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Bia-Alcl – attention, but no panic

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Breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) was first reported in 1997. It is rare peripheral T-cell lymphoma that can develop around breast implants with increasing incidence but highly treatable. BIA-ALCL occurs most frequently in patients with textured surfaces breast implants as no cases are reported with the sole use of smooth implants. Regarding some statistics differences in data from different countries, the lifetime risk of develop a BIA-ALCL after receive a breast implant is 1 in 30,000 patients with textured implants. The latest U.S. Food and Drug Administration (FDA) updated is from March 2017 and has reported 359 medical device reports (MDRs) related to breast implants and ALCL but MDRs are not individual cases (duplicate reports and unconfirmed cases suspicious).

Diagnosis: BIA-ALCL most commonly presents as a swollen breast caused by a delayed unilateral seroma (>1 year since implant placement), and with a capsule that looks itself entirely normal. If there is a suspicion investigation should begin with ultrasound guided aspiration of the seroma. The fluid is sent for analysis: immunohistochemistry, cytology, culture and flow cytometry. CD30 is the main diagnostic test since BIA-ALCL can only be confirmed if it is found in association with the implant capsule or within the effusion and immunohistochemistry as being CD30 positive and ALK negative. If surgical exploration has been carried out, fresh

seroma fluid and the capsule should be sent for cytology and histopathology to rule out BIA-ALCL. Any abnormal breast mass associated with an implant should be biopsied and analysed. Patients diagnosed with BIA-ALCL should have a PET-CT to exclude regional or systemic spread. Any abnormal lymph node in axilla should be excised whole for histology as fine needle aspiration cytology is inaccurate.

Treatment: Most patients have capsule confined disease being the treatment a complete capsulectomy and implant removal. Advanced disease (lymph node or organ metastasis) may require chemotherapy (CHOP anthracycline based-protocol or targeted therapy with brentuximab vedotin). Radiation therapy is only reserved for local unresectable disease (chest wall or mediastinum).

Prognosis: FDA data shows 93% of disease free patients at 3 years follow-up. Overall survival rate is 89% at five years. Survival is significantly higher for patients with Stage I disease with treatment. The number of known deaths worldwide is 16; 13 patients died from direct extension of the cancer and 3 indirect causes.

Surveillance: clinical follow-up at least every 3 to 6 months for a minimum of 2 years, with imaging no more often than every 6 months.

Biography

Dr. Marcio Wallace is a plastic surgeon graduated at INCA – National Institute of Cancer in Rio de Janeiro, Brazil. And a member of SBPC (Brazilian Society of Plastic Surgery) and ISAPS (International Society of Aesthetic Plastic Surgery), who has been working primarily with aesthetic surgery and especially, breast augmentation with silicone implants covered by polyurethane.

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