Whatever your choice of surgery, it can be an emotional and difficult experience for most. Fortunately there are more options now for women with breast cancer, and the options are more effective than ever before at maximizing cancer cure and reducing the side effects of cancer treatment. Use all the resources available to you to make a decision you will be able to live with comfortably. Your surgeon is a great resource, but it is important to try to connect with other women who have been through the experience as well. And make sure you free up enough time and energy so you can focus on making good decisions for yourself and your family.

RECONSTRUCTION AND MASTECTOMY

Reconstruction after mastectomy is the creation of a new and natural-appearing breast by a plastic surgeon. Breast reconstruction has made a big difference both physically and emotionally for many women who have had mastectomies. But it's important to understand the limits of reconstructive surgery before you decide to have it done.

Making the Decision

What's constructed is not a real breast. It may look real, but it will never have full sensation as a breast does. Any surgeon who says, "We're going to take off your breast and give you a new one, and it'll be as good as ever" is either naive or dishonest. The surgeon may tell you that the new breast "feels normal"; at best this is a half truth. It might feel normal to the hand that's touching it, but it will have little sensation itself. However, feeling is part skin sensation and part mental experience. You may have some slight "feeling" return, but it will never feel completely real to you. As a patient told me, you need time to bond with your new breast. And as my many Facebook friends have adamantly informed me it is *not* a free "boob job"!

Reconstruction can make your life a little easier—you can wear a T-shirt or lounge wear and not worry about putting on a bra. If the doorbell rings while you're still in your bathrobe, you don't have to deal with whether you want the mail carrier to see your asymmetry. Wearing bathing suits and

other “revealing” clothes is easier. In *Why Me?* Rose Kushner explains her decision to have reconstruction. She was alone in a hotel room one night, when she was awakened by a fire alarm and the smell of smoke. She jumped out of bed, threw on her clothing, grabbed her glasses, and ran. Downstairs in the lobby with the other guests, she realized that only she had gotten dressed; the others were in their robes. Then she realized why: “This ‘well-adjusted’ mastectomee wasn’t going anywhere publicly with one breast.”[14]

A reconstruction can help some women put their cancer experiences behind them. As one of my patients said, “When I was wearing my prosthesis every day, when I looked at my body and it was concave where there had been a breast, I felt that I was a cancer patient, that I was living with that every single day. With the reconstruction I feel that I’m healthy again, that I can go on with my life.” Another patient says that after her mastectomy “I always felt the hollows under my arm. After my reconstruction, I put my arms down, and something was there. That’s when the tears came; it was splendid to have that back.”

However, reconstruction isn’t right for everybody. One of my patients regretted having it. Displeased with the appearance of her reconstructed breast, she also felt that the plastic surgery functioned as a form of denial. “It caused me to postpone the mourning I had to do over losing a breast,” she says. “Instead of mourning the loss of a breast, I was thinking in terms of getting a breast. So it wasn’t until the process was over, and I saw my new breast, which wasn’t like my other breast, that it hit me that I’d lost a breast. If I had the decision to make now, I don’t think I’d have reconstruction.”

Another woman felt like she was not really given a choice. “I appreciated the option to reconstruct; however, it almost didn’t feel like an option. There was definitely an assumption that I would reconstruct because of my age. I was forty. ‘Here are the names of two great plastic surgeons.’ I was coping with the shock and aftermath of a devastating breast cancer diagnosis. I was on autopilot.” She followed the suggestion and felt all right about it. “After I completed chemo and radiation, the reconstruction [with a flap from her stomach] didn’t match the remaining breast, but I really could not have cared less.” In spite of her plastic surgeon urging her to “do some

fine tuning," she decided she had been through enough surgery. It really bothered the plastic surgeon. The patient had problems with discomfort from the surgery for years after. "I was an active woman who mountain climbed and kayaked. If I knew then what I know now, I would not have reconstructed. To quote Popeye: 'I yam what I yam.' I would have skipped the rest entirely."

Some dissatisfaction may result from the limits of the procedure. The best reconstructions look like real breasts, but others look real only through bras or clothing. Factors that can affect the outcome of reconstruction include your body shape, the treatments you have had, and the type of reconstruction as well as the skill of the reconstructive surgeon. It's important to be realistic about your expectations: What do you hope to get from having a reconstructed breast? Some women are very concerned about symmetry; many others aren't. Do you want to look good in your clothes, or is it important that a new lover won't even know you've had surgery? Do you want to have your remaining breast altered to achieve a closer match? These concerns are not foolish, and you should never hesitate to look for what you want out of guilt over "vanity." You've been through an unpleasant and life-changing experience; you're entitled to do what you can to make its aftermath as comfortable as possible. Talk with your plastic surgeon about all the possibilities and decide what's best for you. Although most plastic surgeons strive to create symmetry in the nude, the most realistic goal and expectation is to obtain symmetry in a bra or clothing. Dr. William Shaw, a former colleague of mine, warned against looking for one universal operation that's best for every patient. "One of the mistakes surgeons and patients both make is to act as if breast reconstruction is some kind of product you can compare objectively—what's the best airplane? One thing I've learned over the years is that there's no one operation that's best for everyone."

And not having reconstruction at all is also an option.

When Should You Have Reconstruction?

You may not be sure at first whether you want reconstruction. Some premastectomy patients are too upset by the cancer and the prospect of a

mastectomy to make yet another major decision at the time. When I come across this kind of ambivalence, I suggest the patient have her mastectomy, take whatever time she needs to deal with it, and then, when she feels ready, come back if she still wants reconstruction. (This, by the way, is equally true of surgery for lumpectomy.) You may also consider a consultation with a plastic surgeon just to obtain information and not make any decisions.

Although plastic surgeons were once reluctant to do immediate reconstruction, it is becoming much more popular. I find some surgeons will actually recommend bilateral mastectomies with immediate reconstruction as being the easiest way to achieve symmetry. It probably is the easiest for the surgeon, who doesn't have to worry about the cosmetic results of breast conservation. It is also easier for the plastic surgeon, who doesn't have to worry about matching the uninvolved breast. But it may not be easier for you.

