Speaker 1 (00:05):

A diagnosis of breast cancer can cause a life changing ripple effect of impact affecting those. We love the most and those upon whom we lean for comfort and strength in the most challenging of times, my name is Aisling Hurley, and I'm the CEO of breast cancer Ireland. And you're listening to more than a lump, a podcast that talks openly and honestly, to a selection of guests about their very personal connection to breast cancer, be it through their career choice, their own firsthand experience of the disease, or through sharing the experience of close family members. My conversations will enter on how breast cancer has informed their perspective on life, love, family health, their goals, and indeed their aspirations. Although each story is utterly unique. The one common thread that runs through each one is that breast cancer is more than a lump.

Jamie Martin-Smith is a consultant plastic surgeon at Beaumont Hospital. In today's episode. Jamie talks to me about his career choice, running the general plastics clinic at bow hospital and managing the full spectrum of plastic surgical cases, as well as a dedicated reconstructive breast surgery clinic. He answers some of the questions that women in our community ask in relation to how long they should wait for reconstruction following treatment, how to physically prepare for breast reconstruction surgery and how to deal with the after effects.

Speaker 1 (01:27):

Jamie, you're very welcome to more than a lump podcast. And thank you for taking the time to come along and chat to me today on this important topic.

Speaker 2 (01:33):

Thanks for having me. I'm delighted to be here,

Speaker 1 (01:35):

I suppose, first and foremost, I'd love to hear a little bit about your choice of career and why you choose breast reconstruction surgery.

Speaker 2 (01:44):

So I, I trained in Ireland and I did the training scheme for plastic surgery and plastic surgery has got hand surgery, trauma, um, burn skin and everything. But part of plastic surgery is microsurgery, which is connecting tiny little vessels under the microscope at tiny sutures. And one of the most common uses for microsurgery is breast reconstruction. And so I went to the England and I worked in the Royal Mars in hospital in London, and I really got a buzz for the technical side of doing loads and loads of microsurgery. And to be honest, then that led to me becoming a breast reconstructive surgeon, because that's the most common procedure we do for breast reconstruction. And I guess that's now evolved to me being pretty comfortable with the aspect of it. And so the challenge in breast reconstruction is I, I guess, you know, the aesthetic outcome, but also helping patients get through the pathway and, you know, trying to, you know, uh, make, help them make their decisions and things like that. So while it was initially the technical draw to what I did, it's now actually the aesthetic and the, you know, the whole background to breast reconstruction and breast cancer.

Speaker 1 (02:49):

And I suppose breast surgery and reconstruction can be an emotive topic for so many women. Um, they're often coming to you having been through the trauma of a diagnosis and treatment. And as many of our guests here on the podcast can attest to, they are somewhat overwhelmed, um, about their journey ahead. At what point do you come in under that whole team and involvement in that patient's journey?

Speaker 2 (03:12):

So I guess so obviously the most, you know, the first person they meet is the breast surgeon who unfortunately has to get of them their diagnosis and go through everything with them. And every patient's totally different. Some people, you know, take it in their stride and all of a sudden, you know, they wanna meet someone. Who's gonna talk about breast reconstruction and some people really don't take it in their stride and they need a couple of visits to talk through the diagnosis and the management plan and things. And I guess the entrance point for me is when the breast surgeon thinks they're ready to talk about it. And they'll, they'll bring up the notion of breast reconstruction to the patient. And there's so many patients, you know, that they just jump at it. It's just like this opportunity to take control. They've spent how many hours waiting and waiting rooms and doing scans, being told what to do, going, you know, being told what the results of their MDT decision is when the doctors sit down and, you know, make a treatment plan and all of a sudden someone's telling them, well, what do you want to do?

