Understanding a Breast Cancer Diagnosis

Types of Breast Cancer

There are several types of breast cancer. The type of breast cancer you have depends on where in the breast it started and other factors.

- Types of Breast Cancer Overview
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- Invasive Breast Cancer (IDC/ILC)
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- Inflammatory Breast Cancer
- Paget Disease of the Breast

Breast Cancer Grade and Other Tests

Doctors use information from your breast biopsy to learn a lot of important things about the exact kind of breast cancer you have.

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- Breast Cancer Ploidy and Cell Proliferation
- Breast Cancer Hormone Receptor Status
- Breast Cancer HER2 Status
- Breast Cancer Gene Expression Tests
- Understanding Your Pathology Report

Stages and Outlook (Prognosis)
If you have been diagnosed with breast cancer, tests will be done to find out the extent (stage) of the cancer. The stage of a cancer helps determine how serious the cancer is and how best to treat it.

- Breast Cancer Stages
- Breast Cancer Survival Rates

Questions to Ask About Your Breast Cancer

You can take an active role in your breast cancer care by learning about your cancer and its treatment and by asking questions. Get a list of key questions here.

- Questions to Ask Your Doctor About Breast Cancer

Types of Breast Cancer

There are many types of breast cancer, and many different ways to describe them. It’s easy to get confused over a breast cancer diagnosis.

The type of breast cancer is determined by the specific cells in the breast that are affected. Most breast cancers are carcinomas, which are tumors that start in the epithelial cells that line organs and tissues throughout the body. When carcinomas form in the breast, they are usually a more specific type called adenocarcinoma, which starts in cells in the ducts (the milk ducts) or the lobules (milk-producing glands).

In situ vs. invasive breast cancers

The type of breast cancer can also refer to whether the cancer has spread or not. In situ breast cancer (ductal carcinoma in situ or DCIS) is a cancer that starts in a milk duct and has not grown into the rest of the breast tissue. The term invasive (or infiltrating) breast cancer is used to describe any type of breast cancer that has spread (invaded) into the surrounding breast tissue.

Ductal carcinoma in situ (DCIS)

Ductal carcinoma in situ (DCIS; also known as intraductal carcinoma) is a non-invasive
or pre-invasive breast cancer.

**Invasive breast cancer (ILC or IDC)**
Invasive (or infiltrating) breast cancer has spread into surrounding breast tissue. The most common types are *invasive ductal carcinoma* and *invasive lobular carcinoma*. Invasive ductal carcinoma makes up about 70-80% of all breast cancers.

**Special types of invasive breast cancers**

Some invasive breast cancers have special features or develop in different ways that affect their treatment and outlook. These cancers are less common but can be more serious than other types of breast cancer.

**Triple-negative breast cancer**
Triple-negative breast cancer is an aggressive type of invasive breast cancer that accounts for about 15% of all breast cancers. It is a difficult cancer to treat.

**Inflammatory breast cancer**
Inflammatory breast cancer is an uncommon type of invasive breast cancer. It accounts for about 1% to 5% of all breast cancers.

**Less common types of breast cancer**

There are other types of breast cancers that affect other types of cells in the breast. These cancers are much less common, and sometimes need different types of treatment.

**Paget disease of the breast**
Paget disease of the breast starts in the breast ducts and spreads to the skin of the nipple and then to the areola (the dark circle around the nipple). It is rare, accounting for only about 1-3% of all cases of breast cancer.

**Phyllodes tumor**
Phyllodes tumors are rare breast tumors. They develop in the connective tissue (stroma) of the breast, in contrast to carcinomas, which develop in the ducts or lobules. Most are benign, but there are others that are malignant (cancer).

**Angiosarcoma**
Sarcomas of the breast are rare making up less than 1% of all breast cancers. Angiosarcoma starts in cells that line blood vessels or lymph vessels. It can involve the breast tissue or the skin of the breast. Some may be related to prior
radiation therapy in that area.

**Hyperlinks**


**References**


Nora M. Hansen. Chapter 63: Paget’s Disease. In: Harris JR, Lippman ME, Morrow M,


Last Medical Review: September 20, 2019 Last Revised: September 20, 2019

Ductal Carcinoma In Situ (DCIS)

About 1 in 5 new breast cancers will be ductal carcinoma in situ (DCIS). Nearly all women with this early stage of breast cancer can be cured.

DCIS is also called intraductal carcinoma or stage 0 breast cancer. DCIS is a non-invasive or pre-invasive breast cancer. This means the cells that line the ducts have changed to cancer cells but they have not spread through the walls of the ducts into the nearby breast tissue.
Ductal carcinoma in situ

Because DCIS hasn’t spread into the breast tissue around it, it can’t spread (metastasize) beyond the breast to other parts of the body.

However, DCIS can sometimes become an invasive cancer. At that time, the cancer has spread out of the duct into nearby tissue, and from there, it could metastasize to other parts of the body.

Right now, there’s no good way to know for sure which will become invasive cancer and which ones won’t, so almost all women with DCIS will be treated.

Treating DCIS
In most cases, a woman with DCIS can choose between breast-conserving surgery (BCS) and simple mastectomy.

See Treatment for Ductal Carcinoma in Situ (DCIS)\(^1\) to learn more.

**Hyperlinks**


**References**


Last Medical Review: September 20, 2019 Last Revised: September 20, 2019
Invasive Breast Cancer (IDC/ILC)

Breast cancers that have spread into surrounding breast tissue are known as invasive breast cancer.

Most breast cancers are invasive, but there are different types of invasive breast cancer. The two most common are invasive ductal carcinoma and invasive lobular carcinoma.

Inflammatory breast cancer and triple negative breast cancer are also types of invasive breast cancer.

Invasive (infiltrating) ductal carcinoma (IDC)

This is the most common type of breast cancer. About 8 in 10 invasive breast cancers are invasive (or infiltrating) ductal carcinomas (IDC).

IDC starts in the cells that line a milk duct in the breast. From there, the cancer breaks through the wall of the duct, and grows into the nearby breast tissues. At this point, it may be able to spread (metastasize) to other parts of the body through the lymph system and bloodstream.

Invasive lobular carcinoma (ILC)

About 1 in 10 invasive breast cancers is an invasive lobular carcinoma (ILC).

ILC starts in the milk-producing glands (lobules). Like IDC, it can spread (metastasize) to other parts of the body. Invasive lobular carcinoma may be harder to detect on physical exam and imaging, like mammograms, than invasive ductal carcinoma. And compared to other kinds of invasive carcinoma, about 1 in 5 women with ILC might have cancer in both breasts.

