Enhanced Recovery after Breast Surgery
An information guide
Enhanced Recovery after Breast Surgery

We appreciate any feedback or comments you have. These can be given directly to your Clinical Nurse Specialist (CNS) or can be added to the space for comments in your patient diary which is in your patient pack.
Introduction

This booklet has been produced to help you and your family understand more about your breast operation. It includes information about the Breast team, the type of cancer you have, the pre-operative assessment clinic, surgery and enhanced recovery.

The aim of the enhanced recovery programme is to get you back to full health as quickly as possible after your operation. Research has shown that the earlier you are out of bed, eating and drinking and performing your arm exercises the better. This will speed your recovery and make complications less likely to develop. This booklet should increase your understanding of the programme and how you can play an active role.

Introduction to the Surgical Breast Team

Before your surgery the Consultant Surgeon who specialises in treating breast conditions will explain the operation to you. You are likely to meet other Surgeons, Advanced Nurse Practitioners, the Radiology team and Clinical Nurse Specialists (CNS) who all work as part of the team. The team works closely together to ensure that you receive a quality service.

After you have seen your Surgeon, a CNS will be available to discuss your treatment plan and continue to provide information advice and support for you and your family throughout your care. There may be a number of different people involved in your treatment. The CNS will be your Keyworker and act as a link between the different services. However, the Nurses work as part of a team and you may see or speak to any of them.

For some people admission to hospital and having surgery can be traumatic and distressing. We are also aware that some of the
technical terms used can be unfamiliar and confusing.

The breast team are highly qualified healthcare professionals who will endeavour to keep you well informed and make your stay in hospital as comfortable as possible.

Useful contacts and telephone numbers

Your Consultant Breast Surgeon is: ..................................................

Secretary Contact Number: ......................................................

Your Clinical Nurse Specialist (CNS) or key worker is: ..................

Contact numbers:

CNS  0161 720 2558 North Manchester General Hospital
     0161 627 8459 the Royal Oldham Hospital

Prosthetic advisor:   Susan Bennici       0161 656 1711

The Clinical Nurse Specialists are available Monday-Friday 9.00 a.m.-4.30 p.m. A 24 hour answer phone is available for you to leave a message if you need to speak to someone. Outside of these hours please contact the ward.

Please contact the CNS or the ward for further advice, prior to visiting A&E or a GP practice if you have any problems after discharge.
What is breast cancer?

Each breast contains a number of lobules, surrounded by fatty tissue. These lobules are where milk is produced towards the end of pregnancy. Milk is carried to the nipple through ducts or tubes.

There are different treatments for different types of breast cancer.

Types of breast cancer

Breast cancer can either be invasive or non-invasive (also described as ‘in situ’). Invasive breast cancer has the potential to spread to other areas of the body. Non-invasive breast cancer has not yet developed the ability to spread to other parts of the body.
Ductal carcinoma in situ (DCIS)
Ductal carcinoma in situ (DCIS) is an early form of breast cancer, sometimes described as pre-cancer, intraductal or non-invasive cancer. The cancer cells are inside the milk ducts (in situ) and have not yet developed the ability to spread either outside the ducts into surrounding breast tissue or to other parts of the body. There are different grades of DCIS. It is thought that if DCIS is left untreated, the cells may become invasive cancer.

As DCIS does not usually have noticeable symptoms (although it may present as a lump), it is most commonly diagnosed from a mammogram (breast x-ray).

Invasive ductal breast cancer
Most breast cancers fall into this category. With invasive ductal cancer, the cancer cells are no longer confined to the breast ducts. They have spread outside the ducts to the surrounding breast tissue and have the potential to spread to other parts of the body. The first place that invasive ductal carcinoma tends to spread to is the axilla (armpit) and that is why you will also have tests on this area.

Invasive lobular breast cancer
Invasive lobular breast cancer occurs when cancer cells in the lobules have begun to spread outside the lobules and into the breast tissue. It behaves differently to other types of breast cancer and is sometimes found in more than one area of the same breast or occasionally in both breasts at the same time. Having breast cancer in one breast means there is a very slightly higher risk of developing cancer in the opposite breast compared to someone who has never had breast cancer. With invasive lobular breast cancer, this risk may be slightly higher than with other types of breast cancer, but is still very low overall.
Invasive lobular breast cancer does not always produce noticeable symptoms. Unlike other types of breast cancer, invasive lobular cancer may show up as a thickening and/or a hardening of the breast tissue rather than a firm, distinct lump.

