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From spare parts via goldilocks procedures to total autologous post mastectomy breast reconstruction with large loco-regional flaps

Introduction: Despite advances in the understanding of local control in breast cancer, some patients fit criteria for a bilateral mastectomy and post-mastectomy radiation to at least one side. Various methods currently exist for immediate reconstruction in this setting, most routine of which are autologous regional flaps or free flap surgery from the abdomen or the buttocks. Patients who wish to avoid the extended surgery and recovery periods of these long autologous reconstructions may require a delayed reconstruction. However using this novel approach, a small breast mound can be reconstructed at the time of the oncological surgery with minimal increase in the complication rates and a moderate increase in the operative time when compared to a bilateral type 4 skin and nipple sparing mastectomy without a reconstruction.

Aim: This paper is a retrospective review of 43 consecutive cases from the Netcare Breastcare Centre of Excellence in Johannesburg South Africa.

Materials and Methods: This study reports a series of 43 patients in which an oncological type 4 skin-sparing mastectomy was performed followed by an immediate autologous reconstruction. The reconstruction used the remaining mastectomy flaps as well as large perforator-based local regional flaps from the sub-mammary area [based on the sub-mammary adipo-fascial perforators] as well as from under the arm [based on the lateral thoracic artery and lateral intercostal perforator vascular territories].

Results: 43 Patients with an average age of 57.6yrs underwent a total of 84 Type 4 SSMs for 48 cancers and one patient requested this reconstruction after risk reducing mastectomies. The mean follow up was 387days [655-203]. 5 patients were smokers and 9 patients had a BMI>35. The staging of this group of patients ranges from TisN0 through to T3N2 disease. 31 tumours were invasive ductal carcinomas, 12 tumours were invasive lobular carcinomas, 2 tumors were mixed tubule-lobular variants and 3 were DCIS. Of the 84 mastectomies performed on 43 patients, 41 patients had bilateral mastectomies and 2 had a unilateral mastectomy with an opposite side matching procedure. Skin sparing mastectomies were performed in 36 breasts and nipple and skin sparing mastectomies were performed in 48 breasts. The average mastectomy mass was 559g [160g-1446g]. 7 patients required neo-adjuvant chemotherapy, 14 patients required adjuvant chemotherapy and 16 patients required radiation. The reconstructions included 8 pure Goldilocks reconstructions, 2 Goldilocks with LICAP, 7 Goldilocks with LICAP and Sub-mammary adipo-fascial flaps [SMAF] and the remaining 67 breasts were reconstructed with a Goldilocks and turnover SMAF flaps. 6 patients, all smokers or with a BMI>35 required debridement and closure for wound healing problems and minor flap necrosis. 4 patients required prolonged dressings for wound healing issues and wound sepsis. Cosmetically, patients were generally happy with their outcome and only 8 requested further procedures. 7 of these patients were improved cosmetically with lipo-filling and 1 patient with implants.

Conclusion: Despite only reconstructing a small to moderate volume breast mound, the aesthetic sub-units of the breast are maintained and positioned in the correct place. The complication rates are acceptable even in high risk patients. The aesthetic outcomes are good and most patients were happy with their reconstruction. Should the aesthetic issues of decreased volume be an issue for the patient, this can easily be addressed by increasing the breast volume with autologous fat grafting or an implant at a later stage.

Biography

Dr Charles Serrurier is a dedicated breast reconstructive and cosmetic plastic surgeon at the Netcare Breast Care Centre of Excellence, situated at Netcare Milpark Hospital. He is registered with the Health Professions Council of South Africa (HPCSA) as a plastic and reconstructive surgeon and is a member if the Association of Plastic and Reconstructive Surgeons of Southern Africa (APRSSA) and the International Society of Aesthetic Plastic Surgeons (ISAPS).Dr Serrurier obtained his medical degree from the University of the Witwatersrand (WITS) in Johannesburg and qualified as a plastic surgeon in 2008. Thereafter he headed the plastic surgery department at Helen Joseph Hospital for five years. During this time, he had a small private practice but concentrated on honing his breast reconstructive skills in the academic environment. Considered as one of the leading breast reconstructive surgeons in South Africa, Dr Serrurier has presented his breast reconstructive work at both local and international congresses. He remains involved with academic practice and lectures and trains plastic surgeons in advanced breast reconstruction.

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