Breast Reconstruction Alternatives

Reconstruction is a medically covered and necessary procedure. California State law (Tanner Bill) also allows for as many procedures as you may need to achieve symmetry as this often involves a procedure on your uninvolved side.

Anyone is entitled to a reconstruction. However, if you have advanced disease or a poor prognosis, it seems more prudent to get treated first. Nevertheless, you can still choose to pursue this, regardless of your prognosis. The procedure can be done immediately following a mastectomy or delayed following a full recovery from the potential effects of chemotherapy and/or radiation therapy. ***Reconstructed breasts will never have the natural fullness and projection in the area of the nipple*** and this should be anticipated.

In general, there are three ways to reconstruct a breast. The first involves intervening at the time of your **lumpectomy** and repairing the resultant defect as best possible and also addressing the opposite breast at the same time with a lift or reduction to match what is done on the lumpectomy side. Ideally, this is done before radiation to minimized the difficulties with delayed reconstruction and also provide a better aesthetic outcome and less down time as a lumpectomy cripple.

The second involves use of **alloplastic** materials such as implants and expanders (balloons to stretch your skin). This is a simpler operation and easier to recover from. It does involve multiple operations. As of today, there are no studies to link silicone with causation of disease. All options for reconstruction are still available should the alloplastic technique fail in any way. Risks associated with implants include malposition, asymmetry, capsular contractures, rippling, implant failure, extrusion and chest wall deformities. This technique is NOT recommended in tissue that has been radiated but you can still choose it if you like. It is also inadequate if you are a larger woman as the largest implants will not produce an adequate mound in this scenario.

New, form stable textured anatomic gel implants, have provided excellent results and make alloplastic techniques much more attractive.

The third method involves using your own tissue (**autogenous** reconstruction). This is a more "elegant" but risky method of reconstruction. It involves a longer operation (4-5 hours) but potentially fewer operations in the long run. There is a longer recovery but a better match with the uninvolved breast *assuming* there are no complications. A successful operation will last you forever. You also received the added benefit of an improved contour from where you tissue is harvested (tummy tuck if you use your tummy tissue).

A recent innovation with tissue stretching and fat grafting has led to the use of the **BRAVA** enhancement device and fat grafting to achieve impressive results. This involves use of an external suction bra that stretches your tissue which is then filled with your own fat harvested from areas of excess. There were concerns about calcifications developing causing some radiologists to mistakenly think there was a breast cancer resulting in unnecessary biopsies. There is also a theoretical

concern about the fat grafts stimulating dormant cancer cells resulting in an earlier than expected recurrence in addition to other risks such as cysts.

Risks of autogenous reconstruction can range from catastrophic with flap failure to nuisance issues such as mild contour irregularities. This also includes the potential for blood clots and emboli, the need for urgent exploration to salvage a flap, donor site morbidity (such as hernia or weakness), decreasing the ability for a coronary by-pass procedure in the future, and the need for additional revisional procedures to improve contours and shapes. Color may also not match well.

There are issues beyond my control that also influence the outcome of a reconstructive procedure. This includes smoking, diabetes, having had radiation to your skin, prior abdominal procedures or incisions near donor sites, obesity and the continued risk of recurrence of cancer. **It is your responsibility to stop smoking prior to any reconstructive procedures if you want to minimize risk.**

Donor sites for autogenous reconstruction include the tummy flap (TRAM), back flap (Latissimus dorsi), buttock flap (Gluteus maximus), and a vast array of others limited only by our imagination. The back flap is a pedicled (attached) flap that leaves a scar on the back and usually requires an implant to augment the volume. The tummy flap leaves a tummy-tuck scar from hip to hip but risks the possibility of bowel injury or hernia. It can be limited by what abdominal procedures you've had before. The buttock flap is usually used for salvage situations as it can leave a depression over you buttock unless harvested bilaterally. Other flaps available can come from you hips and flanks but donor scars are usually poor in quality.

Free tissue transfers can be done where the blood supply to the flap is cut and reconnected under the sternum. This allows for improved blood supply and is the procedure of choice when reconstructing a large breast. It is technically more demanding but can leave better results in both breast mound and donor site. If you choose this, you will have to have the surgery done at the California Pacific Medical Center (888-637-2762)]. You may also look up more information @ www.cpmc.org.

Autogenous reconstructions require 4-7 day in the hospital where alloplastic reconstructions are done on an outpatient basis. Both procedures require general anesthesia.

Nipple reconstruction is done once you've achieved the look and symmetry you desire. Local skin flaps are taken from the top of your mounds and will flatten the projection even more. In addition, nipple reconstructions do not hold up well against time. Subsequently, I am not a fan of nipple reconstruction and instead suggest you get prosthesis from www.myreforma.com and consider tattooing of your skin to give you the illusion of an areola.