It may be seen on a mammogram (breast x-ray) so in some women it is found when attending routine breast screening. However, some invasive lobular breast cancers can be difficult to see on a mammogram as the changes can be very subtle. Therefore an MRI scan may be necessary in addition to other x-ray tests.

**Inflammatory breast cancer**

Inflammatory breast cancer gets its name because the overlying skin of the breast has a red, inflamed appearance – similar to that seen with some infections of the breast. The skin may also feel warm and tender to touch and may appear pitted, like the skin of an orange.

**Paget’s disease of the breast**

Paget’s disease of the breast is another type of breast cancer. It often shows as changes to the nipple. Paget’s disease of the breast is not the same as Paget’s disease of the bone.

Commonly a red, scaly rash involving the nipple is seen which may spread to the areola (the darker skin around the nipple). The rash can feel itchy or you may have a burning sensation. The nipple may be pulled in (inverted) and there may also be some discharge. The symptoms of Paget’s disease can look like other skin conditions such as eczema or psoriasis.

People with Paget’s disease may have an invasive or an ‘in situ’ cancer in their breast as well.
Grade and size of the cancer

In addition to considering the type of breast cancer you have, your doctors will also look at its other characteristics to help decide on the most appropriate treatment for you.

Cancer cells are given a grade according to how different they are to normal breast cells and how quickly they are growing. Breast cancer is graded 1, 2 or 3. In general, a lower grade (1) indicates a slower-growing cancer while a higher grade (3) indicates a faster-growing cancer. With ductal carcinoma in situ (DCIS) the three grades are usually called low, intermediate and high instead of 1, 2 or 3.

Treatment

Ductal carcinoma in situ (DCIS)

DCIS may, if left untreated, develop into invasive cancer. Treatment therefore aims to remove the cancer before it develops the ability to spread.

The treatment offered to you will depend on factors such as the extent of the DCIS, the grade (low, intermediate or high) and where it is within the breast. Treatment will usually include surgery (either breast-conserving surgery or a mastectomy with or without reconstruction) to remove the affected area. Breast-conserving surgery may be followed by radiotherapy. Once the tissue has been removed and examined, it may be that invasive cancer is found as well as non-invasive cancer. If this is the case it may alter your recommended treatment.
Invasive breast cancer

Treatment aims to:-

• remove the cancer in the breast and any affected lymph nodes under the arm – this is called local control. Surgery and radiotherapy are treatments for local control

• destroy any cancer cells that may have already spread from the breast into the body through the bloodstream or the lymphatic system and to reduce the risk of cancer affecting other parts of the body in the future – this is called systemic treatment.

Chemotherapy, hormone therapy and targeted therapy are all types of systemic treatment. Combinations of these treatments may be used depending on the individual characteristics of your cancer and your general health.

The treatment that is considered to be best for you will be discussed at a Multi-Disciplinary Team (MDT) meeting. You will be informed of this decision and the rationale behind it. The proposed treatment plan will then be discussed with you. It will be your choice whether to undertake the treatment being offered.

Surgery

Surgery is the first treatment for most people with breast cancer. This aims to remove the cancer with a margin (border) of normal tissue to reduce the risk of the cancer coming back (known as local recurrence) in the breast. The amount of tissue removed depends on the area of the breast affected and the size of the cancer in your breast. Before surgery, some people with invasive breast cancer may be offered chemotherapy or hormone therapy to shrink the tumour and this may result in less extensive surgery. This is called primary or neo-adjuvant treatment.
Types of operation
There are two main types of operation:

Breast-conserving surgery
Usually referred to as wide local excision or lumpectomy. The cancer is removed with a margin of normal breast tissue. The treated breast may be smaller due to the amount of tissue removed and it may also be misshapen. However, there is increasing use of oncoplastic (cosmetic) surgical techniques which means combining breast cancer surgery with plastic surgery to provide the best cancer treatment with the best cosmetic outcome. This means that there is less likely to be a visible indentation and that the shape and symmetry of the breasts are maintained wherever possible. A partial prosthesis can be fitted post-operatively to correct any asymmetry if needed.
**Mastectomy**

This means removal of all the breast tissue including the nipple area. A simple mastectomy means that the entire breast is removed but the lymph nodes in the armpit and the muscles underneath the breast are not affected – although some lymph nodes may be removed with the breast tissue taken during surgery. You may be suitable to have an immediate reconstruction. Your surgeon will discuss this with you. If you decide not to have the reconstruction, or are not suitable at this time, you may be suitable for a delayed reconstruction in the future.

