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Invited

Special factors in communicating with young patients

G. Freilich. Royal Free Hospital, The Cancerkin Centre, London, United Kingdom

It is axiomatic that a diagnosis of breast cancer is shocking and deeply upsetting for any woman. For those in the 20–40 age group, the impact

is shattering and affects every aspect of their lives and the lives of those around them.

Young patients suffer a devastating assault on their existential, physical, psychological, social, sexual, financial and spiritual wellbeing. They feel a sense of loss and apprehension about the future and, as a consequence, may become anxious and depressed. While the disease is relatively uncommon in younger women, with approximately only 5% of the total incidence occurring in the under-40s, its consequences are profound and must be addressed with special sensitivity and expertise.

Treatment for younger patients is often more complex with significant side effects which can be temporary or permanent. Remission may be achieved, but if there is recurrence or the development of secondary breast cancer, this can overwhelm the patient and those close to her, just when they have begun to accept and adapt to living with the disease.

While each individual's experience is personal to them, in the case of younger women, many will share similar concerns and emotions during and after their treatment. Despite this, due to the comparative rarity of breast cancer in this age group and lack of opportunity for peer communication and support, feelings of isolation can be overwhelming.

This presentation will explore problems, needs and concerns experienced by patients who face an untimely, life-threatening disease, will deal with communication issues and suggest ways in which contact, information and support can contribute to the patient's ability to cope and improve her quality of life.

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Invited

Pregnancy and breast cancer

E. Peccatori. European Institute of Oncology, Haematology-Oncology, Milan, Italy

Pregnancy associated breast cancer (PABC) is an uncommon event that requires multidisciplinary care team and careful evaluation of patient wishes and potential risks for the foetus. Conservative surgery can be performed in many cases, and sentinel node biopsy can be selected, if the tumour is small and no palpable lymph nodes are found in the axilla. No harm to the foetus has been described after this procedure. Even if patients with PABC tend to have larger, more undifferentiated tumours, with more positive lymph nodes when compared to non-pregnant controls, prognosis remains alike, if cases and controls are well matched. Chemotherapy should be delayed after the first trimester, but a number of drugs (mainly anthracyclines, cyclophosphamide and fluoropyrimidines) have been administered to pregnant breast cancer patients, with good anti-tumour activity and the birth of normal infants. Premature delivery and intrauterine growth retardation has been described after chemotherapy administration, though, and a stringent obstetrical care should be pursued in these patients. Thorough long term follow-up of individuals born from mothers who received chemotherapy while pregnant is still incomplete, so risks and benefits of early delivery versus continuation of pregnancy should be always discussed in the third trimester.

Pregnancy in breast cancer survivors was once thought to be hazardous. Concern was raised for the potential growth of micro metastases hastened by the high estrogenic levels of pregnancy, but the clinical evidence points at the opposite direction. Neither the experience of single institutions, nor the evidence from population-based data registries have found that pregnancy after a diagnosis and treatment for breast cancer is detrimental for the prognosis. On the contrary, consistent data from the most recent trials suggest that the relative risk of death for women who had one or more pregnancies after breast cancer diagnosis is approximately halved, even if confidence interval may be rather wide. A number of biases including recollection bias, healthy mother effect, control choice could influence the reported results, but it is rather unlikely that these biases are present in all the studies. Moreover pregnancy could exert an anti tumour effect on micro metastases, which could be immunologic or endocrine related. Data from different studies suggest that it is safer to wait 1–3 years from the end of therapy or diagnosis, since most breast cancer recurrences appear in this lag time. There is no evidence that breastfeeding increases the risk of breast cancer recurrence, nor that it carries any health risk for the child. As previous radiotherapy induces fibrosis and milk shortage, women should be informed and encouraged to breast feed from the unaffected breast.

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Invited

Menopause in young women and other concerns

Abstract not received.