Speaker 2 (04:05):

So there's this cohort of people that jump at the opportunity and, you know, put their hand up straight away. They want to see a breast reconstructive surgeon and that's great, but there's another cohort that really, you know, are push back and they're like, no, I don't really want a breast reconstruction. I just want to, I want to treat this thing head on. And I want to devote all my thought process to the breast cancer and getting rid of it. And so I guess it's dictated by the patient and the breast surgeon most of the time though. Um, they'll come and see me before any surgeries happened before any mastectomies happened. If they've shown any inkling of being interested, uh, they'll come and see me and I'll just talk them through with the options are, um, bearing in mind, I'll have an idea of what their diagnosis and what their cancer's like and what their extra treatments might be in terms of chemo, radiotherapy. So, okay. That kind of, you know, narrows our options a little bit sometimes. Um, but yeah, we talk and we talk for half an hour in the first consultation and if they're keen, we start setting things a open if they're not keen, they head back to the breast surgeons and then they,

Speaker 1 (05:04):

Yeah, yeah. And tell me this then, um, you just mentioned there depending on their treatment and whether they go on for radiation therapy, et cetera, is reconstruction, does reconstruction depend on whether or not they have to have radiation therapy? Like could they be re have a reconstruction and then go on to have radiation therapy or is there

Speaker 2 (05:21):

For sure. So what I mentioned at start like the microsurgery option is when you move your own tissue from one part of the body, to the other classically using your tummy, if you make a breast out of your own fat and your own tissue, it's really resilient. And so you can irradiate that. You can give that radiation and it stands up to it really well, and it doesn't really change shape or size or texture. And you end up with the same result that you had before radiation. So it's a great option. Okay. And I work in a

symptomatic breast unit, which means the women are coming in with a lump and, you know, with maybe more advanced tumors, which means that probably things are at a later stage as opposed to a screening unit where they're cautious on mammogram. That means a lot of my patients end up do needing they, they, they do need radiotherapy from the get go.

Speaker 2 (06:04):

I think they know that going in. And so in my unit, we have a bit more of a biased using the, their own tissue. Okay. In terms of, you know, helping them make their decision, but also kind of telling them what they can and can't have, if you do an implant reconstruction, it's really, you know, uh, not resistant to radiotherapy. Okay. So if they get radiotherapy unexpectedly after an implant reconstruction, it changes the shape and the texture and the position of the implant. And so we try to avoid that and, you know, if there's an unknown, uh, what the patient is gonna have in terms of radiotherapy, we try and talk it through the patient about how much of a disaster it would be in their mind if we had to suddenly change the reconstruction down the line and things like that. So they're the kind of things we talk about, but a lot of it's not set in stone. Um, it kind of all comes back to them what the patient wants in terms of how they want their breast to be reconstructed.

Speaker 1 (06:54):

Absolutely. And as you referred to there, so there's many different options available to them, depending, you know, whether it is an implant, whether it is a flap, as you say, a reconstruction from tissue, from the tummy or the BU or the buttocks or whatever. Um, are they the only types of reconstruction that you do and what is, what tends to be the favor?

Speaker 2 (07:14):

So I, so yeah, anyone that's gone through my clinic, I kind of have a feel and I tell everyone the same thing to make a breast. You need two things, you need skin and you need volume. And that's literally it because I'm creating an aesthetic breast, man. I'm not creating anything that functions I've gotta create something that looks right. Yes. So I need a skin and volume and the right shape of volume, the right amount of volume and the skin, if you, if you're lucky enough that you're in the right head space or that your breast surgeon is happy, you know that you're having an immediate reconstruction, then you get to keep all your own skin in general. Okay. So then we just need volume. Mm. And you can get volume either off the shelf, which is an implant, or you can donate it from your own body, but donating, it comes with a sacrifice.

Speaker 2 (07:54):

I've got it. Take it from somewhere. So you get scars and you get a recovery period from place. I take it from, and that's what scares some people out of it, but that's what other people love about it. That's coming from their body. So it's, it's, it's kind of like, it's not binary either way. There's, you know, there's a range of different thoughts on it. The other option is, yeah, you take implant and that creates a volume, but it creates a very fixed volume. The implant will never change shape with time. It won't drew properly to match the other side. And so there's drawbacks with the implant like that, but you can get really super results with the implant as well. And I guess it, again, it just comes down to patient preference. Some patients are just totally aghast of the idea of me putting an implant or silicone in there. There's so many controversies and things which mostly are ill founded. Um, but some people just can't get their head

around implant. Um, which is fine because I'm kind of biased towards, you know, the technical one that using your own tissue. Sure. Which again, I tell all my patients that I'm completely biased of course,

Speaker 2 (08:53):

But you get a much better reconstruction using your own tissue, but it's a much bigger sacrifice and

Speaker 1 (08:57):

That's the issue. Yeah, of course. And then I suppose, downtime post surgery.

