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BREAST CANCER AND THE RISK OF HEART DISEASE

Living with the dilemma of the treatment for human epidermal growth factor receptor 2 positive breast cancer and the risk of incident heart disease: A qualitative investigation of patients' experiences

Short title: Breast cancer and the risk of heart disease

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Conflicts of interest

None of the authors have any conflicts to declare.

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Abstract

Objective: Herceptin treatment improves survival and reduces the risk of recurrence in human epidermal growth factor receptor 2 (HER2)-positive breast cancer. Yet, it increases women's risk of developing burdensome cardiovascular complications. This study examines how women experience living with HER2-positive breast cancer and the risk of incident heart disease.

Methods: Danish women with breast cancer (n=12; aged 32-75) participated in semi-structured interviews. Themes were deducted using Interpretative Phenomenological Analysis (IPA).

Results: Women described breast cancer as having strong associations with death, whereas heart disease to them meant decreased physical functioning or 'something fixable'. MUGA scans of the heart during the treatment course made them feel safe and generally they did not worry about risk of heart disease. Coping strategies included: Focus on the good aspects of Herceptin and acceptance of risk of heart disease as the price to pay to survive. The two most predominant coping strategies used were information and avoidance.

Conclusion: The women's focus on cancer as the primary disease seems partly to be the result of a complex coping process, by which they dealt with the dilemma of weighing risks, where the risk of dying from breast cancer was perceived as the biggest risk.

Keywords: breast cancer, herceptin treatment, women, illness representations, qualitative interviews, living with cancer

Introduction

Breast cancer is the most common type of cancer among women, and approximately 20% of breast cancers are human epidermal growth factor receptor 2 (HER2)-positive. This more aggressive type of breast cancer is associated with a greater risk of recurrence (Slamon et al., 1987; Slamon et al., 1989). Since treatment with Herceptin (also known as trastuzumab) has significantly improved survival for women with HER2-positive breast cancer (Perez et al., 2011; Piccart-Gebhart et al., 2005), a one-year treatment period with Herceptin following anthracycline-based chemotherapy has become the gold standard. However, these women risk developing burdensome cardiovascular complications (Armenian et al., 2017; Ewertz & Jensen, 2011; Herrmann et al., 2014; Yeh & Bickford, 2009), for example cardiomyopathy, a disease of the heart muscle, associated with left ventricular ejection fraction (LVEF) decrease (i.e. reduced pump function). Even though LVEF decrease often is reversible (de Azambuja et al., 2014; Lenihan & Esteva, 2008), women treated with Herceptin have a seven-fold increased risk for cardiovascular complications (Bowles et al., 2012; Chen et al., 2012)

This complexity of HER2-positive breast cancer is likely reflected in the women's illness representations. Illness representations are patients' common sense beliefs and expectations about an illness (Leventhal, Brissette & Leventhal, 2003) and include both cognitive and emotional aspects, such as how women perceive symptoms related to breast cancer or heart disease. According to The Common-sense Model of self-regulation of health and illness (Leventhal, Brissette & Leventhal, 2003), the primary purpose of illness representations is to guide the individual in terms of deciding how to manage health threats. Thus, women's illness representations of breast cancer and the risk of heart disease likely affect health behaviors, such as symptom management and treatment adherence (Horne & Weinman, 2002), and are important for patients' ability to cope with and adjust to disease (Kaptein et al., 2015). Because of the ambiguity of treatment ("it can cure me, but also make me sick"), coping with HER2-positive breast cancer may be particularly challenging. Coping is defined

as thoughts and behaviors that individuals use to manage internal and external demands of situations that are appraised as stressful (Lazarus & Folkman, 1984, 1987; Lazarus, 1993). Ambiguous events are known to be more stressful than predictable events (Lazarus, 1993). Thus, the emotional strain that many patients experience after being diagnosed with cancer due to e.g. fear of dying, changes to their everyday lives and the intensive treatment course (Denieffe & Gooney, 2011; Vrinten et al., 2017) may potentially be increased in these women.

However, to the best of our knowledge, no studies have explored how women live with being treated for breast cancer while also having to accept the risk of incident heart disease as a treatment-related sequel. A deeper understanding may help us pinpoint gaps in the care and management of these women in clinical practice. Hence, the overall objective of the current study was to examine and elucidate the lived experiences of women with breast cancer and risk for treatment-induced heart disease with respect to illness representations and coping strategies. Specific aims were to elucidate: (i) How do women experience living with breast cancer and risk of treatment-induced heart disease? (ii) Which illness representations do they develop with respect to breast cancer and the risk of incident heart disease? (iii) How do they cope with and adjust to the specific treatment?

