June 2015 Ask the Expert: Breast Reconstruction

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EXPERTS: Karen M. Horton, MD, MSc, FRCSC

Understanding breast reconstruction options can help you to decide how you want to move forward, but the decision is complex and the choices can be hard to navigate.

In June, Living Beyond Breast Cancer expert **Karen Horton, MD, MSc, FRCSC**, answered your questions about breast reconstruction.

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— Question: What age is too old for breast reconstruction?

Dr. Horton: You are never too old to have breast reconstruction! As long as you are healthy enough to undergo a surgical procedure, you are fully informed about the options available to you, and you are willing to take time off from work, play and exercise for up to 6 weeks afterward, reconstruction can be done at any age! Some older women may opt for a less invasive option like placing an implant for reconstruction rather than a complex microsurgical flap reconstruction, and still other women might choose an external prosthesis in their bra. Surgery is not for everyone, but all women should be informed about their options.

— Question: It's been 14 years since my mastectomy, is it too late for reconstruction?

Dr. Horton: Reconstruction can be performed immediately or as a delayed procedure. I have reconstructed a breast in a woman over 35 years after her mastectomy! Some women might not feel ready for surgery at the same time their cancer is being treated. They can have an implant-based reconstruction, a flap or sometimes a combination of options at any time in the future, as long as they are healthy enough to undergo surgery and they have been fully informed about the risks and benefits, expected outcome and potential complications of a surgical procedure.

— Question: How often do implants have to be changed out? I've heard that it's supposed to be every 7-10 years. How risky is that procedure and what is the recovery time like?

Dr. Horton: There is a misconception that implants need to be switched out every 10 years. However, breast implants used for reconstruction or cosmetic breast augmentation are not like tires, and do not need to be changed every 10,000 miles or at a certain point in time! If a saline breast implant were to fail, it would become obvious as the body absorbs the saline and the breast slowly appears deflated. This is not harmful or risky, other than being asymmetrical until the implant is replaced. A silicone gel implant has a small failure rate, known as "rupture." However, as per one of the breast implant manufacturers, it takes more than 50 times the force of a mammogram to rupture a silicone gel breast implant! If there is a concern about a silicone implant, an MRI can evaluate whether it is intact or the shell has broken down; the fill material is cohesive and tends to stay inside the scar tissue shell, known as the capsule. I see my patients every year indefinitely after their implant is placed to ensure they are still looking good and feeling good, and to monitor their implants in the long-run.

— Question: Needing to have 23 lymph nodes removed, resulting in severe lymphedema, I decided not to have reconstructive surgery. Does reconstructive surgery worsen lymphedema? What if cellulitis has been an issue?

Dr. Horton: If you have lymphedema going into reconstruction, it cannot be worsened, but fluid shifts resulting from surgery may cause a temporary retention of fluid that might appear like a flare. If you have never had lymphedema, then any type of reconstructive surgery is extremely unlikely to cause lymphedema.

Radiation therapy to the axilla (armpit area), together with removal of many lymph nodes (there are usually around 30 in total on each side), increases the chance of lymphedema, which tends to be a chronic condition. If you have lymphedema already and have experienced infections such as cellulitis, then a tissue-based reconstruction like a microsurgical free flap may help to bring new circulation to the area and possibly improve the situation a little, but would certainly not worsen it. I would avoid an implant in the setting of lymphedema and recurrent cellulitis.

— Question: I had a lumpectomy by a general surgeon and I was not told I needed expanders if I wanted reconstruction after radiation. Is reconstruction possible at all now?

Dr. Horton: You can certainly have reconstruction after a lumpectomy and radiation! If your goal is to be slightly fuller than your current breast size, then usually a full-sized implant can be placed on the reconstructed side and/or a balancing implant on the other side to give you the results you want. Tissue expanders are not usually needed. Be sure to see a plastic surgeon who specializes in breast reconstruction, and who is comfortable treating radiated breast tissue! If you like the size of the breast that has undergone radiation but it is misshapen, then a "local tissue rearrangement" (breast lift) can be done to rearrange the remaining breast tissue and improve the shape and position of the nipple. Usually, a balancing breast reduction with a lift is done at the same time on the other breast for symmetry.