Speaker 2 (09:02):

Yeah. So again, if you're using an implant getting maybe a little bit technical, it can either go under the muscle or over the muscle, little bit of a recovery difference that over the muscle, recovery's really quick. So recently I, I reconstructed a lady who was she's big into horse riding and the most number one priority for her for reconstruction was to get back on the horses because she, she works with them. She sells 'em and things. So we did in front of the muscle and she was back trying to do stuff with sort of day four day five. Oh, wow. If you go onto the muscle, you've gotta lift the muscle and move stuff in a bit more surgery and stuff on the inside sore, or maybe two, three weeks. Um, recovery is also a very vague word, is recovery, you know, bringing the kids to school or is recovery back working in your full-time job. Sure. And so it's kind of hard. So we kind of explore that the time, if you use your own tissue, you know, it's a big operation you're outta driving for three weeks. You're probably outta work for six to eight weeks. Your body doesn't feel like itself for maybe three months. And, you know, you're bearing that scar forever. So big range.

Speaker 1 (10:03):

Yeah. Wow. Okay. Um, and Jamie, tell me this, um, you know, I've heard different patients talking, uh, at different times about, you know, while they've had a diagnosis and they have their treatment plan in place, and then they're faced a discussion about reconstruction. And I often hear, uh, you and others saying, you know, well, you have the, the patient and perhaps a husband or a partner or boyfriend whomever in the room with them. And the patient is asked, you know, well, what size would you like to be, as opposed to, you know, if you're currently a DEC cup and you are, you can make them both a D or you can make them both a C or whatever. How do you D with that? Or how do you sort of explain that to them?

Speaker 2 (10:39):

So, first question on examination is what do you think of the other side? And, you know, funny enough when I worked in Chelsea they're so outspoken, Irish women as a cohort, it takes them a minute or two they're like, what do you mean? And so then I ask them again, and then they tell me, oh, I kind of would like it a bit smaller or, yeah, it's fine. Um, and a lot of the times women ask to be a little bit smaller and then we say, okay, fine. And then I point out to them that we're making a breast from scratch. Why do we not? Let's make something that they want and in terms of size and depends on body habits and things like that. But generally I give them, you know, my opinion, what I can make. And then they're like, oh yeah, okay, let's do that.

Speaker 2 (11:15):

Or could we go smaller or bigger or whatever. Every so often a lady will have a really small breast and, you know, it's always been in the back of their mind that they hated, you know, their size and always want to be a bit bigger. So sure. We make something a little bit bigger and then we can augment the other side, not a huge fan of that because it involves more implants on the other side. And I would never like to drive someone into an augmentation, but yeah, I mean, everything's on the table. You and we just have to try and work our way through the decision making process.

Speaker 1 (11:41):

And as you say, it gives them back control.

Speaker 2 (11:44):

Yeah,

Speaker 1 (11:44):

Totally. Which is, which is fantastic.

Speaker 2 (11:46):

The other thing is some women, you know, come into me and the, the thought process is, well, I'm, I'm really slim. Uh, you know, I, I definitely don't have enough tissue and sure there are women that are super skinny and there's not enough tissue. And the classical surgical thing of being able to use your own tissue is if you had a big tummy, you could, you know, transfer it and make a breast, but things have evolved, you know, and I can pretty much get enough volume to a breast out of your own tissue on anyone. Wow. It's difficult. If, if it's a bilateral reconstruction, it's much harder because, you know, then I need to get double the amount. Sure. Uh, but for a single breast, you can, you, you can harvest from different sites and put them, connect them together with the microscope and then connect them to the chest.

Speaker 2 (12:30):

Obviously the slimmer you are, the more, technically hard it gets, but it's all doable, impossible. And again, it's that discussion. Yeah. I had a lady previous patient of mine and she had problems with her implant and she's super fit and slim. And I really told, I told her, I don't think I can, we can do anything other than use your own tissue. It was such a sacrifice for her. She had this perfect tummy and know I felt bad suggesting it, but yeah, she, she went for it. It worked really well. And actually she just had, you know, the final stage of her reconstruction and she's really happy, but yeah, it's technically demanding but possible on everyone.

Speaker 1 (13:05):

Now tell me, where do you see the future of reconstruction going in the surgical world?

