

# Latest Options in Breast Reconstruction

By A.N. Mesbahi, M.D.

A recent article published in *The New York Times* pointed out that a stunning number of women undergoing operations for breast cancer never have discussions about breast reconstruction with their general surgeons. They cited a study published in the *Journal of Cancer* which found that only one third of these women had any type of discussion about their reconstructive options. Moreover, many times the full range of reconstructive options are not discussed either by general surgeons, or sometimes, plastic surgeons who may not discuss procedures they do not perform. Although women do not choose to have breast cancer, they can choose to have reconstruction and should, therefore, be fully informed.

Recovering from breast cancer can be a lengthy and difficult process. The emotional and physical toll that breast surgery, chemotherapy, or radiation therapy takes is well documented. However, breast reconstruction can be a fulfilling and rewarding step toward the journey to recovery. The first option encountered by a patient is whether to have reconstruction at the time of the lumpectomy or mastectomy (immediate) or after the surgery (delayed). Many women choose immediate reconstruction for the psychological benefits of restoring the breast.

In general, breast reconstruction falls into two categories: reconstruction with implants or reconstruction with one's own body tissue, also known as flap surgery. Sometimes a combination of the two may be used. The method chosen may depend on a patient's medical condition, breast size, and lifestyle. Generally, implant reconstruction requires shorter surgery time, a shorter hospital stay, and shorter recovery time. The surgery is typically performed in two stages in which a temporary balloon—like device known as a tissue expander is placed first. Three to six months later the final saline or silicone implant is placed. The tissue expander is filled with sterile saline (water) gradually during weekly of-



fice visits to stretch the skin and underlying muscle to re-create the breast mound.

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Flap surgery, although often requiring longer surgery times and recovery periods, has long been considered the “gold standard” in breast reconstruction. Because tissue from one's own body is used, the reconstructed breast looks and feels like a real breast. Common areas where tissue is transferred from include the abdomen, back, or gluteal region. In the past, flap surgery from the abdomen, known as a TRAM flap,

was associated with prolonged recovery times and the potential for permanent abdominal weakness because of the need to use the abdominal muscle tissue, the rectus muscle or abs.

Today, a more intricate procedure is available known as the DIEP flap, which transfers tissue from the abdomen but spares the entire rectus muscle. This is an ideal procedure for someone who exercises regularly or maintains an active lifestyle.

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Finally, a more recent trend has

emerged called “oncoplastic surgery” of the breast. When a lumpectomy requires a large amount of breast tissue to be removed, a significant deformity can result, particularly in women with small to moderate sized breasts. By applying oncoplastic surgery principles, the breast surgeon and the plastic surgeon work together during the same operation to safely remove any cancer and restore a pleasing cosmetic result, respectively. This may involve a type of breast lift or reduction on the side with the cancer and the opposite breast to create better symmetry.

Each year it is estimated that 200,000 women will be diagnosed with breast cancer in the United States. This high number may partially be attributed to early diagnosis and excellent breast cancer awareness. Similarly, it is important for breast cancer patients to be aware of all the reconstruction options and be well informed by knowledgeable breast/general surgeons and plastic surgeons.

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