Less common types of invasive breast cancer

There are some special types of breast cancer that are sub-types of invasive carcinoma. They are less common than the breast cancers named above and each typically make up fewer than 5% of all breast cancers. These are often named after features seen when they are viewed under the microscope, like the ways the cells are arranged.
Some of these may have a better prognosis than the more common IDC. These include:

- Adenoid cystic (or adenocystic) carcinoma
- Low-grade adenosquamous carcinoma (this is a type of metaplastic carcinoma)
- Medullary carcinoma
- Mucinous (or colloid) carcinoma
- Papillary carcinoma
- Tubular carcinoma

Some sub-types have the same or maybe worse prognoses than IDC. These include:

- Metaplastic carcinoma (most types, including spindle cell and squamous, except low grade adenosquamous carcinoma)
- Micropapillary carcinoma
- Mixed carcinoma (has features of both invasive ductal and lobular)

In general, all of these sub-types are still treated like IDC.

**Treating invasive breast cancer**

Treatment of invasive breast cancer depends on how advanced the cancer is (the stage of the cancer) and other factors. Most women will have some type of surgery to remove the tumor. Depending on the type of breast cancer and how advanced it is, you might need other types of treatment as well, either before or after surgery, or sometimes both.

See [Treating Breast Cancer](#) for details on different types of treatment, as well as common treatment approaches based on the stage or other factors.

**Hyperlinks**


**References**


Dillon DA, Guidi AJ, Schnitt SJ. Ch. 25: Pathology of invasive breast cancer. In: Harris
Triple-negative Breast Cancer

Triple-negative breast cancer (TNBC) accounts for about 10-15% of all breast cancers. The term triple-negative breast cancer refers to the fact that the cancer cells don’t have estrogen or progesterone receptors and also don’t make too much of the protein called HER2. (The cells test "negative" on all 3 tests.) These cancers tend to be more common in women younger than age 40, who are African-American, or who have a BRCA1 mutation.

Triple-negative breast cancer differs from other types of invasive breast cancer in that they grow and spread faster, have limited treatment options, and a worse prognosis.
(outcome).

**Signs and symptoms of triple-negative breast cancer**

Triple-negative breast cancer can have the same signs and symptoms as other common types of breast cancer.

**How is triple-negative breast cancer diagnosed?**

Once a breast cancer diagnosis has been made using imaging tests and a biopsy, the cancer cells will be checked for certain features. If the cells do not have estrogen or progesterone receptors, and also do not make too much of the HER2 protein, the cancer is considered to be triple-negative breast cancer.

**Survival rates for triple-negative breast cancer**

Triple-negative breast cancer (IBC) is considered an aggressive cancer because it grows quickly, is more likely to have spread at the time it’s found and is more likely to come back after treatment than other types of breast cancer. The outlook is generally not as good as it is for other types of breast cancer.

Survival rates can give you an idea of what percentage of people with the same type and stage of cancer are still alive a certain amount of time (usually 5 years) after they were diagnosed. They can’t tell you how long you will live, but they may help give you a better understanding of how likely it is that your treatment will be successful.

Keep in mind that survival rates are estimates and are often based on previous outcomes of large numbers of people who had a specific cancer, but they can’t predict what will happen in any particular person’s case. These statistics can be confusing and may lead you to have more questions. Talk with your doctor about how these numbers may apply to you, as he or she is familiar with your situation.

**What is a 5-year relative survival rate?**

A relative survival rate compares women with the same type and stage of breast cancer to women in the overall population. For example, if the 5-year relative survival rate for a specific stage of breast cancer is 90%, it means that women who have that cancer are, on average, about 90% as likely as women who don’t have that cancer to live for at least 5 years after being diagnosed.
Where do these numbers come from?

The American Cancer Society relies on information from the SEER* database, maintained by the National Cancer Institute (NCI), to provide survival statistics for different types of cancer.

The SEER database tracks 5-year relative survival rates for breast cancer in the United States, based on how far the cancer has spread. The SEER database, however, does not group cancers by AJCC TNM stages (stage 1, stage 2, stage 3, etc.). Instead, it groups cancers into localized, regional, and distant stages:

- **Localized**: There is no sign that the cancer has spread outside of the breast.
- **Regional**: The cancer has spread outside the breast to nearby structures or lymph nodes.
- **Distant**: The cancer has spread to distant parts of the body such as the lungs, liver or bones.

5-year relative survival rates for triple-negative breast cancer

(Based on women diagnosed with triple-negative breast cancer between 2010 and 2015.)

<table>
<thead>
<tr>
<th>SEER Stage</th>
<th>5-year Relative Survival Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Localized</td>
<td>91%</td>
</tr>
<tr>
<td>Regional</td>
<td>65%</td>
</tr>
<tr>
<td>Distant</td>
<td>11%</td>
</tr>
</tbody>
</table>

Understanding the numbers

- **Women now being diagnosed with triple negative breast cancer may have a better outlook than these numbers show.** Treatments improve over time, and these numbers are based on women who were diagnosed and treated at least four to five years earlier.
- **These numbers apply only to the stage of the cancer when it is first diagnosed.** They do not apply later on if the cancer grows, spreads, or comes back after treatment.
• These numbers don’t take everything into account. Survival rates are grouped based on how far the cancer has spread, but your age, overall health, how well the cancer responds to treatment, tumor grade\(^3\), and other factors can also affect your outlook.

**Treating triple-negative breast cancer**

Triple-negative breast cancer has fewer treatment options than other types of invasive breast cancer. This is because the cancer cells do not have the estrogen or progesterone receptors or enough of the HER2 protein to make hormone therapy or targeted drugs work.

If the cancer has not spread to distant sites, surgery is an option. Chemotherapy might be given first to shrink a large tumor followed by surgery. It might also be given after surgery to reduce the chances of the cancer coming back. Radiation might also be an option depending on certain features of the tumor.

Because hormone therapy and HER2 drugs are not choices for women with triple negative breast cancer, chemotherapy is often used. In cases where the cancer has spread to other parts of the body (stage IV) chemotherapy and other treatments that can be considered include PARP inhibitors, platinum chemotherapy, or immunotherapy.

For details, see Treatment of Triple-negative Breast Cancer\(^4\).

**Hyperlinks**


**References**

Inflammatory Breast Cancer

Inflammatory breast cancer (IBC) is rare and accounts for only 1-5% of all breast cancers. Although it is often a type of invasive ductal carcinoma, it differs from other types of breast cancer in its symptoms, outlook, and treatment. IBC has symptoms of inflammation like swelling and redness, but infection or injury do not cause IBC or the symptoms. IBC symptoms are caused by cancer cells blocking lymph vessels in the skin causing the breast to look "inflamed."

Symptoms include breast swelling, purple or red color of the skin, and dimpling or thickening of the skin of the breast so that it may look and feel like an orange peel. Often, you might not feel a lump, even if it is there. If you have any of these symptoms, it does not mean that you have IBC, but you should see a doctor right away.

How is inflammatory breast cancer different from other types of breast cancer?

