

## **Prospects**

On Tuesday Dr. Cody reviews the pathology report with us. The tumor is small—1.2 centimeters. The margin of tissue on one side of the tumor was not “clean,” suggesting to the pathologist that some cancerous tissue remained behind. Dr. Cody reads to us the characteristics of the cell, explaining that my cell type is not the best but not the worst—that is, neither the most aggressive type of cell nor the least. For some reason I choose not to inquire more about the characteristics of the cell, sensing, perhaps, that this piece of information is not all good news. He repeats that he would like to do a lumpectomy, a much less extensive surgery than a mastectomy, during which

he would remove only a part of the breast tissue rather than all of it. He would want to follow a lumpectomy with radiation treatments of the area surrounding the site of the tumor if it's possible to do this radiation without overlapping the previously radiated area or, if it does overlap, without exceeding the maximum allowable dosage for a given area. He would guess that this is a stage-one breast cancer, but he can't be sure until he gets the information about the lymph nodes.

I ask if this breast cancer is a result of my previous radiation treatments. It's impossible to know, he replies. I explain that it seems related to me, that I received the most intense dosage of radiation right above the place in my breast where this lump appeared. I think I want the radiation to be the cause—it would explain why I have breast cancer when no one in my large, extended family does. Then again, when I posit radiation as the cause, I feel as if I'm carrying a time bomb, waiting for the next tumor to appear.

Dr. Cody suggests that I make an appointment with Dr. Chu, a radiologist at New York Hospital's Stich Radiation Center who recently presented a paper on treating former Hodgkin's disease patients with radiation a second time. He will obtain my radiation report from Peter Bent Brigham Hospital in Boston and have it sent to Dr. Chu before our meeting. Dr. Chu is a very aggressive radiologist, he says; if anyone can find a way to do the radiation, she will. If she argues against radiation treatments, we can be sure that they should not be done. Dr. Cody explains that the danger with too much radiation to an area is that the skin might ulcerate and not heal. It would be like hav-

ing an open wound very susceptible to infection. Sometimes the radiation can be aimed in such a way that it will not affect previously treated areas. Taking a chance with radiation strikes me as unacceptable but not as unacceptable as my next thought: I may actually need a mastectomy. Although I have heard the possibility before, only now does it strike me as real. We set up an appointment for surgery on April 28—not yet clear whether Dr. Cody will do a lumpectomy or a mastectomy.

In the next week I speak to a friend, one of six women with whom I have met in a psychotherapy study group for the past ten years. She, too, has recently had a mammogram that indicated suspicious calcifications. I am stunned to learn of her situation but impressed by how thoroughly she is researching breast cancer in preparation for her biopsy. She tells me about *Dr. Susan Love's Breast Book*; the bible of women with breast cancer, it is filled with information and advice.

David stays up half the night reading this book. Our previous reading has convinced us that a lumpectomy with radiation, when appropriate, has the same rates of survival as a mastectomy. But we are bothered by the fact that, even in first-stage breast cancer, in which the tumor is less than two centimeters, the nodes are negative for cancer, and there is no obvious metastasis, there is only an 85 percent survival rate after five years. If localized treatments—either lumpectomy with radiation or a mastectomy—work, why aren't there better survival statistics? With the help of the references in Susan Love's book, David finds studies comparing the tissue samples of women whose cancer recurred with those of women whose cancer didn't.

Cancer returned in cases in which the margins surrounding the tissue that was removed were not clean, suggesting that some cancerous tissue remained in the breast. This is why surgeons now make sure that they leave a clean margin of tissue surrounding the site of the tumor, reducing the chances of a recurrence and probably resulting in a survival rate higher than the 85 percent reported on the basis of older data. Furthermore, he learns, many of the women included in the study that yielded these statistics were treated only with local treatments, not with chemotherapy. We plan to go over this with Dr. Cody.



My appointment with Dr. Chu is for Thursday, and David again arranges to come with me. I have assumed that it is normal for partners to accompany “patients” to these appointments, but I discover that many people come alone. Perhaps these women have no mates or their mates can’t leave work. Perhaps they don’t feel that they deserve support. Or perhaps they are braver than I.

