

Frequently Asked Questions About Breast Reconstruction

If you're looking at this section of my web site, you are probably looking for as much information as possible on breast reconstruction. I understand that this is a very personal procedure and would like to provide you with some basic information on the available options. The thought of a mastectomy can be frightening because one must not only face the issues that accompany cancer but also the fears of possible deformity and loss of sexuality.

As your plastic surgeon, I want you to know this need not be the case.

In my opinion there are two goals of breast reconstruction. The first goal is to reconstruct a breast, so that when in clothes the patient feels self-confident and comfortable. This goal is almost always achievable. The second goal is to reconstruct a breast which is attractive and beautiful, even without clothing. The success of this goal, however, is dependent upon several factors, which include: skin elasticity, size of the breast, wound healing ability, and weight.

In the following sections, you will read more about the various techniques used in reconstruction. The choice of technique will be further discussed during your consultation, as it is important to tailor the procedure to your individual circumstances, medical history, and personal desires.

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- **Does Reconstruction Interfere With Treating My Breast Cancer?**
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- **How Do You Reconstruct the Breast?**
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Is everyone a candidate?

Most mastectomy patients are good candidates for reconstruction. However, the best candidates are women whose cancer has been eliminated entirely by the mastectomy.

Does reconstruction interfere with treating my breast cancer?

Breast reconstruction has no known effect on the recurrence of cancer in the breast, nor does it interfere with chemotherapy or radiation treatment.

When can the procedure be performed?

Immediate breast reconstruction: In the past 20 years, much has changed in how the medical community views patients with breast cancer. It wasn't so long ago, that it would have been considered extremely poor practice to reconstruct a woman's breast at the same time as the mastectomy. However, as with all of medicine, research leads to new discoveries and within the field of surgical oncology, it is now not only acceptable but expected that a woman should have reconstruction begun at the same time. Immediate breast reconstruction actually means, that once the anesthetic has worn off, you will wake up with at least the "beginnings" of a new breast. It also helps lessen some of the psychological trauma normally associated with the loss of a breast. Immediate reconstruction has become an appealing option because it combines effective treatment of the cancer with restoration of the breast.

When immediate reconstruction is performed, your breast surgeon can leave more skin available for use in creating your new breast. However, when no reconstruction is planned, the breast

surgeon removes all excess skin so that a prosthesis can be more easily worn without irritating the underlying skin.

Most women are candidates for immediate reconstruction. Patients who might need to delay their reconstruction are those with advanced tumors, those with serious medical problems, and those who are psychologically unprepared for reconstruction.

Delayed breast reconstruction: The other option is a delayed reconstruction, waiting 6 months to many years later. Some women delay the reconstruction, not wanting to deal with this at the same time as the cancer surgery. In addition, some oncologists suggest delaying reconstruction for medical reasons, for example, in women with very large cancers or in cases where the tumor has spread.

How do you reconstruct my breast?

Breast reconstruction is done in 2 steps: first by recreating the “breast mound”, and then by recreating the nipple. This process can be done with either tissue expanders or with your own tissue.

Recreating the Breast Mound:

1. Tissue Expanders / implants – Tissue expanders are round silicone sacs filled with salt water and are very similar to those used for breast augmentation, except that they have a metal filling valve (port) built into them. They are placed beneath the remaining breast skin and muscle after mastectomy and left deflated until the scars have healed. Once the mastectomy scars have healed, they are slowly inflated until they match the uninvolved breast. This filling is performed every two to three weeks in our office to slowly stretch the skin. This process can take several months. Once the inflation phase is complete, a second operation is performed. At this time the tissue expanders are removed, and then replaced with permanent implants.

As of November of 2006, women have two options in implant selection, saline or silicone implants. Each type of implant has benefits and draw-backs, but most women select silicone implants for breast reconstruction because of their more natural feel.

Advantages: Reconstructing the breast with tissue expanders and then implants provides the patient with a quick recovery without any additional scars. This is because the implant is placed through the existing incision used for the mastectomy. When using a patient's own tissue (flap), the recovery is several weeks longer, and there are additional scars on the body in the location that the tissue was taken from.

Disadvantages: Implants, like all medical devices, do not last forever and can leak. Additionally, implants can sometimes become hard (capsular contracture) and may not match the uninvolved breast. When these things happen, revisional surgery is usually necessary to either release the scar, replace the implant, or both. It is quite likely that additional surgeries may be necessary in the course of a patient's lifetime. Also, an implant reconstruction will not feel as natural as a real breast, and it will not perfectly match a real breast in shape. Finally, implants often do not work as well in patients who have had or will require radiation therapy.

Who is a good candidate for an implant reconstruction?

Patients without radiation to the breasts

Thin patients with insufficient abdominal tissue for a TRAM flap

Patients who do not want a scar on the abdomen

Patients who are having mastectomies on both sides (Symmetry is generally excellent in bilateral implant reconstructions)

Patients who have had a prior abdominoplasty (these patients cannot have a TRAM)

Patient's own tissue (flaps) – Plastic surgeons have been using flaps to reconstruct breast cancer patients for many years. There are two main options when we talk about flaps: the **TRAM flap** (transverse rectus abdominus myocutaneous) and the **LD flap** (latissimus dorsi myocutaneous). Big words that describe the part of the body from which we take tissue to reconstruct the breast. When we use flaps, we're acting a little like Robin Hood, who stole from the rich to give to the poor. In the same way, we take tissue from one area (that has plenty), and place it on the chest to reconstruct the breast (that is lacking).

When we use flaps, it is important for the patient to realize that reconstructive surgery causes additional discomfort and leads to a prolonged recovery time. On the other hand, using the patient's own tissue generally gives a more natural feeling breast which matches the uninvolved breast well.

