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RECONSTRUCTION

Options after a MASTECTOMY

By Mary Ross

More than 200,000 women will be diagnosed with breast cancer this year in the United States. More than half of them will have mastectomies. But fortunately, options for reconstruction after a mastectomy have improved tremendously in the past 30 years. Prior to the 1970s, breast cancer patients didn't have many options for either treatment or reconstruction.

For many breast cancer patients, the reconstruction option is a life-renewing experience. "There's no question breast cancer is touching every American. But it's a very treatable form of cancer," says Dr. Jeremy Williams at The Rocky Mountain Center for Breast Surgery at Park Meadows Cosmetic Surgery. "The bar needed to be raised in reconstruction."

Dr. Linda Huang, a Denver plastic surgeon, has performed breast cancer reconstructions for over 20 years and has seen tremendous progress. "Treatment now is more customized," she says. "The scars of the past from a mastectomy were like a shark bite. The doctors didn't have the tools we now have. Almost everyone got a radical mastectomy, and all of the lymph nodes were removed."

In a radical mastectomy the breast, nipple, areola and all the pectoral chest muscles were removed, leaving a long, ugly scar and weakening the arm. This aggressive surgery was the common treatment for breast cancer patients from the time of its invention in 1882 until the 1970s. And reconstruction options either weren't offered or weren't available to many women. "In fact, the majority of women today are now offered reconstruction options," says Porter Hospital surgeon Colleen Murphy. "Most patients can begin the reconstruction procedure immediately following the mastectomy."

Many women also are opting for a bilateral mastectomy, thanks to better reconstruction options, since the chances of getting cancer in the second breast for women who inherited the BRAC gene mutation is 40 percent after having it in one breast. Today, despite these advances, more than half of women who have mastectomies don't have any reconstruction, often because they don't know their options, Williams says. They also may not have access to reconstruction surgery or feel the need for reconstruction. Plus, many

women don't want more surgery or have health issues that put them at risk for more operations.

Implant Reconstruction Procedure

Patients who do want reconstruction have several options. Saline or silicone implants are still the No. 1 choice for 90 percent of women because this procedure does not require surgery on another donor site of the patient's body, like the newer TRAM flap and DIEP flap procedures do, and the recovery time is much less. Plus, the implant reconstruction process can be started at the same time as the mastectomy or at a later date, depending on the wishes of the patient and the advice of the cancer surgeon.

With implant reconstruction, a silicone tissue expander is put into the patient's chest and slowly inflated to stretch the skin and muscle to accommodate the implant and help shape the breast skin and pocket. The implants are inserted after this process is completed and the expander is removed. Later, after the implants are in place, the patient's nipple is replaced using a skin graft from another area of the body. The area is then tattooed to give it a nipple-like color.

TRAM Flap Procedure

Women who want to use their own muscle or fat instead of implants for reconstruction can opt for the TRAM flap procedure, which has been around for 30 years, or the newer DIEP flap procedure, which was developed within the past 10 years.

In the TRAM (transverse rectus abdominus myocutaneous) flap procedure, the surgeon takes the vertical abdominal muscle, more commonly known as "the six pack," and shifts it up to the breast area, where it is then attached horizontally to the mastectomy site. Muscle from the back in the shoulder blade area, a latissimus flap, can also be used.

The disadvantages to this procedure are that muscle taken from these areas leaves a scar and the donor area is permanently weakened, since muscle has been removed. This surgery also takes more time than the implant option due to the delicacy of moving muscle from one location to another and saving the arteries and veins that supply blood to the tissue. Additionally, the hospital stay is longer than it is for implant surgery. This procedure is chosen when an implant fails or when a patient has had radiation for a



lumpectomy and the cancer returns, requiring a mastectomy. Often, the previous radiation changes the stretchability of the chest tissues, leading to thinning and breakdown of the skin over an implant, especially during the expansion procedure. Using a woman's own tissue avoids this problem.

DIEP Flap Procedure

The newest option is the DIEP (deep inferior epigastric perforator) flap procedure, which, until lately, had been performed more frequently on the East and West coasts than in Denver. Only 50 doctors throughout the United States are experienced with this procedure. In the Denver area, Dr. Joyce Aycock at the University of Colorado Hospital and Dr. Jeremy Williams and Dr. Christopher Williams (no relation) perform the DIEP flap procedure at Sky Ridge Medical Center.

Jeremy Williams was particularly interested in expanding the use of the DIEP procedure in Denver because he is a Colorado native and watched his mother endure breast cancer and the discomfort and expense of having to leave the state to have this procedure performed. "My mother spent over \$20,000 traveling back and forth to the East Coast for

surgery," says the 38-year-old Williams, who trained in microsurgery and the DIEP flap procedure at Johns Hopkins.

This intricate surgery requires one general surgeon and two plastic surgeons extensively trained in microsurgery. The DIEP procedure uses the same abdominal skin and fat used in the TRAM procedure, which is the same tissue removed in a "tummy tuck." The difference is that the DIEP procedure leaves in place all the abdominal muscle that the TRAM procedure removes. The skin and fat around the belly button are relocated onto the chest to reconstruct the breast. This microsurgical reconstruction takes up to eight hours because the surgeon has to dissect the blood vessel through the muscle to provide a blood supply to the newly relocated skin and fat while saving the muscle at the donor site.

The advantage to this surgery is a faster recovery than with the TRAM procedure because there is no weakening of the abdominal or back areas. A subsequent procedure is usually done to help shape the breast with fat acquired by liposuction from a fatty area of the patient. Like the implant procedure, reconstruction of the nipple and the tattooing process are done in a subsequent surgery.

Another advantage to the DIEP procedure is that the new breast feels natural and it will grow or shrink like normal breast tissue when the woman gains or loses weight. Another side benefit is the "tummy tuck" the patient gets in the process of harvesting the flap from the lower abdominal region and the liposuction of a fatty area for shaping the breast.

TUG and SGAP flap Procedures

Inner thigh or buttocks tissue can also be used in the most recent techniques. The TUG (transverse upper gracilis) flap and SGAP (superior gluteal artery perforator) flap are used in cases where the women don't have enough donor fat in the abdomen. This surgery is less frequent, and fewer surgeons are familiar with it.

Huang, Williams and Murphy agree that performing reconstructions for breast cancer patients is highly rewarding. These patients have survived a life-and-death struggle and often have a different perspective than their regular patients do. They are grateful for their renewed health and are happy to feel good again about how they look. Reconstruction helps them move on to the new phases of their lives, cancer-free.

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