MACMILLAN
CANCER SUPPORT

UNDERSTANDING RISK-REDUCING BREAST SURGERY

'It was painful for a couple of months but I felt really positive. I had taken back control over my body.'

Aneece, who had a preventative double mastectomy and reconstructive surgery.

About this booklet

This booklet is for anyone who is thinking about having risk-reducing breast surgery. You may consider this if you have a high risk of developing breast cancer. This is usually because you have a strong family history of breast cancer.

The booklet explains what risk-reducing breast surgery is and what it involves. It talks about the different options for risk-reducing breast surgery. There is information about the benefits, limitations and risks of each type of surgery. We also talk about some physical and emotional issues you may experience, and ways to cope with these.

We have included photographs of women who have had breast reconstruction after risk-reducing surgery. This is to help show how a reconstruction may look.

This booklet only gives an overview of risk-reducing breast surgery. It is important to talk about it with your surgeon and breast care nurse. Give yourself plenty of time to think about it to help you to decide what is best for you.

How to use this booklet

The booklet is split into sections to help you find what you need. Some parts of the booklet might not be relevant to your situation. You can use the contents list on page 5 to help you find information that is useful for you.

It is fine to skip parts of the booklet. You can always come back to them when you feel ready.

At the end of this booklet, there are details of other organisations that can help (see pages 101 to 104).

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

Quotes

We have included some quotes from women who have had risk-reducing breast surgery, which you might find helpful. Some quotes are from Aneece, who is on the front cover of this booklet. She has chosen to share her story with us. Others are from our Online Community, which you can visit at **macmillan.org.uk/community**

For more information

We hope this booklet answers some of your questions and helps you deal with some of the feelings you may have.

We have also listed other sources of support and information, which we hope you will find useful. We cannot advise you about the best treatment for you. This information can only come from your doctor, who knows your full medical history.

If you have more questions or would like to talk to someone, call the Macmillan Support Line free on **0808 808 00 00**, 7 days a week, 8am to 8pm. If you would prefer to speak to us in another language, interpreters are available. Please tell us, in English, the language you want to use.

If you are deaf or hard of hearing, call us using NGT (Text Relay) on **08001 0808 808 00 00**, or use the NGT Lite app.

We have some information in different languages and formats, including audio, eBooks, easy read, large print and translations. To order these, visit **macmillan.org.uk/otherformats** or call **0808 808 00 00**.

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‘I went to see a genetics counsellor. There was an 87% chance of developing breast cancer in my lifetime.’

Aneece

MAKING YOUR DECISION

What is risk-reducing breast surgery?

Risk-reducing breast surgery is an operation that significantly reduces the risk of breast cancer developing. It does this by removing the healthy breast tissue. It is also called a risk-reducing mastectomy.

Removing both breasts reduces the risk of getting breast cancer by about 95%. Although almost all the breast tissue is removed, it is not possible to remove it all. A very small amount will remain, so there is still a small risk of developing breast cancer.

Breast reconstruction (see pages 28 to 65) can be done at the same time as risk-reducing breast surgery. This is surgery to make new breast shapes. Most women have this, but some women choose not to. New breast shapes can be made:

- using tissue from another part of your body
- with breast implants.

You will be able to discuss your options for breast reconstruction with a surgeon.

Risk-reducing breast surgery and family history

Risk-reducing breast surgery is only appropriate for a small number of women who have a high risk of getting breast cancer. A high risk means a 3 in 10 (30%) or greater chance of getting breast cancer in your lifetime.

If you have just one female relative diagnosed with breast cancer over the age of 40, your risk will probably be similar to other women the same age as you. In this situation, risk-reducing breast surgery is not usually appropriate. But about 1 in 500 women in the UK (0.2%) have a breast cancer gene mutation that greatly increases their risk of developing breast cancer.

You may be offered risk-reducing breast surgery if one or both of the following are true:

- You have a strong family history of breast cancer or ovarian cancer, or both. This usually means that several close blood relatives on the same side of the family have had breast or ovarian cancer, often before the age of 50. Close relatives are grandparents, parents, sisters and brothers.
- You have had a positive test for any of the main gene mutations (changes) that are linked to an increased risk of breast cancer. These include BRCA1, BRCA2, TP53, PTEN and ATM.

We have a booklet called **Cancer genetics – how cancer sometimes runs in families** that you may find helpful.
See page 96 for ways to order.

Deciding about risk-reducing breast surgery

Whether to have risk-reducing breast surgery is your decision. But you will be supported by a team of specialists who can answer your questions and give you the information you need. You may need lots of time to decide. Or you may already have decided if surgery is right for you.

Risk-reducing breast surgery involves removing healthy tissue rather than removing cancer. Whatever your situation, it is important that you have time to think about your decision.

You will have several appointments with different healthcare professionals. They will talk to you about:

- your risk of breast cancer
- the different options for managing or reducing your risk (see pages 20 to 25)
- what risk-reducing breast surgery involves (see pages 16 to 17)
- your options for breast reconstruction (see page 35)
- your feelings about the surgery and how it may affect you and your relationships (see pages 14 to 15).

This usually takes a few months. This may sound like a long time. But it is important to take time to make sure you make an informed decision.

The following healthcare professionals will support you while you make your decision:

- A clinical geneticist or genetics counsellor will explain your risk of getting breast cancer over the next 5 to 10 years, and over your lifetime. They will also talk to you about ways you can reduce or manage your risk of breast cancer.
- A breast surgeon will talk to you about your risk of breast cancer, and whether you might want to think about having risk-reducing breast surgery. They will also explain other ways to reduce or manage your risk.
- A reconstructive surgeon may be a breast surgeon or a plastic surgeon. They will talk about your options for breast reconstruction with you. They can show you photos of women who have had risk-reducing breast surgery and breast reconstruction. This booklet has photos of women who have had breast reconstruction.
- A breast care nurse will give you information and support.
- A psychologist can help you explore your feelings and expectations about risk-reducing breast surgery. They can help you think about what support you may need to cope with the effects of surgery and changes in the way you see your body (body image).

Talking to women who have had risk-reducing breast surgery

It can be helpful to hear the experiences of other women who have been in a similar situation to you. Your surgeon or breast care nurse can arrange for you to talk to women who have also had risk-reducing breast surgery.

You can also visit our Online Community at **macmillan.org.uk/community** to talk to women who have had a similar experience.

But remember that everyone is different. What is right for others may not be right for you.

'I was determined to do anything I could for my children. It was more important that I did everything I could to stay around for them.'

Aneece

Making your decision

Some women find it helps to take notes at their appointments. This can help with remembering what has been said.

It may also help to write down a list of the advantages and disadvantages of having surgery.

Advantages of risk-reducing breast surgery

- The operation greatly reduces your risk of developing breast cancer.
- After the operation, most women say they feel much less anxious about getting breast cancer and about the impact it could have on their life.
- You will not need to have breast screening.

Disadvantages of risk-reducing breast surgery

- Sometimes it can take up to 6 months or more to fully recover after the operation.
- As with all operations, there can be complications.
- Your body will not look the same as before. You may be unhappy with the change in your appearance.
- Some women feel less confident sexually.
- The results of the surgery are permanent. You cannot change your mind once you have had the operation.
- If you are also having breast reconstruction, you are likely to need more than one operation to get the best cosmetic result.

Your feelings – things to consider

You will need time to explore your feelings about having risk-reducing breast surgery and having your breasts removed. This is important even if you have already decided you want to have the operation. You may have strong emotions after the operation. Taking time to think about how you feel can help you prepare.

If you have a partner, talking with them about your feelings, worries or concerns can help. This means you do not need to try to guess what your partner may be thinking or feeling. If you decide to have surgery, trying to find ways of talking about things can help you communicate better after the operation. You and your partner might find it difficult to talk about how you feel. You can speak to your breast care nurse, counsellor or psychologist for advice.

People may react in different ways when you tell them you are thinking about having risk-reducing breast surgery. Some people may have strong opinions about the surgery, which might be different from your own. This can be difficult to deal with. It is important that you focus on what is important to you. A psychologist or a breast care nurse can help you to do this.

You may want to consider the following things:

- What do your breasts mean to you?
- How would having your breasts removed affect the way you feel about yourself?
- If you have a partner, do you know each other's feelings and concerns about the surgery?
- If you are not in a relationship, have you thought about how the surgery may affect future relationships?
- How could the surgery affect your confidence?
- Are other people in your life affecting your decision?
- If you have an experience of cancer in your family, how is it affecting your decision?
- How anxious do you feel about the possibility of getting breast cancer?
- If you are thinking about having breast reconstruction, have you thought about what your breasts will look and feel like afterwards?
- What are your feelings about other options instead of surgery?

Take as much time as you need to make your decision.

Types of risk-reducing breast surgery

Your surgeon will talk to you about the different types of risk-reducing breast surgery and their risks and benefits. There are three main types of operation.

Skin-sparing mastectomy

This operation removes:

- the nipples
- the darker circles of skin around the nipples (areolas)
- other tissue that makes up the breasts.

The surgeon will leave the skin that covers the breasts. This is used to cover your reconstructed breasts.

Nipple-sparing mastectomy

This operation removes almost all of the tissue that makes up the breasts. But the surgeon will leave the nipples and the skin covering the breasts in place. These will be used to cover the reconstructed breasts. The surgeon takes away all or almost all the breast tissue under the nipples.

There is no greater risk of cancer developing with a nipple-sparing mastectomy than with a skin-sparing mastectomy.

Simple mastectomy

This operation is done if a woman chooses not to have breast reconstruction. The surgeon removes:

- the nipples
- the areolas
- the breast tissue
- about half of the skin covering the breasts.

The skin that remains is used to cover the chest.

We have information about recovery after risk-reducing breast surgery (see pages 78 to 81).

'I had an 8 hour mastectomy and reconstruction. As soon as I woke up, I felt relief. It was painful for a couple of months but I felt really positive.'

Aneece

Talking with your surgeon and breast care nurse

Here are some questions you may want to ask your breast surgeon and specialist nurse about risk-reducing surgery.

- What types of surgery are suitable for me and why?
- What are the possible complications or risks of the surgery?
- Where will cuts be made and what might the scars look like?
- How long will it take for me to recover from the operation?
- If I decide to have surgery, how long will I have to wait to have it?
- Can I talk to someone who has had risk-reducing breast surgery?
- Can I talk to someone about the possible emotional effects of having risk-reducing breast surgery?
- What type of support will be available to me after the operation?
- If I decide not to have breast reconstruction, who can give me advice about breast prostheses, bras, and swimwear?