![Mastectomy Diagram](image)

In cases of invasive cancer it is recommended that some or all of the lymph nodes (glands) under the arm are also removed during surgery.

**Removing the lymph nodes under the arm**

Patients with a diagnosis of invasive breast cancer will have an ultrasound scan under the arm before their breast surgery to assess the lymph nodes. If this appears to be abnormal an FNA (fine needle aspiration) will be done to see if the cancer has spread to the lymph nodes. If this shows the cancer has spread then all or most of your lymph nodes will be removed at the same time as your breast
surgery (axillary clearance). This aims to stop the affected nodes from growing bigger and causing other problems under the arm.

Even if the tests before your surgery show that the lymph nodes are not affected you will have another ultrasound scan of your axilla and your surgeon will still need to remove a sample of the lymph nodes (usually at the same time as your breast cancer surgery) to confirm this. This is known as sentinel lymph node biopsy.

**Sentinel node biopsy**

Sentinel node biopsy is another way of sampling the lymph nodes. This procedure involves injecting a small amount of radioactive material and a dye that identifies the first, or ‘sentinel’, node(s) to receive lymph fluid from the cancer. Once removed and examined if this sentinel node(s) does not contain cancer cells it usually means that the other nodes are clear too so no more will need to be removed. However this procedure has an approximate 5% false negative result.

All of the above operations may be carried out as a day case procedure unless otherwise indicated by your surgeon or CNS.

**Which operation?**

One of the first decisions you may be asked to make is about the type of operation you will have. A separate appointment will be made with the CNS to talk through your choices and discuss how each would affect you and impact on your personal life.
Some people will be offered a choice between breast-conserving surgery and a mastectomy, although this is not always possible. **Studies have shown that long-term survival is the same for breast-conserving surgery followed by radiotherapy as for a mastectomy.**

The type of breast surgery recommended for you will be based on the type of cancer, the size of the tumour, where it is in the breast and how much surrounding tissue needs to be removed. It will also depend on how large your breasts are. The surgeon will want to give you the most effective surgery for the cancer as well as the best cosmetic result possible. In breast-conserving surgery this means keeping as much of your own breast as possible while ensuring the cancer has been completely removed.

There are times when the surgeon *may* need to recommend a mastectomy, for example, when:

- the breast is small and so the remaining tissue would look misshapen after breast-conserving surgery.
- the cancer takes up a large area of the breast or there is more than one area of cancer affecting different parts of the breast
- the tumour is in the centre of the breast or directly behind the nipple

If your surgeon recommends a mastectomy they will explain why this is necessary. It may also be your personal preference to have a mastectomy.

**Breast prosthesis**

If you have a mastectomy you may want to wear a prosthesis – a false breast form. Your CNS will provide you with a post-surgery pocketed bra and a temporary prosthesis before you are admitted to hospital for your operation. **It is important that you bring this with you when you are admitted for your operation.** If for any
reason you have not been provided with one please make your discharge nurse aware of this and they can provide you with one prior to discharge. On the NHS you are entitled to both a temporary (soft, fibre-filled) and permanent (silicone) prostheses without having to pay for them. There are several different types of permanent prostheses available, including those that fit inside a bra and those that stick directly to the skin. The prosthetic advisor can also give you advice about a good fitting bra and can provide you with a selection of catalogues so that you can purchase bras and swimwear, although many high street shops also carry a range of post-operative bras as well. After about six to eight weeks, when your operation site has healed, you can be fitted with a permanent prosthesis. You will need to contact our prosthetic advisor for an appointment (contact number at the front of this booklet). The prostheses last for approximately two years and then may need to be replaced. You are entitled to a replacement prosthesis for 5 years after surgery. After the five years you can still be seen and fitted here but you will need to get a referral letter sent to us from your GP. Our prosthetic advisor can help with this should you have any further questions or are unsure about anything to do with your prosthesis.

Preoperative assessment clinic

What is a preoperative assessment?

