

Post-mastectomy Breast Reconstruction: Pectoralis Major Myomammary Flap versus DIEP and MS-2 TRAM

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Published online: 3 December 2007
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We congratulate Denewer and co-authors for their very interesting two articles, in which they describe a simple, single-stage procedure for reconstruction of large breasts after mastectomy [1, 2].

As mentioned in their recent article, in which they report the results in 118 patients [1], we agree that there are positive cosmetic and functional features, such as reduction of donor side morbidity, reconstruction of the opposite breast, and the possibility of adjusting the volume of both breasts during the course of the same operation. Also, there seems to be no loss of pectoralis major function when only a part of the muscle is spent. In addition the nipple/areola complex can be reconstructed at the same time.

However, from our experience with the use of the pectoralis major myomammary flap for post-mastectomy breast reconstruction and for sternal defect reconstruction [3], we have encountered three specific problems with this method:

- The safety of the skin pedicle can sometimes be poor, as the variation of angiosomes is high.
- Despite the usefulness of this technique, there remains a problem in the induction of a so-called symmastia, as shown in Figures 2, 3, and 4 in the article by Spear et al. [4].
- Good color matching is achieved, but only when no radiation is necessary. We have seen discoloration of such skin pedicles following irradiation.

The one-stage pectoralis reconstruction is certainly a helpful technique, and it is worthwhile for the surgeon to have this option in mind when confronted with immediate reconstructions. In our hands, however, the use of free flaps, such as the muscle-sparing transverse rectus abdominis myocutaneous (MS-2 TRAM) flap or the deep inferior epigastric perforator (DIEP) flap, has proved to be safe and reliable. Free flaps are therefore preferred as the primary choice of reconstruction in our institution [5, 6].

References

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