— Question: What are the pros and cons of implants vs. using tissue from my abdominal area? Does one involve more recovery time than the other?

Dr. Horton: Breast implant reconstruction is quicker to perform upfront and usually only involves a 1- to 2-night hospital stay. You should be able to return to most activities in around 4 to 6 weeks. However, an implant is a foreign body and requires ongoing lifetime maintenance, including implant massage, often preventative antibiotics, and it may require changing in the future if complications such as infection or capsular contracture (hardening of scar tissue around the implant) occur. Use of the abdominal tissue (a flap) generally is a longer surgery, at least 3 to 5 nights in the hospital and a 6 to 8 week physical recovery with two surgery sites (the breast area and the abdominal donor site). But once you are healed from a flap reconstruction, no additional surgery is needed and the results are permanent. A foreign body is avoided and it is the most natural, soft, warm, living tissue reconstruction possible at this point in time.

— Question: Does reconstructive surgery, or certain types of it anyway, makes it harder to find new or recurring cancer?

Dr. Horton: Having breast reconstruction does not affect detection of cancer recurrence or a new cancer in any way. If a new cancer occurs, it would be either in the skin (visible or palpable), or deep on the chest wall that would be detected by MRI, a PET scan or blood test. Fear of recurrence is not a reason to avoid breast reconstruction.

— Question: Can you have reconstructive surgery that only fills in the crater left from a radical mastectomy so your chest doesn't look caved in? I wouldn't mind just being truly flat rather than caved in.

Dr. Horton: It is possible to fill hollows on the chest wall by way of "lipofilling," or free fat grafting, which essentially involves harvesting fat by way of liposuction from the abdomen and inner thighs (most common donor sites) and injecting fat cells into the area that is deficient of volume. Since the fat cells are free-floating and do not have a blood supply, we rely upon the body to give these fat cells a new blood supply and allow them to survive. The rate of fat cell survival (also known as fat graft "take") is only around 30 percent in many instances. For this reason, multiple episodes of fat grafting spaced around 3 to 6 months apart are often needed to fill a defect.

— Question: I would love to hear more about the stem cell reconstruction that Suzanne Somers had. I had a lumpectomy and this sounds like it would be a great option for me. Have any major risks been noted and are the results as good as they sound? Is this something many doctors are able to do?

Dr. Horton: "Stem cell" procedures are currently under investigation and research is ongoing on how to isolate these progenitor cells from fat graft harvesting, whether they in fact do anything different than regular free fat grafting, and the FDA is also looking at this treatment and is considering trying to regulate stem cell transfer as a "drug." It is a hot topic in our professional society research meetings but it is not yet endorsed by our regulatory bodies and is not yet mainstream. Beware of treatments that are not offered by board-certified plastic surgeons who perform breast reconstruction - they are the best ones to advise you about your reconstruction options. If it sounds too good to be true …

— Question: Does reconstruction affect the range of motion of the pectoral muscles? Is there any loss of function after reconstruction (for example, I've heard that doing too many push-ups after reconstruction is bad)?

Dr. Horton: If implants are placed under the pectoralis major muscle, this can affect range of motion and create discomfort or a feeling of tightness. Some plastic surgeons tell their patients to stop doing pectoral muscle exercises altogether after this type of surgery. The vector of the pectoralis muscle is upward and outward, and implants sometimes want to migrate to a less natural position with muscle contraction. I doubt that doing push-ups would cause this to happen more quickly.

I am personally not a fan of putting implants under the muscle, both for cosmetic breast augmentation and for implant reconstruction – instead, I prefer to put them on top of the muscle. This may create some rippling (visible folds of the implant through the skin), but it avoids muscle-related problems. It's a trade-off that I discuss with my patients in detail before they decide on their best option for reconstruction.

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