Breast reconstruction: one size does not fit all

Breast cancer remains the most common cancer diagnosed within the UK, with a lifetime risk in women of one in eight (Cancer Research UK, 2014). Surgery is usually the initial treatment for breast cancer and depending on a number of factors, including the size of the cancer to the host breast, multi-focality or the extent of any in-situ disease, the clinical team may recommend that the woman has a mastectomy. Dixon and Thomas (2012) suggest that the total mastectomy rate is about 33% of all cases, and yet only about 21% of women actually undergo immediate reconstructive breast surgery. An additional 11% opt for a delayed reconstruction after completion of their treatment (Jeevan et al, 2011). This is despite the National Institute for Health and Care Excellence (2009) recommendations that a breast reconstruction should be offered to all patients unless significant comorbidities or requirements for adjuvant treatment preclude this. These figures seem low especially for a society where it could be suggested that breasts are exalted and highly symbolic of womanliness.

Literature and common-sense lead us to believe that the benefits for a woman of having an immediate breast reconstruction are many. The actual surgery is more straightforward when performed immediately at the time of a mastectomy as the breast skin envelope and inframammary fold are preserved which result in a better cosmetic outcome. If a woman has an immediate reconstruction, psychological adjustment may be easier and indeed it may be more straightforward for her to find clothing that suits. Indeed if a woman only has a mastectomy she would need to use a breast prosthesis in the bra to give the illusion of having two breasts and this may not only hamper her use of certain necklines but would also have implications to consider when wearing swimwear.

The reason for the low reconstruction uptake rate may be multi-fold. It could reflect some units not offering these reconstructive procedures, or maybe the woman not wanting to undergo more extensive operations at the time of the initial breast cancer diagnosis. Being diagnosed with a potentially life-threatening disease may impede decision-making and it is up to the health-care professional to pitch the information at the correct level, ensuring the woman has the salient points in order to understand the consequences and implications of treatment offered and choices within this.

The loss of a breast can prompt a vast spectrum of feelings. Some may feel distraught and overwhelmed, while others may be more concerned about being diagnosed with cancer and less concerned that their breast needs to be removed. There certainly are no rules regarding patients disclosing feelings to their health-care team; some choose to unveil much, while others use alternative channels for this. The team should endeavour to communicate with the patient and assist as appropriate, referring on to other avenues of support where necessary.

If a breast reconstruction is performed, further operations may be needed either to replace the implant, if this has been the technique opted for, or the woman may wish for her natural breast to be uplifted as often breast reconstructions can appear more youthful looking. Moreover if there are differences in the size of the natural breast and the reconstructed breast the woman may face additional surgery for reduction or possibly augmentation of her natural breast.

The decisions or possible need for further alterations to the breasts should be discussed with the woman and certainly that the reconstructed breast will usually not have a nipple. This is for oncological reasons, but women do have the option and choice of a nipple reconstruction operation. It is customary for this to take place at least 6 months post initial breast reconstruction as swelling will have reduced, making it easier to place the nipple symmetrically to the one on the natural breast. Patients may then request nipple tattooing, as the reconstructed nipple will initially be the same colour as the rest of the skin. The reconstructed nipple can be tattooed using pinks and browns to match the natural breast. If nipple reconstruction is deemed unnecessary, prosthetic nipples are available via hospital prosthetic departments or from certain specialist shops.

Which technique?

A number of different techniques can be used when reconstructing the breast mound. Some breast reconstructive operations use implants, while others either use a combination of implant and the woman's own tissue, or solely her tissue. There are a number of factors that influence the choice of surgery and correct patient selection for these operations is imperative in order that a good match is achieved.

Tissue-only reconstructions are becoming more common and these will enlarge or shrink as the woman gains or loses weight. They also tend to look more natural than implant-based reconstructions as ptosis is more easily achievable. However, some of these procedures involve extensive operations, especially the method where the abdominal tissue along with its blood supply is harvested and a part of the rib is removed to facilitate microvascular surgery. This enables blood flow to be established in the reconstructed breast. Some women favour this procedure as although it leaves an extensive abdominal scar, the stomach area is much flatter than before. Clearly as the reconstructive technique becomes more extensive, rates of complications such as flap loss or infection become greater, although on the whole if performed by skilled surgical teams, these risks remain relatively small.

The potential need for adjuvant treatment should also be discussed. There is much debate in the literature as to whether radiotherapy should be delivered post

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breast reconstruction. While we understand that this treatment may cause capsular contracture and reduce the cosmetic appearance of implant-based reconstructions it is not clear whether this treatment impacts tissue-only reconstructions. If chemotherapy is recommended then the team may wish this to be delivered preoperatively, thus avoiding any potential delay in starting this treatment because of the extended recovery time.

Managing expectations

Breast reconstructions are becoming more realistic and are involving more ambitious operations that impact on the patient and the health-care professional's time. The use of photographs preoperatively can ensure the patient has realistic expectations of what her reconstructed breast will look like. For some the notion of breast implants may produce images of cosmetic surgery rather than oncoplastic surgery where the primary aim is to treat the cancer.

Conclusions

These reconstructive operations are only the beginning, and we must communicate efficiently and effectively with patients undergoing these procedures in the limited time we have before they start their cancer treatment. We should not forget that the focus must be the patient and we must strive to give individualized quality care in partnership with them, as they dovetail with their chosen support structures. BJHM

Victoria Harmer
Team Leader and Clinical Nurse Specialist
Breast Care Unit
Imperial College Healthcare Trust
Charing Cross Hospital
London W6 8RF
(Victoria.Harmer@imperial.nhs.uk)

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KEY POINTS

- There is a low national uptake for immediate breast reconstructions in the UK (21%).
- Implants and the patient's tissue can be used to reconstruct a breast.
- The decision about whether a breast reconstruction should be offered to a patient and which technique to use should be discussed at the multidisciplinary team meeting.
- Health-care professionals should ensure the patient has all the relevant information preoperatively.
- It is common for further operations be performed in order to exchange implants, gain better symmetry or to complete the reconstruction by reconstructing a nipple.

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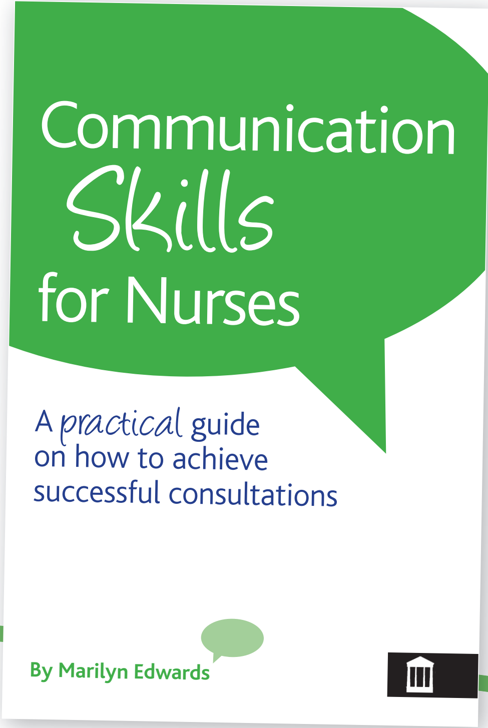

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