Make sure you think it through. Planning a mastectomy with immediate reconstruction will have to allow for any needed chemotherapy and radiation. In addition, you may be limited to the local surgical team that is available at the time when you need surgery. The local plastic surgeon, however, may not be the one you want to do your reconstruction, especially if you want a free flap or a muscle-sparing approach (described below). If you delay reconstruction, you may have a greater choice of surgeons. However, if you are going to have a nipple-sparing mastectomy, it is best to do the reconstruction immediately. My surgical colleague, Laura Klein, suggests that putting tissue expanders in at the time of a nipple-sparing mastectomy can allow a woman to undergo postmastectomy radiation and then complete the reconstruction with a flap later with the team of her choice. If you are going to need postmastectomy radiation therapy, it may also be better to delay because the acute effects of radiation lead to an increase in the incidence of local complications, regardless of the method of reconstruction.[15] However, if you are interested in implant reconstruction and will need radiation, delaying the reconstruction may rule out the implant option. Prior to radiation the breast skin can be expanded quickly, leaving you with an acceptable result (although the radiation usually tightens the tissues around the implant somewhat). After radiation,

however, the skin is usually not amenable to expansion, and a tissue flap is typically required.

There is a pervasive bias that immediate breast reconstruction improves patient quality of life, but the few studies available do not demonstrate such a benefit and instead suggest that breast reconstruction, whether immediate or not, may actually impair quality of life.[16] It is well documented that surgical complications have a big effect on quality of life. One study that looked back on women who had undergone mastectomy and reconstruction found that dissatisfaction with the operation was associated with unhappiness with appearance, complications from reconstruction, having prophylactic surgery, and increased levels of stress.[17] Data from the Mayo Clinic demonstrate substantial postoperative complications after mastectomy with immediate reconstruction. This is in contrast to the much less common and less severe complications after wide excision and radiation or mastectomy alone, which rarely require further surgery.[18] Delayed breast reconstruction in general is associated with fewer postoperative complications as well.

There is no time limit for reconstruction. In fact, current techniques have made it a better option than it used to be. If you had a mastectomy in the past and are now thinking about reconstruction, you should feel encouraged. Even with a radical mastectomy, reconstruction is still possible. Or if you originally decided against reconstruction and now want to reconsider, that's also fine. (Some of my patients had their mastectomies in the winter and didn't want reconstruction but changed their minds in the summer, when they wanted to wear bathing suits and sundresses.) However, you can't think of it as a "boob job"! You had breast cancer, and things will never be the same.

Types of Postmastectomy Reconstruction

Reconstructive surgery is done in a number of ways. It has at least two components: reconstruction of the breast mound and reconstruction of the nipple areolar complex. The reconstruction of the breast mound can be done with artificial substances, your own body tissues, or both.

Implants and Expanders

Of the sixty thousand reconstructions done a year, 85 percent are done with saline or silicone implants. Current options for implant-based reconstruction include immediate or delayed reconstruction with a standard or adjustable implant, two-stage reconstruction with a tissue expander followed by an implant, or reconstruction with the combination of an implant and your own tissue. One-stage implant reconstruction is gaining popularity, although results are best in highly selected patients, typically a C/D cup patient with minimal droop who wants to be a cup size smaller and higher. In the right situation the results can be excellent, although sometimes you may still need a second surgery for revision if your nipple isn't in the right place.

More commonly a tissue expander is placed under the muscle at the time of the mastectomy. After initial healing, the expander is inflated over time with saline during weekly office visits. This process can be quite uncomfortable, as the tissues are stretched out over six to eight weeks. The expander can be used while you are receiving chemotherapy. Once the expansion is complete, the tissues are allowed to relax and adjust to the new position for another one to two months or until chemotherapy is finished. At that point the tissue expander is exchanged for the final implant in an outpatient surgical operation (Figure 13.15).

This two-stage technique of expander-implant reconstruction has become the most common approach to implant-based reconstruction. The final implant is either saline or silicone and is placed behind the pectoralis muscle (Figure 13.16). The outer shell is always silicone and can be either textured or smooth. Most plastic surgeons think that silicone implants tend to provide a softer, more natural feel and maintain their shape better than saline implants. Saline implants tend to be firmer and to provide less natural fullness in the upper portion of the breast, and they are much more likely to produce visible rippling. Nevertheless, silicone implants are not without some drawbacks. If a saline implant ruptures, the fluid leaks out, your body absorbs it, and it is immediately obvious. If a silicone implant ruptures, you may or may not detect it. However, the newer implants have thicker silicone, making this less likely.

