77 Case 36: After Subcutaneous Mastectomy

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77.1 Submitted by Walker: October 2, 2007

This is a 56-year-old female who was operated on initially 26 years ago, where the surgeon did a subcutaneous mastectomy on her for no reason other than he (obviously) had no clue what he was doing. She has no breast pathology, either currently (no breast tissue left) or prior.

She had an attempted redo apparently around 10 years ago, and as you (hopefully) can see by the (large file-sized) photos (Fig. 77.1), she has cause for concern regarding her current breast aesthetics.

I was thinking the only reasonable option currently is to perform a breast reconstruction via removing the current implants and posterior capsule, placing an expander totally submuscularly under pectoralis and serratus then expanding the muscle under the current skin envelope, and replacing with silicone gel prostheses in 3 months, after final expansion at 2 months.

Any sage advice would be greatly appreciated.

Higgs

This is a difficult case. She no doubt understands the breasts will never be perfect but they certainly need to be better than they are now. About 20–30 years ago (which was during my general surgical days) there was a vogue for bilateral subcutaneous mastectomies with nipple-areolar preservation and immediate implantation in women with a strong family history of breast cancer. This was thought to reduce their risk by at least 90 %; remnants of breast tissue remained especially near the areola. The other occasional indication for subcutaneous mastectomy was severe chronic breast pain; however the pain would sometimes remain after removal of the breast tissue.

Regarding your case, did she have silicone implants for the revision 10 years ago? What size and profile are they? Is there any capsular contracture? The implants are high and look subpectoral and the skin and subcutaneous tissues look very thin. All this information would be desirable before embarking on any revision.

Nevertheless I would favor exploration via the inframammary scars and explantation and replacement with high-cohesive, smooth, silicone

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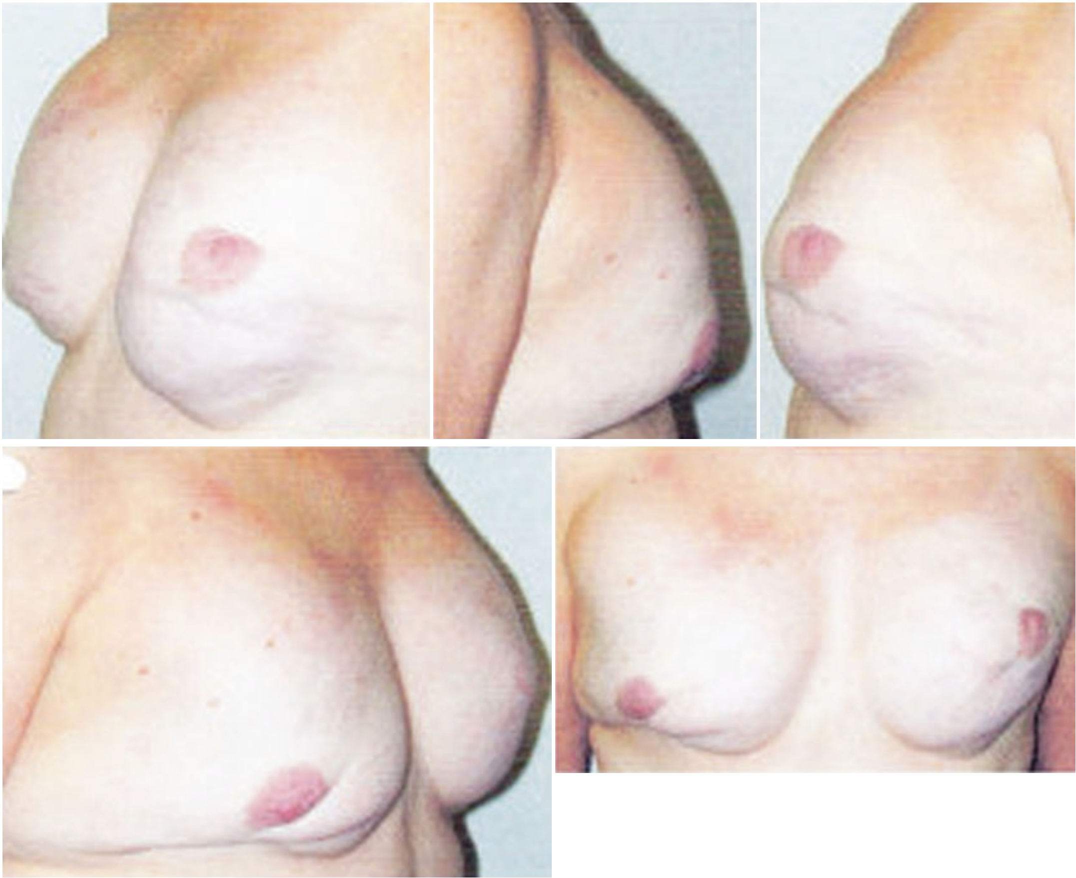