We also have suggested questions for women who have decided to have breast reconstruction (see pages 31 to 32).

The timing of risk-reducing breast surgery

If you decide to have risk-reducing breast surgery, you will need to think about when to have the operation.

Women who have breast cancer gene mutations are more likely to develop breast cancer at a younger age. If you have family members who had breast cancer, the ages when they developed breast cancer may affect your decision.

In general, the younger you are when you have risk-reducing breast surgery, the more likely it is to prevent breast cancer. Your genetic counsellor or breast surgeon can talk to you about how your risk changes with age.

There are other things that can affect the timing of risk-reducing breast surgery. For example, this may include whether you are in a relationship, or have plans for having children and breastfeeding in the future.

Other options for managing a high risk of breast cancer

Risk-reducing breast surgery may not be suitable for some women. Some health conditions, for example a heart problem, could increase the risk of complications during and after surgery. Your surgeon or nurse can tell you more about this.

There are other options for managing a high risk of breast cancer. Some of these may be used instead of risk-reducing breast surgery. Others may be used as well as the surgery.

Having a mammogram

Regular breast screening

Regular breast screening cannot prevent breast cancer. But it can help find it at an early stage, when many breast cancers can be cured. For most women at a high risk of breast cancer, breast screening involves having a combination of:

- MRI scans (magnetic resonance imaging scans)
- mammograms (breast x-rays).

These usually happen once a year. The age at which women start and finish having MRI scans and mammograms will depend on their individual risk of developing breast cancer.

If you are at a high risk of breast cancer, you usually have an MRI scan every year. This happens between the ages of 30 and 49. Sometimes you may have these scans between the ages of 20 and 49.

Doctors may recommend that some women who are at a high risk continue to have MRI scans every year. This can happen if you are over 50 and have a TP53 mutation or dense breast tissue.

Most women at high risk are also offered mammograms every year between the ages of 40 and 59. Doctors may recommend that some women between the ages of 30 and 69 have mammograms every year.

Chemoprevention

Chemoprevention can reduce the risk of a common type of breast cancer called oestrogen receptor-positive (ER positive) breast cancer. It involves taking a tablet every day for 5 years. For some women, this can reduce the risk of getting breast cancer by 30 to 40%.

The two drugs most commonly used are tamoxifen and anastrozole. Other drugs that may be used include raloxifene and exemestane.

If you have not gone through the menopause, you will usually be offered the choice of taking tamoxifen. You need to use contraception while you are taking it. It is not suitable for women who are trying to get pregnant. Anastrozole, exemestane and raloxifene can only be used by women who have gone through the menopause.

Side effects of chemoprevention

The most common side effects of chemoprevention are menopausal symptoms. These can include:

- hot flushes
- vaginal discharge and dryness.

Your doctor or nurse will give you more information about possible side effects.

Tamoxifen can also slightly increase your risk of womb cancer and blood clots. These problems are more common in women who take tamoxifen after they have gone through the menopause.

Anastrozole and exemestane can cause bone thinning and increase the risk of severe bone thinning (osteoporosis). Tamoxifen can also increase this risk when taken before the menopause. Women at risk of osteoporosis are usually given drugs to help protect their bones.

Women with a BRCA1 gene change do not generally get ER positive breast cancer. So if you have a BRCA1 gene change, chemoprevention may not be as effective.

Risk-reducing bilateral salpingo-oophorectomy

This operation removes the ovaries and fallopian tubes. This is because women who inherit a BRCA1 or BRCA2 gene change have a higher risk of getting both ovarian cancer and breast cancer. Removing the ovaries and fallopian tubes greatly reduces the risk of ovarian cancer. It may also reduce the risk of breast cancer.

We have more information about ovarian cancer in our booklet **Understanding cancer of the ovary, fallopian tube and peritoneum**. See page 96 for ways to order.

This operation may be offered to some women as well as risk-reducing breast surgery rather than instead of it.

This operation will cause infertility (inability to become pregnant). If you want children, you may want to think about having the operation after you have completed your family. Most women who have this surgery have it after the age of 35, before the menopause.

After surgery, you usually take hormone replacement therapy (HRT) until the age you would expect to have the menopause. This protects your bone and heart health, and prevents menopausal symptoms. In this situation, HRT does not increase the risk of breast cancer.

Making positive choices

You may also decide that you want to make positive lifestyle changes to improve your health. This includes:

- eating well
- keeping to a healthy weight
- being physically active
- drinking less alcohol
- stopping smoking.

You can get advice on a healthy lifestyle from your GP, cancer specialist or specialist nurse. We also have more information about eating well, keeping to a healthy weight, being active and stopping smoking. See page 96 for ways to order.

BREAST RECONSTRUCTION

What is breast reconstruction?

Breast reconstruction uses surgery to make new breast shapes after an operation to remove both breasts (mastectomy). Most women having risk-reducing breast surgery choose to have breast reconstruction, but some women choose not to.

Breast reconstruction may not be suitable for some women. This is because some medical conditions might increase the risk of complications during and after surgery. Your surgeon or nurse can tell you more about this.

The aim of breast reconstruction is to make breast shapes that look and feel as natural as possible. But it is important to have realistic expectations. It is difficult to know how you will feel about your reconstructed breasts. Some women are not happy with them. Reconstructed breasts will not look or feel exactly the same as your natural breasts. They will be less sensitive and they may feel numb.

Breast reconstruction does not increase the chance of a cancer developing. If you ever need to have any changes in the breast area checked, it does not make it harder to diagnose a possible cancer.

Breast reconstruction can be done at the same time as risk-reducing breast surgery. This is called immediate reconstruction. Or it can be done as a second operation months or sometimes years later. This is called delayed reconstruction.

Most women have an immediate reconstruction. This leaves fewer scars and can look better. You can talk to your breast surgeon about the benefits and disadvantages of immediate and delayed reconstruction before you decide what is best for you.

If you choose not to have reconstruction, your breast care nurse can tell you about breast forms and bras you can wear after surgery. Breast Cancer Care also has information that might be helpful. See pages 101 to 102 for their contact details.

Talking with your surgeon

Breast reconstruction is done by an oncoplastic breast surgeon (breast reconstructive surgeon) or a plastic surgeon. Oncoplastic surgeons are trained in breast cancer surgery and some types of breast reconstruction. Plastic surgeons usually do the more complex breast reconstruction operations. You may need to travel to a plastic surgery unit to have these.

In some hospitals, two surgeons may work together. A breast surgeon removes the breasts (mastectomy). Then a plastic surgeon makes the new breast shapes.

New breast shapes can be made:

- with breast implants (see pages 36 to 46)
- by using tissue taken from another part of your body (see pages 47 to 64)
- with a combination of implants and tissue taken from another part of your body.

Your surgeon will advise you on the types of reconstruction that are most suitable for you. They will show you photos of women who have had breast reconstruction. There are also photos in this booklet of women who have had different types of breast reconstruction.

You can bring a relative or friend to your appointments for support. They can help you remember what was discussed.

You will usually have a choice of more than one type of reconstruction. What is most suitable for you will depend on your:

- general health
- body build
- personal preferences.

It is fine to ask your breast reconstructive surgeon lots of questions and ask to see photos of their previous work. They are used to this, and it could help you make the decision that feels right for you. They will be sensitive to your thoughts and feelings about reconstruction.

Some questions to ask your breast reconstructive surgeon

It can often help to make a list of questions to ask your breast reconstructive surgeon. Here are some questions you might like to ask about reconstruction:

- What types of reconstruction would be suitable for me?
- What are the risks or complications of the different types of surgery, and what are the chances of them happening?
- How long will the operation take?
- How long will I have to wait before I can have the surgery?
- Should I see a plastic surgeon?
- Can I talk to someone who has had this type of operation?

There are also questions you might want to ask your surgeon about their experience. These could include:

- What experience do you have in reconstructive surgery?
- How many of these operations do you do each year?
- Will you be doing the operation yourself?
- Are there any 'before and after' pictures I can see of your previous work?

You may also have questions about the effect breast reconstruction will have on your life. These might include:

- How long will I be in hospital?
- Where will my scars be and what will they look like?
- After surgery, how long will it take before I can go back to everyday activities?
- What can I expect my reconstructed breasts to look and feel like immediately after surgery? How about 6 months or a year after surgery?
- Will I need any further surgery in the future after having a reconstruction?

You may find the answers to some of these questions in our information. But you should still check them with your surgeon, as there may be slight differences.

Giving your consent

Before you have any operation, your surgeon will explain its aims and what to expect. They will ask you to sign a form giving your permission (consent) for the operation to take place.

Before doing this, you should get full information about:

- the type of the operation and exactly what it involves
- the advantages and possible disadvantages
- any other types of operation that may be suitable for you
- possible complications and any significant risks or side effects.

Breast reconstruction can be complex, so you may need several discussions with your surgeon and nurse. It is a good idea to have a relative or friend with you to help you to remember what was said. If there is anything you do not understand, ask your surgeon or nurse so they can explain again. They should always give you time to ask questions.

'The consultation with my plastic surgeon was very in depth and he went through the options, asked me a lot of questions and showed me before and after photos.'

Michelle

Smoking and breast reconstruction

If you smoke, your surgeon will talk to you about the benefits of giving up smoking before surgery.

If you smoke, you are much more likely to develop problems during breast reconstruction. Smoking damages blood vessels. People who smoke are more likely to have problems with wound healing. They are also much more likely to have complications with breast reconstruction operations.

Even if you only stop smoking for a few weeks, this will reduce the risk of complications. So if you smoke, try to stop before surgery and do not smoke during the recovery period. Your hospital and GP will give you help and support to stop smoking.

We have a booklet called **Giving up smoking** that you may find helpful. See page 96 for ways to order.

Types of breast reconstruction

There are three main types of breast reconstruction:

Reconstruction using breast implants

The surgeon puts an implant under the muscle and skin of your chest to make new breast shapes.

Reconstruction using your own tissue

Skin, fat and sometimes muscle are taken from another part of your body to make new breast shapes.

Reconstruction using implants and your own tissue

The surgeon makes breast shapes using implants and tissue taken from another part of your body.

Reconstruction using breast implants

Breast implants are often used for:

- immediate breast reconstruction
- women having both breasts reconstructed.

The surgeon makes new breast shapes by putting breast implants under, or sometimes in front of, the chest muscle.