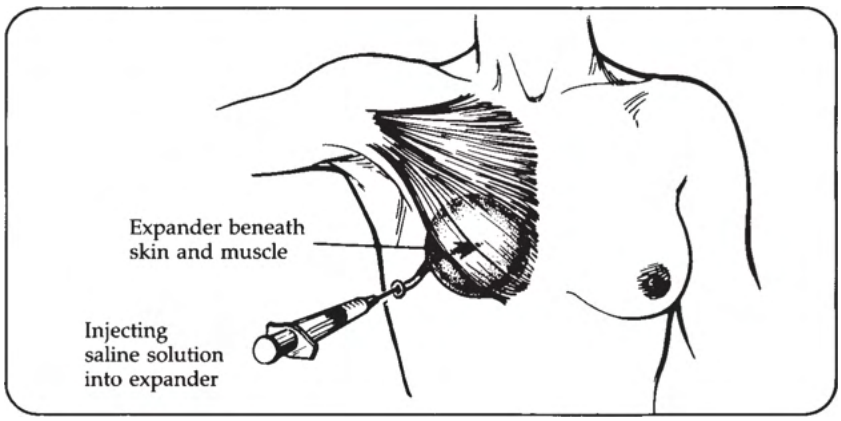


Figure 13.15

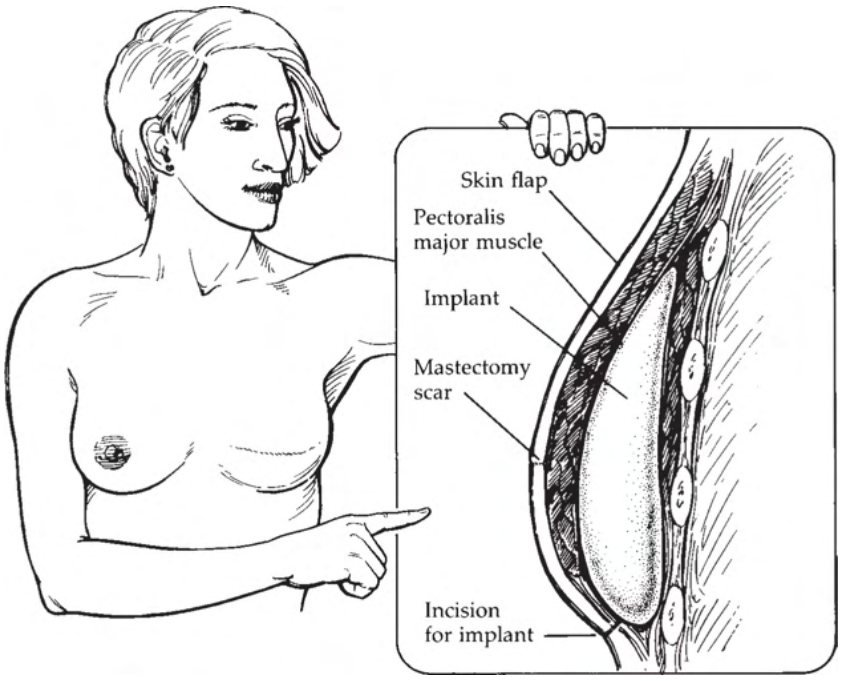


Figure 13.16

Generally the expander-implant reconstruction will be completed in two steps if you have had a nipple-sparing mastectomy, or four steps if not. Stage one is the immediate reconstruction with an expander; stage two is converting it to the final implant; stage three is nipple reconstruction (when needed), and stage four is the tattoo of the areola (when needed). The advantages of this approach, particularly with a nipple-sparing mastectomy, is that it is simple and that most plastic surgeons are comfortable with it, so

they can do it without a special team. There are no scars elsewhere as there would be if your own tissue were used. The disadvantages include the long time it takes to get a breast mound and multiple visits to the plastic surgeon every week or two for inflation. Early complications include bleeding (hematoma) and infection, the latter sometimes requiring implant removal. Although many patients are under the misconception that they are "rejecting" the implant, this really is not true. In fact, in most cases the problem is an infection around the implant or a capsule contracture (a firm scar forms around the implant). Surgery always carries the danger of postoperative infection. An expander or implant can make infection more difficult to treat. Because they are foreign to your body, an infection will not heal by itself. One of my patients developed a very bad infection and had to have the expander removed. In fact, about 5 percent of implants eventually need to be removed, and some of these women choose not to have it replaced.

As many as 50 percent of women who undergo implants will need further surgery within seven years for leaks, deflation, pain, or capsule contracture Moreover, implants or expanders are more likely than other procedures to necessitate you having something done to the other breast to make it match. They're going to give you a nice, perfect, seventeen-year-old's breast, but you're probably not a nice, perfect seventeen-year-old. Because the reconstructed breast doesn't sag much, it may be higher than you want it to be. One of my patients found this particularly displeasing. "The reconstructed breast didn't look like my real breast, and it was much higher," she says. "I had to start wearing a bra, which I don't like at all." Thus, unless the reconstructed breast matches the remaining one, you may need to have the remaining one operated on to match. Ben Anderson says that it is important to remember that an implant reconstruction is not the same as cosmetic implants, where the breast tissue is still in place. The implant without normal breast tissue between the skin and implant feels more like a balloon.

So when plastic surgeons tell you implants are the easiest form of reconstruction, requiring the least amount of surgery, it's true as far as it goes. This approach is the simplest at the time of surgery but may well need additional operations to refine the result as well as surgery to the other breast so that it will match.

It's important to let the plastic surgeon know what size you want to be. I had a relatively flat-chested patient who wanted an implant. She wanted to stay flat-chested; that was what she was used to. But the plastic surgeon was conditioned to think that all women want large breasts. He kept trying to persuade her to let him give her a bigger implant and then enlarge her other breast to match it. Another patient had silicone implants, and the implant on one side encapsulated. But she liked the hard, firm, rocklike texture of that breast, and when she had a mastectomy on the other breast, she wanted the reconstructed breast to match the encapsulated one. The plastic surgeon again had a hard time with that—it wasn't what women are supposed to want. If you know what you want and your plastic surgeon argues with you, argue back or change plastic surgeons. It's your body, not the surgeon's, and it's you who will live with that body.

Sometimes an implant can even have a bonus. One of my Facebook friends wrote that she had been "a large 'C,'" and she'd always wanted a reduction. "When I was diagnosed, I decided to get what I wanted out of it. I had a reduction on the 'good' side, and expanders put in for my reconstruction during my mastectomy to make me a full 'B.' The expander was removed, and a saline implant was put in after chemo through a small incision under the reconstructed breast before I started radiation. I haven't had any trouble, and the reconstruction looks great."

When the operation works well and the patient's expectations are realistic, implants can make a wonderful difference. As one of my patients says, "I forget it's there—it's a part of me now. It's a little harder than my other breast, but otherwise great. I don't have to worry about what I wear."

One caution: implants don't last forever. Even for the woman who has implants to enlarge her breasts, replacing them can be upsetting. For the mastectomy patient, it can be devastating—like losing the breast all over again. Such patients may require the flap reconstruction described below. Having problems with the implant suggests the likelihood of having more problems later on. Even without any problems, implant manufacturers recommend replacing the implants every ten to fifteen years. Patients need to weigh the comparative ease of the implant surgery against the inconvenience and emotional consequences of possible later surgeries.