1. **TRAM flap:** Some patients describe the TRAM flap as the "tummy tuck" procedure, because in this procedure we take extra fat and muscle from the lower abdomen and use this tissue to make the breast. One of the rectus abdominus muscles is moved with the tissue in order to maintain blood supply. The added benefit is that the tummy is tighter and more youthful after the surgery.

Advantages of the TRAM flap: The main advantage of the TRAM flap is that it feels very natural, almost exactly like a real breast. The fat of the abdomen is very similar in consistency to the original breast tissue, and will actually get bigger and smaller as the patient gains and loses weight. This means that as a patient's weight fluctuates, both breasts will maintain symmetry. TRAM flaps are also very useful in those patients who will be receiving, or who have already received, radiation therapy. Finally, TRAM flaps have a lifetime warranty; they will last as long as the patient does, do not need to be replaced, and cannot leak.

Disadvantages of a TRAM flap: The TRAM flap is a major operation. The operative time is approximately four hours for one side and almost six hours for both sides. Unlike tissue expander placement, which typically only requires an overnight stay in the hospital, the initial hospital stay for a TRAM ranges from three to five days. The patient's convalescence after this surgery is also longer and may require absence from work for six to eight weeks. Although rare, occasionally a patient may need a blood transfusion. TRAM flaps do require a large abdominal incision, whereas, tissue expanders are simply placed through the same incision as that used for the mastectomy. Finally, since muscle is being taken from the abdomen, women undergoing TRAM flap reconstruction, may find that they have some abdominal weakness after this procedure.

Who is a good candidate for a TRAM flap?

Healthy patient who is not substantially overweight

Non-smoker

Sufficient lower abdominal tissue to make a breast

2. LD flap: Our other commonly used procedure is the LD flap, during which we are using fat and muscle from the upper back. We use the latissimus muscle to maintain blood flow through the tissue, which means that it is used for the flap and no longer useful to the back. By using this muscle we do weaken the shoulder by approximately 5%. One of the drawbacks to the LD flap is that we must often use an implant with the flap, because the flap isn't big enough to match the uninvolved breast. This reconstruction is usually used for those patients that have had radiation or simply do not have enough skin on the chest to reconstruct the breast with the use of a tissue expander alone. By using the LD flap, we can bring more skin to the chest and complete the reconstruction. However, if the patient has enough abdominal skin for a TRAM flap, this would be another alternative.

Recreating the Nipple and Areola:

The second step of breast reconstruction is recreating a nipple and areola. This procedure is usually completed three months or more after the breast mound is complete, i.e. three months after the final implants are placed or the flaps are created and positioned.

Nipple reconstruction is a relatively quick procedure that can be done as an outpatient. Sometimes, we create a nipple using simply the tissue that is already on the reconstructed breast, and other times we use a skin graft. This skin is usually taken from the abdomen.

Depending on the technique chosen, you will either have a dressing which is sutured on and which must remain dry for one week, or you may be able to wash the area immediately. This depends on whether or not a skin graft is needed. Once the nipple has completely healed, then the areola, or pigmented skin that normally surrounds a nipple, can be reconstructed with tattooing. We usually have patients wait at least 4 to 6 months to ensure that the ink of the tattoo will take well.

How Long Before My Reconstruction Is Complete?

I am commonly asked by my patients to give them a timeline for the completion of their reconstruction. Chemotherapy and radiation therapy are two very important factors to be taken into consideration. Generally speaking, patients should not undergo any surgery while they are being treated with chemotherapy and/or radiation therapy, so this treatment may add 6 months or more to the completion of the breast reconstruction.

In those instances in which no chemotherapy or radiation therapy is to be given, reconstruction with flaps will take approximately 6 months to complete (breast mound, then nipple, then tattooing). Reconstruction with expanders and implants will take a little longer, usually 9 to 12 months.

Will Insurance Help Cover the Cost of Surgery?

At this point all insurance companies are mandated by the federal government to pay for breast reconstruction after mastectomy. They are also required to cover any balancing work done to the opposite breast.

BREAST RECONSTRUCTION PROCEDURE COMPARISON

	Tissue Expansion and Implant	Latissimus Flap and Implant	TRAM Flap (Abdominal Tissue)
Initial Surgery	Moderate	Involved	Highly Involved
Secondary Surgery	Needed if Tissue Expander is not the final implant Needed for nipple and areola reconstruction	Possible for revisions May be needed for nipple and areola reconstruction	Possible for revisions May be needed for nipple and areola reconstruction
Hospitalization	Commonly 1-2 days	Commonly 2-3 days	Commonly 3-4 or more days
Scars	No additional scars	Scar located on the upper back	Scar located on the abdomen
Shape and Feel	No ptosis (sagging) Firm, little motion No change with weight fluctuation	Moderate to natural ptosis (sagging) Less firm, more motion Little change with weight fluctuation	Natural ptosis (sagging) Soft, Normal motion Symmetric change with weight fluctuation
Opposite Breast	Surgery often required to achieve optimal symmetry	Surgery for symmetry more optional	Surgery for symmetry almost always optional
Impact of Radiation	Significant	Moderate	Varies
Secondary Gain	Flexibility with breast size in bilateral cases	None	Flatter abdomen similar to a tummy tuck
Average Back to Work Time	2 weeks	4 weeks	6-8 weeks

Breast reconstruction is one of the most satisfying aspects of my practice. As the medical director of the Women's Plastic Surgery Centre, I am very interested in providing advice and answers to women who wish reconstruction. For more information about breast reconstruction, please call my office for a consultation.

For more information on breast cancer, you may want to refer to the following links:

[American Cancer Society](#)
[Susan G. Komen for the cure](#)
[Breast Cancer.Org](#)