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Plastic Surgery Is Not for Everyone: Options Following a Mastectomy

ELAINE SCHATTNER

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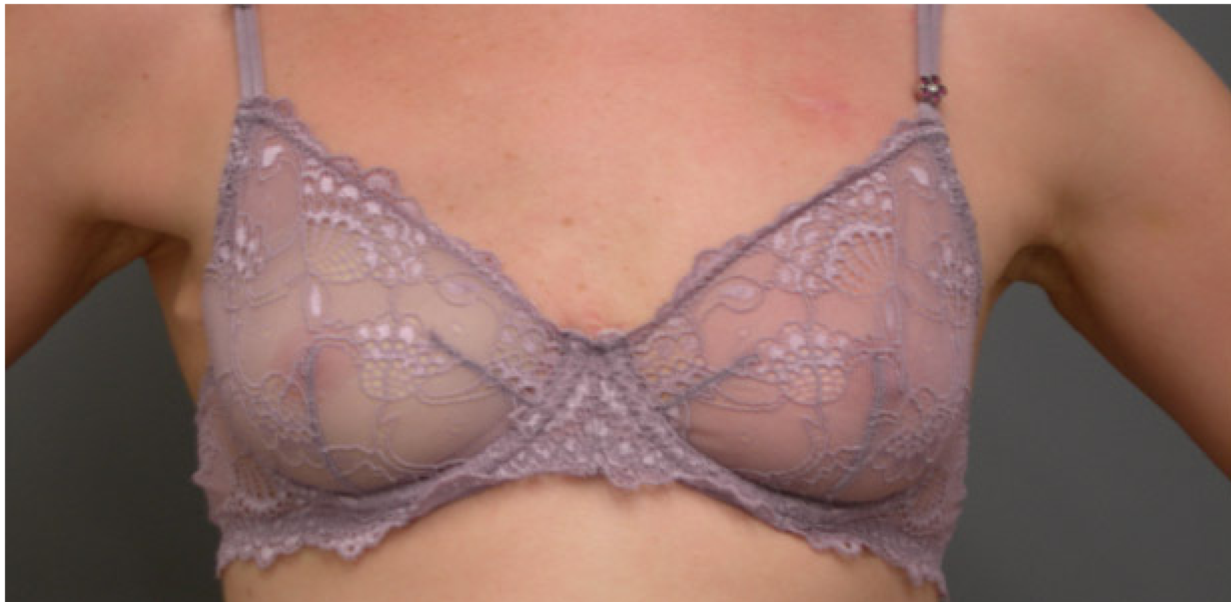
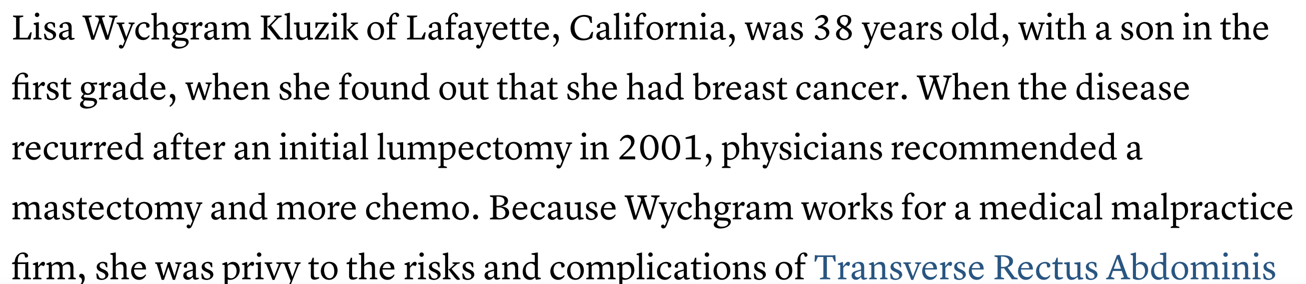
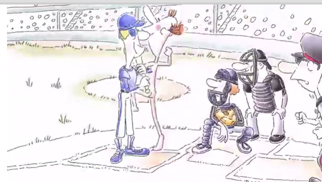
A woman with a breast cancer diagnosis faces many sudden choices, and in the emotional frenzy, reconstruction decisions may get short shrift



Lisa Wychgram Kluzik of Lafayette, California, was 38 years old, with a son in the first grade, when she found out that she had breast cancer. When the disease recurred after an initial lumpectomy in 2001, physicians recommended a mastectomy and more chemo. Because Wychgram works for a medical malpractice firm, she was privy to the risks and complications of Transverse Rectus Abdominis





"Already I had an idea of what could go wrong," Wychgram says. She didn't want implants, either. A friend had those inserted after undergoing bilateral mastectomy. "They kept becoming infected, so she had them removed."

