

A woman's breast is the most important symbol of her femininity. The loss of one or both breasts can have a devastating impact on self image and cause a woman to withdraw socially. After mastectomy, each patient must come to deal with the reality of her diagnosis in her own time, but the chest wall defect serves as a constant reminder of her illness.

Because the primary focus during initial breast cancer treatment is upon oncologic issues, reconstruction has historically been delayed until primary and adjuvant therapies have been delivered. Delayed reconstruction is usually initiated a minimum of 3 to 6 months after mastectomy, but has often been put off for years out of fear of recurrence. As surgeons have become increasingly concerned with the devastating psychological impact of breast cancer surgery, data have also been developed to support early reconstruction.

News of Interest
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Immediate
Breast
Reconstruction

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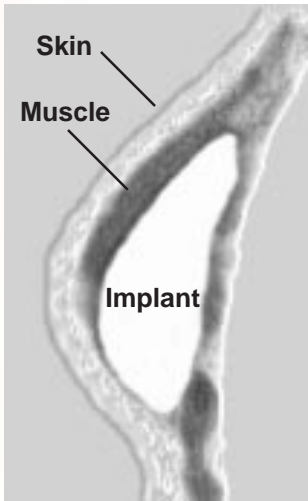


THE FOUNDATION
FOR RECONSTRUCTIVE
PLASTIC SURGERY

Since the first radical mastectomy by Halsted in 1882, surgeons have been encouraged to develop reconstructive techniques to replace the breast. After diagnosis today, patients must be counseled regarding the various treatment options before a decision about surgery is made. Knowledge of reconstructive techniques can provide a tremendous support to those undergoing mastectomy, and the knowledge that reconstruction is available may encourage patients to seek medical attention sooner.

Methods

Among the pertinent considerations in the selection of a reconstructive method are the oncologic status of the opposite breast, the patient's anatomy, and her expectations. Reconstruction using a saline filled Silastic implant is the preferred method of many because of its relative technical simplicity and its short recovery period. It is best employed for a small breasted woman or when the patient prefers alteration of her opposite breast. Because surgery is usually performed through the mastectomy incision, it is important for the oncologic and plastic surgeons to coordinate the planned access.



Tissue expanders are a modification of the implant which utilize the principle of gradual tissue stretching for recruitment. Expansion provides a better vascularized cover for the prosthesis, allows use of larger implants than would otherwise be possible, and may provide a slightly more ptotic breast. The expander is serially inflated to the desired size and exchanged at a second procedure for a permanent implant. Expanders

help surgeons avoid flap transfers for patients who prefer implant reconstruction, but whose tissues are marginal as cover.

Autogenous Reconstruction

Tissues may be transferred to the chest for breast reconstruction from a number of different areas, including the abdomen ("TRAM" flap), back (latissimus dorsi), buttock (gluteus), and thighs (TFL). Disadvantages include greater technical difficulty and a longer recovery for the patient. There may be loss of muscle and fatty contour in some of the donor areas and a permanent scar always results. Chief among the advantages of these methods are the natural and aesthetically superior results obtained. Women with successful autologous tissue reconstructions enjoy a warm, soft, breast which behaves like the natural breast both in and out of clothing. For most, symmetry is achievable without altering the opposite normal breast. This is even true when the patient is large-breasted (as illustrated below).

Timing

For many years surgeons recommended that patients wait for years after mastectomy before considering breast reconstruction. Many were concerned that early reconstruction may stimulate malignant disease or obfuscate its recurrence, delaying treatment. More recent

data have shown that immediate reconstruction does not conceal tumor recurrence and in the vast majority of cases does not interfere with the timing of adjuvant radiation or chemotherapy. There has been no evidence of altered survival times for the reconstructed patients, leading many to advocate primary restoration for the majority of patients with early disease.

Studies from Georgiade and Noone focused primarily upon prosthetic implantation and reported no significant difference in relapse-free survival or any delay in adjuvant therapy for patients with immediate reconstruction. Similar conclusions about TRAM flap reconstruction came from Jabs, Hugo, et al. A series from

Godfrey and Godfrey of primary microvascular free flap reconstructions included 21 patients in Stage IIb or higher. With a mean follow-up of 25.2 months they found no adverse impact from immediate reconstruction even among 15 clinical Stage III and IV patients.

Such data strongly suggest that immediate reconstruction has application even in patients with clinically advanced disease. Also, since so many patients in all stages are now receiving adjuvant chemotherapy, primary reconstruction allows women to avoid the 6-12 month breastless period during

which chemotherapy would otherwise contraindicate reconstruction.

