News
The University of Texas Health Science Center at Dallas
5323 Harry Hines Boulevard Dallas, Texas 75235 (214)688-3404

June 10, 1980

CONTACT: Susan Rutherford
Office: 214/688-3404
Home: 214/349-7820

*****Breast reconstructive surgery offers hope to the cancer victim.

DALLAS--Breast cancer surgery is often physically mutilating. Added to this, it can be emotionally devastating.

For women anxious to get back into the mainstream of life, new breast reconstruction surgery techniques offer hope. An increasing number of these patients are testifying to the emotional rehabilitation that breast reconstruction can bring.

"We can't restore a normal breast," says Dr. Fritz E. Barton, a recognized authority in cancer reconstructive surgery. "But the question is whether having an artificial breast is better than having none."

Barton, professor and newly appointed chairman of the Division of Plastic Surgery at Southwestern Medical School, stresses that those women considering breast reconstruction should not look for miracles from their plastic surgeon. Yet he says that often women do think they look better and feel better with an artificial breast.

Breast cancer surgery--specifically the mastectomy--is in anybody's terms both mentally and emotionally debilitating.

For many women, the primary concern after a mastectomy is a feeling of lost femininity. The absence of a breast with its unsightly scar leaves them feeling less attractive, less a woman. Some fear undressing in front of their husbands, opting instead to wear a bra both day and night.

Other women, aware of the fact that breast cancer is the most common killer of American women and that their lives have possibly been shortened by the disease, are more preoccupied with the fear of dying. In 1979 there were approximately 106,000 invasive breast cancers diagnosed in this country. And while the death rate for some other cancers has dramatically decreased in the last 50 years, the incidence of death from breast cancer has remained basically the same. The probability of a newborn girl in the U.S. developing invasive breast cancer during her lifetime is 9.4 percent, or approximately one out of 11.

For all breast cancer victims who undergo breast removal as part of their cancer treatment, reconstructive surgery can symbolize a return to normal--almost like being whole again.

And now many medical insurance companies are opening up that possibility to more and more women by classifying the surgery as rehabilitative rather than cosmetic. Expense of the surgery ranges from $1,000 to $6,000.

Barton explains that better surgical results from improved techniques and modern prostheses are encouraging increasingly more women to opt for the surgery. Early procedures using tissue taken from other parts of the body and "walked" to the breast area through many operations with many scars, are now obsolete. So are the old techniques leaving the patient with a "tennis ball" look and feel. The results of earlier procedures were often complicated by a tough scar tissue that would develop around the implants. And inadequate skin would not allow the new breast to "drape" properly. Instead breasts were firm and lacked natural motion. The reconstructed breast would often look like the patient was standing up when she was lying down.

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It was only three years ago that the first operation was performed utilizing rediscovered surgical techniques plus modern prostheses. Barton says that criticisms from patients and surgeons of early reconstructions were "probably legitimate and were fair aesthetic assessments." The standards in the early 70s were first to get the body to retain the prosthesis and then to get the new breast mound to look good with clothes, as a convenient internal prosthesis to substitute for an external one.

"The patient had to go through a lot for basically unimpressive results," says Barton. "But now with new techniques we're talking about something altogether different. Our standards of acceptability have changed and our goals are much higher. Now we're talking about an aesthetically reasonable option both in and out of clothes, not just something to fill a bra. The appearance out of clothes, the texture and feel are now reasonably close to normal."

The improved surgical techniques being used today were actually devised by a doctor named Tanzini around the turn of the century. Barton says we have had to rediscover Tanzini's work. Tanzini lived at the same time as Halsted, the physician who developed the radical mastectomy which has saved countless lives. Public enthusiasm for Halsted's monumental achievements in curbing the death rate from breast cancer buried Tanzini's reconstructive work.