Methods

Study design and procedure

To gain an in-depth understanding of women's experiences, one-to-one, semi-structured interviews were conducted. This method allows for adjusting questions according to the women's individual understanding, the discovery of new topics, and preliminary interpretation of meaning together with the patient (Kvale & Brinkmann, 2009; Brinkmann, 2014).

Inclusion criteria were: women aged 18+, diagnosed with HER2-positive breast cancer, undergoing or recently ended primary treatment with Herceptin, and competent to give informed consent. Access to the patient group was established through a cardiologist (ABSB) at Odense University Hospital, Odense, Denmark, who conducted the study Cardiac Toxicity in Medical Treatment of Breast Cancer (ID on [ClinicalTrials.gov](https://clinicaltrials.gov): OUH Protocol Record S-20140090) on the same patient group, offering echocardiography (ultra sound examination of the heart) to investigate early identification of risk for developing heart failure. Participants in the interview study were purposefully selected from the women in the larger study to ensure a broad variation in age, treatment trajectory and clinical characteristics, such as disease development and treatment. Every time a woman was scheduled for an echocardiography in the inclusion period January – April 2017, it was evaluated whether the characteristics of this woman could enhance the sample's variation on the pre-specified criteria. ABSB then informed the woman about the interview study and asked for consent to be contacted by CS, who conducted the interviews. All women who were approached for participation in the interview study, chose to participate.

The interviews took place between January – May 2017 at Odense University Hospital. All interviews were audiotaped and conducted in an undisturbed room.

Ethics

All patients received oral and written information about the study and gave written informed consent prior to inclusion. They had been informed about their increased risk for heart disease at the hospital when treatment was initiated and were aware of it before being approached for the present study.

Before the interview the women were informed that they could decline answering specific questions and were free to ask for a break or terminate the interview at any point. They were also

debriefed after each interview to follow up on emotions that potentially had emerged during the interview. Participants' names have been changed to pseudonyms.

The study was approved by the Danish Data Protection Agency (reference 2015-57-0008). According to Danish law on ethics related to health research (law no 593 (§14,1) of 14 June 2011), ethical committee approval is not required for this type of study.

Interview guide

In accordance with the research questions the interview guide included the following topics:

1. Illness Representations of breast cancer and heart disease
2. Living with HER2-positive breast cancer and risk of heart disease
3. Coping strategies, including informational needs and experiences with information acquisition

Each of these topics was initially examined with broad questions, such as *“How do you perceive cancer now, compared to when you were diagnosed?”* followed by more specific questions, such as *“In what way has cancer become a greater concern to you now, than earlier?”*, to explore illness representations and the experience of living with breast cancer and risk of heart disease. The interview guide is included in Appendix 1.

Data analysis

The interviews were transcribed and analyzed according to the guidelines of Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2007). IPA allows for an in-depth examination of how participants understand and experience their personal and social world, with specific focus on the meaning of experiences, events, and states (Smith, 2011). It involves a detailed analysis of each case

followed by the search for patterns across cases and has previously been used to examine the experience of dealing with breast cancer including illness representations and coping strategies (Loaring, Larkin & Shaw, 2015). The analytical process is described in Table 1.

Sample characteristics

The sample comprised 12 Danish women diagnosed with HER2-positive breast cancer, aged 32-75 (mean 51 years). All women received standard treatment, e.g. surgery followed by three types of chemotherapy (epirubicin, cyclofosamid and taxan), radiation therapy, and the 12-months treatment with Herceptin, which was initiated at the start of treatment with taxan, and consisted of 17 injections (once every three weeks). All women received five multigated acquisition (MUGA) scans during their 1-year treatment course to discern whether the pump function of the heart was affected. Patient characteristics are presented in Table 2.

Results

The interviews lasted approximately 1.5 hours. Eight themes were identified covering the three topics illness representations, living with HER2-positive breast cancer and risk of heart disease, and coping strategies (see Table 3).

