

Bilateral Mastectomy Reconstruction in the Previously Augmented Patient

TO THE EDITOR:

I was delighted to read the article by Drs. Spear, Clemens, and Dayan on “Considerations of Previous Augmentation in Subsequent Breast Reconstruction” (*Aesthetic Surg J* 2008;28:285–293). This is a particularly timely and relevant article, because we have entered into an era in which a large number of women who have undergone breast augmentation have matured into the age group that has a high percentage of breast cancer. Plastic surgeons are increasingly treating those patients with breast cancer who have been previously augmented.

The current article is a retrospective review of the senior author’s experience in 32 patients undergoing breast reconstruction subsequent to breast augmentation. They suggest that a higher percentage of breast cancer is detect-

ed mammographically in those with subpectoral augmentation versus subglandular placement, but this was not statically significant because of the insufficient population size. They also show that there is no delay in cancer detection. Both concepts have been previously demonstrated. Their experience with reconstruction appeared to use the standard spectrum of reconstructive techniques used in non-augmented patients. It is clear from the authors’ perspective that breast conservation therapy with or without radiation therapy yields a poorer aesthetic outcome. This is an opinion that I share.

I have taken a more aggressive stance to breast reconstruction in the previously augmented patient.¹ The lifetime rate of developing a contralateral breast cancer is around 15%, and this is similar to those patients with duc-

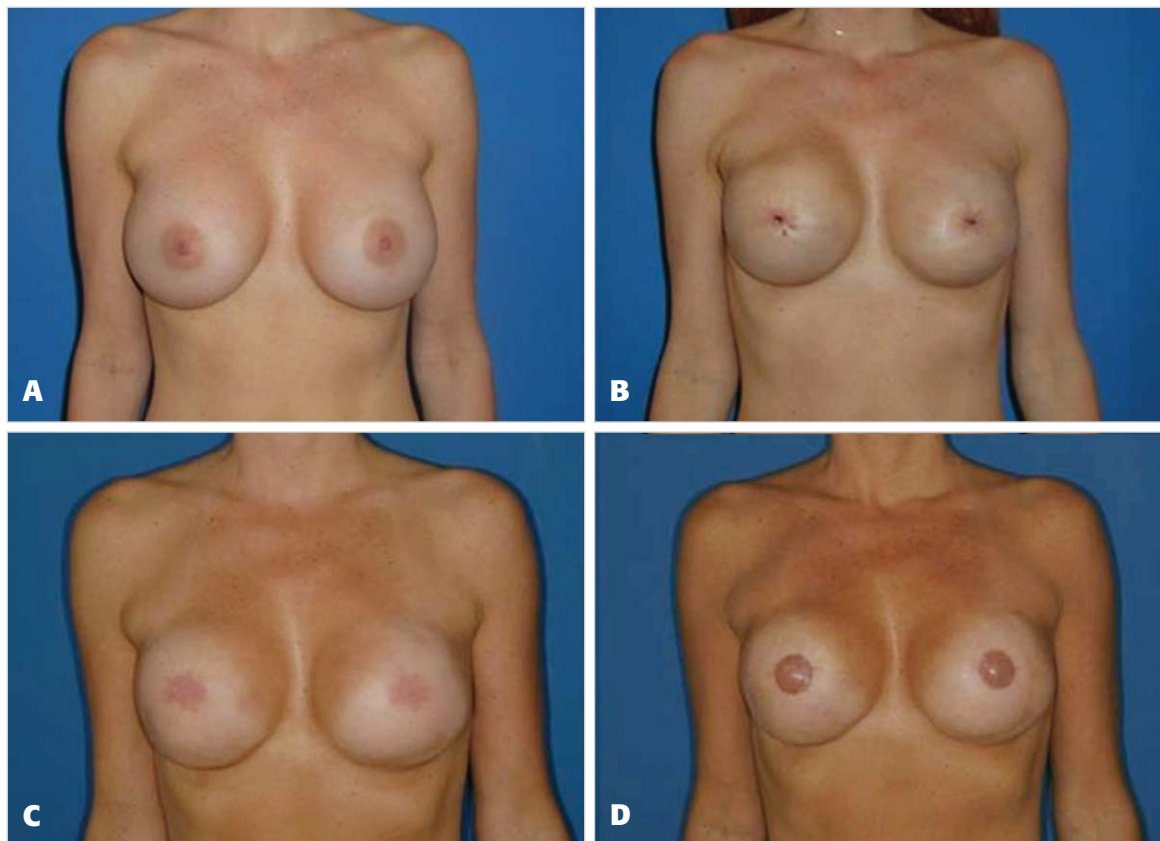


Figure 1. **A**, Preoperative view of a 37-year-old woman who was diagnosed with invasive ductal cancer in the right breast 5 years after undergoing subpectoral breast augmentation. **B**, Postoperative view 1 week after bilateral skin-sparing mastectomies and immediate reconstruction with replacement of saline implants with Inamed Corp. (Santa Barbara, CA) style 45 400-cc silicone implants, bilateral medial capsulotomy, bilateral lateral/inferior capsulorrhaphy, and Sun flap closure. **C**, View 3 months postoperatively. **D**, View 1 week after nipple-areolar complex tattooing (from Chasan,¹ with permission).