After surgery, Wychgram visited a specialty shop that sells standard mastectomy bra inserts, but she was unhappy with her asymmetric appearance and felt uncomfortable. "I play tennis, and when you wear an 'off-the-shelf' prosthesis, it's like putting a water balloon on your chest," she says. "It's heavy. It doesn't move with you."

Following years of frustration, an Internet search led Wychgram to Irene Healey, a sculptor and anaplastologist -- a creator of absent body parts -- who founded New Attitude. Healey's Toronto-based company uses laser-scanning and modeling software to create individualized breast prostheses. Wychgram traveled to Canada for a detailed consultation.

When the custom-designed prosthesis arrived, Wychgram's son, then 11 years old, noticed the difference right away. "Oh my gosh, you're even," he said. "You look great, mom."

Now, at 49, Wychgram has no regrets about her decision to skip reconstruction. She plays tennis, does yoga, and skis -- activities she says might be limited if she'd had implants or other chest-wall surgery. The custom prosthesis was expensive, but worth it: "Oh, definitely," she says. "I'm going back to get a new one."

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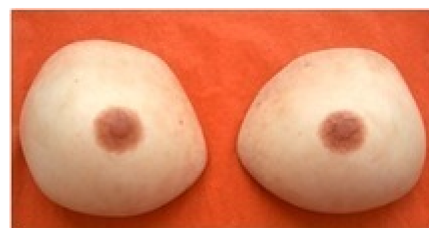

Every year, 80,000 or so women have one or both breasts removed for a cancer-related condition in the United States. Plastic surgery to reshape the breast, long within the purview of wealthy women, has become routine in some communities. Since President Clinton signed the Women's Health and Cancer Rights Act of 1998, which mandates that Medicare, Medicaid, and most insurers cover the costs, the proportion of women undergoing reconstruction has doubled. Now, some say,

perhaps the pendulum has swung too far: The decision for women after mastectomy isn't if they'll have plastic surgery, but how and when.

In 2011, newly-diagnosed patients are plugged into a treatment plan that incorporates reconstruction from the get-go. Well-meaning physicians may assume that surgical generation of a breast mound helps a woman heal psychologically. A husband or lover taking a supportive or selfish stance on the matter -- or the patient herself -- might consider reconstruction a strange silver lining, among many alleged lifts of the breast cancer experience. Why not go for a better look?

What may come as a surprise is that some women, including young patients, may not opt for reconstruction even when the costs are covered. The reasons vary: Rowers, windsurfers, swimmers, and other athletes avoid potential weakening of abdominal and chest muscles; mothers fear not being able to lift their children; others worry, plainly, about the time and costs of extra surgery and the long-term complications of implants or grafts.

In the past decade, a handful of companies have developed technology to match pieces to a woman's shape, flesh tone, areola, and nipple. The custom-designed, external prosthetic devices simply insert into a bra and provide good, sometimes superior cosmetic results in clad women. Yet few patients or doctors know about this safe, lower-cost alternative to plastic surgery.

When they do choose reconstruction, their options are more varied than they once were.

Plastic surgery has come a long way since Dr. William Halsted advanced a surgical technique for aggressively treating breast cancer in the late 19th century at the Johns Hopkins Hospital. In that era, women often held off seeking care until the tumors were bulky, typically piercing the chest wall and spreading to lymph nodes near the clavicle and armpit. Halsted developed a method to remove the entire breast, underlying pectoralis muscles and glands. The radical mastectomy became standard treatment for patients with breast cancer until the modern era.

In 1895, Dr. Vincent Czerny, operating at the University in Heidelberg, reported constructing a soft tissue mound on a woman's chest after mastectomy. He removed a lipoma -- a benign fatty tumor -- from a woman's flank and stuck it onto her chest wall. In the early 1900s, other surgeons experimented with grafting strips of muscle and fat to form flaps of tissue over mastectomy sites.

Halsted, who was highly influential, cautioned his colleagues against surgical manipulation of the chest wall for cosmetic purposes. He warned that by manipulating the wound after mastectomy, the surgeon might inadvertently spread tumor cells. Reconstruction could mask a tumor's recurrence, he advised.

