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LEGA ITALIANA PER LA LOTTA CONTRO I TUMORI

*prevenire è vivere*

LILT

*for*

women

CAMPAGNA NASTRO ROSA 2019



**PREVENTION HAS NO AGE.**

Start to protect yourself from breast cancer immediately.

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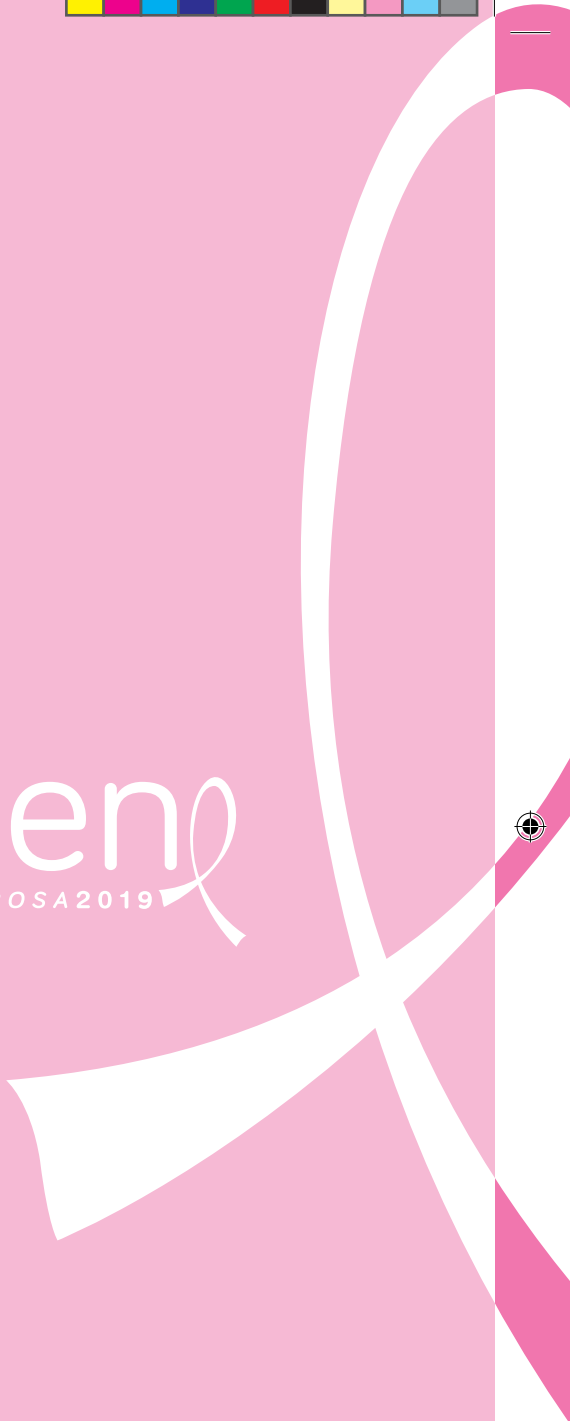


LILT

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## LETTER OF THE PRESIDENT



Breast cancer is the first “big killer” for women. Ironically, despite the annual steady increase in the incidence of this pathology, there is a slow but continuous and progressive decrease in mortality.

Both thanks to more and more correct information and to a greater awareness of women towards early diagnosis, which proved strategically decisive and successful in terms of healing and better quality of life.

*We still have 5 issues to address and solve:*

- *Identify preclinical cancer (through genomics, liquid biopsy);*
- *The development of breast cancer at an increasingly younger age;*
- *Necessarily uniform the extent of breast screening in all regions;*
- *Block the possible onset of metastasis;*
- *Taking care of the more than 700,000 women who have lived the experience customizing its follow-up.*

Over the last five years, the increase in the incidence of breast tumor has been more than 15%, in particular, with an increase among young women aged 35 to 50.

This is an age group therefore “excluded” from the screening programme provided (for now) by the National Health Service, reserved for women between the ages of 50 and 69.

The Italian League for the Fight against Tumors (LILT), with its “Nastro rosa awareness campaign” every year, in October, reaffirms the role of the culture as prevention as a way of life, with the purpose of all women undergo breast examinations, advising them from the age of 18: practice monthly self-examination; at the age of 30: to make an annual breast examination with ultrasound examination; at the age of 40: undergo adequate clinical-instrumental checks (breast examination, echo - mammography).





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Breast cancer should not be considered as a single disease, presenting different biological behavior and prognosis. Accordingly, correctly identifying the biomolecular characteristics of the tumor ensures the innovative therapeutic possibilities, more and more appropriate, targeted and personalized.

Today, however, the availability of both new therapeutic methods and increasingly refined “imaging” techniques has in fact encouraged women to undergo periodic clinical-instrumental checks, for effective early diagnosis and healthy longevity.

Today, breast cancer is recoverable at around 80-85% of cases. This means that 15-20% of women who face the disease fail to overcome it. But we also know that an early diagnosis of breast cancer, when the tumor is a few millimeters, would result in a healability of more than 95% of cases.

In 2022, in four years' time, LILT will celebrate 100 years since its founding, and it would be nice to exhaust its “mission” by committing to achieve and celebrate this milestone. What a magnificent party it would be!

IT IS in this spirit that we feel that we declare a winning war against cancer pathology. Hence a ode to hope and life in a difficult battle, not short, but certainly victorious if, together, we will know in the concreteness of the facts to take care of ourselves and our environment, because today we know the importance of risk factors from the environment, being cancer an environmental disease on a genetic basis.

We will work together so that the more than 3.5 million Italians who first-hand experienced the cancer can peacefully live with this disease, as well as a chronic pathology (comparable to osteoarthritis, diabetes, hypertension) and the can get closer and closer to our common goal ending: Zero mortality from cancer!

**Prof. Francis Schittulli**

*Breast surgeon-surgeon oncologist*

*National President of the Italian League for the Fight against Cancer*





## THE BREAST

The breast is for the woman an organ that performs three noble functions: aesthetic, sexual and maternal. It consists of glandular, fatty ("fat") and fibrous tissues. The latter is scaffolding to the gland, rich in blood vessels, lymphatics and nerve bundles. The mammary gland thus formed externally by the skin, supported later by the large pectoral muscle. Breast milk is produced in the breast at the level of small glandular structures called lobules and transported to the nipple through the breast ducts.

The development and changes of the mammary gland occur mainly as a result of the stimulation of female hormones, estrogen and progesterone, depending on the hormonal stage and age of the woman.

Generally the glandular component is very represented in young and pre-menopausal women. On the contrary, in post-menopausal and as you age, the fatty tissue of the breast tends to increase. This makes mammography, in young women and more generally in women with dense breasts, more difficult to interpret, necessitating integration with breast ultrasound.

Even in the male breast there is a minimal component of glandular tissue that can rarely be the site of cancer (1% compared to women).

### Knowing about Breast Cancer

The cells that make up the mammary gland reproduce continuously, both to generate the replacement with new cells, and to repair damaged ones.

The process of cell reproduction and growth is very complex and regulated by multiple genes. In normal conditions this process takes place according to a physiological program, in a precise and regular way.

However, aging and various environmental factors can damage these genes, resulting in abnormal and uncontrolled growth of the cells that make up the inner lining of the ducts (galatophores and lobaries) and the consequent development of a (cancerogenesis). The process of carcinogenesis takes place slowly, over many years.

The diagnostic-instrumental examinations available today for effective early diagnosis allow the tumor to be detected at an early stage of its growth, when the tumor shows no sign of itself and is not palpable (preclinical injury) or even in a preceding the development of the infiltrating tumor (preneoplastic lesion).





