

Immediate reconstruction with tissue expanders in breast carcinoma

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Abstract. Performing an intervention valid from the oncological and aesthetic point of view is not always possible. Sometimes particular situations lead to a demolitive surgery rather than a quadrantectomy with obvious little satisfactory results. Actual trend in favour of an immediate or second-time reconstruction is not univocal. We believe the general surgeon, without the plastic surgeon's collaboration, could obtain a positive result in performing the first time of the reconstructive intervention (tissue expander positioning). We know it is not true and immediate reconstruction should be auspicious for most of patients and is now requested also by over-50 patients.

Key words: Breast carcinoma, tissue expanders, reconstruction

Performing an intervention valid from the oncological and aesthetic point of view is not always possible.

Sometimes particular situations (such as carcinoma in small breasts, suspicious calcifications in different quadrants, multicentricity, multifocality, in situ carcinomas excised with small healthy margins) lead to a demolitive surgery rather than a quadrantectomy with obvious little satisfactory results.

Actual trend in favour of an immediate or second-time reconstruction is not univocal.

We believe the general surgeon, without the plastic surgeon's collaboration, could obtain a positive result in performing the first time of the reconstructive intervention (tissue expander positioning).

The patient in fact could avoid external prostheses, another anaesthesia and has obvious psychological benefits.

Obviously the surgeon must use some technical cunning in performing this kind of surgery: nerve (n. toracico lat. ant., n. toraco dorsale, n. of Bell) and muscle sparing to avoid post-operative atrophies; reducing skin asportation (skin sparing mastectomy, nipple sparing or radical modified mastectomy without too thin skin grafts and too low surgical scars, that could

obstaculate cutaneous expansion where mostly requested (at the lower aspect of the neo-breast).

According to our experience using incorporated magnetic valve versus distant valve expanders is a better conduct.

When the local conditions permit the filling, we are used to fill the expander so much as possible (about 50% of total capacity) because precocious expansion is better tolerated and there are good psychological implications: seeing a breast outline makes the patients more collaborative and quiet in facing the oncologic post-operative therapy.

Immediate reconstruction request is larger and larger, even if not so widespread yet, and a fundamental negative role is played by general physicians who dissuade the patient, for lack of information, in their opinion from an "uncertain" result that could make the follow-up "difficult".

We know it is not true and immediate reconstruction should be auspicious for most of patients and is now requested also by over-50 patients.

We are conscious that great work to improve reconstruction technical aspects and to achieve a good general physicians' and patients' information still should be done.