To get to the Stich Radiation Center, we walk east on East Sixty-eighth Street past Sloan-Kettering, past New York Hospital and Rockefeller University, past Payne Whitney to what feels like the end of the earth or at least the end of hospital land. We enter a tastefully decorated foyer where the receptionist directs us to the basement. In the elevator there’s a notice to patients: because the radiation machine is old and the new one has not yet arrived,

appointments for radiation are being delayed. Oh great! You have cancer and need radiation but, because of technical problems, you will have to wait. Are they really putting off treatments designed to save people's lives?

When we reach the basement level, I speak to another receptionist who greets me as if she is expecting me. We sit in a huge waiting room where an overhead TV blares afternoon soap operas, a great diversion from our real-life dramas. I recall that at Peter Bent Brigham also the radiology department was located in the bowels of the hospital. It's like testing nuclear bombs in the desert—stay away from heavily populated areas. At the Brigham I waited for hours, surrounded by people of all ages crowded together, sick with radiation-induced nausea, and growing increasingly angry about the long wait. I remember the small children who had lost their hair, so unbowed and innocent as they were wheeled to their next treatment. The staff of the radiology department, except for the technicians who administered the treatments, was gruff and insensitive. I assume these people had not bargained on working with human beings, just x-rays. One doctor, upon hearing my reports of nausea and vomiting, told me that he had never had a patient as "bad" as I. Another routinely made me wait three hours, with his nurse making excuses for him. "He had an emergency," she said. But on every day that I have an appointment? I wondered. I tried to imagine a radiology emergency, with the doctor rushing to an accident, x-ray machine in hand. Another time I told the nurse how depressed I was feeling and asked to speak with a social worker. She panicked and called a psychiatrist, who

met with me once and insisted that I did not need to talk to anyone, that of course I was upset. He offered to prescribe medication for depression.

This place seems completely different. The staff is pleasant. Today, at least, there are few patients, perhaps because of the shortage of machines. I am called by a nurse who gives me the uniform gown and slippers. She shows me to a room where I sit on a high examining table, feeling cold. David comes in and I talk with him from my great height. A doctor, a handsome, middle-aged Indian woman, comes in and takes my medical history. She is very formal and not friendly. Why is she keeping her distance? She examines me briefly and I joke nervously about the dots tattooed on my chest and my back from the previous radiation treatments. I explain my situation and the need to determine whether radiation is again possible. The two-page report that she received from the Brigham is not sufficient, she tells us. We will need to obtain the complete records, including all the x-rays, the design of the mantle that protected my heart and lungs, and the dosage and exact direction of the radiation. Eager to get on with this determination, I volunteer to contact my friend Martha, a doctor who lives in Boston, who should be able to expedite the sending of my records. By the end of the interview, I feel that my relentless friendliness and eagerness to be a helpful patient have persuaded this doctor to relax a bit with us.

She leaves the room, and David and I wait, talking about my options. I am here learning about the possibility of radiation for me, given the evidence that a lumpectomy with radiation provides results as good as those of a mas-

tectomy, is less invasive, and certainly less disfiguring. But on the deepest level I still feel that more is better, that a mastectomy is better than a lumpectomy. It seems perfectly rational to get rid of the offending part. Isn't it better to throw out the whole apple if it's rotten? Why take a chance? Although I try to replace my hysterical reasoning with a more considered approach, my heart is not in it. The variety of options doesn't interest me, and I feel surprisingly indifferent to this one or that. I just want to get on with it.

The Indian doctor returns with Dr. Chu and a young Asian woman who is a resident. They each shake hands with us warmly and then get down to the business of examining me. I like the fact that all of them are women, and obviously competent women, engaged in this technical science. It's a funny scene. They begin a kind of hunting expedition of my torso, looking for the tattooed dots that are clues to where I was radiated. Although they are pleased about what they can piece together about my previous treatment, I begin to worry about how imprecise is the application of this science of radiology. I recall that my radiotherapists at the Brigham were corrected by their supervisor for directing the radiation too near my ear. A year later I was deaf in that ear. No wonder I worry about imprecision.

As I listen to Dr. Chu, I wonder if she is wearing a wig and not a very good wig at that, but she seems too engrossed in her work to care about such vanities. Does she, too, have cancer? If so, how does she manage to work at such a high-powered job? My mind drifts to thoughts about my own patients and how I will juggle their visits if I

go through radiation treatments. I'm struck by how much I love my work and how determined I am to continue to see patients. With Hodgkin's disease I had the opposite reaction. I was glad to take a break from writing a dissertation and from the endless doubts that plagued me about my choice of academics as a career. In retrospect, taking that break was a bad idea. I had too much time alone to think.