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## Breast Cancer

It is the most common cancer of women and its incidence is particularly high in Western countries with a more advanced economy. In Italy, one in eight women suffers from breast cancer. It is estimated that more than 50,000 cases of breast cancer are diagnosed in Italy every year. Over the last five years, the increase in the incidence of this disease has been 15%. Particularly among women aged 25 to 45, the increase is estimated to have been around 30%.

Fortunately, however, for more than 15 years there has been a progressive reduction in mortality from this cancer. Most (about 70%) breast cancers originate from duct cells (ductal carcinoma), while a lower percentage from breast lobules (lobular carcinoma).

A more important distinction is between infiltrating carcinoma (capable of invading surrounding tissues and possibly spreading remotely, giving rise to metastases) and carcinoma in situ (not able to develop metastases).

- ***Carcinoma in situ***: cancer cells are confined within the breast ducts or lobules and do not infiltrate the surrounding tissue. For this reason, in situ carcinoma does not metastasize and does not require chemotherapy treatment;
- ***Infiltrating carcinoma***: cancer cells cross the wall of ducts and lobules and, by infiltrating the lymphatic and blood vessels present in the supporting connective tissue, can spread to the lymph nodes or other organs and/or apparatuses.

Some biological characteristics of breast cancer help to better define its prognosis (prognostic factors) and to choose the most effective medical treatments (predictive factors);

- ***Receptors for the hormones estrogen and progesterone***: Cancer cells in most cases have specific structures to which the hormones estrogen and progesterone bind, stimulating their growth. The presence of hormonal receptors is considered to be a positive condition of prognosis, as cancer cells retain a characteristic common to healthy breast cells, which is a hormonal-dependent organ as it is subjected to hormonal regulation.

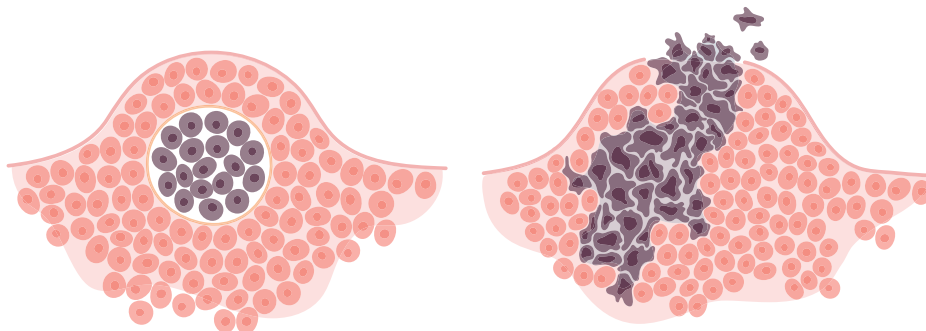
All cancers with receptors for estrogen and/or progesterone can be effectively treated with drugs that interfere with production or hormonal action (hormonal therapy);







- **Degree of cellular differentiation (grading):** Indicates how much the cancer cell is like the healthy counterpart. A well-differentiated tumor has a better prognosis than a poorly differentiated one.
- **Proliferation index:** is expressed by a percentage that indicates how “active” is the growth of that particular tumor. The higher this index, the higher the rate of tumor growth.
- **HER2:** is a protein on the surface of cancer cells that regulates their growth and against which targeted therapies (biological therapies) have been developed. The increased presence of the HER2 receptor is indicative of increased disease aggression and is therefore considered as one of the criteria of choice for recommending specific bio-chemotherapy treatments.



*Benign and malignant cancer cells*

Scientific research is constantly discovering new genes and proteins that can play key roles in tumour transformation processes. A better understanding of the biology of breast cancers will further improve the characterisation of the disease, its susceptibility to treatments and customize more and more effective treatments.







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## PRENEOPLASTIC LESIONS

The spread of screening programmes and new and accurate diagnostic means has meant that more and more lesions are found that do not indicate the presence of a cancer, but an initial alteration of breast cells. These are pathological forms that can in some cases precede breast cancer (preneoplastics). From a radiological point of view they often manifest themselves with the appearance of microcalcifications or non-palpable lesions that require a diagnostic study with microbiopsia.

*The ones that are most attentive today are represented by:*

- *Atypical ductal hyperplasia*
- *Intraeal lobulary cancers (LIN)*
- *Preneoplastic lesions can be a risk condition for the development of a tumor or, in a minority of cases, can be a warning of the presence of a carcinoma in the surrounding tissue.*

For this reason, when microbioptic examination is found, surgical removal of the affected area or closer monitoring over time may be necessary, as suggested by the breast specialist.

## IS IT POSSIBLE TO PREVENT BREAST CANCER?

The answer is partly yes. Preventive strategies are based on two very specific and integrated approaches: primary and secondary prevention.

Primary prevention aims to identify and remove the causes that contribute to the development of a tumor (risk factors).

Pharmacological is a promising mode of primary prevention, even in breast cancer.

It aims to prevent the appearance of the tumour by taking substances that prevent or disrupt the process of carcinogens (e.g. vitamin A derivatives or hormonal substances) by the woman. While the results of breast cancer drug prevention are encouraging, however, this approach is not yet considered a standard.

If there is no unanimous consent to use these substances, on the contrary it is certain





that healthy eating habits and healthy lifestyles promote the prevention of many chronic-degenerative diseases including cancer.

Secondary prevention is also essential, with the aim of obtaining its diagnosis as early as possible. The discovery of the tumor (usually with mammography and ultrasound) in its initial phase allows less aggressive therapies and greater chances of healing. It is now the winning weapon in the fight against breast cancer.

### **Breast cancer prevention: how to reduce the risk**

The main risk factors for the onset of breast cancer are not modifiable. Others, if removed, can significantly reduce the risk of developing breast cancer.

#### **Non-modifiable risk factors**

The following factors increase the risk of developing breast cancer.

- **Age:** The probability of getting breast cancer increases with the woman's age (although about 60% of breast cancers are now diagnosed in women under the age of 55);
- **Women's reproductive history:** prolonged exposure to estrogen and progesterone, which occurs in early menarch (before age 11) or late menopause (over 55 years); nullparity (no pregnancy) or first pregnancy beyond 35 years; no breastfeeding.
- **Familiarity:** presence in the family of several members (mother, sister, aunt, grandmother, etc.) with a lived breast and/or ovarian cancer;
- **Cancers and previous treatments:** cancer in the other breast, uterus (endometrium) or ovary; preneoplastic lesions of the breast; previous chest wall radiotherapy (e.g. for lymphomas in a young age);
- **Mutations of specific genes:** some mutations of specific genes (e.g. BRCA1 and BRCA2, if inherited, increase the risk of developing breast and ovarian cancers ("genetic predisposition"; see box).





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## GENETIC TESTING AND BREAST CANCER

As with other cancers, breast cancer is also in most cases of “sporadic” origin. This means that the damage to the genes that will lead to the development of the tumor disease is not “inherited”, but is realized in the individual during life due to various endogenous and exogenous factors (see paragraph: risk factors). In 8% of cases breast cancer develops as a result of mutations of specific genes, such as those carried by the BRCA1 and BRCA2 genes, “inherited” with the genetic makeup received from parents. IT’Sit has been documented that women carrying specific mutations in these genes have a higher risk of developing breast and/or ovarian cancer during their lifetime. In particular, women who inherited the BRCA1 mutation have a 45-80% chance of developing breast cancer during their lifetime and 20-40% an ovarian cancer.

