Breast cancer patients face a host of difficulties in adapting to life after surgery. Learn how you can help your patient cope with the physical, emotional, and psychological aspects of recovering from mastectomy.

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Sara is a 53-year-old, postmenopausal woman who has a strong family history of breast cancer. Her mother and sister were both diagnosed with breast cancer in their mid-40s, along with her two maternal aunts. Sara has two children, the first of which she gave birth to when she was 38 years old. After going through menopause, Sara, who was already overweight, gained about 15 pounds. She’s concerned about when she’ll be diagnosed with breast cancer, not if she’ll get the disease.

Breast cancer is the most common type of cancer in American women and one of the leading causes of cancer deaths in women, second only to lung cancer. In 2007, it’s estimated that 240,000 people, including men, will be diagnosed with breast cancer in the United States.

Treatment for breast cancer depends on the type and stage of the cancer and the patient’s choice. A mastectomy is performed when breast-conserving therapy is contraindicated or when the patient chooses this option. A patient who’s undergoing a mastectomy not only requires your attention to her physical needs, but she’ll also need a great deal of support—and lots of education.

In this article, I’ll help you understand what you need to know to provide care, support, and education for your mastectomy patient in the best way possible.

First, let’s review the types of breast cancer, who’s most at risk, diagnostic testing, and how breast cancer is staged.

**Two main types**
Ductal cancer, occurring in the ducts that connect the lobes and the nipple, accounts for about 80% of all breast cancers.
cancer, occurring in the lobes where milk is produced, accounts for 10% to 15% (see Anatomy of the breast). In either case, the cancer can be noninvasive (in situ) or invasive (infiltrating). Invasive cancer extends into the surrounding breast tissue and may metastasize.

Let’s take a closer look.

**Noninvasive** breast cancer includes:
- **Ductal carcinoma in situ**—an early form of breast cancer in which the cancerous cells are confined to the duct; it has an excellent prognosis with treatment (see Picturing ductal carcinoma).
- **Lobular carcinoma in situ**—a collection of abnormal cells is present but doesn’t extend beyond the affected lobule; women with lobular carcinoma in situ have an increased risk of developing invasive breast cancer in either breast later in life. (Often, lobular carcinoma in situ is categorized as a marker for increased risk for invasive breast cancer rather than a type of breast cancer itself.)

**Invasive** breast cancer includes:
- **Infiltrating ductal carcinoma**—cancerous cells break through the duct wall and invade the breast tissue; the most common sites for metastases are the bones, lungs, liver, and brain (see Picturing ductal carcinoma).
- **Infiltrating lobular carcinoma**—cancerous cells invade the lobe; this type of cancer can metastasize to unusual areas, such as the gastrointestinal tract, peritoneum, and ovaries, and is more likely to occur bilaterally.

**Inflammatory breast cancer** is rare and usually isn’t detected by mammogram or ultrasound because it grows diffusely, not as
a defined tumor. The breast appears red and swollen and feels warm. Skin in the area may appear pitted, like the skin of an orange. Sometimes, there’s also a lump in the breast. Because it’s an accelerated form of cancer, it’s managed more aggressively than other types of breast cancer.

Other less common types of breast cancer include tubular, medullary, and mucinous, which are identified by the appearance or characteristics of the cancer cell.

Who’s at risk?
Risk factors for breast cancer include:
- Female gender
- Family history of breast cancer (maternal or paternal, female or male first-degree relative, such as a mother or daughter, or more than one second-degree relative, such as an aunt, cousin, or grandmother)
- Ashkenazi (Eastern European) Jewish heritage
- Mutation of the BRCA-1 or BRCA-2 gene (associated with a 50% to 80% lifetime risk of developing breast cancer)
- Increasing age
- Early menarche
- Late menopause
- No history of pregnancy
- Older than age 30 at first live birth
- Dense breasts (less fat than glandular and connective tissue)
- History of prolonged hormone replacement therapy, therapeutic radiation to the chest, or accidental exposure to ionizing radiation
- History of atypical hyperplasia, a type of benign breast disease
- History of breast, ovarian, endometrial, or colon cancer.