Breast implants have a silicone outer cover with silicone gel or salt water (saline) inside. They come in a range of sizes and can be round or teardrop-shaped.

Reconstruction using breast implants can be a one-stage or two-stage procedure.

One-stage procedure

The surgeon puts either fixed-size implants or expandable implants under your chest muscle.

Fixed-size implants

The surgeon puts permanent silicone implants under or sometimes in front of the chest muscle to create new breast shapes.

The surgeon may use a surgical mesh to support the implants and improve the shape of the reconstructed breasts. It can be made from different materials, such as a synthetic material or a tissue-like material made from animal or human tissue.

Sometimes, the surgeon uses your own tissue to make supporting slings for the implants. This may be suitable if you want your reconstructed breasts to be smaller or more lifted.

The surgeon attaches the supporting material to the chest muscle and the chest wall to create a sling. This holds the lower part of the implants in place. It also helps give the breasts a natural droop without stretching the chest muscle.

Your surgeon can explain the possible benefits and disadvantages of using a supporting material.

Expandable implants

If your chest muscle needs to be stretched, the surgeon can use expandable implants. Expandable implants have an outer chamber of silicone gel and a hollow inner chamber. This inner chamber can be filled with saline through a valve (port).

The surgeon puts the expandable implants under your chest muscle. You then wait a few weeks for the tissues to heal. After this, the muscle and skin begin to stretch to form your new breast shapes.

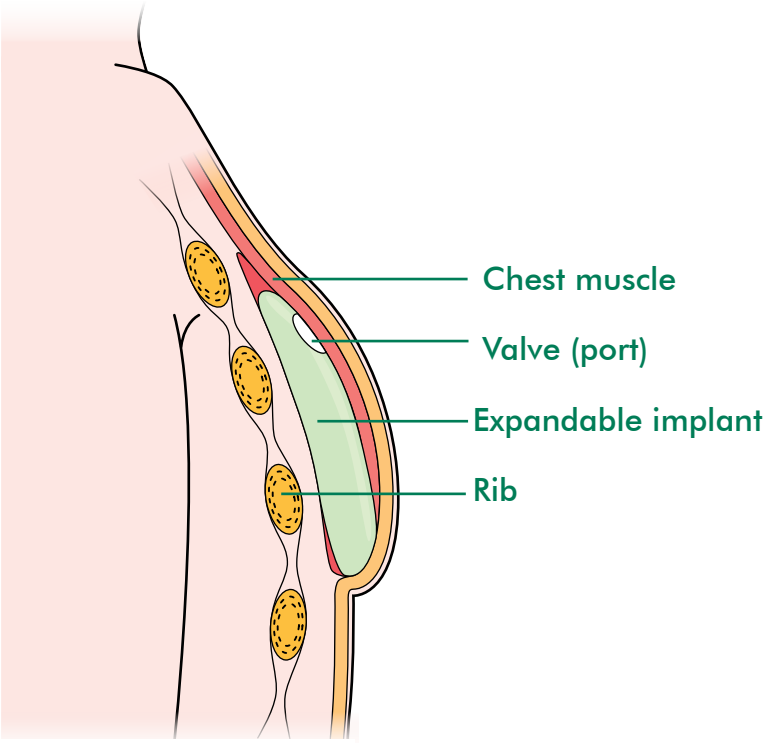
Every 1 to 2 weeks, a nurse or doctor injects saline into the implants. They do this through a port under the skin of your underarm. You may feel some aching or tightness in the breast area for a day or two after each injection. This process continues over several weeks.

After a few more weeks, once the muscle has been stretched, the nurse or doctor may remove some saline through the port. The surgeon can then take the port out during a small operation. The operation can be done under a local or general anaesthetic.

Two-stage procedure

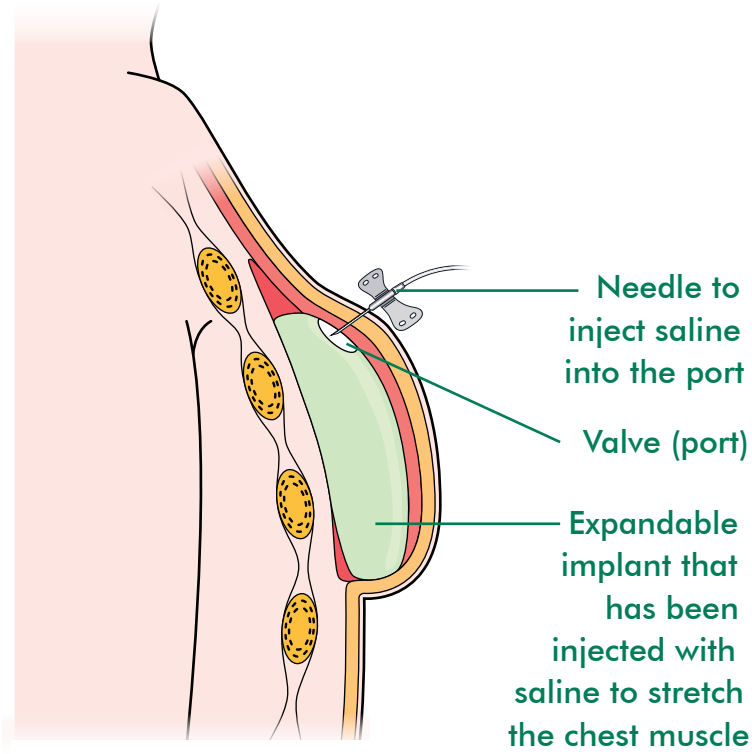
The surgeon puts a temporary tissue expander under the chest muscle to stretch it. A temporary tissue expander has a hollow inner chamber that can be filled with saline. But it does not have the silicone gel outer chamber that permanent expandable implants have.

A temporary tissue expander in the breast



A nurse or doctor injects saline into the expander through a port just under the skin of the chest. This increases the size of the expander and stretches the chest muscle to form the breast shapes.

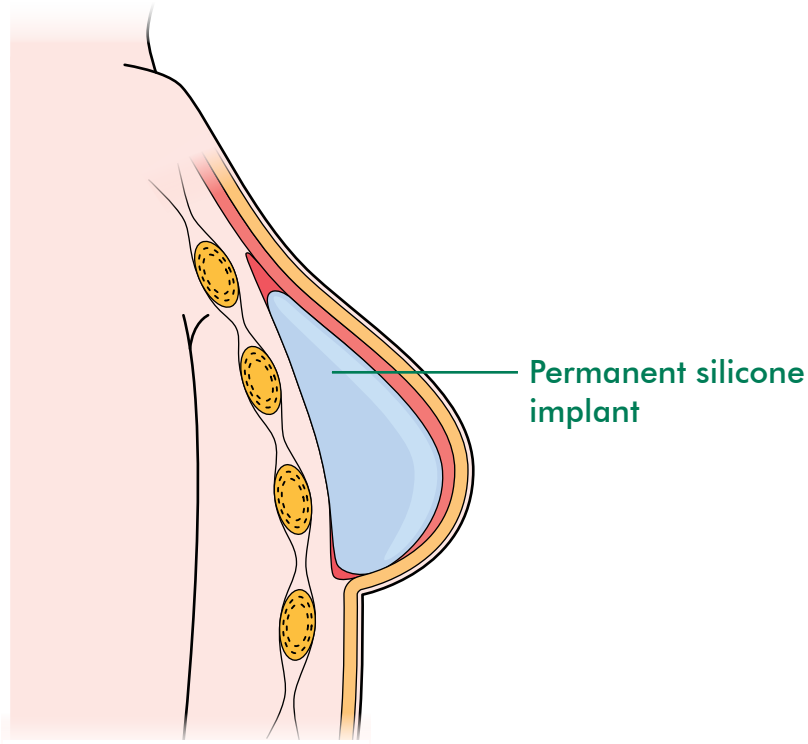
Saline is injected through a port into the temporary implant



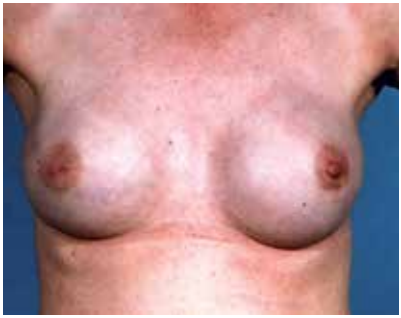
Once the temporary implants have expanded to their final size, they stay in place for a few months. This allows the muscle to stretch fully.

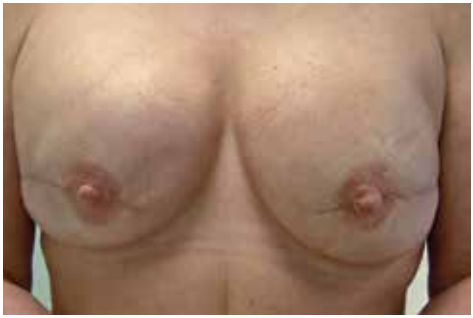
You then have an operation to have the implants taken out. At the same time, the surgeon puts permanent silicone implants under your chest muscle. This gives you your final breast shapes.

The expandable implant is removed and a permanent silicone implant is put in its place

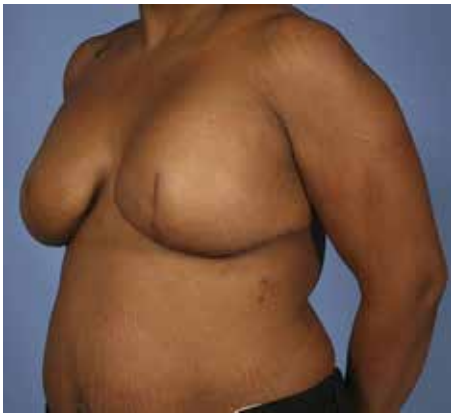


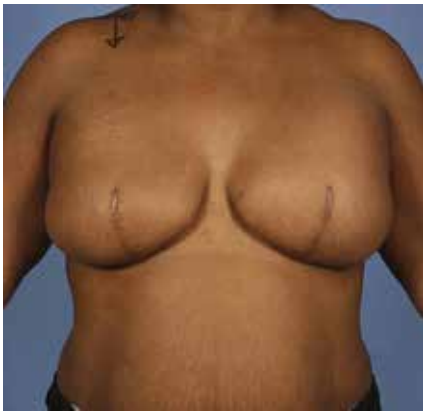
Reconstruction of both breasts with expander implants – the photo on the right also shows nipple reconstruction





Reconstruction of both breasts with expander implants (without nipple reconstruction)





What are the benefits?