Women with BRCA2 mutations have a 25-60% risk of developing breast cancer and 10-20% of developing ovarian cancer. From this it is that having inherited the mutation does not mean that you have inherited the certainty that cancer will develop at some point in your life. Instead, you are faced with a family predisposition, having inherited a higher risk of developing the disease than those who do not carry the mutation.

Genetic testing therefore does not provide cancer diagnosis, but increases information about the risk of getting cancer in later life. The current possibility of such tests prompts many women to ask for them to be carried out, especially if one or more family members have developed a tumor. In fact, the presence of one or more cases of cancer in a family (familiarity for a tumor) does not necessarily indicate the presence of an inherited genetic mutation. The multidisciplinary oncology genetic assessment can resolve doubts and establish the opportunity to carry out genetic tests that can define the specific cancer risk.

Therefore, such tests should only be requested and carried out as part of a multi-specialist assessment with the oncologist geneticist. This allows both unnecessary psychological repercussions on the individual woman who may misestimate her risk of developing cancer, and a waste of financial resources.

In the case of breast cancer, predictive models (BRCAPRO, Cuzick-Tyrer, BOADICEA, etc.) are used to identify women to test for BRCA1/BRCA2 gene mutations ( BRCAPRO, Cuzick-Tyrer, BOADICEA, etc.) that rely not only on the presence of breast cancer cases ( some members of the family, but also on other factors. For example, the following





table is used in some regions as a selection tool to identify women to be started at health facilities for the management of the family-family risk of breast cancers, linked mammography screening activity.

Age of onset	Breast cancer					Ovarian cancer
	Before 40 years old	Between 40 and 49 years old		Between 50 and 59 years old	After 60 years old	Whatever
		2 breasts	1 breast			
Mother	2	2	1	1	0	1
Sister 1	2	2	1	1	0	1
Sister 2	2	2	1	1	0	1
Daughter 1	2	2	1	1	0	1
Daughter 2	2	2	1	1	0	1
Paternal grandmother	2	2	1	1	0	1
Paternal aunt 1	2	2	1	1	0	1
Paternal aunt 2	2	2	1	1	0	1
Maternal grandmother	1	1	1	0	0	1
Maternal aunt 1	1	1	1	0	0	1
Maternal aunt 2	1	1	1	0	0	1
Father	2	2	2	2	2	-
Brother	2	2	2	2	2	-
Female cousin	0	0	0	0	0	0
Niece	1	1	1	0	0	1

Only women defined as “high risk” of carrying a BRCA1/BRCA2 mutation are indicated to perform their genetic testing. LILT promotes women’s awareness of the proper use of genetic testing for early detection of breast cancer as part of a multidisciplinary oncology genetic consultancy. The proper use of genetic testing and other tools allows the knowledge of the individual risk of developing the disease and to accurately target the best preventive strategies. LILT is also engaged in the search for new, more widely usable and less expensive methods that are currently being tested (e.g. tests using saliva to determine DNA mutations related to the increased risk cancer).





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## EDITABLE RISK FACTORS AND LIFESTYLE HABITS

- **Hormone replacement therapy:** estrogen and progesterone-based drugs, taken after menopause to relieve disorders, may slightly increase the risk of developing breast cancer. The risk is proportional to the duration of treatment;
- **Obesity:** the risk of breast cancer is higher in women who develop an obesity or overweight condition after menopause. Weight excess during puberty is also associated with increased risk of developing breast cancer in adulthood; In excess fatty tissue, more insulin and estrogen are produced that can stimulate cell proliferation;
- **Poor physical activity:** regular exercise reduces the risk of developing breast cancer. It helps to maintain body weight, promotes the increase of immune defenses and restores balanced hormonal ratios to the body;
- **Low consumption of fresh fruits and vegetables:** a high-calorie diet, high in fat and refined sugars or frequent consumption of red meat, increases the risk of developing breast cancer as well as other pathologies. On the contrary, the Mediterranean diet, and more generally the consumption of fresh fruits, vegetables and extra virgin olive oil, reduce the risk;
- **Alcohol:** the risk of breast cancer increases in proportion to the amount of alcohol taken;
- **Smoking:** breast cancer also appears to increase in smokers.

Changing lifestyles means eliminating those risk factors on which more than 20% of breast cancers depend. For this reason, the scientific world considers lifestyle control. Regular physical activity, control body weight, limit alcohol consumption, carefully choose one's diet and regulate the intake of therapy after menopause.

**A valid tool for the prevention of breast cancer, effective and recommended as examinations and substances commonly used for early diagnosis. It is also good to know that:**

- **Benign alterations of the breast (particularly cysts and fibroadenomas) and pain (mastalgia) do not increase the risk of developing breast cancer;**
- **In case there is a documented and significant familiarity it is advisable to consult specialized facilities to undergo genetic counseling and receive adequate information and guidance;**
- **Studies carried out in recent years have made it possible to better clarify the**





role of Hormone Replacement Therapy (TOS), that is, of those hormonal drugs used in menopause to relieve symptoms and complications related to this particular stage of life, such as risk factor. The use of TOS must be justified and in any case recommended by the doctor.

## WHAT ELSE CAN YOU DO TO REDUCE THE RISK?

Many women know that breast cancer can occur even in the absence of specific risk factors, for causes that are not yet known. This is the importance of early diagnosis, which is also carried out by paying attention to any changes presented by the breast, participating in mammography screening programs and undergoing periodic clinical-instrumental checks.

## WHAT ARE THE SIGNS THAT SHOULD INDUCE A MEDICAL EXAMINATION?

Unfortunately, even today many women, inadequately informed about the benefits of early diagnosis in the absence of symptoms, do not undergo preventive checks and often discover, with their own hands, the presence of a lump. For this reason it is necessary that women also experience signs and symptoms with which a breast cancer can present itself. In most cases breast cancer manifests itself as a lump, variously hard at palpation.

**In addition, other signs should be taken into account:**

- **Retraction of the skin;**
- **Localised or diffused redness;**
- **Retraction or modification of the nipple;**
- **Cretion from the nipple;**
- **The appearance of a lump in the armpit.**

Typically, breast cancer does not cause pain. None of these signs or symptoms is definitely indicative of the presence of breast cancer. For this reason, any change that the woman has in her breasts must lead her to request a check-up from her doctor and/or a breast surgeon.





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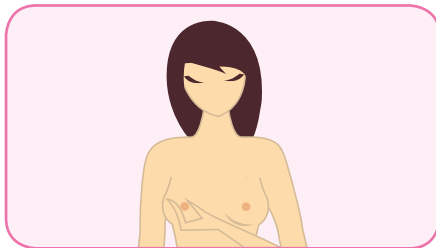
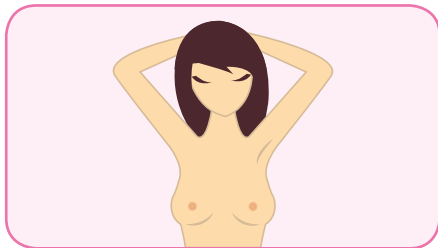
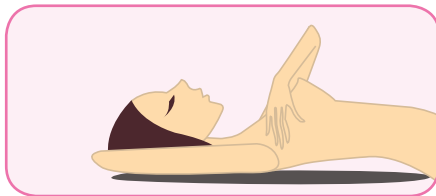
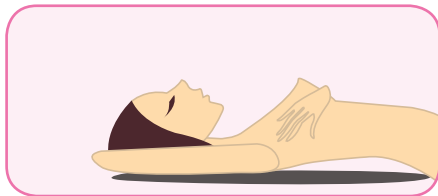
## WHAT ARE THE EXAMS TO FIND OUT EARLY BREAST CANCER?