Flap Procedures

The breast mound can also be reconstructed using your own tissue. In the myocutaneous flap, a flap of skin, muscle, and fat is taken from another part of your body and moved. It's your own tissue, and because you've got extra skin, it can make a bigger breast and a more natural droop. You may feel more normal, as it's real tissue, skin, and fat, though it has little sensation. These flaps can come from the abdomen (transverse rectus abdominis muscle, or TRAM flap), back (latissimus dorsi flap), or buttock (gluteus maximus flap).

There are two different techniques for the myocutaneous flap. One is the pedicle, or attached flap (Figure 13.17). Here the tissue is removed except for its feeding artery and vein, which remain attached, almost like a leash. The site from which the tissue was removed is sewn closed. The new little island of skin and muscle is then tunneled under the skin into the mastectomy wound. Because the blood vessels aren't cut, the blood supply remains.

The other option is the "free flap." In this procedure the tissue is removed, and the feeding artery and vein are cut. Then the tissue is moved to a new location, and the artery and vein are sewn to an artery or vein in the chest or armpit; the surgeons use a microscope to help them reconnect the tiny blood vessels.

The pedicle flap can only be done from tissue close enough to reach to the breast and so is limited to the abdomen (TRAM) or back (latissimus). The free flap is less limited. The most common free flaps are from the abdomen, either based on the lower blood vessels that feed the skin (inferior epigastric) or from the blood vessels that pass through the muscle into the fat and skin (deep inferior epigastric perforator flap, or DIEP). Other free flaps include those from the infraumbilical area (superficial inferior epigastric artery flap, or SIEA) and the buttocks (SGAP or IGAP, depending on whether it's based on the superior gluteal artery perforator or the inferior one). This means you can have a flap reconstruction even if your abdomen has been scarred and can take advantage of whatever abundance nature granted you (Figure 13.18). The advantage of the pedicle flap is that it's easier, so more plastic surgeons can do it. It still involves at

least three procedures (reconstruction, nipple, and tattoo) and four if you need something done to the second breast to match.

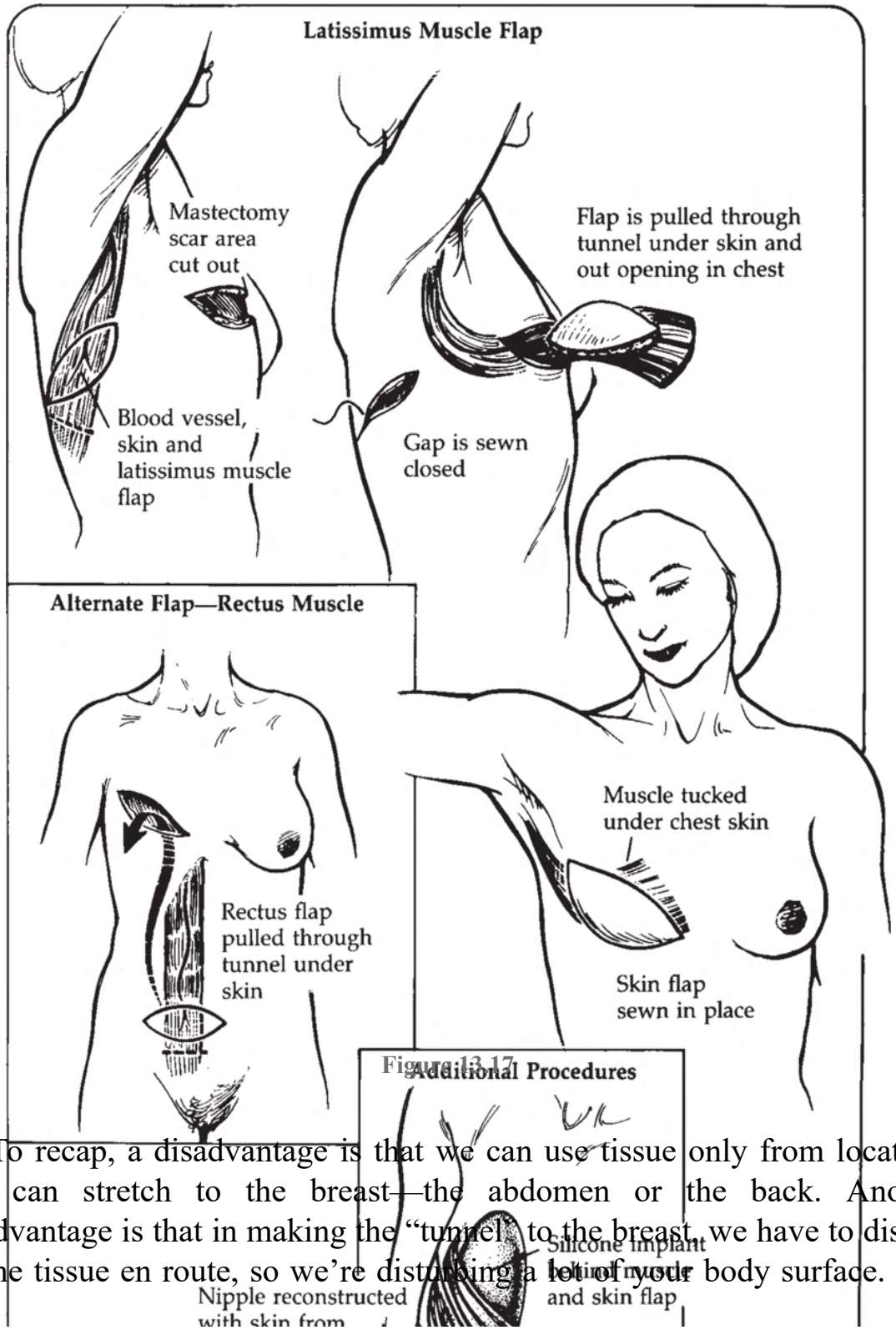
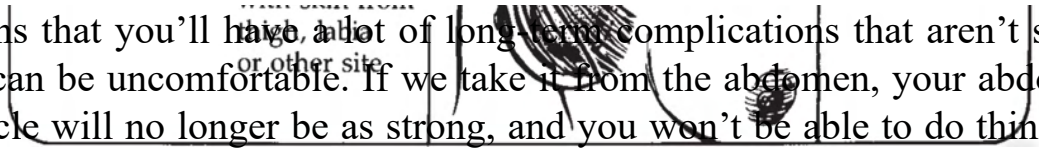