- It is an easier operation than other types of breast reconstruction.
- It has a slightly shorter recovery time than other types of breast reconstruction.
- It leaves less scarring on the breast and no scars elsewhere on your body.
- It can give a good appearance, particularly for women with small breasts or women who are having both breasts reconstructed.

What are the limitations?

- You may need several visits to the hospital over a few months for tissue expansion.
- The operation will leave a scar on or under both breasts.
- Implants do not feel as soft or as warm as breasts made using your own tissue.
- To get the best result, you usually need more operations. This may be to reposition the implants. Or it may be done to add fat over the implants (lipomodelling – see pages 70 to 71) to improve the shape and give a more natural feel.
- The implants may change in shape when the muscle over them tightens (contracts).
- Some women may be able to see a rippling effect through their skin. This is caused by creasing or folds in the implants.
- Reconstructed breasts have less sensation than natural breasts. They may feel numb.
- You may need surgery to replace an implant if it leaks or if the tissue around the implant tightens.

What are the risks?

With any operation, there are risks, such as infection. There are also some risks specific to implants.

Removal of implants

Up to 1 in 10 women (10%) need to have an implant taken out within the first 3 months after surgery. After 9 months, this will have gone up to 1 in 7 women (15%). This can happen because of wounds not healing properly, which can cause infection. Smoking further increase the risk.

If an implant need to be removed, there will usually be a delay of a few months before a new implant is put in. During this time the breast will be flat. The delay is needed to give the tissues time to heal and to treat any infection.

Infection around the implants

It is not that common to have an infection in the tissue around the implants. But if this happens, the implant usually has to be removed until the infection clears. The implant can then be replaced with a new one. You will be given antibiotics at the time of your operation to reduce the risk of infection.

If an implant needs to be removed because of infection, the final appearance of the reconstructed breast may not be as good. It is important to follow any advice you are given about preventing infection.

Tightening or hardening of tissue around the implants

A breast implant is not a natural part of you. Because of this, your body reacts to it by forming a capsule of scar tissue around the implant.

Over a few months, the scar tissue can shrink (contract) as part of the natural healing process. In some women, the capsule can become very tight. This is called capsular contracture. The reconstructed breasts may then feel hard or painful. They may also change shape.

Smoking and infections increase the risk of capsular contracture.

Capsular contracture can be treated by taking fat from another part of your body and injecting it around the implants (lipomodelling). Or you may need an operation to remove the capsule or scar tissue and replace the implants. Some women may need to have the breasts reconstructed with a flap of their own tissue.

Rippling of implants

The surgeon usually places the implants under the chest muscle. But the chest muscle is thin, so implants are close to the skin. If the implant is placed over the muscle, then the implant is also very close to the skin. This can make the implants crease, which can produce rippling. You may be able to see this all the time. Or you may only be able to see it when you move and the muscle contracts. Your surgeon may suggest injecting fat under the skin (lipomodelling) to thicken the tissue over the implants. This can reduce the appearance of rippling. Lipomodelling may need to be repeated to get of the rippling completely.

Damage (rupture) to implants

It is very difficult to damage implants. You should continue with your normal activities, including sports and air travel, without worrying that it will affect your implants. Implant rupture is now rare. Less than 1 in 20 women (5%) will have had an implant rupture within 10 years of having firm or solid gel implants.

But occasionally implants might split or tear. Most silicone implants contain a firm gel. This is unlikely to leak in significant amounts, even if the outer cover is damaged. If this happens, it should not affect your health. But the implant will need to be replaced.

If saline leaks out of an expander device, it will not cause any harm. But the implant device will go flat and will need to be replaced.

Safety and silicone breast implants

Quality control

A few years ago, there were concerns about the quality of the silicone used to fill breast implants. This happened because unapproved silicone was found in breast implants made in France by a company called Poly Implant Prostheses (PIP). PIP implants have not been used in the UK since 2010.

Breast implants used in the UK must be approved by the Medicines and Healthcare Products Regulatory Agency (MHRA). This organisation is responsible for ensuring that medical devices, including breast implants, are safe and fit for use.

If you are concerned about having breast implants, it is important to discuss this with your surgeon before your operation. They will be able to tell you the type of implants they use and who makes them.

Breast implant associated anaplastic large cell lymphoma (BIA-ALCL)

Anaplastic large cell lymphoma (ALCL) is an extremely rare type of non-Hodgkin lymphoma that can sometimes affect the breast. Women with breast implants have an increased risk of developing ALCL in the tissue around an implant. This is called breast implant associated anaplastic large cell lymphoma (BIA-ALCL).

It is estimated that between about 1 in 4000 and 1 in 8000 women who have a breast implant will develop BIA-ALCL. This is a small risk. But it is important to talk with your reconstructive surgeon before deciding on implant surgery.

If BIA-ALCL develops, it is most likely to show up as a swelling or an increase in the size of the breast. This can happen months or years after implant surgery. It can usually be successfully treated by an operation to remove the implant and the capsule of tissue surrounding it.

Reconstruction using your own tissue

Flap reconstruction is a type of breast reconstruction that uses your own tissue. It is more complex than implant reconstruction. It involves moving a flap of skin, fat and sometimes muscle from another part of your body to your chest wall. This creates a breast shape. The flap is taken from a part of your body called the donor site. Most flap reconstructions use tissue from the tummy (abdomen). But tissue from the back, buttocks or thighs can also be used.

Blood supply

The reconstructed breasts need a good blood supply to keep them healthy. There are two ways a surgeon can do this.

Free flap reconstruction

With a free flap reconstruction, the surgeon takes a flap of tissue from another part of your body. They disconnect it from its blood supply. They then move the flap of tissue to your chest and connect it to a new blood supply there. It is complex surgery. It is only done by plastic surgeons in specialist units.

Most breast reconstructions using tissue from the tummy are free flap reconstructions. All reconstructions using tissue from the buttock or thigh are free flap reconstructions.

Pedicled flap reconstruction

With a pedicled flap reconstruction, the surgeon takes a flap of tissue from your back or tummy. They keep it connected to its original blood supply. They then tunnel the tissue and its blood supply under your skin and out onto your chest. All reconstructions using tissue from the back are pedicled flap reconstructions. So are some that use tissue from the tummy.

Who is it suitable for?

Reconstruction using your own tissue may be suitable if you:

- do not want breast implants
- have immediate or delayed reconstruction
- want large breasts
- want your breasts to have a more natural shape and feel.

Flap reconstructions, especially free flap operations, may not be suitable if you:

- have health problems such as diabetes
- are very overweight
- smoke.

What are the benefits?

- It gives a more natural shape, movement and feel to the reconstructed breasts.
- It is suitable for all breast shapes.
- It can create breasts with a more natural droop.
- You can often avoid having an implant.

What are the limitations?

- You will have a scar on the part of your body that the tissue flaps are taken from.
- You may have a patch of skin or circle of skin on the reconstructed breasts. This patch of skin comes from a different part of your body. Because of this, it may be a different texture and colour from the breast skin. Your breast surgeon will be able to give you more information about this.
- It involves having surgery to another part of your body to remove the skin flap.
- You will have a longer operation, hospital stay and recovery.
- Reconstructed breasts have less sensation than the original breasts. They may feel numb.

What are the risks?

With any operation, there are risks, such as infection. There are also some specific risks with this type of reconstruction.

Second operation

Your surgeon and nurses will check the reconstructed breasts for a few days after the operation. They will want to be sure that the breasts have a good blood supply. If there are any signs of a problem during this time, you may need another operation so they can check it. This is to make sure the reconstructed breast tissue stays healthy and heals well.

Loss of part or all of the reconstructed breast

Most operations are successful. But occasionally some or all of the tissue dies soon after the operation. This can happen if the blood supply to a reconstructed breast is not good enough. If this happens, you may not be happy with the appearance of your breasts. If you want to improve the appearance of the breasts, you may need another operation.

Fat necrosis

Fat necrosis can cause a firm lump in a reconstructed breast. It can happen when fatty tissue does not have a good enough blood supply.

Small areas of fat necrosis can often be absorbed by the body over time. But some women need surgery or liposuction to remove the area of fat necrosis. This will improve the appearance of the breast. But it can leave a dent in the reconstructed breast. The appearance can be improved by injecting fat into your breast (lipomodelling).

If you feel a lump in your reconstructed breast, you should always get it checked.

Reconstruction using tissue from your back

This is known as a latissimus dorsi flap (LD flap). The surgeon uses a muscle called the latissimus dorsi (LD) and some overlying fat and skin from your back. The surgeon tunnels the flap and its blood supply under the skin below your armpit. They then put it into position on your chest to make a new breast shape.

Some women have a combination of an LD flap and implant reconstruction. The implants give more volume to the breasts. The flaps covers the implants. This gives the breasts a more natural look and feel. Sometimes, surgeons use liposuction to take fat from another part of the body. They then inject this into the muscle to create reconstructed breasts. This is called lipomodelling. It may be used to create larger breast shapes so implants are not needed.

Occasionally, the surgeon moves a large amount of fat with the LD muscles. This is called an extended latissimus dorsi flap. It may be done so implants are not needed.

Who might it be suitable for?

Using tissue from the back may be suitable for women with breasts of any size.

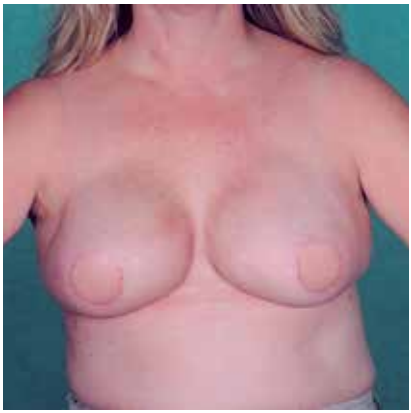
It may not be suitable for women who have jobs or hobbies that involve:

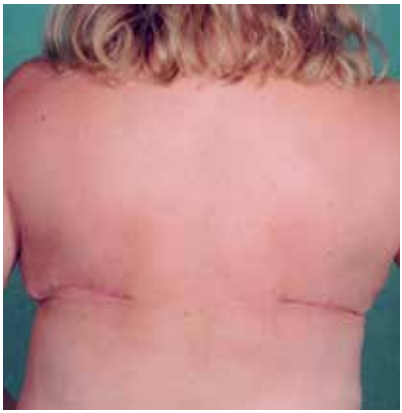
- using their arms above shoulder height
- heavy lifting or climbing.