Women who don’t exercise, menopausal women who are obese, and women who drink as little as one alcoholic drink per day also have a slightly higher risk of developing breast cancer (two drinks per day increases the risk of breast cancer by about 25%, according to the National Cancer Institute).

Aim for early detection
To detect breast cancer in patients at average risk, the American Cancer Society recommends a clinical breast exam every 3 years for women in their 20s and 30s. Beginning at age 40, asymptomatic women should have a clinical breast exam and a mammogram every year. Annual mammograms should continue as long as the woman is in good health. The American Cancer Society acknowledges that women should know how their breasts normally feel and report any changes promptly to their health care providers; thus, it considers breast self-exam an option for women in their 20s. Many health care providers, however, still regard breast self-exam as an important part of
breast cancer detection. Women themselves are often the first to detect changes, thickening, or a lump in the breast.

Women with a history of breast cancer or chest wall radiation, a strong family history of breast cancer, or high-risk pathologies (such as lobular carcinoma in situ or atypical ductal hyperplasia) would benefit from consulting with a breast cancer risk clinic for screening guidelines. Magnetic resonance imaging (MRI) may be recommended for women with a confirmed BRCA-1 or BRCA-2 mutation, a high risk for the mutation (because it’s present in relatives), or a family history of breast cancer in multiple first-degree relatives (often occurring at a young age and bilaterally). If something abnormal is found on the mammogram or MRI, further diagnostic testing is done (see Breast imaging techniques).

Screening for a woman with a family history of breast cancer should begin when she’s 10 years younger than the age at which the family member was diagnosed. For a woman with a known BRCA-1 or BRCA-2 mutation, screening should begin at age 25 or 30.

In Sara’s case, she was very diligent about getting her yearly mammograms and doing her monthly breast self-exams. Her mammograms showed extremely dense breasts, with no abnormalities noted. Neither Sara nor any of her family members had been tested for the presence of mutations in the BRCA-1 and BRCA-2 genes. After being seen in a high-risk breast cancer clinic, it was recommended that Sara get an MRI due to her family history and dense breasts. The MRI showed an abnormality that after biopsy revealed invasive ductal carcinoma with a small focus of lobular carcinoma in situ.

After breast cancer is diagnosed, the oncologist will stage it according to the American Joint Committee on Cancer guidelines. Staging is based on the tumor size, lymph node involvement, and whether the cancer has metastasized. See Staging breast cancer for more information.

Breast imaging techniques

While mammography remains the gold standard, these screening tools can detect more types of breast cancer, find them at earlier stages, and identify those that require aggressive treatment.

- **Digital mammography**—creates electronic images rather than images on film. The images can be better manipulated and transmitted via e-mail for further review, and there’s less need for repeat imaging. It has been shown to be superior to standard mammography in pre- or perimenopausal women younger than age 50 who have dense breasts.

- **Magnetic resonance imaging (MRI)**—uses magnetic fields, not radiation, to create images of the body. MRI is a sensitive test that can lead to false positives and is currently only recommended for screening in select groups. The American Cancer Society recommends that women with cancer in one breast should get an MRI scan of the other breast. It also recommends that healthy women at high risk for breast cancer should have MRI scans. A recent study showed that MRI was better than standard mammography at detecting ductal carcinoma in situ. We still need to learn more about the role of MRI in routine breast cancer screening.

- **Ultrasound**—sends high-frequency sound waves through the breast and converts them into images, helping to distinguish between a fluid-filled and solid abnormality. It may be the first test done when a lump is found in a young woman with dense breasts, which limit the accuracy of a mammogram. Ultrasound is also done if a palpable abnormality doesn’t show up on a mammogram.

- **Digital tomosynthesis mammography**—creates a three-dimensional image. The comparison between a conventional mammogram and a digital tomosynthesis mammogram is similar to the comparison between a conventional X-ray and a computed tomography scan. Currently only being used for research purposes, digital tomosynthesis mammogram may make cancer detection easier in dense breast tissue, and it delivers a lower dose of radiation than a conventional two-view mammogram. It also applies less pressure than a standard mammogram, so it’s more comfortable.