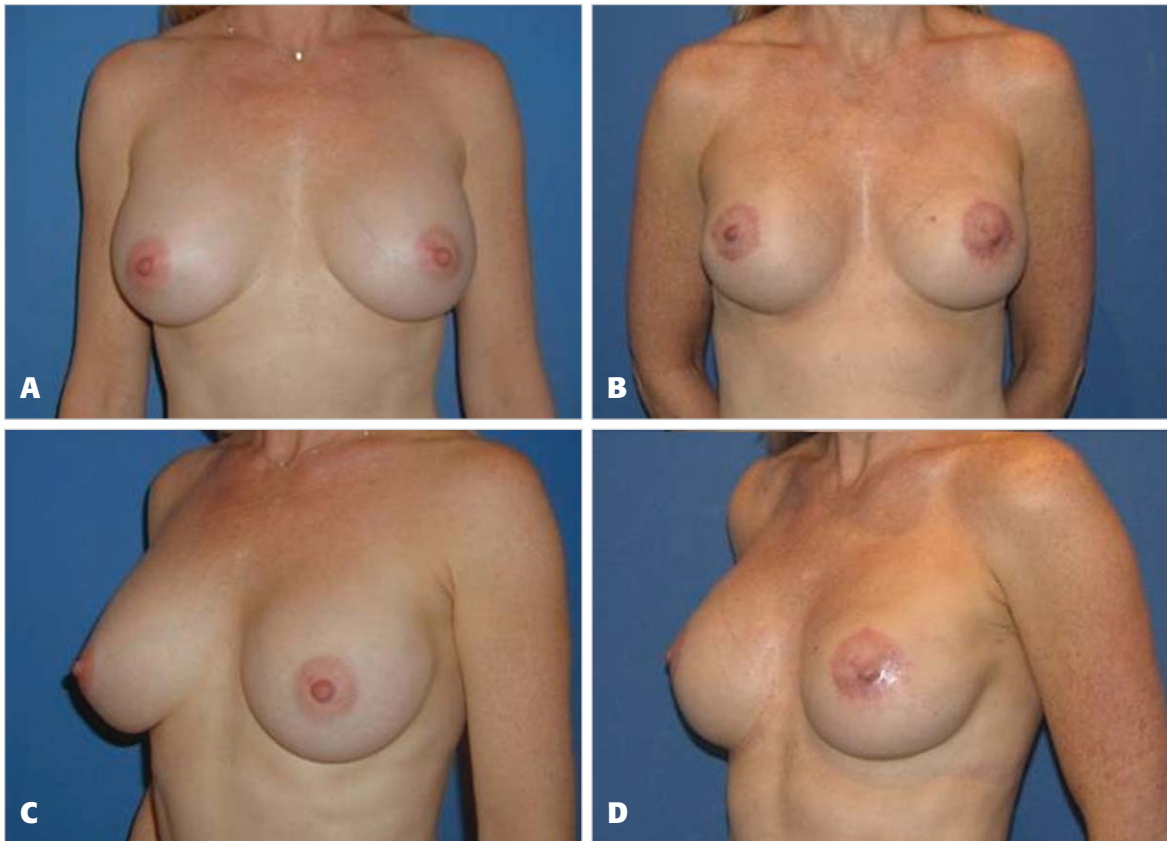


Figure 2. **A, C,** Preoperative views of a 45-year-old woman who had undergone subpectoral breast augmentation in 1999 followed by reaugmentation with 325-cc saline implants filled to 340 cc in 2000. She was diagnosed with ductal carcinoma in situ in the left breast. **B, D,** Postoperative view 8 weeks after subpectoral bilateral nipple-preserving mastectomies, replacement of saline implants with 375-cc style 20 Inamed Corp. (Santa Barbara, CA) silicone implants, bilateral medial capsulotomy, bilateral lateral/inferior capsulorrhaphy, and circumareolar mastopexy.

tal carcinoma in situ (DCIS).² Otherwise stated, women with a first primary breast cancer are at a 2- to 6-fold increased risk of developing contralateral breast cancer compared with the risk in the general population of women developing a first primary breast cancer.³ Bilateral skin-sparing mastectomies are performed in most patients (Figure 1). In those with DCIS, we perform bilateral nipple-areola preservation (Figure 2). If the implant is subpectoral, a medial capsulotomy is performed, often in conjunction with a lateral capsulorrhaphy to replace the deficiency of tissue medially.^{4,5} If the implant is subglandular, the pectoralis major muscle is elevated and an AlloDerm sling (LifeCell Corp., Branchburg, NJ)^{6,7} is used. A concomitant mastopexy is performed if needed. This approach has produced the finest quality aesthetic result.

One of the principal challenges in obtaining an optimal result in breast reconstruction is fostering interest and enthusiasm among general/oncologic surgeons in obtaining superior cosmetic outcomes. This requires familiarizing our colleagues with the fact that a skin-sparing mastectomy does not increase the rate of recurrence, and also with the concept of performing a mastectomy through a smaller incision.

I applaud Dr. Spear and his co-authors for presenting a topic that is so timely.

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DISCLOSURES

The author has no disclosures with respect to this letter.

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