part of treatment and recovery.

Regular exercise can help to improve body weight, muscle strength, confidence and mood. It can also help reduce treatment side effects. For example, yoga has been shown to reduce the ongoing fatigue that some women report after their treatment has finished.

Before starting exercise you should speak with your treating team about which exercises are safe for you. This may include referral to an accredited exercise physiologist (AEP) or physiotherapist. There may also be exercise programs provided by your treating hospital or health service that you can access. A GP chronic disease management plan will give you access to up to five Medicare-subsidised visits to an exercise physiologist or physiotherapist. For more information about healthy lifestyles visit bcna.org.au.

Emotional wellbeing


I think for patients diagnosed with DCIS the psychological effect of diagnosis is as traumatic as if you had stage 1 cancer. It is confusing as a patient to be told you do/do not have cancer and especially as treatment is no different and follow-up the same as patients with breast cancer.

As hard as it may seem, I tried to stay as positive and optimistic as possible. Being informed, asking questions, and leaning on my family and friends to 'listen'. I also started to meditate and do some mindfulness exercises - my motto was 'It isn't going to hurt.' - I tried lots of different ways to try and stay calm and not to let the fear and anxiety overtake me.

The experience of being diagnosed with and treated for DCIS is often described as an emotional roller-coaster because of the ups and downs and changes that happen along the way. You might feel confused about what DCIS is and yet, even though it is not invasive breast cancer, find it is treated in a similar way.

Although DCIS is not invasive breast cancer and has a very good prognosis, you may understandably feel very anxious and frightened by the experience. DCIS is a confusing diagnosis, partly because of the uncertainty of its natural progression and invasive potential, the wide spectrum of disease, and new evidence about the effectiveness of various treatment options.

You may struggle to come to terms with the fact that you are being offered treatment such as mastectomy at the same time as being told your DCIS may do you no harm. Terms such as 'early cancer', 'pre-malignant', 'abnormal cells' and 'non-invasive breast cancer' can add fear and confusion to the diagnosis and what it means for you. Uncertainty for the future and fear of developing invasive breast cancer may be high.




Some women may find reports based on early tests for DCIS change once they have had surgery and the full picture of their diagnosis is clear. It can be difficult to make sense of all of the factors that need to be considered, such as your individual risk, the clinical features of your DCIS on your pathology report, and the potential benefits and harms of different treatment options.

It is common to feel shocked, anxious and alone. Some women say they feel as though they shouldn't be anxious about a diagnosis of DCIS, because it is less important than a diagnosis of invasive breast cancer, or they feel that they shouldn't complain because they 'don't have real cancer' and don't need to have chemotherapy. Emotions can swing between relief of not having invasive breast cancer and guilt that you feel devastated by the diagnosis when you 'should feel lucky'. You may also feel anxious about how to share your diagnosis with others, when you struggle to understand it yourself.

If you need support to work through any of the emotional effects that you experience, it is important to know that there are people who can support you. Don't be afraid to talk to your treating team about how you feel. Some women find it helpful to speak to their breast care nurse or specialist.

You may also find it helpful to speak to a psychologist or counsellor who understands DCIS and can support you to adjust emotionally. A counsellor can help you to make sense of your diagnosis and treatment as well as communicate well with others. They can also help you to work out where you need further explanation or discussion with your treating team. Your breast care nurse, specialist or GP can arrange a referral for you. It is important to know referrals to a private service require a mental health care plan. This is not a requirement for public health service referrals.

A GP mental health treatment plan gives you up to 10 Medicare-subsidised sessions per calendar year with a clinical psychologist. You may also be eligible for a Medicare rebate for a general psychologist, social worker or counsellor. Speak to your GP about being referred under a chronic disease management plan. BCNA has two fact



sheets that may be useful for further information: *Chronic disease management plans* and *GP mental health treatment plans*. Both fact sheets can be downloaded from bcna.org.au. You can also phone the BCNA Helpline and speak with a cancer nurse on **1800 500 258** or call Cancer Council on **13 11 20** for information and support.

BCNA's online network (bcna.org.au/onlinenetwork) is also available 24 hours a day if you feel that connecting with someone in a similar situation will help.

If an online network doesn't suit you, you can contact Cancer Council's Cancer Connect program where you can speak to a volunteer who has had DCIS.

