

Familial breast cancer (breast cancer in the family)

Information for the public

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About this information

NICE guidelines provide advice on the care and support that should be offered to people who use health and care services.

This information explains the advice about familial breast cancer (breast cancer in the family) that is set out in NICE guideline CG164.

This is an update of advice on familial breast cancer that NICE produced in 2004, 2006 and 2013.

Does this information apply to me?

Yes, if:

- you are a woman (18 years or over) who might be at higher risk of breast cancer than the general population because of breast and/or ovarian cancer in your family
- you are a woman who has had breast cancer and has breast and/or ovarian cancer in your family.

If you are a man (18 years or over) who might be at higher risk of breast cancer because of breast and/or ovarian cancer in your family, the information about referral to a specialist genetics service, genetic counselling and genetic testing applies to you.

Familial breast cancer

Breast cancer is the most common cancer in women in the UK. Between 100 and 120 women in 1,000 develop breast cancer by the age of 80. Men can also get breast cancer, but it is much rarer than in women. About 1 in 1,000 men develop breast cancer in their lifetime.

Sometimes breast cancer runs in families so there are more cases in a family than would be expected by chance. This is called 'familial breast cancer'. Families that have familial breast cancer may have men with breast cancer and sometimes have other cancers, such as ovarian cancer or prostate cancer. In these families, cancers may develop at a younger age than usual.

Your care team

A range of professionals who specialise in different areas of treatment or support may be involved in your care. These could include GPs, specialist nurses, specialist doctors, psychologists and clinical genetic specialists.

Working with you

Your care team should talk with you about familial breast cancer. They should explain in detail the options for reducing your risk of cancer, including surveillance (regular scans) to pick up any cancer as early as possible. Your family or carer can be involved in helping to make decisions, but only if you agree. You should have the opportunity to ask any questions you have – there is a [list of questions](#) you might like to ask to help you with this.

You may also like to read NICE's information for the public on [patient experience in adult NHS services](#). This sets out what adults should be able to expect when they use the NHS. We also have more information on the NICE website about using [health and social care services](#).

Risk factors for breast cancer

There is no single cause of breast cancer but there are things known as risk factors that can increase your risk. Age is the biggest known risk factor, with about 4 out of 5 of all breast cancers occurring in women over 50. Other risk factors are taking hormone replacement therapy (HRT) for symptoms of menopause, taking the oral contraceptive pill, drinking alcohol, and being overweight after the menopause. Breastfeeding and physical activity may reduce risk.

Occasionally families have a faulty gene, which may be passed down from mothers or fathers to their children. A person who inherits a fault in a *BRCA1*, *BRCA2* or *TP53* gene is at high risk of developing breast cancer. The number of people (women and men) with a fault in one of these genes is very small. Having a faulty gene is a risk factor, but does not automatically mean that you will develop breast cancer.

How breast cancer risk is described

The NICE guideline refers to 3 levels of risk for developing breast cancer: **general population risk**, **moderate risk** and **high risk**. The healthcare team estimates risk by carefully considering your risk factors for breast cancer and your family history. You can find out more about this in the sections called [risk factors for breast cancer](#) and [first steps – finding out about your family history](#).

General population risk

Women whose risk is the same as the **general population** have about an 11% chance of developing breast cancer in their lifetime. That is, for this level of risk, 110 women in every 1,000 will develop breast cancer. In the general population, most breast cancers develop after the age of 50.

Moderate risk

Women with a **moderate risk** have a lifetime risk of developing breast cancer of greater than 17% but less than 30%. That is, for this level of risk more than 170 but fewer than 300 women in every 1,000 will develop breast cancer. These women have a 3 to 8% chance of developing breast cancer between the ages of 40 and 50. That is, for this level of risk, between 30 and 80 women in every 1,000 will develop breast cancer between the ages of 40 and 50. So, women with a moderate risk have a slightly higher chance of developing breast cancer at a younger age than women in the general population.

High risk

Women with a **high risk** have a 30% or greater chance of developing breast cancer in their lifetime. That is, for this level of risk, 300 or more women in every 1,000 will develop breast cancer. These women have an 8% or greater chance of developing breast cancer between the ages of 40 and 50. That is, for this level of risk, 80 or more women in every 1,000 will develop breast cancer between the ages of 40 and 50. So, women with a high risk have a much higher chance of developing breast cancer at a younger age than women in the general population.

