A JOHNS HOPKINS PRESS HEALTH BOOK

THE COMPLETE GUIDE TO Breast Reconstruction

Choosing the Best Options after Your Mastectomy

FIFTH EDITION

Kathy Steligo

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JOHNS HOPKINS UNIVERSITY PRESS
BALTIMORE

Note to the Reader: This book is not meant to substitute for medical care of people with breast cancer, and treatment should not be based solely on its contents. Instead, treatment must be developed in a dialogue between the individual and their physician. Our book has been written to help with that dialogue.

Drug dosage: The author and publisher have made reasonable efforts to determine that the selection of drugs discussed in this text conform to the practices of the general medical community. The medications described do not necessarily have specific approval by the US Food and Drug Administration for use in the diseases for which they are recommended. In view of ongoing research, changes in governmental regulation, and the constant flow of information relating to drug therapy and drug reactions, the reader is urged to check the package insert of each drug for any change in indications and dosage and for warnings and precautions. This is particularly important when the recommended agent is a new and/or infrequently used drug.

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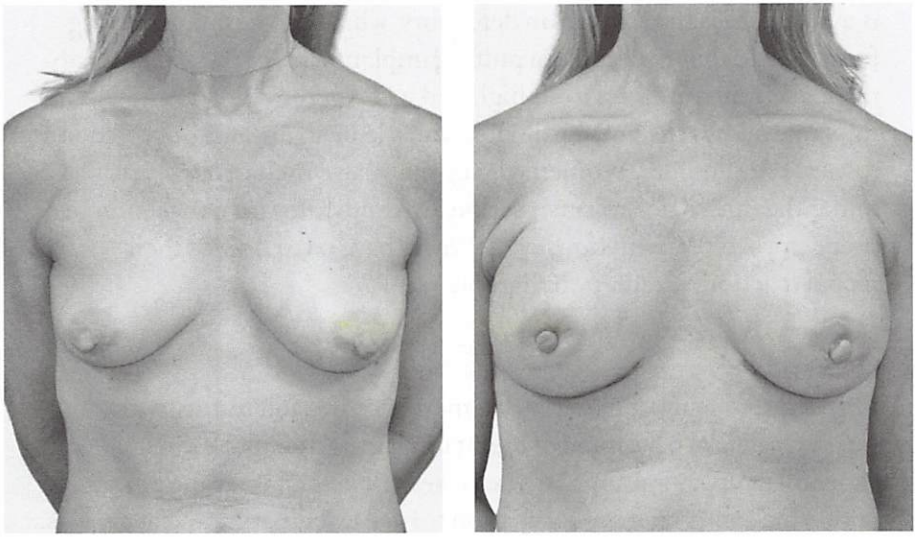
FIGURE 6.5 Before (*left*) and after (*right*) bilateral nipple-sparing mastectomy with immediate direct-to-implant reconstruction.



Images provided by PRMA Plastic Surgery, Center for Advanced Breast Reconstruction

— EXPERT INSIGHT —

Another Option with Implants

KAREN HORTON, MD, FACS

An alternative to tissue expansion and direct-to-implant reconstruction involves the placement of a smooth, round saline-filled implant that is permanent but postoperatively adjustable, giving patients control over their final results. Precisely matched to the dimensions of your breast, chest, and aesthetic goals, the implant can be placed prepectorally (on top of the muscle) in nearly every instance, allowing for a more natural look and shape. After surgery, just one or two saline fills, if any, are done in the office via an injection port that is left in place for three months after surgery. While an adjustable device gives you the option to keep the saline implant to avoid more surgery, most patients choose to switch to a more natural-feeling silicone implant after the swelling is gone and the port is removed.

When combined with a nipple-sparing mastectomy, this type of prepectoral breast reconstruction is completed within three months. The chronic tightness and pain that some patients experience is avoided, as is the animation deformity, which can be embarrassing for patients, that results from putting implants under the muscle. Submuscular implants tend to sit high and wide on the chest, as the implant follows the pull of the chest muscle in an up-and-out direction toward the shoulder. Women who initially have their implants placed under the muscle for reconstruction are candidates for conversion to a prepectoral reconstruction, even if years have passed since their reconstruction or radiation therapy.

I had risk-reducing, nipple-sparing mastectomies and reconstruction with prepectoral placement of breast implants. After much research, I chose the prepectoral approach because I felt it would give me the best option for continuing my occupations of yoga, acrobatics, and aerial arts. I did not want my pectoralis muscles moved as they are in subpectoral reconstruction. I am happy with my reconstruction. I am glad I do not have to do this again, but I would make the same choices. I was back at yoga, a bit wobbly, at seven weeks post initial surgery and three weeks after exchange and fat grafting. Are my reconstructed breasts perfect? No. There are some ripples when I bend over. Fat grafting has helped, but much of the fat has been resorbed. Is the appearance of my breasts better than the originals? Yes! Sensation is returning in my nipples, but they are always hard and the sensation is not pleasant. In a bra, bathing suit, and clothing, I look better than I did before surgery. More importantly, I can still do the things I love without pain, weakness, or animation deformity.

—Amy

I did not think I would be able to look in the mirror if I had no reconstruction, but I knew I did not want to have fat removed from other parts of my body and endure more scars and healing time. I wanted my reconstruction to be over and done; I did not want to have to go back for fills and more surgery. Then I discovered nipple-sparing mastectomy with direct-to-implant reconstruction. The surgery was minimal, and recovery was short. My procedure was a success; and three or four