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Oral Abstracts for the 1st British Breast Cancer Research Conference

O-1 BREAST SKIN ENVELOPE NECROSIS AFTER SKIN SPARING MASTECTOMY AND IMMEDIATE BREAST RECONSTRUCTION – HOW COMMON IS IT?

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Aim: To establish the incidence of necrosis of the breast skin envelope after skin sparing mastectomy (SSM) and immediate breast reconstruction (IBR) and investigate the possible contributing factors and management of this complication.

Methods: This was a retrospective study of 59 patients who underwent SSM and IBR.

Results: Sixty-five SSM and IBR were carried out in 59 patients including 6 patients who had bilateral operations. Type of reconstructions included autologous only in 43 cases (ELD-28 and TRAM-15), autologous with implant in 18 and implant only in 4 cases.

Necrosis of the breast skin envelope was seen in 12/65 cases (18%). Skin necrosis was 50% (6/12) in smokers compared to 11% (6/53) in non-smokers. Fifty percent of patients who had type 4 (reduction pattern incision) SSM developed skin necrosis compared to 12% for type 1 (circumareolar incision) SSM. 4/5 (80%) patients who were smoker and had type 4 SSM developed skin necrosis. There was no significant difference in BMI, weight of the breast and grade of surgeon between the necrosis and non-necrosis group. Ten patients (84%) were managed conservatively and only 2 patients needed debridement and closure in theatre. The average time for the area of skin necrosis to heal was 8 weeks.

Conclusion: Breast skin envelope necrosis was noted in 18% of SSM and IBRs. Most patients can be managed conservatively. However patients should be adequately counselled preoperatively about this complication and the long time taken for it to heal. The risk is particularly high in smokers and patients having type 4 skin sparing mastectomy.

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O-2 SKIN REDUCING MASTECTOMY AND IMMEDIATE RECONSTRUCTION: THE EFFECT OF RADIOTHERAPY ON OUTCOME

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Aim: Skin reducing mastectomy and implant reconstruction (SRMIR) is an emerging breast reconstruction technique. The de-epithelialised inferior skin flap of a 'wise' pattern mastectomy is sutured to the lower border of the pectoralis major muscle, providing a vascularized envelope for the implant.

We aimed to assess patient satisfaction following SRMIR and to determine if radiotherapy affected outcomes.

Method: A prospective database of consecutive women undergoing SRMIR was analysed. Demographics, treatment and complications were recorded. A validated breast evaluation questionnaire provided patient reported outcomes.

Results: SRMIR was performed in 98 women (120 breasts). An expander ($n = 57$) or definitive implant ($n = 41$) was used. Fifty women had contralateral surgery: 26 breast reduction/mastopexy, 1 augmentation, 23 mastectomy/reconstruction. Mean follow-up was 23 months (2–53). Radiotherapy information was available for 71 women: 43 had breast radiotherapy, 28 did not. Eleven women (11%) had early complications (six had had radiotherapy): 7 infected seroma (5 required implant removal), 2 skin necrosis and 2 haematoma. Capsular contracture requiring surgery occurred in 2 women following radiotherapy.

The questionnaire response rate was 52%. Reported satisfaction was high, with or without radiotherapy (90% very/moderately) in professional/social situations. Bilateral mastectomy and reconstruction achieved the best symmetry score (4.1/5) compared with women who had a contralateral breast reduction/mastopexy (3.3/5) or unilateral surgery (2.9/5).

Conclusions: In this series, 90% of women having SRMIR are satisfied and 97% would recommend breast reconstruction to a friend. Immediate SRMIR can provide satisfactory reconstruction in a single stage regardless of radiotherapy.

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O-3 IMMEDIATE BREAST RECONSTRUCTION AFTER SKIN-SPARING MASTECTOMY: ANALYSIS OF 160 CONSECUTIVE CASES

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