Inflammatory breast cancer differs (IBC) from other types of breast cancer in several
ways:

- IBC doesn’t look like a typical breast cancer. It often does not cause a breast lump, and it might not show up on a mammogram. This makes it harder to diagnose.
- IBC tends to occur in younger women (younger than 40 years of age).
- African-American women appear to develop IBC more often than white women.
- IBC is more common among women who are overweight or obese.
- IBC also tends to be more aggressive—it grows and spreads much more quickly—than more common types of breast cancer.
- IBC is always at a locally advanced stage when it’s first diagnosed because the breast cancer cells have grown into the skin. (This means it is at least stage III.)
- In about 1 of every 3 cases, IBC has already spread (metastasized) to distant parts of the body when it is diagnosed. This makes it harder to treat successfully.
- Women with IBC tend to have a worse prognosis (outcome) than women with other common types of breast cancer.

**Signs and symptoms of inflammatory breast cancer**

Inflammatory breast cancer (IBC) causes a number of signs and symptoms, most of which develop quickly (within 3-6 months), including:

- Swelling (edema) of the skin of the breast
- Redness involving more than one-third of the breast
- Pitting or thickening of the skin of the breast so that it may look and feel like an orange peel
- A retracted or inverted nipple
- One breast looking larger than the other because of swelling
- One breast feeling warmer and heavier than the other
- A breast that may be tender, painful or itchy
- Swelling of the lymph nodes under the arms or near the collarbone
Tenderness, redness, warmth, and itching are also common symptoms of a breast infection or inflammation, such as mastitis if you’re pregnant or breastfeeding. Because these problems are much more common than IBC, your doctor might suspect infection at first as a cause and treat you with antibiotics.

This may be a good first step, but if your symptoms don’t get better in 7 to 10 days, more tests need to be done to look for cancer. The possibility of IBC should be considered more strongly if you have these symptoms and are not pregnant or breastfeeding, or have been through menopause.

IBC grows and spreads quickly, so the cancer may have already spread to nearby lymph nodes by the time symptoms are noticed. This spread can cause swollen lymph nodes under your arm or above your collar bone. If the diagnosis is delayed, the cancer can spread to distant sites.

If you have any of these symptoms, it does not mean that you have IBC, but you should
see a doctor right away. If treatment with antibiotics is started, you’ll need to let your doctor know if it doesn’t help, especially if the symptoms get worse or the affected area gets larger. Ask to see a specialist (like a breast surgeon) or you might want to get a second opinion if you’re concerned.

How is inflammatory breast cancer diagnosed?

Imaging tests

If inflammatory breast cancer (IBC) is suspected, one or more of the following imaging tests may be done:

- Mammogram
- Breast ultrasound
- Breast MRI (magnetic resonance imaging) scan

Sometimes a photo of the breast is taken to help record the amount of redness and swelling before starting treatment.

Biopsy

Breast cancer is diagnosed by a biopsy, taking out a small piece of the breast tissue and looking at it in the lab. Your physical exam and other tests may show findings that are "suspicious for" IBC, but only a biopsy can tell for sure that it is cancer.

Tests on biopsy samples

The cancer cells in the biopsy will be examined in the lab to determine their grade.

They will also be tested for certain proteins that help decide which treatments will be helpful. Women whose breast cancer cells have hormone receptors are likely to benefit from treatment with hormone therapy drugs.

Cancer cells that make too much of a protein called HER2 or too many copies of the gene for that protein may be treated by certain drugs that target HER2.

Stages of inflammatory breast cancer

All inflammatory breast cancers start as Stage III (T4dNXM0) since they involve the
skin. If the cancer has spread outside the breast to distant areas it is stage IV.

For more information, read about breast cancer staging.

**Survival rates for inflammatory breast cancer**

Inflammatory breast cancer (IBC) is considered an aggressive cancer because it grows quickly, is more likely to have spread at the time it’s found, and is more likely to come back after treatment than other types of breast cancer. The outlook is generally not as good as it is for other types of breast cancer.

Survival rates can give you an idea of what percentage of people with the same type and stage of cancer are still alive a certain amount of time (usually 5 years) after they were diagnosed. They can’t tell you how long you will live, but they may help give you a better understanding of how likely it is that your treatment will be successful.

*Keep in mind that survival rates are estimates and are often based on previous outcomes of large numbers of people who had a specific cancer, but they can’t predict what will happen in any particular person’s case. These statistics can be confusing and may lead you to have more questions. Talk with your doctor about how these numbers may apply to you, as he or she is familiar with your situation.*

**What is a 5-year relative survival rate?**

A relative survival rate compares women with the same type and stage of breast cancer to women in the overall population. For example, if the 5-year relative survival rate for a specific stage of breast cancer is 70%, it means that women who have that cancer are, on average, about 70% as likely as women who don’t have that cancer to live for at least 5 years after being diagnosed.

**Where do these numbers come from?**

The American Cancer Society relies on information from the SEER* database, maintained by the National Cancer Institute (NCI), to provide survival statistics for different types of cancer.

The SEER database tracks 5-year relative survival rates for breast cancer in the United States, based on how far the cancer has spread. The SEER database, however, does not group cancers by AJCC TNM stages\(^5\) (stage 1, stage 2, stage 3, etc.). Instead, it groups cancers into localized, regional, and distant stages:
• **Localized:** There is no sign that the cancer has spread outside of the breast.
• **Regional:** The cancer has spread outside the breast to nearby structures or lymph nodes.
• **Distant:** The cancer has spread to distant parts of the body such as the lungs, liver or bones.

### 5-year relative survival rates for inflammatory breast cancer

(Based on women diagnosed with inflammatory breast cancer between 2009 and 2015.)

<table>
<thead>
<tr>
<th>SEER Stage</th>
<th>5-year Relative Survival Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional</td>
<td>52%</td>
</tr>
<tr>
<td>Distant</td>
<td>18%</td>
</tr>
<tr>
<td>All SEER Stages</td>
<td>39%</td>
</tr>
</tbody>
</table>

**Understanding the numbers**

- **Women now being diagnosed with inflammatory breast cancer may have a better outlook than these numbers show.** Treatments improve over time, and these numbers are based on women who were diagnosed and treated at least four to five years earlier.
- **These numbers apply only to the stage of the cancer when it is first diagnosed.** They do not apply later on if the cancer grows, spreads, or comes back after treatment.
- **These numbers don’t take everything into account.** Survival rates are grouped based on how far the cancer has spread, but your age, overall health, how well the cancer responds to treatment, tumor grade⁶, and other factors can also affect your outlook.

*SEER = Surveillance, Epidemiology, and End Results

### Treating inflammatory breast cancer

Inflammatory breast cancer (IBC) that has not spread outside the breast or nearby lymph nodes is stage III. In most cases, treatment is chemotherapy first to try to shrink the tumor, followed by surgery to remove the cancer. Radiation is given after surgery, and, in some cases, more treatment may be given after radiation. Because IBC is so
aggressive, breast conserving surgery (lumpectomy) and sentinel lymph node biopsy are typically not part of the treatment.