Dr. Chu continues to search my torso, talking to me about a woman in my situation whom they have just treated with radiation. They will need the more detailed records, but there might be a possibility of arranging a safe protocol of radiation treatments for this cancer. After a silence the resident asks, "How important is it to you that we save the breast?" Without hesitation I answer, "Not important. What's important is that I get well." What am I saying? That it's not important to me to save my breast? What universe am I in that I say this with assurance?

We leave and the resident's question echoes in my mind. I've given them the signal that I am not as intent on saving my breast as I know some women are. In fact, sometimes I seem determined to get rid of it. I sense that there's some uncertainty among these experts about using radiation and that I seem headed for a mastectomy.



On Friday we drive to the country and I am again in my own private world, working over all the ramifications of this breast cancer. During the ride I think about Molly



and Zach and the future. Will I be around for them? Will I be at their graduations from high school or from college? Will I see them make choices about their careers and relationships? Will they marry? Will they have children? Will I still be alive then? I think about my parents and all they have suffered. If I die, they will lose a child, my children will lose a mother. I stop these thoughts because they are too dangerous; they will tear me apart.

I notice that I cycle through these thoughts as if they were ordinary, mundane. They occupy me the way other, ordinary thoughts used to—plans for dinner, the children's school work, my work, grocery shopping, calling friends. Soon all these ordinary activities will fall away, lose significance, not get addressed by me. Everything I love will be tainted by this illness. Even our house in the country, usually a haven from everyday pressures, will be no refuge. I long for the pleasure of musing about the future with confidence that it will come to be. But I'm on that desolate plain where nothing that is good or happy can be seen.

This weekend I try to adjust to the probability of a mastectomy. Friday evening, while David is visiting some friends, I climb into bed and read Susan Love's book. By the time David returns, I've read enough about treatments, survival rates, and recurrences to have worked myself into a full-blown state of panic. David, however, continues to read the book with a vengeance. Because its extensive information overwhelms and frightens me, he sifts through it and protects me from reading about all the more horrible things that could happen to me. Over the weekend new questions occur to me and I go to David, David to the book, and we learn.

It is remarkable how quickly I master this medical information when it concerns my life. I never considered myself good at science, but I see now that I merely lacked motivation. I have learned about staging and lymph node involvement. I have learned about precancerous conditions, which sometimes lead to cancer and can be discovered only if a woman has a biopsy. Knowledge of them gives a woman a warning to be watched closely; it also gives her something to worry about. I have learned that the pathologist determines how aggressive the cancer is by how differentiated the cells look (that is, how much they differ in appearance from normal cells), and by how many cells are dividing and how rapidly. The pathologist can also determine whether the cancer has invaded a blood or lymphatic vessel and whether there are dead cancer cells, both signs of a rapidly growing tumor.

David calls Craig for his opinion. Craig maintains that the choice between a lumpectomy with radiation and a mastectomy is essentially a choice between two very good options. Each treatment has excellent results with first-stage breast cancer. We are still working to understand the options even though we sense that my only option may be a mastectomy. We are also reading beyond the section on lumpectomies in Susan Love's book. I never thought we would have to read that far.

A mastectomy continues to seem completely barbaric to me. Although David still holds me at night, I lie curled up, as if holding myself together. In the morning I shower, put on my bra, and see my cleavage. I love my cleavage. My breasts are beautiful, a part of my body I have always liked. I feel incredibly sad. I imagine that in the future I will have to dress carefully to conceal myself. No more clothes that

allow anyone a peek at my breasts. During the day David and I walk and talk. The children are about the house somewhere. We manage to feed them, see to their baths, and get them to bed. But it feels as if the two of us are alone, trying desperately to cope with the realities ahead of us.