It is important to discover the tumor as early as possible. Discovering a tumor when measuring less than one centimeter, the probability of healing is more than 90%, interventions are conservative and do not cause serious aesthetic damage to the woman. *The most important elements for proper palpation of the breast that can help in the early diagnosis of breast cancer are:*

- *To palpate both breasts in a rotary (circular) direction with their fingers joined and flat;*
- *Do not miss the palpation of the armpit and nipple;*
- *Look in the mirror if there are any irregularities in the skin;*
- *Highlight with a slight squeezing of the nipple if there are secretions.*

### Self-examination

It is the examination that the same woman should perform every month, from a young age (20-25 years), according to the procedures described above. The methodology of the examination is simple, but it is good that a doctor teaches it. It is particularly important that the woman understands that the purpose of self-examination is not the diagnosis but the only "knowledge" of the characteristics of her breasts and therefore the identification of any changes that have occurred over time and/or persistent, from communicate with your doctor in a timely manner.







*In particular, be careful if:*

- *The skin of the breast or areola appears altered, reddened, thickened, or retracted or with embossed nodules;*
- *The nipple appears retracted, especially if the indentation of the nipple has recently and if small rashes or crusts appear on the skin of the areola;*
- *Spontaneous appearance of secretions from the nipple, especially if siereal or blood;*
- *At the palpation of the breast or armpit cable you notice the appearance of a tumefaction;*
- *The breast appears reddened and increased in volume;*
- *It should not raise alarm if you periodically experience pain or tension in the breast, especially at the menstrual cycle.*

### **Breast clinic visit**

It is the examination of the breast performed by your doctor or a specialist (expert in breastology), in order to detect the presence of nodules or other suspicious clinical signs, deserving of further investigation. The visit, even if carried out by medical experts, is not enough to exclude the presence of cancer and any results must be supplemented by other examinations. In the presence of a lump, the clinical examination must be an integral part of the instrumental diagnostic tests. The breast examination is also an opportunity for an in-depth conversation with the woman on the problem of "breast cancer".

### **Mammography**

It is the most suitable and valid technique in diagnosing, with a rather simple methodology, most early-stage breast cancers, even before they are palpable.

For this reason, mammography is currently the most appropriate technique that can be used as a basic test in a screening program and which should never be given up in the case of suspected cancer, whatever the age of the woman. The risk of developing a radiation-induced tumor caused by mammography is only hypothetical.

Today mammography can be done with digital equipment that improves the quality of images with a reduced dose of radiation.





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### **Breast tomosynthesis**

Breast tomosynthesis represents a technological evolution of digital mammography and a further aid for the early diagnosis of breast diseases. It is a high-definition three-dimensional digital mammography, a diagnostic tool that allows to study the breast "in layers". In tomosynthesis capture, at radiation dose levels comparable to those of a digital mammogram, images of the breast are obtained at different angles and then a processing software reconstructs it by dissecting it into slices of the thickness of 1 Mm.

Breast tomosynthesis can be especially useful for the study of dense breasts to identify lesions that could be masked by the overlap of normal structures. In light of early promising studies on the benefits of tomosynthesis over two-dimensional mammography, it is expected that this innovative technology will soon play an important role in the integrated breast diagnostic process. The test technique is not substantially different from the standard mammography, including the placement of the breast on the mammogram plane and gradual compression of the mammogram.

### **Breast ultrasound**

Despite the continuous revolution in imaging and the rapid evolution of technology, ultrasound should not be used as the only test for the early detection of non-palpable breast cancers. Moreover, it sometimes offers irreplaceable contributions in the diagnosis of benign nodular lesions.

In the current state of knowledge, therefore, except in particular cases (e.g. young age) it is advisable that ultrasound is used mainly in association with mammography and possibly, for particular cases, breast magnetic resonance imaging.

### **Mammography or breast ultrasound?**

Mammography is the election exam for breast cancer research especially in women over 40. It is the optimal survey to detect the presence of microcalcifications, which can sometimes be an expression of tumor or preneoplastic lesions. The use of 3D technique with tomosynthesis is now preferable to the traditional one, because the image quality is better and the use of X-rays further reduced. Mammography, however,





may have diagnostic limits for breast density, characteristic of young women and more generally of childbearing age.

In these cases the study is completed with the performance of a breast ultrasound and sometimes a breast MRI. Ultrasound is the most useful examination to distinguish a solid lump from a fluid cyst and allows better characterization of the lump and its vascularization through color-doppler evaluation.

### **Magnetic resonance imaging (RMM)**

The role of RMM for early detection of breast cancer is now limited to diagnostic surveillance of women carrying BRCA gene alterations or in young women with dense breasts and/or strong familiarity. RMM is an examination that is used in the judgment of the radiologist or breast specialist, supplementing mammography and ultrasound, in cases where there is a discrepancy between previous examinations or in the presence of a confirmed carcinoma, for better local stadium. However, the examination may give falsely suspicious results. It must therefore be performed in breast centers.

### **Needle picks**

They can be performed, usually under ultrasound guidance, both with a thin needle ("agoaspirato", which allows the cytological examination of the vacuumed material) and with needle of slightly larger size ("agobiopsy", which allows the histological examination of the fragments of removed fabric). The so-called "vacuum assisted biopsy" is a type of minimally invasive biopsy, performed under local anesthesia, which unlike the previous one allows to take more whistlats of tissue and to have a better histological characterization with a single introduction Aug. The procedure is outpatient, does not require sedation but only a simple local anesthesia, and is performed using a dedicated tool with the help of the ultrasound or mammogram. This type of diagnostic assessment is the most widely used for the study of microcalcifications. All of the above procedures are oncologically safe and have an exclusively diagnostic function. This means that if you encounter a tumor or preneoplastic injury, you must have limited surgery anyway.

The cytological or histological examination is indicated for the woman who presents to mammography or ultrasound lesions deserving of diagnostic deepening, to





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confirm or exclude the presence of a carcinoma. If once to acquire this information was necessary to resort to surgery, today it is possible to have diagnostic confirmation through safe, reliable and minimally invasive procedures, consisting of withdrawals of a few cells or tissue through the needlesuckation that is practically painless.



#### **Other clinical-diagnostic examinations**

Once the diagnosis of breast cancer is made, other examinations are useful to define the extent of the disease (stadiation). They include a standard chest X-ray, abdominal ultrasound and dosage of tumor markers in the blood (CEA and Ca15-3). It is pointed out that cancer markers are not useful for early detection of cancer because they are poorly sensitive and specific. In some cases it may be necessary to complete the stadion with a bone scintigraphy. In the case of advanced disease, computer tomography (CT) and positron emission tomography (PET-TAC) can be used as in-depth examinations and for the evaluation of the effectiveness of therapies.





## ORGANIZED SCREENING

"Screening" is an English term for selection. A screening test is an examination that can identify, in the supposedly healthy population, people who may be ill. These people, "selected" through the screening test, are subjected to further examinations that have instead "diagnostic purposes". For breast cancer, the selection is made by mammography.

To be "positive" to the screening test, therefore, does not equate to "being certain to be affected by cancer", means instead that there has been the discovery of worthy signs of diagnostic deepening. In Italy, the "screening programme" consists of an active invitation through individual communication to enter a path in which both the screening test and the further examinations and treatment, if necessary, are insured. Today, there are 3 cancer screening programs that have been found to be "effective", that is, able to reduce the mortality rate for that type of cancer in the screened population. This is the screening of cervical cancer, colorectal and breast cancer.