IBC that has spread to other parts of the body (stage IV) may be treated with chemotherapy, hormone therapy, and/or with drugs that targets HER2.

For details, see Treatment of Inflammatory Breast Cancer[^7].

**Hyperlinks**

3. [www.cancer.org/treatment/understanding-your-diagnosis/tests/mri-for-cancer.html](http://www.cancer.org/treatment/understanding-your-diagnosis/tests/mri-for-cancer.html)

**References**


Hennessy BT, Gonzalez-Angulo AM, Hortobagyi GN, et al. Disease-free and overall survival after pathologic complete disease remission of cytologically proven inflammatory breast carcinoma axillary lymph node metastases after primary systemic


Yang WT, Le-Petross HT, Macapinlac H, Carkaci S, Gonzalez-Angulo AM, Dawood S,
Angiosarcoma of the Breast

Angiosarcoma is rare cancer that starts in the cells that line blood vessels or lymph vessels. Many times it’s a complication of previous radiation treatment to the breast. It can happen 8-10 years after getting radiation treatment to the breast.

Signs and symptoms of angiosarcoma

Angiosarcoma can cause skin changes like purple colored nodules and/or a lump in the breast. It can also occur in the affected arms of women with lymphedema, but this is not common. (Lymphedema is swelling that can develop after surgery or radiation therapy to treat breast cancer.)

How is angiosarcoma of the breast diagnosed?

One or more of the following imaging tests may be done to check for breast changes:

- Diagnostic mammogram
- Breast ultrasound
- Breast MRI (magnetic resonance imaging) scan

Angiosarcoma is diagnosed by a biopsy, removing a small piece of the breast tissue and looking at it in the lab. Only a biopsy can tell for sure that it is cancer.

Treating angiosarcoma

Angiosarcomas tend to grow and spread quickly. Treatment usually includes surgery to remove the breast (mastectomy). The axillary lymph nodes are typically not removed. For more information on sarcomas, see Soft Tissue Sarcoma.
Hyperlinks


References


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Paget Disease of the Breast

Paget disease of the breast is a rare type of breast cancer involving the skin of the nipple and the areola (the dark circle around the nipple). Paget disease usually affects only one breast. In 80-90% of cases, it’s usually found along with either ductal carcinoma in situ (DCIS) or infiltrating ductal carcinoma (invasive breast cancer).

Signs and symptoms of Paget disease of the breast

The skin of the nipple and areola often looks crusted, scaly, and red. There may be blood or yellow fluid coming out of the nipple. Sometimes the nipple looks flat or inverted. It also might burn or itch. Your doctor might try to treat this as eczema first, and if it does not improve, recommend a biopsy.

How is Paget disease of the breast diagnosed?

Most people with Paget disease of the breast also have tumors in the same breast. One or more of the following imaging tests may be done to check for other breast changes:

- Diagnostic mammogram
- Breast ultrasound
- Breast MRI (magnetic resonance imaging) scan

Paget disease of the breast is diagnosed by a biopsy, removing a small piece of the breast tissue and looking at it in the lab. In some cases, the entire nipple may be removed. Only a biopsy can tell for sure that it is cancer.

Treating Paget disease of the breast

Paget disease can be treated by removing the entire breast (mastectomy) or breast-conserving surgery (BCS) followed by whole-breast radiation therapy. If BCS is done, the entire nipple and areola area also needs to be removed. If invasive cancer is found, the lymph nodes under the arm will be checked for cancer.

If no lump is felt in the breast tissue, and your biopsy results show the cancer has not spread, the outlook (prognosis) is excellent.

If the cancer has spread (is invasive), the outlook is not as good, and the cancer will be
staged and treated like any other invasive ductal carcinoma\cite{8}.

**Hyperlinks**

3. [www.cancer.org/treatment/understanding-your-diagnosis/tests/mri-for-cancer.html](http://www.cancer.org/treatment/understanding-your-diagnosis/tests/mri-for-cancer.html)

**References**


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Breast Cancer Hormone Receptor Status

Breast cancer cells taken out during a biopsy or surgery will be tested to see if they have certain proteins that are estrogen or progesterone receptors. When the hormones estrogen and progesterone attach to these receptors, they fuel the cancer growth. Cancers are called hormone receptor-positive or hormone receptor-negative based on whether or not they have these receptors (proteins). Knowing the hormone receptor status is important in deciding treatment options. Ask your doctor about your hormone receptor status and what it means for you.

What are estrogen and progesterone receptors?

Receptors are proteins in or on cells that can attach to certain substances in the blood. Normal breast cells and some breast cancer cells have receptors that attach to the hormones estrogen and progesterone, and depend on these hormones to grow.

Breast cancer cells may have one, both, or none of these receptors.

- **ER-positive**: Breast cancers that have estrogen receptors are called *ER-positive* (or ER+) cancers.
- **PR-positive**: Breast cancers with progesterone receptors are called *PR-positive* (or PR+) cancers.
- **Hormone receptor-positive**: If the cancer cell has one or both of the receptors above, the term *hormone-receptive positive* (also called *hormone-positive* or HR+) breast cancer may be used.
- **Hormone receptor-negative**: If the cancer cell has neither the estrogen nor the progesterone receptor, it's called hormone-receptor negative (also called *hormone-negative* or HR-).

Keeping the hormones estrogen and progesterone from attaching to the receptors can help keep the cancer from growing and spreading. There are drugs that can be used to do this.

Why is knowing hormone receptor status important?

Knowing the hormone receptor status of your cancer helps doctors decide how to treat...
it. If your cancer has one or both of these hormone receptors, hormone therapy drugs can be used to either lower estrogen levels or stop estrogen from acting on breast cancer cells. This kind of treatment is helpful for hormone receptor-positive breast cancers, but it doesn’t work on tumors that are hormone receptor-negative (both ER- and PR-negative).

All invasive breast cancers should be tested for both of these hormone receptors either on the biopsy sample or when the tumor is removed with surgery. About 2 of 3 breast cancers have at least one of these receptors. This percentage is higher in older women than in younger women. DCIS should be checked for hormone receptors, too.

**What do the hormone receptor test results mean?**

A test called an immunohistochemistry (IHC) is used most often to find out if cancer cells have estrogen and progesterone receptors. The test results will help guide you and your cancer care team in making the best treatment decisions.

Test results will give you your hormone receptor status. It will say a tumor is **hormone receptor-positive** if at least 1% of the cells tested have estrogen and/or progesterone receptors. Otherwise the test will say the tumor is **hormone receptor-negative**.

**Hormone receptor-positive** (or hormone-positive) breast cancer cells have either estrogen (ER) or progesterone (PR) receptors or both. These breast cancers can be treated with hormone therapy drugs that lower estrogen levels or block estrogen receptors. Hormone receptor-positive cancers tend to grow more slowly than those that are hormone receptor-negative. Women with hormone receptor-positive cancers tend to have a better outlook in the short-term, but these cancers can sometimes come back many years after treatment.