All women who have a faulty *BRCA1*, *BRCA2* or *TP53* gene are at **high risk**. See the section called [risk factors for breast cancer](#) to find out more about faulty genes.

First steps – finding out about your family history

If you are concerned about breast cancer in your family, you should first talk to your GP. They should ask whether you have first-degree blood relatives (mother, sister, daughter, father, brother, son) or second-degree blood relatives (aunt, uncle, grandparent, niece, nephew, half-sister, half-brother) who have had breast cancer or other cancers (this is called 'taking a family history').

For each blood relative who has had a cancer, your GP will want to know as much of the following as possible.

- Their relationship to you (mother, sister, daughter, father, brother, son, aunt, uncle, grandparent, niece, nephew, half-sister, half-brother).
- The age at which their cancers (not just breast cancer) were diagnosed.
- Where in their body the cancer started (for example, the breast or ovaries).
- Whether the same family member has had more than 1 cancer, including whether they have had breast cancer in both breasts (known as bilateral breast cancer).

If you don't already know the answers to these questions, your GP may ask you to do some 'homework' by discussing your family history of cancer with relatives.

Your GP will want to know if a faulty gene has already been identified in your family.

Your GP will also ask about your ethnic background because people from a Jewish background are more likely to carry the faulty genes, which may put them at higher risk of breast cancer.

If your family history matches any of the examples shown in the table below, your GP should offer you a referral to a service with specialist skills in estimating breast cancer risk.

Type of cancer	Relatives affected	Age at diagnosis	Referral for estimation of breast cancer risk
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Female breast cancers only	1 first-degree relative	Under 40	Yes
	2 first-degree relatives	Any age	Yes
	1 first- and 1 second-degree relative	Any age	Yes
	3 first-degree relatives	Any age	Yes
	3 second-degree relatives	Any age	Yes
Male breast cancer	1 first-degree male relative	Any age	Yes
Bilateral breast cancer	1 first-degree relative	Under 50 for diagnosis of first cancer	Yes
Breast and ovarian cancer	1 first-degree relative with breast cancer and 1 first-degree relative with ovarian cancer	Any age	Yes
	1 first-degree relative with breast cancer and 1 second-degree relative with ovarian cancer	Any age	Yes
	1 second-degree relative with breast cancer and 1 first-degree relative with ovarian cancer	Any age	Yes
<p>First-degree relatives include mother, father, daughter, son, sister, brother.</p> <p>Second-degree relatives include grandparent, aunt, uncle, niece, nephew, half-sister, half-brother.</p>			

Next steps – referral for estimating breast cancer risk

After referral, your risk of breast cancer will be estimated. Breast cancer risk is estimated using risk factors for breast cancer, questionnaires to collect family history of cancer and computer programs that estimate risk. For more information on this see the sections called [risk factors for breast cancer](#) and [first steps – finding out about your family history](#).

As shown in the section called [how breast cancer risk is described](#), risk is divided into 3 groups: general population risk, moderate risk and high risk.

It's important to remember that most women do not get breast cancer. Even if you have a moderate or high risk, it does not mean that you will develop breast cancer.

Genetic counselling and genetic testing

If your estimated breast cancer risk suggests that you are at high risk of developing breast cancer, you should be offered genetic counselling before you are offered any genetic testing.

Genetic counselling

Genetic counselling can be very important in helping you understand how your family history, lifestyle and other factors affect your risk of breast cancer. Information about genetic counselling and what it involves should be provided before it starts.

During genetic counselling, a clinical genetic specialist (an expert in the links between genes and disease) should discuss your risks of carrying a faulty gene and developing cancer. They should present risk in a way that you can understand and should give you a written summary of this discussion. The more information you have been able to supply about your family history the more accurate the risk estimate will be. If it's appropriate, the genetic counsellor may tell you about genetic testing which can look for inherited faults in genes known to be linked to breast cancer. These genes are called *BRCA1*, *BRCA2* and *TP53*. The discussion should include what genetic testing involves, what a positive, inconclusive or negative result means for you and other family members and how long it will take to get the results. The effects of knowing the results on you and other members of your family should also be discussed.