Fig. 77.1 (*Top* and *bottom*) This patient had bilateral subcutaneous mastectomies with insertion of implants 26 years ago and revision surgery 10 years ago

gel implants in pockets determined usually at the time of surgery. You will need a wider, larger implant than the current ones. I would not remove any capsule as this will help to cover the new implants. If possible the pocket should be partially or totally submuscular, provided the new implants are centered on the nipples. I think tissue expansion is unnecessary here. She has adequate skin (if not subcutaneous tissue) and a total submuscular pocket as planned should be carefully dissected to center on the nipple. Prior expansion could result in a capacious pocket with difficulty siting the implant correctly. Part of her current problem is the implants being too high.

Finally, do not feel obliged to operate on her, especially if you have any doubts about your ability to perform what is required. Further inadequate revisions will cost her more, in all ways, than one good one.

Walker

They are silicone, around 10 years old and submuscular, Baker 1 or 2 capsules.

Mangubat: October 11, 2007

This is a miserable case and I am sorry for her. First some observations:

1. NAC (nipple-areolar complexes) are:
   (a) Several centimeters different in superior/inferior level
   (b) Not in the expected breast meridian
2. Nipple to IMF (inframammary fold) is very short suggesting that the original breast was ptotic.

The skin appears to be thick and leathery and is probably not very pliable.

To address these problems:

1. Remove implants but do not bother with the capsule. If it is really thick, you may want to score it, but removing contact of the scar from the implant should resolve any contracture.
2. I agree about placing the expander totally submuscular but I would consider:
   (a) Using Mentor Spectrum implants with adjustable fill ports.
   (b) You can overfill the implant percutaneously by 200 % just like an expander without damaging it.
   (c) This gives you the opportunity to observe how the tissue will react to expansion before operating.
   (d) If the breast takes on a nice shape, all you need to do is pull the port and leave the implant in place.
   (e) Depending on the thickness of the existing scar, you could inject dilute steroid catabolic to the scar. Obviously this is a dangerous move, but desperate times need desperate measures.
   (f) I suspect you will need to keep the overfill for several months. Let the breast become a little ptotic for a more natural shape.
3. The two most important things to accomplish here are inframammary fold (IMF) and nipple-areolar complex (NAC) symmetry. To do this you will need to:
   (a) Adjust the IMF when the implant has reached its full capacity. This will require a small lateral IMF incision to gain access to the implant capsule. After adjusting the IMF level, close the wound and return to tissue over expansion; if possible, get the right nipple to IMF distance to be equal to the left. Although I think this is unlikely, do the best you can. I suspect it will take 6 months to achieve any suppleness to the tissue, but you need to be patient. After it softens, deflate the implant to the "desired size" and judge the suppleness and the NAC mobility; this is key to the final step.
   (b) Finally, adjust BOTH NAC positions with conservative mastopexies; draw the correct breast meridian lines and move the right NAC up and medially. The left just needs medial movement. Obviously, blood supply may be compromised so be careful to avoid any tension on the NAC.
4. Leave the fill ports in for a few more months:
   (a) Repeat contractures would be expected so leaving the ports in allows you to over-expand the capsule and soften it.
   (b) The breast size may change and you can make minor corrections without a major surgery.
   (c) If after a year, if she looks good, pull the fill ports and convert the Spectrum expander to a Spectrum implant.