



Treating Breast Cancer

Local treatments

Some treatments are *local*, meaning they treat the tumor without affecting the rest of the body.

Most women with breast cancer 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.

- [Surgery for Breast Cancer](#)
- [Radiation for Breast Cancer](#)

Systemic treatments

Drugs used to treat breast cancer are considered *systemic therapies* because they can reach cancer cells almost anywhere in the body. They can be given by mouth or put directly into the bloodstream. Depending on the type of breast cancer, different types of drug treatment might be used, including:

- [Chemotherapy for Breast Cancer](#)
- [Hormone Therapy for Breast Cancer](#)
- [Targeted therapy for Breast Cancer](#)
- [Immunotherapy for Breast Cancer](#)

Common treatment approaches

Typically, treatment plans are based on the type of breast cancer, its stage, and any special situations. Your treatment plan will depend on other factors as well, including

your overall health and personal preferences.

- [Treatment of Breast Cancer by Stage](#)
- [Treatment of Inflammatory Breast Cancer](#)
- [Treating Breast Cancer During Pregnancy](#)

Who treats breast cancer?

Based on your treatment options, you might have different types of doctors on your treatment team. These doctors could include:

- A **breast surgeon** or **surgical oncologist**: a doctor who uses surgery to treat breast cancer
- A **radiation oncologist**: a doctor who uses radiation to treat cancer
- A **medical oncologist**: a doctor who uses chemotherapy and other medicines to treat cancer
- A **plastic surgeon**: a doctor who specializes in reconstructing or repairing parts of the body

You might have many other specialists on your treatment team as well, including physician assistants (PAs), nurse practitioners (NPs), nurses, psychologists, nutritionists, social workers, and other health professionals.

- [Health Professionals Associated With Cancer Care](#)¹

Making treatment decisions

It's important to discuss all of your treatment options, including their goals and possible side effects, with your doctors to help make the decision that best fits your needs. It's also very important to ask questions if there's anything you're not sure about.

If time permits, it is often a good idea to seek a second opinion. A second opinion can give you more information and help you feel more confident about the treatment plan you choose.

- [Questions to Ask Your Doctor About Breast Cancer](#)²
- [Breast Reconstruction Surgery](#)³
- [Seeking a Second Opinion](#)⁴

Thinking about taking part in a clinical trial

Clinical trials are carefully controlled research studies that are done to get a closer look at promising new treatments or procedures. Clinical trials are one way to get state-of-the-art cancer treatment. In some cases they may be the only way to get access to newer treatments. They are also the best way for doctors to learn better methods to treat cancer. Still, they're not right for everyone.

If you would like to learn more about clinical trials that might be right for you, start by asking your doctor if your clinic or hospital conducts clinical trials.

- [Clinical Trials⁵](#)

Considering complementary and alternative methods

You may hear about alternative or complementary methods that your doctor hasn't mentioned to treat your cancer or relieve symptoms. These methods can include vitamins, herbs, and special diets, or other methods such as acupuncture or massage, to name a few.

Complementary methods refer to treatments that are used along with your regular medical care. Alternative treatments are used instead of a doctor's medical treatment. Although some of these methods might be helpful in relieving symptoms or helping you feel better, many have not been proven to work. Some might even be harmful.

Be sure to talk to your cancer care team about any method you are thinking about using. They can help you learn what is known (or not known) about the method, which can help you make an informed decision.

- [Complementary and Alternative Medicine⁶](#)

Help getting through cancer treatment

People with cancer need support and information, no matter what stage of illness they may be in. Knowing all of your options and finding the resources you need will help you make informed decisions about your care.

Whether you are thinking about treatment, getting treatment, or not being treated at all, you can still get supportive care to help with pain or other symptoms. Communicating with your cancer care team is important so you understand your diagnosis, what treatment is recommended, and ways to maintain or improve your quality of life.

Different types of programs and support services may be helpful, and can be an important part of your care. These might include nursing or social work services, financial aid, nutritional advice, rehab, or spiritual help.

The American Cancer Society also has programs and services – including rides to treatment, lodging, and more – to help you get through treatment. Call our National Cancer Information Center at 1-800-227-2345 and speak with one of our trained specialists.

- [Palliative Care](#)⁷
- [Find Support Programs and Services in Your Area](#)⁸

Choosing to stop treatment or choosing no treatment at all

For some people, when treatments have been tried and are no longer controlling the cancer, it could be time to weigh the benefits and risks of continuing to try new treatments. Whether or not you continue treatment, there are still things you can do to help maintain or improve your quality of life.

Some people, especially if the cancer is advanced, might not want to be treated at all. There are many reasons you might decide not to get cancer treatment, but it's important to talk to your doctors and you make that decision. Remember that even if you choose not to treat the cancer, you can still get supportive care to help with pain or other symptoms.

- [If Cancer Treatments Stop Working](#)⁹

The treatment information given here is not official policy of the American Cancer Society and is not intended as medical advice to replace the expertise and judgment of your cancer care team. It is intended to help you and your family make informed decisions, together with your doctor. Your doctor may have reasons for suggesting a treatment plan different from these general treatment options. Don't hesitate to ask him or her questions about your treatment options.

Surgery for Breast Cancer

Most women with breast cancer have some type of surgery as part of their treatment. There are different types of breast surgery, and it may be done for different reasons, depending on the situation. For example, surgery may be done to:

- Remove as much of the cancer as possible (breast-conserving surgery or mastectomy)
- Find out whether the cancer has spread to the lymph nodes under the arm (sentinel lymph node biopsy or axillary lymph node dissection)
- Restore the breast's shape after the cancer is removed (breast reconstruction)
- Relieve symptoms of advanced cancer

Your doctor may recommend a certain operation based on your breast cancer features and your medical history, or you may have a choice about which type to have. It's important to know your options so you can talk about them with your doctor and make the choice that is right for you.

Surgery to remove breast cancer

There are two main types of surgery to remove breast cancer:

- **Breast-conserving surgery** (also called a *lumpectomy*, *quadrantectomy*, *partial mastectomy*, or *segmental mastectomy*) – A surgery in which only the part of the breast containing the cancer is removed. The goal is to remove the cancer as well as some surrounding normal tissue. How much of the breast is removed depends on the size and location of the tumor and other factors.
- **Mastectomy** – A surgery in which the entire breast is removed, including all of the breast tissue and sometimes other nearby tissues. There are several different types of mastectomies. Some women may also get a double mastectomy, in which both breasts are removed.

Choosing between breast-conserving surgery and mastectomy

Many women with early-stage cancers can choose between breast-conserving surgery (BCS) and mastectomy. The main advantage of BCS is that a woman keeps most of her breast. But in most cases she will also need radiation. Women who have mastectomy for early stage cancers are less likely to need radiation.

For some women, mastectomy may be a better option, because of the type of breast

cancer, the large size of the tumor, previous treatment history, or certain other factors.

Some women might be worried that having a less extensive surgery might raise their risk of the cancer coming back. But the fact is, in most cases, mastectomy does not give you any better chance of long-term survival or a better outcome from treatment. Studies following thousands of women for more than 20 years show that when BCS can be done along with radiation, having a mastectomy instead does not provide any better chance of survival.

Surgery to remove nearby lymph nodes

To find out if the breast cancer has spread to axillary (underarm) lymph nodes, one or more of these lymph nodes will be removed and looked at under the microscope. This is an important part of figuring out the stage (extent) of the cancer. Lymph nodes may be removed either as part of the surgery to remove the breast cancer or as a separate operation.

The two main types of surgery to remove lymph nodes are:

- **Sentinel lymph node biopsy (SLNB)** – A procedure in which the surgeon removes only the lymph node(s) under the arm to which the cancer would likely spread first. Removing only one or a few lymph nodes lowers the risk of side effects from the surgery.
- **Axillary lymph node dissection (ALND)** – A procedure in which the surgeon removes many (usually less than 20) lymph nodes from under the arm. ALND is not done as often as it was in the past, but it might still be the best way to look at the lymph nodes in some situations.

To learn more about these procedures and when they might be done, see [Lymph Node Surgery for Breast Cancer](#).

Breast reconstruction after surgery

Any women undergoing surgery for breast cancer may have the option of breast reconstruction. In the case of a mastectomy, a woman might want to consider having the breast mound rebuilt to restore the breast's appearance after surgery. In some breast-conserving surgeries, a woman may consider having fat grafting in the affected breast to correct any dimples left from the surgery. The options will depend on each women's specific situation.

There are several types of reconstructive surgery, although your options may depend on your medical situation and personal preferences. You may have a choice between having breast reconstruction at the same time as the breast cancer surgery (immediate reconstruction) or at a later time (delayed reconstruction).

If you are thinking about having reconstructive surgery, it's a good idea to discuss it with your breast surgeon and a plastic surgeon **before** your mastectomy or BCS. This gives the surgical team time to plan out the treatment options that might be best for you, even if you wait and have the reconstructive surgery later.

To learn about different breast reconstruction options, see our section on [breast reconstruction](#)¹.

Surgery for advanced breast cancer

Although surgery is very unlikely to cure breast cancer that has spread to other parts of the body, it can still be helpful in some situations, either as a way to slow the spread of the cancer, or to help prevent or relieve symptoms from it. For example, surgery might be used:

- When the breast tumor is causing an open wound in the breast (or chest)
- To treat a small number of areas of cancer spread (metastases) in a certain part of the body, such as the brain
- When an area of cancer spread is pressing on the spinal cord
- To treat a blockage in the liver
- To provide relief of pain or other symptoms

If your doctor recommends surgery for advanced breast cancer, it's important that you understand its goal—whether it's to try to cure the cancer or to prevent or treat symptoms.

Wire localization to guide surgery

Sometimes, if the cancer in your breast can't be felt, is hard to find, and/or is difficult to get to, a mammogram or ultrasound may be used to place a wire in the cancerous area to guide the surgeon to the right spot. This is called **wire localization or needle localization**. If a mammogram is used you may hear the term **stereotactic wire localization**. Rarely, a MRI might be used if the mammogram or ultrasound are not successful.

After your breast is numbed, a mammogram or ultrasound is used to guide a thin hollow needle to the abnormal area. Once the tip of the needle is in the right spot, a thin wire is put in through the center of the needle. A small hook at the end of the wire keeps it in place. The needle is then taken out. The surgeon uses the wire as a guide to the part of the breast to be removed.

The surgery done as part of the wire localization may be enough to count as breast conserving surgery if the margins are negative. If cancer cells are found at the edge of the removed tissue (also called a positive margin), more surgery may be required.

It should be noted that a wire-localization procedure is sometimes used to perform a surgical biopsy of a suspicious area in the breast to determine if it is cancer or not.

Hyperlinks

1. www.cancer.org/cancer/breast-cancer/reconstruction-surgery.html

References

Cheville AL. Chapter 39: Preserving and Restoring Function after Local Treatment. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Chung AP and Giuliano AE. Chapter 37: Sentinel Lymph Node Biopsy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Cody III HS and Plitas G. Chapter 38: Axillary Dissection. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

McLaughlin. Chapter 40: Lymphedema. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

Morrow M and Golshan M. Chapter 33: Mastectomy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Morrow M and Harris JR. Chapter 35: Breast-Conserving Therapy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on June 28, 2017.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: June 1, 2016 Last Revised: August 18, 2016

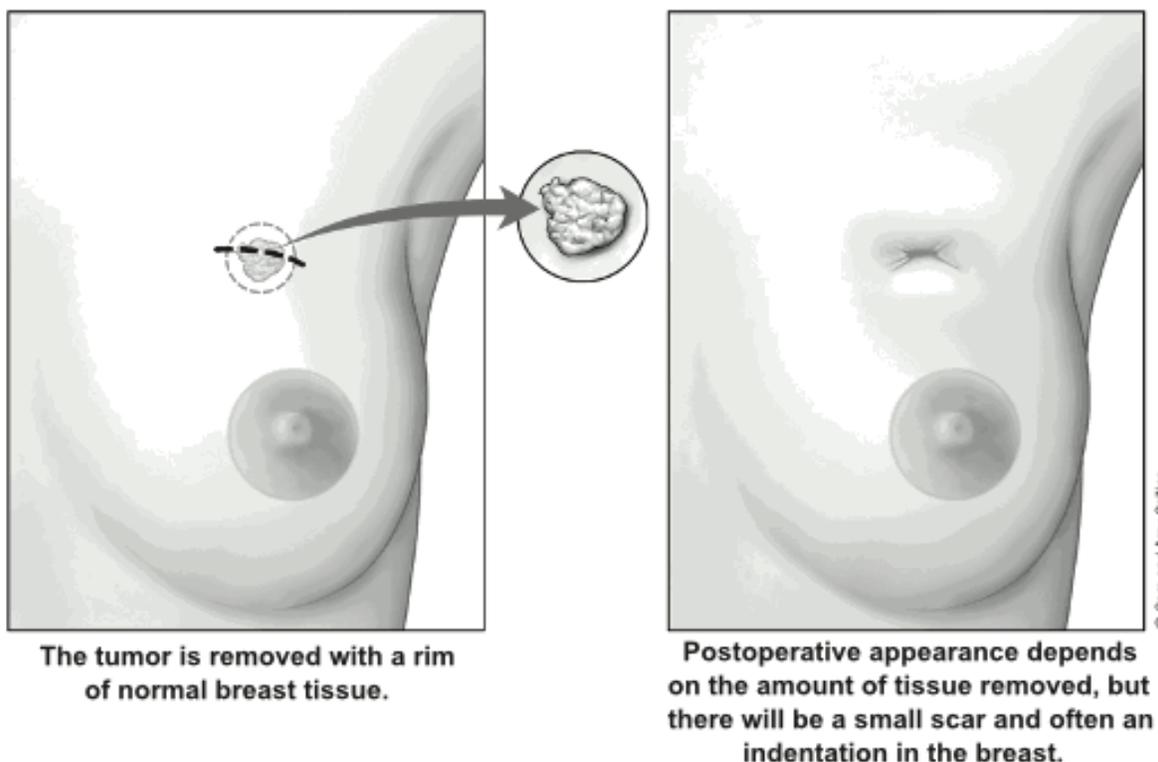
Breast-conserving Surgery (Lumpectomy)

Breast-conserving surgery (BCS) is an operation to remove the cancer while leaving as much normal breast as possible. Some surrounding healthy tissue and lymph nodes are usually also removed. How much of the breast is removed depends on the size and location of the tumor and other factors. Breast-conserving surgery is sometimes called *lumpectomy*, *quadrantectomy*, *partial mastectomy*, or *segmental mastectomy*. It's often an option for a woman with early-stage cancer, and allows her to keep most of her breast.

- Breast-conserving surgery allows a woman to keep most of her breast, but makes it likely she will also need radiation.
- Not all women with breast cancer are candidates for BCS. Talk to your doctor to find out whether BCS is an option for you.
- Studies show that choosing BCS (plus radiation) over mastectomy does not affect a woman's chances of long-term survival.
- If you think you may want breast reconstruction, talk to your doctor before your

breast cancer surgery.

- After BCS, most women will have radiation therapy. Some women might get other treatments as well, such as hormone therapy or chemotherapy.
- Side effects of BCS may include pain, a scar and/or dimple where the tumor was removed, a firm or hard surgical scar, and sometimes lymphedema, a type of swelling, in the arm.



Lumpectomy/partial mastectomy

Who can get breast-conserving surgery?

Breast-conserving surgery (BCS) is a good option for many women with early-stage cancers. The main advantage is that a woman keeps most of her breast. However, she will in most cases also need radiation therapy, given by a radiation oncologist (a doctor who specializes in radiation). Women who have their entire breast removed (mastectomy) for early stage cancers are less likely to need radiation, but they may be referred to a *radiation oncologist* for evaluation because each patient's cancer is unique.

BCS might be a good option if you:

- Are very concerned about losing your breast
- Are willing to have radiation therapy and able to get to the appointments
- Have not already had your breast treated with radiation therapy or BCS
- Have only one area of cancer on the breast, or multiple areas that are close enough to be removed together without changing the look of your breast too much
- Have a small tumor (5 cm [2 inches] or smaller), which is also small relative to your breast size
- Are not pregnant or, if pregnant, will not need radiation therapy immediately (to avoid risking harm to the fetus)
- Do not have a genetic factor such as a *BRCA* mutation, which might increase your chance of a second cancer
- Do not have certain serious connective tissue diseases such as scleroderma or lupus, which may make you especially sensitive to the side effects of radiation therapy
- Do not have inflammatory breast cancer

Recovering from breast-conserving surgery: What to expect after surgery

This type of surgery is typically done in an outpatient surgery center, and an overnight stay in the hospital is usually not needed. Most women should be fairly functional after going home and can often return to their regular activities within 2 weeks. Some women may need help at home depending on how extensive their surgery was.

Ask a member of your health care team how to care for your surgery site and affected arm. Usually, you and your caregivers will get written instructions about care after surgery. These instructions should cover:

- How to care for the surgery site and dressing
- How to care for your drain, if you have one (This is a plastic or rubber tube coming out of the surgery site that removes the fluid that collects during healing.)
- How to recognize signs of infection
- Bathing and showering after surgery
- When to call the doctor or nurse
- When to start using your arm again and how to do arm exercises to prevent stiffness
- When you can start wearing a bra again

- What to eat and not to eat
- Use of medicines, including pain medicines and possibly antibiotics
- Any restrictions on activity
- What to expect regarding sensations or numbness in the breast and arm
- What to expect regarding feelings about body image
- When to see your doctor for a follow-up appointment
- Referral to a Reach To Recovery volunteer. Through our [Reach To Recovery program](#)¹, a specially trained volunteer who has had breast cancer can provide information, comfort, and support.

Side effects of breast-conserving surgery

Side effects of breast-conserving surgery can include:

- Pain or tenderness or a "tugging" sensation in the breast
- Temporary swelling
- Hard scar tissue that forms in the surgical site
- Change in the shape of the breast
- Nerve (neuropathic) pain (sometimes described as burning or shooting pain) in the chest wall, armpit, and/or arm that doesn't go away over time. This can also happen in mastectomy patients and is called [post-mastectomy pain syndrome](#)² or PMPS.

As with all operations, bleeding and infection at the surgery site are also possible. If [axillary lymph nodes are also removed](#), other side effects such as [lymphedema](#)³ may occur.

How can the doctors be sure all of the cancer was removed?

During the surgery, the surgeon will try to remove all of the cancer, plus some surrounding normal tissue.

After surgery is complete, a doctor, called a pathologist, will use a microscope to look at the tissue that was removed. If the pathologist finds no cancer cells at any of the edges of the removed tissue, it is said to have *negative* or *clear margins*. Sometimes breast cancer cells spread past what the imaging studies are able to show. So if microscopic (smaller than the human eye can see) cancer cells are found at the edges of the tissue, it is said to have *positive margins*.

The presence of positive margins means that some cancer cells may still be in the breast after surgery, so the surgeon may need to go back and remove more tissue. This operation is called a *re-excision*. If cancer cells are still found at the edges of the removed tissue after the second surgery, a mastectomy may be needed.

Will I need breast reconstruction surgery after breast-conserving surgery?

Before your surgery, talk to your breast surgeon about how breast-conserving surgery might change the look of your breast. The larger the portion of breast removed, the more likely it is that you will see a change in the shape of the breast afterward. If your breasts look very different after surgery, it may be possible to have some type of [reconstructive surgery](#)⁴ or to have the size of the unaffected breast reduced to make the breasts more symmetrical (even). It may even be possible to have this done during the initial surgery. It's very important to talk with your doctor (and possibly a plastic surgeon) **before** the cancer surgery to get an idea of how your breasts are likely to look afterward, and to learn what your options might be.

Will more treatment be needed after breast-conserving surgery?

Most women will need [radiation therapy](#) to the breast after breast-conserving surgery. Sometimes, to make it easier to aim the radiation, small metallic clips (which will show up on x-rays) may be placed inside the breast during surgery to mark the area.

Many women receive [hormone therapy](#) after surgery to help lower the risk of the cancer coming back. Some women might also need [chemotherapy](#) after surgery. If so, radiation therapy is usually delayed until the chemotherapy is completed.