Speaker 2 (13:12):

The future hopefully is, you know, the breast surgeons figuring out all the cures, that's the most likely future at some stage that'll become obsolete. Um, the future, one of the, what would be cool is if we could just lipo so fat, and if we could just create a sort of framework in the breast that we could sequentially inject fat. So that means there wouldn't be any scars. We just suck fat from wherever on

your body. You want to lose it from, and I sequentially just injected into the breast and you can kind of do that now as in, just make a breast from injected fat, but it's really hard to get the form of a breast, the projection and the Chronicle shape and things like that. So you really need like an internal scaffold, and we're not far off that in the labs. And I wouldn't is that the next thing to do? Mm. Um, cuz that would be great. Cuz the problem we use your own tissues is big scars and I gotta talk people through that and show 'em all the pictures and you know, for some people it's too much, but if I could just say, well, I'll take it off your bum or your ties or your tummy. Um, I'll just take whatever I can get and then I'll make a breast out of it. It just, that would be brilliant.

Speaker 1 (14:13):

Fantastic. It really would be a fantastic outcome. Um, Jamie also, um, the aesthetic of the reconstructed breast and its sensitivity, is it, this, does it have the same sense as the other breast by way of touch or feel or tipping or whatever if you banged it. Um, and also another question I would have is in relation to nipple alignment and how that works.

Speaker 2 (14:35):

Um, so sensation, so sensation from your breast primarily comes through the breast. So when you lose the breast, you lose most of your sensation. However, a lot of the skin has its own sensory supply and in a varied way, it comes back. If so, if you have immediate breast reconstruction, get to keep your own skin, a lot of people get some sensation in that skin. Um, if you use an implant, you'll never get a proper sensation of it being you. It's always an implant on the skin. If you use your own tissue, it integrates perfectly with the rest of your body and it, it softens and it, and it hangs like a normal breast and it moves like a normal breast. And I guess what I would say about that is I had a lady who had a delayed reconstruction and actually she had an implant previously, which was really solid and stuck to her chest.

Speaker 2 (15:20):

And I used, I swapped out the implant for her own, for her own tissue on the tummy, which is a much obviously softer and more natural reconstruction and you can shape it and things. And on day four in the hospital, little, when she leaned over to spit after brushing her teeth, she felt her breast move away from her chest away. Normal breast would move as you lean over. And she said, she just felt this wave of emotion. And it's funny, it's those kind of little stories that just make it all worthwhile because you know, um, she didn't expect it at all. Yeah. So it's not necessarily the sensation that you and you would talk about up the skin, it's just sensation of being a part of you. And for that reason I could use your own tissue just so far. Yeah.

Speaker 1 (15:56):

And not being sort of that far an object. Yeah. Yeah.

Speaker 2 (15:58):

Yeah. And the second question you asked in relation to nipple reconstruction, it depends, um, you can do nipple sparing, uh, reconstructions and, uh, mastectomy where you get to keep all the nipple and the, all the skin. And I can just work through a scar and put everything in through a hole. Um, it's less common. Um, primarily because often in, in someone who's in the classic age category of breast cancer, the nipple has drooped or dropped a little bit and it it's quite hard to do the operation, um, when it's in that position. But certainly in a young person, it's definitely an option. Um, the second thing that I say is most

commonly I'm reconstructing a nipple and that's just using the skin on the breast reconstruction kind of a technique where you lift it up, twist around itself and create this little projecting nipple essentially.

Speaker 2 (16:49):

And it's kind of like the final piece, cuz you only do that at the very end. Once the instruction has a chance to settle and once you've maybe done adjustments to the natural side to lift it, to make it match or whatever. So when you've got symmetry and you finally put the nipple on at the end, it's actually a really nice thing for patients. It suddenly they look down and it kind of looks like a breast again. Uh, and interesting. I had a previous patient who, I dunno that I talk her into it, but I definitely pushed the merits of breast of nip, Puerto reconstruction. And she emailed me and she, she emailed me afterwards and she just thanked me for kind of pushing her into it. Cuz she said, when she looked down and she saw it, she got again, got emotional, just seeing it and they can look pretty good. But then on top of that, you can do 3d nipple tattoos with, you know, we can do them in the hospital, actually better off with this, some tattoo artist who specialize in it and they can look amazing to the point that when you look at them, you've gotta do a double take.