We see Dr. Cody again on Tuesday. Having spoken to his colleagues, he is not optimistic about the possibility of repeating radiation with me. The danger of my skin ulcerating seems too great. He is now tending toward a mastectomy, as I am. We are still waiting for my records from Boston and for Dr. Chu's recommendation, but it is clear that we are reaching a consensus. Dr. Cody describes the mastectomy procedure and tells me what to expect. He will remove the breast and a number of lymph nodes under my arm, but he will not remove the muscle. The breast tissue and the nodes will then be examined at the lab to see if there is any further evidence of cancer. They will also do what is called an estrogen-receptor test, which will provide further information to help in the decision about whether chemo makes sense for me. Women with tumors that are estrogen receptive can benefit from taking tamoxifen, for example, which blocks estrogen and which researchers hope can stop the growth of malignant cells that are dependent on estrogen for growth.

Dr. Cody will have to cut some nerves in the course of the surgery, so I will probably lose sensation in part of my arm. Without lymph nodes to drain the arm, some women develop a condition called lymphedema in which the arm

fills up with fluid. It will be important to avoid injury to that arm, such as cuts, bruises, or burns. I should not receive injections in that arm or even have my blood pressure taken there. After the surgery a temporary drain placed in the incision and connected to a small bag will collect the fluid, and the wound will be covered by a wide bandage. I will need to exercise regularly to get my arm back in shape.

If we decide on a mastectomy, I will need to consider whether I want breast reconstruction. Some women decide against it, but many feel it helps them adjust to the mastectomy. I can wait to decide, Dr. Cody explains, but, if the reconstruction is begun at the time of the mastectomy, only one further operation will be needed to complete the process. He suggests that I consult Dr. Michael Breckman, a plastic surgeon, to discuss the options. In any case, he has scheduled surgery for April 28, when Dr. Breckman can be present should I decide on reconstruction. Dr. Cody also gives me the names of several oncologists to discuss the question of chemotherapy.

Each step I take, each decision I make, moves me to a new plane where an entirely different set of questions awaits me. I'm to have a mastectomy. Will I have an implant? What does that mean? What will it be like? What doctor, what surgery, how many appointments? What pain, discomfort, or disfigurement? If I do not have reconstruction, there are other questions. What will it feel like to have one breast and a flat chest on the other side? What will I wear? What is a prosthesis? Where do you get them? As the day continues, my questions become clearer. I know that David rather than I will be on the phone to Dr. Cody in the morning. While I am reluctant to impose,

David feels entitled to attention. Instead I wait with my questions and suffer.

Dr. Cody is great. He gets on the line each time we call. He answers our questions and is patient while we learn, painstakingly, what he knows inside out. Now that a mastectomy seems likely, our questions are about why he and the books always mention chemotherapy along with a mastectomy. We have surmised that mastectomies are generally done on women with more advanced cancers than mine who obviously need chemotherapy. So why would I need it? What we discover is that the very nature of breast cancer is under discussion. Although localized treatments such as lumpectomy with radiation or mastectomy yield good survival rates, many researchers and doctors believe that breast cancer is not a localized disease but a systemic one—that is, a cancer that sends cells out into other parts of the body. It should therefore be treated with chemotherapy—with chemicals that reach all parts of the body, attack dividing cells such as cancer cells, and cause them to die. Dr. Cody confirms that there is growing sentiment that chemotherapy should be used in addition to a lumpectomy and radiation or a mastectomy, in many, though not all, first-stage breast cancers.

Although the statistics for first-stage breast cancer are reassuring, David finds them more consoling than I do; he is an optimist after all. Chemotherapy would boost my survival rate an additional three or four points. But I am skeptical. I remember saying when I had Hodgkin's disease that a 95 percent survival rate meant nothing to me. The cancer would either kill me or not, fifty-fifty. My current skepticism derives from the fact that, even though

from 85 to 90 percent of my group will survive, and approximately 94 percent if chemotherapy is administered, who knows whether I will fall into that percentage?

Efforts to obtain my records from Boston become very complicated. Martha reports that the doctors in Boston would like me to be treated there. Although I may be a fine addition to their follow-up study, I'm furious at their arrogance. Don't they believe that first-stage breast cancer can be just as competently treated in New York, where I have a life? They send some reports but not the complete records. I do learn that they doubt this cancer was caused by my radiation treatments for Hodgkin's disease because the dosages I was given were fairly low. I'm not convinced though. Radiation is radiation, and I know that my skin, even today, feels as thin as tissue paper.