1. Illness representations

1a. HER2-positive breast cancer: “*A disease with no control*”

All women had strong illness representations about cancer in general, but having HER2-positive breast cancer, many saw their situation as different from other women with breast cancer. The women feared dying from cancer or getting cancer again. For some, this fear was caused by the knowledge

of the aggressiveness of HER2-positive breast cancer. Linked to this fear, they perceived breast cancer as a horrible, disabling and potentially lethal disease that is not controllable and affects many people:

“...and I thought okay now you’ll die, because that’s what you do, you know. That was the only thing I could think of; you’ll die. (...) I know with my common sense that it is not like that but emotionally yes, when you hear the word cancer then it’s death. (Kathrine, 42)

1b. Heart disease: “I’m not sure what it will mean to me”

Knowledge about heart disease varied, and many women had difficulty describing what heart disease represented to them. They described it as a specific disease (e.g. heart attacks) and as a reduced level of functioning. In addition, most women described heart disease as localized to the heart, something that was acceptable to live with, even though it meant restriction in everyday-life. Generally, the women expressed less concern about being affected by Herceptin, because they could not relate to what it would mean for them to have issues with the heart:

“...I’m not sure how it will affect the heart [Herceptin], and I’ve never had anything with my heart ehm, so I wonder about that (...) and what heart disease will mean to you, if you had it. But I think it’s difficult when you don’t have it.” (Margrethe, 46)

Chemotherapy and radiation therapy made the women feel sick, which made the treatments seem worse. The lack of side effects of Herceptin was the main reason why most women did not fear their heart being damaged. Paradoxically, this lack of side effects led to insecurity and made them question the effectiveness of treatment, because side effects related to other treatments, such as chemotherapy, were interpreted as signs of it working. Later on, when the treatment only consisted of Herceptin, several women experienced an increase in their concerns related to the risk of heart disease:

“It is possible that in the end where I only received herceptin, ehm it started to take up space you know the thing with- with the heart (...) Because now I didn’t have to relate to how chemo and radiation made me feel you know. Then I only had the other thing to think about like, ehm I wonder if my heart is pumping good enough.” (Kimmie, 54)

1c. Breast cancer as the primary focus

In general, the women focused on what they concretely could relate to and had strong representations of. Most women perceived treatment for HER2-positive breast cancer and the follow-up MUGA scans as a cohesive treatment course for their primary diagnosis breast cancer. Women not experiencing side effects from Herceptin perceived the risk of heart disease as secondary and as ‘part of the package’.

“With all the side effects that I mentioned earlier then- then I just think that, this is the price for me to live, so it’s okay. If I must have a reduced pump function with whatever that brings, then that’s maybe something about I can’t run as fast and that- that’s okay. I can live with a lot of things.” (Susan, 39)

Women whose hearts were affected by Herceptin during the treatment course experienced a change in their illness representations and now focused equally on heart disease and breast cancer, as they had developed concrete representations of the risk of heart disease:

“Even though it deteriorated [the pump function] I think well it mustn’t do it again, well- and if it does then we interrupt... because I’m not living my life with a heart, that’s bad the rest of my life. I have enough with the disabilities I struggle with now.” (Charlotte, 63)

Living with HER2-positive breast cancer and the risk of heart disease

2a. The experience of a 1-year long treatment course: “*From all to nothing*”

Most women had expected a short treatment course of a few months, as that was what they had heard in relation to cancer treatment. It caused them emotional distress that they had to be treated for one year with Herceptin. They also felt that the treatment took over their everyday lives, leaving them with little personal control:

“... when I was told that it lasts this long I thought oh no... that was the first time I broke down in tears. (...) I felt that something was taken away from me... that I couldn't control myself, ehm and couldn't take responsibility for my everyday life, going to work (...) suddenly, there was something else that came and said well you have to go through this course...” (Charlotte, 63)

Being dependent on the health care system for a year caused the women considerable distress, trying to keep track of all the appointments and treatments. However, over time coming to the hospital became associated with a sense of security that was hard to let go of by the end of the treatment course. Furthermore, the women worried if their heart could be affected even after treatment and wished to have it checked. Some of them therefore agreed with the cardiologist to get an extra scan after the treatment course.