Speaker 1 (17:38):

And can I ask you, so what you're saying then is the patient would go, would have their mastectomy and either go directly into reconstruction surgery. They would have their ideally their, um, DF flap, which is from the tummy or whatever muscle in their own, um, reconstruction done. But then they should wait to have the nipple done. So that's a second or a third potentially. Yeah.

Speaker 2 (17:59):

There's, there's always extra little bits. Okay. Um, just unless you do like a nipple sparing reconstruction and you're literally just putting in volume, if I'm replacing the nary oil complex, just that circle. If I'm putting tummy skin there, where that used to be. Um, unfortunately for the recovery period, I wanna see how my reconstruction is doing in terms of making sure it's healthy and there's no problems. So I need that little bit of skin untouched. So I can't go making a nipple on top of it. Cause I would just kind of distort it, be very hard to monitor it and look after it. So there's always, you know, actually little bit, but a nipple reconstruction is, you know, days you walk in, you walk out just local anesthetic. Oh wow. Um, like it takes 20 minutes. It's like a dental appointment. Okay. So that's not a big deal.

Speaker 2 (18:40):

No, no, no. But classically there is always one little adjustment cuz you know, I make, I make it as good as I can and say, well, we come back to clinic and we, I always tell the patient, well, what do you think? And you know, to a little more here, put a little bit more in, in here and that's, you know, then we talk about, can I do that? And there's usually little adjustments and then there's a cohort of women that I've either made a lifted smaller breast and then we're gonna have to come back for a reduction on the other side or the other cohort is where I've tried to match it. Like for like, and matching it like for like is, uh, is great. Cuz you get like, it's like an immediate result. They get to look down and see, you know, their cleavage being the same and the size and the volume all the same. We're just missing the nipple. Um, and that's, you know

Speaker 1 (19:17):

Yeah. And as you say, it takes time for the breast to settle into its shape, you know, before you do anything else.

Speaker 2 (19:22):

Uh, so the adjustments, yeah. It generally, you, you are not gonna get through the pathway as quick as you want. That's there, there is always the adjustments, if we're gonna do it right, you've gotta kind of do it slowly. Let things settle after each stage cuz we're making, you know, the breast for life. As in, if you using your own tissue and nipple or an implant reconstruction looks like what it's gonna look like as soon as you're done. So you can kind of crack

Speaker 1 (19:46):

On key things for me when, when we talk about, uh, reconstruction and I've chatted to so many of our breast, um, ambassadors, and some have said, you know, straight away they wanted reconstruction. They couldn't have it quick enough, you know, to feel that feminine self again. And others were just, as we said earlier, so nervous and just really wanted their tumors out first and foremost and they really didn't care. Um, and didn't want to face that trauma of another unnecessary as they would say surgery.

Speaker 2 (20:14):

Yeah. That's the thing about it. It's it's it's this time that these women ha make their own decision and you know, I it's, another one of my parts of this field is like it's the only cancer that, that there is that the patient decides on part of the treatment pathway and everything else, skin cancer, colon on cancer. We just tell them what we have to do in terms of getting rid of the cancer. And some people yeah. Are gas, you know, can't get over the fact that, you know, they can't have a reconstruction and sometimes, and then they're chomping at the bit. They wanna see me as soon as radiation's finished. When can we have the surgery? When can I, you know, make a, make a new breast? When can we do it? And it's all this pressurized situation for them and the, a much larger cohort of women once they get through all their treatment are just kind of like, well, I'll go see Jamie or whoever it is. And then we'll get our breast reconstruction and you know, it'll happen when it happens. Um, and then obvious the people who are allowed having immediate reconstruction and might get back to that later, they allowed, um, yeah, for them, it's just, I can't wake up without something there. Yeah. It's just not an option.

Speaker 1 (21:16):

Yeah. Yeah, absolutely. And I've noticed, um, recently I, we got feedback through an education and outreach program that we do complementary throughout the country. Um, and one of our coordinators was out speaking to, to a group of women and one lady said, um, what do we do if we have implants, how can we check ourselves thoroughly and know that we're able to spot signs and symptoms with an implant,

Speaker 2 (21:41):

A reconstruction implant, or an augmentation implant

Speaker 1 (21:44):

Probably augmentation in their, in their case. So

Speaker 2 (21:48):

There's good evidence to say that someone who's got an augmentation picks up their cancer a little bit earlier, really for two reasons, one they're breast aware and two, because the implant is under the breast pushing things out.