Hyperlinks

1. www.cancer.org/treatment/support-programs-and-services/reach-to-recovery.html
2. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/pain/post-mastectomy-pain-syndrome.html
3. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/lymphedema.html
4. www.cancer.org/cancer/breast-cancer/reconstruction-surgery.html

References

Cheville AL. Chapter 39: Preserving and Restoring Function after Local Treatment. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Chung AP and Giuliano AE. Chapter 37: Sentinel Lymph Node Biopsy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Cody III HS and Plitas G. Chapter 38: Axillary Dissection. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

McLaughlin. Chapter 40: Lymphedema. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

Morrow M and Golshan M. Chapter 33: Mastectomy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Morrow M and Harris JR. Chapter 35: Breast-Conserving Therapy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on June 28, 2017.

OJ Vilholm, S Cold, L Rasmussen and SH Sindrup. The postmastectomy pain syndrome: an epidemiological study on the prevalence of chronic pain after surgery for breast cancer. *British Journal of Cancer* (2008) 99, 604 – 610.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: September 13, 2017 Last Revised: September 13, 2017

Mastectomy

Mastectomy is a way of treating breast cancer by removing the entire breast through surgery. It's often done when a woman cannot be treated with [breast-conserving surgery \(lumpectomy\)](#), which spares most of the breast. It can also be done if a woman chooses mastectomy over breast-conserving surgery for personal reasons. Women at very high risk of getting a second cancer sometimes have a double mastectomy, the removal of both breasts.

Types of mastectomies

There are several different types of mastectomies, based on how the surgery is done and how much tissue is removed.

Simple (or total) mastectomy

In this procedure, the surgeon removes the entire breast, including the nipple, areola, and skin. Some underarm lymph nodes may or may not be removed depending on the situation. Most women, if they are hospitalized, can go home the next day.

Skin-sparing mastectomy

In this procedure, most of the skin over the breast is left intact. Only the breast tissue, nipple and areola are removed. The amount of breast tissue removed is the same as with a simple mastectomy. Implants or tissue from other parts of the body are used at the time of surgery to reconstruct the breast.

Many women prefer skin-sparing mastectomy because it offers the advantage of less scar tissue and a reconstructed breast that seems more natural. But it may not be suitable for larger tumors or those that are close to the surface of the skin.

The risk of local cancer recurrence with this type of mastectomy is the same as with other types of mastectomies.

Nipple-sparing mastectomy

Nipple-sparing mastectomy is a variation of the skin-sparing mastectomy. In this procedure, the breast tissue is removed, but the breast skin and nipple are left in place. This can be followed by breast reconstruction. The surgeon often removes the breast

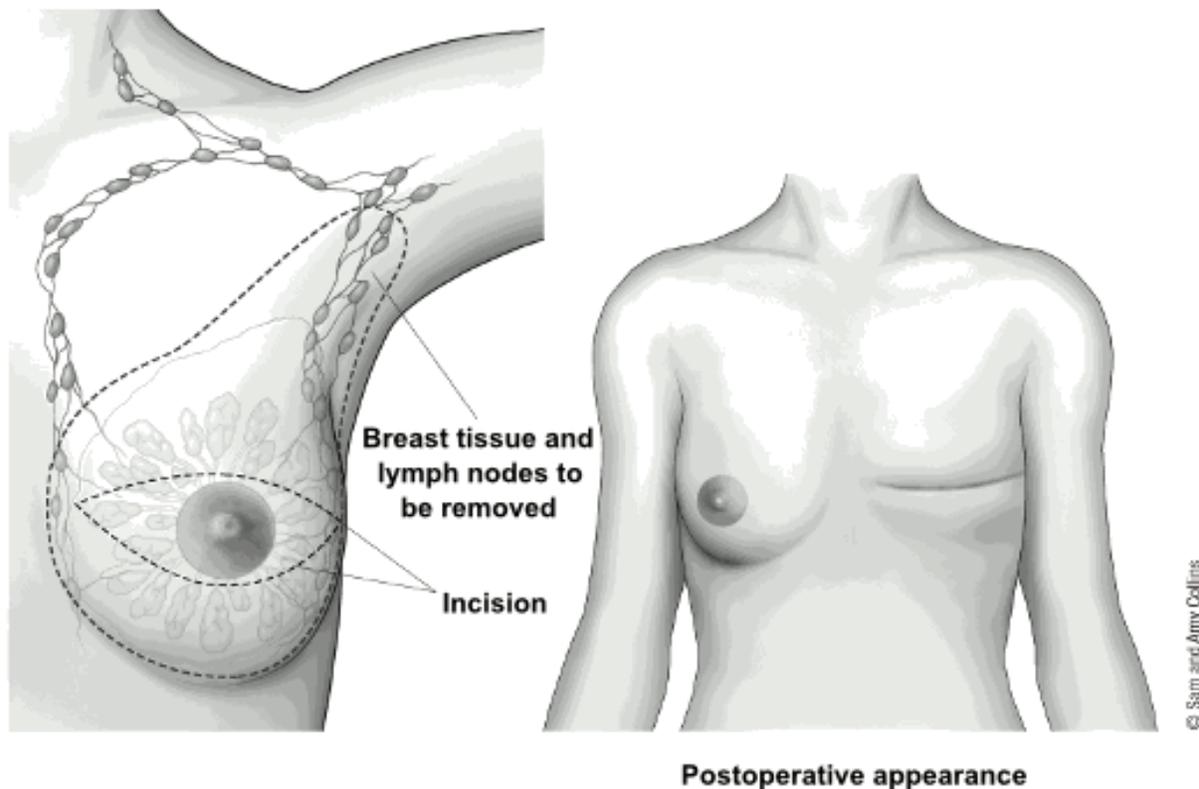
tissue beneath the nipple (and areola) during the procedure to check for cancer cells. If cancer is found in this tissue, the nipple must be removed. Even if no cancer is found under the nipple, some doctors give the nipple tissue a dose of radiation during or after the surgery to try to reduce the risk of the cancer coming back.

It is more often an option for women who have a small, early-stage cancer near the outer part of the breast, with no signs of cancer in the skin or near the nipple. Cancer cells are more likely to be hidden in the nipple if the breast tumor is larger or close to the nipple. This means there is a higher risk the cancer will come back if the nipple is not removed.

There are still some issues with nipple-sparing surgeries. Afterward, the nipple may not have a good blood supply, causing the tissue to shrink or become deformed. Because the nerves are also cut, there often may be little or no feeling left in the nipple. For women with larger breasts, the nipple may look out of place after the breast is reconstructed. As a result, many doctors feel that this surgery is best done in women with small to medium sized breasts. This procedure leaves less visible scars, but if it isn't done properly, it can leave behind more breast tissue than other forms of mastectomy. This could result in a higher risk of cancer developing than for a skin-sparing or simple mastectomy. This was more of a problem in the past, but improvements in technique have helped make this surgery safer. Still, many experts do not yet consider nipple-sparing mastectomy to be a standard treatment for breast cancer.

Modified radical mastectomy

A modified radical mastectomy combines a simple mastectomy with the removal of the lymph nodes under the arm (called an *axillary lymph node dissection*).



Modified radical mastectomy

Radical mastectomy

In this extensive operation, the surgeon removes the entire breast, axillary (underarm) lymph nodes, and the pectoral (chest wall) muscles under the breast. This surgery was once very common, but less extensive surgery (such as the modified radical mastectomy) has been found to be just as effective and with fewer side effects, so this surgery is rarely done now. This operation may still be done for large tumors that are growing into the pectoral muscles.

Double mastectomy

If a mastectomy is done on both breasts, it is called a double (or bilateral) mastectomy. When this is done, it is often a risk-reducing surgery for women at very high risk for getting breast cancer, such as those with a *BRCA* gene mutation. Most of these mastectomies are simple mastectomies, but some may be nipple-sparing.

Who should get a mastectomy?

Many women with early-stage cancers can choose between breast-conserving surgery (BCS) and mastectomy. You may have an initial gut preference for mastectomy as a way to "take it all out as quickly as possible." But the fact is that in most cases, mastectomy does not give you any better chance of long-term survival or a better outcome from treatment. Studies following thousands of women for more than 20 years show that when BCS can be done with radiation, doing a mastectomy instead does not provide any better chance of survival.

Although most women and their doctors prefer BCS (with radiation therapy) when it's a reasonable option, there are cases where mastectomy is likely to be the best choice. For example, mastectomy might be recommended if you:

- Are unable to have radiation therapy
- Would prefer a more extensive surgery instead of having radiation therapy
- Have had the breast treated with radiation therapy in the past
- Have already had BCS along with re-excision(s) that did not completely remove the cancer
- Have two or more areas of cancer in the same breast that are not close enough to be removed together without changing the look of the breast too much
- Have a larger tumor (greater than 5 cm [2 inches] across), or a tumor that is large relative to your breast size
- Are pregnant and would need radiation therapy while still pregnant (risking harm to the fetus)
- Have a genetic factor such as a *BRCA* mutation, which might increase your chance of a second cancer
- Have a serious connective tissue disease such as scleroderma or lupus, which may make you especially sensitive to the side effects of radiation therapy
- Have inflammatory breast cancer

For women who are worried about breast cancer recurrence, it is important to understand that having a mastectomy instead of breast-conserving surgery plus radiation *only* lowers your risk of developing a second breast cancer in the same breast. It does not lower the chance of the cancer coming back in other parts of the body.

Should I have breast reconstruction surgery after mastectomy?

After having a mastectomy a woman might want to consider having the breast mound rebuilt to restore the breast's appearance. This is called [breast reconstruction](#)¹. Although each case is different, most mastectomy patients can have reconstruction.

Reconstruction can be done at the same time as the mastectomy or sometime later.

If you are thinking about having reconstructive surgery, it's a good idea to discuss it with your surgeon and a plastic surgeon **before** your mastectomy. This allows the surgical teams to plan the treatment that's best for you, even if you wait and have the reconstructive surgery later. Insurance companies typically cover breast reconstruction, but you should check with your insurance company so you know what is covered.

Some women [choose not to have reconstructive surgery](#)². Wearing a breast prosthesis (breast form) is an option for women who want to have the contour of a breast under their clothes without having surgery. Some women are also comfortable with just 'going flat,' especially if both breasts were removed.

Recovering from a mastectomy: What to expect after surgery

In general, women having a mastectomy stay in the hospital for 1 or 2 nights and then go home. However, some women may be placed in a 23-hour, short-stay observation unit before going home. How long it takes to recover from surgery depends on what procedures were done, and some women may need help at home. Most women should be fairly functional after going home and can often return to their regular activities within about 4 weeks. Recovery time is longer if breast reconstruction was done as well, and it can take months to return to full activity after some procedures.

Ask your health care team how to care for your surgery site and arm. Usually, you and your caregivers will get written instructions about care after surgery. These instructions should cover:

- How to care for the surgery site and dressing
- How to care for your drain, if you have one (this is a plastic or rubber tube coming out of the surgery site attached to a soft rubber ball that collects the fluid that occurs during healing)
- How to recognize signs of infection
- Bathing and showering after surgery
- When to call the doctor or nurse
- When to start using your arm again and how to do arm exercises to prevent stiffness
- When you can start wearing a bra again
- When to begin using a prosthesis and what type to use
- What to eat and not to eat
- Use of medicines, including pain medicines and possibly antibiotics

- Any restrictions on activity
- What to expect regarding sensations or numbness in the breast and arm
- What to expect regarding feelings about body image
- When to see your doctor for a follow-up appointment
- Referral to a Reach To Recovery volunteer. Through our [Reach To Recovery program](#)³, a specially trained volunteer who has had breast cancer can provide information, comfort, and support.

Side effects of mastectomy

To some extent, the side effects of mastectomy can depend on the type of mastectomy you have (with more extensive surgeries tending to have more side effects). Side effects can include:

- Pain or tenderness
- Swelling at the surgery site
- Buildup of blood in the wound (hematoma)
- Buildup of clear fluid in the wound (seroma)
- Limited arm or shoulder movement
- Numbness in the chest or upper arm
- Nerve (neuropathic) pain (sometimes described as burning or shooting pain) in the chest wall, armpit, and/or arm that doesn't go away over time. It is also called [post-mastectomy pain syndrome or PMPS](#)⁴.

As with all operations, bleeding and infection at the surgery site are also possible. If axillary lymph nodes are also removed, other side effects such as [lymphedema](#)⁵ may occur.

Will more treatment be needed after mastectomy?

Some women might get other treatments after a mastectomy, such as [radiation therapy](#), [hormone therapy](#), [chemotherapy](#), or [targeted therapy](#). Talk to your doctor about what to expect.

Hyperlinks

1. www.cancer.org/cancer/breast-cancer/reconstruction-surgery.html

2. www.cancer.org/cancer/breast-cancer/reconstruction-surgery/breast-reconstruction-alternatives.html
3. www.cancer.org/treatment/support-programs-and-services/reach-to-recovery.html
4. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/pain/post-mastectomy-pain-syndrome.html
5. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/lymphedema.html

References

Cheville AL. Chapter 39: Preserving and Restoring Function after Local Treatment. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Chung AP and Giuliano AE. Chapter 37: Sentinel Lymph Node Biopsy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Cody III HS and Plitas G. Chapter 38: Axillary Dissection. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Gieni M, Avram R, Dickson L, et al. Local breast cancer recurrence after mastectomy and immediate breast reconstruction for invasive cancer: a meta-analysis. *Breast* 2012;21(3):230–236.

McLaughlin. Chapter 40: Lymphedema. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

Morrow M and Golshan M. Chapter 33: Mastectomy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Morrow M and Harris JR. Chapter 35: Breast-Conserving Therapy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on June 28, 2017.

OJ Vilholm, S Cold, L Rasmussen and SH Sindrup. The postmastectomy pain syndrome: an epidemiological study on the prevalence of chronic pain after surgery for breast cancer. *British Journal of Cancer* (2008) 99, 604 – 610.

Petit JY, Veronesi U, Orecchia R, et al. Nipple-sparing mastectomy with nipple areola intraoperative radiotherapy: one thousand and one cases of a five years experience at the European Institute of Oncology in Milan (EIO). *Breast Cancer Res Treat* 2009;117(2):333–338.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: September 13, 2017 Last Revised: September 13, 2017

Lymph Node Surgery for Breast Cancer

If breast cancer spreads, it typically goes first to nearby [lymph nodes](#)¹. Knowing whether the cancer has spread to your lymph nodes helps medical providers find the best way to treat your cancer.

If you have been diagnosed with breast cancer, it's important to find out [how far the cancer has spread](#)². To help find out if the cancer has spread beyond the breast, one or more of the lymph nodes under the arm (axillary lymph nodes) are removed and checked under a microscope. This is an important part of staging. When the lymph nodes contain cancer cells, there is a higher chance that cancer cells have also spread to other parts of the body. Treatment decisions will often depend on whether cancer is found in the lymph nodes.

Lymph node removal can be done in different ways, depending on whether any lymph

nodes are enlarged, how big the breast tumor is, and other factors.

Biopsy of an enlarged lymph node

If any of the lymph nodes under the arm or around the collar bone are swollen, they may be checked for cancer spread directly with a needle [biopsy](#)³ (either a fine needle aspiration [FNA] or a core needle biopsy). Less often, the enlarged node is removed with surgery. If cancer is found in the lymph node, more nodes will need to be removed during an axillary lymph node dissection (described below).

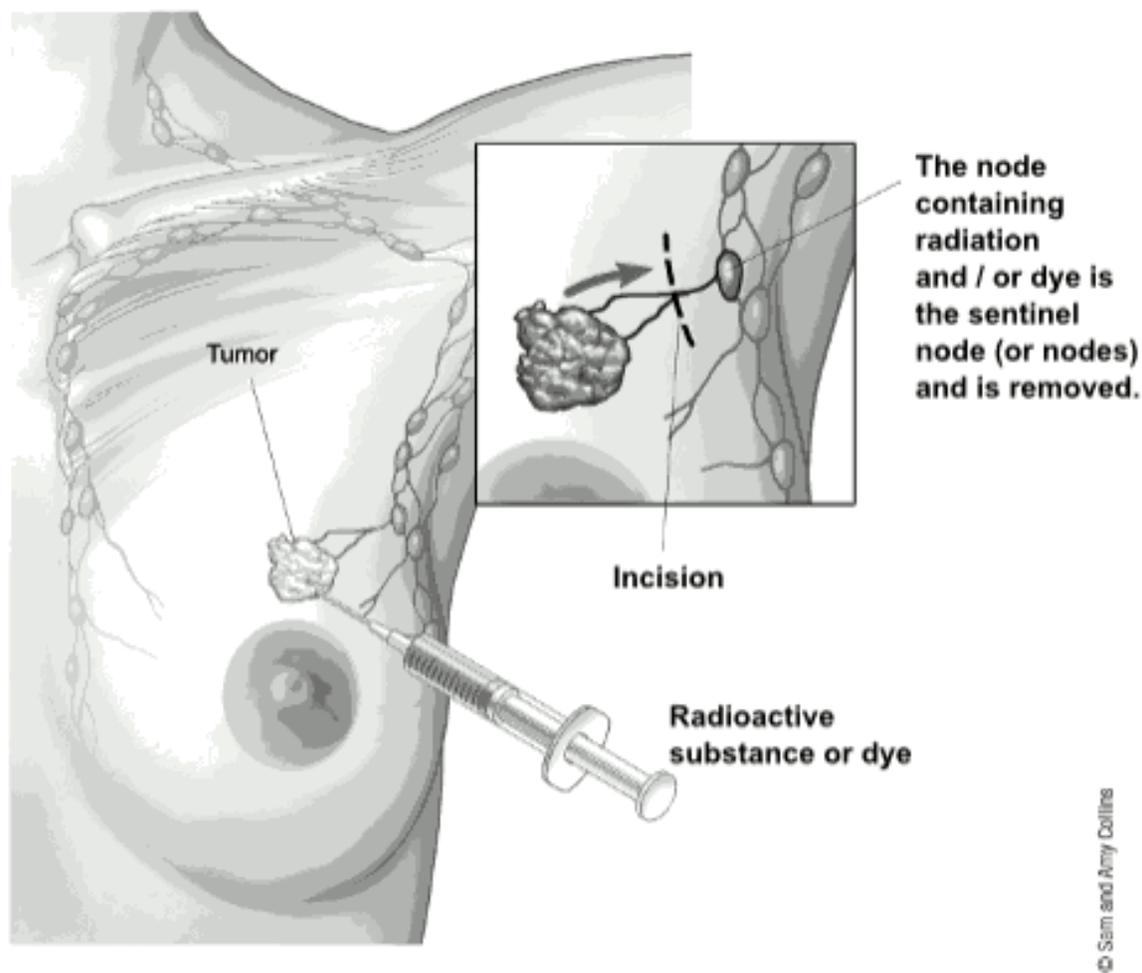
Types of lymph node surgery

Even if the nearby lymph nodes are not enlarged, they will still need to be checked for cancer. This can be done in two different ways. Sentinel lymph node biopsy is the most common and least invasive way, but in some cases a more extensive axillary lymph node dissection might be needed.

Lymph node surgery is often done as part of the main surgery to remove the breast cancer, but in some cases it might be done as a separate operation.

Sentinel lymph node biopsy (SLNB)

In a sentinel lymph node biopsy (SLNB), the surgeon finds and removes the first lymph node(s) to which a tumor is likely to spread (called the sentinel nodes). To do this, the surgeon injects a radioactive substance and/or a blue dye into the tumor, the area around it, or the area around the nipple. Lymphatic vessels will carry these substances along the same path that the cancer would likely take. The first lymph node(s) the dye or radioactive substance travels to will be the sentinel node(s).



Sentinel lymph node biopsy

After the substance has been injected, the sentinel node(s) can be found either by using a special device to detect radioactivity in the nodes, or by looking for nodes that have turned blue. To double check, both methods are often used. The surgeon cuts the skin over the area and removes the node(s) containing the dye or radioactivity.

The few removed lymph nodes are then checked closely for cancer cells by a doctor called a *pathologist*. This is sometimes done during the surgery. This way, if cancer is found in the sentinel lymph node(s), the surgeon may go ahead with a full axillary dissection (ALND) to remove more lymph nodes while you are still on the operating table. If no cancer cells are seen in the node(s) at the time of the surgery, or if the sentinel node(s) are not checked by a pathologist at the time of the surgery, they will be examined more closely over the next several days.