On Easter weekend in the country, I reflect on how my life circles back on itself. In 1976, my surgery was on Good Friday, and its scheduling lent itself to no end of Christian religious analogies—a last supper, stigmata wounds in my hands from the IVs, in my sides from surgery, and in my feet from incisions made during a diagnostic procedure. In the parable, there is a resurrection on Easter, so I obliged by coming around after my surgery. I remember a friend bringing me white Easter lilies. This Easter, the resurrection is harder to pull off. I must resurrect myself for Molly by putting aside my preoccupation and meeting her needs. No holiday escapes her, and I must meet the challenge of her expectations of a basket of candy, hidden in an unusual

place, a festive breakfast table, and a cheerful mother. She will have her disappointments in the weeks ahead, but these I can prevent today. The effort to be alive for others seems herculean. Today I feel less afraid of death than of always feeling like this, detached and distant from my children. A living death.

We plan the day to Molly's satisfaction. She and Zach search for their baskets. Her breakfast plate holds a stuffed animal, a pink rabbit that she names "Flower," and Zach's holds a Queen Latifah CD. I love my children so much it hurts. In trying to act alive, I actually find my way to feeling again.

My friends get me through the weeks following the biopsy. My diagnosis has sent ripples throughout our world. After our immediate family and friends, there are our acquaintances—people from Molly and Zach's school, David's colleagues, and mine. Then there are friends of my family and friends of friends.

At first I feel only an outpouring of love and affection. Each day I return to a long tape of messages on my answering machine. David and I spend much of the evening talking to friends. I can see that I will need to set some limits on phone calls in order to preserve my time with the kids, but right now I need these conversations. Because my friends also are in shock, they can understand what a blow this is to me.

As time goes on, people's reactions become more complicated. Once they absorb the news, they begin to protect themselves from their own feelings of vulnerability. Sometimes this means convincing themselves that they are different from me. They reassure themselves that by eating carrots or exercising they will be spared. They ask questions

that leave me feeling blamed. Is there breast cancer in my family? Do I eat red meat, or meat treated with antibiotics, or any meat at all? Does my diet contain fat? Do I exercise? Have I been under a lot of stress? I begin to feel set apart, isolated, and viewed as responsible for this cancer.

Of course, no one blames me directly. Nor do people sigh with relief if they decide that some aspect of my lifestyle must be the cause of my predicament. Most people would be horrified at the suggestion that they are blaming me. But I do feel judged and angry that people are considering their own psychic needs over my feelings.

Some people recount positive stories of survival. I hear about one woman who had breast cancer and bicycled twenty miles a day throughout chemotherapy; another who looked gorgeous the entire time; and a third who told no one of her diagnosis and acted as if her life were absolutely normal. Why are these stories not consoling to me? I have no desire to bicycle twenty miles a day. Nor do I expect to look gorgeous, let alone presentable. People want me to look and act as I always do, or better, so that they can ignore that cancer really hurts people, makes them look gaunt and unattractive, and sometimes kills them.

Others tell me stories of triumph over cancer that leave me with a whole new array of catastrophes that could befall me. One woman had breast cancer that was not treated with chemotherapy and the cancer spread to the other breast, but she is fine now. Another woman had a mastectomy twenty years ago and then a recurrence ten years ago, but she is fine. An eighty-year-old woman who had breast cancer once, skin cancer twice, and then uterine cancer also is fine. I am now filled with new worries about



recurrences, aggressive tumors, skin cancer, uterine cancer, a future of new and untold cancers.

Still others don't seem to discriminate at all in the stories they relate; they tell me just any story that pops into their heads. Someone's uncle just died of lung cancer. Someone else's friend has leukemia. I'm treated to the details of someone's cousin's death and even an acquaintance's friend's mother's death. As I push down my panic, I try to remember that the person telling me is afraid. People dispel their anxiety by ridding themselves of these stories, giving them to me. Now I hold the fear they cannot bear to feel.

I suddenly realize that my children are going to have to deal with people's reactions as well. I tell Zach, very casually, that people are upset because I have breast cancer and they might say strange things to him. He asks what I mean, and I explain that people might speak to him in a very meaningful voice and say, "How *are* you, Zach?" He becomes very animated and his face lights up as he says, "Yeah, that already happened. When I went to Adam's house after school, his mother asked how I was and told me I should help myself to food in the refrigerator and that I was welcome in their house anytime. It was nice, but it felt a little weird."