**Hormone receptor-negative** (or hormone-negative) breast cancers have neither estrogen nor progesterone receptors. Treatment with hormone therapy drugs is not helpful for these cancers. These cancers tend to grow faster than hormone receptor-positive cancers. If they come back after treatment, it’s often in the first few years. Hormone receptor-negative cancers are more common in women who have not yet gone through menopause.

**Triple-negative** breast cancer cells don’t have estrogen or progesterone receptors and also don’t make too much of the protein called **HER2**. These cancers tend to be more common in women younger than 40 years of age, who are African-American, or who have a mutation in the BRCA 1 gene. Triple-negative breast cancers grow and spread faster than most other types of breast cancer. Because the cancer cells don’t have
hormone receptors, hormone therapy is not helpful in treating these cancers. And because they don’t have too much HER2, drugs that target HER2 aren’t helpful, either. Chemotherapy can still be useful. See Triple-negative Breast Cancer to learn more.

**Triple-positive** cancers are ER-positive, PR-positive, and HER2-positive. These cancers can be treated with hormone drugs as well as drugs that target HER2.

**Hyperlinks**


**References**


Breast Cancer HER2 Status

Some women have breast tumors with higher levels of a protein known as HER2—these are called HER2-positive breast cancers. Ask your doctor about your HER2 status and what it means for you.

What is HER2 and what does it mean?

HER2 is a growth-promoting protein on the outside of all breast cells. Breast cancer cells with higher than normal levels of HER2 are called HER2-positive. These cancers tend to grow and spread faster than other breast cancers, but are much more likely to respond to treatment with drugs that target the HER2 protein.

How are breast tumors tested for HER2?

Women newly diagnosed with invasive breast cancers should be tested for HER2.

A biopsy or surgery sample of the cancer is usually tested with either immunohistochemical stains (IHC) or Fluorescent in situ hybridization (FISH).

See Testing Biopsy and Cytology Specimens for Cancer and Understanding Your Pathology Report: Breast Cancer to get more details about these tests.

What do the test results mean?

The results of HER2 testing will guide you and your cancer care team in making the best treatment decisions.

It is not clear if one test is more accurate than the other, but FISH is more expensive...
and takes longer to get the results. Often the IHC test is done first.

- If the IHC result is 0 or 1+, the cancer is considered **HER2-negative**. These cancers do not respond to treatment with drugs that target HER2.
- If the IHC result is 3+, the cancer is **HER2-positive**. These cancers are usually treated with drugs that target HER2.
- If the IHC result is 2+, the HER2 status of the tumor is not clear and is called "equivocal." This means that the HER2 status needs to be tested with FISH to clarify the result.

**Triple-negative** breast tumors don’t have too much HER2 and also don’t have estrogen or progesterone receptors. They are HER2-, ER-, and PR-negative. Hormone therapy and drugs that target HER2 are not helpful in treating these cancers. See [Triple-negative Breast Cancer](#) to learn more.

**Triple-positive** breast tumors are HER2-, ER-, and PR-positive. These cancers are treated with hormone drugs as well as drugs that target HER2.

**Hyperlinks**


**References**


Breast Cancer Gene Expression Tests

Gene expression tests are a form of personalized medicine - a way to learn more about your cancer and tailor your treatment.

These tests are done on breast cancer cells after surgery or biopsy to look at the patterns of a number of different genes. This process is sometimes called gene expression profiling.

The patterns found can help predict if certain early stage breast cancers are likely to come back after initial treatment. Doctors can also use the information from some of these tests to know which women will most likely benefit from chemotherapy after breast surgery.2

Testing options

The Oncotype DX, MammaPrint, and Prosigna are examples of tests that look at different sets of breast cancer genes. More tests are in development. The type of test that's used will depend on your situation. Keep in mind that these tests are usually used for early stage cancers, and testing isn't needed in all cases. For example, if breast
cancer is advanced, it might be clear that chemotherapy is needed, even without gene expression testing.

**Oncotype DX**

The Oncotype DX test is used for stage I, II or IIIa hormone receptor-positive tumors that have not spread to more than 3 lymph nodes and are HER2 negative. It can also be used for DCIS (ductal carcinoma in situ or stage 0 breast cancer).

This test looks at a set of 21 genes in cancer cells from tumor biopsy or surgery samples to get a “recurrence score,” which is a number between 0 and 100. The score reflects the risk of the breast cancer coming back (recurring) in the next 10 years and how likely you will benefit from getting chemo after surgery.

- **A low score (0-25) means a low risk of recurrence.** Most women with low-recurrence scores do not benefit from chemotherapy and have good outcomes when treated with hormone therapy.
- **A high score (26-100) means a higher risk of recurrence.** Women with high-recurrence scores are more likely to benefit from the addition of chemotherapy to hormone therapy to help lower the chance of the cancer coming back.

For women age 50 or younger who have a low recurrence score of 16-25, there might be a small to moderate benefit from the addition of chemotherapy. Talk to your doctor about your options.

**MammaPrint**

The MammaPrint test can be used to help determine how likely breast cancers are to recur in a distant part of the body after treatment. It can be used for any type of invasive breast cancer that’s 5cm (about 2 inches) or smaller and has spread to no more than 3 lymph nodes. This test can be done regardless of the cancer's hormone and HER2 status.

The test looks at 70 different genes to determine if the cancer is at low risk or high risk of coming back (recurring) in the next 10 years. The test results come back as either “low risk” or “high risk.” This test is also being studied as a way to determine whether certain women might benefit from chemotherapy.

**Prosigna**
The Prosigna test can be used to predict the risk of recurrence in the next 10 years in women who have gone through menopause and whose invasive breast cancers are hormone receptor-positive. It can be used to test stage I or II cancers that have not spread to the lymph nodes, or stage II cancers with no more than 3 positive lymph nodes.

The test looks at 50 genes and classifies the results as low, intermediate, or high risk.

What do the test results mean?

Some gene expression testing can help predict which women will most likely benefit from chemotherapy after breast surgery. (This is called adjuvant chemotherapy.) Hormone therapy is a standard treatment for hormone receptor-positive breast cancers, but it's not always clear when to use chemotherapy. These tests can help guide that decision. Still, these tests cannot tell any one woman for certain if her cancer will come back with or without chemotherapy.

These tests continue to be studied in large clinical trials to better understand how and when to best use them. In the meantime, ask your doctor if these tests might be useful for you.

Hyperlinks


References


Gnant M, Filipits M, Dubsky P, et al. Predicting risk for late metastasis: The PAM50 risk of recurrence (ROR) score after 5 years of endocrine therapy in postmenopausal women with HR+ early breast cancer: A study on 1,478 patients for the ABCSG-8 trial.