Genetic testing for people who have not had breast or ovarian cancer

Genetic testing is performed to find out if there is a faulty gene (*BRCA1*, *BRCA2* or *TP53*) in the family. Genetic testing is only offered if the family history suggests that cancers within a family might have happened because of a faulty gene. Many different gene faults are possible; some are common whereas others are rare and found in only a few families. Because healthcare professionals do not know exactly which fault they are looking for, the best chance of finding a faulty gene is to test a relative who has already had breast cancer or ovarian cancer (the same faulty genes can cause both types of cancer). If a faulty gene is found in this relative, healthcare professionals then know which genetic fault caused their cancers and can offer a test to family members who have not had cancer. The genetic test will show whether these family members have inherited the faulty gene and so have an increased risk of developing breast cancer in the future.

If a close relative (mother, father, daughter, son, sister, brother) with breast or ovarian cancer is not available for testing, you should be offered testing yourself if your family history suggests you have at least a 10% chance of having a faulty gene.

Genetic testing is carried out on a blood sample.

Genetic testing for people who have or have had breast or ovarian cancer

If you've had breast cancer or ovarian cancer you should be offered genetic testing if there is at least a 10% (1 in 10) chance of a faulty gene in your family. If you've been given a diagnosis of breast cancer within the past month and you have a family history of breast cancer, you may be offered immediate genetic testing (known as 'fast track' or 'rapid' testing) as part of a research trial. If you are offered 'fast track' testing but you decide against it, you can have genetic testing later on when you are ready.

Early detection of breast cancer by surveillance

Women without breast cancer but at moderate or high risk

If you have a moderate or high risk of developing breast cancer you may be offered regular scans of your breasts to check for breast cancer. Using scans for the early detection of breast cancer is called 'surveillance'.

Depending on your age, your estimated risk of cancer and whether you have a faulty gene or a high chance of a faulty gene, your breast care team may offer a mammogram or an MRI scan, or both.

Mammograms and MRI scans take images of the insides of the breasts. Mammograms produce images using low-dose X-rays whereas MRI scans use magnetic waves. The breast care team looks at these images to search for signs of cancer. Not all breast changes are due to cancer.

The type of surveillance recommended by NICE for women of different ages and levels of risk is shown in the table below.

		Risk group
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Age (years)	Moderate	High	High with more than 30% chance of a faulty <i>BRCA</i> gene	High with a faulty <i>BRCA1</i> or <i>BRCA2</i> gene	High with more than 30% chance of a faulty <i>TP53</i> gene	High with a faulty <i>TP53</i> gene
20–29	None	None	None	None	Yearly MRI	Yearly MRI
30–39	None	You may have a yearly mammogram	Yearly MRI and possibly yearly mammogram	Yearly MRI and possibly yearly mammogram	Yearly MRI	Yearly MRI
40–49	Yearly mammogram	Yearly mammogram	Yearly mammogram and yearly MRI	Yearly mammogram and yearly MRI	Yearly MRI	Yearly MRI
50–59	You may have a yearly mammogram	Yearly mammogram	Yearly mammogram MRI if mammogram shows dense breasts	Yearly mammogram MRI if mammogram shows dense breasts	Mammogram as part of the population screening programme ^[1] MRI if mammogram shows dense breasts	You may have yearly MRI
60–69	Mammogram as part of the population screening programme ^[1]	Mammogram as part of the population screening programme ^[1]	Mammogram as part of the population screening programme ^[1] MRI if mammogram shows dense breasts	Yearly mammogram MRI if mammogram shows dense breasts	Mammogram as part of the population screening programme ^[1] MRI if mammogram shows dense breasts	You may have yearly MRI

70+	Mammogram as part of the population screening programme ^[1]	Mammogram as part of the population screening programme ^[1]	Mammogram as part of the population screening programme ^[1]	Mammogram as part of the population screening programme ^[1]	Mammogram as part of the population screening programme ^[1]	None
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Women aged 50 to 70 are offered mammograms every 3 years as part of the population screening programme^[1]. If you have a family history of breast cancer you may have yearly mammograms or MRI scans after you reach 50, as shown in the table.

Other imaging options

Sometimes women may be offered ultrasound scans when:

- an MRI scan would normally be used but is not suitable (for example, because they have claustrophobia and do not want to go into the MRI machine), or
- more investigation is needed after a mammogram or MRI scan.

Women who have had breast cancer

If you have breast cancer you should be offered yearly mammograms for 5 years.