Concerns about DCIS coming back or invasive breast cancer developing

I was worried and anxious daily for about a year after my diagnosis, and hypervigilant about checking anything that seemed abnormal in the breast affected and the other breast. I really was not prepared for that.

After finishing treatment for DCIS, it is common for women diagnosed with DCIS to worry about DCIS coming back or that invasive breast cancer will develop. It is also common for women to overestimate their risk of developing invasive breast cancer due to inconsistencies with the language used to describe DCIS or confusion about diagnosis and risk in individual cases.

While women who have been diagnosed with DCIS do have a higher risk of developing DCIS again than women in the general population, it can be helpful to remember that DCIS can be treated successfully and most women diagnosed and treated for DCIS will never have DCIS again.

Negative emotions like anger, frustration and sadness are normal, so don't feel guilty if you experience these emotions. They are a normal reaction to a major life event and part of coming to terms with what you have been through.

Some women want a lot of information about the chance that their DCIS may come back or that an invasive breast cancer may develop. Others prefer not to know. Make sure you ask as many questions as you need to, so that you get the information you want.

It is important to remember that you will still get normal aches and pains from time to time, and may develop other medical conditions as a normal part of ageing. The problem is that once you've had a DCIS diagnosis, you tend to be much more aware of your body and may worry unnecessarily. While most aches and pains are nothing to worry about, if your symptoms are severe and haven't settled in a few days, you should have them checked by a doctor.

Relationships

I'd like women who are diagnosed with DCIS to know that no matter how 'light' the cancer, it can still have a huge impact on your life, both now and in the future. I was told by the diagnosing doctor that I had 'light' cancer, or not capital letter cancer. But what does this really mean and how am I supposed to explain it to the people close to me?

I spoke a lot to my mum and partner – but I hid it from most other people. I didn't want to be any more emotionally vulnerable than I already was and somehow that worked for me. I tell everyone now about my experience, but at the time I was quite secretive.

It can be challenging to understand what DCIS is and how to explain it to others, including children. Cancer can be something that is hard for people to understand, and to try to explain DCIS to them can be overwhelming.

It is likely that those close to you may have many questions about your diagnosis of DCIS and the treatments that you may need. Talk to a member of your treating team if you are having difficulties answering questions about your diagnosis and treatment.

Partners

As with any significant experience, both partners in a relationship can feel worried after treatment for DCIS. It can be difficult to understand the disease, and while it is a precancerous condition, the treatment is similar to invasive breast cancer and the emotional impact can still be significant.

Talking openly and honestly with each other will help even if it is not easy to achieve. If you are facing a mastectomy, be sure to discuss your partner's feelings about this as well.


Things that may help:

- Set time aside each day to talk openly with your partner.
- Tell your partner how you are feeling - don't expect that they should know, even if you have been together for a long time.
- Ask your partner to come to your medical appointments with you so you both have a good understanding of what you are dealing with. A bonus is that your partner can write notes that you can both refer to later.
- Read about DCIS with your partner so you both understand what's happening.
- Be specific about what you want from your partner - don't expect them to be able to read your mind.

Children

Your children are likely to be affected by your diagnosis and will pick up if something is wrong. Talk to your children about your diagnosis and treatment so they understand what is happening. It is important to communicate clearly to children that the treatment outlook is very good and the aim is cure.

There are many sources of support depending of the age of the child. Your treating team, especially your breast care nurse or hospital social worker, can tell you what is available for you.



As a general rule, the way children respond to a parent's illness and cope with any upheaval depends on their age and maturity. For more information visit bcna.org.au or ring the BCNA Helpline on **1800 500 258**.

Friends and colleagues

Friends and colleagues may not understand your diagnosis or know what you need or how to best help you. Some people may never have heard of DCIS and be unsure what it means for you. Sometimes they may not know what to say or how to treat you. Often it is best to be up-front and let people know how you'd like to be treated and what you need. You may welcome their questions about how you're going, or you may prefer not to discuss your health. Whatever your choice, it would help them to know your preference. Some women are happy for their work colleagues to know about their diagnosis. Some tell only a select few, while others prefer not to tell anyone except perhaps their immediate supervisor.

Do whatever feels right for you. Even if you're happy for others to know, you may prefer to tell them by email or ask a trusted colleague to tell them for you.

