Breast reconstruction overview

Royal Berkshire NHS Foundation Trust

Breast reconstruction is offered to women who have had or are about to have a mastectomy (delayed or immediate) to treat breast cancer. It is also offered to women who are considering risk-reducing breast tissue removal surgery – because they are at a high risk of developing breast cancer due to genetic likelihood.

Most women who have had a mastectomy can have reconstruction but not all women choose to do so for various reasons.

This leaflet is designed to give you the facts you need to make an informed decision about breast reconstruction. The decision to have breast reconstruction is a matter of personal choice and there is no right or wrong answer. No single source of information can provide every fact or give you all the answers. You and those close to you should discuss any questions and concerns about reconstructive surgery with your surgeon and breast care nurse.

Goals of reconstruction

Women choose breast reconstruction for different reasons. The goals of reconstruction are:

- To make your breasts look balanced when you are wearing a bra.
- To regain a breast contour.
- To give the convenience of not needing an external artificial breast (prosthesis).
- In clothes (or underwear, or a swimming costume), your appearance will be similar to before your surgery. Even without clothes, you may feel better with a recreated breast giving you a more natural shape. It can help to restore your self-confidence and feelings of femininity, attractiveness and sexuality.

Limitations

Unfortunately, what we cannot do is make an exact copy of your natural breast. Results vary between patients who have the same procedures and this is due to many factors that include; breast size and shape, skin quality, previous scarring and/or radiotherapy, tissue atrophy (wasting), patients' weight, body shape, rib angulation and symmetry and your body's reaction to foreign material (i.e. breast implants).

Before making a decision about whether to have a reconstruction you need to have realistic expectations about the possible result and be aware of the limitations. Sometimes, two or more operations over a period of approximately six months may be needed to give the best possible result.

- Reconstruction will not be able to give back the exact appearance and shape of your breast.
- Your new breast will lack the sensitivity of your natural breast (and may be completely numb).

- Some women, particularly those having a delayed reconstruction (having had a mastectomy already), need to have two or three operations to get a good match with the opposite breast.
- You may also want / need to have an operation on your other breast to reduce or increase the size or lift the breast (mastopexy) in order to achieve the best cosmetic outcome.
- The difference between the reconstructed breast and the remaining breast can be seen when you are nude. When wearing a bra though, they may be close enough to one another in size and shape that you will feel comfortable about how you look in most types of clothing.

Your body image and self-esteem may improve after your reconstruction surgery following a previous mastectomy but this is not always the case. Breast reconstruction does not fix things you were unhappy about before your surgery. Also, you may be disappointed with how your breast looks after surgery. You and those close to you must be realistic about what to expect from reconstruction.

Types of breast reconstruction

Several types of operations are available for breast reconstruction but you may not be suitable for all types of procedure.

Outlined below are the most commonly used breast reconstruction techniques, which include:

- Silicone implants in in a pre-pectoral position (on top of the muscle) with an Acellular Dermal Matrix (ADM) or a sub-pectoral position (under the muscle) either with an ADM or Dermal sling using the lower breast skin if you have enough tissue or breast ptosis (droop).
- DIEP (or TRAM) abdominal flap reconstruction, which is done by the plastic surgeons in Oxford as it involves microsurgery.
- Latissimus dorsi (LD) muscle back flap reconstruction either with an expandable implant or without (autologous – all your own tissue) and with/without secondary lipmodelling (grafting fat from your abdomen and injecting it into the LD muscle flap).

Not everyone is suitable for all techniques and your surgeon will examine you and outline the different options available to you.

Separate information leaflets are available for each of the different techniques to explain them in more detail.

Immediate or delayed reconstruction with breast cancer

- **Immediate reconstruction** is reconstructive surgery that is done at the same time as the mastectomy, when the breast tissue is removed. The benefit with immediate reconstruction is that your natural breast skin is retained helping to shape the reconstruction more like your natural breast and minimise scarring, and with fewer operations compared to the delayed option. Your surgeon will discuss with you the option of nipple-sparing mastectomy if appropriate, but not all women are suitable for this option.
- **Delayed reconstruction** is surgery that is done at a later time following a mastectomy. For some women, reconstruction is too much to think about at the time of the cancer diagnosis, and their preference is to have a simple mastectomy and get on with any other cancer treatment. In this setting, we need to recreate both the skin envelope and tissue volume that has been lost, so the scarring pattern is different and involves removing tissue from other

parts of your body, e.g. back or stomach. Delayed reconstruction is offered if you need radiotherapy because radiotherapy increases the risk of complications and can adversely affect the reconstruction leading to poor cosmetic outcomes.