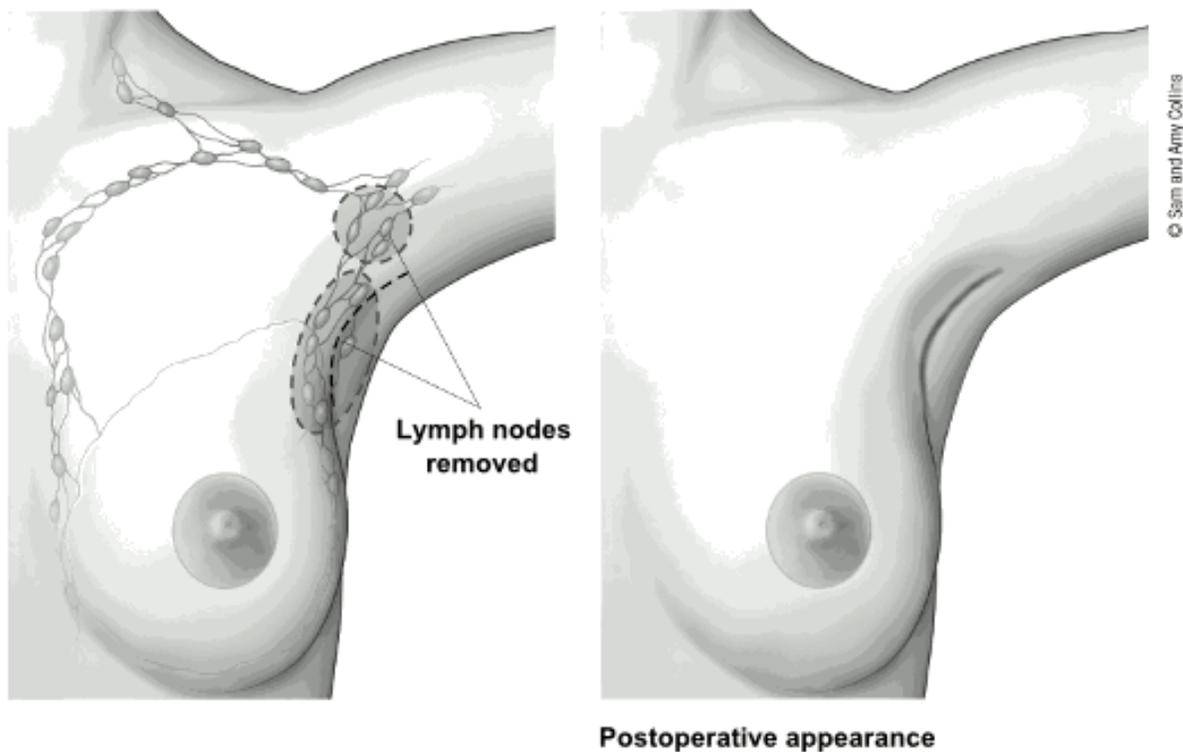
If cancer is found in the sentinel node(s) later, the surgeon may recommend a full ALND at a later time to check more nodes for cancer. Recently, however, studies have shown that in some cases it may be just as safe to leave the rest of the lymph nodes behind. This is based on certain factors, such as the size of the breast tumor, what type of surgery is used to remove the tumor, and what treatment is planned after surgery. Based on the studies that have looked at this, skipping the ALND may be an option for women with tumors 5 cm (2 inches) or smaller who are having breast-conserving surgery followed by radiation. For some women who have had [mastectomy](#) and will also have [radiation](#), skipping the ALND might be an option.

If there is no cancer in the sentinel node(s), it's very unlikely that the cancer has spread to other lymph nodes, so no further lymph node surgery is needed.

Although SLNB has become a common procedure, it requires a great deal of skill. It should be done only by a surgeon who has experience with this technique. If you are thinking about having this type of biopsy, ask your health care team if they do them regularly.

Axillary lymph node dissection (ALND)

In this procedure, anywhere from about 10 to 40 (though usually less than 20) lymph nodes are removed from the area under the arm (axilla) and checked for cancer spread. ALND is usually done at the same time as a mastectomy or [breast-conserving surgery \(BCS\)](#), but it can be done in a second operation. This was once the most common way to check for breast cancer spread to nearby lymph nodes, and it is still sometimes needed. For example, an ALND may be done if a previous biopsy has shown one or more of the underarm lymph nodes have cancer cells.



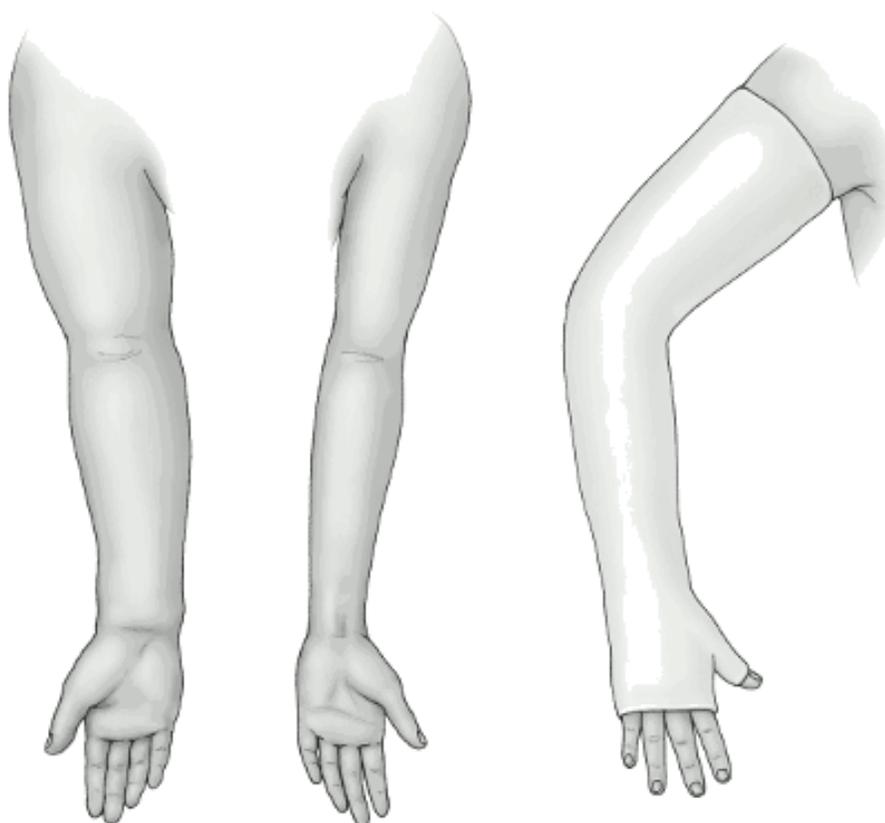
Axillary lymph node dissection

Side effects of lymph node surgery

As with any operation, **pain, swelling, bleeding, blood clots, and infection** are possible.

Lymphedema

A possible long-term effect of lymph node surgery is swelling in the arm or chest called [lymphedema](#)⁴. Because any excess fluid in the arms normally travels back into the bloodstream through the lymphatic system, removing the lymph nodes sometimes blocks drainage from the arm, causing this fluid to build up.



Left, an arm showing lymphedema swelling beside an unaffected arm. Right, a compression garment used to help control lymphedema.

© Sam and Amy Collins

This is less common after a sentinel lymph node biopsy (SLNB) than an axillary lymph node dissection (ALND).

The risk is thought to be in the range of 3-7% in women who have a SLNB and around 30% in women who have a ALND . It may be more common if radiation is given after surgery or in women who are obese. Sometimes the swelling lasts for only a few weeks and then goes away. But in some women, it lasts a long time. If your arm is swollen, tight, or painful after lymph node surgery, be sure to tell someone on your cancer care team right away.

Limited arm and shoulder movement

You might also have **limited movement in your arm and shoulder** after surgery. This is more common after ALND than SLNB. Your doctor may advise exercises to help keep you from having permanent problems (a frozen shoulder).

Some women notice a rope-like structure that begins under the arm and can extend down toward the elbow. This is sometimes called **axillary web syndrome** or **lymphatic cording**. It is more common after ALND than SLNB. Symptoms may not appear for weeks or even months after surgery. It can cause pain and limit movement of the arm and shoulder. This often goes away without treatment, although some women may find physical therapy helpful.

Numbness

Numbness of the skin on the upper, inner arm is a common side effect because the nerve that controls sensation here travels through the lymph node area.

Hyperlinks

1. www.cancer.org/cancer/cancer-basics/lymph-nodes-and-cancer.html
2. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/stages-of-breast-cancer.html
3. www.cancer.org/treatment/understanding-your-diagnosis/tests/testing-biopsy-and-cytology-specimens-for-cancer.html
4. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/lymphedema.html

References

Cheville AL. Chapter 39: Preserving and Restoring Function after Local Treatment. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Chung AP and Giuliano AE. Chapter 37: Sentinel Lymph Node Biopsy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Cody III HS and Plitas G. Chapter 38: Axillary Dissection. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Doscher ME, Schreiber JE, Weichman KE, Garfein ES. Update on Post-mastectomy Lymphedema Management. *Breast J*. 2016 Sep;22(5):553-60.

Giuliano AE, Hunt KK, Ballman KV, et al. Axillary dissection vs no axillary dissection in women with invasive breast cancer and sentinel node metastasis. *JAMA*. 2011;305:569-575.

Lawenda BD, Mondry TE, Johnstone PA. Lymphedema: A primer on the identification and management of a chronic condition in oncologic treatment. *CA Cancer J Clin*. 2009; 59:8–24.

McLaughlin. Chapter 40: Lymphedema. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

Morrow M and Golshan M. Chapter 33: Mastectomy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Morrow M and Harris JR. Chapter 35: Breast-Conserving Therapy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on June 28, 2017.

OJ Vilholm, S Cold, L Rasmussen and SH Sindrup. The postmastectomy pain syndrome: an epidemiological study on the prevalence of chronic pain after surgery for breast cancer. *British Journal of Cancer* (2008) 99, 604 – 610.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014

Last Medical Review: September 13, 2017 Last Revised: September 13, 2017

Exercises After Breast Cancer Surgery

This information was developed with assistance from the Oncology Section of the American Physical Therapy Association.

Many women with breast cancer have some kind of surgery, even though other kinds of treatment are done, too. You may have had a:

- Breast biopsy
- Lymph node biopsy or removal
- Breast conservation surgery (lumpectomy)
- Mastectomy
- Breast reconstruction

Any of these can affect how well you can move your shoulder and arm, take a deep breath, or do your daily activities, like dressing, bathing, and combing your hair. Pain and stiffness can cause weakness and limit movement of your arm and shoulder.

Exercises can help restore movement.

No matter what type of surgery you have, it's important to do exercises afterward to get the arm and shoulder moving again. Exercises help to decrease side effects of your surgery and help you get back to your usual activities.

If you've had radiation therapy after surgery, exercises are even more important to help keep your arm and shoulder flexible. Radiation may affect your arm and shoulder long after treatment is finished. Because of this, it's important to develop a regular habit of doing exercises to maintain arm and shoulder mobility after radiation treatments for breast cancer.

It's very important to talk with your doctor before starting any exercises so that you can decide on a program that's right for you. Your doctor might suggest you see a physical therapist or occupational therapist, or a cancer exercise specialist certified by the American College of Sports Medicine. These health professionals are specially trained to design an exercise program just for you. You might need this kind of help if you do not have full use of your arm within 3 to 4 weeks of surgery.

Some exercises should not be done until drains and sutures (stitches) are removed. But some exercises can be done soon after surgery. The exercises that increase your

shoulder and arm motion can usually be started in a few days. Exercises to help make your arm stronger are added later.

The week after surgery

The tips and exercises listed below should be done for the first 3 to 7 days after surgery. **Do not do them until you get the OK from your doctor.**

- Use your affected arm (on the side where your surgery was) as you normally would when you comb your hair, bathe, get dressed, and eat.
- Lie down and raise your affected arm above the level of your heart for 45 minutes. Do this 2 or 3 times a day. Put your arm on pillows so that your hand is higher than your wrist and your elbow is a little higher than your shoulder. This will help decrease the swelling that may happen after surgery.
- Exercise your affected arm while it's raised above the level of your heart by opening and closing your hand 15 to 25 times. Next, bend and straighten your elbow. Repeat this 3 to 4 times a day. This exercise helps reduce swelling by pumping lymph fluid out of your arm.
- Practice deep breathing exercises (using your diaphragm) at least 6 times a day. Lie down on your back and take a slow, deep breath. Breathe in as much air as you can while trying to expand your chest and abdomen (push your belly button away from your spine). Relax and breathe out. Repeat this 4 or 5 times. This exercise will help maintain normal movement of your chest, making it easier for your lungs to work. Do deep breathing exercises often.
- Do not sleep on your affected arm or lie on that side.

General guidelines for these exercises

The exercises described here can be done as soon as your doctor says it's OK. They're usually started a week or more after surgery. Be sure to talk to your doctor before trying any of them. Here are some things to keep in mind after breast surgery:

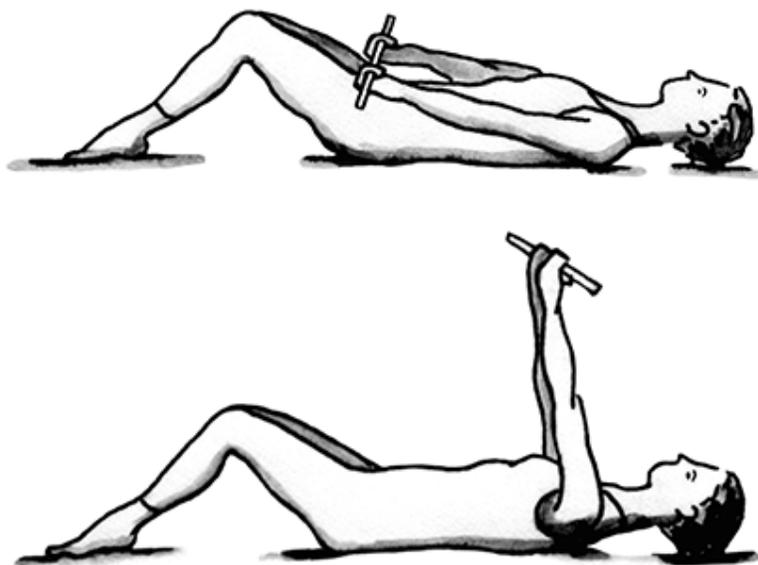
- You will feel some tightness in your chest and armpit after surgery. This is normal, and the tightness will decrease as you do your exercises.
- Many women have burning, tingling, numbness, or soreness on the back of the arm and/or on the chest wall. This is because the surgery can irritate some of your nerves. These feelings might increase a few weeks after surgery. But keep doing your exercises unless you notice unusual swelling or tenderness. (If this happens, let your doctor know about it right away.) Sometimes rubbing or stroking the area

with your hand or a soft cloth can help make the area less sensitive.

- It may be helpful to do the exercises after a warm shower when muscles are warm and relaxed.
- Wear comfortable, loose clothing when doing the exercises.
- Do the exercises slowly until you feel a gentle stretch. Hold each stretch at the end of the motion and slowly count to 5. It's normal to feel some pulling as you stretch the skin and muscles that have been shortened because of the surgery. Do not bounce or make any jerky movements when doing any of the exercises. You should not feel pain as you do them, only gentle stretching.
- Do each exercise 5 to 7 times. Try to do each exercise correctly. If you have trouble with the exercises, talk to your doctor. You may need to be referred to a physical or occupational therapist.
- Do the exercises twice a day until you get back your normal flexibility.
- Be sure to take deep breaths, in and out, as you do each exercise.
- The exercises are set up so that you start them lying down, move to sitting, and finish them standing up.

Here are some of the more common exercises that women do after breast surgery. Talk to your doctor or therapist about which of these are right for you and when you should start doing them. Do not start any of these exercises without talking to your doctor first.

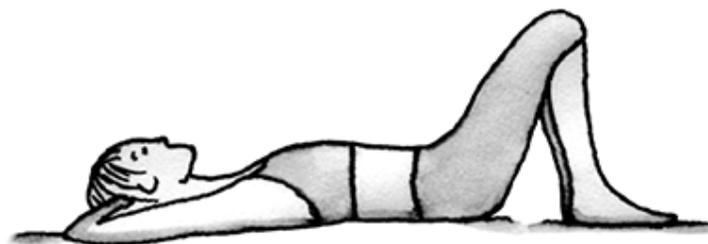
Wand exercise



This exercise helps increase your ability to move your shoulders forward. You will need a broom handle, yardstick, or other stick-like object to use as the wand in this exercise. Do these exercises on a bed or the floor. Lie on your back with your knees bent and your feet flat.

- Hold the wand across your belly in both hands with your palms facing up.
- Lift the wand up over your head as far as you can. Use your unaffected arm to help lift the wand until you feel a stretch in your affected arm.
- Hold for 5 seconds.
- Lower arms and repeat 5 to 7 times.

Elbow winging



This exercise helps increase the movement in the front of your chest and shoulder. It may take many weeks of regular exercise before your elbows will get close to the bed or floor. Do these exercises on a bed or the floor. Lie on your back with your knees bent and your feet flat.

- Clasp your hands behind your neck with your elbows pointing toward the ceiling.
- Move your elbows apart and down toward the bed or floor.
- Repeat 5 to 7 times.

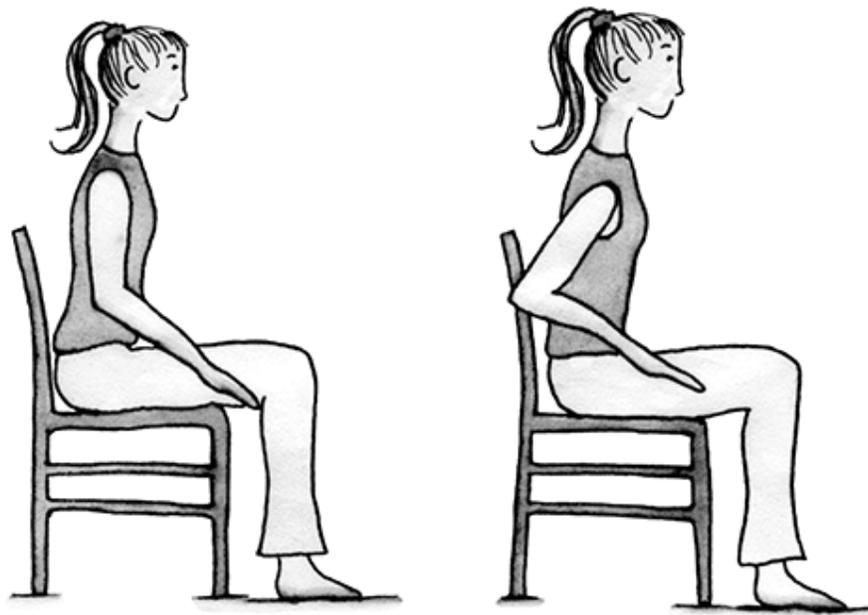
Shoulder blade stretch



This exercise helps increase your shoulder blade movement.

- Sit in a chair very close to a table with your back against the back of the chair.
- Place the unaffected arm on the table with your elbow bent and palm down. Do not move this arm during the exercise.
- Place the affected arm on the table, palm down, with your elbow straight.
- Without moving your trunk, slide the affected arm forward, toward the opposite side of the table. You should feel your shoulder blade move as you do this.
- Relax your arm and repeat 5 to 7 times.