- **Positron emission tomography**—creates images of chemical changes in breast tissue that accurately detect aggressive tumors, such as in inflammatory breast cancer, large lymph nodes, and skeletal lesions. However, its sensitivity to detect small primary lesions and invasive lobular carcinoma is limited.

Surgery: The mainstay of treatment

Now let’s review the surgical options available to Sara.

Sometimes referred to as a segmental or partial mastectomy, a lumpectomy, or tumor excision, is considered breast-conserving therapy. During this outpatient procedure, the surgeon removes the tumor and a small amount of tissue around it,
but preserves as much of the breast as possible (see *Picturing breast cancer surgery*). In some cases, the surgeon also removes the axillary lymph nodes. Lumpectomy also provides biopsy material to determine what type of tumor cell the patient has. For a patient with ductal carcinoma in situ, lumpectomy may be the only surgery required. However, it should always be combined with radiation therapy for invasive breast cancer and for most cases of ductal carcinoma in situ.

If the tumor is confirmed malignant, the surgeon will discuss other treatment options, including additional surgery, with the patient.

A **simple mastectomy** involves removing the entire breast, leaving the axillary lymph nodes intact (see *Picturing breast cancer surgery*). It’s usually performed in patients with noninvasive cancer, but may be performed after a patient with invasive breast cancer has undergone a lumpectomy and axillary lymph node dissection with no clear margins at the lumpectomy site. During a simple mastectomy, the surgeon may also perform sentinel lymph node mapping and biopsy. See *Lymph node link* for more information. Some patients who are at a high risk for developing breast cancer opt to have a simple mastectomy done prophylactically. Many patients who choose this option have been found to carry mutations in the BRCA-1 or BRCA-2 genes. Breast removal may also be indicated in cases where the tumor is centrally located, although some of these patients are candidates for breast-conserving lumpectomy followed by radiation therapy.

A **modified radical mastectomy** involves removing the breast and level I and II axillary lymph nodes (see *Lymph node link*). Lymph node removal is used to determine the probability that the cancer has spread to other parts of the body. When the patient

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**Picturing breast cancer surgery**

In lumpectomy, the surgeon removes the breast mass, surrounding tissue, and, possibly, nearby axillary lymph nodes through a small incision near the nipple. The breast mound is preserved.

**Lumpectomy**

In simple mastectomy, the surgeon makes an elliptical incision around the breast and then removes the entire breast, leaving axillary lymph nodes and pectoral muscles intact.