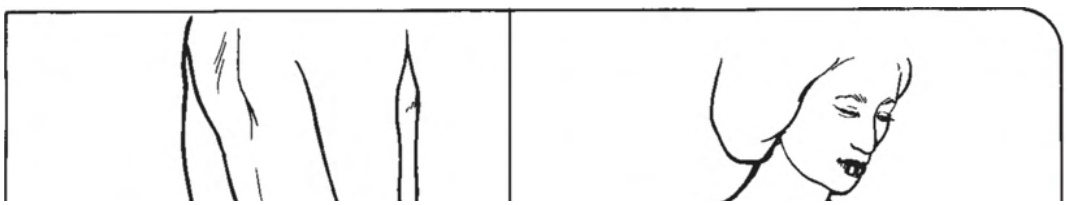
Figure 13.17

To recap, a disadvantage is that we can use tissue only from locations that can stretch to the breast—the abdomen or the back. Another disadvantage is that in making the "tunnel" to the breast, we have to disturb all the tissue en route, so we're disturbing a lot of your body surface. This



means that you'll have a lot of long-term complications that aren't serious but can be uncomfortable. If we take it from the abdomen, your abdominal muscle will no longer be as strong, and you won't be able to do things like sit-ups as well as you used to. One of my patients now has to wear a panty girdle all the time to help support her weakened abdominal muscle. Another has found that since the operation, the area around her upper abdomen is so sensitive that she can't wear anything with a waistband. There is a 25 percent chance of getting a lifetime bulging of the abdomen as well from where the tissue flap was taken. I should add, however, that these problems are relatively unusual, and most patients who have had the procedure have had few problems and much satisfaction. If the tissue is taken from your back, there will be fewer problems, although the muscles may weaken somewhat. This may interfere with shoulder strength for special sports like mountain climbing or competitive swimming. You also may need more physical therapy. Some women have a lot of stiffness and pain after this flap because it throws their whole shoulder girdle off. In either case, you'll have a long scar on the area from which the flap has been taken.

With the free flap, the surgeon has to be skilled at sewing blood vessels together under the microscope (Figure 13.19) or using a coupler (a staple-like apparatus to connect small blood vessels), and many plastic surgeons aren't. In expert hands there are fewer complications than with the pedicled flaps because free flaps have a better blood supply. It's about five to eight hours of surgery, and you'll probably be in the hospital for four to seven days. If the blood supply is disturbed, part or all of the flap can die, and further surgery will be necessary. The patient I mentioned earlier, who developed an infection from her silicone expanders, was unable to have either the latissimus (back) or rectus (abdominal) procedure because of medical problems in her back and abdomen. The free gluteus flap was the only alternative she had left. Although it was difficult surgery that involved a long healing period, she feels it was well worth the pain and inconvenience.