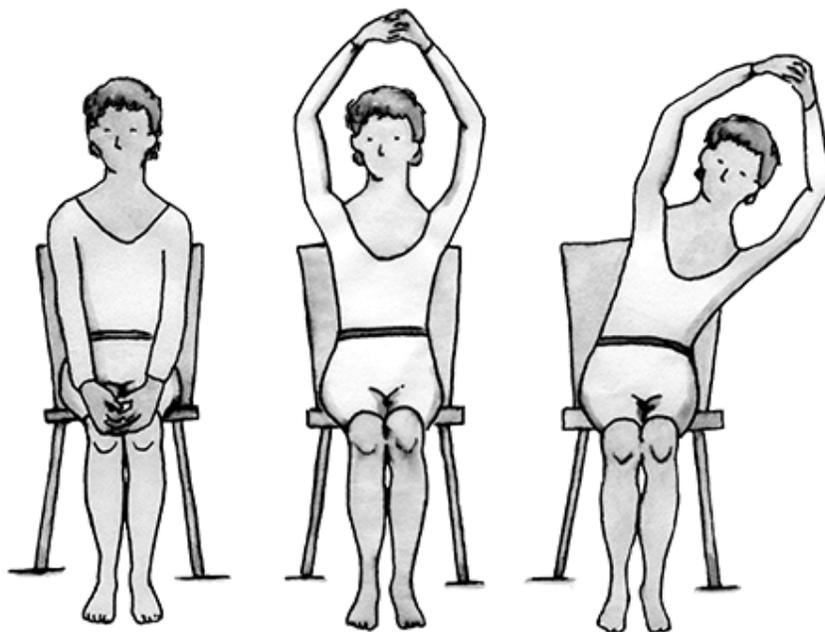
Shoulder blade squeeze



This exercise also helps increase shoulder blade movement.

- Sit in a chair in front of a mirror. Face straight ahead. Do not rest against the back of the chair.
- Your arms should be at your sides with your elbows bent.
- Squeeze your shoulder blades together, bringing your elbows behind you. Keep your shoulders level as you do this. Do not lift your shoulders up toward your ears.
- Return to the starting position and repeat 5 to 7 times.

Side bends



This exercise helps increase movement of your trunk and body.

- Sit in a chair and clasp your hands together in front of you. Lift your arms slowly over your head, straightening your arms.
- When your arms are over your head, bend your trunk to the right keeping your arms overhead.
- Return to the starting position and bend to the left.
- Repeat 5 to 7 times.

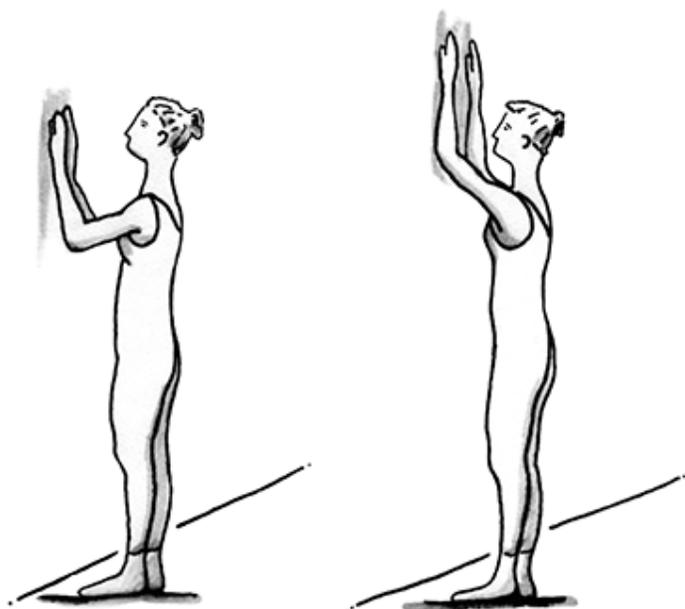
Chest wall stretch



This exercise helps stretch your chest.

- Stand facing a corner with your toes about 8 to 10 inches from the corner.
- Bend your elbows and put your forearms on the wall, one on each side of the corner. Your elbows should be as close to shoulder height as possible.
- Keep your arms and feet in place and move your chest toward the corner. You will feel a stretch across your chest and shoulders.
- Return to the starting position and repeat 5 to 7 times.
- The picture shows stretching both sides at the same time, but you may find it more comfortable to stretch one arm at a time.
- Be sure you keep your shoulders dropped far away from your ears as you do this stretch.

Shoulder stretch



This exercise helps increase your mobility in your shoulder.

- Stand facing the wall with your toes about 8 to 10 inches from the wall.
- Put your hands on the wall. Use your fingers to "climb the wall," reaching as high as you can until you feel a stretch.
- Return to the starting position and repeat 5 to 7 times.
- The picture shows both arms going up at the same time, but you might find it easier to raise one arm at a time.
- Be sure you keep your shoulders dropped far away from your ears as you raise your arms.

Things to keep in mind after breast surgery

Start exercising slowly and increase as you are able. Stop exercising and talk to your doctor right away if you:

- Get weaker, start losing your balance, or start falling
- Have pain that gets worse
- Have new heaviness, aching, tightness, or other strange sensations in your arm
- Have unusual swelling or swelling gets worse
- Have headaches, dizziness, blurred vision, new numbness, or tingling in your arms or chest

It's important to exercise to keep your muscles working as well as possible, but it's also important to be safe. Talk with your doctor about the right kind of exercises for your condition, and then set goals for increasing your level of physical activity.

Other kinds of exercise

Exercise to help improve aerobic (heart-lung) capacity is also important for women who have had breast cancer. There's evidence that fitness and weight loss may even help lower the risk that some types of cancer will come back after treatment. Ask your doctor about fitness exercises during and after breast cancer treatment.

Other exercises are designed to help reduce your risk of [lymphedema](#)¹, or swelling in the arm on the side where you had surgery. The exercises shown here are mainly designed to help regain range of motion (flexibility) of the arm and shoulder. Ask your doctor about your lymphedema risk and if you should use exercises to help reduce that risk.

Strengthening exercises are now recommended as part of regular exercise programs to improve health. These are not started until 4 to 6 weeks after surgery, and must be tailored to your general health, medical condition, and fitness. Strength building starts by using small hand weights, and is increased slowly over time. Again, this is best addressed with your doctor or physical therapist. It's probably best to start a strengthening program in a supervised setting with a cancer exercise trainer or physical therapist to be sure you're doing the exercises properly.

This information was developed with assistance from the Oncology Section of the American Physical Therapy Association.

Hyperlinks

1. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/lymphedema.html

References

Anderson RT, Kimmick GG, McCoy TP, et al. A randomized trial of exercise on well-being and function following breast cancer surgery: the RESTORE trial. *J Cancer Surviv.* 2012;6(2):172-181.

McNeely ML, Campbell K, Ospina M, et al. Exercise interventions for upper-limb dysfunction due to breast cancer treatment. *Cochrane Database Syst Rev.* 2010;(6):CD005211.

NLN Medical Advisory Committee. Position Statement of the National Lymphedema Network: Exercise. October 2013. Accessed at www.lymphnet.org/resources/position-paper-exercise on April 12, 2016.

Petito EL, Nazário AC, Martinelli SE, Facina G, De Gutiérrez MG. Application of a domicile-based exercise program for shoulder rehabilitation after breast cancer surgery. *Rev Lat Am Enfermagem.* 2012;20(1):35-43.

Sagen A, Kaaresen R, Sandvik L, Thune I, Risberg MA. Upper limb physical function and adverse effects after breast cancer surgery: a prospective 2.5-year follow-up study and preoperative measures. *Arch Phys Med Rehabil.* 2014;95(5):875-881.

Last Medical Review: September 13, 2017 Last Revised: September 13, 2017

Radiation for Breast Cancer

Some women with breast cancer will need radiation, often in addition to other treatments. The need for radiation depends on what type of surgery you had, whether your cancer has spread to the lymph nodes or somewhere else in your body, and in some cases, your age. Tumors that are large or involve the skin might also need radiation. You could have just one type of radiation, or a combination of different types.

Radiation therapy is treatment with high-energy rays (such as x-rays) or particles that destroy cancer cells. Two main types of radiation therapy can be used to treat breast cancer:

- **External beam radiation:** This type of radiation comes from a machine outside the body.
- **Internal radiation (brachytherapy):** For this treatment, a radioactive source is put inside the body for a short time.

When might radiation therapy be used?

Not all women with breast cancer need radiation therapy, but it may be used in several situations:

- After [breast-conserving surgery](#) (BCS), to help lower the chance that the cancer will come back in the breast or nearby lymph nodes.
- After a [mastectomy](#), especially if the cancer was larger than 5 cm (about 2 inches), or if cancer is found in the lymph nodes.
- If cancer has spread to other parts of the body, such as the bones or brain.

External beam radiation

This is the most common type of radiation therapy for women with breast cancer. A machine focuses the radiation on the area affected by the cancer.

Which areas need radiation depends on whether you had a mastectomy or breast-conserving surgery (BCS) and whether or not the cancer has reached nearby lymph nodes.

- If you had a mastectomy and no lymph nodes had cancer, radiation is focused on the chest wall, the mastectomy scar, and the places where any drains exited the body after surgery.
- If you had BCS, you will most likely have radiation to the entire breast (called whole breast radiation), and an extra boost of radiation to the area in the breast where the cancer was removed (called the tumor bed) to help prevent it from coming back in that area. The boost is often given after the treatments to the whole breast have ended. It uses the same machine, with lower amounts of radiation, but the beams are aimed at the tumor bed. Most women don't notice different side effects from boost radiation than from whole breast radiation.
- If cancer was found in the lymph nodes under the arm (axillary lymph nodes), this area may be given radiation, as well. In some cases, the area treated might also include the nodes above the collarbone (supraclavicular lymph nodes) and the nodes beneath the breast bone in the center of the chest (internal mammary lymph nodes).

When will I get radiation therapy?

If you will need external radiation therapy after surgery, it is usually not started until your surgery site has healed, which is often a month or longer. If you are getting chemotherapy as well, radiation treatments are usually delayed until chemotherapy is complete.

Preparing for external beam radiation therapy

Before your treatment starts, the radiation team will carefully figure out the correct angles for aiming the radiation beams and the proper dose of radiation. They will make some ink marks or small tattoos on your skin to focus the radiation on the right area. Check with your health care team whether the marks they use will be permanent.

External radiation therapy is much like getting an x-ray, but the radiation is stronger. The procedure itself is painless. Each treatment lasts only a few minutes, but the setup time—getting you into place for treatment—usually takes longer.

Types and schedules of external beam radiation

The traditional schedule for getting whole breast radiation has been 5 days a week (Monday through Friday) for about 5 to 6 weeks. But many doctors are now using **accelerated breast irradiation** in select patients to give larger doses over a shorter time. There are several different types of accelerated breast irradiation:

- **Hypofractionated radiation therapy:** In this approach, radiation is given in larger doses using fewer treatments – typically for only 3 weeks. In women treated with breast-conserving surgery (BCS) and without cancer spread to underarm lymph nodes, this schedule has been shown to be just as good at keeping the cancer from coming back in the same breast as giving the radiation over 5 weeks. It might also lead to fewer short-term side effects.
- **Intraoperative radiation therapy (IORT):** In this approach, a single large dose of radiation is given in the operating room right after BCS (before the breast incision is closed). IORT requires special equipment and is not widely available.
- **3D-conformal radiotherapy:** In this technique, the radiation is given with special machines so that it is better aimed at the area where the tumor was removed (tumor bed). This allows more of the healthy breast to be spared. Treatments are given twice a day for 5 days. Because only part of the breast is treated, this is considered to be a form of accelerated partial breast irradiation. (Other forms of accelerated partial breast irradiation are described under Brachytherapy.)

Since more research is needed to know if all of the newer methods will have the same long-term results as standard radiation, not all doctors use them. Women who are interested in these approaches may want to ask their doctor about taking part in clinical trials of accelerated breast irradiation going on now.

Possible side effects of external radiation

The main short-term side effects of external beam radiation therapy to the breast are:

- Swelling in the breast
- Skin changes in the treated area similar to a sunburn (redness, skin peeling, darkening of the skin)
- Fatigue

Your health care team may advise you to avoid exposing the treated skin to the sun because it could make the skin changes worse. Most skin changes get better within a few months. Changes to the breast tissue usually go away in 6 to 12 months, but it can take longer.

External beam radiation therapy can also cause side effects later on:

- Some women may find that radiation therapy causes the breast to become smaller and firmer.
- Radiation may affect your options for breast reconstruction later on. It can also raise the risk of problems if it's given after reconstruction, especially tissue flap procedures.
- Women who have had breast radiation may have problems breastfeeding later on.
- Radiation to the breast can sometimes damage some of the nerves to the arm. This is called **brachial plexopathy** and can lead to numbness, pain, and weakness in the shoulder, arm, and hand.
- Radiation to the underarm lymph nodes can cause lymphedema, a type of pain and swelling in the arm or chest.
- In rare cases, radiation therapy may weaken the ribs, which could lead to a fracture.
- In the past, parts of the lungs and heart were more likely to get some radiation, which could lead to long-term damage of these organs in some women. Modern radiation therapy equipment allows doctors to better focus the radiation beams, so these problems are rare today.
- A very rare complication of radiation to the breast is the development of another

cancer called an angiosarcoma.

Brachytherapy

Brachytherapy, also known as *internal radiation*, is another way to deliver radiation therapy. Instead of aiming radiation beams from outside the body, a device containing radioactive seeds or pellets is placed into the breast tissue for a short time in the area where the cancer had been removed.

For women who had breast-conserving surgery (BCS), brachytherapy can be used along with external beam radiation as a way to add an extra boost of radiation to the tumor site. It may also be used by itself (instead of radiation to the whole breast) as a form of accelerated partial breast irradiation. Tumor size, location, and other factors may limit who can get brachytherapy.

Types of brachytherapy

There are different types of brachytherapy:

- **Interstitial brachytherapy:** In this approach, several small, hollow tubes called catheters are inserted into the breast around the area where the cancer was removed and are left in place for several days. Radioactive pellets are inserted into the catheters for short periods of time each day and then removed. This method of brachytherapy has been around longer (and has more evidence to support it), but it is not used as much anymore.
- **Intracavitary brachytherapy:** This is the most common type of brachytherapy for women with breast cancer. A device is put into the space left from BCS and is left in place until treatment is complete. There are several different devices available (including MammoSite, SAVI, Axxent, and Contura), most of which require surgical training for proper placement. They all go into the breast as a small catheter (tube). The end of the device inside the breast is then expanded so that it stays securely in place for the entire treatment. The other end of the catheter sticks out of the breast. For each treatment, one or more sources of radiation (often pellets) are placed down through the tube and into the device for a short time and then removed. Treatments are typically given twice a day for 5 days as an outpatient. After the last treatment, the device is collapsed down again and removed.

Early studies of intracavitary brachytherapy as the only radiation after BCS have had

promising results as far as having at least equal cancer control compared with standard whole breast radiation, but may have more complications including poor cosmetic results. Studies of this treatment are being done and more follow-up is needed.

Possible side effects of intracavitary brachytherapy

As with external beam radiation, intracavitary brachytherapy can have side effects, including:

- Redness at the treatment site
- Bruising at the treatment site
- Breast pain
- Infection
- Damage to fatty tissue in the breast
- Weakness and fracture of the ribs in rare cases
- Fluid collecting in the breast (seroma)

References

Ajkay N, Collett AE, Bloomquist EV et al. A comparison of complication rates in early-stage breast cancer patients treated with brachytherapy versus whole-breast irradiation. *Ann Surg Oncol*. 2015 Apr;22(4):1140-5.

Correa C, Harris EE, Leonardi MC et al. Accelerated Partial Breast Irradiation: Executive summary for the update of an ASTRO Evidence-Based Consensus Statement. *Practical Radiation Oncology* (2017) 7, 73-79.

Khan A and Haffty BG. Chapter 42: Postmastectomy Radiation Therapy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

Morrow M and Harris JR. Chapter 35: Breast-Conserving Therapy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed.

Philadelphia: Wolters Kluwer Health; 2014.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on June 28, 2017.

Shaitelman SF, Schlembach PJ, Arzu I, et al. Acute and short-term toxic effects of conventionally fractionated vs hypofractionated whole-breast irradiation: A randomized clinical trial. *JAMA Oncol*. 2015;1:931-941.

Smith GL, Xu Y, Buchholz TA, et al. Association between treatment with brachytherapy vs whole-breast irradiation and subsequent mastectomy, complications, and survival among older women with invasive breast cancer. *JAMA*. 2012;307:1827-1837.

Stmad V, Ott OJ, Hildebrandt G, et al. 5-year results of accelerated partial breast irradiation using sole interstitial multicatheter brachytherapy versus whole-breast irradiation with boost after breast-conserving surgery for low-risk invasive and in-situ carcinoma of the female breast: a randomised, phase 3, non-inferiority trial. *Lancet*. 2016 Jan 16;387(10015):229-38.

Whelan T, MacKenzie R, Julian J, et al. Randomized trial of breast irradiation schedules after lumpectomy for women with lymph node-negative breast cancer. *J Natl Cancer Inst*. 2002;94:1143–1150.

Whelan TJ, Pignol J, Levine MN, et al. Long-Term Results of Hypofractionated Radiation Therapy for Breast Cancer. *N Engl J Med* 2010; 362:513-520.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: July 1, 2017 Last Revised: October 3, 2017

Chemotherapy for Breast Cancer

Chemotherapy (chemo) uses anti-cancer drugs that may be given intravenously (injected into your vein) or by mouth. The drugs travel through the bloodstream to reach cancer cells in most parts of the body. Occasionally, chemo may be given directly into the spinal fluid which surrounds the brain and spinal cord.

When is chemotherapy used?

Not all women with breast cancer will need chemo, but there are several situations in which chemo may be recommended:

- **After surgery (adjuvant chemotherapy):** Adjuvant chemo is used to try to kill any cancer cells that might have been left behind or have spread but can't be seen, even on [imaging tests](#)¹. If these cells were allowed to grow, they could form new tumors in other places in the body. Adjuvant chemo can lower the risk of breast cancer coming back.
- **Before surgery (neoadjuvant chemotherapy):** Neoadjuvant chemo can be used to try to shrink the tumor so it can be removed with less extensive surgery. Because of this, neoadjuvant chemo is often used to treat cancers that are too big to be removed by surgery at the time of diagnosis (called **locally advanced cancers**). Also, by giving chemo before the tumor is removed, doctors can better see how the cancer responds to it. If the first set of chemo drugs doesn't shrink the tumor, your doctor will know that other drugs are needed. It should also kill any cancer cells that have spread but can't be seen. Just like adjuvant chemo, neoadjuvant chemo can lower the risk of breast cancer coming back.
- **For advanced breast cancer:** Chemo can be used as the main treatment for women whose cancer has spread outside the breast and underarm area, either when it is diagnosed or after initial treatments. The length of treatment depends on how well the chemo is working and how well you tolerate it.

Sometimes it is not clear if chemotherapy will be helpful. There are tests available, such as Oncotype DX and MammaPrint, that can help determine which women will most likely benefit from chemo after breast surgery. See [Breast Cancer Gene Expression Tests](#)² for more information.

Which chemotherapy drugs are used for breast cancer?

In most cases (especially as adjuvant or neoadjuvant treatment), chemo is most effective when combinations of drugs are used. Today, doctors use many different

combinations, and it's not clear that any single combination is clearly the best.

The most common drugs used for adjuvant and neoadjuvant chemo include:

- Anthracyclines, such as doxorubicin (Adriamycin) and epirubicin (Ellence)
- Taxanes, such as paclitaxel (Taxol) and docetaxel (Taxotere)
- 5-fluorouracil (5-FU)
- Cyclophosphamide (Cytosan)
- Carboplatin (Paraplatin)

Most often, combinations of 2 or 3 of these drugs are used.

Chemotherapy for advanced breast cancer

Chemo drugs useful in treating women with breast cancer that has spread include:

- Taxanes, such as paclitaxel (Taxol), docetaxel (Taxotere), and albumin-bound paclitaxel (Abraxane)
- Anthracyclines (Doxorubicin, pegylated liposomal doxorubicin, and Epirubicin)
- Platinum agents (cisplatin, carboplatin)
- Vinorelbine (Navelbine)
- Capecitabine (Xeloda)
- Gemcitabine (Gemzar)
- Ixabepilone (Ixempra)
- Eribulin (Halaven)

Although drug combinations are often used to treat early breast cancer, advanced breast cancer more often is treated with single chemo drugs. Still, some combinations, such as paclitaxel plus carboplatin, are commonly used to treat advanced breast cancer.

For cancers that are [HER2-positive](#)³, one or more drugs that target HER2 may be used with chemo. (See [Targeted Therapy for Breast Cancer](#) for more information about these drugs.)

How is chemotherapy given?

Chemo drugs for breast cancer are typically given into a vein (IV), either as an injection

over a few minutes or as an infusion over a longer period of time. This can be done in a doctor's office, chemotherapy clinic, or in a hospital setting.