**Simple mastectomy**
## Staging breast cancer

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
<th>5-year relative survival rate</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td><strong>Tis, N0, M0:</strong> Ductal or lobular carcinoma in situ with no associated invasion of normal breast tissue; no regional lymph node metastasis; no distant metastasis</td>
<td>100%</td>
</tr>
<tr>
<td>I</td>
<td><strong>T1, N0, M0:</strong> Tumor is 2 cm or less at its greatest dimension; no regional lymph node metastasis; no distant metastasis</td>
<td>98%</td>
</tr>
</tbody>
</table>
| II A  | • **T0, N1, M0:** No evidence of primary tumor; metastasis to movable ipsilateral axillary lymph nodes; no distant metastasis  
        • **T1, N1, M0:** Tumor is 2 cm or less at its greatest dimension; metastasis to movable ipsilateral axillary lymph nodes; no distant metastasis  
        • **T2, N0, M0:** Tumor is more than 2 cm but 5 cm or less at its greatest dimension; no regional lymph node metastasis; no distant metastasis | 88%                           |
| II B  | • **T2, N1, M0:** Tumor is more than 2 cm but 5 cm or less at its greatest dimension; metastasis to movable ipsilateral axillary lymph nodes; no distant metastasis  
        • **T3, N0, M0:** Tumor is more than 5 cm at its greatest dimension; no regional lymph node metastasis; no distant metastasis | 76%                           |
| II A  | • **T0, N2, M0:** No evidence of primary tumor; metastasis to ipsilateral axillary lymph node(s) fixed or matted; or in clinically apparent ipsilateral internal mammary nodes in the absence of clinically evident lymph node metastasis; no distant metastasis  
        • **T1, N2, M0:** Tumor is 2 cm or less at its greatest dimension; metastasis to ipsilateral axillary lymph node(s) fixed or matted; or in clinically apparent ipsilateral internal mammary nodes in the absence of clinically evident lymph node metastasis; no distant metastasis  
        • **T2, N2, M0:** Tumor is more than 2 cm but 5 cm or less at its greatest dimension; metastasis to ipsilateral axillary lymph node(s) fixed or matted; or in clinically apparent ipsilateral internal mammary nodes in the absence of clinically evident lymph node metastasis; no distant metastasis  
        • **T3, N1, M0:** Tumor is more than 5 cm at its greatest dimension; metastasis to movable ipsilateral axillary lymph nodes; no distant metastasis  
        • **T3, N2, M0:** Tumor is more than 5 cm at its greatest dimension; metastasis to ipsilateral axillary lymph node(s) fixed or matted; or in clinically apparent ipsilateral internal mammary nodes in the absence of clinically evident lymph node metastasis; no distant metastasis | 56%                           |
| II B  | • **T4, N0, M0:** Tumor of any size with direct extension to (a) chest wall or (b) skin; no regional lymph node metastasis; no distant metastasis  
        • **T4, N1, M0:** Tumor of any size with direct extension to (a) chest wall or (b) skin; metastasis to movable ipsilateral axillary lymph nodes; metastasis to ipsilateral axillary lymph node(s) fixed or matted; or in clinically apparent ipsilateral internal mammary nodes in the absence of clinically evident lymph node metastasis; no distant metastasis  
        • **T4, N2, M0:** Tumor of any size with direct extension to (a) chest wall or (b) skin; metastasis to ipsilateral axillary lymph node(s) fixed or matted; or in clinically apparent ipsilateral internal mammary nodes in the absence of clinically evident lymph node metastasis; no distant metastasis | 49%                           |
| II C  | • Any **T, N3, M0:** Tumor of any size; metastasis to ipsilateral infraclavicular lymph node(s) with or without axillary lymph node involvement; or in clinically apparent ipsilateral internal mammary lymph node(s) and in the presence of clinically evident axillary lymph node metastasis; or metastasis to ipsilateral supraclavicular lymph node(s) with or without axillary or internal mammary lymph node involvement; no distant metastasis | *                             |
| IV    | Any **T, any N, M1:** Tumor of any size; either regional lymph node metastasis or no regional lymph node metastasis; distant metastasis | 16%                           |

* No survival rate is available for Stage IIIC breast cancer because the stage was only recently defined. Inflammatory breast cancer is always classified as Stage III unless it has spread to distant lymph nodes or organs (Stage IV).

T = primary tumor; N = regional lymph nodes; M = distant metastasis

has an invasive form of breast cancer, this procedure may be indicated in the following instances:

- tumor greater than 5 cm (some institutions set the limit at 4 cm)
- no clear margins seen with lumpectomy or reexcision
- breast with more than one tumor
- patient with collagen vascular disease, such as scleroderma or lupus, that contraindicates radiation therapy
- prior radiation to the breast or chest wall
- patient doesn’t live within reasonable driving distance of a radiation treatment facility
- breast removal is the patient’s choice.

A more extensive surgery, a **radical mastectomy** involves the removal of not only the breast and axillary lymph nodes, but also the pectoralis major and minor muscles. For many years, this was the most common surgery for breast cancer; it’s rarely performed today.

When Sara met with the surgeon, she was given the option of a lumpectomy with radiation therapy or a mastectomy, along with a sentinel lymph node biopsy for the local control of her breast cancer. She was a bit conflicted about her choices and feared for the unaffected breast. After all, she had many risk factors—strong family history, age of first live birth, postmenopausal obesity, dense breasts, and now the presence of lobular carcinoma in situ. After consultation with her high-risk clinic team and her family, Sara decided on bilateral mastectomy. While a prophylactic mastectomy of the uninvolved breast doesn’t completely prevent the chance of breast cancer recurrence, it does reduce it greatly, thus decreasing her anxiety associated with future breast cancer. She met with a plastic surgeon, but decided against breast reconstruction.