Speaker 1 (21:59):

Okay. Of course. And then it would be more noticeable.

Speaker 2 (22:01):

So the implant goes underneath all the breast tissue. It's either under the muscle or just on top of the muscle underneath all the breast issue. Okay. And so there shouldn't be any issue itself exam you'll feel the implant and you'll feel your breast tissue draped around it. Um, but yeah, there's decent evidence to say you'll pick it up quicker.

Speaker 1 (22:15):

Wow. That's very interesting. I will, I will certainly feed that back to them.

Speaker 2 (22:18):

Yeah. And it's not a reason to worry about, I'm not, it sounds like a pluggy augmentation, but no, um, it, it's not a reason it's not something to worry about at all. Yeah.

Speaker 1 (22:27):

I know you will. You will have laid a lot of people's fears because I think that was, that was coming through quite a lot in, in a couple of different groups that were being, um, spoken to the, the, the idea of breast augmentation and implants and how could I detect and you know, if the implant is sitting there, but as you say, the breast issue is up on, on top. Yeah. So it will actually be a lot easier to detect, which is fantastic. Uh, so Jamie, we've talked about the physical costs cost to the body, you know, with recovery and all of that is part of the treatment journey. But what is the, I suppose the cost as in the monetary cost, is there one and also the emotion and personal cost, whether it's family downtime, business downtime, you know, what, what have you experienced there?

Speaker 2 (23:08):

Yeah, I guess I'll answer separately. So like we live in a, in a pretty great health service in that if you get into it, you get a free ride the whole way through pretty much. Okay. The problem is getting into these services. But as a breast cancer patient, you're generally in a service. Okay. The I system means that, you know, people like me and breast of hill, we're all paid by the HSE. And so if you want a breast reconstruction, you come and see me for free and outpatients, and then you go on my list. Unfortunately there is a waiting time for delayed reconstruction, but once you get there, you just, there's a standard hospital charge of, I think, 80 qui a day. Okay. So that's four days by 80, so it's not huge. So it is accessible to everyone. And then the medical card covers it.

Speaker 2 (23:50):

If you don't have, you know, if, if you can't pay the 80 qui a day and you've a medical card, then it's free the whole way. Okay. Wow. So there should be no cost barrier and sure people can go privately and, uh,

try and do this thing in private hospitals, but it it's, it's not necessary. So everything is there. Wow. The, the, like the cost, your family and emotional cost. I mean, that's much harder think to judge. And that's obviously much more to the point that it, when I meet people the first time, if, if you're like a young mom with like three small kids, or if you're, you know, you run your own business and you're not gonna get paid. If you're not there running the business, maybe six to eight weeks downtime for using your own tissue is too much of a price to pay. I definitely have that conversation with women. And they're like, okay, do you know what? Let's just go for an impact or let's go for no reconstruction. And yeah, we, you back away from the harder one, purely cuz of the, you know, emotional cost or the cost to your, to your lifestyle in terms of job or kids.

Speaker 1 (24:45):

And I suppose a little element of guilt in that, you know, I've had, you know, my tumor removed. Why am I now looking for this aesthetically pleasing reconstruction?

Speaker 2 (24:57):

Yeah. And, and that comes up the whole time. And my answer to that is that, you know, this is all a cancer pathway, so this is not just reconstruction, that's aesthetic. Sure. The goal is an aesthetic outcome, but this is just part of the pathway. And secondly is everyone worries about, you know, oh, I'm doing this to my family. So your family just want what's best for you. And what's best for you is a reconstruction if you're up for it because there's loads of studies that show that you'll actually do better in life with a breast reconstruction. Like there's pretty good evidence to say that you return to work are quicker that your self-actualization psychological wellbeing. So if it's all generally much better with breast reconstruction, it's obviously not a definite, but in general terms, it's not a reason to feel guilty.

Speaker 1 (25:37):

Listen, Jamie, thank you so much for spending time with us today and, and chatting with us. I'm sure, you know, you've given people a lot of food for thought and you have relaxed and elated. A lot of fears that a, of, uh, women going through diagnosis will, will feel thank you so much for today.

Speaker 2 (25:50):

Great. It's a pleasure.

Speaker 1 (25:53):

The information in this podcast is based on the personal stories of those. We have chatted to. If you are concerned in any way, please contact your GP immediately, or you can contact us at breast cancer, ireland.com.