Before your operation you will attend the preoperative assessment clinic which is run by registered nurses. The purpose of this clinic is to assess your general health before having an anaesthetic and undergoing surgery. It also gives you an opportunity to ask any questions about your admission and prepare you for your operation and discharge home. This usually takes place 2-4 weeks before your operation.
How long will my appointment take?
Your assessment will normally take between 30-60 minutes. However, you may have to undergo certain tests in other parts of the hospital or see another health professional which may prolong your appointment.

What to bring with you
Please bring all the medications that you are currently taking including any tablets, inhalers, liquids, eye drops, etc. If you have a medical alert card, medical implant e.g. pacemaker, or have an advance directive (if you are a Jehovah’s Witness), it is important to bring these details with you.

Preoperative assessment with the nurse
During your assessment you will be asked questions about your general health, social circumstances and any previous operations and illnesses.
You may also undergo some or all of the following tests:
• recording of temperature, pulse and blood pressure
• ECG (heart tracing)
• chest X-ray
• blood test
• screening for MRSA (commonly known as the hospital superbug)

What to bring with you when you are admitted
The following information is to give you some guidance on what you will need to bring into hospital with you. Please remember that storage space for personal belongings is limited, so only bring necessary items with you.

• dressing gown
• footwear that is secure and non-slip
• towel
• toiletries
• sanitary products (if required)
• a packet of disposable hand wipes to freshen up
• something to do/read
• glasses/hearing aids (if used)
• appointment letter
• any medications you are taking
• for mastectomy patients you will need your post surgery pack with your bra and temporary prosthesis
• exercise leaflet (from your information pack)

After your operation
As part of the enhanced recovery programme you will be expected to play an active role in your recovery as this will help you to feel well sooner. Eating, drinking and moving around are important elements in the enhanced recovery programme. You can wash and shower as normal after your operation.

Dressings
The dressings used are mostly waterproof, however if they do come off do not worry as they can be removed 5 days after surgery at home. Underneath you will find some smaller paper dressings called steristrips these can stay on until you return to clinic but again if they come off before this do not worry. If you have any
concerns regarding your wound or dressings after your operation then please contact your CNS or the ward.

**Moving around after surgery**

The nursing staff will help you out of bed as soon as you are able after the operation. Being out of bed and in an upright position plus walking regularly helps to improve lung function and reduce the risk of a chest infection. Early mobilisation is also encouraged to decrease tiredness and reduce the risk of blood clots.

**Drains**

After breast surgery you may have one or more surgical drains in place near to your wound. This is a small tube that goes under your skin and is held in place by a stitch so that it doesn’t accidentally slip out. These can sometimes be a bit uncomfortable but they are an important part of your treatment and recovery and help the healing process.

**When will my drain be removed?**

Visits from the district nurse will have been arranged to look after your drains and remove them as advised.

**What to look out for**

- leaking of fluid around the drain
- burning sensation and/or the drain site becoming red and warm to touch
- no drainage at all.

**If you are concerned you can do any of the following**
• inform your district nurse when she next visits
• or ring your CNS on 0161 720 2558 or 0161 627 8459
• or ring the ward.
Nausea and sickness
The majority of patients do not experience problems with nausea or sickness. However, if you experience nausea this is usually caused by the anaesthetic drugs and should soon settle. You can be given medicine to help reduce this. It is important to relieve the nausea so that you feel better and can eat and drink normally which will aid your recovery.

Monitoring
There are different things that need to be monitored during your enhanced recovery including:

• pain assessment
• arm exercises (see booklet)

You will be encouraged to write down some of this information in your ‘patient diary’.

Complications of surgery
Undergoing surgery is not without risk. Being on the enhanced recovery programme will considerably reduce the risk of developing complications and reduce your length of stay. Major complications are relatively rare and minor complications are seldom more than troublesome, although they can delay you going home in some instances. Considerable steps are taken to help reduce these risks. The following complications are the most common with this type of surgery:

Infection
The nurses and doctors take great care to prevent infection when operating or attending to wounds and drains. If you are a smoker
you can greatly reduce the risk of a chest infection and improve wound healing by stopping smoking now. Help is available via the NHS Smoking Cessation Service.