During the operation, the surgeon identified the sentinel lymph node, sending it to pathology for review. Unfortunately, the sentinel lymph node was positive for cancer. The surgeon then performed a standard axil-
lary lymph node dissection.

What kind of postop care will a patient like Sara need? Let’s take a look at that next. I’ll be focusing on the care of patients who’ve decided to delay breast reconstruction, like Sara. Be aware, however, that some patients opt for reconstruction at the time of surgery. Their care may be somewhat different (for example, they may have more drains after surgery and more postop activity restrictions). As with any other procedure, familiarize yourself with your facility’s policies for specific courses of action.

**Education station**

Your focus when caring for a mastectomy patient is providing education. She’ll need to know how to take care of her drain and change her wound dressings, how to manage her pain, how to handle sensory alterations (such as numbness, burning, and phantom pain), how to avoid restricted range of motion (ROM), and a host of other issues. The ideal time to start teaching a patient with breast cancer is before she undergoes surgery. After the procedure is complete and she’s awake and alert, you can reinforce what you told her earlier. In addition to verbal communication, it’s also important to give your patient information in print form that she can refer to later. You’ll also offer additional information and review your teaching when she returns for follow-up visits.

Let’s take a closer look at what you should teach your patient.

**Drain care 101**

Drain care is often the biggest concern for patients and their family members. If your patient had a modified radical mastectomy, she’ll likely have two drains. If she had a simple mastectomy or a mastectomy with sentinel lymph node biopsy, like Sara, she’ll probably have only one drain.

The Jackson-Pratt drain is the most commonly used drain for mastectomies, and it’s relatively simple to maintain. While you take care of your patient’s drain for the first time after her surgery, explain what you’re doing. Encourage her to assume the care of her drain as soon as she feels up to it. With her permission, it’s a good idea to involve family members, friends, or other patient supporters in learning about drain care as well.

**Get pain under control**

Postop pain control is another major concern for most patients undergoing a mastectomy. A patient who has had axillary lymph node surgery usually experiences more pain than a patient who has had a simple mastectomy. Pain is usually well controlled with oral opioids or oral nonopioids, such as ibuprofen or acetaminophen. However, your patient may need patient-controlled analgesia initially after surgery.

When you discuss pain control options with your patient, emphasize that although discomfort, soreness, and stiffness are normal, she shouldn’t wait until she’s in excruciating or disabling pain to take a pain reliever. Explain how she can quantify her level of pain using a pain scale, and ask her to reevaluate and record her pain level after she takes medication. The goal is for her to feel comfortable enough to exercise, sleep well, and resume as many of her usual activities as possible.

If your patient is taking an opioid, give her pointers on how to avoid constipation, a common adverse effect of these drugs. Remind her that it’s easier to prevent than to treat constipation. Many pain management experts recommend the over-the-counter medication Senokot-S or a generic equivalent for patients taking prescription pain relievers that may cause constipation. Bulk laxatives aren’t recommended because they may worsen constipation. Your patient should stick to a high-fiber diet and increase her fluid intake as well. If she’s still having problems, she might want to request a prescription-strength medication for relieving consti-
In rare cases, a patient may experience severe, chronic postmastectomy pain, including long-lasting and continuous pain in the axilla, medial upper arm, or lateral chest wall. If your patient has this type of pain, recommend that she be referred to a pain management clinic.

If your patient had an axillary lymph node procedure, she may experience sensory alterations, including numbness and burning in her chest and arm, as a result of nerve irritation. If she had a mastectomy, she may also feel phantom sensations that seem to come from the missing breast. These sensations can take weeks, even years, to fade.

**Up and at ’em**

We all know the importance of getting a patient moving after surgery. The average mastectomy patient doesn’t realize how much she’s limiting or guarding her upper body until she’s taking pain medication and feels well enough to move with greater ROM.

Most mastectomy patients have restricted ROM in the arm and shoulder on the surgical side. A patient who has had axillary lymph nodes removed may experience greater restriction than a patient who has had another type of surgery. Either way, encourage your patient to adhere to the arm exercise program prescribed by her practitioner. With exercise, most restriction usually resolves within a few months after surgery. If your patient doesn’t already have specific ROM instructions, your facility’s physical therapy department should be able to recommend a good program.