It's a week since my consultation with Dr. Chu and my last meeting with Dr. Cody, and it is now time for my consultation with Dr. Breckman. The waiting room of his office is elegantly furnished, so different from the modern,

sterile offices I have seen so much of lately. Of course, a plastic surgeon would have Oriental rugs and an ornately tiled bathroom. This is the medical specialty that makes the rich and famous “beautiful people.” But the people waiting to see Dr. Breckman do not fit that bill. Some have obvious medical problems. One man’s hands are wrapped in bandages, another walks with a limp. Some look worried; some not. It dawns on me that there is a difference between a cosmetic surgeon and a doctor of plastic and reconstruction surgery. I feel better knowing that Dr. Breckman does more than nose jobs and tummy tucks.

The office into which I am ushered looks a bit like a dentist’s. It has a chair that reclines and cabinets full of silver instruments and medical supplies. One wall is completely mirrored. I’m about to hear about a whole new set of medical procedures of which I would happily prefer to remain ignorant. Dr. Breckman is middle-aged and a little soft in the body, not taut as one would expect of a plastic surgeon. He talks very fast. David has joined me and asks how he came to choose plastic surgery. Dr. Breckman explains that he studied another specialty but couldn’t stand to see so many patients die. He prefers patients who live to appreciate his work. After some small talk, he sits on a stool and begins the speech he has surely given hundreds of times. He is not relating to me at all, not even relating to the prototypical woman with breast cancer. Otherwise he would assume that I am upset and address that fact. Instead, he gets down to technical business.

Although he prefers silicone implants, he no longer does them because of the controversy about their possible role in connective-tissue diseases. And because I might sue

him, I suspect. There is also a reconstructive surgery in which a flap of tissue from your own body is used. I tell him that I have read about these surgeries and am not interested. Somehow, mutilating one part of my body to fix another doesn't make sense. He tells me that breast reconstruction with a saline implant requires two surgeries—one to insert a temporary implant, which can be done at the same time as the mastectomy, and another, later surgery to insert a permanent implant. The temporary implant has a valve into which he inserts a needle and injects saline (salt water) weekly. This procedure stretches the skin gradually and takes about twelve weeks. Temporary implants feel harder than real breasts. At the time of the second implant, many women have the other breast reduced. Without the reduction, the breasts will hang differently. It is also possible to have a nipple made from flesh taken from my thigh or some other part of my body. This procedure can be done in his office.

I can't comprehend half of what he is saying. I've never really tried to picture a mastectomy let alone a reconstructed breast. This implant idea strikes me as rather absurd, and the notion that women would have this done voluntarily simply to enlarge their breasts seems unimaginable. I express none of my feelings, and I go along with the idea that I will have an implant. I will. I will be cut up, sewn together, inflated. I can't bear to make yet another careful decision, so I'll just do this. I have read that in considering reconstruction I should ask the doctor to show me photos of his work. He does show me one photo of a woman standing naked from the waist up with two big breasts sticking straight out. She certainly doesn't look

appealing, but then again who would, posing like that for a black-and-white snapshot?

I try to listen as Dr. Breckman talks about the different shapes of breasts there are to choose from, including one called a teardrop. Asian women tend to choose one shape and American women another. It is also possible to choose the size you want, within reason. He jokes that this is the time women can get the large breasts they've always wanted. I'm appalled. I can choose from a variety of breasts, and I have my choice of size and shape. I cannot believe that this doctor is talking to me like this. Here I sit, naked above the waist, in front of a mirrored wall, talking as if I'm choosing a dress. Doesn't this man know that I'm not here for fun? Doesn't he know that I'm about to have my breast cut off? Why isn't he mentioning what is really happening and how horrific this experience is for me? I'm a piece of meat. No, a mannequin. He is fiddling with my form. I'm not a person to him. He knows nothing about me. He wants to know nothing. I have a life. I have children. I went to Harvard just as he did. When we leave, David tells me that he liked Dr. Breckman. Sure, if you don't have cancer, I think, if you don't have feelings, if you're not living in a nightmare in which strange men are about to cut up your body.

