115 ORAL

Long term cosmetic results of immediate breast reconstruction by implants

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Aims: To evaluate long term cosmetic results of immediate breast reconstruction with implants after mastectomy for breast cancer.

To analyse parameters involved in the cosmetic results.

Materiel and Method: Between 1989 and 1995 a prospective study was performed at the Curie Institut. 218 women were evalueted after immediate breast reconstruction with implants. All these women beneficiated of total mastectomy with axillary dissection followed by immediate breast reconstruction (implants). Any necessary correction of the controlateral breast and the nipple areolar complex confection were also performed.

Results: Mean age is 48 years old. 99% of these women were evalueted (52 month follow-up). We used – respectively Becker, permanent and expandeurs-in 54, 39 and 7%. Most skin incisions for mastectomy werer horizontally oriented (77%). Progressive deterioration of long term cosmetic results is statistically documented. Only age and capsular influenced the final results. Other studied factors (type of implant, incision, age, volume...) had no importance. Breast asymetry and depigmentation of the nipple areolar complex are two important factors, retrospectively studied.

Conclusion: These results confirm progressive deterioration of cosmetic results, mostly by capsular contracture. Asymetry and depigmentation of the nipple areolar complex may also contribute to this fact.

116 ORAL

Breast cancer – A new technique of reconstruction

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Objective: The aim of the study was to present our original experience in reconstructive surgery of breast cancer.

Material and Methods: Between 1994 and 1998 nine patients with breast cancer underwent reconstruction of the breast using omental pedicle flap after mastectomy. Operative technique. Stage I. The horseshoe-shaped incision is made and subcutaneous mastectomy is done. Stage II. By upper-middle laparotomy an omentum is mobilized using Turner-Warwick method. The omental flap is then lead through subcutaneous tunnel into the breast bed. The flap is tailored giving the breast its natural form and size. The drainage tube is left in the bed and the skin is sutured cosmetically.

Results: In 7 patients no postoperative complications were noted. We observed bleeding in one case, which was treated conservatively. The only serious complication necessitating amputation was necrosis of transplant.

Conclusion: Obtained results led us to conclude that reconstruction of the breast using omental pedicle flap is safe and applicable surgical procedure. Taking into consideration low rate of complication, easy to perform, excellent cosmetic effect and cost-effectiveness, this form of reconstruction is the method of choice for early stage, young, highly motivated patients with small to moderate size of breast.

117 POSTER

Breast reconstruction with free microvascular TRAM flap

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In 1990–1995 a total of 185 breasts were reconstructed in 175 patients using a free microvascular TRAM flap. 22 were immediate reconstructions. The mean age was 48 (30–67). Mean time since mastectomy was 5 yrs (0.5–23). 82% of the patients had received radiotherapy after the mastectomy or breast resection, 36% had been node positive.

Two flaps were lost (1%). Ten reoperations (5%) were performed for vessel thrombosis, six (3%) patients needed revision for partial necrosis of the flap, eight (4%) had reoperation for hematoma. During follow-up 12 (6%) developed laxity of the abdominal wall requiring plasty, and twenty (14%) patients developed distant metastases after delayed reconstruction, two patients have died. One patient had local recurrence with concomitant liver metastases. Of the 22 patients with immediate reconstruction, one has died of cancer and two had distant metastases, one has had DCIS in the opposite breast.

Conclusion: Local recurrence is not a major concern after this procedure. The long delay of reconstruction explains the good survival. The operation is reliable giving good cosmetic results.

118 POSTER

Morbidity following immediate breast reconstruction (IBR) after mastectomy

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IBR following mastectomy with either autogenous or prosthetic techniques has been used widely in the treatment of patients with breast cancer. The aim of this study was to evaluate the final outcome and the complications after IBR. Between 1980 and 1985 119 IBR were performed. Following mastectomy and axillary node clearance and in 52 (43.67%) the implant was inserted in a subpectoral pocket, in 10 (8.4%) a tissue expander was used and in the remaining 57 (47.89%) cases a latissimus dorsi flap with implant was used. 59 (49.5%) patients were premenopausal and 60 (50.5%) postmenopausal. The mean age was 49.32 years (range 29–67 years) and the mean follow up was 153 months (range 60–217). The complications were as follows: Lymphoedema 15 (12.6%), Poor cosmetic result 14 (11.76%), Brachial plexus neuropathy 5 (4.2%), Infected prosthesis 4 (3.6%), Wound infection 2 (1.68%), Capsular contraction 9 (7.5%), Deep venous thrombosis 1 (0.84%), Skin necrosis 5 (4.2%), Contralateral breast cancer 7 (5.88%), Symptomatic capsular rupture 3 (2.5%), Recurrence: Mastectomy scar 2 (1.68%), Ipsilateral axilla 1 (0.84%), Metastases: Bone 5 (4.8%), Supraclavicular LN 3 (2.52%)

Immediate breast reconstruction is a safe operation and the cosmetic result in most of the cases is satisfactory with a low incidence of complications including recurrence and long distance metastases.

119 POSTER

After mastectomy: Breast reconstruction. The nurse's counselling role

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Breast cancer is one of the most serious health threats facing women. Even in today's age of liberation a woman's physical attractiveness determines her status and security rather than her skills interests and values. The treatment of breast cancer is particularly emotionally charged because it requires partial or total removal of an organ that is tied intimately to self-image, self-esteem, sense of attractiveness, femininity, sexuality and reproductive and nurturing capacity. All women agree that breast removal would lead to a loss of their sense of being a woman, this loss of self-esteem may result in decreased sexual satisfaction following mastectomy. Understanding the impact of mastectomy as a distortion of the woman's body image, enhances the nurses ability to promote patient and family adaptation to this disfiguring operation. Response to loss of a body part will be related to: 1) the visibility of the loss 2) the functional loss 3) the emotional investment in, or the significance to the patient of the part affected. Of course, the nurse who has continuous contact with the patient is a powerful force in the patient's early efforts to adapt to the experience. Nursing intervention must be carried out in three areas: 1) the patient's perceptions of the event 2) the patient's coping strategies 3) the situational support available to the patient. So specific nursing counselling intervention falls into three main categories. 1) expression and exploration of feeling 2) inclusion of partner or significant others 3) rehabilitation. The emotional support provided by expert nursing staff, well informed about women's needs for rieducation, reassurance and understanding makes the several days' hospitalization conforting. Nowadays that breast conservation and reconstruction procedures are more widely performed, it is important that women who must undergo a mastectomy are given realistic information about reconstruction which is an important point in the process of physical and psychological rehabilitation. The degree of satisfaction with the results is strictly related to expectation. A good acceptance of reconstruction is a balanced and realistic attitude which avoids the disappointment of idealization. For the nurse it is necessary to give correct information and to thorough by explore the woman's motivations and expectation. 84% of 38 patients who replied to a follow-up satisfation-evaluation questionnaire said they would not hesitate to recommend reconstruction to other mastectomized women.