**Support and comfort**

Many mastectomy patients find that bras or camisoles specifically designed for patients recovering from breast cancer surgery provide much-needed support and comfort. These garments also help keep gauze dressings intact without having to apply tape to the skin. Some facilities routinely provide such garments for mastectomy patients. If your facility doesn’t, be sure to educate your patient about where she can obtain them. Check with your local division of the American Cancer Society for a mastectomy product list, which provides information about places that sell mastectomy products. Federal law mandates that all insurance companies cover the costs of mastectomy bras and other mastectomy products.

**On the lookout**

Besides routine postop assessments, you’ll need to check for signs of infection (redness around the incision, a feeling of warmth, or purulent drainage) in the extremity, chest, or trunk on the surgical side and watch for complications, such as hematoma and cellulitis. Usually caused by bacteria, cellulitis is an inflammation with infection of the skin and surrounding tissue that can lead to tissue death and systemic infection. Tell your patient to call her health care provider immediately if she has swelling lasting longer than 1 week, especially if it’s accompanied by redness or heat, a fever, or swollen lymph nodes. Mild cellulitis can be treated at home with oral antibiotics, but patients with severe cases of cellulitis generally need inpatient treatment with I.V. antibiotics. If your patient had a flap procedure for breast reconstruction, be on the look out for flap necrosis (the flap appears dark and purplish or black), which is most likely to occur in the first 6 to 12 hours after surgery.

**Be aware of lymphedema**

If your patient had any lymph nodes removed, she may be at increased risk for lymphedema (an abnormal collection of protein-rich fluid accompanied by chronic inflammation and fibrosis). That’s because removing lymph nodes changes the way lymph fluid flows. If remaining lymph vessels can’t effectively remove excess fluid, it can accumulate and cause lymphedema.
A patient who has undergone axillary lymph node surgery may develop lymphedema in the hand, arm, or trunk on the surgical side. It can occur any time, from the immediate postop period to several decades after surgery. The highest lymphedema rates seem to occur among modified radical mastectomy patients who receive postsurgical radiation therapy (up to 30%). The rate appears to be much lower in sentinel lymph node biopsy patients who receive postsurgical radiation therapy (up to 7%). Although there’s no cure for lymphedema at present, it can be controlled, so prompt intervention is important.

Health care providers disagree about the specific lymphedema precautions that breast cancer surgery patients need to take, and even about which patients should follow them. Differing opinions exist due to the lack of research proving that lymphedema can be prevented after lymph node surgery. Some believe that breast cancer surgery patients—especially those who’ve had a sentinel lymph node biopsy—have been unnecessarily alarmed about the risks of developing lymphedema. Still, advise your patient to follow the standard precautions outlined in Decreasing lymphedema risk.

Despite precautions, lymphedema may still occur. Tell your patient to watch for these signs:
- Feeling of fullness or heaviness in the arm on the surgical side
- Feeling of tightness in the skin on the surgical side
- Less movement and flexibility than usual in the hand or wrist
- Difficulty fitting the arm on the surgical side into a sleeve
- Feeling of tightness around a ring, watch, or bracelet without weight gain.

Elevate your patient’s arm on the surgical side using a small pillow. Tell her that she can continue doing so at home for 4 to 6 weeks after surgery to help reduce initial swelling and discomfort. Give your patient a small foam ball and tell her to squeeze it with the hand on her surgical side to help circulate lymph fluid.

**Coping with the loss**
Your patient may be experiencing the mastectomy as a loss and may need to grieve. Or she may feel a sense of relief after a mastectomy if she’s been dealing with the disease for months by the time she has surgery. For some, the anxiety associated with waiting for the final lymph node report and potential future treatments—usually chemotherapy or hormonal therapy—

**Decreasing lymphedema risk**
Here are tips you can give your mastectomy patient on how she may be able to decrease her risk of lymphedema. Because these tips aren’t proven to be effective, avoid using the word “never.” Instead, use “when possible.” Keep in mind that your patient’s health care provider may not agree that she should observe all of these precautions.