What are the limitations?

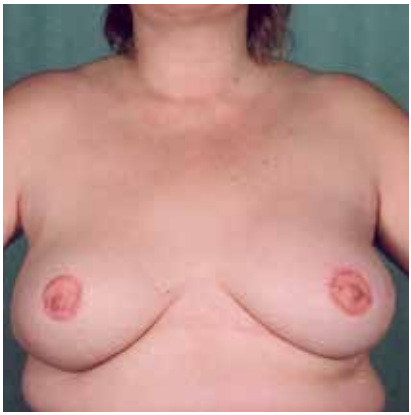
- You will have scars on your back and on the reconstructed breasts.
- It may take several months for the muscle in your reconstructed breasts to feel part of the breasts and not the back. The muscle may twitch sometimes.
- If you would like larger breasts, you may need the LD flap with an implant or lipomodelling.
- There may be a small bulge under your armpit where the muscle is tunnelled under the skin. You may feel fullness under your arm. This usually improves over time but may not go away completely.

Front and back view 2 months after skin-sparing risk-reducing mastectomy using a latissimus-dorsi flap (without nipple reconstruction)





Skin-sparing risk-reducing mastectomy using an LD flap and nipple reconstruction (with tattooing)



What are the risks?

With any operation, there are risks, such as infection. There are also some specific risks with this type of reconstruction.

Build-up of fluid (seroma) under the wounds on the back

This sometimes happens after the operation but usually gets better within a few weeks.

Changes in sensation

Sometimes surgery can cause numbness, pain or oversensitivity in the area of your back where the tissue was taken from. The chance of this happening is higher after an extended LD flap operation, where more tissue is taken from the back.

Shoulder weakness

After the operation, you will have some weakness in your back and shoulders. This will improve over time. There are other muscles in the back that can compensate for the loss of the LD muscle. You should regain full shoulder strength for most activities 6 to 12 months after surgery. But you may notice weakness during some movements. For example, you may have problems with:

- pushing your arms down to get out of the bath
- raising your arms above shoulder height.

Most women can return to daily activities without any problems, including sports such as swimming and tennis. However, having LD flap surgery can affect your ability to take part in some sports, such as rowing, rock climbing, cross-country skiing and high-level competitive racquet sports.

Reconstruction using tissue from your tummy

Reconstructed breasts are most commonly made using tissue from your tummy (abdomen). Most women have a reconstruction called a free DIEP flap (deep inferior epigastric perforator flap).

With a free DIEP flap, the surgeon uses a flap of fat and skin from the tummy area to create a breast shape. They separate the tissue and its blood vessels from your tummy. They then move the flap to the breast area and connect it to a new blood supply in your chest.

Other types of reconstruction using tissue from the tummy area include the following:

- Free SIEA flap (superficial inferior epigastric artery flap). This is similar to the DIEP flap, but the surgeon uses a different blood vessel to create the new blood supply.
- TRAM flap (transverse rectus abdominus muscle flap). The surgeon uses a muscle, as well as fat and skin, from your tummy area to create a new breast shape. This is usually done as a free flap operation. After removing the muscle, the surgeon may put a mesh in. This is to strengthen the tummy wall and stop a bulge or hernia developing.
- MS-TRAM flap (muscle sparing transverse rectus abdominal muscle flap). The surgeon takes only a part of the muscle from your tummy area to create a new breast shape. This is usually done as a free flap operation.

Who is it suitable for?

This type of reconstruction may be suitable for women:

- with breasts of any size
- who do not want implants.

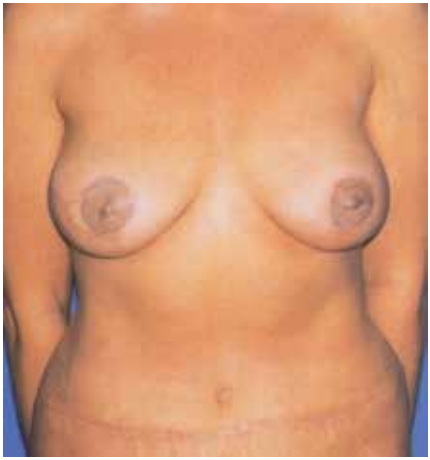
It may not be suitable for women who:

- have previous scarring on the tummy area
- are very slim and do not have enough tissue on their tummy
- smoke
- have diabetes or other illnesses, such as rheumatoid arthritis or other autoimmune diseases, that interfere with blood circulation to their tissue.

What are the limitations?

- You may have a patch of skin on your breast which is a different skin tone.
- You will have a scar across your tummy below your belly button, from hip to hip.
- Most operations using tissue from the tummy are successful. But they have a slightly higher risk of complications than operations using tissue from the back.
- Some women have some loss of sensation (numbness) in the tummy area.

Free TRAM flap reconstruction of both breasts with nipple reconstruction



What are the risks?

With any operation, there are risks, such as infection. There are also some specific risks with this type of reconstruction.

Fluid under the wound (seroma)

Sometimes, after wound drains are taken out, fluid builds up under the wound. This is called a seroma. A seroma sometimes happens after the operation, but it usually gets better within a few weeks. You may be asked to buy supportive underwear to wear for 6 weeks after surgery. Wearing this will support your tummy and help to reduce swelling and seroma.

Muscle weakness

TRAM flaps use one of the muscles from the front of the tummy (the ones that form the six-pack). These muscles are important for lifting and physical work. They also work with the back muscles. If they are weakened, you may get back pain and find some sports and physical activities more difficult. A physiotherapist may give you exercises to do to strengthen your tummy. A MS-TRAM flap uses only part of the muscle. Because of this, it is less likely to cause muscle weakness than a standard TRAM flap operation.

In a DIEP or SIEA flap, no muscle is used. This preserves the strength of the tummy more.

Hernia or bulge in the tummy area

Some women develop a bulge or hernia in the tummy area. If a muscle is used in the breast reconstruction, there is a higher risk of this happening. But a bulge can develop after any type of flap surgery that uses tissue from the tummy.

Sometimes the surgeon will use a mesh to strengthen the abdominal wall. This is used to try to prevent a bulge or hernia. This mesh may be permanent, or it can be designed to dissolve away in time.

Reconstruction using tissue from your thighs

This is a free flap operation. It uses tissue from the upper inner thighs. It may be an option when the tummy area cannot be used.

There are two different operations that use tissue from the thighs:

- A TMG flap (transverse myocutaneous gracilis flap) or TUG flap (transverse upper gracilis flap). This uses skin, fat, and usually muscle from the thigh.
- A PAP flap (profunda artery perforator flap). This uses skin and fat from the thigh.

The plastic surgeon removes tissue from the thigh and attaches it to the chest using microsurgery. They use high magnification microscopes to operate on areas that are too small to be seen.

Who is it suitable for?

This type of reconstruction may be suitable for women who:

- have small to medium size breasts
- have previous scarring on the tummy area
- have upper thighs that touch
- are slim.

It may not be suitable for women who want large breasts reconstructed.

What are the limitations?

- You will have a scar on your breasts and on your upper inner thighs.
- If you want larger breasts, you may need implants as well.
- Your upper thighs may become numb or lose some feeling.

What are the risks?

With any operation, there are risks, such as infection. There are also some specific risks with this type of reconstruction.

Build-up of fluid (seroma) under the wounds on the thighs

Sometimes after wound drains are taken out, fluid builds up under the wound. This is called a seroma. This sometimes happens after the operation, but usually gets better within a few weeks. We have more information about seroma.

Swelling of the legs

You may be asked to wear supportive clothing, such as cycling shorts and support (TED) stockings, for up to 6 weeks after the operation. These will reduce the risk of swelling in the legs and groin area after the operation.

Long term swelling in the legs is rare. Your surgeon will take care to prevent this. There are fine tubes, called lymph vessels, in the legs. They drain fluid from the tissues. If some of these tubes are damaged during the operation, fluid may build up in the lower legs. This fluid build-up is called lymphoedema. Although lymphoedema can be treated, it never goes away completely.

Tightness in the upper inner thighs

The area around the scars may be flatter than normal and can feel tight. This is because skin, muscle and fat are removed from the upper inner thigh during a TUG flap.

Reconstruction using tissue from your buttocks

This is a free flap operation. It uses fat and skin taken from your buttocks. It may be an option when the tummy (abdomen) or thighs cannot be used.

There are two different operations that use tissue from the buttocks:

- Free SGAP flap (free superior gluteal artery perforator flap). This is when tissue is taken from the upper part of the buttocks.
- Free IGAP flap (free inferior gluteal artery perforator flap). This is when tissue is taken from the lower part of the buttocks.

Who is it suitable for?

This type of reconstruction may be suitable for women who:

- have breasts of any size
- have previous scarring on the tummy area
- are slim.

What are the limitations?

- You will have a scar on your breasts and a scar on your buttocks. A SGAP flap leaves a diagonal scar on the upper buttocks. This can usually be hidden by underwear with a higher waistband. An IGAP flap scar may be hidden in the crease between the lower buttocks and thigh.
- Tissue in the buttocks is firmer than tissue in the tummy. This means a breast reconstructed with buttock tissue may feel firmer than one made from tummy tissue.
- There is a limit to the amount of tissue that can be taken and to the size of breast that can be reconstructed.

Table comparing breast reconstruction options

We have included a table over the next few pages to help you compare different breast reconstruction surgeries. The table shows what each operation involves. This includes:

- how long you might need to stay in hospital for
- how long your recovery may take
- where you will have scars
- when and why certain surgeries may not be suitable.

The timings we give are only a guide, and there may be differences between hospitals. Only your surgeon can give you information about exactly what to expect.

The table includes a recovery time after surgery. This is when you can expect to get back to doing most normal activities. But a full recovery can take longer. Your full recovery time will depend on the operation you have and whether there are any problems after surgery.

Always ask your surgeon or specialist nurse if there is anything you are not sure about.