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Breast Cancer Ploidy and Cell Proliferation

Finding out more information about the DNA in the breast cancer cells can help predict how fast the cancer cells are dividing and growing.

What is ploidy and what does it mean?

The ploidy of cancer cells refers to the amount of DNA they contain.

- If there’s a normal amount of DNA in the cells, they are said to be diploid. These cancers tend to grow and spread more slowly.
- If the amount of DNA is abnormal, then the cells are called aneuploid. These cancers tend to be more aggressive. (They tend to grow and spread faster.)

Tests of ploidy may help figure out long-term outcomes, but they rarely change treatment and are considered optional. They are not usually recommended as part of a routine breast cancer work-up.

What is cell proliferation?

Cell proliferation is how quickly a cancer cell copies its DNA and divides into 2 cells. If the cancer cells are dividing more rapidly, it means the cancer is faster growing or more aggressive.

The rate of cancer cell proliferation can be estimated by doing a Ki-67 test. In some cases, Ki-67 testing to measure cell proliferation may be used to help plan treatment or estimate treatment outcomes. But test results can vary depending on things like the lab doing the testing, the testing method, and what part of the tumor is tested.

Another way to determine cell division is the S-phase fraction, which is the percentage of cells in a sample that are copying their DNA as it gets ready to divide into 2 new cells.

If the S-phase fraction or Ki-67 labeling index is high, it means that the cancer cells are dividing more rapidly.
Breast Cancer Grades

Knowing a breast cancer’s grade is important to understand how fast it’s likely to grow and spread.

What is a breast cancer’s grade?

Cancer cells are given a grade when they are removed from the breast and checked in the lab. The grade is based on how much the cancer cells look like normal cells. The grade is used to help predict your outcome (prognosis) and to help figure out what treatments might work best.

A lower grade number (1) usually means the cancer is slower-growing and less likely to spread.

A higher number (3) means a faster-growing cancer that’s more likely to spread.

Grading breast cancer cells

Three cancer cell features are studied and each is assigned a score. The scores are then added to get a number between 3 and 9 that is used to get a grade of 1, 2, or 3, which is noted on your pathology report. Sometimes the terms well differentiated, moderately differentiated, and poorly differentiated are used to describe the grade.
instead of numbers:

- **Grade 1 or well differentiated** (score 3, 4, or 5). The cells are slower-growing, and look more like normal breast tissue.
- **Grade 2 or moderately differentiated** (score 6, 7). The cells are growing at a speed of and look like cells somewhere between grades 1 and 3.
- **Grade 3 or poorly differentiated** (score 8, 9). The cancer cells look very different from normal cells and will probably grow and spread faster.

Our information about [pathology reports](http://www.cancer.org/treatment/understanding-your-diagnosis/tests/understanding-your-pathology-report.html) can help you understand details about your breast cancer.

**Grading ductal carcinoma in situ (DCIS)**

DCIS is also graded on how abnormal the cancer cells look.

**Necrosis** (areas of dead or dying cancer cells) is also noted. If there is necrosis, it means the tumor is growing quickly.

- The term *comedocarcinoma* is often used to describe DCIS with a lot of necrosis.
- The term *comedonecrosis* may be used if a breast duct is filled with dead and dying cells.

Comedocarcinoma and comedonecrosis are linked to a higher grade of DCIS.

See [Understanding Your Pathology Report: Ductal Carcinoma In Situ](http://www.cancer.org/treatment/understanding-your-diagnosis/tests/understanding-your-pathology-report/breast-pathology/ductal-carcinoma-in-situ.html) for more on how DCIS is described.

**Hyperlinks**

1. [www.cancer.org/treatment/understanding-your-diagnosis/tests/understanding-your-pathology-report.html](http://www.cancer.org/treatment/understanding-your-diagnosis/tests/understanding-your-pathology-report.html)

**References**
Breast Cancer Stages

After someone is diagnosed with breast cancer, doctors will try to figure out if it has spread, and if so, how far. This process is called staging. The stage of a cancer describes how much cancer is in the body. It helps determine how serious the cancer is and how best to treat it. Doctors also use a cancer’s stage when talking about survival statistics.

The earliest stage breast cancers are stage 0 (carcinoma in situ). It then ranges from stage I (1) through IV (4). As a rule, the lower the number, the less the cancer has spread. A higher number, such as stage IV, means cancer has spread more. And within a stage, an earlier letter means a lower stage.

How is the stage determined?

The staging system most often used for breast cancer is the American Joint Committee on Cancer (AJCC) TNM system. The most recent AJCC system, effective January 2018, has both clinical and pathologic staging systems for breast cancer:

- The pathologic stage (also called the surgical stage) is determined by examining tissue removed during an operation.
- Sometimes, if surgery is not possible right away or at all, the cancer will be given a clinical stage instead. This is based on the results of a physical exam, biopsy, and imaging tests. The clinical stage is used to help plan treatment. Sometimes, though, the cancer has spread further than the clinical stage estimates, and may not predict...
the patient’s outlook as accurately as a pathologic stage.

In both staging systems, 7 key pieces of information are used:

- **The extent (size) of the tumor (T):** How large is the cancer? Has it grown into nearby areas?
- **The spread to nearby lymph nodes (N):** Has the cancer spread to nearby lymph nodes? If so, how many?
- **The spread (metastasis) to distant sites (M):** Has the cancer spread to distant organs such as the lungs or liver?
- **Estrogen Receptor (ER) status:** Does the cancer have the protein called an estrogen receptor?
- **Progesterone Receptor (PR) status:** Does the cancer have the protein called a progesterone receptor?
- **Her2 status:** Does the cancer make too much of a protein called Her2?
- **Grade of the cancer (G):** How much do the cancer cells look like normal cells?

In addition, Oncotype Dx® Recurrence Score results may also be considered in the stage in certain circumstances.

Once all of these factors have been determined, this information is combined in a process called **stage grouping** to assign an overall stage. For more information see Cancer Staging.

Details about the first three factors (the TNM categories) are below. However, the addition of information about ER, PR, and Her2 status along with grade has made stage grouping for breast cancer more complex than for other cancers. Because of this, it is best to ask your doctor about your specific stage and what it means.

**Details of the TNM staging system**

Numbers or letters after T, N, and M provide more details about each of these factors. Higher numbers mean the cancer is more advanced.

**T categories for breast cancer**

T followed by a number from 0 to 4 describes the main (primary) tumor’s size and if it has spread to the skin or to the chest wall under the breast. Higher T numbers mean a larger tumor and/or wider spread to tissues near the breast.
TX: Primary tumor cannot be assessed.

T0: No evidence of primary tumor.

Tis: Carcinoma in situ (DCIS, or Paget disease of the breast with no associated tumor mass)

T1 (includes T1a, T1b, and T1c): Tumor is 2 cm (3/4 of an inch) or less across.

T2: Tumor is more than 2 cm but not more than 5 cm (2 inches) across.