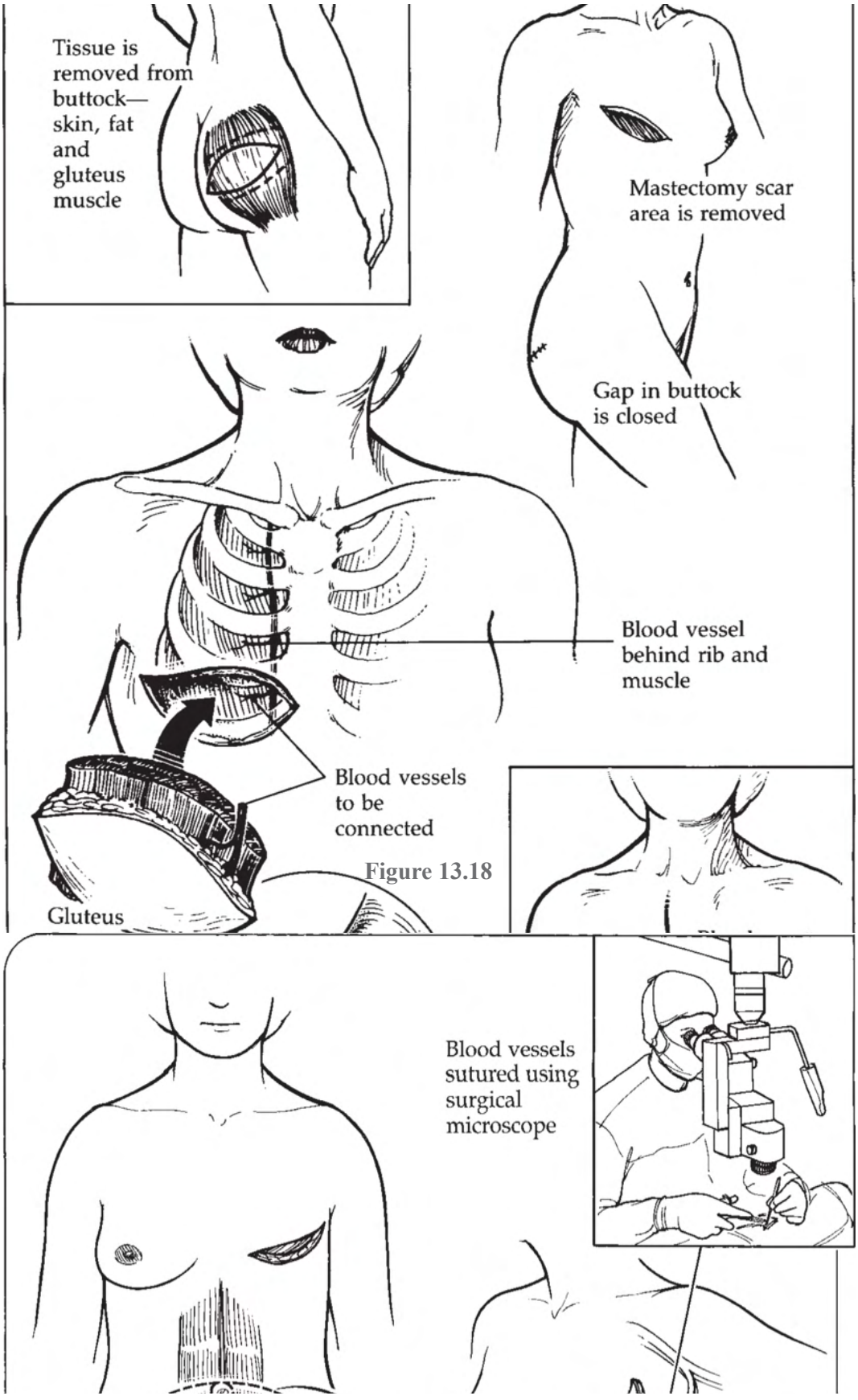

Tissue is removed from buttock—skin, fat and gluteus muscle
Mastectomy scar area is removed
Gap in buttock is closed
Blood vessel behind rib and muscle
Blood vessels to be connected
Gluteus
Blood vessels sutured using surgical microscope

Figure 13.18

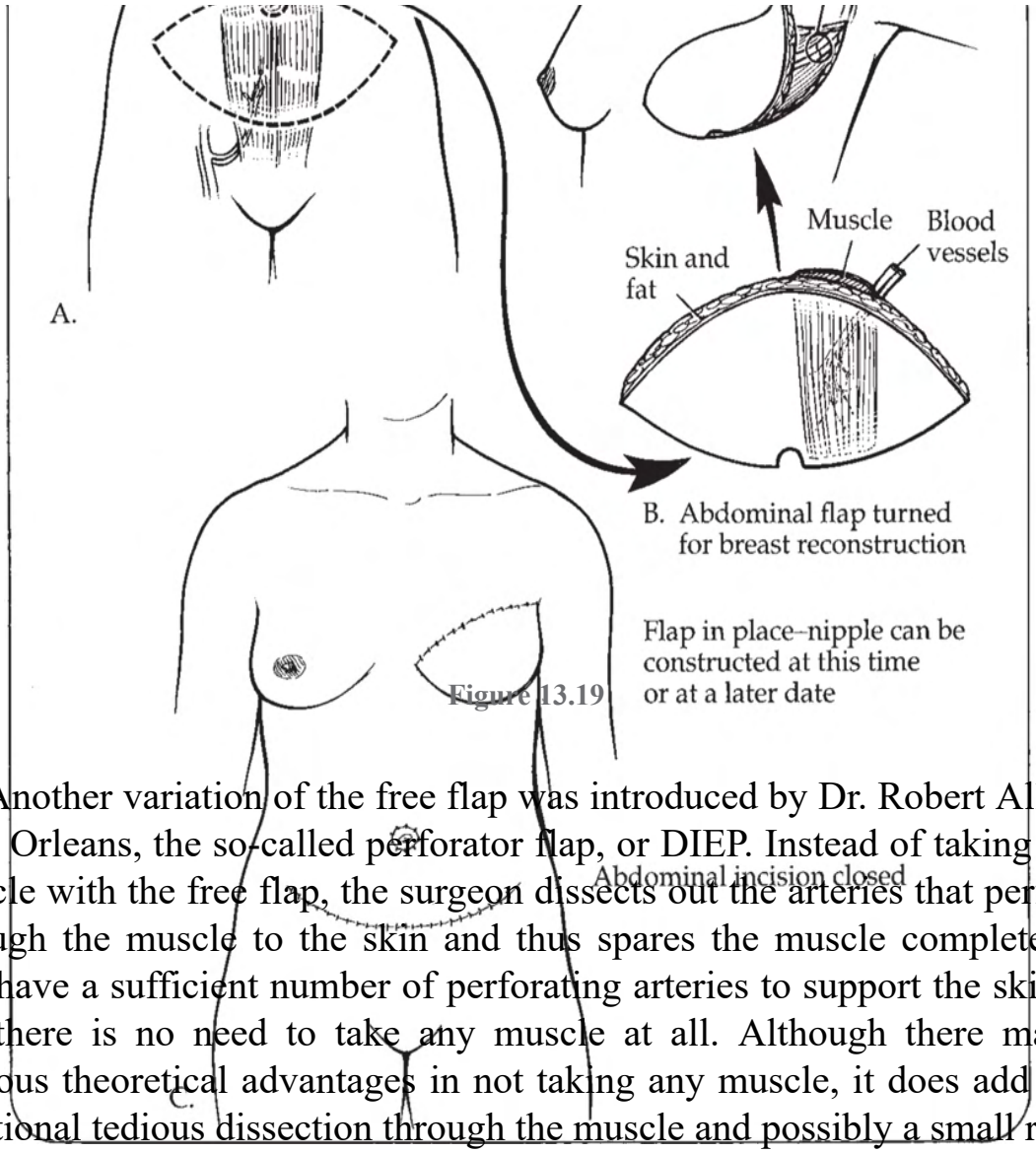


Figure 13.19

Another variation of the free flap was introduced by Dr. Robert Allen of New Orleans, the so-called perforator flap, or DIEP. Instead of taking some muscle with the free flap, the surgeon dissects out the arteries that perforate through the muscle to the skin and thus spares the muscle completely. If you have a sufficient number of perforating arteries to support the skin and fat, there is no need to take any muscle at all. Although there may be obvious theoretical advantages in not taking any muscle, it does add some additional tedious dissection through the muscle and possibly a small risk of complications related to this portion of the dissection. Also, because one still has to dissect through the muscle, it is uncertain how much benefit there is in trying to save a small amount of muscle. In the end, it becomes a practical decision as to whether it's worthwhile to do the extra dissection to save a little muscle. The concept of the perforator flap has been very helpful in focusing our attention on the perforating arteries rather than the amount of muscle. As a result, there's a tendency to take less and less muscle and do a "muscle-sparing" free flap. When there are large perforators that make dissection fairly easy, then it is worthwhile to do a perforator flap. This approach usually requires four procedures—the mastectomy with immediate free flap followed by a nipple-sparing operation and then a tattoo

of the areola. Finally, you may need to have something done to the other breast to match.