	Breast implants	Back LD flaps	Tummy TRAM and MS-TRAM flaps	Tummy SIEA or DIEP flaps	Buttock SGAP or IGAP flaps	Thigh TMG or PAP flaps
Will I need an implant?	Yes	Implants may be placed behind the flap.	No	No	No	Implants occasionally used.
Average length of surgery	1 ½ to 2 ½ hours (two surgeons) 3 to 4 hours (one surgeon)	3 to 5 hours	About 4 to 6 hours	4 to 6 hours	4 to 6 hours	4 to 6 hours
Time in hospital	1 to 3 days	3 to 5 days	3 to 7 days	4 to 8 days	4 to 8 days	4 to 8 days
Recovery time	4 to 6 weeks	6 to 8 weeks	6 to 12 weeks	6 to 12 weeks	6 to 12 weeks	6 to 12 weeks
Scars	On breasts only.	Scars on breasts and scars on the back.	Scars on breasts and from hip to hip, near the bikini line.	Scars on breasts and from hip to hip, near the bikini line.	Scars on breasts and scar on upper buttocks (SGAP) or in the creases under lower buttocks (IGAP).	Scars on breasts and in the crease of the upper, inner thighs.

Effects on muscles	Very little or no change in muscle strength.	May cause slight shoulder weakness. LD muscles in breasts may twitch.	Risk of weakness in tummy muscles. Mesh is used to strengthen them.	Small risk of weakness in tummy muscles.	No change in muscle strength.	No change in muscle strength.
Things to consider	May give a less natural shape and feel than your own tissue. You may need further surgery to replace an implant if certain problems develop.	May not be suitable if you need to regularly use your arms above shoulder height. May affect ability to do: • sports such as climbing • racquet sports or swimming at a professional level.	May not be suitable if you: • are very slim or overweight • have scars on your tummy from previous surgery • have health problems such as diabetes • smoke.	May not be suitable if you: • are very slim or overweight • have scars on your tummy from previous surgery • have health problems such as diabetes • smoke.	May not be suitable if you: • have health problems such as diabetes • are very overweight • smoke.	Small risk of lymphoedema (long-term swelling) in lower leg. May not be suitable if you: • have health problems such as diabetes • are very overweight • smoke.

‘I have had my nipples reconstructed and tattooed and I feel like any other person.’

Aneece

IMPROVING THE FINAL LOOK AND SHAPE

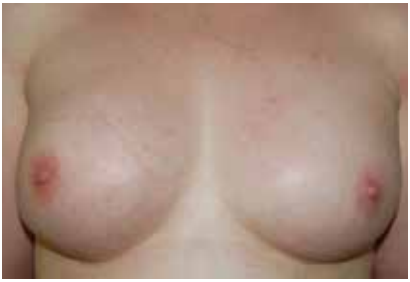
Fat transfer (lipomodelling)

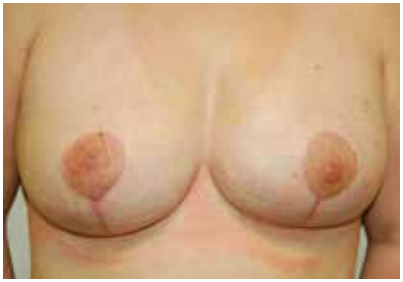
After breast reconstruction, there may be dents or unevenness in the outline (contour) of the new breasts. This may improve over a few months. But if the breasts still look uneven, your surgeon can inject fat into your breasts to improve the appearance. This is called lipomodelling. It is also called lipofilling or autologous fat grafting.

Surgeons can also use lipomodelling to enlarge reconstructed breasts.

Women who have breast implants may have lipomodelling to make the reconstructed breasts look and feel more natural. It can also be used to cover the appearance of rippling sometimes seen over implants. Lipomodelling may also make breasts reconstructed with implants feel warmer.

Bilateral mastectomies with implants and lipomodelling





Lipomodelling is done as a day-case. This means you can go home the same day. It is usually done under a general anaesthetic. But it sometimes may be done with a local anaesthetic to numb the area. It involves taking fat from another part of your body and injecting it into the breasts. For example, fat from the thigh, tummy or occasionally the lower back can be used. The area where the fat was taken from is likely to be bruised, sore or numb afterwards. This will get better within a few weeks.

If you have lipomodelling done many times, you can also get irregularities in the area where the fat is taken. If this happens, let your surgeon know as these can be smoothed out.

Some of the fat injected into the breasts will be absorbed into the body. For a few weeks after the operation, you should wear a non-wired, supporting bra 24 hours a day. You should also avoid strenuous exercise. This will help reduce fat loss from the breast reconstruction. You may also be advised to wear supportive underwear to reduce swelling and bruising in the areas where the fat was taken from.

Fat injections usually need to be repeated a few times. How many times varies from person to person. Injecting fat more than once also helps to make sure any uneven areas are smoothed out.

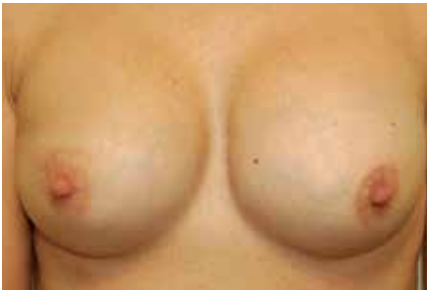
Lipomodelling is not usually done until the reconstructed breasts have fully healed. This usually takes about 6 to 12 months. Your reconstructive surgeon can give you more information and discuss the risks and benefits of lipomodelling.

The nipple

It may be possible to keep your nipples as part of risk-reducing breast surgery with immediate reconstruction. There are three ways a surgeon may do this:

- The nipples are left attached to the skin of the breasts and the breast tissue that lies under the skin is removed.
- The nipples are removed alone or along with the surrounding darker skin (areolas). They are then reattached (grafted) onto the reconstructed breasts.
- You have an operation to reposition the nipples and reduce the breast skin. This is called a mastopexy. The scars from this operation look like an upside-down T. You then have a second operation to remove the breasts through the lower scar under the breasts.

Implant reconstruction after double nipple-sparing mastectomy



Sometimes a preserved nipple needs to be removed in the weeks following breast reconstruction. This may happen if the blood supply to the nipple is not good enough and the nipple dies. It may also occasionally happen if there are cancer cells found in the tissue removed near the nipple. After risk-reducing breast surgery, samples of the removed breast tissue are examined under a microscope.

Nipple reconstruction

If your nipples were removed as part of your surgery, you will usually be offered nipple reconstruction. Occasionally this is done at the same time as breast reconstruction. But it is usually done some time afterwards. This delay lets the reconstructed breasts settle into their final shape so that the surgeon can position the nipples accurately.

The time between operations for breast and nipple reconstruction may vary, but it is usually about 4 to 6 months.

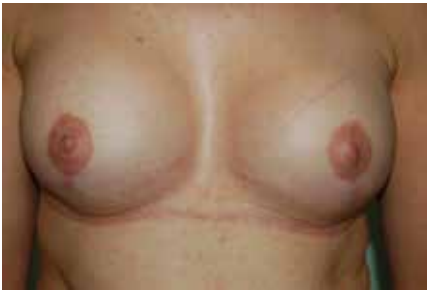
Nipple reconstruction is usually done under a local anaesthetic and you can go home the same day.

Your nipple shape may be reconstructed using a skin flap. The surgeon folds skin onto your reconstructed breast into a nipple shape. They make it bigger than normal. This is because the reconstructed nipple will shrink and may flatten with time.

When you go home, you will have a dressing over the nipple areas. These will be removed when you have a follow-up appointment. Your nursing team will advise you about this.

A reconstructed nipple does not react to temperature changes or touch and does not have the same sensation as a natural nipple.

Bilateral mastectomy with implants and nipple reconstruction



Nipple/areola tattooing

If you have new nipple shapes made, you can have them and the areas around them tattooed to make them look more natural. This is sometimes called micro-pigmentation. Nipple tattooing is usually done in the hospital outpatient department.

A reconstructed breast does not have the same sensation as before surgery. Most women do not feel any discomfort when the tattooing is being done. If you have feeling in the nipple area, you can be given local anaesthetic cream to numb it.

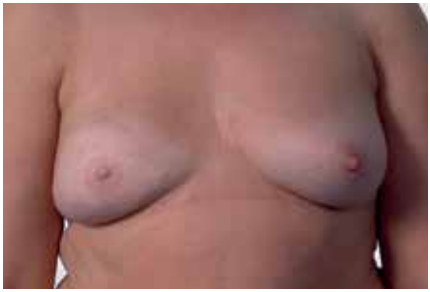
A tattooing session usually takes 30 to 40 minutes for each nipple. It may need to be done more than once to give the best result. The tattoo usually lasts about 18 months to 2 years.

Some units offer three-dimensional (3D) tattooing. This can create the appearance of nipples and areolas without nipple reconstruction. The area is tattooed in different shades to create a 3D appearance.

Nipple prosthesis

If you do not want to have nipple reconstruction or tattooing, you may choose to have a silicone nipple. You can attach this to your reconstructed breast. You fix the nipple to your breast with special adhesive. It can stay in place for up to 3 months.

Nipple prosthesis on the right breast



Ready-made nipple prostheses come in different shades and sizes.

‘If anything I have more body confidence. I just feel really lucky. I can’t say 100% that I won’t ever get cancer, but a big risk has gone.’

Aneece

AFTER YOUR OPERATION AND RECOVERY

Recovery after your operation

Your breast care nurse will give you advice and support before and after surgery to help with your recovery.

When you wake up, you will have a drip (infusion) into a vein in the back of your hand or in your arm. It will be removed when you are able to drink enough.

If you are having reconstructive surgery using tissue flaps, you will also have a catheter to drain urine from your bladder. This will be taken out once you are able to get up and move around.

Immediately after surgery, your wounds may be covered with dressings or sticky plastic strips. These are left in place until the wounds have healed.

Your reconstructed breasts will be swollen to begin with. The swelling gradually gets better over a few weeks.

If you have breast reconstruction using your own tissue, the reconstructed breasts will need to be kept warm for the first few hours after the operation. Warmth improves blood flow to the tissue. You may have a special blanket called a Bair Hugger™, which circulates warm air over you. Or you may have thick gauze pads over the breasts.

There will be drainage tubes coming out of the wounds. These will be attached to a small container to collect any excess blood or body fluid. A nurse will remove them a few days after the operation.

Once you are up and moving, your surgeon or nurse will tell you whether you should keep the area dry or if you can gently shower the wounds with clean water.

Pain or discomfort

After any type of operation, you will have some pain or discomfort. Some women need painkillers for a few weeks after surgery. Make sure you ask for pain-relieving medicines if you need them. This will help you recover more quickly.

Numbness

You will usually have some numbness or pins and needles across your chest or reconstructed breasts. You may also have numbness under your upper arms.

These symptoms improve over months to years, but it is common to have some permanent numbness. Most people adjust to this over time.

