As a nurse, I have been in the difficult position of breaking the news of a scary diagnosis to a patient. But in 2004, the roles were reversed and I found myself a patient hearing the frightening results.

I was 52 years old and premenopausal when a routine mammogram revealed an area of microcalcifications in the upper outer quadrant of my left breast. Though a diagnostic mammogram 8 months later revealed no changes, by the first year, the microcalcifications had multiplied and changed in configuration.

Final diagnosis after a wire-guided, excisional biopsy was atypical hyperplasias, consisting of ductal, lobular, microcalcifications.

Further evaluation
I was placed into the fine needle aspiration (FNA) study at the University of Kansas Medical Center's High Risk Breast Prevention Center, which showed adenocarcinoma, most likely lobular. Because cancer cells were detected, the oncologist recommended breast magnetic resonance imaging (MRI).

The MRI was negative for a defined tumor. Not satisfied, the oncologist decided that I needed a sonogram and a repeat FNA in which samples from each breast quadrant would be evaluated separately. The sonogram was negative, but while doing the FNA, the oncologist thought she felt a tumor with the needle and had the radiologist reexamine the sonogram. There were two small tumors close to the chest wall, making them difficult to identify.

My second FNA pinpointed the cancer to the same area of microcalcifications found on the initial mammogram. My oncologist told me that I needed a core biopsy, followed by mastectomy, chemotherapy, and radiation. Though shocking, I was prepared for this news.

Often, the entire tumor can be removed by core needle biopsy, however, it’s difficult to determine if clean margins have been obtained. The results of the biopsy showed invasive ductal carcinoma, moderately differentiated.

Opting for surgery
Lobular cancer is also a risk factor for cancer in the contralateral breast, so I opted for a bilateral mastectomy. Reconstruction can be done at the time of mastectomy if radiation isn’t being considered. I had a modified radical mastectomy on the left and a prophylactic mastectomy on the right. Five lymph nodes, including the sentinel node bilaterally and three other nodes on the left came back disease-free. The biopsy report showed three additional tumors, all lobular with two invasive. No ductal carcinoma was found, indicating that the core biopsy had obtained it all. Clean margins were also noted, indicating that the tumors weren’t invasive to the chest wall.

After surgery, computerized tomography scans of my chest and abdomen and a bone scan ensured that I didn’t have cancer metastasis to these areas.

I’ve learned a lot in a short period of time about breast cancer and being a patient. What I haven’t mentioned is the perseverance necessary to convince surgeons and oncologists to continue investigating abnormal findings. By the time the cancer was palpable or visible on the mammogram, it would have been invasive and my outcome wouldn’t be as favorable had I not pushed my providers. I am grateful to say that my survival expectation for the next 5 years is 98%.

Because of my experience, I want to reiterate that you need to listen to yourself and to your patients. We can’t be advocates for our patients if we don’t really listen to them. We can’t be our own advocates if we don’t listen to ourselves. OR

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