on state anxiety at time0 and time4, depressive symptoms at time4, fatigue at time1 to time5, than patients without an AD during their life. Also Physical and Environmental QoL at time5, and Breast symptoms at time3 and time5 were worse.

Patients with an MDD during their life scored significantly higher on state anxiety at time 0, time 1, and time 3, depressive symptoms at time 0 to time 4, and fatigue at time 0 to time 5 than patients with no MDD during their life. Physical QoL at time 0 and time 4, Psychological QoL at time 0, time 4, and time 5, Social and General QoL at time 0, body image at time 1 and time 5, side effects at time 1 and time 3, breast symptoms at time 1, and future perspective at time 2 were worse.

Conclusions: Prevalence of lifetime MDD or AD was 18% and 15%, respectively, in this group of BC patients. These patients had more state anxiety, depressive symptoms, and fatigue, and a worse QoL and health status at various moments in the two years after initial surgery compared with women who did not have a diagnosis of AD or MDD. This suggests that women who ever in their life had an MDD or AD are at risk of experiencing negative feelings and emotions and a worse QoL after treatment for BC. Therefore, patient's history regarding MDD or AD should be asked during the patient's first visit to the hospital, so that patients can be offered tailored psychological care if necessary or desired.

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Follow-up of Breast Cancer Patients: West Sussex Breast Unit Experience

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Background: The primary aim of this study was to investigate the contribution of clinical examination, patient self examination and surveillance screening on breast cancer recurrence within 5-year follow up, secondary aim was survival at 5-years.

Methods: Our study included all newly diagnosed operable breast cancer between 1 January 2003 to 31 June 2003 at West Sussex Breast Unit. Exclusion criteria were operations for recurrent cancers and metastatic disease at presentation. Patients were divided into those presenting as symptomatic patients and screening. These patients were followed for five years and the patients were investigated for recurrence (local, new contralateral and metastases) and survival at 5-years.

Results: During the study period 120 women were operated consecutively, 64 were symptomatic and 56 were screening patients. The mean age of symptomatic patients was 64 years old (range 42−90), screening patients 59 years old (range 51−70). The proportion of women with high grade cancers was higher in symptomatic compared to screening group − DCIS alone (symptomatic 3%, screening 21%); Grade 1 (11%, 21%); Grade 2 (39%, 34%); Grade 3 (47%, 24%).

In the symptomatic group there were 13 recurrences (20%) compared to the screening group with 4 recurrences (7%) as summarised by Table 1.

Table 1. Breast cancer recurrence and metastases within 5 years and mode of detection

	Ipsilateral breast	Contralateral breast	Axilla recurrence	Metastases
Symptomatic	1 Surveillance mammogram	1 Patient detected	2 Clinical examination 1 Patient detected 1	9 Patient detected 9 Bone 4 Brain 2 Liver 1 Lung 1 Supraclavicular node 1
Screening	1 Patient detected	0	0	3 Patient detected 3 Lung 1 Bone 1 Peritoneal 1
Total	2	1	2	12

The proportion of patients alive at 5-years was 67% amongst the symptomatic group and 86% amongst the screening group. Amongst the symptomatic group 6 patients (9%) died due to metastatic breast cancer compared to 3 (5%) screening patients.

Conclusion: Our study showed that only one axilla recurrence was detected by clinical examination all other recurrence and metastatic disease was mainly patient detected. This would concur with other studies that clinical examination in follow-up clinic has limited value for breast cancer survival. Our study suggests that valuable resources in terms of clinic and specialist time could be better channelled to provide a symptomatic open-access clinic.

However potential problems may be encountered by abandoning clinical follow-up that include anxiety of patients, resistance from medical professionals to change practice, reliability of patients detecting symptoms and reporting these to a health professional, the increased responsibility of those in primary care and resource re-allocation for open-access follow-up.

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An Algorithm for Screening and Treatment of Breast Cancer Related Lymphedema

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Background: Breast cancer related lymphedema (BCRL) has a high disease burden and can compromise the quality of breast cancer survivorship. Currently, there is evidence advocating both conservative and micro-surgical treatment, with effectiveness dependent on the BCRL stage. However, an evidence based integrated BCRL treatment regimen is lacking. We propose a multidisciplinary screening program with the aim of preventing BCRL progression and ensure disease regression by early identification and treatment initiation.

Methods: All women with early stage breast cancer are included in this screening program. We use preoperative and sequential postoperative bilateral upper limb volume measurements and patient perception to identify lymphedema. A 10% limb volume increase, between post-operative and baseline volume measurements, and/or patient perception of (refractory) swelling constitutes a diagnosis of lymphedema. Upon lymphedema diagnosis, patients are referred to a lymph therapist for initiation of conservative therapy in the form of complex decongestive physiotherapy. Therapy effect is evaluated after 3 months. In case of unsatisfactory symptom or limb volume reduction, the patient is considered for surgical treatment. A plastic surgeon evaluates the possibility of microsurgical lymph vessel repair in the form of lymphatic-venous anastomoses. This minimal invasive surgery can improve lymph flow in the affected limb. If despite this, symptom improvement and patient satisfaction remains minimal, autologous lymph node transplantation is considered.

Results: The primary endpoints are limb volume and perceived symptoms (refractory swelling). Secondary endpoints are quality of life, long-term limb volume and perceived symptoms, lymph-transport capacity (lymphoscintigraphy) and shoulder/arm disabilities.

Conclusion: This multidisciplinary screening program is a structured approach for the treatment of BCRL that will ultimately lead to a reduction of the negative functional, psychosocial and cosmetic consequences resulting from chronic lymphedema.

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Perceptions of Fertility and Risk in Young Breast Cancer Patients

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Background: With better treatment options available, breast cancer survival rates are improving and quality of life issues post cancer treatments are consequently becoming increasingly important. Previous studies have shown that the possible loss of fertility due to treatment for breast cancer in young women is a frequently neglected issue. This can result in considerable anxiety. Our study aimed to examine women's fears and beliefs regarding issues such as pregnancy post breast cancer and ovarian stimulation and whether conversations with health professionals were of benefit.

Materials and Methods: Findings from a literature review and a previous focus group study formed the basis of the questionnaires. They were further developed through cognitive interviews with 9 patients. The final questionnaires were sent to 263 women with early stage breast cancer, aged below 40 at time of diagnosis, attending a UK regional cancer centre.

Results: 88 questionnaires were returned. Women who recalled a fertility conversation with a health professional were more satisfied overall with discussions than those who did not (median satisfaction 7/10 versus 1.75/10 respectively, $p < 0.0001$). Common barriers to fertility discussions were health professionals not prioritising fertility issues (39% of respondents), women already had children (34%), there was insufficient time (28%) and that it would delay treatment (27%). 66% of participants expressing an opinion (33/50) believed pregnancy increased the chance of cancer returning. 66% (33/50) believed ovarian stimulation increased risk of recurrence. 12% (10/84) of participants thought they would try for a baby in the future, 17% (14/84) were unsure and 71% (60/84) did not want to. 52% (11/21) of women without children were prepared to delay chemotherapy by up to 8 weeks and 42% (20/48) of women with one child or more would delay.