T3: Tumor is more than 5 cm across.

T4 (includes T4a, T4b, T4c, and T4d): Tumor of any size growing into the chest wall or skin. This includes inflammatory breast cancer.

N categories for breast cancer

N followed by a number from 0 to 3 indicates whether the cancer has spread to lymph nodes near the breast and, if so, how many lymph nodes are involved.

Lymph node staging for breast cancer is based on how the nodes look under the microscope, and has changed as technology has improved. Newer methods have made it possible to find smaller and smaller collections of cancer cells, but experts haven’t been sure how much these tiny deposits of cancer cells affect outlook.

It’s not yet clear how much cancer in the lymph node is needed to see a change in outlook or treatment. This is still being studied, but for now, a deposit of cancer cells must contain at least 200 cells or be at least 0.2 mm across (less than 1/100 of an inch) for it to change the N stage. An area of cancer spread that is smaller than 0.2 mm (or fewer than 200 cells) doesn’t change the stage, but is recorded with abbreviations (i+ or mol+) that indicate the type of special test used to find the spread.

If the area of cancer spread is at least 0.2 mm (or 200 cells), but still not larger than 2 mm, it is called a micrometastasis (one mm is about the size of the width of a grain of rice). Micrometastases are counted only if there aren’t any larger areas of cancer spread. Areas of cancer spread larger than 2 mm are known to affect outlook and do change the N stage. These larger areas are sometimes called macrometastases, but are more often just called metastases.

NX: Nearby lymph nodes cannot be assessed (for example, if they were removed previously).
**N0**: Cancer has not spread to nearby lymph nodes.

**N0(i+)**: The area of cancer spread contains fewer than 200 cells and is smaller than 0.2 mm. The abbreviation "i+" means that a small number of cancer cells (called isolated tumor cells) were seen in routine stains or when a special type of staining technique, called *immunohistochemistry*, was used.

**N0(mol+)**: Cancer cells cannot be seen in underarm lymph nodes (even using special stains), but traces of cancer cells were detected using a technique called *RT-PCR*. RT-PCR is a molecular test that can find very small numbers of cancer cells. (This test is not often used to find breast cancer cells in lymph nodes because the results do not influence treatment decisions.)

**N1**: Cancer has spread to 1 to 3 axillary (underarm) lymph node(s), and/or tiny amounts of cancer are found in internal mammary lymph nodes (those near the breast bone) on sentinel lymph node biopsy.

**N1mi**: Micrometastases (tiny areas of cancer spread) in the lymph nodes under the arm. The areas of cancer spread in the lymph nodes are at least 0.2 mm across, but not larger than 2 mm.

**N1a**: Cancer has spread to 1 to 3 lymph nodes under the arm with at least one area of cancer spread greater than 2 mm across.

**N1b**: Cancer has spread to internal mammary lymph nodes on the same side as the cancer, but this spread could only be found on sentinel lymph node biopsy (it did not cause the lymph nodes to become enlarged).

**N1c**: Both N1a and N1b apply.

**N2**: Cancer has spread to 4 to 9 lymph nodes under the arm, or cancer has enlarged the internal mammary lymph nodes

**N2a**: Cancer has spread to 4 to 9 lymph nodes under the arm, with at least one area of cancer spread larger than 2 mm.

**N2b**: Cancer has spread to one or more internal mammary lymph nodes, causing them to become enlarged.

**N3**: Any of the following:

**N3a**: either:
Cancer has spread to 10 or more axillary lymph nodes, with at least one area of cancer spread greater than 2 mm,

OR

Cancer has spread to the lymph nodes under the collarbone (infraclavicular nodes), with at least one area of cancer spread greater than 2 mm.

**N3b:** either:

Cancer is found in at least one axillary lymph node (with at least one area of cancer spread greater than 2 mm) and has enlarged the internal mammary lymph nodes,

OR

Cancer has spread to 4 or more axillary lymph nodes (with at least one area of cancer spread greater than 2 mm), and tiny amounts of cancer are found in internal mammary lymph nodes on sentinel lymph node biopsy.

**N3c:** Cancer has spread to the lymph nodes above the collarbone (supraclavicular nodes) with at least one area of cancer spread greater than 2 mm.

**M categories for breast cancer**

M followed by a 0 or 1 indicates whether the cancer has spread to distant organs -- for example, the lungs, liver, or bones.

**MX:** Distant spread (metastasis) cannot be assessed.

**M0:** No distant spread is found on x-rays (or other imaging tests) or by physical exam.

**cM0(i+):** Small numbers of cancer cells are found in blood or bone marrow (found only by special tests), or tiny areas of cancer spread (no larger than 0.2 mm) are found in lymph nodes away from the underarm, collarbone, or internal mammary areas.

**M1:** Cancer has spread to distant organs (most often to the bones, lungs, brain, or liver).

**Examples using the full staging system**

Because there are so many factors that go into stage grouping for breast cancer, it's not...
possible to describe here every combination that might be included in each stage. The many different possible combinations mean that two women who have the same stage of breast cancer might have different factors that make up their stage.

Here are 3 examples of how all of the factors listed above are used to determine the breast cancer stage:

**Example #1**

If the cancer size is between 2 and 5 cm (T2) but it has not spread to the nearby lymph nodes (N0) or to distant organs (M0) AND is:

- Grade 3
- Her2 negative
- ER positive
- PR positive

The cancer stage is IB.

**Example #2**

If the cancer is larger than 5 cm (T3) and has spread to 4 to 9 lymph nodes under the arm or to any internal mammary lymph nodes (N2) but not to distant organs (M0) AND is:

- Grade 2
- Her2 positive
- ER positive
- PR positive

The cancer stage is IB.

**Example #3**

If the cancer is larger than 5 cm (T3) and has spread to 4 to 9 lymph nodes under the arm or to any internal mammary lymph nodes (N2) but not to distant organs (M0) AND is:

- Grade 2
- Her2 negative
• ER negative
• PR negative

The cancer stage is IIIB.

These are only 3 examples out of many possible combinations of factors. To understand what your breast cancer stage is, and what it means, talk to your doctor.

Hyperlinks

2. www.cancer.org/treatment/understanding-your-diagnosis/staging.html

References


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Survival Rates for Breast Cancer

Survival rates can give you an idea of what percentage of people with the same type and stage of cancer are still alive a certain amount of time (usually 5 years) after they were diagnosed. They can’t tell you how long you will live, but they may help give you a better understanding of how likely it is that your treatment will be successful.
Keep in mind that survival rates are estimates and are often based on previous outcomes of large numbers of people who had a specific cancer, but they can’t predict what will happen in any particular person’s case. These statistics can be confusing and may lead you to have more questions. Talk with your doctor about how these numbers may apply to you, as he or she is familiar with your situation.

What is a 5-year relative survival rate?