*The results of a study funded by LILT and the Ministry of Health – IMPATTO Project*

- *showed that mammography screening in our country led to:*
- *A reduction in mortality from breast cancer;*
- *A reduction in the number of demolition interventions, as the tumour lesion is still small;*
- *A better prognosis, thanks to early diagnosis.*

The National Health Service, through the Regions, offers free of charge to all women aged 50 to 69 (age group at greatest risk) the possibility to perform a mammogram every two years, through an invitation letter showing the date, the time and place of the exam. There are "organized screening programmes" across much of the country that involve the implementation of a mammogram (and any necessary investigations) every 2 years for women in the 50-69 age group.

The extension of screening to all women aged 45-50 and women over 69 is currently being studied. The Italian League for the Fight against Cancer hopes that organized screening programmes will be extended from the age of 40, annually and for the whole life span.





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The LILT strongly recommends adhering to the invitation to perform the screening mammography sent by its own ASL and therefore offers the widest collaborative availability for widespread awareness of the female population, also through their own Provincial Sections. For women over the age of 50 or over 70, The LILT recommends that you consult your doctor, or specialists with expertise in breast, to agree on any individual prevention and early diagnosis programmes (autopalpation, visit, instrumental diagnostic investigations).

#### **What happens if a woman is “positive” to screening mammography?**

Any feedback to the mammography of a lump or doubtful finds will be followed by a further invitation to undergo in-depth examinations (again free), which can range from the simple integration of the data acquired during the examination with other mammography images, with ultrasound, with the possible needle aspiration in the presence of a lump or with magnetic resonance imaging.

#### **Spontaneous screening**

The mammography screening offered by the National Health Service is therefore a very effective tool for the early diagnosis of breast cancers, which for reasons of health costs does not cover all age groups and that provides only for the execution of mammography. It should be borne in mind that breast cancer affects in about 30% of cases women under the age of 50, which are therefore not covered by mammography screening.

There is also the possibility that the tumor may appear in the interval between a negative screening mammogram and the next, or that in a dense breast it may not be visible a lump that, on the contrary, may better be characterized by breast ultrasound. For this reason, women should know that they too are entrusted with a responsibility for the early detection of the tumor, through autopalpation and the regular and periodic execution of clinical checks in which the breastologist, on the basis of age and individual risk, in addition to carrying out the specialist visit, will suggest more suitable prevention and diagnosis strategies (type of examination and frequency of execution).





## WHAT DIAGNOSTIC PATHWAYS CAN BE IMPLEMENTED OUTSIDE OF A SCREENING PROGRAM?

### **Asymptomatic woman**

#### *Under 40 years of age*

Correct information and teaching of self-examination. No instrumental preventive control, except for a high-risk woman, included in a specific diagnostic surveillance program.

#### *Age over 40 years*

Mammography with a periodicity of 12 to 24 months, supplemented by ultrasound, especially in women with radiologically dense breasts.

### **Symptomatic woman**

#### *Age less than 35 years*

In the presence of a lump, breast examination, ultrasound and possible agoaspiration are considered sufficiently useful. The persistence of doubt involves the completion of the diagnostic pathway with mammography and with any other diagnostic-instrumental examinations.

#### *Age over 35 years*

Mammography in association with breast examination and ultrasound: allows an accurate diagnosis and protects against the non-diagnosis of radiologically undetectable carcinomas. If images that are difficult to interpret, or that have elements of suspicion, you need to make needle picking. On a case-by-case basis, it will be necessary to decide whether or not the withdrawal with a needle should be preceded by the RMM.

#### *Self-examination in the age of screening*

Improving diagnostic investigations used for an ever-earlier diagnosis of breast cancer has meant that very small tumours, not appreciable to palpation or even alterations that precede development can be detected cancer. Then what is the role of self-palpation in the prevention of breast cancer?

Periodically self-examination of the breast allows each woman to “acquire confidence” with her breast and to appreciate any changes that may occur in the interval between







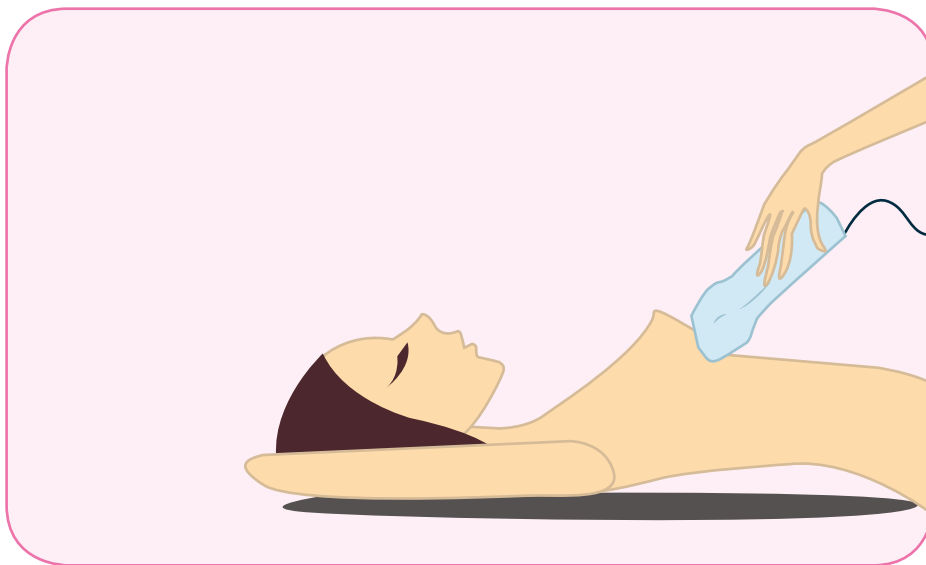
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examination and the subsequent check-Such surveillance can generate concerns or false alarms, but raising awareness of women's self-palpation means encouraging them not to be afraid to know and discover an injury, to consult their doctor or breast cancer for any doubts and to indulge in a to reflect on the importance of prevention.

#### ***What therapies might you need?***

Breast cancer is actually a heterogeneous group of diseases for which today we have a wide range of complementary and varied therapeutic options, including surgery, radiotherapy and medical therapies ( chemotherapy, biological or molecular target therapies).

The patient receiving a diagnosis of breast cancer will be followed by a team of medical specialists, consisting of radiologist, surgeon breast surgeon, anatomist, oncologist, radiotherapist, plastic surgeon and psychologist, who will evaluate in detail on the based on the biological size and characteristics of the tumor and the patient's health condition which is the most effective strategy in terms of healing and better quality of life.





## ***Surgery***

Surgery is still the primary and irreplaceable weapon for the treatment and healing of breast cancer. There are essentially two techniques for intervention: conservatism and demolition. The conservative surgical technique (quadrantectomy or tumorctomy), applicable in the case of small tumors, consists of removing only the tumor and a limited part of the surrounding healthy breast tissue. This technique allows a good aesthetic result, while still ensuring the radicality of the treatment.

The demolition technique (mastectomy), less and less frequent, consists of the total removal of the breast. In these cases, surgery is increasingly associated with reconstructive surgery techniques performed, whenever possible, in the same operating session. It is an essential part of surgical care to the attention to the study of the axillary lymph nodes, structures that filter the lymph resulting from the mammary gland. In the past these lymph nodes were always completely removed for their histological examination. The methodology of the election today, when indicated, is the technique of the sentinel lymph node that removes and histologically examines the lymph node or those that are first found on the possible path of lymphatic spread of the tumor. This reduces hospitalization time and possible complications, such as swelling of the arm (lymphedema).