**Cardiovascular problems**

This is a complication associated with any surgery and anaesthetic. An operation causes a stress response in the body which in turn can put undue stress on the heart. Stopping smoking can help reduce the risk. If you have had heart problems in the past please make your surgeon and anaesthetist aware. You will have a heart tracing (ECG) prior to your operation and the anaesthetist and pre-operative assessment nurses will ensure that you are fit enough to undergo an operation.

**Blood clots**

Because you will be lying still during your operation the circulation in your legs becomes sluggish and the blood can clot. This is called a deep vein thrombosis (DVT). This can cause pain and swelling in your calf. More seriously, a part of the clot can become dislodged and travel to the lungs causing a blockage (pulmonary embolism) which can seriously affect your breathing. You may be required to wear compression stockings which squeeze your legs to help the blood flow around your body. Early mobilisation and leg exercises will also help to keep the blood flowing.
Signs of a possible blood clot

If you experience any of the following in the days or weeks after your operation you should contact a health care professional immediately:

• pain or swelling in your leg
• the skin in your leg is hot or discoloured (red, purple, blue)
• your feet are numb or tingling
• the veins near the surface of your legs appears larger than normal
• you feel pain in your chest, back or ribs which gets worse when you breath in deeply
• you cough up blood.

What to expect after surgery

The following are all possible after-effects. Some people may get some or all of these whilst others get none:

Pain and discomfort

You are likely to have pain or discomfort after surgery. Many patients find the most discomfort in the armpit. Everyone’s experience is different. Some people find changing position and using pillows to support the wound can help reduce pain or discomfort. If you are in any pain tell the nursing staff (or contact your CNS or GP after you have been discharged) as you may need a stronger dose or different type of pain relief.

Bruising and swelling

Bruising is common after surgery but will disappear over time. Swelling is also common and may affect your breast, chest wall, shoulder and/or arm. It is a normal part of the healing process and should lessen six to eight weeks after your surgery. If the swelling is
uncomfortable and feels heavy some women find that wearing a supportive bra day and night can help. If swelling persists, particularly in your arm, talk to your CNS.

**Seroma**

Following the removal of wound drains, many people who have had breast surgery or lymph node removal experience fullness and swelling under the arm, in the breast area or around the area where the drains were inserted. This can also occur even if you did not have any drains. This is due to a collection of fluid called a seroma. The build-up of fluid may cause some discomfort but it is not a cause for concern. The fluid is usually reabsorbed by the body over time.

If the seroma is large, causes discomfort, restricts arm movement or doesn’t subside, the fluid can be drawn off (aspirated) using a needle and syringe by a member of the breast team. This is usually a painless procedure as the area around the wound is likely to be numb.

Not all seromas need to be drained. A health care professional will need to assess the fluid build up before deciding whether to do this. Sometimes a seroma will refill after it has been aspirated. Some people may need to have the fluid aspirated several times over a period of weeks before it goes away completely.

**Wound infection**

Any of the following symptoms could mean you have a wound infection:

- the wound feels tender, swollen or warm to touch
- redness in the area
- discharge from the wound
- feeling generally unwell with a raised temperature.
Contact your CNS if you think you may have a seroma or wound infection. If it is the weekend, please contact the ward.

**Haematoma**

This is another rare complication where occasionally blood collects in the tissue causing swelling, discomfort and hardness and may require a return to theatre to stop the bleeding.

**Change in sensation**

Following breast surgery you may notice:

- loss of (or reduced) sensation or feeling
- numbness or coldness
- weakness in the arm
- sensitivity to touch or pressure
- pins and needles, burning sensations, tingling or shooting pains.

If you have had your lymph nodes removed you may have a change in, or loss of, sensation down the inner side of your upper arm or under the arm.

These symptoms may be temporary and mild but can persist in some people.

**Stiff shoulder**

Your arm and shoulder on the operated side may feel stiff and sore for some weeks. Your CNS will have given you a leaflet with some gentle exercises to help you start to get back the range of movement you had before your surgery. It is important to start these the day after your operation.
Cording
You may find a cord-like structure appears, causing pain and restricted movement in your armpit. This often resolves spontaneously. However, if symptoms persist please contact your CNS for referral for physiotherapy.

Arm swelling (lymphoedema)
Surgery to the lymph nodes under the arm can affect the vessels that drain lymph fluid from the arm. This can lead to a build-up of lymph fluid causing swelling. Swelling soon after the operation will usually settle over time as the lymph vessels open and drain more effectively.

