one would expect to lead to pessimism or despair. These findings advance decision science by incorporating current theories of positive emotion which highlights the importance of positive mood for broadening thought and building future resources when facing the long term sequelae of recurrent disease.

Conclusions: Clinically, it is important to understand the processes which lead women to select unnecessarily aggressive therapies or decline therapy altogether from a sense of despair rather than reasoned deliberation. The importance of understanding women's decision behavior at various points in the treatment continuum lies in targeting problematic areas where structured decision interventions may improve decision quality and subsequent psychological outcomes in this chronic and life-threatening disease.

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Choice of surgical treatment in breast cancer is not influenced by personality and quality of life

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Background: When confronted with the diagnosis early stage breast cancer women are usually allowed to choose their surgical treatment. The options are breast conserving therapy followed by radiotherapy (BCT) or mastectomy (MTC). Personal characteristics that may influence this decision were assessed in this study.

Methods: Women referred to the outdoor clinic with breast disease were asked to participate in a prospective study concerning quality of life. Before breast cancer was diagnosed the women completed questionnaires concerning quality of life (WHOQOL-100), personality (NEO-FI), depressive symptoms (CES-D), fatigue (FAS), and anxiety (STAI). Regression analyses were performed to see whether any of the clinical, psychological or personality factors or the clinical parameters were of significance in the decisional process.

Results: Between September 2002 and January 2007 609 women were included in the study of whom 225 were diagnosed with early stage breast cancer. Of these women 133 choose BCT and 90 women opted for MTC as surgical treatment. Two women requested to be treated with hormonal therapy only.

There were no differences between the two treatment groups concerning demographic, personality, and psychological characteristics. The women who opted for MTC had larger tumors on radiology ($p < 0.001$), and women who choose for BCT had tumors that were found more often with a breast cancer screening program.

Logistic regression analyses showed that only participation in a breast screening program and a high score on the domain social relationships of the WHOQOL-100 had a significant influence on the treatment choice and predisposed for BCT.

Conclusions: The choice between BCT and MTC is based on personal preference of the woman. So far this choice cannot be explained by personality or pre-existent overall QoL. This implies that differences in QoL found after breast cancer treatment are caused by the chosen type of surgery.

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Evaluation of a breast reconstruction service: multi-disciplinary care and satisfaction with information leads to improved outcomes

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Background: At the Queen Elizabeth Hospital (TQEH) in Adelaide, South Australia, a 350 bed publicly funded hospital situated in the culturally diverse western suburbs, a collaborative service is provided for women considering breast reconstruction.

Comprised of the Breast surgical team, in conjunction with the Plastics and Reconstructive surgical team, a multidisciplinary approach to care of these women and their families has developed. Until now this service had not been evaluated from a client perspective.

Methods: A self-report questionnaire was developed with specific questions asked about the woman's pre and post-operative experience. All women who had undergone a breast reconstruction in the past ten years were eligible.

Information was collected on:

- The surgical consultations they received pre operatively
- Their hospital experience after their surgery
- Their psychological outcomes once treatment was completed

Results: 112 surveys were sent. 50 surveys were completed and returned. Results were entered into a database (Predictive Analytics Software) and analysed with Fisher's exact test.

Key findings were:

- Main source of initial information about reconstruction was breast surgeon and breast care nurse
- Patients seen in TQEH outpatients clinic were more likely to see a breast care nurse than those seen privately ($p = 0.05$)
- All those who were happy with the result (72%, $n = 34$) felt they had received adequate information after the first plastic surgeon consultation, only 63% (5 out of 8) patients who were not happy felt they were satisfied with the information provided ($p = 0.012$)
- Those that were satisfied with the information received and consequently understood more about the procedure were glad they had reconstruction ($p = 0.018$; 0.015) and were more confident post operatively ($p = 0.008$, 0.006)
- Women were happy to recommend the surgery if they had received adequate information pre operatively ($p = 0.028$)
- 86% of those who saw a plastics nurse pre-operatively were more confident after the surgery, but only 54% of those who didn't see a plastics nurse were more confident after surgery ($p = 0.05$)

Conclusions:

- Satisfaction of information and improved understanding were linked to improved psychological outcomes post operatively in this group of women.
- Both medical and nursing involvement with these women was shown to be important.

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Collateral damage – the full impact of breast cancer on the family unit

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Aim: To objectively assess the psycho-social impact surgery and other adjuvant treatment modalities for breast cancer has on patients' spouses/ partners.

Method: The Nottingham Health Profile index of Distress (NHPD) is a generic undimensional 24-item measure of illness-related distress. It consists of 24 dichotomous (Yes/No) items that yield a score ranging from 0 to 24. Higher scores indicate more distress. Participants were asked to fill in the NHPD while attending with their partners to follow up clinics.

Results: 61 participants took part in the study (Mean Age: 61.4). All were males. Most were retired ($n = 32$). Most of their partners have had their surgery within the last five years ($n = 42$). The median NHPD score for the sample was 8. Higher scores were noted in the elderly (p 0.03). Chemotherapy was described as the most disturbing experience by the majority ($n = 36$), yet receiving chemotherapy was not associated with higher scores (p 0.043) unlike Radiotherapy which was (p 0.049). Lower scores were noted in those whose partners have had their diagnosis within the last five years ($p < 0.001$).

Discussion: Duration since diagnosis has no impact on the NHPD score; however there seems to be a recent improvement in communication, leading to a better understanding of the disease from both patients and their partners. The elderly seem to be distressed the most and adjuvant therapy was described as the most disturbing experience. Breast cancer impacts on both the patients and their families alike and patients' partners should also be considered during consultations and offered support if needed.

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Personality and not type of surgery affects body image in women with breast problems

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Background: The objective of this prospective study was to examine the changes in body image over time in women with breast problems and to determine which factors (sociodemographic, clinical, personality) predict body image scores at different time points over a one-year period.

Materials and Methods: Women with breast problems ($n = 384$) completed prior to diagnosis (Time-1) and one (Time-2), three (Time-3), six (Time-4), and 12 months (Time-5) after primary surgery a measure of body image (WHOQOL-100-facet Body Image). Before diagnosis was known, personality was assessed (NEO-FFI). Clinical data were derived from medical files.