## ***Conservative surgery***

Removal limited to a part of the breast, that containing the tumor and part of the healthy tissue that surrounds it (glandular resection; quadrantectomy), generally followed by radiotherapy.

## ***Mastectomy***

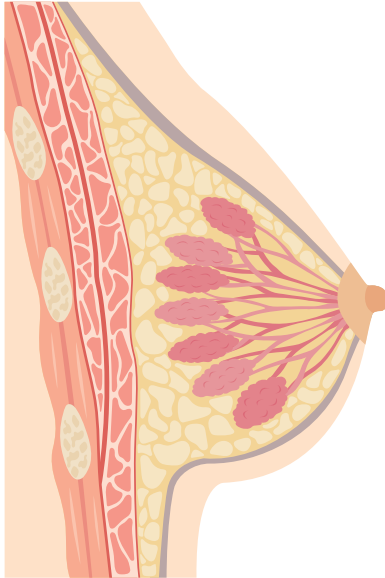
Complete removal of the mammary gland along with the nipple, skin above and axillary lymph nodes (radical mastectomy), or with preservation of the outer skin casing and if possible of the areola and nipple (mastectomy "skin-nipple sparing").





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## WHAT REHABILITATION - *After breast cancer?*



The surgical interventions for the removal of breast cancers are of various types: the entire mammary gland (mastectomy) or part (quadrantectomy) can be removed along with one or all of the lymph nodes placed in the armpit cable, which drain the mammary region and upper limb (sentinel lymphnode and full armpit lymphadenectomy).

When it is necessary to remove the entire mammary gland, it is possible to reconstruct the breast by several surgical techniques, more or less sophisticated.

Reconstruction can be immediate, that is, carried out in conjunction with the demolition intervention, or postponed a few months after the first intervention.

Although accurate, conservative and demolition/reconstructive interventions can cause, to varying degrees, post-operative outcomes in the region of surgery and in the arm on the operated side.

It is good that the patient is informed about the possible occurrence of mild complications or side effects of surgical and radiotherapy therapies.

Some outcomes may appear early, that is, in the first days after surgery, others may manifest themselves after a few weeks or even after more time, sometimes even years. In the following pages we will answer the questions that are most frequently asked of us after breast surgery extended to the armpit cord, with removal of all lymph nodes.





***I'm afraid to move my arm and when I move it I feel pain. Should I hold it still?***

Keeping your arm steady after the wound helps increase the pain in the movement, so it's best to move it normally. In addition, the arm should be used naturally, for common daily activities (combing, washing, taking and laying objects even placed at the top). It is not necessary to strive or to keep your arm still.



***I'm afraid to raise my arm completely because there are "cords" pulling in the armpit, sometimes up to the elbow.***

These "cords" (lymphosclerosis), which sometimes appear under the skin of the armpit after surgery, should not scare or limit the movement of the arm. Perform the exercises slowly, repeating them many times until you get a gradual lengthening, imagining that the arm extends into space, without a particular force (exercise more on perception than on motricity). Exercises are effective if they result in a moderate stretching effect under the armpit.



***I have an annoying swelling under my armpit. Is he going to leave?***

After the removal of drainage, it may be necessary to suck with a syringe the serum that forms under the armpit (sieroma). The production of serum can last a few weeks and then decrease progressively. This does not prevent you from moving your arm loosely for daily activities, just as it is important to move with fluency if it persists or appears during radiotherapy, or at a distance of time, a slight swelling in the area under the armpit. The movement will help to restore lymphatic and venous circulation, reducing discomfort. It can be useful to carry out daily exercises by adding a light massage of touching (similar to a caress) from the armpit to the side and to the shoulder blade. At the end of the massage can be applied an ointment of arnica or a phlebotonic. If the swelling reoccurs over time, it is useful to undergo some manual lymph drainage sessions, carried out by physiotherapists specializing in lymphology. It is possible that the discomfort is accentuated by high temperatures, as a result of physical exertion or if you use inappropriate bras, which leave furrow.



***I have no sensitivity under the armpit and/or inside the arm. Will it be back to normal? I feel tingling, stinging, shaking under the armpit and/or inside the arm. What's happening to me? I feel a weight under my armpit, like I have a bearing. What's it going to be?***

During surgery, some branches of a nerve of skin sensitivity may be injured. In most cases the symptoms due to nerve injury gradually decrease in the following months. In some people, particularly emotional, these sensations can be felt with greater intensity and for a long time. An activity involving global body movements and relaxation and breathing techniques can be useful in reducing symptoms.



***I feel the scar he pulls when I raise my arm. What can I do?***

Already a few days after the removal of the stitches, the scar can be treated daily using special elasticating creams for sale in pharmacies. The massage should be performed with the fingertips of the fingers on the scar and must produce a circular movement on the skin, without causing redness of the area. Self-treatment with elasticating creams can continue





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for several months. In the execution of the exercises, prefer the movements that induce a progressive and continuous stretching of the scar and surrounding tissues. If the scar grips are deep it may be useful to turn to experienced physiotherapists in the manual disconnect of the scars; In the most resistant cases, special subcutaneous stings with anesthetic and anti-inflammatory performed by an experienced doctor or plastic surgery can be used.



*I have no pain, but I can't raise my arm like the other one and, even if I strain, I can't straighten my elbow above my head.*

During surgery, a nerve that normally keeps the shoulder blade attached to the chest can be damaged. The lesion of this nerve makes the elevation movements of the arm more difficult and can result in a protrusion of the shoulder blade also called the winged shoulder blade. Sometimes the nerve injury can be irreversible and the function of the limb recovered only partially. Postural re-education and specific exercises for the winged shoulder blade can be performed in any physiotherapy center. The motor deficit can last for several months, so it is advisable to schedule an appropriate rehabilitation period.

### *Will I have a swollen arm?*

The lymphatic circulation of the upper limb is slowed by surgical removal of the lymph nodes of the armpit and radiotherapy. Two or three people in ten experience over time, sometimes almost immediately after surgery or after radiotherapy or even after years, a visible swelling in the arm or parts of it (infidel).



*My arm is swollen! The doctor says it is "normal", a consequence of the intervention.*

*Will it deflate itself or do I have to cure it?*

Swelling (infidel), at the initial stage, can occur in a part of the limb (arm, forearm, hand) and can sometimes regress spontaneously. The sporadic manifestation can, over time, become permanent and the limb can be permanently swollen. In this case it is good to undergo appropriate physical therapies, since lymphedema tends to gradually increase over time and to worsen. At the first signs of recurrent swelling, it is advisable to turn to wards or physiotherapists specialized in lymphedema therapy, to treat it at an early stage. Early therapies will be more effective and can be decisive at this stage.

### *Suddenly there were red patches on my arm and I feel it warm. What's going on?*



The removal of the lymph nodes is the cause of a lymphatic failure that can predispose the limb to inflammatory/infectious processes that occur with redness of the skin, localized heat or temperature increase (fever), pain and sudden increase in limb volume (edema). Pain is often the first symptom.

This inflammatory process can sometimes also manifest itself in the breast. Treatment consists of a drug therapy based on antibiotics and anti-inflammatory drugs, for which you need to consult your doctor in a timely manner. Lymphangitis should not be confused with the phlebitis or thrombophlebitis which are pathologies of the venous system and should be treated differently.

In the case of high temperature you can place a bag containing cold water or ice on the warmer areas of the limb. Episodes of lymphangitis can occur and are generally caused by some traumatic event for the limb (insect bites, small wounds, prolonged efforts, direct exposure to heat sources), or allergic reactions. It is advisable to take precautions, taking special care in avoiding small injuries.