Friends or colleagues of women diagnosed with DCIS can phone BCNA's Helpline on **1800 500 258** to find information, talk to someone about how they're feeling, and discuss ways they can best provide support. BCNA's work and breast cancer hub also provides detailed information for work colleagues about ways to offer support. For more information visit bcna.org.au/work-and-breast-cancer.

Friends and colleagues can also phone Cancer Council on **13 11 20** for information and support.

Sexual wellbeing

Breast surgery and radiotherapy can affect how women feel about themselves. The changes to your body, along with changes to your energy levels will affect how you feel about yourself.

Sex and intimacy are very personal but important components of life. DCIS and its treatment can affect sexual wellbeing in many different ways. Women who have had a mastectomy may experience sadness, loss and grief (before, during and after) at losing a breast; so do many women who undergo breast conservation surgery and radiation therapy which cause changes to their breast.

These factors can have an impact on your sense of sexual wellbeing, feelings of attractiveness, self-esteem and confidence. In addition, loss of sensation in your breast or in your reconstructed breast can alter your sexual libido. Discuss with your partner different ways of arousal that can help restore your sexual satisfaction. Also talk openly about how your changes affect your partner.

It is known that health professionals rarely initiate discussions about sexual wellbeing, and many women and couples find it hard to raise the subject themselves. But, if you do have concerns about your sexual wellbeing, it is important to discuss these with your GP or breast care nurse. They may be able to suggest things you can try, and tell you what has worked for other women. Your GP or breast care nurse may also be able to recommend a counsellor, psychologist or sex therapist who may be able to help.

Sometimes it is good to have some guidance to discuss these issues. Your breast care nurse will be a great resource, and if they can't help you with a particular issue they will refer you to another trained health professional.

BCNA's booklet *Breast cancer and sexual wellbeing* will help you identify similar issues that may affect you during and after treatment, and provide suggestions of strategies that may help you to manage them. You can download it from bcna.org.au.

For more information, support or referral call the BCNA Helpline on **1800 500 258** or Cancer Council on **13 11 20**.

Financial and practical support

While DCIS is a curable condition, it still involves treatment that can be expensive if you are treated in the private system (e.g. mastectomy and breast reconstruction).

In addition, time off work and general day-to-day expenses can result in short or longer-term financial strain or hardship. It can also be difficult knowing how to navigate financial and practical support when diagnosed with what is defined as a 'precancerous condition', and feeling anxious not knowing whether or not your entitlements will be the same.

For some people, getting by financially is no easy task even at the best of times. Although finances may seem trivial in comparison to your diagnosis, money worries can have a big impact on how you and your family cope.

Costs of tests and treatments

Public hospital health care is free to Australian citizens and most permanent residents of Australia. If you have private health insurance, you will be able to choose whether to be treated in a public or private hospital and also choose your doctor.

Talking to your doctor about whether you want to be treated in the public or private system is an important conversation to have early in your diagnosis. The likely costs of any tests, treatment and support services (including follow-up tests and appointments) that may be incurred in the private system will give you a clear idea of where you stand.

If you are privately insured, your private health insurance may help you cover some of your costs, but you might still be left with substantial out-of-pocket fees and charges.

If you don't feel comfortable talking about money, it might be helpful to think of health care in the same way as any other service you pay for, where you would often ask for a quote first. When you have so many other things to deal with, you don't need to be worrying about unexpected or surprisingly high bills.

Your costs will largely depend on whether:

- have your treatment in the public or private system
- are working and need to take time off or reduce your work hours
- live in a rural area and need to travel for treatment
- are eligible for a Centrelink Health Care Card or receive a Centrelink pension
- have insurance such as income protection.

Your doctor may be able to request that you are bulk-billed for some tests, which will reduce the amount you have to pay after any refunds. It is okay to ask to be bulk-billed or sent to a provider who offers bulk-billing services.

Finding assistance

If you are struggling financially, there are a number of financial schemes that can help you through a difficult patch. It can also be difficult finding out about how to access financial support and your eligibility when diagnosed with DCIS. Someone in your treating team (such as a social worker or your GP) can help you to find more information about the financial supports available and what the eligibility criteria are.

Your pharmacist and Medicare can explain the 'safety net' associated with the cost of treatment including medical bills.