Barton and other plastic surgeons place emphasis on treating the disease before reconstruction is contemplated. And Barton stresses the necessity of a delay between the time of most mastectomies and of breast reconstruction. This is especially true when the patient has been given a poor prognosis--50 percent of those with invasive breast cancer will have a recurrence and 75 percent of all recurrences happen within the first two years. Also, the reconstruction should be postponed if there are any difficulties in wound healing after the mastectomy, or if the patient needs chemotherapy or radiation therapy as treatment for the disease.

The type of reconstruction largely depends upon how extensive the mastectomy was and on how much skin and muscle remain after the cancer surgery. A modified radical mastectomy, used most commonly, involves removal of the breast tissue, some overlying breast skin (including the nipple area) and the removal of lymph nodes under the arm. For those patients having radical (or Halsted) mastectomies, the same thing holds true. But this operation is generally more deforming since it includes removal of underlying chest muscles as well.

The reconstruction procedure is relatively simple for those women with adequate muscle tissue remaining for breast bulk and padding, and with adequate skin for stretching over an implant. The implant, which is a plastic sac filled with silicone gel or saline solution, is inserted under the chest muscles, and the skin is carefully stretched over the new breast mound.

While this situation is ideal and requires minimal reconstruction, most women tend not to fall within this category. This is where Tanzini's techniques, unearthed in 1977, come into the picture.

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Barton explains that on a person's back is a muscle which is the mirror image of the pectoralis major muscle removed in a radical mastectomy. The surgical procedure involves detaching most of the back muscle, the latissimus dorsi, while leaving it still attached under the arm so that the muscle can retain its blood supply. Then it is pulled around in front, going under the skin of the underarm area, and positioned where the pectoralis major was. Since additional skin is usually needed to cover the new breast mound, an elipse of skin is carried with the muscle from the patient's back and is added to existing skin in front. The implant is placed under the muscle and the final stitches are made. Often this can work in a one-stage operation.

Some patients decide to stop after getting only a breast mound. Yet a nipple reconstruction is possible also. This usually requires at least one more operation.

Depending on the pigmentation of the other nipple ("symmetry is beauty," says Barton), a nipple and areola can be grafted either from the ear lobe and behind the ear, or from the upper thigh area or from the vulva. Or the nipple from the remaining breast can be shared to form two. Technically, the nipple is only the protruding part while the areola is the circle of skin surrounding the nipple. When, for example, the ear is used, a nipple can be made by taking a piece of tissue from the ear lobe and the areola can be constructed from a circle of skin taken from behind the ear.

One of the primary considerations of the plastic surgeon is to keep the tissue alive after it is reshuffled to another part of the body.

One procedure which is not routinely used involves carefully removing and "banking" the patient's own nipple area after a mastectomy. The banking is done by grafting the nipple complex onto the groin. Here it will stay until it can be repositioned at the time of reconstruction. This is a way of keeping the tissue alive while the mastectomy wound is healing and the patient is given time to watch for a recurrence.

Barton cautions that this procedure should only be used in carefully selected patients, however. "A cancer cell is like a seed," he says. "It can be planted anywhere in the body and will grow. And it's highly conceivable that the nipple can retain cancer cells and transplant them onto the thigh."

As to the outcome of the reconstructive surgery, Barton tells his patients that "a great deal of it is out of our hands. Some breasts drape just right, some are less gracefully draped. Everybody's tissue behaves differently. You perform the operation ten times and the results will look very different each time."

And he says he must sometimes discourage a patient from having reconstructive surgery because her motivations are not realistic. "If a woman's husband won't sleep in the same bedroom with her and she wants to get the surgery to enhance her sexual appeal, the question is 'Will the semblance of a breast solve her marital incompatibility?' If she feels as though it will, I will probably be reluctant to operate. We have to make a reading of the woman's expectations to see if what the patient is seeking can possibly be delivered.

"The patient should not expect the breast to be like a natural breast," says Barton. "Her choice is to stay the way she is or to have an artificial breast. But artificial is not necessarily bad. Makeup, clothing, haircuts--we live with artificial all the time. And we do it because we look better that way."

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