## RADIOTHERAPY

### *Partial breast radiotherapy*

An experimental treatment that involves, for particular cases, the only irradiation of the area containing cancer (small size) and not of the entire breast and skin, as in external beam radiotherapy. This implies a shorter duration of treatment until the possibility of concluding it at the same time as surgery, as in the case of intraoperative radiotherapy.

### *Radiotherapy after mastectomy*

External radiotherapy needed in selected cases to reduce the risk of tumor recurrence on the chest wall or lymph nodes (species of internal breast). In all cases, radiotherapy does not cause any particular discomfort, nor hair loss. Its side effects are mainly local and mostly characterized by a thickening and redness of the skin of the breast. Intraoperative radiotherapy (or IORT): this is a technique in which a single, high dose of radiation is administered during surgery or directly on the tumor, or, with removed neoplastic tissue, directly on the bed (to eliminate the risk of microscopic infiltration). One of the advantages of this technique is to be able to deliver radiation directly to the target, saving adjacent healthy structures and/or those below.

### *Systemic drug therapies*

Medical therapies aim to eliminate any remaining cancer cells (metastases) from surgery and radiotherapy, reducing the risk of disease recurrence and increasing the chances of recovery. Medical therapies include chemotherapy, hormonal therapy and biological therapies, which are otherwise combined or associated with the stage of the disease and the biological characteristics of the tumor. In some cases, to promote or reduce surgical exeresis of the tumor it may be necessary to carry out drug therapy before surgery (neoadjuvant drug therapies).

### *Hormone therapy*

Use drugs that block the action or production of estrogen. It is used as a single treatment or after chemotherapy in cases where tests performed on the tumor demonstrate the presence of receptors for estrogen and progesterone. Hormone therapies are generally well tolerated and free of the side effects classically described for chemotherapy.





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### ***Chemotherapy***

Use drugs that are administered cyclically after surgery (adjuvant chemotherapy), that is, before this (neoadjuvant chemotherapy) in locally advanced cases or to reduce the size of the tumor. The benefit of chemotherapy on healing can also be significant in the early stages of the disease.

### ***Biological therapies***

They use drugs that act in a targeted, selective way, mainly interfering with the mechanisms that regulate tumor growth. For this reason the toxicity of these drugs compared to the most common chemotherapy is generally reduced, while retaining the maximum therapeutic benefit. One example is drugs that act selectively on the HER2 receptor, which are shown when the tumour has high levels of this protein.

## **AFTER TREATMENT**

Healing with breast cancer can be. And today you must!

More and more women are taking up their role as women, wives, companions, mothers and workers after overcoming the disease. To all of them must be directed to another type of prevention, which takes into account the specific problems generated by the experience of the “lived” disease.

One of the biggest concerns of those who have been treated for breast cancer is that the disease may recur.

A lot can also be done to prevent recurrence: women with breast cancer should consult their doctor to carry out periodic clinical-instrumental checks and to counteract the possible side effects of medical treatments and Surgical. Finally, rehabilitation must no longer be just physical, but also social, occupational and psychological. In fact, one should not be afraid to resort to psychological support to overcome such a shocking and destabilizing event: winning cancer means above all breaking taboos!







The results of recent scientific studies show that even after the diagnosis of breast cancer, adopting "healthy" lifestyles is more than useful.

*Also at this stage it is recommended to:*

- *Maintain an adequate body weight;*
- *Prefer a diet rich in fresh fruits, vegetables and extra virgin olive oil;*
- *To carry out constant and regular physical activity;*
- *Limiting alcohol consumption;*
- *Avoid smoking.*

These few rules improve the prognosis of the disease and will help to live longer and better.

## AND TO PREVENT CERVICAL CANCERS?

### **What does the term "HPV" mean?**

The term HPV (English acronym for Human Papilloma Virus) refers to a family of more than 100 viruses, consisting of DNA, that can infect the lining cells (epithelials) of the skin and several mucous, some of which are responsible for the onset of pathologies, cancer and non-cancer, at the expense of various organs (cervix, mouth, throat, cervix uterine, vulva, vagina and anus). Of the 40 HPV strains that affect the genital areas, only 13 are responsible for cervical cancer and, for this reason, are defined as high-risk strains: among these the strains called "16 and "18" are responsible for 70% of cervical cancers. At the skin level other HPV strains (strains "6" and "11") are defined as "low risk" as they are generally not able to produce cellular modifications that will evolve in a tumor, but can induce the formation of warts or condilomas (benign growths appearing in the anus-genital area of men and women).

### **How do I get HPV infection?**

HPV is widespread in the population and is the main sexually transmitted infection. It is estimated that about 80% of sexually active women contract infection of any type of HPV in their lifetime and that more than half of these infections due to a high-





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risk strain. HPV transmission is mainly done through sexual intercourse. The use of condoms, although it reduces the risk of infection, does not completely eliminate it since the virus can also infect parts of skin not protected by the condom. Infection, especially for high-risk strains, is more common among younger girls. The young age at first sexual intercourse (especially under 16 years), the number of sexual partners, diseases or therapies that weaken the immune system affect the risk of contracting HPV infection.

#### **Will the infection develop once the infection is contracted?**

N. 60-90% of HPV infections, including those from oncogenic (or "high-risk") types, are transient because the virus is eliminated by the immune system within 1-2 years of contagion. In addition, most people who have contracted the infection have no symptoms, but can transmit the virus. In the case of persistent infection, in about 5 years, precancerous lesions can develop that, if left untreated, can progress to cancer. Estimated time for the onset of cervical cancer varies between 20 and 40 years.

Cigarette smoking, the use of oral contraceptives, the high number of births, the presence of other sexually transmitted diseases and familiarity have been identified as factors that promote progression from infection to preneoplastic lesions, up to Cancer. If the infection does not heal, it can cause alterations of the cells of the cervix of various types, generally called dysplasias and classified in CIN (intraepithelial cervical cancer) and SIL (intraepithelial squamous lesion) according to varying degrees of Gravity. Cervical cancer, given the frequency of HPV infection, is a rare outcome. In fact, fortunately only 1% of women who have developed high-risk HPV infection will develop cervical cancer.

However, it represents the fourth most common cancer in the female sex, with an estimated 528,000 new cases per year and 266,000 deaths worldwide in 2012 (most of them in developing countries). In Italy, it is estimated that in 2012 there were about 1500 new cases of cervical cancer and about 700 deaths. Since the evolution of precancerous lesions towards cervical cancer is not frequent and takes a long time, participation in screening allows for early diagnosis of preneoplastic lesions (screening





is diagnosed every year in Italy about 130,000 precancerous lesions of the cervix) as well as the established pathology, with an estimated reduction in the incidence of this tumor by about 30% compared to 2002. Equally important in the prevention of cervical cancer is vaccination against HPV infection.

### **HPV equals cervical cancer?**

N. Cervical cancer is the most common, but it is not the only, neoplasia for which some HPV viruses are responsible. Oncogen strains of HPV are responsible for about 90% of anus cancers, about 70% of vagina cancers, 50% of penile tumors and 40% of vulva tumors. HPV is also responsible for 26% of orarynx cancers (particularly tonsil and language base tumours). Various studies have documented low-risk HPV DNA (particularly 6 and 11) in 100% of anogenital condilomas and almost all of recurrent juvenile respiratory papillomatosis. These data contributed to the decision to extend HPV vaccination to males as well.