- **Delayed-immediate reconstruction** is an alternative option for women who we know are going to need radiotherapy after a mastectomy but want a reconstruction. In this setting, we can perform as skin-sparing or nipple-sparing mastectomy as we would in an immediate reconstruction, but then we place an implant into the "pocket" in a subcutaneous (under the skin) position. This is a temporary implant, that is purely there to preserve the skin envelope and will be removed at a later date when you then come to have a definitive reconstruction. The definitive reconstruction would not be performed until 6 to 12 months after radiotherapy so that the skin is as good as it can be. This offers the potential of additional reconstructive options over a delayed reconstruction (e.g. implant only reconstruction) but carries additional risks and benefits over a delayed reconstruction. The additional risks of a temporary implant are:
  - Skin necrosis – the skin has less blood supply coming to it following the skin-sparing technique, and if there is not enough blood supply then some patches of the skin may die off, and this may require further surgery (up to 2%). There is a big increased risk in smokers (25%).
  - Nipple necrosis – in the nipple-sparing technique, the nipple also has less blood supply coming to it, and again if there is not enough blood supply then part or all of the nipple and areola may die off, and may require further surgery. This is seen in up to 5% with a big increased risk in smokers (25%).
  - Numbness – the reconstruction will feel numb, with no or reduced sensation in the skin and no sensation in the nipple if it has been preserved.
  - Infection – this is the biggest concern with all implant-based techniques, with the resultant need to remove the implant in severe cases (around 7-10%). The risk is greatly increased in smokers, diabetics, and overweight patients.
  - Wrinkling/rippling of the implant – you may notice some wrinkles or ripples to the implant under the skin, particularly if you are slim. These are often smoothed out in a bra.
  - Rotation of the implant – we tend to used shaped (anatomical) implants for a more natural look, which have more fullness at the lower part of the implant. If these then move in the pocket they have been placed in, the fullness will be in the wrong place.
  - Visibility or palpability of the implant – in slim patients you may be able to see the outline of the implant, and feel the edges of it.
  - Capsular contraction – your body recognises the implant as not part of you, and forms a scar tissue bag called a capsule around the implant. This happens in everyone, and starts as a thin layer. Following radiotherapy this can thicken and harden, and in doing so squeeze on the implant and change how it looks as well as make it feel tight and uncomfortable.
  - Seroma (fluid build-up) – this is an inevitable consequence of having a mastectomy and usually resolves with time. As a result you will need a drain to stay in for 2-4 weeks after your operation to remove the fluid and reduce tension on the scar.

Decisions about reconstructive surgery depend on many factors such as:

- Your overall health.
- The type of breast cancer.
- The size of your natural breast.
- The amount of tissue available (for example, very thin women may not have the excess body tissue on their back or abdomen or thighs or buttocks to enable these techniques).
- Your desire to match the appearance of the opposite breast.

Other important factors to consider:

- You may choose to wait until after your initial breast surgery to decide about reconstruction if you do not want to think about this issue while you are coping with a diagnosis of cancer.
- You may simply not want to have any more surgery than is needed.
- Not all surgery is completely successful, and you may not be pleased with your cosmetic result.
- Your ability to heal may be hindered by previous surgery, chemotherapy, radiation, smoking, alcohol, diabetes, various medications, and other factors.
- You may not be a candidate for reconstruction at all if you are obese, too thin, or have circulatory, heart or lung problems.
- We may recommend surgery to reshape the remaining breast to match the reconstructed breast. This could include reducing or enlarging the size of the breast or lifting the breast.

What happens next?

- You will see one of our oncoplastic and reconstructive breast surgeons in clinic. This is usually a longer appointment than normal as it takes time to go through the options with you.
- We will summarise your history to date and ask you some other questions that are important to take into consideration for reconstructive surgery. We will need to take your height and weight if you don’t already know them, along with your bra size. You will then be examined, including your back and abdomen.
- We can then outline which reconstructive options you are suitable for, and discuss the pros and cons of each with you. Not all options are suitable for every patient.
- We cannot tell you which operation you should have but can guide you as to what maybe the most appropriate reconstruction for you, taking into account your views on the risks, recovery periods, hobbies / activities and priorities. Different patients will choose different available options based on their own personal circumstances.
- We will give you some written information to take away, as well as ask you to make an appointment to see the breast care nurses to see some photographs of examples of the different options and discuss things with them.
- Once you have decided how you would like to proceed we will see you again or arrange an appointment for you to see the plastic surgeon to discuss the DIEP abdominal flap.

Contact us

If you have any problems regarding your care or treatment at this hospital, please talk to us. Your feedback will help us to improve and develop our service. Please speak to a member of staff in the clinic or on the ward, or if you would rather talk to a senior member of staff, ask to speak to the ward/departmental manager or matron.

Or speak to our Patient Advice and Liaison Service (PALS) who can offer you 'on the spot' support and advice as well as practical information at a time when you are feeling confused and anxious. PALS can be contacted on 0118 322 8338, email PALS@royalberkshire.nhs.uk or ask a member of staff, the receptionists or the switchboard to contact them.

Consultant Surgeons

Mr B Smith	Consultant Oncoplastic and Reconstructive Breast Surgeon
Miss N Dunne	Consultant Oncoplastic and Reconstructive Breast Surgeon
Mr G Cuffolo	Consultant Oncoplastic and Reconstructive Breast Surgeon

Our clinical teams can be contacted via Clinical Administration Team 3 (CAT 3) on 0118 322 6890, then press the option for 'breast'.

Breast Care Nurses

Fiona Ellison
Vanesa Lobo Gallego
Sarah Cleaver
Maxine Halford
Daniela Costescu

The breast care nurses can be contacted on telephone number 0118 322 7420, and please leave a message if you get the answerphone. Or email them on breastcarenurses@royalberkshire.nhs.uk.

More information

If you have any questions about the procedure or this information, please speak to your surgeon or breast care nurse.

To find out more about our Trust visit www.royalberkshire.nhs.uk

Please ask if you need this information in another language or format.

Mr B Smith/Miss N Dunne, RBFT Breast Unit, September 2021
Next review due: September 2023