Although the consultation has been incredibly upsetting, I spend little time thinking about reconstruction. I feel remiss for not weighing this decision carefully and talking to other women about their experience, but I lack the emotional energy. I'm dealing with the reality of cancer; whether I have one breast, a reconstructed breast, or a prosthesis inside my bra seems of little significance right

now. Dr. Cody has said that most women seem to feel better with reconstruction. I make a decision based solely on the fact that with reconstruction I will be comfortable throwing on a T-shirt.

Because a month has passed since my biopsy, I need to repeat all the pre-op tests except the chest x-ray in preparation for the mastectomy. I also meet with an admitting nurse who talks to me about my upcoming hospital stay. She weighs me in at 113 pounds and determines that my height is five feet three inches. She writes down "mastectomy of the left breast." She is my age and talks with me about how many of her friends have had breast cancer. Because she seems attuned to the reality and impact of this disease, I let down my guard a bit. She carefully describes what to expect: the inpatient surgery unit; the gown, slippers, and robe; the surgery; the recovery room; the hospital stay. The more she talks to me, the more willpower I must exert to avoid falling apart. She has made all this too real, and I am hit with waves of fear and sadness. At the end of the interview she tells me that the nurse who works with mastectomy patients will be on vacation, so there will be no one making an effort to talk to me about the experience. I should ask a nurse to find one of the information packages they prepare for mastectomy patients. I receive this news as a declaration that no one will be there to take care of me and that I'd better be prepared to fight for myself. I leave the hospital feeling shakier than when I arrived, much like the feeling you have in realizing that you've just missed being hit by a car. How could such a straightforward conversation with an understanding nurse rattle me so deeply? It's not the prospect of my impending surgery but the

thought of how alone I am in this that terrifies me. I can manage the surgery, but how will I manage the first day without my breast, the days of waiting to hear if they found cancer in my lymph nodes, the fear in the middle of the night that I will die and leave my children bereft?

During the week David and I speak to Zach and Molly about my upcoming surgery. We decide to keep the explanation simple and wait for their questions. I am not going to describe the mastectomy. The idea of having a breast removed seems like too much for them right now. It might be only for me that it's too much, but so be it. I will tell them more when it feels right to me. I explain that the doctor has to make a cut in my breast so that he can take out the small lump that is cancerous. He will then sew up the skin, and it will heal just like a cut. Molly grabs the shirt over her chest and scrunches the two sides together, as if joining the two parts of a torn shirt. "Like this?" she asks. "That's it," I say, noting to myself that she grabbed her shirt exactly where her breast is. Zach doesn't say much except to ask how long it will take until I'm better. I tell them I'll return from the hospital after a few days and stay home to recuperate for a week or so.

I visit a young friend and her new baby on Thursday. We talk about her labor and delivery and about my cancer. I hold the baby for a while. Then she nurses him. I am very moved by the experience. I cry but am surprised that these are not angry tears. They're more in gratitude for having had such a wonderful experience as a mother, though tinged with sadness that those days have passed. I feel what a grandmother must feel—proud of this young woman, reminiscent. I am going to lose a breast, but I've

had this experience of my children sucking, feeling satisfied, and playing at my breast. I only hope I will get to be a grandmother.

We spend the weekend before my surgery in the country. Good friends are at their house nearby, but I don't want to see anyone. On Saturday morning David and I sit on our deck and watch the birds at the feeder. In the afternoon Molly and I drive to the nursery to buy some blue phlox and yellow violets for the bed in front of the house. In the afternoon I garden as if to prove something or perhaps to mourn something; as I dig in the earth, I imagine that I won't be able to shovel with my left arm in the future. Knowing that I tend to exaggerate, I push that thought aside and kneel down to join Molly as she digs small holes and excitedly plants the flowers we bought. Then I decide to take a bike ride. The last planting. The last bike ride. I'm quite melodramatic today. Zach has put new pedals on for me, and I manage to fall off as I try to negotiate them. What would Freud say? I have managed to get myself cut up and bruised three days before I'll be cut up and bruised in surgery. What I won't do to gain some control over what is happening to me, as if it's better to be the perpetrator of my own injuries than simply to submit to the upcoming surgery.