Often, a slightly larger and sturdier IV is required in the vein system to administer chemo. They are known as [central venous catheters](#)⁴ (CVCs), central venous access devices (CVADs), or central lines. They are used to put medicines, blood products, nutrients, or fluids right into your blood. They can also be used to take out blood for testing.

Many different kinds of CVCs are available. The 2 most common types are the port and the PICC line. For breast cancer patients, the central line is typically placed on the opposite side of the breast that had surgery.

Doctors give chemo in cycles, with each period of treatment followed by a rest period to give you time to recover from the effects of the drugs. Cycles are most often 2 or 3 weeks long. The schedule varies depending on the drugs used. For example, with some drugs, the chemo is given only on the first day of the cycle. With others, it is given for a few days in a row, or once a week. Then, at the end of the cycle, the chemo schedule repeats to start the next cycle.

Adjuvant and neoadjuvant chemo is often given for a total of 3 to 6 months, depending on the drugs used. The length of treatment for advanced breast cancer is based on how well it is working and what side effects you have.

Dose-dense chemotherapy

Doctors have found that giving the cycles of certain chemo drugs closer together can lower the chance that the cancer will come back and improve survival for some women. For example, a drug that would normally be given every 3 weeks might be given every 2 weeks. This can be done for both neoadjuvant and adjuvant treatment. It can lead to more problems with [low blood cell counts](#)⁵, so it's not an option for all women. A chemo combination sometimes given in a dose-dense time frame is doxorubicin (Adriamycin) and cyclophosphamide (Cytoxan), followed by paclitaxel (Taxol).

Possible side effects of chemo for breast cancer

Chemo drugs can cause [side effects](#)⁶. These depend on the type and dose of drugs given, and the length of treatment. Some of the most common possible side effects include:

- Hair loss

- Nail changes
- Mouth sores
- Loss of appetite or [weight changes](#)⁷
- Nausea and vomiting
- Diarrhea

Chemo can also affect the blood-forming cells of the bone marrow, which can lead to:

- Increased chance of infections (from low white blood cell counts)
- Easy bruising or bleeding (from low blood platelet counts)
- Fatigue (from low red blood cell counts and other reasons)

These side effects usually go away after treatment is finished. There are often ways to lessen these side effects. For example, drugs can be given to help prevent or reduce nausea and vomiting.

Other side effects are also possible. Some of these are more common with certain chemo drugs. Ask your cancer care team about the possible side effects of the specific drugs you are getting.

Menstrual changes and fertility issues

For younger women, changes in menstrual periods are a common side effect of chemo. Premature menopause (not having any more menstrual periods) and infertility (not being able to become pregnant) may occur and may be permanent. Some chemo drugs are more likely to cause this than others. The older a woman is when she gets chemotherapy, the more likely it is that she will go through menopause or become infertile as a result. When this happens, there is an increased risk of bone loss and osteoporosis. There are medicines that can treat or help prevent problems with bone loss.

Even if your periods have stopped while you are on chemo, you may still be able to get pregnant. Getting pregnant while on chemo could lead to birth defects and interfere with treatment. If you are pre-menopausal before treatment and are sexually active, it's important to discuss using birth control with your doctor. It is not a good idea for women with [hormone receptor-positive breast cancer](#)⁸ to take hormonal birth control (like birth control pills), so it's important to talk with both your oncologist and your gynecologist (or family doctor) about what options would be best in your case. Women who have finished treatment (like chemo) can safely go on to have children, but it's not safe to get pregnant while on treatment.

If you think you might want to have children after being treated for breast cancer, talk with your doctor before you start treatment. Learn more from our section on [fertility concerns for women with cancer](#)⁹.

If you are pregnant when you get breast cancer, you still can be treated. Certain chemo drugs can be taken safely during the last 2 trimesters of pregnancy. We have more details in our section on [breast cancer during pregnancy](#).

Heart damage

Doxorubicin, epirubicin, and some other chemo drugs rarely can cause permanent heart damage (called cardiomyopathy). The risk is highest if the drug is used for a long time or in high doses.

Most doctors will check your heart function with a test like an echocardiogram (an ultrasound of the heart) or a MUGA scan before starting one of these drugs. They also carefully control the doses, watch for symptoms of heart problems, and may repeat the heart test during treatment. If the heart function begins to worsen, treatment with these drugs will be temporarily or permanently stopped. Still, in some people, signs of damage might not appear until months or years after treatment stops. Damage from these drugs happens more often if other drugs that can cause heart damage (such as those that target HER2) are used also, so doctors are more cautious when these drugs are used together.

Nerve damage (neuropathy)

Many drugs used to treat breast cancer, including the taxanes (docetaxel and paclitaxel), platinum agents (carboplatin, cisplatin), vinorelbine, eribulin, and ixabepilone, can damage nerves outside of the brain and spinal cord. This can sometimes lead to symptoms (mainly in the hands and feet) like numbness, pain, burning or tingling sensations, sensitivity to cold or heat, or weakness. In most cases this goes away once treatment is stopped, but it might last a long time in some women or may become permanent. There are medicines that could help (See [Peripheral Neuropathy Caused By Chemotherapy](#)¹⁰.)

Hand-foot syndrome

Certain chemo drugs, such as capecitabine and liposomal doxorubicin, can irritate the palms of the hands and the soles of the feet. This is called hand-foot syndrome. Early symptoms include numbness, tingling, and redness. If it gets worse, the hands and feet can become swollen and uncomfortable or even painful. The skin may blister, leading to

peeling or even open sores. There is no specific treatment, although some creams or steroids given before chemo may help. These symptoms gradually get better when the drug is stopped or the dose is lowered. The best way to prevent severe hand-foot syndrome is to tell your doctor when symptoms first come up, so that the drug dose can be changed or other medicines can be given.

Chemo brain

Many women who are treated for breast cancer report a slight decrease in mental functioning. They may have some problems with concentration and memory, which may last a long time. Although many women have linked this to chemo, it also has been seen in women who did not get chemo as part of their treatment. Still, most women function well after treatment. In studies that have found chemo brain to be a side effect of treatment, the symptoms most often last for a few years. (See [Chemo Brain](#).¹¹)

Increased risk of leukemia

Very rarely, certain chemo drugs can cause diseases of the bone marrow, such as [myelodysplastic syndromes](#)¹² or even [acute myeloid leukemia](#)¹³, a cancer of white blood cells. When this happens it is usually within 10 years after treatment. For most women, the benefits of chemo in helping prevent breast cancer from coming back or in extending life are far likely to exceed the risk of this rare but serious complication.

Feeling unwell or tired (fatigue)

Many women do not feel as healthy after chemo as they did before. There is often a residual feeling of body pain or achiness and a mild loss of physical functioning. These may be very subtle changes that happen slowly over time.

[Fatigue](#)¹⁴ is another common problem for women who have received chemo. This may last up to several years. It can often be helped, so it's important to let your doctor or nurse know about it. Exercise, naps, and conserving energy may be recommended. If you have sleep problems, they can be treated. Sometimes women become depressed, which may be helped by counseling and/or medicines.

Hyperlinks

1. www.cancer.org/treatment/understanding-your-diagnosis/tests/imaging-radiology-tests-for-cancer.html
2. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-

- [diagnosis/breast-cancer-gene-expression.html](#)
3. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/breast-cancer-her2-status.html
 4. www.cancer.org/treatment/treatments-and-side-effects/central-venous-catheters.html
 5. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/low-blood-counts.html
 6. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects.html
 7. <https://www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/eating-problems/weight-changes.html>
 8. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/breast-cancer-hormone-receptor-status.html
 9. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/fertility-and-sexual-side-effects/fertility-and-women-with-cancer.html
 10. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/peripheral-neuropathy.html
 11. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/changes-in-mood-or-thinking/chemo-brain.html
 12. www.cancer.org/cancer/myelodysplastic-syndrome.html
 13. www.cancer.org/cancer/acute-myeloid-leukemia.html
 14. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/fatigue.html

References

Callahan RD and Ganz PA. Chapter 52: Long-Term and Late Effects of Primary Curative Intent Therapy: Neurocognitive, Cardiac, and Secondary Malignancies. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Dang C and Hudis CA. Chapter 44: Adjuvant Systemic Chemotherapy in Early Breast Cancer. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on July 28, 2017.

Osborne CK. Chapter 53: Adjuvant Systemic Therapy Treatment Guidelines. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: August 1, 2017 Last Revised: October 3, 2017

Hormone Therapy for Breast Cancer

Some types of breast cancer are affected by hormones in the blood. [ER-positive and PR-positive breast cancer](#)¹ cells have receptors (proteins) that attach to estrogen, which helps them grow. There are different ways to stop estrogen from attaching to these receptors.

Hormone therapy is a form of systemic therapy, meaning it reaches cancer cells almost anywhere in the body and not just in the breast. It's recommended for women with hormone receptor-positive (ER-positive and/or PR-positive) breast cancers, and it does not help women whose tumors are hormone receptor-negative (both ER- and PR-negative).

When is hormone therapy used?

Hormone therapy is often used after surgery (as adjuvant therapy) to help reduce the risk of the cancer coming back. Sometimes it is started before surgery (as neoadjuvant therapy) as well. It is usually taken for at least 5 years.

Hormone therapy can also be used to treat cancer that has come back after treatment or that has spread to other parts of the body.

How does hormone therapy work?

About 2 out of 3 breast cancers are hormone receptor-positive. Their cells have receptors (proteins) that attach to the hormones estrogen (ER-positive cancers) and/or progesterone (PR-positive cancers). For these cancers, high estrogen levels help the cancer cells grow and spread.

There are several types of hormone therapy, which use different ways to keep estrogen from helping the cancer grow. Most types of hormone therapy for breast cancer either lower estrogen levels or stop estrogen from acting on breast cancer cells.

Drugs that block estrogen receptors

These drugs work by stopping estrogen from stimulating breast cancer cells to grow.

Tamoxifen

This drug blocks estrogen receptors on breast cancer cells. It stops estrogen from connecting to the cancer cells and telling them to grow and divide. While tamoxifen acts like an anti-estrogen in breast cells, it acts like an estrogen in other tissues, like the uterus and the bones. Because of this, it is called a selective estrogen receptor modulator (SERM).

[Tamoxifen](#)² can be used in several ways:

- For women with hormone receptor-positive breast cancer treated with surgery, tamoxifen can help lower the chances of the cancer coming back and raise the chances of living longer. It can also lower the risk of getting a new cancer in the other breast. Tamoxifen can be started either after surgery (adjuvant therapy) or before surgery (neoadjuvant therapy) and is usually taken for 5 to 10 years. For early-stage breast cancer, this drug is mainly used for women who have not yet gone through menopause. (If you have gone through menopause, aromatase inhibitors are usually used instead.)
- For women who have been treated for ductal carcinoma in situ (DCIS) that is hormone receptor-positive, taking tamoxifen for 5 years lowers the chance of the DCIS coming back. It also lowers the chance of getting an invasive breast cancer.
- For women with hormone-positive breast cancer that has spread to other parts of the body, tamoxifen can often help slow or stop the growth of the cancer, and might even shrink some tumors.
- In women at high risk of breast cancer, tamoxifen can be used to help lower the risk of developing breast cancer.

Toremifene (Fareston) is another SERM that works in a similar way, but it is used less often and is only approved to treat metastatic breast cancer. It is not likely to work if tamoxifen has already been used and has stopped working. These drugs are taken by mouth as a pill. The most common side effects of tamoxifen and toremifene are:

- Hot flashes
- Vaginal dryness or discharge
- Mood swings

Some women with cancer spread to the bones may have a **tumor flare** with pain and swelling in the muscles and bones. This usually decreases quickly, but in some rare cases a woman may also develop a high calcium level in the blood that is hard to control. If this happens, the treatment may need to be stopped for a time.

Rare, but more serious side effects are also possible:

- If a woman has gone through menopause, these drugs can increase her risk of developing **uterine cancer**. Tell your doctor right away about any unusual vaginal bleeding (a common symptom of both of these cancers). Most uterine bleeding is not from cancer, but this symptom always needs prompt attention.
- **Blood clots** are another uncommon, but serious side effect. They usually form in the legs (called **deep vein thrombosis** or DVT), but sometimes a piece of clot may break off and end up blocking an artery in the lungs (**pulmonary embolism** or PE). Call your doctor or nurse right away if you develop pain, redness, or swelling in your lower leg (calf), shortness of breath, or chest pain, because these can be symptoms of a DVT or PE.
- Rarely, tamoxifen has been associated with **strokes** in post-menopausal women, so tell your doctor if you have severe headaches, confusion, or trouble speaking or moving.

Depending on a woman's menopausal status, tamoxifen can have different effects on the bones. In pre-menopausal women, tamoxifen can cause some bone thinning, but in post-menopausal women it is often good to strengthen bone. The benefits of taking these drugs outweigh the risks for almost all women with hormone receptor-positive breast cancer.

Fulvestrant (Faslodex)

Fulvestrant is a drug that blocks and damages estrogen receptors. This drug is not a SERM – it acts like an anti-estrogen throughout the body. It is also known as a selective estrogen receptor degrader (SERD).

Fulvestrant is used to treat metastatic breast cancer, most often after other hormone drugs (like tamoxifen and often an aromatase inhibitor) have stopped working.

It is given by injections into the buttocks. For the first month, the shots are given 2 weeks apart. After that, they are given once a month. Common short-term side effects can include:

- Hot flashes and/or night sweats
- Headache
- Mild nausea
- Bone pain
- Injection site pain

Because fulvestrant blocks estrogen, in theory it could cause weakened bones (osteoporosis) if taken for a long time. Fulvestrant is currently approved only for use in post-menopausal women. It is sometimes used “off-label” in pre-menopausal women, often combined with a luteinizing-hormone releasing hormone (LHRH) agonist to turn off the ovaries (see the section on Ovarian Ablation below).

Treatments that lower estrogen levels

Some hormone treatments work by lowering estrogen levels. Because estrogen encourages hormone receptor-positive breast cancers to grow, lowering the estrogen level can help slow the cancer’s growth or help prevent it from coming back.

Aromatase inhibitors (AIs)

Aromatase inhibitors (AIs) are drugs that stop estrogen production. Before menopause, most estrogen is made by the ovaries. But for women whose ovaries aren’t working, either due to menopause or certain treatments, a small amount of estrogen is still made in the fat tissue by an enzyme (called aromatase). AIs work by blocking aromatase from making estrogen.

These drugs are useful in women who are past menopause, although they can also be used in premenopausal women in combination with ovarian suppression (see below).

There are 3 AIs that seem to work about equally well in treating breast cancer:

- Letrozole (Femara)
- Anastrozole (Arimidex)
- Exemestane (Aromasin)

These drugs are pills taken daily.

Use in adjuvant therapy: After surgery, taking an AI, either alone or after tamoxifen, has been shown to work better than taking just tamoxifen for 5 years to reduce the risk of the cancer coming back .

Schedules that are known to be helpful include:

- Tamoxifen for 2 to 3 years, followed by an AI to complete 5 years of treatment
- An AI for 2 to 3 years followed by Tamoxifen to complete 5 years of treatment
- Tamoxifen for 5 years, followed by an AI for 5 years
- An AI for 5 years
- Tamoxifen for 5 to 10 years (if you are unable to take an AI)

For most post-menopausal women whose cancers are hormone receptor-positive, most doctors recommend taking an AI at some point during adjuvant therapy. Right now, standard treatment is to take these drugs for about 5 years, or to alternate with tamoxifen for a total of at least 5 years, or to take in sequence with tamoxifen for at least 3 years. Studies are now being done to see if taking an AI for more than 5 years would be more helpful. Tamoxifen is an option for some women who cannot take an AI. Taking tamoxifen for 10 years is considered more effective than taking it for 5 years, but you and your doctor will decide the best schedule of treatment for you.

If you have early-stage breast cancer and had not gone through menopause when you were first diagnosed, your doctor might recommend taking tamoxifen first, and then taking an AI later if you go through menopause during treatment. Another option is taking a drug called a luteinizing hormone-releasing hormone (LHRH) analog, which turns off the ovaries, along with an AI. An AI should not be taken alone for breast cancer treatment in pre-menopausal women because it is unsafe and can increase hormone levels.

Use in cancer that comes back or has spread: AIs can also be used to treat more advanced hormone-positive breast cancers, especially in post-menopausal women. They are often continued for as long as they are helpful.

Possible side effects: The AIs tend to have fewer serious side effects than tamoxifen. They don't cause uterine cancers and very rarely cause blood clots. They can, however, cause **muscle pain and joint stiffness and/or pain**. The joint pain may be similar to a feeling of having arthritis in many different joints at one time. Switching to a different AI may improve this side effect, but it has led some women to stop treatment. If this happens, most doctors recommend using tamoxifen to complete 5 to 10 years of hormone treatment.

Because AIs drastically lower the estrogen level in women after menopause, they can also cause **bone thinning**, sometimes leading to osteoporosis and even fractures. If you are taking an AI, your bone density may be tested and you may also be given drugs, such as bisphosphonates or denosumab (Xgeva, Prolia), to strengthen your bones.

Ovarian suppression

For pre-menopausal women, removing or shutting down the ovaries (ovarian suppression), which are the main source of estrogen, effectively makes them post-menopausal. This may allow some other hormone therapies, such as AIs, to be used.

There are several ways to remove or shut down the ovaries to treat metastatic breast cancer, as well as some women with early-stage disease:

- **Oophorectomy:** Surgery to remove the ovaries. This is a form of permanent ovarian ablation.
- **Luteinizing hormone-releasing hormone (LHRH) analogs:** These drugs are used more often than oophorectomy. They stop the signal that the body sends to the ovaries to make estrogen, which causes temporary menopause. Common LHRH drugs include goserelin (Zoladex) and leuprolide (Lupron). They can be used alone or with other hormone drugs (tamoxifen, aromatase inhibitors, fulvestrant) as hormone therapy in pre-menopausal women.
- **Chemotherapy drugs:** Some chemo drugs can damage the ovaries of pre-menopausal women so they no longer make estrogen. Ovarian function returns months or years later in some women, but in others the damage to the ovaries is permanent and leads to menopause. This side effect can sometimes be a helpful (if unintended) consequence of chemotherapy with regard to breast cancer treatment.

All of these methods can cause symptoms of menopause, including hot flashes, night sweats, vaginal dryness, and mood swings.

Less common types of hormone therapy

Some other types of hormone therapy that were used more often in the past, but are rarely given now. These include:

- Megestrol acetate (Megace), a progesterone-like drug
- Androgens (male hormones)
- High doses of estrogen

These might be options if other forms of hormone therapy are no longer working, but they can often cause side effects.

Hyperlinks

1. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/breast-cancer-her2-status.html
2. www.cancer.org/cancer/breast-cancer/risk-and-prevention/tamoxifen-and-raloxifene-for-breast-cancer-prevention.html

References

Davies C, Pan H, Godwin J, et al. Long-term effects of continuing adjuvant tamoxifen to 10 years versus stopping at 5 years after diagnosis of oestrogen receptor-positive breast cancer: ATLAS, a randomised trial. *Lancet*. 2013;381:805-816. Erratum in: *Lancet*. 2013 Mar 9;381(9869):804.

Gray RG, Rea D, Handley K, et al. Long-term effects of continuing adjuvant tamoxifen to 10 years versus stopping at 5 years in 6,953 women with early breast cancer. *J Clin Oncol* (Meeting Abstracts) June 2013 vol. 31 no. 18_suppl 5.

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on July 31, 2017.

Osborne CK. Chapter 53: Adjuvant Systemic Therapy Treatment Guidelines. In: Harris

JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Pritchard KI. Adjuvant endocrine therapy for non-metastatic, hormone receptor-positive breast cancer. https://www.uptodate.com/contents/adjuvant-endocrine-therapy-for-non-metastatic-hormone-receptor-positive-breast-cancer?source=search_result&search=Adjuvant%20endocrine%20therapy%20for%20non-metastatic,%20hormon&selectedTitle=1~150. *UpToDate*; Last updated Feb 24, 2017. Accessed July 31, 2017.