- Ask that blood pressure readings be taken in the arm opposite the surgical side. If you’ve had bilateral axillary lymph node dissection, you may want to ask to have your pressure taken in one of your thighs.
- Avoid wearing tight elastic or jewelry on the arm on the surgical side.
- Wear heavy duty gloves for gardening or similar activities.
- Use a thimble when hand sewing.
- Use an electric razor when shaving your underarms.
- Ask that any procedures involving a needle (blood draws, I.V. insertions, or injections) be done in the arm opposite the surgical side.
- Wear a heavy-duty oven mitt during cooking and baking.
- Wear sunscreen with an SPF of at least 30.
- Wear long-sleeved shirts or use insect repellent when you’re likely to be around biting insects.
- Wear rubber gloves when doing dishes or cleaning with harsh detergents.
- Sleep on your back or on the nonsurgical side.
- Carry luggage and handbags on the nonsurgical side.
- Examine your upper body in a mirror from time to time to detect any differences between the surgical side and the other side; if you notice any signs and symptoms of lymphedema and they last for 1 to 2 weeks, contact your health care provider.

Research has shown that women who gain more than 10 pounds after mastectomy have a higher risk of developing lymphedema; women who engage in some type of regular aerobic exercise have a lower risk.

An informative booklet, What Every Woman Facing Breast Cancer Should Know About Lymphedema: Hand and Arm Care Following Surgery or Radiation Therapy for Breast Cancer, is available from the American Cancer Society by calling 1-800-ACS-5345. You may want to recommend this booklet to your mastectomy patients who have undergone lymph node surgery.
becomes yet another stressful situation. Your facility’s social worker can offer support to your patient and her family.

Make sure to assess your patient’s coping ability and her reaction to the physical changes that accompany surgery. You may also want to refer her to a breast cancer survivor support group. The American Cancer Society, for example, has a Reach to Recovery program that’s designed to help breast cancer patients retain—or recover—a positive self-image. Breast cancer survivors offer face-to-face or phone assistance and practical advice to others who’ve recently undergone the same type of surgery. The Cancer Hope Network and the Y-Me National Breast Cancer Organization have similar programs available via telephone.

The Reach to Recovery volunteer can also provide your patient with a temporary breast form she can place inside her bra. Or, you can prepare a breast form for her yourself. Materials (nylon covers and cotton fluff) are available free of charge from the American Cancer Society. The forms are easy to make; you need only adjust them to your patient’s bra size and skin tone. Your patient can wear this temporary breast form after her drains are removed. Later, her surgeon will likely give her a prescription for a prosthesis. She’ll be fitted for the prosthesis about 6 weeks after surgery, after she’s well healed.

Now, let’s check in with our patient.

After surgery, Sara had a special wristband to alert staff not to use her right arm for venipunctures or blood pressure measurements because of the risk of lymphedema. She had two Jackson-Pratt drains, one from either side of the lateral chest. The nurses taking care of Sara showed her and her husband how to care for the drains. They both felt comfortable with their ability to care for the drains at home.

Before discharge, the clinical nurse specialist (CNS) gave Sara temporary breast forms and a mastectomy product list for her geographical area from the American Cancer Society. She also taught Sara about lymphedema, ROM exercises, and the importance of pain control, as well as constipation prevention while taking opioids. She supplemented her teaching with written information. The CNS also answered Sara’s questions related to chemotherapy, which is a part of her treatment plan because she had a positive axillary lymph node. She also consulted a social worker to assist Sara with psychosocial issues related to both her and her children’s coping patterns.

On her postop visit, Sara reported her drain totals to her surgeon, who then removed both drains. Her pain was well controlled on acetaminophen and she didn’t have any evidence of lymphedema. She reported doing her exercises as prescribed and demonstrated very good ROM. While she was worried about her chemotherapy treatments that would begin in about a month, Sara felt that the continued support...
and education of her health care team would help her get through the treatments.

Compassionate care
Being diagnosed with breast cancer and then undergoing a mastectomy procedure can be daunting challenges for your patient. Your expert nursing care, teaching, respect, and support can help your patient recover from breast cancer surgery not only physically, but emotionally and psychologically as well.

Learn more about it