More recently the superior gluteal artery perforator flap, or SGAP, or the inferior gluteal artery perforator flap, or IGAP, have been added to the options. Another procedure gaining some popularity is the transverse upper gracilis flap, or TUG flap. This flap takes one of the muscles in the medial thigh (gracilis) with tissue from the upper inner thigh. Sacrificing this muscle usually has no effect on leg function, and the flap can usually supply enough tissue for an A or B cup reconstruction.

As I noted earlier, both versions of the flap procedure require not only highly trained plastic surgeons but also specialized teams. You will want to find a center where they do this a lot and the whole staff is comfortable with the procedure and with its potential risks and complications. Researching and talking to people is important to find the right place. It may be necessary to travel to find the surgeon and team that can best fit your needs.

The advantage of reconstruction with your own tissue includes a softer, more natural-appearing breast mound that will gain and lose weight as you do. The disadvantages include the longer duration of anesthesia, greater blood loss, a longer recovery period, risk of losing part of the flap due to inadequate blood supply, and problems at the donor site. The risk of complications tends to be higher in older and more obese women as well as those with compromised vascular microcirculation, such as smokers or women with diabetes.

Free flap procedures have the advantage that less if any muscle is taken and so there are fewer problems at the donor site. They have better blood supply, although there is a small risk of the small blood vessel connections clotting, resulting in partial or complete flap loss. The disadvantages include the increased duration of surgery and the potential risk of clotting in the newly attached blood vessels.

After mastectomy and an immediate flap reconstruction you come out of anesthesia feeling like a Mack truck just hit you. You've had hours of surgery on both your breast and your abdomen, back, or buttocks. You have continuous pain medication through an IV with a button you can press so you can control the timing. You're kept on bed rest for one to two days, and you have a catheter so you don't have to go to the bathroom. By about the third or fourth day you start feeling a little better, and you can get out of bed

and walk around a bit. You're usually in the hospital about four to six days. There are drains placed in the abdominal scars as well as in the chest. You may have pain deep in your chest, which can also feel numb, as well as your abdomen or the other area the tissue has been taken from. So the double operation is certainly an ordeal. In addition, you'll need further operations for the nipple and other breast. Sometimes after the operation there is a little too much tissue in one place or another, so the surgeon does some fine-tuning. It won't hurt because the area is now numb.

If a flap procedure is the operation you want, you should take the time to research and locate who in your area can do it. If there's no one in your area and you still want a particular form of reconstruction, you can always wait, have the mastectomy first, and then find the right plastic surgeon when your treatment is done.

Eric Halvorson, is a plastic surgeon from Chapel Hill, North Carolina, who helped with this chapter, says, "What I tell my patients is that implant reconstruction spreads the risk you take over your lifetime—there is less risk with the initial operation, but living with implants carries the risks of capsular contracture, rupture, infection, malposition, exposure. Tissue flap reconstruction puts all the risk up front—the surgery and recovery are longer, with risks of flap failure, wound healing complications, donor site complications, and so on—but once everything is healed, they will rarely have other problems. Also, implant reconstructions tend to look worse with time, whereas tissue flap reconstructions tend to look better with time."

Making a Decision

To decide what's best for you, you should discuss it with your surgeon and, separately, with a plastic surgeon. Make sure you have thought about your goals for reconstruction and share them with both: Do you want to be higher, lower, larger, smaller? Some people assume that their only option is to look the same, but modern techniques have given women the option to change the appearance of their breasts following mastectomy. Some women are even happier with their breasts after mastectomy. Your surgeon will look at you, see how your body hangs together and how your breasts look before your surgery, and tell you what kind of procedure she thinks would be best

for you. Make sure you ask which procedures she is familiar with and performs regularly. Women have come to me after being told they're not a candidate for a flap, when in reality the plastic surgeon they saw just doesn't know how to do the operation. Get a second or even third opinion. Look at websites that discuss reconstruction. My former colleague Robert Goldwyn, who has done many reconstructions, points out something crucial: you should always be shown pictures of the best and the worst results your plastic surgeon has had. Some doctors will show only the best results, an act comparable to false advertising. It's important for you to know the limits of what the procedure can do for you and the risks you run of having far from ideal results.

You will also need to decide whether you want the reconstruction done immediately or at a later time. When reconstruction is done immediately, you'll have surgery only once. Also, if the surgeon performs a skin-sparing mastectomy, it is easier for the plastic surgeon to close the incision over the implant or flap. In my experience, though, many women don't have immediate reconstruction because they don't want to go through so much surgery at once. Immediate reconstruction involves a longer time in the operating room (usually about six to eight hours) and is harder to schedule. Wound-healing complications also tend to be higher with immediate reconstruction, although the cosmetic result can be better.

Once you have the new breast, you may want a nipple and areola if they were removed at the time of mastectomy. We don't do it right away because the surgeon needs to be sure it's in the right place. There's a lot of swelling after reconstructive surgery, so we need to wait until that goes down and the reconstructed breast has had time to "settle down" due to gravity. The nipple can be created using skin from the breast or flap, but it won't be the same color as your original nipple. It can be tattooed. The areola can be reconstructed with a skin graft or a tattoo. Sometimes the skin from your inner thigh is used, as it's darker than breast skin. If the skin graft is not dark enough, it can also be tattooed. Skin grafts tend to have more texture and are thus more realistic, but taking the skin graft will put one more scar on your body unless you take it from someplace where there is already a scar. Whether you want to bother with the nipple depends on why you want the reconstruction. If it's just for convenience to look symmetrical under clothes without having to bother with a prosthesis, you may decide against

it. If you want the new breast to look as real as possible, you'll probably want the nipple. Again, it's your decision—you're the one who'll go through the surgery, and you're the one who'll live with the results. I've had a couple of patients who, before they had the nipple put on, showed their reconstruction to anyone who was curious, then once the nipple was on, they didn't want to show it. Somehow it felt more like a real breast, and displaying it seemed immodest.