If you have a family history and are at high risk of another breast cancer you should also have:

- yearly MRI scans if you are between 30 and 49
- yearly mammograms if you are between 50 and 69 and do not have a faulty *TP53* gene
- mammograms as part of the population screening programme^[1] if you are 70 or over and do not have a faulty *TP53* gene.

If you have had breast cancer and you have a faulty *TP53* gene, you may be offered yearly MRI scans between the ages of 20 and 69 years.

^[1] For information and advice about population screening programmes see www.cancerscreening.nhs.uk/breastscreen (England), www.breasttestwales.wales.nhs.uk/home (Wales) and www.cancerscreening.hscni.net (Northern Ireland).

Information and support for women having surveillance

Your healthcare professional should discuss your individual situation with you to help you decide whether to have a mammogram or an MRI scan, or both if you are eligible. You should be given written information about the benefits and risks of mammograms and MRI scans.

Risks include:

- The possibility that a mammogram or MRI scan might give a 'false positive' result. A false positive result would indicate breast cancer when in fact there is no cancer. This may cause worry and lead to unnecessary treatment.
- The possibility that the results of the mammogram or MRI scan might not be clear and other tests or scans might be needed. These may turn out to be negative (no cancer present), but can be uncomfortable and cause worry.
- The possibility that a mammogram or MRI scan might give a 'false negative' result. A false negative result would indicate no cancer when in fact a cancer has been missed.
- The risks of being exposed to radiation (X-rays) during the mammogram.

Benefits include:

- The likelihood that any cancer will be detected at an early stage when it is smaller. This may improve the chance of completely removing the cancer and may mean that you need less treatment.

If you decide to have surveillance, you should be given details of what the scans will involve and how long your surveillance programme will last. The breast care team should make sure you know and understand the reasons for any changes to your surveillance programme. Reasons might include another member of the family developing breast cancer, a faulty gene being identified in the family or a change because you no longer need the same surveillance programme now that you are older. For more information about surveillance for women without breast cancer but a moderate or high risk, see the table in the section called [early detection of breast cancer by surveillance](#).

Information about treatments to reduce risk

There are treatments that can help reduce your risk if you are estimated to be at high or moderate risk of developing breast cancer. These include drug treatment and risk-reducing surgery. Healthcare professionals should talk to you about all the possible treatments. They should tell you

about the possible benefits and side effects of each treatment (including drug treatments) and give you written information that you can read after your appointment. Healthcare professionals should give you an idea of how much each treatment might reduce your risk and use a decision aid so that you can make a decision about whether to go ahead with any of the options.

NICE has produced some [decision aids](#) which you and your healthcare professionals might find useful:

- [Decision aid for premenopausal women at moderately increased risk](#)
- [Decision aid for premenopausal women at high risk](#)
- [Decision aid for postmenopausal women at moderately increased risk](#)
- [Decision aid for postmenopausal women at high risk](#)

Some options for reducing risk may not be suitable for you, depending on your exact circumstances. If you think that your care does not match this advice about treatments for reducing risk, talk to your healthcare team.

Drug treatment to reduce the risk of breast cancer

Drug treatment can reduce the risk of breast cancer in women who are at high or moderate risk because of breast or ovarian cancer in their family. Some of these drugs are not suitable for people who have osteoporosis (fragile bones that break easily) and some are not suitable for people who have had thrombosis (blood clots) or endometrial cancer. All options for reducing your risk should be discussed with you so that you can weigh up the possible benefits and risks and decide what to do.. If you have had both breasts removed (called a bilateral mastectomy) your risk will now be very low and drug treatment should not be necessary.

If you are at high risk and you haven't yet had the menopause, you should be offered a drug called tamoxifen if appropriate. If you're at high risk and have been through the menopause you should be offered a drug called anastrozole unless you have fragile bones that break easily (osteoporosis). Tamoxifen or another drug called raloxifene are other treatment options for women with osteoporosis.

If you are at moderate risk and you haven't yet had the menopause, you may be offered tamoxifen. If you're at moderate risk and have had the menopause, you may be offered anastrozole if you don't have osteoporosis. Or you may be offered tamoxifen or raloxifene depending on your

circumstances. Again, healthcare professionals should discuss all treatment options with you before you make any decisions.

Anastrozole, tamoxifen or raloxifene should not be taken for more than 5 years. You should stop tamoxifen at least 2 months before trying for a baby and 6 weeks before planned surgery.