Occasionally the swelling can last and may never completely go away although it can usually be controlled. This is known as lymphoedema and can occur weeks or months after surgery, or even years later. If you notice any swelling in your arm or fingers inform your CNS. They will be able to refer you to a lymphoedema specialist for further advice and treatment if necessary.

Returning home after breast surgery
Although you should be feeling well when you are discharged you may find even simple tasks leave you exhausted. It is common to feel very tired for some time following surgery. It is tempting to try and resume your usual activities once you get home but this can add to your general fatigue.
Things you should do

• get out of bed and dressed every day. This will encourage your normal sleep pattern to return and help you build strength

• accept offers of help such as shopping and gardening from family and friends

• take gentle exercise, such as walking, to improve mobility and strength. Gradually increase the distance as you feel stronger.

• eat and drink as normal.

• take painkillers if you have pain or discomfort. This will help you to feel better more quickly and enable you to do your arm exercises. You may need to take these for a few weeks after surgery.

Some people can feel very “down” after surgery. Many different emotions arise which can cause confusion and mood swings. There is no right or wrong way to feel. If you are feeling low and would like to speak about your feelings please contact your clinical nurse specialist for support.

You can resume sexual activity as soon as you feel able, however give yourself time and don’t expect too much.

Things you should not do

• don’t lift any heavy items for at least 6-8 weeks after surgery. This can put pressure on the healing wound

• don’t drive until you feel confident that you feel comfortable wearing your seatbelt and can perform an emergency stop. Some medication may affect your response time so refrain from driving if this occurs. Check with your insurance company that you are covered to drive following surgery
• avoid heavy household chores such as vacuuming for at least 6 weeks
• do not return to work until you have spoken to your consultant. This is particularly important if your job involves physical activity rather than sitting down.

Support after discharge
It is important that we are aware of how you are feeling when you first go home. Within 3 days of being discharged from hospital your CNS will contact you. If you have been discharged over the weekend and need advice, you will need to contact the ward and speak with a member of the nursing team.

If you have any problems or concerns within normal office hours (Monday-Friday 9.00-5.00) please contact the CNS office on 0161 720 2558 (North Manchester General Hospital) or 0161 627 8459 (The Royal Oldham Hospital).

If no-one is available to take your call when you ring please leave a message on the answerphone and a member of the nursing team will phone you back. The answerphone is accessed regularly during the day.

Other help available
Following your diagnosis you are now entitled to free prescriptions. You will need to get a form from your GP.

During you treatment and recovery if you have any financial concerns please speak to your CNS who can provide you with information or refer you to people who can help with this.
Other useful contact numbers:

**Beechwood Cancer Care Centre**: 0161 476 0384

**Breast Cancer Care**: 0800 800 6000
www.breastcancercare.org.uk

**Bury Cancer Support Centre**: 07899 990260
   Mondays, Tuesdays and Wednesdays 10:30am – 4pm

**Cancer Aid Network** (Oldham): 01457 874927

**Chaplaincy**: North Manchester 0161 720 2990
   Oldham 0161 627 8796
   Bury 0161 778 3568
   Chaplaincy Co-ordinator 0161 778 5259

**Citizens Advice Bureau**:  
Tel 03444 889 622 10.00 am - 4.00 pm Monday to Friday  
Drop in services are also available - please phone for details

**Help with Health Costs**: 0300 330 1343

**Linda Rigby**, Macmillan Benefit Advisor 061 922 3517

**Macmillan Cancer Support**: 0808 808 0000
Macmillan Information Centre:
North Manchester General 0161 604 5244
The Christie at Oldham 0161 918 7745

Oldham Cancer Support Centre: 0161 906 2940 (Chris Hoyle)
e-mail: chrishoyle@nhs.net or infor@oldhamcancersupport.org.uk

Patient Advice and Liaison Service (PALS): 0161 604 5897

Pennine Patient User Partnership (P.U.P.P.): 0161 627 8699

Rochdale Breast Cancer Support Group:
Margaret 01706 868094

Switchboard: 0161 624 0420
If English is not your first language and you need help, please contact the Ethnic Health Team on 0161 627 8770

For general enquiries please contact the Patient Advice and Liaison Service (PALS) on 0161 604 5897

For enquiries regarding clinic appointments, clinical care and treatment please contact 0161 624 0420 and the Switchboard Operator will put you through to the correct department / service

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