If you are being treated in the private system, it is advisable to confirm with your health fund before you have any treatment what your level of cover is, what the rebate will be for your proposed treatment, and what your out-of-pocket costs will be. To do this you may need to provide a list of Medicare item numbers that your specialist (e.g. your breast surgeon) is charging you. If you are unsure about these, talk to your specialist's receptionist or the practice nurse to help you clarify what item numbers are included in your specialist's fees. If there are any items on the bill that do not have a Medicare item number, ask why you are being charged this fee.

While you may find much of the information available is directed to women diagnosed with breast cancer, you will find the following information and support is also available to you and useful for your individual circumstances.

Cancer Council provides a pro bono program that provides free legal, financial and workplace advice to people affected by cancer including DCIS, who cannot afford to pay for advice. You can phone Cancer Council **13 11 20** or BCNA's helpline on **1800 500 258** for advice.

BCNA's *Financial and practical assistance* fact sheet provides information on a range of benefits, subsidies and services that may be available to you and your family to help reduce the financial impact of your diagnosis. You can download a copy of the fact sheet from **bcna.org.au**.


The Cancer Council resource *Cancer and your finances* provides information to help you understand more about how to manage your finances after a cancer diagnosis. You can download this from **cancercouncil.com.au** or phone **13 11 20** to ask for a copy to be sent in the mail.

Living in a rural or remote area

Living outside of a metropolitan or major city can mean you have extra challenges such as isolation from support, distance from treatment facilities and interruption to your livelihood. This can add to the cost of treatment as well as the stress associated with breast cancer. Your breast care nurse, treating team, social worker and BCNA's Helpline staff can help you find the services and support that you are eligible for. Call BCNA's Helpline on **1800 500 258**.

Breast prostheses reimbursement program

A permanent prosthesis is made from silicone and resembles the shape and weight of the breast. It fits inside a bra to restore shape and maintain balance and alignment of the spine.



The cost of breast prostheses ranges from about \$150 to more than \$500. Women who have had a mastectomy can claim up to \$400 against the cost of a prosthesis every two years through the Australian Government's External Breast Prostheses Reimbursement Program. This program does not cover the costs of mastectomy bras.

If a breast prosthesis costs more than \$400, some private health funds will reimburse some of the cost. Medicare will then pay the remainder up to \$400. Some private health funds will also cover the cost of a mastectomy bra and swimwear. If you have private health cover, check with your insurer to find out what they will cover. You'll need to claim from your private health insurer before making a claim from Medicare. Women who have had a double mastectomy can claim for the cost of a prosthesis for each breast, up to \$800. Claims can be lodged with Medicare. See the Medicare website humanservices.gov.au for more information and reimbursement forms.


Treatment and work

If you are in paid employment when diagnosed with DCIS, continuing to work during treatment can help maintain a sense of normality, help you keep contact with others, and provide an income.

However, if you experience significant fatigue or other side effects from treatment, you may need to ask your employer to help by making reasonable adjustments to your work and environment.

If you do plan to work during your treatment, it is in your best interests to talk to your employer as soon as you can. They may be able to work out a job share arrangement, reduced working hours, arrange block time off while you're having treatment, offer practical supports such as parking close to the building, having frequent breaks during the day or working from home.

You can find out about your entitlements to paid and unpaid leave from supervisors, human resources or, if available, you can talk to your union representative.



To help support conversations with your employer, your treating team will be able to give you information about the likely physical and emotional side effects of the treatment you will have to help you make decisions about work. Your treating team may also be able to refer you to other support (e.g. a social worker).

BCNA's work and breast cancer hub provides detailed information for employees, employers and colleagues about work and breast cancer that you may find helpful too, including rights and responsibilities, tips for returning to work and managing finances and work. It also provides specific information for people who are self-employed. For more information visit bcna.org.au/work-and-breast-cancer.

Questions you might like to ask about your diagnosis and treatment

This booklet has provided information about the different treatments that may be offered for DCIS. However, everyone is different, and what is right for someone else may not be right for you. To actively participate in decision-making about your treatment and care, you need to fully understand the options that are offered. Ask as many questions as you need to, and speak up if you have concerns or worries.