2b. “*MUGA scans give me a sense of security*”

The MUGA scans that the women received during the treatment course made them feel safe. As their heart was being monitored and thereby protected, they did not worry about it themselves:

“I must admit that- that I haven't really given it many deep thoughts (...) and ehm then I've received that every three months or something like that right, so I've been feeling a little safe about that also because every time they've told me that my heart rhythm has been okay.” (Sarah, 75)

The women were also positive about receiving echocardiography during their treatment course with Herceptin, and felt that it contributed to reducing their worries.

3. Coping strategies

3a. Negotiating with heart disease: *"The price to live"*

Because of the association between HER2-positive breast cancer and death, all women felt a need to do everything it took to make sure they survived. This meant continuously weighing risks: 'What is worse – cancer or potential heart disease?' or 'What will affect me the most; recurrence of cancer or a reduced pump function?'. As described under *1. Illness representations*, the women evaluated that breast cancer contained the greatest risk for them, and therefore this was the primary – if not only – focus. They were willing to live with the risk of heart disease to increase their chances of surviving, as they saw treatment with Herceptin as necessary:

"With all the side effects that I mentioned earlier then- then I just think that, this is the price for me to live, so it's okay. If I should have a reduced pump function with whatever that brings, then that's maybe something about I can't run as fast and that- that's okay. I can live with a lot of things." (Susan, 39).

3b. *"Herceptin does something good for me"*

Seven of the women mentioned that they tried to focus on the positive aspects of Herceptin: They received Herceptin because it did something good for them and helped them becoming cancer-free.

"... I was told out here [at the hospital] that it [Herceptin] was kind of the wonder cure, ehm just with the HER-2 so, I was just happy about it. I still feel that way like just pour more in me I would like to do a year more, you know." (Kathrine, 42)

It was important for these women to get all 17 treatments. They hoped that completing all treatments could help them believe that they would not get cancer again. They were concerned about

their heart, however, their primary concern was, whether their heart would be strong enough to get all 17 treatments, whereas they did not worry about what happened if they developed heart disease.

3c. Information as a coping strategy

Half of the women wished to have as much detailed and specific information as possible, which helped them deal with the treatment course by structuring it, to experience a sense of security or to reduce the emotional strain. :

“I can never get too much information (...) The only thing that I in some way can, control in this course, is what I know. (...) That, now at least I know, that I’m getting this and this and this. I know the names of all the medicine and- and what they do and for what and- well, that is what I can do. (...) then I have control over- well nothing, but then I can pretend that I have.” (Susan, 39)

The other half of the women wished to know very little, as information increased their emotional distress. Especially information about Herceptin was something they wished to avoid. They tried not to think about the risks of the Herceptin treatment, as the risk of dying from cancer was already a lot for these women to cope with.

To cope with the different treatments and to keep track of them all, it was important for at least half of the women to focus on one treatment at a time (chemotherapy, Herceptin, etc.). By receiving information on one treatment at a time, it was easier for the women to relate to the specific treatment and what was important for them to be aware of during that time.

Discussion

The current study examined the lived experiences of women with HER2-positive breast cancer at risk for treatment-induced heart disease with respect to illness representations and coping strategies.

Women had stronger illness representations related to breast cancer than to heart disease. Breast cancer was related to death and seen as an uncontrollable disease, whereas heart disease was perceived as something relatively benign, controlled and specific to the heart. The lengthy treatment period with Herceptin caused the women emotional distress, yet being connected to the health care system for over a year and receiving MUGA scans also created a sense of security. Most of the women accepted the risk of getting heart disease to survive breast cancer and tried to perceive Herceptin as something positive that helped them becoming cancer free. Information acquisition gave half of the women a sense of control, whereas the other half did not wish to have any information, as it led to emotional distress.

Cancer tends to be perceived as a deadly disease, whereas heart disease is perceived as less of a health threat (Mosca, Ferris, Fabunmi, Robertson, & American Heart, 2004), which was supported in the current study. The women's illness representations of cancer as uncontrollable and closely related to death are also in line with previous findings (Anagnostopoulos & Spanea, 2005; Buick & Petrie, 2002; Melnyk & Shepperd, 2012; Vrinten et al., 2017).

The women in the present study experienced a complex dilemma in terms of "*what is worst: The risk of dying from breast cancer or the risk of developing heart disease?*". Research on multi-morbidity (i.e., more than one chronic condition) suggests that patients often give a different status to their different diseases (Bower et al., 2012). Based on their illness representations, the women in our study appraised the side effects of cancer treatment and the risk of dying from HER2-positive breast cancer as worst. Prioritizing the risk, you perceive as the biggest is a normal response when dealing with an illness threat (Leventhal, Brisette & Leventhal, 2003; Bower et al., 2012). Thus, in

line with findings among patients dealing with cancer and cancer-induced thrombosis, who prioritize cancer treatment (Noble, Prout, & Nelson, 2015), dealing with breast cancer was the main priority of the women in the present study.