### **What can be done against HPV?**

Since the beginning of the 1980s in Western countries, mortality from cervical cancer has been in continuous and sharp decline, as a result of screening and early diagnosis campaigns through Pap-test. This disease remains an important cause of illness and death for women in poorer countries, where these screening programmes fail to reach large swathes of the population and where 85% of cases occur and almost 90% of deaths occur. More recently the Pap-test has been flanked, and depending on the strategies sometimes replaced, the so-called HPV-DNA test, an examination that identifies on the surface of the uterine cervix the presence of HPV DNA (not the presence of cellular lesions, as in the case Pap-test).

Hpv infection has been possible in Italy since 2008. It's in fact, you can get vaccinated against high-risk HPV strains, which are responsible for most cases of cancer. Since that year, a campaign has been in place that recommends and offers free vaccination against the virus to girls between 11 and 12 years, at which age it is assumed that they have not yet come into contact with the virus. The most common are two vaccines that are administered intramuscularly: one bivalent and one quadrivalent.





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The first is directed against strains 16 and 18 of the virus (high-risk "oncogenic" strains), while in the second, to protect against such strains, is also added the one against 6 and 11 (strains associated with the formation of condilomas at the genital level). From 2017 a third vaccine is available that, in addition to HPV 6, 11, 16 and 18, provides protection against seven other serotypes capable of inducing tumor pathologies. The effectiveness of such vaccines is close to 98%. In girls aged 11-12, two doses given over 6 months provide good protection. For vaccinations at a later age, three doses are recommended instead. It is not yet certain how long the protection of these vaccines seems to last at least ten years, but if ongoing studies confirm this, booster doses could be useful to prolong their effect.

#### **Is the HPV vaccine safe?**

Vaccines that are authorised against HPV infections in Italy are characterized, in addition to very high effectiveness, by equal levels of safety and tolerability. They do not contain the weakened or killed viral agent, but only particles from the virus envelope (so-called Vlp: virus-like particles). These molecules mimic the outermost part of the virus and stimulate the immune response. They do not contain viral DNA and therefore do not have the ability to infect cells, replicate and thus cause infection. Data from studies of millions of girls has now shown that HPV vaccines do not cause major adverse events.

Among these the most common are a slight fever and redness and swelling at the injection point. There may also be headaches, gastrointestinal disorders, a slight sense of discomfort or muscle aches, but these are still passenger phenomena.

The safety of these vaccines was confirmed in 2015 by a study by the World Health Organization (WHO) of almost 10 years in more than 110 countries, for a number of doses >200 million, which confirmed its substantial safety.

#### **If I get vaccine, can I avoid the Pap-test?**

N. Vaccination defends against infection, but does not relieve those who have been vaccinated from responding to the call to screen for cervical cancer from the age of 25. The HPV vaccine only protects against certain strains of HPV and not from those that, although less frequently, can induce alterations to cervical cells.





### **Does the vaccine allow me not to use a condom?**

N. The use of condoms is always recommended, even to vaccinated people, during occasional intercourse, to protect against many other sexually transmitted infections. Should only girls be vaccinated?

The ideal condition is to vaccinate girls who have not yet started sexual activity, which remains the main vehicle of transmission of the virus. But the Plan National Vaccine Prevention 2017-2019 extends vaccination to males in their eleventh year of age, both to stop the circulation of the virus, and to protect them from tumors rarer than that of the uterus, but dependent on the same viral strains, as the rarest carcinomas of anus, penis, oral cord and throat.

The very high protection obtained with the vaccine is reduced in the event that the individual has already come into contact with one of the HPV strains against which it is directed. However, as protection against residual strains persists and the vaccine appears to be protected against component strains, HPV vaccination is approved by the European and Italian regulators up to the age of 26 (purchaseable in some regions at a discounted price).





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## LILT

### Who is the LILT

The LILT, Italian League for the Fight against Tumors, is the only public entity on an association basis existing in Italy with the specific purpose of fighting cancer. LILT is the oldest national organization in the industry. It was founded in 1922 and already in 1927 obtained legal recognition and the title of "Moral Entity" by decree of Vittorio Emanuele III, King of Italy. It operates not for profit throughout the country, under the supervision of the Ministry of Health. It collaborates with the State, the Regions, provinces, municipalities and other bodies and bodies operating in the field of cancer. He is a member of the European Cancer Leagues (ECL) and plays an institutional role in European cancer programming. It maintains relations with the European Cancer Society and similar institutions in China, Albania and Kosovo. In August 2009, LILT joined the international European Men's Health Forum (EMHF) network.

### The mission

The main goal of LILT is to defeat cancers through primary, secondary and tertiary prevention. Prevention, in fact, has always been considered the priority institutional task of the LILT - as well highlighted by the pay-off "Prevent is Living" - and still represents the most effective weapon in the fight against cancer. This is confirmed by the reduced mortality for some cancers and the lengthening and improvement of the quality of life of the cancer patient.

### Activities

LILT has always been a reference point in the field of cancer prevention, both in Italy and abroad, offering numerous services and stimulating, through conventions and protocols of understanding, an exchange of information and experiences in order to establish and synergies. There is no doubt that the promotion and implementation of a culture of prevention (primary, secondary and tertiary) is the main activity of LILT. For this reason it is the largest public body dedicated to the fight against cancer, understood in all its aspects.

#### *Primary prevention*

Proper nutrition and health education through the dissemination of educational-information material (awareness campaigns, school meetings, etc.); provincial and





regional events; national demonstrations; fight against smoking (smoking cessation routes, information campaigns, green line SOS LILT 800 998877).

### ***Secondary prevention***

Specialist visits and examinations for early diagnosis with the aim of identifying any early-stage cancers, thus greatly increasing the possibility of complete healing and resorting to inaggressive treatments.

### ***Tertiary prevention***

Physical, mental, social and occupational rehabilitation of the cancer patient. A valuable task that the LILT is able to offer thanks to the activities of the Provincial Sections, Prevention Points (outpatients) and in collaboration with the National Health Service.

### ***Home care***

Valuable integration to hospital care, through the Provincial Sections, which guarantee medical, psychological, nursing and in many cases also psycho-social and economic care. Particular attention to the cancer patient, to build around him a network of solidarity, security and information, to offer him the certainty of not being alone. In this regard, the LILT has made a substantial contribution to the drafting and promotion of the Manifesto of the Rights of the Oncological Sick, which protects the sick and his family both in the work and social spheres.

## **How to support LILT**

### **With a donation**

Donations can be made:

- For the National Headquarters
  - by credit card by connecting to the [www.lilt.it](http://www.lilt.it) website;
  - With a deposit on cc/p 28220002  
IBAN Code: IT73 H076 0103 2000 0002 8220 002;
  - With a deposit on cc/b Monte dei Paschi di Siena,  
Rome Branch, Via del Corso 232  
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- It is directly to the LILT Section of your province by consulting the website [www.lilt.it](http://www.lilt.it).

### **5 per thousand for LILT**

You can help the LILT by devolving the 5 per thousand of the Irpef. It is sufficient to sign in the space "Funding of Health Research" or "Funding of Scientific Research and University" for the National Headquarters (C.F. 80118410580) and in the space "Support of Volunteering and Other Organizations "It's not the first place that we've had a problem with social welfare," he said. 10, c. 1, lett. (a) of D.Lgs. 460 of 1997" to support the LILT Section of its Province, which is located on [www.lilt.it](http://www.lilt.it) by clicking on "The LILT in Italy" and selecting your Region.

### **Social quotas**

To become a LILT member, you only need to pay the annual fee (10 euros, as an ordinary member; 150 euros, as a supporter; 300 euros, as a beneficiary member).

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***Provincial Section of Cagliari for providing all the part about rehabilitation.***





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