As I talk with David about the surgery, I weep with a deep sadness for my impending loss and I search for some resolve. How can I choose to do this? How can I consciously agree to have my breast removed? Everything in me fights this thought. I remember the surgical floor from last time. How will I go to the hospital in the morning, wait upstairs, walk through those doors and down that

long surgical hall? How will I climb up on the table? And, like a lamb, bring myself to the slaughter?

This surgery will enable Dr. Cody to determine for sure the stage of my breast cancer. I think back to Hodgkin's disease and the more complicated staging process. First, I had a lymphangiogram, a procedure in which the doctor made an incision in each of my feet so that he could inject dye into my lymph system. He then took x-rays to get a complete picture of my lymph system so that he could look for tumors. The prospect of incisions in my feet seemed the most terrifying—no one had explained that my feet would be numbed first. When I had the abdominal surgery in which they removed my spleen and biopsied my nodes and organs, I was prey to endless bad jokes about my personality. I expect that the mastectomy will be less debilitating, but I feel myself preparing, as before, for the trauma that is surgery. I try various tricks—like imagining what Dr. Cody will do to me, as if envisioning his knife and the operation will make it less horrific. Then I tell myself not to think about it, that in a year I will have adjusted to it as I did with my earlier surgery. But then again, who misses a spleen when looking in the mirror?

I speak on the phone to my mother. She immediately understands my worries about what more they might find, and she tells me about her anxiety in the weeks before her hysterectomy a few years ago. I appreciate hearing this piece of her experience for the first time. I also speak to Gina in California. We have been close friends since high school. She wants to help, to be here. She would come. I just need to talk to her.



Saturday night David and I again lie on our bed in our room upstairs. I have not always appreciated how little he notices about my body, what I'm wearing, how my hair looks. But right now I love his indifference to the perfection or imperfection of my body. I actually believe that he does not care about this breast. He cares about what I must go through, but he does not mourn the loss for himself. Nor does he worry about feeling put off by my body, though I do know that somewhere he must have those feelings. After my radiation treatments in 1976, at dinner with a close friend, David described with great hilarity his trying to respond to my interest in sex when I had lost my hair and had a body covered with tattooed dots and magic marker lines. I wanted to feel normal, he understood. Although his story was painful to hear, I knew that he told it as a way to recover.

On Sunday I feel very agitated. I want to speak about underwear to women who have had a mastectomy. I can think only about bras and how I will dress until the implant is inflated to the size of a breast. I call a few friends who have had breast cancer, none of whom recall this problem. It's reassuring that they are busy in their lives and have no recollection of underwear concerns. But I feel alone, not believing I will ever be so busy as to forget this experience. I speak to one friend who recognizes that I am looking for more than underwear, that I am reacting to the nurse's warning that I will have little help adjusting to the mastectomy. She offers to contact SHARE and Cancer Care, organizations that provide support for cancer patients. I finally exhaust my desire to solve the bra problem

and settle on one friend's solution—a bra with a pocket for padding on one side. I will also buy myself a silk chemise, something that will feel soft against my skin, look pretty, and cover me up. I laugh when I realize that I'm already planning my recovery and that I am staving off my terror about surgery by simply worrying about a bra.

We pack up to return to New York on Sunday afternoon. Zach and Jonathan play basketball until the moment we leave and Molly says goodbye to Stephanie and her friends. Gail and Bob, Jonathan and Stephanie's parents, come by to wish me well. It's awkward for all of us. We are close to them because we love each other's children. We offered our support to them when Stephanie had kidney problems at birth and Gail had cancer surgery. We have similar experiences and yet very different lives. Bob grew up on a farm, runs a landscape business, and works sixteen hour days. Gail grew up on Long Island and is the bridge between country and city, between Bob and us. I am touched by their effort to come and wish me well. Although I appear calm, I am screaming inside. As I embrace each of them, I wonder whether hugs will feel uncomfortable with one breast. Will I draw back as if to protect my breast or to keep people from feeling that part of my body?

I realize that I have resigned myself to this surgery. I have done my mental kicking and screaming, and it's time to quiet my angry resistance to the loss of my breast. There are certain things one simply must do, however grotesque and unimaginable, and this is one of them. Now there is only the event to focus on—the surgery. Everything drops

away but the steps I must accomplish to get myself there—see my patients, pack my suitcase, make lists of phone numbers and the kids' schedules and activities. The single-mindedness of what I must do somehow calms me.