Constipation

Constipation is common after surgery. Here are some tips that can help:

- Drink plenty of fluids.
- Increase the amount of fibre in your diet.
- Eat fruit and vegetables.

Some painkillers can cause constipation. You may need to take laxatives while you are on these. Your doctor can prescribe these for you or you can get them from your local chemist.

Wearing a bra

If you had breast reconstruction, you may be advised to wear a bra to support your newly reconstructed breasts. A soft, supportive bra without underwires will be more comfortable to begin with. Ask your breast care nurse for advice.

If you have reconstruction with implants, you may be given a Velcro® band to wear for several weeks. This sits on top of the implants and helps make sure they stay in the correct position. You should wear this during the day and at night.

Exercises

Your physiotherapist or breast care nurse will show you exercises to do. At first, you may have some discomfort when you move your arms. But it is important to continue to use your arms and to do the exercises suggested. You will also be given specific exercises to do if you have had surgery to another part of your body, such as your tummy.

Checking the breast tissue

After surgery, samples of your breast tissue are sent to a laboratory and examined under a microscope. This is to make sure there are no changes in the cells that might be the early stages of cancer.

If any cancer changes are found, your doctor and nurse will talk to you about any further treatment you might need.

Going home

Your surgical team will let you know how long you can expect to be in hospital for after your operation. This will depend on:

- the type of surgery you have
- whether you have had immediate or delayed reconstruction.

If you have breast implants, you may be in hospital for up to 3 days. After an operation using tissue flaps, you may be in hospital for up to 7 days.

At home

When you first get home, it is a good idea to have someone around who can help you. You will probably feel tired for the first 1 to 2 weeks at home. After this, you can start doing more and gradually increase your level of activity.

Avoid strenuous housework such as vacuuming. Just do light tasks to begin with and slowly build up from there. Don't move or lift anything heavy for a few weeks until your surgeon says it is okay to do so. This includes lifting babies or children.

'The hardest thing was not being strong enough to look after George, who was only two at the time. I'd had the operation done for my boys but I felt like I was letting them down.'

Aneece

Possible complications after surgery

Most complications are mild and can be treated. But some women have more serious or long-term problems. Smoking, being overweight or having diabetes can increase this risk.

Bruising and bleeding

Bruising to the breasts and donor sites is very common after the operation. It usually goes away within 3 weeks.

In some women, blood may collect in a reconstructed breast or donor site. This is called a haematoma. It is most likely to happen in the first 24 hours after surgery. It can cause swelling and pain. The wound drain will usually carry away the blood. But if the bleeding continues, some women need an operation to stop the bleeding and remove the haematoma.

Blood clots

Surgery and bed rest increase the risk of developing a blood clot in the legs after breast surgery. This is called deep vein thrombosis (DVT). You will usually be given compression stockings to wear to try to prevent DVT. You will also be encouraged to move around as soon as possible after the operation. Some women may also be given blood-thinning injections for a few days after the operation.

Fluid under the wound (seroma)

Sometimes after wound drains are taken out, fluid builds up under the wound. This is called a seroma.

If this happens, it may be left to settle on its own. Or you may need to have the fluid removed. A surgeon or nurse can do this with a small needle and syringe. The fluid can build up again, so it may need to be removed more than once.

Delay in wound healing

Wounds usually heal within 6 weeks. But sometimes wound healing can be delayed. This may be because of infection. Or there may not be a good blood supply to the wound.

Smoking or being very overweight can delay wound healing. Stopping smoking (if you smoke) and eating a healthy, balanced diet with enough protein and vitamin C helps tissues heal.

Infection

When you go home after your operation, check your wounds regularly. Tell your breast care nurse or surgeon immediately if you have any signs of infection, such as:

- redness or change in colour over the breast, around the scar area or both
- fluid being released (discharge) from the wound
- a fever (a temperature above 38°C or 100.4°F)
- uncontrollable shivering (rigors)
- feeling generally unwell.

Your doctor can prescribe antibiotics to treat an infection. If you have an implant, you may need to go into hospital for observation. You may have to have antibiotics given into a vein.

Raised, thickened scars

In a small number of women, tissue along the scars may become thickened and red. This makes the scar wider and look raised above the skin.

If you have any concerns about your scars, talk to your nurse or surgeon. They can check that the scars are healing. If there is a problem, they can give you treatment to help.

Chronic pain

Pain usually gets better in the weeks following surgery. But some women continue to have pain for months or even years after the operation.

Pain that continues for a long time is called chronic pain. There are several different causes of chronic pain, and many of these can be treated. If you have pain that does not improve, tell your breast surgeon. They can do tests to find out the cause or recommend a treatment to help.

Recovering at home

Adjusting to the change in your body

You will need time to adjust to the change in your body. Looking at and touching your reconstructed breasts will help you get used to them. Try to gradually build up the amount of times you look at and feel your breasts. If you find this difficult or are avoiding looking at your breasts, it is important to talk to someone. Your healthcare team can give you extra support if you need it.

Sex

It is usually fine to have sex after your operation. But it is important that you feel comfortable when having sex. This will probably be a few weeks after your operation, but it may take longer. Ask your surgeon or specialist breast nurse if there is anything you need to be careful about.

Looking after your skin

Your wounds may feel itchy after your operation. But try not to scratch the healing skin. The itching will get better as the wounds heal. It usually takes about 6 weeks for wounds to heal fully.

Once your wounds have healed, most surgeons will recommend you massage the scars on your reconstructed breasts and at the donor site (if you have one). Do this with body oil or moisturiser at least once a day. Massaging along the length of the scars helps stop them sticking to tissue underneath. It can also help soften your scars. Your surgeon or breast care nurse can tell you what they recommend, and show you how much pressure to use.

After your operation, scars will be quite firm and may be slightly raised. If you have lighter skin they will be red, and if you have dark skin they will be darker.

It can take from 18 months to 2 years for scars to settle and fade. Tell your doctor or specialist breast nurse if:

- the scars remain red and raised
- you have concerns about how your scars are healing.

There are specific scar treatments that can help the scars settle and fade.

It is very important to protect your scars from the sun. Use a suncream with a high sun protection factor (SPF) of at least 50 if any area of scarring is exposed to the sun. You may be advised to do this for up to 2 years.

Work

When you can return to work depends on the type of work you do and the type of operation you had. If your job does not involve heavy manual work, you should be able to go back to work sooner. You are likely to feel more tired than usual for a while. You may find it difficult to concentrate fully at first.

Driving

You can usually start driving again:

- once you can use the gear stick and handbrake
- as long as you can do an emergency stop and move the steering wheel suddenly if necessary.

Some women are able to drive within a few weeks after surgery. Others find it takes longer. Insurance companies often have their own guidelines about when you can drive again after an operation. You should check this with your car insurance company.

Checking your breasts

You will not need to have any further screening tests following risk-reducing breast surgery. But you should still check your breast area regularly, as there will be a small amount of breast tissue remaining.

It may take some time for you to get used to the feel and look of your reconstructed breasts. Ask your nurse to show you how to check your breasts. They can also give you leaflets to remind you what to do.

Things to look out for include:

- breast tissue that feels different, for example harder or tighter
- a change in the appearance or shape of a breast
- a change in the skin's texture, for example puckering, dimpling, a rash or thickening
- a lump or lumpy area you can feel in the breast or armpit
- a change in the appearance or colour of the breast
- a rash or change along the scar line
- swelling of the upper arm
- discharge from the nipple (if not removed)
- a rash or swelling on the nipple or the areola (if not removed)
- pain or discomfort.

There can be other causes for these changes other than cancer. But it is important to tell your nurse or doctor if you find anything that concerns you. They will examine you and arrange tests to check for anything unusual. These can include an ultrasound, MRI scan or biopsy.

If you are not happy with the results

The way you feel about your breast reconstruction will depend partly on what you expect from the surgery. Make sure you discuss your expectations with your surgeon before you decide to have the surgery.

It takes several months for the breasts to settle into their final shape. So the way you feel about the appearance of your breasts may change over time. It can take up to 2 years for swelling to settle, wounds to heal and redness to fade.

If you have concerns about your reconstructed breasts, talk to your surgeon or breast care nurse. It usually takes more than one operation to achieve a good result. Your surgeon may be able to offer you another operation to improve the result. If you are still unhappy after talking with your surgeon, you can ask to be referred to another surgeon for a second opinion.

How you judge the success of breast reconstruction may be different from how a surgeon will think about it. Sometimes exploring feelings about your breasts, the surgery and reconstruction can be more helpful than another operation. A psychologist or counsellor can help you to do this and focus on what feels right for you.

Your sex life

Having breast surgery may affect your sex life and the way you think and feel about your body (your body image). Usually this improves with time.

If you have had breast reconstruction, this will create breast shapes. But the sensations in the breasts and nipples will not be the same as in your natural breasts. If you were previously aroused by having your breasts touched, your sexual arousal may be affected. Although this can take time to adjust to, you will eventually still be able to enjoy a fulfilling sex life.

We have a booklet called **Cancer and your sex life – information for women** that you may find helpful. See page 96 for ways to order.

If you have a partner

If you have a partner, there will often be a period of adjustment for you both. Talking to each other and sharing your feelings and fears can help you overcome most difficulties with time.

It may take you time to feel comfortable showing your partner your reconstructed breasts. The surgery may affect how you feel and think about yourself sexually. Your partner may be worried about hurting your breasts as you recover. They may not know how to express their love physically and emotionally. Talking about your feelings can help.

Even if you do not feel like having sex, there are other sensual and affectionate ways of showing how much you care for someone. Some examples of this include cuddles, kisses and massages. You can wait until you and your partner feel ready to have sex – there is no right or wrong time.

If you are having sexual difficulties with your partner that are not improving, help is available. You can get sex counselling through Relate (see page 104). Or ask your doctor to refer you to a sex counsellor.

'For a few months, I definitely kept my top on more but I soon got used to it. Simon reassured me that it didn't make any difference to him as I was still me.'

Aneece

Emotional effects

Risk-reducing breast surgery can cause many different emotions. Many women feel a sense of relief when the surgery is over. But it can still take time to get used to your new appearance. It is normal to have some concerns about how you see and feel about your body (body image). If these do not improve, talk to your breast care nurse.

You will already have had a lot to cope with. You may be dealing with the news that your family has a strong history of breast cancer, and the impact this might have on you and your family. If you have children, you may worry about whether they will be affected in the future.

Many women say that having risk-reducing breast surgery has reduced their anxiety about developing breast cancer. And many would recommend surgery to women in a similar situation. However, they may still have feelings of loss for their previous appearance and sense of health.