A relative survival rate compares women with the same type and stage of breast cancer to women in the overall population. For example, if the 5-year relative survival rate for a specific stage of breast cancer is 90%, it means that women who have that cancer are, on average, about 90% as likely as women who don’t have that cancer to live for at least 5 years after being diagnosed.

Where do these numbers come from?

The American Cancer Society relies on information from the SEER* database, maintained by the National Cancer Institute (NCI), to provide survival statistics for different types of cancer.

The SEER database tracks 5-year relative survival rates for breast cancer in the United States, based on how far the cancer has spread. The SEER database, however, does not group cancers by AJCC TNM stages (stage 1, stage 2, stage 3, etc.). Instead, it groups cancers into localized, regional, and distant stages:

- **Localized**: There is no sign that the cancer has spread outside of the breast.
- **Regional**: The cancer has spread outside the breast to nearby structures or lymph nodes.
- **Distant**: The cancer has spread to distant parts of the body such as the lungs, liver or bones.

**5-year relative survival rates for breast cancer**

(Based on women diagnosed with breast cancer between 2008 and 2014.)

<table>
<thead>
<tr>
<th>SEER Stage</th>
<th>5-year Relative Survival Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Localized</td>
<td>99%</td>
</tr>
<tr>
<td>Regional</td>
<td>85%</td>
</tr>
</tbody>
</table>
Understanding the numbers

- **Women now being diagnosed with breast cancer may have a better outlook than these numbers show.** Treatments improve over time, and these numbers are based on women who were diagnosed and treated at least five years earlier.

- **These numbers apply only to the stage of the cancer when it is first diagnosed.** They do not apply later on if the cancer grows, spreads, or comes back after treatment.

- **These numbers don’t take everything into account.** Survival rates are grouped based on how far the cancer has spread, but your age, overall health, how well the cancer responds to treatment, **tumor grade**, the presence of **hormone receptors** on the cancer cells, **Her2 status**, and other factors can also affect your outlook.

*SEER= Surveillance, Epidemiology, and End Results

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**References**


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Breast Cancer

It’s important to be able to have frank, open discussions with your cancer care team. They want to answer all of your questions, so that you can make informed treatment and life decisions.

Here are some questions that you can use to help better understand your cancer and your treatment options. Don’t be afraid to take notes and tell the doctors or nurses when you don’t understand what they’re saying. You might want to bring another person with you when you see your doctor and have them take notes to help you remember what was said.

Not all of these questions will apply to you, but they should help get you started. Be sure to write down some questions of your own. For instance, you might want more information about recovery times or you may want to ask about nearby or online support groups where you can talk with other women going through similar situations. You may also want to ask if you qualify for any clinical trials.

Keep in mind that doctors aren’t the only ones who can give you information. Other health care professionals, such as nurses and social workers, can answer some of your questions. To find out more about speaking with your health care team, see The Doctor-Patient Relationship.

When you’re told you have breast cancer

- Exactly what type of breast cancer do I have?
- How big is the cancer? Where exactly is it?
- Has the cancer spread to my lymph nodes or other organs?
- What’s the stage of the cancer? What does that mean?
- Will I need any other tests before we can decide on treatment?
- Do I need to see any other doctors or health professionals?
- What is the hormone receptor status of my cancer? What does this mean?
- What is the HER2 status of my cancer? What does this mean?
- How do these factors affect my treatment options and long-term outlook (prognosis)?
- What are my chances of survival, based on my cancer as you see it?
- Should I think about genetic testing? What are my testing options? Should I take a home-based genetic test? What would be the reasons for and against testing?
- How do I get a copy of my pathology report?
• If I’m concerned about the costs and 
  insurance coverage for my diagnosis and treatment, who can help me?

When deciding on a treatment plan

• How much experience do you have treating this type of cancer?
• Should I get a second opinion? How do I do that?
• What are my treatment choices?
• What treatment do you recommend and why?
• Should I think about taking part in a clinical trial?
• What would the goal of the treatment be?
• How soon do I need to start treatment?
• How long will treatment last? What will it be like? Where will it be done?
• Should my biopsy tissue be sent for a gene expression test to help decide if chemotherapy might be helpful for me?
• What should I do to get ready for treatment?
• What risks or side effects are there to the treatments you suggest? Are there things I can do to reduce these side effects?
• How will treatment affect my daily activities? Can I still work fulltime?
• Will I lose my hair? If so, what can I do about it?
• Will I go through menopause as a result of the treatment? Will I be able to have children after treatment? Would I be able to breastfeed?
• What are the chances the cancer will come back (recur) after this treatment?
• What would we do if the treatment doesn’t work or if the cancer comes back?
• What if I have transportation problems getting to and from treatment?

If you need surgery

• Is breast-conserving surgery (lumpectomy) an option for me? Why or why not?
• What are the positive and negative sides of breast-conserving surgery versus mastectomy?
• How many surgeries like mine have you done?
• Will you have to take out lymph nodes? If so, would you advise a sentinel lymph node biopsy? Why or why not?
• What side effects might lymph node removal cause?
• How long will I be in the hospital?
• Will I have stitches or staples at the surgery site? Will there be a drain (tube) coming out of the site?
• How do I care for the surgery site? Will I need someone to help me?
• What will my breasts look and feel like after my treatment? Will I have normal feeling in them?
• What will the scar look like?
• Is breast reconstruction surgery, an option if I want it? What would it mean in my case?
• Can I have reconstruction at the same time as the surgery to remove the cancer? What are the reasons for and against having it done right away or waiting until later?
• What types of reconstruction might be options for me?
• Should I speak with a plastic surgeon about reconstruction options?
• Will I need a breast form (prosthesis), and if so, where can I get one?
• Do I need to stop taking any medications or supplements before surgery?
• When should I call your office if I’m having side effects?

**During treatment**

Once treatment begins, you’ll need to know what to expect and what to look for. Not all of these questions may apply to you, but asking the ones that do may be helpful.

• How will we know if the treatment is working?
• Is there anything I can do to help manage side effects?
• What symptoms or side effects should I tell you about right away?
• How can I reach you on nights, holidays, or weekends?
• Will I need to change what I eat during treatment?
• Are there any limits on what I can do?
• Can I exercise during treatment? If so, what kind of exercise should I do, and how often?
• Can you suggest a mental health professional I can see if I start to feel overwhelmed, depressed, or distressed?
• Will I need special tests, such as imaging scans or blood tests? How often?
After treatment

- Will I need a special diet after treatment?
- Are there any limits on what I can do?
- Am I at risk for lymphedema?
- What can I do to reduce my risk for lymphedema?
- What should I do if I notice swelling in my arm?
- What other symptoms should I watch for?
- What kind of exercise should I do now?
- What type of follow-up will I need after treatment?
- How often will I need to have follow-up exams, blood tests, or imaging tests?
- How will we know if the cancer has come back? What should I watch for?
- What will my options be if the cancer comes back?

Hyperlinks


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