Rimawi MF and Osborne CK. Chapter 43: Adjuvant Systemic Therapy: Endocrine Therapy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Stearns V and Davidson NE. Chapter 45: Adjuvant Chemo Endocrine Therapy. In: Harris JR, Lippman ME, Morrow M, Osborne CK, eds. *Diseases of the Breast*. 5th ed. Philadelphia: Wolters Kluwer Health; 2014.

Tjan-Heijnen VC, Van Hellemond IE, Peer PG, et al. First results from the multicenter phase III DATA study comparing 3 versus 6 years of anastrozole after 2-3 years of tamoxifen in postmenopausal women with hormone receptor-positive early breast cancer. Presented at: *2016 San Antonio Breast Cancer Symposium*; December 6-10; San Antonio, TX. Abstract S1-03.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: August 1, 2017 Last Revised: September 26, 2017

Targeted Therapy for Breast Cancer

As researchers have learned more about changes in cancer cells that cause them to grow out of control, they've developed new types of drugs that target some of these cell changes. These targeted drugs are designed to block the growth and spread of cancer cells. These drugs work differently from chemotherapy drugs, which attack all cells that are growing quickly (including cancer cells).

Targeted drugs sometimes work even when chemo drugs do not. Some targeted drugs can help other types of treatment work better. Targeted drugs also tend to have different side effects than chemo.

Targeted therapy for HER2-positive breast cancer

For about 1 in 5 women with breast cancer, the cancer cells have too much of a growth-promoting protein known as HER2/neu (or just HER2) on their surface. These cancers, known as [HER2-positive breast¹cancers²](#), tend to grow and spread more aggressively. A number of drugs have been developed that target this protein:

- **Trastuzumab (Herceptin):** This is a monoclonal antibody, which is a man-made version of a very specific immune system protein. It is often given along with chemo, but it might also be used alone (especially if chemo alone has already been tried). Trastuzumab can be used to treat both early- and late-stage breast cancer. When started before or after surgery to treat early breast cancer, this drug is usually given for a total of 6 months to a year. For advanced breast cancer, treatment is often given for as long as the drug is helpful. This drug is given into a vein (IV) and is infused over 30-90 minutes. Another type of trastuzumab called **trastuzumab and hyaluronidase-oysk injection (Herceptin Hylecta)** is also available. It is given as a subcutaneous (under the skin) shot that takes about 2 to 5 minutes to inject.
- **Pertuzumab (Perjeta):** This monoclonal antibody can be given with trastuzumab and chemo, either before surgery to treat early-stage breast cancer, or to treat advanced breast cancer. This drug is given into a vein (IV).
- **Ado-trastuzumab emtansine (Kadcyla, also known as TDM-1):** This is a monoclonal antibody attached to a chemotherapy drug. It is used by itself to treat advanced breast cancer in women who have already been treated with trastuzumab and chemo. This drug is also given in a vein (IV).
- **Lapatinib (Tykerb):** This is a kinase inhibitor. It is a pill taken daily. Lapatinib is used to treat advanced breast cancer, and might be used along with certain chemotherapy drugs, trastuzumab, or hormone therapy drugs.
- **Neratinib (Nerlynx):** This is another kinase inhibitor. It is a pill that is taken daily. Neratinib is used to treat early-stage breast cancer after a woman has completed one year of trastuzumab and is usually given for one year. Some clinical trials show that it may also be effective in advanced breast cancer, as well.

Side effects of targeted therapy for HER2-positive breast cancer

The side effects of these drugs are often mild, but some can be serious. Discuss what you can expect with your doctor.

Some women develop **heart damage** during or after treatment with trastuzumab, pertuzumab, or ado-trastuzumab emtansine. This can lead to **congestive heart failure**. For most (but not all) women, this effect lasts a short time and gets better when the drug is stopped. The risk of heart problems is higher when these drugs are given with certain chemo drugs that also can cause heart damage, such as doxorubicin (Adriamycin) and epirubicin (Ellence). Because these drugs can cause heart damage, doctors often check your heart function (with an echocardiogram or a MUGA scan) before treatment, and again while you are taking the drug. Let your doctor know if you develop symptoms such as **shortness of breath, leg swelling, and severe fatigue**.

Lapatinib and neratinib can cause **severe diarrhea**, so it's very important to let your health care team know about any changes in bowel habits as soon as they happen. Lapatinib can also cause **hand-foot syndrome**, in which the hands and feet become sore and red, and may blister and peel. Pertuzumab can also cause diarrhea.

If you are pregnant, you should not take these drugs. They can harm and even cause death to the fetus. If you could become pregnant, talk to your doctor about using effective birth control while taking these drugs.

Targeted therapy for hormone receptor-positive breast cancer

About 2 of 3 breast cancers are hormone receptor-positive (ER-positive or PR-positive). For women with these cancers, treatment with [hormone therapy](#) is often helpful. Certain targeted therapy drugs can make hormone therapy even more effective, although these targeted drugs might also add to the side effects.

CDK4/6 inhibitors

Palbociclib (Ibrance), ribociclib (Kisqali), and abemaciclib (Verzenio) are drugs that block proteins in the cell called cyclin-dependent kinases (CDKs), particularly CDK4 and CDK6. Blocking these proteins in hormone receptor-positive breast cancer cells helps stop the cells from dividing. This can slow cancer growth.

These drugs are approved for women with advanced hormone receptor-positive, HER2-negative breast cancer and are taken as pills, typically once or twice a day.

There are different ways to use these drugs.

- Any of the three drugs can be given along with an [aromatase inhibitor](#) (such as letrozole) or [fulvestrant](#) to women who have gone through menopause.
- Palbociclib or abemaciclib can be given with fulvestrant to women who are still having regular periods (premenopausal) or are almost in menopause (perimenopausal). These women, however, must also be on medicines, such as [luteinizing hormone-releasing hormone \(LHRH\) analogs](#), that stop the ovaries from making estrogen.
- Ribociclib can be given with an aromatase inhibitor to women who have not gone through menopause. Again, these women must also be on medicines that suppress the ovaries, such as a luteinizing hormone-releasing hormone (LHRH) analogs.

Abemaciclib can also be used by itself in women who have previously been treated with hormone therapy and chemotherapy.

The most common [side effects](#)³ are low blood cell counts and fatigue. Nausea and vomiting, mouth sores, hair loss, diarrhea, and headache are less common side effects. Very low white blood cell counts can increase the risk of serious infection. A rare but possibly life-threatening side effect is inflammation of the lungs, also called interstitial lung disease or pneumonitis.

Everolimus (Afinitor)

Everolimus is used for women who have gone through menopause and have advanced hormone receptor-positive, HER2-negative breast cancer. It is used along with the aromatase inhibitor exemestane (Aromasin) for women whose cancers have grown while being treated with either letrozole or anastrozole (or if the cancer started growing shortly after treatment with these drugs was stopped).

This targeted therapy drug blocks mTOR, a protein in cells that normally helps them grow and divide. Everolimus may also stop tumors from developing new blood vessels, which can help limit their growth. In treating breast cancer, this drug seems to help hormone therapy drugs work better. Everolimus is a pill that is taken once a day.

Common [side effects](#)⁴ of everolimus include mouth sores, diarrhea, nausea, feeling weak or tired, low blood counts, shortness of breath, and cough. Everolimus can also increase blood lipids (cholesterol and triglycerides) and blood sugars, so your doctor will check your blood work periodically while you are taking this drug. It can also increase your risk of serious infections, so your doctor will watch you closely for infection.

Everolimus is also being studied for use in earlier-stage breast cancer, with other hormone therapy drugs, and in combination with other treatments.

Targeted therapy for women with *BRCA* gene mutations

Olaparib (Lynparza) and **talazoparib (Talzenna)** are drugs known as *PARP inhibitors*. PARP proteins normally help repair damaged DNA inside cells. The *BRCA* genes (*BRCA1* and *BRCA2*) also help repair DNA (in a slightly different way), but mutations in one of those genes can stop this from happening. PARP inhibitors work by blocking the PARP proteins. Because tumor cells with a mutated *BRCA* gene already have trouble repairing damaged DNA, blocking the PARP proteins often leads to the death of these cells.

Olaparib and talazoparib can be used to treat metastatic, HER2-negative breast cancer in women with a *BRCA* mutation who have already gotten [chemotherapy](#). Olaparib can also be used in women who have already received [hormone therapy](#) if the cancer is hormone receptor-positive. Only a small portion of women with breast cancer have a mutated *BRCA* gene. If you are not known to have a *BRCA* mutation, your doctor will test your blood to be sure you have one before starting treatment with this drug.

These drugs come in pills that are taken once a day.

Side effects can include nausea, vomiting, diarrhea, fatigue, loss of appetite, taste changes, low red blood cell counts (anemia), low platelet counts, low white blood cell counts, belly pain, and muscle and joint pain. Rarely, some people treated with a PARP inhibitor have developed a blood cancer, such as [myelodysplastic syndrome](#)⁵ or [acute myeloid leukemia \(AML\)](#)⁶.

Targeted therapy for cancers with a *PIK3CA* gene mutation

Alpelisib (Piqray) is a targeted drug known as a *PI3K inhibitor*. It can be used along with fulvestrant to treat postmenopausal women with advanced hormone receptor-positive, HER2-negative breast cancer with a *PIK3CA* mutation that has grown during or after treatment with an [aromatase inhibitor](#). About 30-40% of breast cancers have a mutated *PIK3CA* gene. Your doctor will test your blood or tumor for this mutation before starting treatment with this drug.

This drug comes in pills that are taken once a day.

Side effects can include high blood sugar levels, signs of kidney, liver, or pancreatic problems, diarrhea, rash, low blood counts, nausea and vomiting, fatigue, decreased

appetite, mouth sores, weight loss, low calcium levels, blood clotting problems, and hair loss. Very severe skin reactions, such as rashes with peeling and blistering, are possible and should be reported to a doctor. Patients with a history of severe skin reactions should tell their doctor before taking alpelisib.

Hyperlinks

1. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/breast-cancer-her2-status.html
2. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/breast-cancer-her2-status.html
3. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects.html
4. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects.html
5. www.cancer.org/cancer/myelodysplastic-syndrome.html
6. www.cancer.org/cancer/acute-myeloid-leukemia.html

References

Baselga J, Campone M, Piccart M, et al. Everolimus in postmenopausal hormone-receptor-positive advanced breast cancer. *N Engl J Med*. 2012;366:520529.

Freedman RA et al. TBCRC 022: Phase II trial of neratinib + capecitabine for patients (Pts) with human epidermal growth factor receptor 2 (HER2+) breast cancer brain metastases (BCBM). *J Clin Oncol* 35, 2017 (suppl; abstr 1005).

Gao et al. *Sci. Signal*. 2013 & Cerami et al. *Cancer Discov*. 2012. Accessed at http://www.cbioportal.org/results/cancerTypesSummary?case_set_id=all&gene_list=PIK3CA&cancer_study_list=5c8a7d55e4b046111fee2296 on May 29, 2019.

Ma CX and Dickler M. Treatment approach to metastatic hormone receptor-positive, HER2-negative breast cancer: Endocrine therapy. https://www.uptodate.com/contents/treatment-approach-to-metastatic-hormone-receptor-positive-her2-negative-breast-cancer-endocrine-therapy?source=search_result&search=everolimus&selectedTitle=5~150. Last updated Jun 20, 2017. Accessed July 1, 2017.

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa:

Lippincott Williams & Wilkins; 2015.

Mukohara T. PI3K mutations in breast cancer: prognostic and therapeutic implications. *Breast Cancer (Dove Med Press)*. 2015;7: 111–123.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on July 1, 2017.

Schott AF. Systemic treatment for HER2-positive metastatic breast cancer. https://www.uptodate.com/contents/systemic-treatment-for-her2-positive-metastatic-breast-cancer?source=search_result&search=breast%20cancer%20treatment&selectedTitle=16~150. Last updated Jun 07, 2017. Accessed July 1, 2017.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: July 1, 2017 Last Revised: May 31, 2019

Immunotherapy for Breast Cancer

Immunotherapy is the use of medicines to stimulate a person's own immune system to recognize and destroy cancer cells more effectively. Immunotherapy can be used to treat some types of breast cancer.

Immune checkpoint inhibitors

An important part of the immune system is its ability to keep itself from attacking normal cells in the body. To do this, it uses “checkpoints” – proteins on immune cells that need to be turned on (or off) to start an immune response. Breast cancer cells sometimes use these checkpoints to avoid being attacked by the immune system. Drugs that target these checkpoints, known as immunotherapy drugs, help to restore the immune response against the breast cancer cells.

PD-L1 inhibitors

Atezolizumab (Tecentriq) targets PD-L1, a protein that is found on some tumor cells and immune cells. Blocking this protein can help boost the immune response against breast cancer cells. This can shrink some tumors or slow their growth.

Atezolizumab can be used along with Abraxane (albumin-bound paclitaxel) in people with advanced [triple negative breast cancer](#) whose tumor makes the PD-L1 protein. It can be used as part of the first treatment in some people.

Atezolizumab is given as an intravenous (IV) infusion every 2 weeks.

Possible side effects

Side effects of atezolizumab can include fatigue, cough, nausea, loss of appetite, constipation, and diarrhea.

Other, more serious side effects occur less often. Immunotherapy drugs work by basically removing the brakes on the body's immune system. Sometimes the immune system starts attacking other parts of the body, which can cause serious or even life-threatening problems in the lungs, intestines, liver, hormone-making glands, kidneys, or other organs.

It's very important to report any new side effects to your health care team quickly. If serious side effects do occur, treatment may need to be stopped and you may get high doses of corticosteroids to suppress your immune system.

More information about immunotherapy

To learn more about how drugs that work on the immune system are used to treat cancer, see [Cancer Immunotherapy](#)¹.

To learn about some of the side effects listed here and how to manage them, see [Managing Cancer-related Side Effects](#)².

Hyperlinks

1. www.cancer.org/treatment/treatments-and-side-effects/treatment-types/immunotherapy.html
2. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects.html

References

Schmidt P, Adams S, Rugo HS, Scheeweiss A, Barrios CH, Iwata H, et al. Atezolizumab and Nab-Paclitaxel in Advanced Triple-Negative Breast Cancer. *N Engl J Med*. 2018 Nov 29;379(22):2108-2121. doi: 10.1056/NEJMoa1809615. Epub 2018 Oct 20.

Last Medical Review: March 13, 2019 Last Revised: March 13, 2019

Treatment of Breast Cancer by Stage

This information is based on AJCC Staging systems prior to 2018 which were primarily based on tumor size and lymph node status. Since the updated staging system for breast cancer now also includes the ER, PR and HER2 status, the stages may be higher or lower than previous staging systems. Whether or not treatment strategies will change with this new staging system are yet to be determined. You should discuss your stage and treatment options with your physician.

The stage (extent) of your breast cancer is an important factor in making decisions about your treatment options. In general, the more the breast cancer has spread, the more treatment you will likely need. But other factors can also be important, such as:

- If the cancer cells contain [hormone receptors](#)¹ (that is, if the cancer is ER-positive or PR-positive)
- If the cancer cells have large amounts of the [HER2 protein](#)² (that is, if the cancer is HER2-positive)
- Your overall health and personal preferences
- If you have gone through menopause or not
- How fast the cancer is growing (measured by grade or other measures)

Talk with your doctor about how these factors can affect your treatment options.

Stage 0

Stage 0 cancer means that the cancer is limited to the inside of the milk duct and is a

non-invasive cancer. The treatment approaches for these non-invasive breast tumors are often different from the treatment of invasive breast cancer. Stage 0 breast tumors include [ductal carcinoma in situ \(DCIS\)](#).

Lobular carcinoma in situ (LCIS) used to be categorized as Stage 0 but this has been changed, because it is not cancer, but does indicate a higher risk of breast cancer. See [Lobular Carcinoma in Situ \(LCIS\)](#)³ for more information.

Stages I to III

[Treatment for stages I to III](#) breast cancer usually includes surgery and radiation therapy, often along with chemo or other drug therapies either before or after surgery.

- **Stage I:** These breast cancers are still relatively small and either have not spread to the lymph nodes or have only a tiny area of cancer spread in the sentinel lymph node (the first lymph node to which cancer is likely to spread).
- **Stage II:** These breast cancers are larger than stage I cancers and/or have spread to a few nearby lymph nodes.
- **Stage III:** These tumors are larger or are growing into nearby tissues (the skin over the breast or the muscle underneath), or they have spread to many nearby lymph nodes.

Stage IV (metastatic breast cancer)

[Stage IV cancers](#) have spread beyond the breast and nearby lymph nodes to other parts of the body. Treatment for stage IV breast cancer is usually a systemic (drug) therapy.

Recurrent breast cancer

Cancer is called recurrent when it comes back after treatment. Recurrence can be local (in the same breast or in the surgery scar), regional (in nearby lymph nodes), or in a distant area. [Treatment for recurrent breast cancer](#) depends on where the cancer recurs and what treatments you've had before.

Triple-negative breast cancer

Triple-negative breast cancer cells don't have estrogen or progesterone receptors and

also don't have too much of the protein called HER2. 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 much HER2, drugs that target HER2 aren't helpful, either. Chemotherapy is usually the standard treatment.

An immunotherapy drug, [atezolizumab \(Tecentriq\)](#), has been approved for use along with the chemotherapy drug, [albumin-bound paclitaxel \(Abraxane\)](#), for people with advanced triple negative breast cancer whose tumor makes the PD-L1 protein.

Because there are not many current treatments for this type of breast cancer, if you are in otherwise good health, you might want to think about taking part in a [clinical trial](#)⁴ testing a newer treatment.

Hyperlinks

1. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/breast-cancer-hormone-receptor-status.html
2. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/breast-cancer-her2-status.html
3. www.cancer.org/cancer/breast-cancer/non-cancerous-breast-conditions/lobular-carcinoma-in-situ.html
4. www.cancer.org/treatment/treatments-and-side-effects/clinical-trials.html

References

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on July 20, 2017.

Schmidt P, Adams S, Rugo HS, Scheeweiss A, Barrios CH, Iwata H, et al. Atezolizumab and Nab-Paclitaxel in Advanced Triple-Negative Breast Cancer. *N Engl J Med*. 2018 Nov 29;379(22):2108-2121. doi: 10.1056/NEJMoa1809615. Epub 2018 Oct 20.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer

of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: July 1, 2017 Last Revised: March 13, 2019

Treatment of Lobular Carcinoma in Situ (LCIS)

Lobular carcinoma in situ (LCIS) means abnormal cells are in the lobules of the breast. LCIS is sometimes grouped with ductal carcinoma in situ (DCIS) as a type of non-invasive breast cancer, but LCIS is different from DCIS and is not cancer. It is a benign (noncancerous) condition that puts you at risk to develop invasive cancer.

Does LCIS need to be treated?

Having LCIS does increase your risk of developing invasive breast cancer later on. But since LCIS is not a true cancer or pre-cancer, often no treatment is recommended. Sometimes if a needle biopsy result shows LCIS, the doctor might recommend that it be removed completely (with an excisional biopsy or some other type of breast-conserving surgery) to help make sure that LCIS was the only thing there. This is especially true if the LCIS is described as pleomorphic or if it has necrosis (areas of dead cells), in which case it might be more likely to grow quickly.

With LCIS, close follow-up is very important. This usually includes a yearly mammogram and a breast exam. Close follow-up of both breasts is important because women with LCIS in one breast have the same increased risk of developing cancer in both breasts. There isn't enough evidence to recommend getting routine magnetic resonance imaging (MRI) in addition to mammograms for all women with LCIS, but it's reasonable for women with LCIS to talk with their doctors about their other risk factors and the benefits and limits of being screened yearly with MRI.

Most of the time, LCIS is only a risk factor for developing breast cancer, except in a certain kind of LCIS, called pleomorphic LCIS. This type may be more likely to turn into invasive cancer than most types of LCIS. Some doctors feel that this kind of LCIS needs to be removed completely with surgery.

Newer evidence is suggesting LCIS may be more of a pre-cancer than we thought. More research is being done.

Can you lower your risk of invasive breast cancer?

If you have LCIS, you may want to consider taking a hormone medicine such as tamoxifen, raloxifene, or aromatase inhibitors to help reduce your risk of breast cancer. You might also want to consider taking part in a clinical trial for breast cancer prevention, or discussing other possible prevention strategies (such as getting to a healthy weight or starting an exercise program) with your doctor.

