PIPS Tips

A PUBLICATION OF THE PITTSBURGH INSTITUTE OF PLASTIC SURGERY

BREAST RECONSTRUCTION

In my last article for this publication I talked about Bilateral Breast Reduction and the uniform satisfaction, in fact delight, on the part of large breasted women with that procedure. Today I would like to talk about a procedure which proves to be at least as gratifying for the plastic surgeon who undertakes it as it is for the woman who undergoes it. That procedure, or really a "family" of procedures, is **Breast Reconstruction**.

Women who lose a breast to breast cancer are faced with not just the loss of a body part but also the loss of a body part which contributes to their femininity and sense of self, given the importance of the female breast to the female form and female function, in terms of breastfeeding, etc. Even though the surgical removal of a cancer-containing female breast (Mastectomy) is not as radical as it once was, even Subtotal Mastectomy, otherwise known as "Lumpectomy", still can leave in its wake a smaller, deformed female breast, particularly if such surgery is followed by external radiation of the breast which can promote further shrinkage and distortion.

Over the years inventive plastic surgeons have devised a number of techniques of breast reconstruction which singly or in combination can address virtually any post-mastectomy deformity, from the breast which is reduced by a "Lumpectomy" to the absence of a breast and even to the absence of a breast and underlying pectoral muscle, typical of those women who years ago underwent a Radical Mastectomy when that procedure was deemed to be the procedure of choice in treating breast cancer. These procedures, again individually or collectively, challenge the technical skills and artistic sensibilities of even the most experienced plastic surgeon and, as a result, for most plastic surgeons prove very satisfying. And, given the ability of one or more of these procedures to return a breast cancer patient to a sense of "wholeness", prove very gratifying as well.

Breast Reconstruction procedures attempt to restore a female breast by one of two ways, either by use of a state-of-the-art, saline-filled breast implant or by use of the patient's own tissues (primarily skin, fat and muscle) or, occasionally, by a combination of the two. An individual whose breast is reduced but not completely removed (for example, via a "Lumpectomy") may require nothing more than a breast implant to augment her reduced breast to a size which is comparable to that of her other breast. An individual who has undergone removal of an entire breast but is left with a redundancy of skin in the area that breast formerly occupied again may require nothing more than a breast implant to recreate a breast mound accompanied, or followed at a later date, by reconstruction of the absent nipple-areola. An individual who has undergone removal of an entire breast and is not left with any redundancy of skin in the area that breast formerly occupied may require what is known as "tissue expansion" (nothing more than a gradual stretching of the skin by an inflatable silicone balloon) prior to the use of a breast implant to recreate the breast mound.

All of the foregoing procedures certainly are satisfactory and, in fact, relatively simple solutions to the problem of a reduced or absent breast, particularly when one considers that most of them can be undertaken under "local" anesthesia (similar to that which a dentist employs to fill a decayed tooth) or "local" anesthesia supplemented by sedation via intravenous medication and, in any case, on an outpatient basis. These procedures tend to produce a relatively youthful looking breast which may not match the opposite breast, particularly in a mature woman whose breasts are ptotic (droopy) as a result of the loss of skin elasticity secondary to age, gravity, pregnancy, breastfeeding, etc. Consequently, while a mature woman who undergoes any of the foregoing procedures may be left with two breasts which are comparable in terms of volume, those breasts may not be comparable in terms of shape and/or position.

For that reason Breast Reconstruction employing skin, fat and muscle transferred from either the corresponding side of the back (known as the Latissimus Dorsi Musculocutaneous Flap) or the lower abdomen (known as the Rectus Abdominis Musculocutaneous Flap) may be preferable, since such tissues lend themselves not only to creation of a breast mound but also to shaping and positioning of that mound in a way which more closely approximates the shape and position of the opposite breast. Again, a corresponding nipple-areola often can be reconstructed at the same time or at a later date, which in fact is my preference, since delayed reconstruction of the nipple-areola allows the patient to participate in the choice of size and position of that reconstructed nipple-areola.

Occasionally the opposite breast requires a little "fine-tuning" in terms of either augmentation, reduction or lifting (otherwise known as Mastopexy) in order that the patient may be left with two breasts which are fairly symmetrical in terms of not only volume but also shape and position.

Given the availability today of mammograms and other sophisticated diagnostic tools, Breast Reconstruction in the appropriately selected individual really should not interfere with her cancer surgeon's or oncologist's ability to evaluate her relative to recurrence or metastasis (spread) of her original breast cancer.

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