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INVITED COMMENTARY

Breast cancer following augmentation mammoplasty – a review of its impact on prognosis and management

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This review article¹ draws attention to an important clinical scenario that we are increasingly facing. Unfortunately no consensus on management exists or on the exact advice to be given to women prior to having breast augmentation procedures. Fortunately the literature supports no worsening of breast cancer prognosis in patients with breast implants. It is important to be able to reiterate such facts to patients. However, it remains more difficult to perform mammography with a silicone or saline implant in place and for some women (particularly those with strong family history or gene carriers) this is a potential cause of anxiety and should be fully explored.

The review explores the question of management of this patient group and particularly the role of breast-conserving surgery. Radiotherapy following wide local excision has a high risk of capsule formation. This problem is explored in a number of the articles each quoting differing levels of marked capsule formation and negative cosmetic effects. Some variation in effects may be due to the way the radiotherapy is planned and delivered (use of smaller fractions) as well as inherent patient differences. Due to these problems a number of articles discuss the role of mastectomy and total reconstruction even in tumours suitable for breast-conserving surgery. This has obvious merit, and is a treatment plan we employ providing it will negate the need for radiotherapy. This approach is

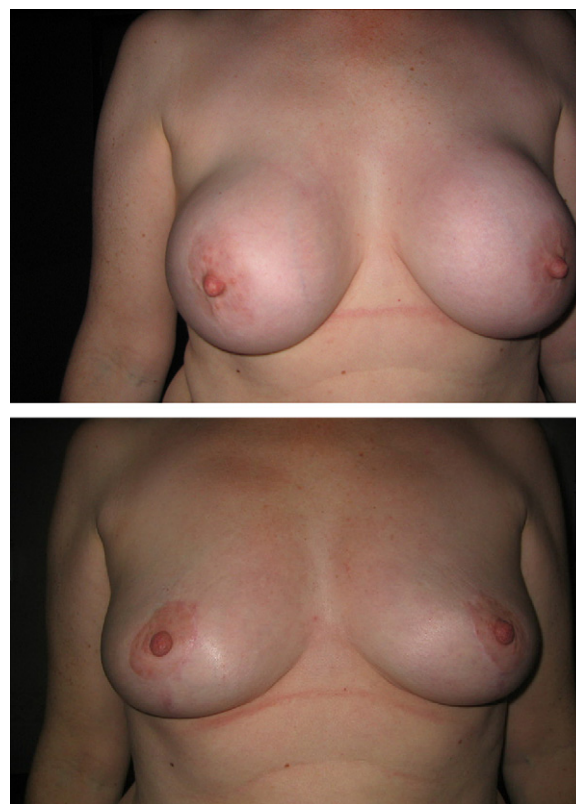


Figure 1 Removal of 280 ml implants and vertical mastopexy leaving adequate breast tissue for reshaping of the breast.

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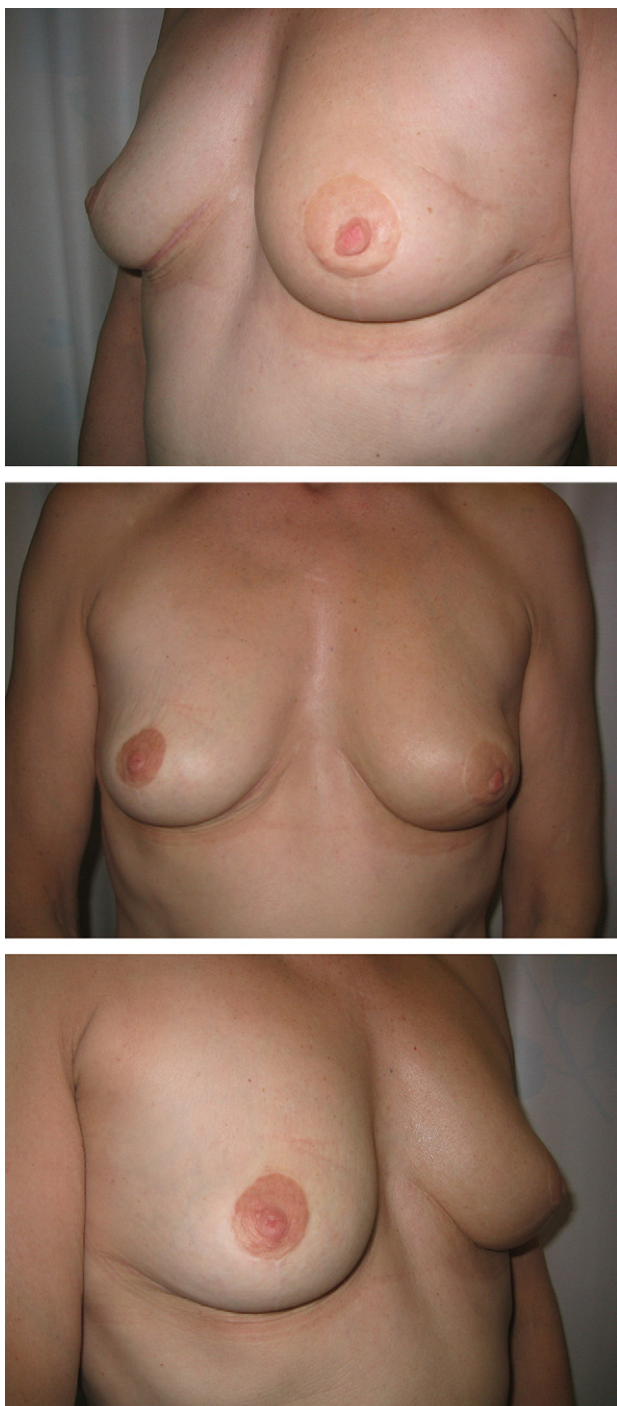


Figure 2 Post operative and radiotherapy views following implant explantation and therapeutic mammoplasty. This slender patient presented following a wide local excision for invasive cancer in the left breast. She had 300 ml silicone implants. She required further excision or mastectomy. The excision was performed by therapeutic mammoplasty with removal of both implants. Although some asymmetry remains in this most difficult of cases an acceptable outcome is attained.

particularly worth considering when the patient is very slender with little breast tissue. Problematic capsule formation is more likely to be cosmetically obvious and the revision options are more limited.

Some patients will express a strong preference for leaving the implants in place. Although acceptable to do so, it should be remembered that if the patient develops a problematic capsule the only reliable option available is simple removal or an autologous reconstruction. Capsulectomy and replacement is prone to a high capsule rate and the ability to remove and perform a mastopexy safely is hampered by the radiotherapy.

We feel that breast-conserving surgery does remain a good option for a number of these patients. Some of these women have changed weight since their implants were placed, often many years prior, and may have developed some inherent laxity of the breast tissue. Others had a moderate breast volume even prior to implant placement. These factors often allow the surprising creation of a breast of acceptable form and size upon removal of the implants (Fig. 1). Careful assessment of laxity and breast volume is feasible with the implant in place to allow patient selection. The use of oncoplastic techniques such as therapeutic mammoplasty² (Fig. 2) then becomes highly feasible. This has not been discussed in this article. We believe this route should be sought and discussed whenever possible as it removes the risks of implant capsule and subsequent surgical revisions. It allows the reshaping of the breast (in this highly cosmetically conscious group) prior to radiotherapy, may give the best chance of symmetry long term while maximising the ability to remove a tumour with an adequate margin.

References

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