When this advice was updated (March 2017), anastrozole, tamoxifen and raloxifene did not have a licence in the UK for reducing the risk of breast cancer in people without breast cancer but with breast cancer in their family. Healthcare professionals should explain the possible benefits and harms of taking these drugs so that you can make a decision. They should record the details of these discussions. You can find more information about licensing medicines from [NHS Choices](#).

Surgery to reduce the risk of breast cancer

If you are at high risk of developing breast cancer or you have had breast cancer, risk-reducing surgery might be an option. This is called a risk-reducing bilateral mastectomy. The surgery involves removing as much healthy tissue as possible from both breasts. This operation greatly reduces, but does not completely remove, the risk of breast cancer in the future.

Before you make any decisions about risk-reducing mastectomy, you should be referred for genetic counselling. Discussion of your options for reducing risk should include all the possible benefits and risks of risk-reducing mastectomy. These include the likely reduction in the risk of breast cancer and the effects of mastectomy on your body image and your sexual relationship with your partner.

If you are considering risk-reducing mastectomy you should be able to discuss your options for breast reconstruction (rebuilding) with experienced surgeons before the operation. They should tell you how they can rebuild your breasts using tissue from another part of your body or synthetic 'implants'. Breast reconstruction can be done as part of the mastectomy or at a later date. The surgeons should make sure that you know that your breasts may have a very different appearance and feel after reconstruction surgery.

Breast tissue that is removed during mastectomy will be examined after the operation for signs of cancer. Before the operation your healthcare professional should discuss with you the possibility that cancer might be detected in the breast tissue that has been removed.

If you are thinking about risk-reducing mastectomy, you should be given details of support groups where you can talk to other women who have already had the operation.

Surgery to reduce risk isn't suitable for everyone. It may not be an option if you have other conditions (for example, a heart condition) that would increase the risk of surgery. You will still be able to have surveillance even if you decide against surgery or surgery isn't suitable for you. This will help to ensure that any new cancer is picked up early. The breast cancer team will support you throughout the surveillance programme.

Surgery to reduce the risk of ovarian cancer

A few women who carry a faulty gene are at higher risk of ovarian cancer as well as breast cancer. Many of these women also decide to have their ovaries and fallopian tubes removed. This operation is called a risk-reducing bilateral salpingo-oophorectomy. Removing the ovaries causes an early menopause, which means that women will not be able to have more children. This should be discussed before the operation.

If you choose to have surgery before the menopause to reduce your risk of ovarian cancer you should be told about the advantages and disadvantages of taking hormone replacement therapy (HRT) after the operation to manage the symptoms of early menopause (such as hot flushes, loss of sex drive, weight gain) and reduce the risk of osteoporosis and heart disease. The discussion should include how HRT can help manage troublesome menopausal symptoms and how HRT may affect your risk of developing breast cancer. The type of HRT offered will depend on whether or not you've also had a hysterectomy (removal of your womb).

Information about risk of familial breast cancer

If you are concerned about your risk of familial breast cancer, you should be given the following standard written information:

- risk levels in the general population and in people with a family history, including a definition of family history
- the message that, if your family history changes, your risk may change
- breast awareness information
- lifestyle advice regarding breast cancer risk, including:
 - HRT and oral contraceptives
 - lifestyle, including diet and alcohol

- breastfeeding, family size and timing of having a baby
- contact details of those providing support and information, including local and national support groups
- information about bringing a relative or friend to appointments
- details about clinical trials or studies that may be appropriate for you to take part in.

If required, you may also receive:

- advice about how to obtain a full family history
- information about how your risk will be assessed
- details of your likely risk of developing breast cancer
- details of mammographic and MRI surveillance options, if appropriate, including the risks and benefits
- details of counselling and genetic testing, including what the tests mean
- information about the risks and benefits of surgery to reduce the risk of developing breast cancer (when surgery is being considered), including both the physical and psychological impact
- information about the risks and benefits of drug treatments to reduce the risk of developing breast cancer.

Being 'breast aware'

Whether you are at increased risk of breast cancer or not, your GP should advise you to be 'breast aware'. This means:

- knowing what is normal for you
- looking at and feeling your breasts
- knowing what changes to look for
- reporting any changes without delay
- attending routine breast screening depending on your age.

Your GP should also advise you how you might reduce your risk of developing breast cancer.

