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Reconstruction Do-Overs

BY KATHY LATOUR

For reconstruction redos, there are new techniques—and red flags.

Breast reconstruction has given women the option to replace a breast that has been removed because of cancer. But reconstruction techniques, like most medical procedures, have improved through the years for those who, for a variety of reasons, must have their old reconstruction redone.

In 1986, I chose to have my right breast reconstructed after undergoing a modified radical mastectomy with axillary node dissection at age 37. Since I faced four months of chemotherapy for stage 2 breast cancer, my surgeon suggested I not have immediate reconstruction at the time of surgery but wait a year to allow myself to finish treatment and be ready emotionally and physically to have the reconstruction.

The delayed reconstruction gave me time to research my options, and in the summer of 1987 I tried in vain to talk my carefully chosen, board-certified plastic surgeon into doing a transverse rectus abdominis myocutaneous (TRAM) flap that would move my abdominal muscle, fat, and skin, still attached to the blood supply, from my abdomen to my chest.

I wanted a TRAM flap for a couple of reasons. Using one's own tissue results in a breast that gains and loses weight along with the rest of the body, and, while we didn't know it then, studies show less risk of infection compared with using an implant. And the method would provide me a tummy tuck in the deal. But the surgeon took one look at the caesarean section scar from the birth of my daughter and said he would not cut across the scar because it would destroy the integrity of my stomach. Darn.

So, we went with the LD flap where the latissimus dorsi muscle is tunneled under the skin from the upper back to the chest wall. A small silicone implant was inserted under the muscle to increase the size of the breast, and, to make a long story short, after having the first implant replaced with a second model a year after surgery because of a hardening of the scar tissue (known as capsular contracture), having the left breast surgically lifted to match the right breast, and

having the areola and nipple tattooed, I had a nice replica of the real thing.

Choosing a Redo

Fast forward to fall 2007 when my annual mammogram and subsequent biopsy indicated I had ductal carcinoma in situ (DCIS) in my other breast. The location of the DCIS meant lumpectomy wasn't an option, so I scheduled a second mastectomy and met with a plastic surgeon to discuss immediate reconstruction—and some tweaking to my then 20-year-old reconstruction on the other side to remove an indentation above the breast that had always bothered me.

Because I wanted to update my old reconstruction, the discussion with my plastic surgeon was more complicated than just matching an existing breast. It also meant I was part of a small group of women who have a reconstruction redo.

A reconstruction redo can happen immediately or years down the road—and for any number of reasons. The woman may dislike the outcome, or the breasts no longer match because of age, the power of gravity, an implant rupture, or infection.

Every woman undergoing a reconstruction redo is unique, says John Canady, MD, president of the American Society of Plastic Surgeons and a professor of plastic surgery at the University of Iowa. “Obviously no two women come to primary reconstruction with the same issues,” he says, “and no two women come in for a redo with the same issues.”

Canady says redoing reconstruction is where “the artistic” comes in and each has to be considered on a case-by-case basis. He urges women to consult with experienced plastic surgeons in well-established practices, where they will find board-certified, skilled surgeons who have done a surgery numerous times. And, Canady says, get more than one opinion.

“It’s amazing to me how people will go to multiple places looking for a car but go to one doctor’s office when making a decision about something they will have to live with the rest of their lives.”

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My original plastic surgeon had retired, so I asked around before choosing William Carpenter, MD, at Baylor University Medical Center in Dallas. Carpenter says the majority of reconstruction redos he sees come from “implant malfunction,” meaning there is capsular contracture or the implant has ruptured.

“Another reason patients come in a long time after reconstruction,” Carpenter says, “is that the opposite breast has changed over the period of time, and they need some sort of a balancing procedure, either on the other side or on the cancer side where the reconstruction was done, or both.” He says he has had little trouble with insurance companies covering the redos.

Every case involves some customization, Carpenter explains, with some patients needing more skin, some needing more volume, some patients needing a bigger implant, others a smaller implant.

Carpenter examined my existing reconstruction and recommended a second back flap because it would give me the best match to the other breast. I also learned that the scar for this back flap would be about half the length of the first since I would be having a skin-sparing mastectomy, one of the advances that has allowed for a much better cosmetic result.

Basically, the tissue was removed through a circular incision about the size of a silver dollar around the areola. After the surgeon removed the tissue, Carpenter cut a similar size piece of skin from my back that, still attached to the muscle, was then tunneled under the skin to my chest wall. Under the muscle he placed an expander sack that was filled with fluid over a three-month period until the skin was stretched to accommodate the permanent implant.

During the second surgery, he put in the new implant on the left and opened the old reconstruction on the right, where he found that the old implant had ruptured and was “a mess.” He cleaned it out and replaced the old implant with the same type of implant he was using on the left. The teardrop shape would fill in the indentation that had bothered me for so long. The implants I chose were part of a clinical trial for a new cohesive silicone gel that one person described as having the consistency of a gummy bear, meaning that, unlike the old silicone gel implants, if it is cut, it doesn’t run like a liquid.

Carpenter says redos that involve scar tissue from surgery or capsular contracture present some significant challenges. Radiated tissue presents another set of problems because these patients generally don’t have implants, he says, meaning they have some sort of flap reconstruction and may need another flap in the redo.

New “free flap” procedures, meaning the tissue is completely detached from the blood supply from the stomach, hip, or buttocks and then reconnected with microsurgery, have provided surgeons additional options, but they take a very experienced surgeon because of the complexity of reattaching tiny blood vessels, Canady says.

For example, the deep inferior epigastric perforator (DIEP) free flap spares the abdominal muscles, taking only skin, fat, and blood vessels from the abdominal area. These new techniques “are thrilling,” says Canady, but the issue will be whether the insurance companies will fairly reimburse a 10- or 12-hour reconstruction. Again, Canady says to shop for the right plastic surgeon and not to feel you are getting something less if it’s not a multiple-hour microsurgery.

My second surgery gave me back the nice replica, but some infection issues delayed really enjoying them. It leaves me repeating my favorite mantra when it comes to breast reconstruction: It’s a lot harder to put it back on than it is to take it off.

—*Lacey Meyer contributed research to this article.*