Furthermore, the women experienced more discomfort and side effects in relation to breast cancer than to heart disease. Illnesses that create discomforts are perceived as more troublesome than the cause of death itself (Williams, 2004). In addition, the MUGA scans made the women feel safe, as their heart was being monitored, so they did not need to worry.

There is a strong portrait of cancer in the public domain, opposed to heart disease, which could have affected the women's illness representations. If the women had had more knowledge about heart disease in general and stronger representations of how it could affect them, they might have been more worried about it. This is supported by the women whose hearts were affected by Herceptin. They experienced more distress related to the risk of incident heart disease and considered to end treatment with Herceptin to protect their heart. They now experienced heart disease as a potential health threat and had to reassess whether they had to change their health behaviors, in this case adherence to treatment, to reduce the threat. This finding also supports the dynamic feature of illness representations (Frostholt, Carstensen & Hvidt, 2013) and how illness representations can affect health behaviors (Diefenbach & Leventhal, 1996; Horne & Weinman, 2002).

The current study found that many women chose to focus solely on the positive aspects of Herceptin treatment and how Herceptin helped them. Ignoring the risk of heart disease may be an emotion-focused coping strategy that helped them minimize their fear and emotional distress (Lazarus & Folkman, 1984). Half of the women did not wish to receive any specific information about the treatment. The other half of the women wished an increased amount of information, as they found it helpful to cope with the treatment course. This could be perceived as a problem-focused coping strategy, as additional information helped them to experience treatment-related control. These findings

support the importance of matching information to patients' needs and preferences, which may help them to cope with the situation and adjust to living with breast cancer (Henman, Butow, Brown, Boyle, & Tattersall, 2002).

The study has some limitations that need to be considered when interpreting the findings. It is a single-center study, and the experience of women treated at other hospitals could potentially be different. Further, as the women were participating in a larger study on cardiac toxicity in medical treatment of breast cancer, they may have had an increased awareness about the risk of heart disease and may have coped with it differently than the general population of women with HER2-positive breast cancer. Possibly, the increased focus on heart disease made the women worry more about the risk.

This study also has several strengths. To the best of our knowledge, this is the first study to examine how women with HER2-positive breast cancer live with and experience the treatment course and risk of treatment-related incident heart disease. In addition, the qualitative study design, allowed for an in-depth understanding of the women's experiences and how these experiences form their illness perceptions and coping (Smith & Osborn, 2007).

In conclusion, this qualitative study of women with HER2-positive breast cancer pointed to the primacy of cancer over the risk of treatment-induced heart disease. The focus on cancer as the primary disease seems partly the result of a complex coping process, in which women deal with the dilemma by weighing risks, where the risk of dying from breast cancer is perceived as the biggest.

The results can help health professionals understand how women experience the treatment course of HER2-positive breast cancer and suggest that it might be beneficial to provide more information about Herceptin to the women who wish more specific information about the treatment. Thus, it would be important to identify these women in the clinical setting. Based on the study findings, this information should preferably be delivered face-to-face in the beginning of treatment with Herceptin.

However, further research on women's needs and preferences for information provision is warranted, e.g. in a quantitative survey. Further examination of the subgroups presented in this study, e.g. the women with a reduced pump function, would also be beneficial.

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Table 1. *Overview of analytical process in the present study, based on Smith & Osborn, 2007*

1. Two pilot interviews were conducted to gain relevant experience. The first author (CS) conducted all interviews.
2. After each interview, CS made field notes and discussed field notes and relevant topics (ethics, possible themes, etc.) from the interviews with NR and SSP as an ongoing process throughout the interview period January – April 2017.
3. All interviews were transcribed in detail and coded by CS in the following process:
 - a. All interviews were transcribed and examined in detail (CS). All patients were asked if they wished to read and correct or comment on the transcription. None of the participants wished to overlook the transcripts.
 - b. Initial thoughts about the specific content were noted by the first author (CS) in the left margin of the transcription, forming an incipient interpretation.
 - c. Based on these notes, the first author (CS) went through the transcription a third time, noting emerging themes in the right margin. Thus, all themes were derived from the data.
4. Emerging themes from all interviews were compared and clustered in a preliminary analysis by the first author (CS) and discussed in the research group (CS, NR & SSP).
5. After this analysis, the research group (CS, NR & SSP) discussed and prioritized which themes to present and elaborate on, based on the importance to the research questions.