Because LCIS is linked to an increased risk of cancer in both breasts, some women with LCIS choose to have a bilateral simple mastectomy (removal of both breasts but not nearby lymph nodes) to lower this risk. This is more likely to be a reasonable option in women who also have other risk factors for breast cancer, such as a *BRCA* gene mutation or a strong family history. This may be followed by delayed breast reconstruction.

Hyperlinks

1. https://www.uptodate.com/contents/atypia-and-lobular-carcinoma-in-situ-high-risk-lesions-of-the-breast?source=search_result&search=LCIS&selectedTitle=1~21#H20980309

References

Cuzick, J et al. Anastrozole for prevention of breast cancer in high-risk postmenopausal women (IBIS-II): an international, double-blind, randomised placebo-controlled trial. *The Lancet*. 2014;383 (9922):1041 - 1048.

Goss, P.E., et al., Exemestane for Breast-Cancer Prevention in Postmenopausal Women. *New England Journal of Medicine*. 2011. 364(25): p. 2381-2391.

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology:

Breast Cancer. Version 2.2017. Accessed at www.nccn.org on July 11, 2017.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer Risk Reduction. Version 1.2017. Accessed at www.nccn.org on July 31, 2017.

Sabel MS and Collins LC. Atypia and lobular carcinoma in situ: High risk lesions of the breast. UpToDate. https://www.uptodate.com/contents/atypia-and-lobular-carcinoma-in-situ-high-risk-lesions-of-the-breast?source=search_result&search=LCIS&selectedTitle=1~21#H20980309 (www.uptodate.com/contents/atypia-and-lobular-carcinoma-in-situ-high-risk-lesions-of-the-breast?source=search_result&search=LCIS&selectedTitle=1~21#H20980309)¹. Literature review current through: Jul 2017. | This topic last updated: Jan 19, 2017. Accessed July 31, 2017.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: June 1, 2016 Last Revised: August 18, 2016

Treatment of Ductal Carcinoma in Situ (DCIS)

Ductal carcinoma in situ (DCIS) means the cells that line the milk ducts of the breast have become cancer, but they have not spread into surrounding breast tissue.

DCIS is considered non-invasive or pre-invasive breast cancer. DCIS can't spread outside the breast, but it still needs to be treated because it can sometimes go on to become invasive breast cancer (which can spread).

In most cases, a woman with DCIS can choose between breast-conserving surgery (BCS) and simple mastectomy. But sometimes a mastectomy might be a better option.

Breast-conserving surgery (BCS)

In breast-conserving surgery (BCS), the surgeon removes the tumor and a small amount of normal breast tissue around it. Lymph node removal is not always needed with BCS, but it may be done if the doctor thinks the area of DCIS might also contain invasive cancer. The chances an area of DCIS contains invasive cancer goes up with tumor size and how fast the cancer is growing. If lymph nodes are removed, this is usually done as a sentinel lymph node biopsy (SLNB).

If BCS is done, it is usually followed by radiation therapy. This lowers the chance of the cancer coming back in the same breast (either as more DCIS or as an invasive cancer). BCS without radiation therapy is not a standard treatment, but it might be an option for certain women who had small areas of low-grade DCIS that were removed with large enough cancer-free surgical margins.

Mastectomy

Simple mastectomy (removal of the entire breast) may be needed if the area of DCIS is very large, if the breast has several areas of DCIS, or if BCS cannot remove the DCIS completely (that is, the BCS specimen and re-excision specimens still have cancer cells in or near the surgical margins). Many doctors will do a SLNB along with the mastectomy. This is because if an area of invasive cancer is found in the tissue removed during a mastectomy, the doctor won't be able to go back and do the SLNB later, and so may have to do a full axillary lymph node dissection (ALND).

Women having a mastectomy for DCIS may choose to have breast reconstruction immediately or later.

Hormone therapy after surgery

If the DCIS is hormone receptor-positive (ER-positive or PR-positive), adjuvant treatment with tamoxifen (for any woman) or an aromatase inhibitor (for women past menopause) for 5 years after surgery can lower the risk of another DCIS or invasive cancer developing in either breast. If you have hormone receptor-positive DCIS, discuss the pros and cons of hormone therapy with your doctors.

References

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and*

Rosenberg's Cancer: Principles and Practice of Oncology. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on July 31, 2017.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: June 1, 2016 Last Revised: August 18, 2016

Treatment of Breast Cancer Stages I-III

The [stage](#)¹ (extent) of your breast cancer is an important factor in making decisions about your treatment.

Most women with breast cancer in stages I, II, or III are treated with surgery, often followed by radiation therapy. Many women also get some kind of drug therapy. In general, the more the breast cancer has spread, the more treatment you will likely need. But your treatment options are affected by your personal preferences and other information about your breast cancer, such as:

- If the cancer cells contain [hormone receptors](#)² (that is, if the cancer is ER-positive or PR-positive)
- If the cancer cells have large amounts of the [HER2 protein](#)³ (that is, if the cancer is HER2-positive)
- How fast the cancer is growing (measured by [grade](#)⁴ or [Ki-67](#)⁵)
- Your overall health
- If you have gone through menopause or not

Talk with your doctor about how these factors can affect your treatment options.

What type of drug treatment(s) might I get?

Most women with breast cancer in stages I to III will get some kind of drug therapy as part of their treatment. This may include:

- Chemotherapy
- Hormone therapy (tamoxifen, an aromatase inhibitor, or one followed by the other)
- HER2 targeted drugs, such as trastuzumab (Herceptin) and pertuzumab (Perjeta)
- Some combination of these

The types of drugs that might work best depend on the tumor's hormone receptor status, HER2 status, and other factors.

Treating stage I breast cancer

These breast cancers are still relatively small and either have not spread to the lymph nodes or have spread to only a tiny area in the sentinel lymph node (the first lymph node to which cancer is likely to spread).

Surgery

Surgery is the main treatment for stage I breast cancer. These cancers can be treated with either [breast-conserving surgery](#) (BCS; sometimes called lumpectomy or partial mastectomy) or [mastectomy](#). The nearby [lymph nodes](#) will also need to be checked, either with a sentinel lymph node biopsy (SLNB) or an axillary lymph node dissection (ALND).

In some cases, [breast reconstruction](#)⁶ can be done at the same time as the surgery to remove the cancer. But if you will need radiation therapy after surgery, it is better to wait to get reconstruction until after the radiation is complete.

Radiation therapy

If BCS is done, [radiation therapy](#) is usually given after surgery to lower the chance of the cancer coming back in the breast and to also help people live longer.

In a separate group, women who are at least 70 years old may consider BCS *without* radiation therapy if ALL of the following are true:

- The tumor was 2 cm (a little less than 1 inch) or less across and it has been removed completely.
- None of the lymph nodes removed contained cancer.

- The cancer is ER-positive or PR-positive, and hormone therapy is given.

Radiation therapy in this set of women still lowers the chance of the cancer coming back, but it has not been shown to help them live longer.

If mastectomy is done, radiation therapy is less likely to be needed, but it might be given depending on the details of your specific cancer. You should discuss if you need radiation treatment with your doctor. They may send you to a doctor who specializes in radiation, called a *radiation oncologist*, for evaluation.

Adjuvant systemic therapy (chemo and other drugs)

For women who have a hormone receptor-positive (ER-positive or PR-positive) breast cancer, most doctors will recommend [hormone therapy](#) (tamoxifen or an aromatase inhibitor, or one followed by the other) as an adjuvant (additional) treatment, no matter how small the tumor is. Women with tumors larger than 0.5 cm (about ¼ inch) across may be more likely to benefit from it. Hormone therapy is typically given for at least 5 years.

If the tumor is larger than 1 cm (about ½ inch) across, adjuvant [chemotherapy](#) (chemo) is sometimes recommended. A woman's age at the time of diagnosis may help in deciding if chemo should be offered or not. Some doctors may suggest chemo for smaller tumors as well, especially if they have any unfavorable features (a cancer that is growing fast; hormone receptor-negative, HER2-positive; or having a [high score on a gene panel such as Oncotype DX⁷](#)).

For HER2-positive cancers, 6 months to a year of adjuvant [trastuzumab](#) (Herceptin) is usually recommended as well.

Treating stage II breast cancer

These breast cancers are larger than stage I cancers and/or have spread to a few nearby lymph nodes.

Local therapy (surgery and radiation therapy)

Stage II cancers are treated with either [breast-conserving surgery \(BCS; sometimes called lumpectomy or partial mastectomy\)](#) or [mastectomy](#). The nearby [lymph nodes](#) will also need to be checked, either with a sentinel lymph node biopsy (SLNB) or an axillary lymph node dissection (ALND).

Women who have BCS are treated with [radiation therapy](#) after surgery. Women who have a mastectomy are typically treated with radiation if the cancer is found in the lymph nodes. Some patients who have a SLNB that shows cancer in a few lymph nodes may not have the rest of their lymph nodes removed (ALND) to check for more cancer. In these patients, radiation may be discussed as a treatment option after mastectomy.

If you were initially diagnosed with stage II breast cancer and were given treatment such as chemotherapy or hormone therapy before surgery, radiation therapy might be recommended if cancer is found in the lymph nodes at the time of the mastectomy. A doctor who specializes in radiation, called a *radiation oncologist*, may review your case to discuss whether radiation would be helpful to you.

If chemotherapy is also needed after surgery, the radiation is delayed until the chemo is done.

In some cases, breast reconstruction can be done during the surgery to remove the cancer. But if you will need radiation after surgery, it is better to wait to get reconstruction until after the radiation is complete.

Neoadjuvant and adjuvant systemic therapy (chemo and other drugs)

Systemic therapy is recommended for women with stage II breast cancer. Some systemic therapies are given before surgery (neoadjuvant therapy), and others are given after surgery (adjuvant therapy). Neoadjuvant treatments are often a good option for women with large tumors, because they can shrink the tumor before surgery, possibly enough to make BCS an option. But this doesn't improve survival more than getting these treatments after surgery. In some cases, systemic therapy will be started before surgery and then continued after surgery.

The drugs used will depend on the woman's age, as well as tumor test results, including hormone-receptor status, HER2 status, and the score on a [gene panel such as Oncotype DX[®]](#). Treatment may include:

- [Chemotherapy](#): Chemo can be given before or after surgery.
- [HER2 targeted drugs](#): If the cancer is HER2-positive, HER2 targeted drugs are started along with chemo. Both trastuzumab (Herceptin) and pertuzumab (Perjeta) may be used as a part of neoadjuvant treatment. Then trastuzumab is continued after surgery for a total of 6 months to a year of treatment.
- [Hormone therapy](#): If the cancer is hormone receptor-positive, hormone therapy (tamoxifen, an aromatase inhibitor, or one followed by the other) is typically used. It can be started before surgery, but because it continues for at least 5 years, it needs

to be given after surgery as well.

Treating stage III breast cancer

In stage III breast cancer, the tumor is large (more than 5 cm or about 2 inches across) or growing into nearby tissues (the skin over the breast or the muscle underneath), or the cancer has spread to many nearby lymph nodes.

If you have inflammatory breast cancer: Stage III cancers also include some inflammatory breast cancers that have not spread beyond nearby lymph nodes. Treatment of these cancers can be slightly different from the treatment of other stage III breast cancers. You can find more details in our section about [treatment for inflammatory breast cancer](#).

There are two main approaches to treating stage III breast cancer:

Starting with neoadjuvant therapy

Most often, these cancers are treated with neoadjuvant [chemotherapy](#) (before surgery). For HER2-positive tumors, the [targeted drug](#) trastuzumab (Herceptin) is given as well, sometimes along with pertuzumab (Perjeta). This may shrink the tumor enough to allow a woman to have [breast-conserving surgery \(BCS\)](#). If the tumor doesn't shrink enough, a [mastectomy](#) is done. Nearby [lymph nodes](#) will also need to be checked. A sentinel lymph node biopsy (SLNB) is often not an option for stage III cancers, so an axillary lymph node dissection (ALND) is usually done.

Often, [radiation therapy](#) is needed after surgery. If [breast reconstruction](#)⁹ is done, it is usually delayed until after radiation is complete. In some cases, additional (adjuvant) chemo is given after surgery as well. Women with HER2-positive cancers receive trastuzumab after surgery to complete 6 months to a year of treatment with this drug. Women with hormone receptor-positive (ER-positive or PR-positive) breast cancers will also get adjuvant [hormone therapy](#) which can typically be taken at the same time as trastuzumab.

Starting with surgery

Another option for stage III cancers is treatment with surgery first. Because these tumors are fairly large and/or have grown into nearby tissues, this usually means getting a mastectomy. For women with fairly large breasts, BCS may be an option if the cancer

hasn't grown into nearby tissues. SLNB may be an option for some patients, but most will need an ALND. Surgery is usually followed by adjuvant chemotherapy, and/or hormone therapy, and/or trastuzumab. Radiation is recommended after surgery.

Hyperlinks

1. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/stages-of-breast-cancer.html
2. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/breast-cancer-hormone-receptor-status.html
3. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/breast-cancer-her2-status.html
4. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/breast-cancer-grades.html
5. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/ploidy-and-cell-proliferation.html
6. www.cancer.org/cancer/breast-cancer/reconstruction-surgery.html
7. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/breast-cancer-gene-expression.html
8. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/breast-cancer-gene-expression.html
9. www.cancer.org/cancer/breast-cancer/reconstruction-surgery.html

References

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on July 20, 2017.

Sparano JA, Gray RJ, Makower KI, Pritchard KS, Albain DF, Hayes CE, et al. Adjuvant chemotherapy guided by a 21-gene expression assay in breast cancer [published online ahead of print June 3 2018]. *NEJM*. 2018; doi: 10.1056/NRJMoa1804710.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer

of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: June 1, 2016 Last Revised: January 7, 2019

Treatment of Stage IV (Metastatic) Breast Cancer

Most women with stage IV breast cancer are treated with systemic therapy. This may include hormone therapy, chemotherapy, targeted therapy, or some combination of these. Local treatments such as surgery or radiation might also be used to help prevent or treat symptoms.

Stage IV cancers have spread beyond the breast and nearby lymph nodes to other parts of the body. When breast cancer spreads, it most commonly goes to the bones, liver, and lungs. It may also spread to the brain or other organs.

Treatment options for stage IV breast cancer

For women with stage IV breast cancer, systemic (drug) therapies are the main treatments. These may include:

- [Hormone therapy](#)
- [Chemotherapy](#) (chemo)
- [Targeted drugs](#), such as trastuzumab (Herceptin) and pertuzumab (Perjeta)
- Some combination of these

[Surgery](#) and/or [radiation therapy](#) may be useful in certain situations (see below).

Treatment can often shrink tumors (or slow their growth), improve symptoms, and help women live longer. These cancers are considered incurable.

Systemic (drug) treatments for stage IV breast cancer

The types of drugs used for stage IV breast cancer depend on the hormone receptor status and the HER2 status of the cancer:

- **Hormone receptor-positive cancers:** Women with hormone receptor-positive (ER-positive or PR-positive) cancers are often treated first with hormone therapy (tamoxifen or an aromatase inhibitor). This may be combined with a targeted drug such as palbociclib (Ibrance), ribociclib (Kisqali), abemaciclib (Verzenio), or everolimus (Afinitor). Women who haven't yet gone through menopause are often treated with tamoxifen or with medicines that keep the ovaries from making hormones along with other drugs. . Because hormone therapy can take months to work, chemo is often the first treatment for patients with serious problems from their cancer spread, such as breathing problems.
- **Hormone receptor-negative cancers:** Chemo is the main treatment for women with hormone receptor-negative (ER-negative and PR-negative) cancers, because hormone therapy isn't helpful for these cancers.
- **HER2-positive cancers:** Trastuzumab (Herceptin) may help women with HER2-positive cancers live longer if it's given along with chemo or with other medications such as hormonal therapy or other anti-HER2 drugs. Pertuzumab (Perjeta), another targeted drug, might be added as well. Another option is the targeted drug ado-trastuzumab emtansine (Kadcyla), which is given alone or with lapatinib.
- **HER2-negative cancers in women with a *BRCA* gene mutation:** These women are typically treated with chemotherapy (and hormone therapy, if the cancer is hormone receptor-positive). An option after getting chemo is treatment with a targeted drug called a PARP inhibitor, such as olaparib (Lynparza).

Treatment often continues until the cancer starts growing again or until side effects become unacceptable. If this happens, other drugs might be tried.

Local or regional treatments for stage IV breast cancer

Although systemic drugs are the main treatment for stage IV breast cancer, local and regional treatments such as surgery, radiation therapy, or regional chemotherapy are sometimes used as well. These can help treat breast cancer in a specific part of the body, but they are very unlikely to get rid of all of the cancer. These treatments are more likely to be used to help prevent or treat symptoms or complications from the cancer.

Radiation therapy and/or surgery may also be used in certain situations, such as:

- When the breast tumor is causing an open wound in the breast (or chest)
- To treat a small number of metastases in a certain area, such as the brain
- To help prevent bone fractures
- When an area of cancer spread is pressing on the spinal cord
- To treat a blood vessel blockage in the liver
- To provide relief of pain or other symptoms

In some cases, regional chemo (where drugs are delivered directly into a certain area, such as into the fluid around the brain and spinal cord) may be useful as well.

If your doctor recommends such local or regional treatments, it is important that you understand their goal—whether it is to try to cure the cancer or to prevent or treat symptoms.

Relieving symptoms of advanced breast cancer

Treatment to relieve symptoms depends on where the cancer has spread. For example, pain from bone metastases may be treated with radiation therapy, drugs called bisphosphonates such as pamidronate (Aredia) or zoledronic acid (Zometa), or the drug denosumab (Xgeva). For more, see our information about the [treatment of bone metastases](#)¹.

Advanced cancer that progresses during treatment

Treatment for advanced breast cancer can often shrink the cancer or slow its growth (sometimes for many years), but after a time, it tends to stop working. Further treatment options at this point depend on several factors, including previous treatments, where the cancer is located, and a woman's age, general health, and desire to continue getting treatment.

Progression while on hormone therapy

For hormone receptor-positive (ER-positive or PR-positive) cancers that were being treated with hormone therapy, switching to another type of hormone therapy sometimes helps. For example, if either letrozole (Femara) or anastrozole (Arimidex) were given, using exemestane, possibly with everolimus (Afinitor), may be an option. Another option might be using fulvestrant (Faslodex) or an aromatase inhibitor (such as letrozole), along with a [CDK inhibitor](#) such as palbociclib (Ibrance) or abemaciclib (Verzenio). If the cancer has a [PIK3CA mutation](#) and has grown while on an aromatase inhibitor,

fulvestrant with alpelisib might be considered. If the cancer is no longer responding to any hormone drugs, chemotherapy is usually the next step.

Progression while on chemotherapy

If the cancer is no longer responding to one chemo regimen, trying another may be helpful. Many different drugs and combinations can be used to treat breast cancer. However, each time a cancer progresses during treatment, it becomes less likely that further treatment will have an effect.

Progression while getting HER2 drugs

HER2-positive cancers that no longer respond to trastuzumab (Herceptin) might respond to lapatinib (Tykerb), another drug that attacks the HER2 protein. This drug is often given along with the chemo drug capecitabine (Xeloda), but it can be used with other chemo drugs, with trastuzumab, or even alone (without chemo). Other options for women with HER2-positive cancers include pertuzumab (Perjeta) with chemo and trastuzumab, or ado-trastuzumab emtansine (Kadcyla).

Because current treatments are very unlikely to cure metastatic breast cancer, if you are in otherwise good health, you may want to think about taking part in a [clinical trial](#)² testing a newer treatment.

Hyperlinks

1. www.cancer.org/treatment/understanding-your-diagnosis/advanced-cancer/treating-bone-metastases.html
2. www.cancer.org/treatment/treatments-and-side-effects/clinical-trials.html

References

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on July 20, 2017.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: June 1, 2016 Last Revised: May 31, 2019

Treatment of Recurrent Breast Cancer

For some women, breast cancer may come back after treatment – sometimes years later. This is called a *recurrence*. **Recurrence can be local (in the same breast or in the surgery scar), regional (in nearby lymph nodes), or in a distant area.** Cancer that is found in the opposite breast without any cancer elsewhere in the body is not a recurrence—it is a new cancer that requires its own treatment.