There are people and organisations that can help you talk through and deal with your feelings and emotions (see page 104). Your breast care nurse can talk over your situation with you.

We have a booklet called **Body image and cancer** that you may find helpful. See page 96 for ways to order.

FURTHER INFORMATION

About our information

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

Order what you need

You may want to order more leaflets or booklets like this one. Visit **be.macmillan.org.uk** or call us on **0808 808 00 00**.

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

Online information

All of our information is also available at **macmillan.org.uk/information-and-support** There you will also find videos featuring real-life stories from people affected by cancer, and information from health and social care professionals.

Other formats

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

- audiobooks
- Braille
- British Sign Language
- easy read booklets
- eBooks
- large print
- translations.

Find out more at **macmillan.org.uk/otherformats** If you would like us to produce information in a different format for you, email us at **cancerinformationteam@macmillan.org.uk** or call us on **0808 808 00 00**.

Help us improve our information

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

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

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

Other ways we can help you

At Macmillan, we know how a cancer diagnosis can affect everything, and we are here to support you.

Talk to us

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

Macmillan Support Line
Our free, confidential phone line is open 7 days a week, 8am to 8pm. Our cancer support specialists can:

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

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

Information centres
Our information and support centres are based in hospitals, libraries and mobile centres. There, you can speak with someone face to face.

Visit one to get the information you need, or if you would like a private chat, most centres have a room where you can speak with someone alone and in confidence.

Find your nearest centre at **macmillan.org.uk/informationcentres** or call us on **0808 808 00 00**.

Talk to others

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

Support groups

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

Online Community

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

The Macmillan healthcare team

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

'Everyone is so supportive on the Online Community, they know exactly what you're going through. It can be fun too. It's not all just chats about cancer.'

Mal

Help with money worries

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

Financial guidance

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

Help accessing benefits

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

Macmillan Grants

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

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

Help with work and cancer

Whether you are an employee, a carer, an employer or are self-employed, we can provide support and information to help you manage cancer at work. Visit **macmillan.org.uk/work**

My Organiser app

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

Other useful organisations

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

Breast cancer organisations

Asian Women Cancer Group
Tel 07934 591384
Email info@asianwomencancergroup.co.uk
www.asianwomencancergroup.co.uk
Helps women of all cultures who have been affected by breast cancer. Provides emotional support and financial guidance.

Breast Cancer Care
Helpline 0808 800 6000 (Mon to Fri, 9am to 4pm, Sat, 9am to 1pm)
Email info@breastcancercare.org.uk
www.breastcancercare.org.uk
Provides information, practical and emotional support to people affected by breast cancer. Specialist breast care nurses run the helpline. Also offers a peer support service where anyone affected by breast cancer can be put in touch with a trained supporter who has had personal experience of breast cancer.

Breast Cancer Care Scotland and Northern Ireland
Tel 0345 077 189
Email movingforward@breastcancercare.org.uk

Breast Cancer Care Wales
Tel 0345 077 1893
Email movingforward@breastcancercare.org.uk

Breast Cancer Haven
Tel 020 7384 0000 (London)
Email info@thehaven.org.uk
www.breastcancerhaven.org.uk
Havens are day centres providing support, information and complementary therapies before, during or after cancer treatment. They have a network of centres across the UK. Details of other UK Haven centres are on the website.

Breast Cancer Now
Tel 0333 20 70 300
(Mon to Thu, 9am to 5pm, and Fri, 9am to 4pm)
Email supporterengagement@breastcancernow.org
www.breastcancernow.org
Committed to fighting breast cancer through research and awareness.

Breast Cancer Now – Scotland
Tel 0131 226 0763
Email scotland@breastcancernow.org

General cancer support organisations

Cancer Black Care
Tel 020 8961 4151
Email
info@cancerblackcare.org.uk
www.cancerblackcare.org.uk
Offers UK-wide information and support for people with cancer, as well as their friends, carers and families, with a focus on those from BME communities.

Cancer Focus Northern Ireland
Helpline 0800 783 3339
(Mon to Fri, 9am to 1pm)
Email
nurseline@cancerfocusni.org
www.cancerfocusni.org
Offers a variety of services to people affected by cancer in Northern Ireland, including a free helpline, counselling and links to local support groups.

Cancer Research UK
Helpline 0808 800 4040
(Mon to Fri, 9am to 5pm)
www.cancerresearchuk.org
A UK-wide organisation that has patient information on all types of cancer. Also has a clinical trials database.

Cancer Support Scotland
Tel 0800 652 4531
(Mon to Fri, 9am to 5pm)
Email
info@cancersupportscotland.org
www.
cancersupportscotland.org
Runs cancer support groups throughout Scotland. Also offers free complementary therapies and counselling to anyone affected by cancer.

Macmillan Cancer Voices
www.macmillan.org.uk/
cancervoices
A UK-wide network that enables people who have or have had cancer, and those close to them such as family and carers, to speak out about their experience of cancer.

Maggie's Centres
Tel 0300 123 1801
Email
enquiries@maggiescentres.org
www.maggiescentres.org
Has a network of centres in various locations throughout the UK. Provides free information about cancer and financial benefits. Also offers emotional and social support to people with cancer, their family, and friends.

Penny Brohn UK
Helpline 0303 3000 118
(Mon to Fri, 9.30am to 5pm)
Email
helpline@pennybrohn.org.uk
www.pennybrohn.org.uk
Offers a combination of physical, emotional and spiritual support across the UK, using complementary therapies and self-help techniques.

Tenovus
Helpline 0808 808 1010
(Daily, 8am to 8pm)
Email
info@tenovuscancercare.org.uk
www.
tenovuscancercare.org.uk
Aims to help everyone in the UK get equal access to cancer treatment and support. Funds research and provides support such as mobile cancer support units, a free helpline, benefits advice and an online 'Ask the nurse' service.

Counselling and emotional support

British Association for Counselling and Psychotherapy (BACP)

Tel 01455 883 300
Email bacp@bacp.co.uk
Promotes awareness of counselling and signposts people to appropriate services across the UK. You can search for a qualified counsellor at **itsgoodtotalk.org.uk**

College of Sexual and Sexual and Relationship Therapists (COSRT)

Tel 020 8543 2707
Email info@cosrt.org.uk
www.cosrt.org.uk
Has a directory of therapists to help members of the public find professional support in their local area.

Relate

Email relate.enquiries@relate.org.uk
www.relate.org.uk
Offers advice, relationship counselling, sex therapy, workshops, mediation, consultations and support face to face, by phone and online.

LGBT-specific support

LGBT Foundation

Tel 0345 330 3030
(Mon to Fri, 10am to 10pm, Sat 10am to 6pm)
Email helpline@lgbt.foundation
www.lgbt.foundation
Provides a range of services to the LGBT community, including a helpline, email advice and counselling. The website has information on various topics including sexual health, relationships, mental health, community groups and events.

Disclaimer

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

Thanks

This booklet has been written, revised and edited by Macmillan Cancer Support's Cancer Information Development team. It has been approved by our Senior Medical Editor, Professor Mike Dixon, Professor of Surgery and Consultant Surgeon.

With thanks to: Jayne Knight, Breast Reconstruction Nurse Specialist; Ms Katherine Krupa, Consultant Breast Surgeon; Rebecca Spencer, Macmillan Breast Reconstruction Nurse Specialist; Christina Summerhayes, Consultant Breast Surgeon; and Mrs Eva Weiler-Mithoff, Consultant Plastic and Reconstructive Surgeon.

Surgical photos supplied by: Professor Mike Dixon, Elaine Sassoon and Calliope Valassiadou.

Thanks also to the people affected by cancer who reviewed this edition, and to those who shared their stories.

We welcome feedback on our information. If you have any, please contact **cancerinformationteam@macmillan.org.uk**

Sources

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

Martin L, et al. Acellular dermal matrix (ADM)-assisted breast reconstruction procedures. Joint guidelines from the Association of Breast Surgery and the British Association of Plastic, Reconstructive and Aesthetic Surgeons. EJSO 39 (2013) 425e429. 2013.

National Institute for Health and Care Excellence (NICE). Early and locally advanced breast cancer: diagnosis and management. Guidelines. July 2018.

National Institute of Health and Care Excellence (NICE). Breast reconstruction using lipomodelling after breast cancer treatment. 2012.

Rainsbury D, Willett A. Association of Breast Surgery (ABS) and British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS). Oncoplastic Breast Reconstruction: Guidelines for Best Practice. ABS and BAPRAS, 2012.

Can you do something to help?

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

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

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

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

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

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

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

Call us to find out more

0300 1000 200

macmillan.org.uk/getinvolved

Please fill in your personal details

Mr/Mrs/Miss/Other

Name

Surname

Address

Postcode

Phone

Email

Please accept my gift of £

(Please delete as appropriate)
I enclose a cheque / postal order / Charity Voucher made payable to Macmillan Cancer Support

OR debit my:
Visa / MasterCard / CAF Charity Card / Switch / Maestro

Card number

Valid from

Expiry date

Issue no

Security number

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Don't let the taxman keep your money

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

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

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

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

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

Registered with FUNDRAISING REGULATOR

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

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

This booklet is for anyone who is thinking about having risk-reducing breast surgery. You may consider this if you have a high risk of developing breast cancer.

The booklet explains what risk-reducing breast surgery is and what it involves. It talks about the different options for risk-reducing breast surgery, and the possible benefits, risks and limitations of each type of surgery.

We're here to help everyone with cancer live life as fully as they can, providing physical, financial and emotional support. So whatever cancer throws your way, we're right there with you. For information, support or just someone to talk to, call **0808 808 00 00** (7 days a week, 8am to 8pm) or visit **macmillan.org.uk**.

Would you prefer to speak to us in another language? Interpreters are available. Please tell us in English the language you would like to use. Are you deaf or hard of hearing? Call us using NGT (Text Relay) on **18001 0808 808 00 00**, or use the NGT Lite app.

Need information in different languages or formats? We produce information in audio, eBooks, easy read, Braille, large print and translations. To order these, visit **macmillan.org.uk/otherformats** or call our support line.

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CANCER SUPPORT
RIGHT THERE WITH YOU

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MAC11680_E06_N. Next planned review 2021.
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The Information Standard
Certified member

This organisation has been certified as a producer of reliable health and social care information.
www.theinformationstandard.org

What's this logo? Visit **macmillan.org.uk/ourinformation**