What's more, these procedures were generally unsuccessful. Infections were frequent. Inadequate blood supply to the primitive grafts led to gangrene and, sometimes, fatal results. Through most of the 20th century, the process involved multiple procedures, delays, complications and, ultimately, failure. It wasn't until 1963, with the introduction of silicone gel implants, that the field of breast enhancement -- what doctors call augmentation mammoplasty -- was born.

Plastic surgeons readily adapted the silicone implants for post-mastectomy chests. Still, through the 1970s and, in some communities, significantly later, surgeons were reluctant to carry out the procedure. Many considered the matter paternalistically, for it was mainly younger, educated, and married women who would undergo reconstruction. Doctors perceived these women as lucky to be alive, and that extra surgery begged trouble.

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"The bar is constantly raised higher," says Dr. Walter Erhardt, past president of the American Society of Plastic Surgeons. His perspective stems from over 30 years' work in private practice in Albany, Georgia. "The results we're getting nowadays are better than what we got five or 10 years ago, and a whole lot better than what we were getting 15 and 20 years ago."

Only three in seven women get the chance to learn about reconstruction before they begin cancer treatment.

Erhardt attributes progress in cosmetic outcomes to improved surgical methods, combined with earlier collaboration among each patient's physicians. "Years ago we worked in silos," he says -- meaning that the general and breast surgeons, medical and radiation oncologists, and plastic surgeons rarely spoke before a patient began treatment. Typically, women visited plastic surgeons months or years after treatment of the disease, if ever. "Other doctors set the canvas for what we can do," he emphasizes. This limited reconstruction possibilities, especially for patients who received radiation to the chest wall.

"Now we start talking around the time of a patient's diagnosis," he says. "Women can choose from so many options. In the last few years, more general surgeons are willing to perform skin and nipple-sparing mastectomies, he notes. This yields better cosmetic results.

Still, the data suggest that only three in seven women get the chance to learn about reconstruction before they begin cancer treatment, Erhardt says. "In the old days, the general surgeons had the attitude that if they're saving a woman's life, she should be happy and not worry about anything else."

"Every woman needs the choice," Erhardt says. Still, it's probably not the right thing for every patient: "It's additional surgery; it's additional time off; it's additional expenses." These all factor in. Reconstruction may not be suitable for some women with other illnesses. "And I've seen some patients who, despite getting a good reconstruction, have never been able to get over the loss of their breast, or having had cancer," he says.

More often than not, Erhardt sees positive outcomes: "Reconstruction provides simplicity in women's lives," he says. After breast cancer, patients don't have to put on a body part every day, and they enjoy greater freedom in clothing. The benefits don't only apply to younger women. "From grandmothers, the constant thing I hear

is that they don't want to worry about the prosthesis. They're with grandchildren at the beach, and if the prosthesis gets knocked out by a wave they're embarrassed."

The issue goes beyond convenience, he suggests. "It's about closure."

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Plastic surgery's not for everyone, says Dr. Costanza Cocilovo, a breast surgeon at Georgetown University. She estimates that one in five patients in her practice would prefer not to have the extra surgery. But for women who don't undergo reconstruction, the options are slim: "The standard prosthesis that Medicare will pay for is really horrible," she says. "It can be very upsetting, especially for older women if they've had a mastectomy on one side. They find it very difficult and embarrassing, because the alternatives are so unappealing."

A woman with a breast cancer diagnosis faces many sudden choices. Deciding whether to have a lumpectomy or mastectomy, and then choosing among oncologists and treatments -- chemotherapy, radiation, antibody infusions and possibly participating in a clinical trial -- involves a deluge of information.

In the frenzied and emotionally-loaded period of a new illness needing treatment, the decision on reconstruction may get short shrift, says Dr. Susan Cassidy, a physician and lawyer who has served as CEO of Contour Med, a manufacturer in Little Rock. Because insurance, by law, covers the costs of plastic surgery, and doctors in well-served communities tend to promote the procedure, breast cancer patients may not take sufficient pause to adequately contemplate the risks and benefits. "A woman should be informed about all the options, including custom prostheses," Cassidy says.

Whether she decides on implants, saline or silicone, or to have a TRAM-flap or other grafting procedure, the decision should be active, and considered. With knowledge in hand, she might move forward with reconstruction, knowingly and eagerly, or choose to hold off, entirely. It's a matter of choice.

Images: 1. Wearing a breast prosthesis/New Attitude; 2. Custom breast prostheses/New Attitude.

ABOUT THE AUTHOR

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