Questions to ask about familial breast cancer

These questions may help you discuss familial breast cancer or the treatments you have been offered with your healthcare team.

About familial breast cancer

- Can you tell me more about familial breast cancer? Can my condition be passed on to my children (female and male)?
- Can men pass on the faulty genes to daughters or sons?
- How do I tell my children about my condition and when should I do it?
- Who should I contact if I have any worries?
- If another member of my family gets breast or ovarian cancer, will this increase my own risk? What should I do if this happens?

Finding out about breast cancer risk

- Can you tell me more about the tests/investigations to find out about breast cancer risk? How accurate are the results?
- What do the tests involve? Will I need to have them in hospital?
- How long will I have to wait to have these tests? How long will it take to get the results? Who will give me the results?
- What happens if I don't want a genetic test? Could I be forced to have one if my family put pressure on me?
- Will the results of a genetic test affect any life or travel insurance?
- My daughter can't decide if she wants the test or not. Will someone discuss it with her?
- Can I still be at high or moderate risk if I don't have a faulty gene?

Breast cancer surveillance

- Am I entitled to mammograms or MRI scans, or both?
- Can you give me more details about mammograms and MRI scans? What do they involve? What are the risks and benefits?
- If I have a mammogram and an MRI scan, will they be done in the same place? Will I have them together?
- Can I stop having mammograms and/or scans if I decide I don't want them any more?
- What is my risk from radiation if I have yearly mammograms and MRI scans from age 30?
- I don't qualify for an MRI scan; can I get one done privately?
- Now I'm 50 my yearly mammogram has stopped. But breast cancer risk increases with age, so why am I only entitled to a mammogram every 3 years now?
- I'm over 70. Does this mean I won't have mammograms any more?
- Where can I find out more about the breast cancer screening programme?

Treatments for reducing risk

- Can you tell me about options to reduce my risk of developing breast cancer? What are the pros and cons of the different options?
- How much might they reduce my risk?
- Is there some other information (like a leaflet, DVD or a website I can go to) about the options for reducing risk? Can you discuss this information with me?
- Do you have any more information that might help me make a decision?
- I don't want drugs or surgery now. Can I have them later or just continue with my surveillance?

Drug treatment

- What is the evidence that this drug treatment will reduce my risk?
- How much will it reduce my risk and how long will I have to take it?
- Might I have any serious side effects?

- Might this drug affect my ability to have children?
- Can I take HRT?
- I am a man at high risk. Is drug treatment suitable for me?

Surgery

- What are the risks and benefits of having surgery to reduce risk?
- What might be the psychological effects of surgery?
- Might it affect my relationship with my partner?
- Can I choose my surgeon to do breast reconstruction?
- I want my ovaries removed now but I want to have children later. Do I have any other options?
- Can I wait until I am older to have my ovaries removed?
- If I have my ovaries removed can I take HRT to help with menopausal symptoms that I might experience?
- What are the symptoms of menopause that I might experience after the operation?
- Are there any complementary therapies I can take for menopausal symptoms if I do not want to take HRT?
- Might HRT increase my risk of breast cancer?
- How long should I take HRT for?
- If I stop taking HRT might my menopausal symptoms return?
- I am a man at high risk. Do I have any options for surgery?
- Can you give me details of any support groups for people thinking about breast or ovarian surgery to reduce breast cancer risk?

Contact information

- Who do I contact once I'm in the system?
- Is there a single point of contact or do I have a list of people?

- If I want another consultation with a specialist, can I arrange one?

Sources of advice and support

- [Breast Cancer Now](#), 0333 20 70 300
- [Breast Cancer Care](#), 0808 800 6000
- [Cancer Research UK Patient Information](#) (previously CancerHelp UK), 0808 800 4040
- [Macmillan Cancer Support](#), 0808 808 00 00
- [National Hereditary Breast Cancer Helpline](#), 01629 813000
- [Target Ovarian Cancer](#), 020 7923 5475

You can also go to [NHS Choices](#) for more information.

For more information about population screening programmes for breast cancer see:

- [NHS Breast Screening Programme for England](#)
- [Breast Test Wales](#)
- [NI Breast Screening Programme](#)

NICE is not responsible for the quality or accuracy of any information or advice provided by these organisations.

Other NICE guidance

- [Early and locally advanced breast cancer](#) (2009) NICE guideline CG80

Update information

March 2017: Added links to the patient decision aids.

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Accreditation