The questions below are some of the questions women have told us they wanted to ask about their treatment. Not all of these will be appropriate for you. You should add any other questions you can think of on page 66 and 67. If you can, take someone with you to your appointments so that they can write down what you're told and you can read it again later. Remember, take one step at a time and don't allow yourself to be rushed. Talk to the people closest to you, or others who've been through treatment, if you want more opinions or advice.

Questions that you might want to ask or have someone ask for you

Questions to ask your doctor about DCIS

- Do I have breast cancer?
- What tests do I need to determine the type and stage of the DCIS?
- Will my DCIS be tested for hormone receptors and what will this mean for me?
- What treatment approach do you recommend?
- What are the possible side effects or complications of this treatment?
- In general, how effective is this treatment in women with a similar diagnosis?
- Am I at risk of having DCIS again?
- Am I at risk of developing invasive breast cancer?
- How will I know if I develop invasive breast cancer or DCIS again?
- What will happen if I develop invasive breast cancer?
- How will you treat DCIS if it does return?
- How often will I need follow-up visits after I finish treatment?
- What lifestyle changes can help reduce my risk of DCIS coming back?
- Do I need a second opinion?
- Should I see a genetic counsellor?

Questions you might like to ask your treating team

- Who are the members of my treating team?
- Who will be my main contact person?
- Who will be involved in discussions about my treatment?
- Who can I contact if I have questions about my treatment?
- Has my case been discussed by a multidisciplinary team?
- Can you write down what you have told me? Draw where my DCIS is on a diagram?
- Can I get a written summary of the treatments you recommend I have?
- What impact will being pregnant have on the timing of my treatment?
- Will I need to travel for treatment?
- Can you refer me for a second opinion?
- Who should I contact in an emergency?
- Will I be supported by a breast care nurse?
- Can you give me a quote of what my out-of-pocket costs are likely to be?
- Can I have a copy of my pathology report? Can you explain my diagnosis and what the terms mean?

Questions you might like to ask your surgeon about breast surgery

- What type of surgery is best for me?
- What will surgery involve?
- Do you specialise in breast surgery? If not, can you refer me to someone who specialises in breast surgery?
- Are there any clinical trials that may be relevant for me?
- Where will the scars be and what will they look like? Can you show me photos of some of your previous similar surgeries?
- How long will I be in hospital?
- How long will I take to recover?
- What side effects can I expect?
- Who should I contact if side effects happen?
- How much will the surgery cost?
- Do I need surgery to my lymph nodes in my armpit?
- How long will my operation take?
- What can I do to make myself more comfortable after my surgery?
- How much will the surgery cost in the private system? How much in the public system? Do these figures include the anaesthetist's fees?
- Do you charge any fees that are not covered by Medicare such as a booking fee?
- Is there someone I can talk to about my concerns around out-of-pocket costs (e.g. a social worker or independent financial adviser)?
- Can I get a referral to a public hospital if I am worried about costs?

Questions you might like to ask your surgeon about breast reconstruction

- If I have a breast reconstruction, can it be done in the same operation as my breast surgery?
- If I decide to have a breast reconstruction later, how long will I have to wait?
- If I decide not to have a breast reconstruction now, can I change my mind later?
- If I have a breast reconstruction, how will it affect the timing or types of other treatment available to me?
- What type of breast reconstruction do you recommend for me?
- How much will breast reconstruction cost?
- Do you specialise in breast reconstruction? If not, can you refer me to someone who does?
- Have you discussed all the possible reconstructive options with me?
- How will my breast look and feel after breast reconstruction?
- Can you show me photographs of different breast reconstructions?
- How safe are breast implants?
- Will having a reconstruction affect whether or not my DCIS comes back?
- Will I be able to breastfeed?
- Can I have my reconstruction in the public system?
- How long is the waiting list?
- Will a plastic surgeon be involved in my surgery?

Questions you might like to ask about radiotherapy

- Will radiotherapy be recommended for me?
- Where will I need to go for radiotherapy?
- If I have to travel a long way for radiotherapy, can I get financial support for travel and accommodation costs?
- How long will radiotherapy last?
- What side effects can I expect? How can I manage them?
- Who should I contact if side effects develop?
- Can I still work while I'm having radiotherapy?
- Can I still drive while I'm having radiotherapy?
- When will I have radiotherapy?
- Will radiotherapy affect whether I can have a breast reconstruction?
- Will radiotherapy affect whether I can breastfeed?
- How much will radiotherapy cost?