Table 2. *Characteristics of interviewed women with breast cancer*

Characteristics	No. of participants (%)
Participants	12 (100%)
Mean age (range)	51 (32-75)
Surgical treatment for breast cancer	
Mastectomy	6 (50%)
Lumpectomy	6 (50%)
Adjuvant treatment for breast cancer	
Chemotherapy	12 (100%)
Herceptin	12 (100%)
Radiation therapy	10 (83,3%)
Endocrine treatment	8 (66%)
Time since start of Herceptin treatment	
1-4 months	3 (25%)
5-8 months	4 (33,3%)
9-12 months	4 (33,3%)
3 months post ended treatment	1 (8,3%)

Table 3. *Most relevant themes from the analysis in relation to the research questions*

1. Illness representations

- 1a. HER2-positive breast cancer: *“A disease with no control”*
 - 1b. Heart disease: *“I’m not sure what it will mean to me?”*
 - 1c. Breast cancer as the primary focus
-

2. Living with HER2-positive breast cancer and the risk of heart disease

- 2a. The experience of a 1-year long treatment course: *“From all to nothing”*
 - 2b. *“MUGA scans gives me a sense of security”*
-

3. Coping

- 3a. Negotiating with heart disease: *“The price to live”*
 - 3b. *“Herceptin does something good for me”*
 - 3c. Information as a coping strategy
-

Briefing

The study is about getting a deeper understanding about what it is like to live with breast cancer and the increased risk of incident heart disease due to treatment with herceptin.

First, I would like to ask you if it is alright for me to tape the interview? This is to ensure I get all details from the interview. Do you have any questions before we begin?

- Opening questions
 - Can you tell me a little bit about yourself?
 - When were you diagnosed with breast cancer? Can you tell me about that experience?
 - What type of treatment do you receive here at OUH? Are you treated anywhere else as well?
 - When did you begin on herceptin treatment?

- Information
 - Can you tell me about how you experienced beginning treatment with herceptin?
 - What kind of information did you receive when you started on treatment with herceptin?
 - What information have you found a need for since you began herceptin treatment?
 - How has your experience with the health care professionals been?
 - Can you think of specific times where you have missed information from the health care professionals?
 - If yes: how did it affect your experience and what would you have liked instead?

- Have you experienced getting too much information?
 - If yes: How did it affect you?
- Have you been active seeking information out yourself? / What have you looked for?
- How do you experience the possibility to obtain more information at OUH?
- What do you think is important to tell newly diagnosed patients that are going through treatment with herceptin?
 - When and how?
- What do you think is important to tell the health care professionals about your treatment?

- Illness representations
 - Do you know anybody who has cancer and/or heart disease, or has had it earlier?
 - If yes: How do you think it as affected your perception of breast cancer and the risk of incident heart disease?
 - What comes to mind when you hear the word cancer?
 - What comes to mind when you hear the word heart disease?
 - What did you think about the risk of incident heart disease?
 - What do you think about it now?
 - How did you feel about the treatment containing the risk of incident heart disease?
 - How do you feel about it now?
 - Is it correctly understood, that you experience it as one/two diseases?

- Living with breast cancer and the risk of incident heart disease / Coping
 - Can you tell me about a typical day in your life as it looks right now?

- Have you experienced big changes in your life since beginning of the treatment?
 - What differences related to good days and bad days do you experience?
 - How is to manage both breast cancer treatment and the heart scans?
 - Can you tell me something about what you do to handle the treatment course?
 - Have you felt a need to make changes in your everyday life to handle everything?
 - How has it been for you?
 - Can you think of a specific situation(s) where it was difficult for you to handle it all?
 - What do you think about when you are finishing your treatment here at OUH?
-
- De-briefing
 - Is there anything you would like to add before we end the interview?
 - How was your experience of the interview?
 - Was there anything that was difficult to answer? (what)
 - Was there anything I missed asking about that could be relevant for me for the next interview?