Treating local recurrence

For women whose breast cancer has recurred locally, treatment depends on their initial treatment.

- If you had breast-conserving surgery (lumpectomy), a local recurrence in the breast is usually treated with [mastectomy](#).
- If the initial treatment was mastectomy, recurrence near the mastectomy site is treated by removing the tumor whenever possible. This is often followed by [radiation therapy](#).

In either case, [hormone therapy](#), [targeted therapy](#) (like trastuzumab), [chemotherapy](#), or some combination of these may be used after surgery and/or radiation therapy.

Treating regional recurrence

When breast cancer comes back in nearby lymph nodes (such as those under the arm

or around the collar bone), it is treated by [removing those lymph nodes](#), if possible. This may be followed by radiation aimed at the area. Systemic treatment (such as chemo, targeted therapy, or hormone therapy) may be considered after surgery as well.

Treating distant recurrence

In general, women whose breast cancer comes back in other parts of the body, such as the bones, lungs, or brain, are treated the same way as those found to have stage IV breast cancer in these organs when they were first diagnosed (see [Treating Stage IV \(Metastatic\) Breast Cancer](#)). The only difference is that treatment may be affected by previous treatments a woman has had.

Recurrent breast cancer can sometimes be hard to treat. If you are in otherwise good health, you may want to think about taking part in a [clinical trial](#)¹ testing a newer treatment.

Should your cancer come back, see [Understanding Recurrence](#)² for more general information on how to manage and cope with this phase of your treatment.

Hyperlinks

1. www.cancer.org/treatment/treatments-and-side-effects/clinical-trials.html
2. www.cancer.org/treatment/survivorship-during-and-after-treatment/understanding-recurrence.html

References

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

National Comprehensive Cancer Network (NCCN). Practice Guidelines in Oncology: Breast Cancer. Version 2.2017. Accessed at www.nccn.org on July 20, 2017.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: June 1, 2016 Last Revised: August 18, 2016

Treatment of Inflammatory Breast Cancer

Inflammatory breast cancer (IBC) is an uncommon type of invasive breast cancer that typically makes the skin on the breast look red and feel warm. It also may give the breast skin a thick, pitted appearance that looks a lot like an orange peel. These changes are caused by cancer cells blocking lymph vessels in the skin.

Because inflammatory breast cancer has reached these vessels and has caused changes in the skin, it is considered to be at least a stage III breast cancer. IBC that has spread to other parts of the body is considered stage IV. These cancers typically grow quickly and can be challenging to treat.

Treating stage III inflammatory breast cancer

IBC that has not spread outside the breast or nearby lymph nodes is stage IIIB or IIIC. Treatment usually starts with chemotherapy (chemo) to try to shrink the tumor. If the cancer is HER2-positive, targeted therapy is given along with the chemo. This is typically followed by surgery (mastectomy) to remove the cancer. Radiation therapy often follows surgery. In some cases, more chemo may be given after surgery but before radiation. If the cancer is hormone receptor-positive (ER- or PR-positive), hormone therapy is given as well. Combining these treatments has improved survival significantly over the years.

Chemotherapy (possibly along with targeted therapy)

Chemo drugs enter the bloodstream and circulate throughout the body to reach and destroy cancer cells wherever they are, so chemo is considered a type of systemic therapy. It treats both the main tumor as well as any cancer cells that have broken off and spread to lymph nodes or other parts of the body.

Using chemo before surgery is called *neoadjuvant* or *preoperative* treatment. Most women with IBC will receive two types of chemo drugs (although not necessarily at the

same time):

- An anthracycline, such as doxorubicin (Adriamycin) or epirubicin (Ellence)
- A taxane, such as paclitaxel (Taxol) or docetaxel (Taxotere)

Other chemo drugs may be used as well.

If the cancer is HER2-positive (the cancer cells make too much of a protein called HER2), the targeted therapy drug trastuzumab (Herceptin) is usually given, sometimes along with another targeted drug, pertuzumab (Perjeta). These drugs can lead to heart problems when given with an anthracycline, so one option is to give the anthracycline first (without trastuzumab or pertuzumab), followed by treatment with a taxane and trastuzumab (with or without pertuzumab).

Surgery and further treatments

If the cancer improves with chemo, surgery is typically the next step. The standard operation is a modified radical mastectomy, where the entire breast and the lymph nodes under the arm are removed. Because IBC affects so much of the breast and skin, breast-conserving surgery (partial mastectomy or lumpectomy) and skin-sparing mastectomy are not options. It isn't clear that sentinel lymph node biopsy (where only one or a few nodes are removed) is reliable in IBC, so it is also not an option.

If the cancer does not respond to chemo (and the breast is still very swollen and red), surgery cannot be done. Either other chemo drugs will be tried, or the breast may be treated with radiation. Then if the cancer responds (the breast shrinks and is no longer red), surgery may be an option.

If breast radiation isn't given before surgery, it is given after surgery, even if no cancer is thought to remain. This is called *adjuvant radiation*. It lowers the chance that the cancer will come back. Radiation is usually given 5 days a week for 6 weeks, but in some cases a more intense treatment (twice a day) can be used instead. Depending on how much tumor was found in the breast after surgery, radiation might be delayed until further chemo is given. If breast reconstruction is to be done, it is usually delayed until after the radiation therapy that most often follows surgery.

Treatment after surgery and radiation often includes additional systemic treatment. This is known as *adjuvant therapy* and can include chemo, hormone therapy (tamoxifen or an aromatase inhibitor) if the cancer cells contain hormone receptors, and/or trastuzumab if the cancer is HER2-positive.

Treating stage IV inflammatory breast cancer

Patients with metastatic (stage IV) IBC are treated with systemic therapy. This may include:

- Chemotherapy
- Hormonal therapy (if the cancer is hormone receptor-positive)
- Targeted therapy with a drug that targets HER2 (if the cancer is HER2-positive)

One or more of these treatments might be used. Surgery and radiation may also be options in certain situations. See [Treatment of Stage IV \(Metastatic Breast Cancer\)](#) for more information.

Regardless of the stage of the cancer, participation in a [clinical trial](#)¹ of new treatments for IBC is also a good option because IBC is rare, and these studies often allow access to drugs not available for standard treatment.

Hyperlinks

1. www.cancer.org/treatment/treatments-and-side-effects/clinical-trials.html

References

Dawood S, Merajver SD, Viens P, et al. International expert panel on inflammatory breast cancer: Consensus statement for standardized diagnosis and treatment. *Ann Oncol.* 2011;22:515523.

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Breast Cancer. Version 2.2017. Accessed at www.nccn.org on July 20, 20167

Robertson FM, Bondy M, Yang W, et al. Inflammatory breast cancer: The disease, the biology, the treatment. *CA Cancer J Clin.* 2010;60:351-375.

Sinclair S, Swain SM. Primary systemic chemotherapy for inflammatory breast cancer. *Cancer*. 2010;116(11 Suppl):2821-2828.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Last Medical Review: June 1, 2016 Last Revised: August 18, 2016

Treating Breast Cancer During Pregnancy

If you are diagnosed with breast cancer while pregnant, your treatment options will be more complicated because you will want to get the best treatment for your cancer while also protecting the baby. The type and timing of treatment will need to be planned carefully and coordinated between your cancer care team and your obstetrician.

The goal when treating a pregnant woman with breast cancer is the same as when treating a non-pregnant woman: to cure the cancer whenever possible, or to control it and keep it from spreading if it can't be cured. But the extra concern of protecting a growing fetus may make treatment more complicated.

Is it safe to treat breast cancer during pregnancy?

If you are pregnant and have breast cancer, you may have hard choices to make, so be sure you know all your options and get expert help. Pregnant women can safely get treatment for breast cancer, although the types of treatment used and the timing of treatment might be affected by the pregnancy. If you are pregnant and have been diagnosed with breast cancer, your treatment recommendations will depend on:

- The size of the tumor

- Where the tumor is located
- If the cancer has spread and if so, how far
- How far along you are in the pregnancy
- Your overall health
- Your personal preferences

Surgery for breast cancer is generally safe while you're pregnant. Chemotherapy seems to be safe for the baby if given in the second or third trimester of pregnancy, but it isn't safe in the first trimester. Other breast cancer treatments, such as hormone therapy, targeted therapy, and radiation therapy, are more likely to harm the baby and are not usually given during pregnancy.

Treatment choices can become complicated if there is a conflict between the best known treatment for the mother and the well-being of the baby. For example, if a woman is found to have breast cancer early in her pregnancy and needs chemotherapy right away, she may be advised to think about ending the pregnancy. A counselor or psychologist should also be part of your health care team to help give you the emotional support you may need.

Some older studies found that ending a pregnancy in order to have cancer treatment didn't improve a woman's prognosis (outlook). Even though there were flaws in these studies, ending the pregnancy is no longer routinely recommended when breast cancer is found. Still, this option may be discussed when looking at all the treatment choices available, especially for aggressive cancers that may need treatment right away, such as [inflammatory breast cancer](#)¹.

Breast cancer surgery during pregnancy

Surgery to remove the cancer in the breast and nearby lymph nodes is a major part of treatment for any woman with early breast cancer, and generally is safe in pregnancy.

Options for breast cancer surgery might include:

- Removing the entire breast ([mastectomy](#))
- Removing just the part containing the cancer (lumpectomy or [breast-conserving surgery](#) [BCS])

Mastectomy is used more often for pregnant women with breast cancer because most women who have BCS need radiation therapy afterward. If radiation is given during pregnancy, it could affect the baby, so it can't be given until after delivery. But delaying

radiation too long could increase the chance of the [cancer coming back](#)².

If the cancer is found in the third trimester, BCS might be an option because there might be little or no delay in radiation treatments, especially if chemotherapy is planned after surgery. (Radiation is normally given after chemotherapy treatments are complete.) But if the cancer is found early in the pregnancy, it may mean a longer delay in starting radiation. For women in this situation, mastectomy is likely a better option than BCS followed by radiation.

Checking lymph nodes for cancer spread

In addition to removing the tumor in the breast, one or more lymph nodes in the armpit (axillary lymph nodes) also need to be removed to check for cancer spread. One way to do this is an axillary lymph node dissection (ALND). This removes many of the lymph nodes under the arm. Another procedure, called a sentinel lymph node biopsy (SLNB), might be an option depending on how far along you are in pregnancy and your cancer stage. This procedure uses slightly radioactive tracers and a blue dye to pinpoint the nodes most likely to contain cancer cells. SLNB allows the doctor to remove fewer nodes. But there are concerns about the effects the SLNB dye might have on the baby. Because of these concerns, some experts recommend that SLNB be used only later in pregnancy, and that the blue dye not be used during the procedure.

Is anesthesia safe during pregnancy?

Surgery for breast cancer generally carries little risk to the baby. But there are certain times in pregnancy when anesthesia (the drugs used to make you sleep for surgery) may be riskier for the baby.

Your surgeon and anesthesiologist, along with a high-risk obstetrician, will need to work together to decide the best time during pregnancy to do the operation. If the surgery is done later in the pregnancy, your obstetrician may be there just in case there are any problems with the baby during surgery. Together, your doctors will decide which anesthesia drugs and techniques are the safest for both you and the baby.

Treatment after surgery

Depending on the cancer's stage, you may need more treatment such as chemotherapy, radiation therapy, hormone therapy, and/or targeted therapy after surgery to help lower the risk of the [cancer coming back](#)³. This is called **adjuvant treatment**. In some cases, this treatment can be put off until after delivery.

Chemotherapy

Chemotherapy (chemo) may be used after surgery (as adjuvant treatment) for some earlier stages of breast cancer. It also may be used by itself for more advanced cancers.

Chemo is not given during the first 3 months (first trimester) of pregnancy. Because most of the baby's internal organs develop during this time, the safety of chemo hasn't been studied in the first trimester. The risk of miscarriage (losing the baby) is also the greatest during this time.

For many years, it was thought that all chemo would harm an unborn baby no matter when it was given. But studies have shown that certain chemo drugs used during the second and third trimesters (months 4 through 9 of pregnancy) don't raise the risk of birth defects, stillbirths, or health problems shortly after birth, though they may increase the risk of early delivery. Researchers still don't know if these children will have any long-term effects.

If you have early breast cancer and you need chemo after surgery (adjuvant chemo), it will usually be delayed until at least your second trimester. If you are already in the third trimester when the cancer is found, the chemo may be delayed until after birth. The birth may be induced (brought on) a few weeks early in some cases. These same treatment plans may also be used for women with more advanced cancer.

Chemo is generally not recommended after 35 weeks of pregnancy or within 3 weeks of delivery because it can [lower the mother's blood cell counts](#)⁴. This could cause bleeding and increase the chances of infection during birth. Holding off on chemo for the last few weeks before delivery allows the mother's blood counts to return to normal before childbirth.

Treatments that typically must wait until after delivery

Some treatments for breast cancer can harm the baby and are not safe during pregnancy. If these treatments are needed, they are usually scheduled after the baby is born.

Radiation therapy: Radiation therapy to the breast is often used after breast-conserving surgery (lumpectomy) to help reduce the risk of the cancer coming back. The high doses of radiation used for this can harm the baby any time during pregnancy. This may cause miscarriage, birth defects, slow fetal growth, or a higher risk of childhood cancer. Because of this, doctors don't use radiation treatment during pregnancy.

For some women whose cancer is found later in the pregnancy, it may be possible to have a lumpectomy during pregnancy and then wait until after the baby is born to get radiation therapy. But this treatment approach has not been well-studied. Waiting too long to start radiation can increase the chance of the cancer coming back.

Hormone therapy: Hormone therapy is often used as adjuvant treatment after surgery or as treatment for advanced breast cancer in women with hormone receptor-positive (ER-positive or PR-positive) breast cancer. Hormone therapy drugs used for breast cancer include tamoxifen, anastrozole, letrozole, and exemestane.

Hormone therapy should not be used during pregnancy because it can affect the baby. It should be delayed until after the woman has given birth.

Targeted therapy: Drugs that target HER2, such as trastuzumab (Herceptin), pertuzumab (Perjeta), ado-trastuzumab emtansine (Kadcyla) and lapatinib (Tykerb), are an important part of the treatment of HER2-positive breast cancers. In women who aren't pregnant, trastuzumab is used as a part of adjuvant treatment after surgery, pertuzumab can be used with trastuzumab before surgery, and all of these drugs can be useful in treating advanced cancer. But based on animal studies and reports of women who were treated during pregnancy, none of these drugs are considered safe for the baby if taken during pregnancy.

Everolimus (Afinitor) and palbociclib (Ibrance) are also targeted drugs that can be used along with hormone therapy to treat advanced breast cancer. Again, these drugs are not thought to be safe to use during pregnancy.

Can I breastfeed during cancer treatment?

Most doctors recommend that women who have just had babies and are about to be treated for breast cancer should stop (or not start) breastfeeding.

If breast surgery is planned, stopping breastfeeding will help reduce blood flow to the breasts and make them smaller. This can help with the operation. It also helps reduce the risk of infection in the breast and can help avoid having breast milk collect in biopsy or surgery areas.

Many chemo, hormone, and targeted therapy drugs can enter breast milk and be passed on to the baby. Breastfeeding isn't recommended if you are getting chemo, hormone, or targeted therapy.

If you have questions, such as when it might be safe to start breastfeeding, talk with

your health care team. If you plan to start breastfeeding after you've stopped for a while, plan ahead. Breastfeeding experts can give you extra help if you need it.

How does pregnancy affect survival rates for breast cancer?

Pregnancy can make it harder to find, diagnose, and treat breast cancer. Most studies have found that the outcomes among pregnant and non-pregnant women with breast cancer are about the same for cancers found at the same stage, but not all studies agree.

Some doctors believe that ending the pregnancy may help slow the course of more advanced breast cancers, and they may recommend that for some women with advanced breast cancer. It's hard to do research in this area, and good, unbiased studies don't exist. Ending the pregnancy makes treatment simpler, but older studies that looked at pregnant women did not find that ending the pregnancy improves a woman's overall survival or cancer outcome. Of note, there were some flaws that could have biased the outcomes of these studies. For example, the women who had more advanced disease were more likely to end their pregnancies. It's hard to know if outcomes would be different with more modern treatments.

Studies have not shown that the treatment delays that are sometimes needed during pregnancy have an effect on breast cancer outcome, either. But this, too, has proven to be a difficult area to study. Finally, there are no reports showing that breast cancer itself can harm the baby.

Hyperlinks

1. www.cancer.org/cancer/breast-cancer/understanding-a-breast-cancer-diagnosis/types-of-breast-cancer/inflammatory-breast-cancer.html
2. www.cancer.org/treatment/survivorship-during-and-after-treatment/understanding-recurrence.html
3. www.cancer.org/treatment/survivorship-during-and-after-treatment/understanding-recurrence.html
4. www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/low-blood-counts.html

References

Abdel-Hady el-S, Hemida RA, Gamal A, et al. Cancer during pregnancy: Perinatal

outcome after in utero exposure to chemotherapy. *Arch Gynecol Obstet.* 2012;286:283-286.

Ali SA, Gupta S, Sehgal R, Vogel V. Survival outcomes in pregnancy associated breast cancer: A retrospective case control study. *Breast J.* 2012;18:139-144.

Amant F, von Minckwitz G, Han SN, et al. Prognosis of women with primary breast cancer diagnosed during pregnancy: Results from an international collaborative study. *J Clin Oncol.* 2013;31:2532-2539.

Castillo JJ, Rizack T. Chapter 64: Special Issues in Pregnancy. In: Niederhuber JE, Armitage JO, Dorshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa. Elsevier: 2014.

Donnelly EH, Smith JM, Farfán EB, Ozcan I. Prenatal radiation exposure: Background material for counseling pregnant patients following exposure to radiation. *Disaster Med Public Health Prep.* 2011;5:62-68.

Guidroz JA, Scott-Conner CEH, Weigel RJ. Management of pregnant women with breast cancer. *J Surg Oncol.* 2011;103:337-340.

Filippakis GM, Zografos G. Contraindications of sentinel lymph node biopsy: Are there any really? *World J Surg Oncol.* 2007;5:10.

Litton JK. Gestational breast cancer: Treatment. <https://www.uptodate.com/contents/gestational-breast-cancer-treatment>. UpToDate. Literature review current through: Jul 2017. | This topic last updated: Nov 20, 2015. Accessed July 20, 2017.

Loibl S, Han SN, von Minckwitz G, et al. Treatment of breast cancer during pregnancy: An observational study. *Lancet Oncol.* 2012;13:887-896.

Morrow M, Burstein HJ, Harris JR. Chapter 79: Malignant Tumors of the Breast. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. *DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology*. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

Murphy CG, Mallam D, Stein S, et al. Current or recent pregnancy is associated with adverse pathologic features but not impaired survival in early breast cancer. *Cancer.* 2012;118:3254-3259.

National Comprehensive Cancer Network: NCCN Clinical Guidelines in Oncology.

Breast Cancer, V.2.2016. Accessed at www.nccn.org/professionals/physician_gls/pdf/breast.pdf on June 1, 2016.

Petrek JA, Dukoff R, Rogatko A. Prognosis of pregnancy-associated breast cancer. *Cancer*. 1991, *Cancer*. 1991;67:869-872.

Wolff AC, Domchek SM, Davidson NE, Sacchini V, McCormick B. Chapter 91: Cancer of the Breast. In: Niederhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. *Abeloff's Clinical Oncology*. 5th ed. Philadelphia, Pa: Elsevier; 2014.

Zagouri F, Psaltopoulou T, Dimitrakakis C, Bartsch R, Dimopoulos MA. Challenges in managing breast cancer during pregnancy. *J Thorac Dis*. 2013;5(Suppl 1):S62-67.

Last Medical Review: August 1, 2017 Last Revised: September 27, 2017

Written by

The American Cancer Society medical and editorial content team
(www.cancer.org/cancer/acs-medical-content-and-news-staff.html)

Our team is made up of doctors and oncology certified nurses with deep knowledge of cancer care as well as journalists, editors, and translators with extensive experience in medical writing.

American Cancer Society medical information is copyrighted material. For reprint requests, please see our Content Usage Policy (www.cancer.org/about-us/policies/content-usage.html).

cancer.org | 1.800.227.2345