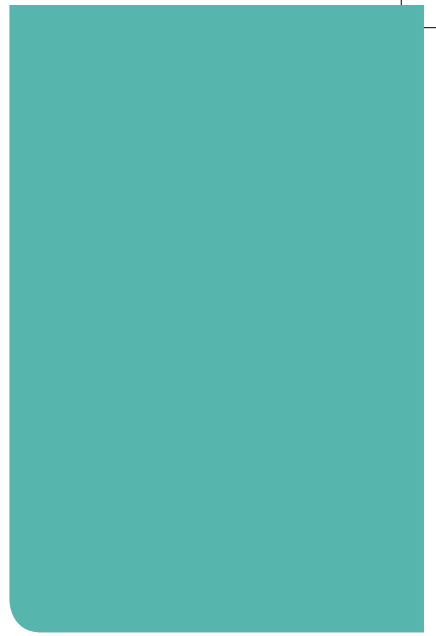
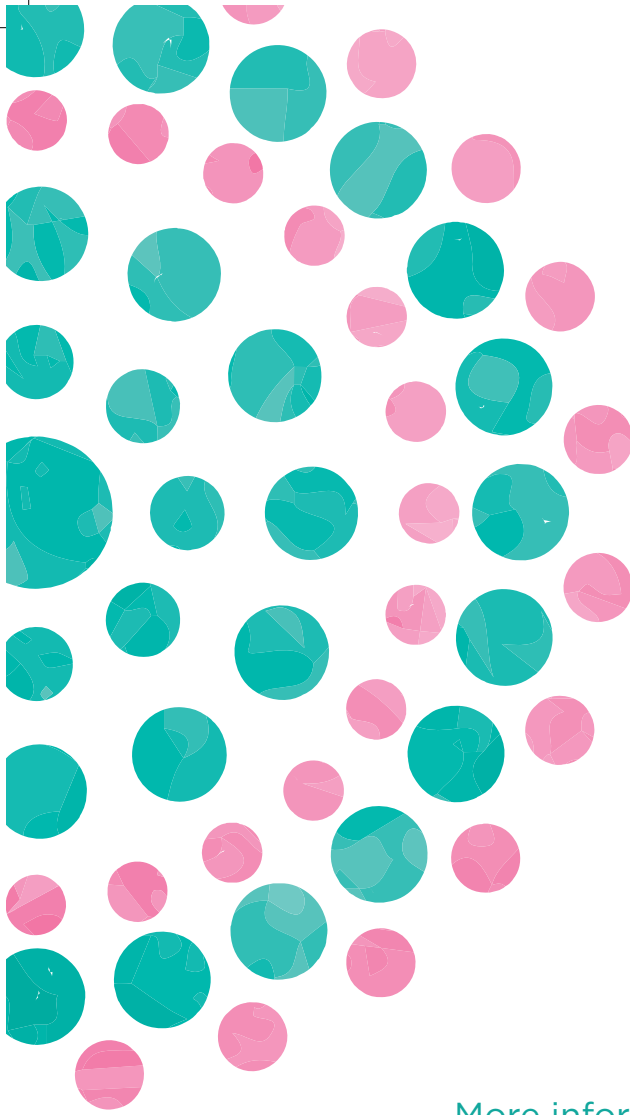
Questions you might like to ask about clinical trials

- Are there any clinical trials that might be appropriate for me?
- What is the purpose of the trial?
- What treatments or tests does the trial involve?
- What treatments or tests will I have if I do not join the trial?
- What are the advantages and disadvantages of joining the trial?
- What are the possible side effects of the treatment or tests being studied in the trial?
- What are the possible side effects of the treatments or tests I will have if I do not join the trial?
- What follow-up tests will I have if I join the trial?
- Can I leave the trial at any time?
- Are there any costs involved if I join the trial?
- Can I ask to see the results of the trial when they become available?



Notes

A series of horizontal dotted lines for writing notes.



March 2019

More information

About Breast Cancer Network Australia

Breast Cancer Network Australia (BCNA) is the peak national organisation for Australians personally affected by breast cancer. We work to ensure that people diagnosed with breast cancer and their families receive the very best support, information, treatment and care possible.

Breast
Cancer
Network
Australia



bcna.org.au
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1800 500 258