The Unacceptable Reconstruction

Sometimes reconstruction isn't entirely successful despite the best efforts. It may not give you the look you want, or it may be a source of chronic pain or medical problems. It can cause unpleasant sensations, ranging from pins and needles, to burning, to sharp pain. You may find it hard to adapt to the feel of an implant. An implant may seem solid, even rocklike to the touch. The breast's hardness isn't due to the saline implant but to the scar tissue that has formed around it, encasing it in a tough capsule. One woman described her implant reconstruction like, "wearing an iron bra that [she] couldn't take off!"

Sometimes plastic surgeons may focus on crafting the "perfect breast," not on replicating the patient's natural breast. The result is often a breast that is or feels too big. Even when the breast with its implant is matched in size to the original breast, the new breast is often heavier because the implant and scar tissue weigh more than breast tissue. Also, the new nipple may be higher or lower than the nipple on the other breast.

Because surgeons see women lying on an operating table, they see breasts from a different perspective than do the women, who usually see themselves standing before a mirror or looking down at their breasts. As a result they may misjudge the way a breast will hang when the woman is on her feet. If it is a good match for her other breast, which appears flatter when she is lying on her back, it will probably look smaller when she stands up. Most plastic surgeons are aware of this and will sit you up in the operating room to make sure things look symmetrical.

You don't have to simply resign yourself to such problems. A plastic surgeon can surgically remove the hard scar tissue and replace the implants,

exchange an implant for a tissue flap, reduce or enlarge a breast, or lift and reorient nipples. Technology is improving and so are surgical techniques, as experience with the procedure—and the demand for it—grows. Get a referral to a plastic surgeon from a friend or your breast surgeon, explain your problem, and have the plastic surgeon outline a plan for correcting it. If possible, get a second opinion. Again, ask for pictures of the plastic surgeon's best and worst outcomes.

Occasionally, if the skin has been altered by radiation or is not elastic enough to make additional reconstructive surgery advisable, the best course may be to remove the implant and get a prosthesis instead.

Sometimes you can feel ambivalent about the outcome. One woman on Facebook found the first reconstruction okay and not the second. "In 1996 I had a tram transplant," she said. "I was very happy with the end result, as it was my own body being used rather than a silicon implant. The second was in 2004. This time we used the latissimus flap. Different result. As it turned out, by the time they wrapped the muscle around my torso, there was little left for the breast pocket. The solution was to add an implant. I came within two days of getting on the table when I realized that I had put myself through all of this to avoid an external object in my body and canceled the procedure. So now I look odd to a first-time viewer, but I'm comfortable in my own skin."

Some don't stop getting things fixed until they have it right: "I had both breasts reconstructed after BC . . . last change I made was to change implants & wanted silicone & try to get my real size back. Before OR asked doc to have 4 size options. Prior to anesthesia I sat up in OR & announced to all present that I wanted all 4 sizes tried out with the Doc sitting me up for all to see which suited me best. Had great ones put in & no bruising."

Today a reasonably good breast reconstruction can be achieved after mastectomy by any of these techniques, using expanders and implants or your own tissue from the abdomen, buttocks, back, or thighs. Achieving symmetry between the nonmastectomy breast and the reconstructed breast, however, sometimes requires reshaping, reducing, or enlarging the normal breast. A large, droopy breast on the normal side can be reduced to match the reconstructed breast. If the breast volume is satisfactory, then the breast can be reshaped by "mastopexy" techniques to lift the nipple and reshape the breast. A normal breast that is too small may be augmented with an

implant behind the muscle. This should be done cautiously because the implant-augmented breast tends to be firmer without the natural droop, thus presenting a potential problem for achieving symmetry if the reconstruction opposite is done with one's own tissue. Also, you should be careful about the potential problems in follow-up of this breast, as this side, unlike the mastectomy side, will still require regular breast exams and annual mammography.

PROSTHESES

Many women don't get reconstruction because they are very comfortable with a prosthesis. It isn't invasive and can be removed at will. As I was writing this, a former patient of mine told me of her experience with a Beverly Hills surgeon "who tried to sell me a breast as if he was selling a car." When she said that at the moment all she was looking for was information and didn't yet know whether she wanted reconstruction, he was appalled and demanded, 'Why not?'" She explained her reservations about getting additional surgery and said she had come to learn more and discuss the pros and cons of reconstruction. Then he sent her to an office where she was shown the before-and-after photo album. "It felt like it was a showroom and they were selling. I didn't buy any of it and have been quite satisfied with my prostheses for the past sixteen years. Please remind women that they have choices, and some (many?) of us are doing just fine 'au naturel' with prosthetics."

The option of wearing a prosthesis will probably be offered to you in the hospital after your surgery (unless you've had immediate reconstruction and obviously won't need one). In most areas of the country the hospital arranges for someone to visit you to talk about prostheses while you're still there. Your visitor will be from Reach for Recovery or a firm that sells prostheses. You can get a temporary prosthesis first and then shop around for a permanent one. The prosthesis fits into a pocket in a postmastectomy bra (Figure 13.1). You can shop for them in person or online, from catalogs, in medical supply houses, or in fancy lingerie stores. Each supplier has its advantages and disadvantages. You may be put off by the implications of mutilation—the wheelchairs and artificial limbs in medical supply outlets.

In a lingerie store you may feel painfully reminded of the breast you no longer have. Your doctor or the American Cancer Society can help you find the stores, catalogs, or websites to buy your prosthesis, or you can ask friends who've had mastectomies. Y-ME, a volunteer organization of breast cancer survivors, will send you a prosthesis if they have the size required in stock.

There are suppliers that will make a custom prosthesis for you; it's expensive, and your insurance company may not pay for it, but you might want a precise match. (It's a good idea to check with your insurance company before buying your prosthesis anyway; different companies have different quirks, and you may want to be sure of what your own expenses will be.) Medicare pays for a prosthesis every year or two—with a prescription. (Why you need a prescription for a prosthesis, I don't know—I've never met a woman who bought one for the fun of it. But the ways of bureaucracies are mysterious.) There are also specific forms for swimming, though most of the better prostheses are made of silicone and are waterproof.

Prostheses come in a range of prices and quality. If you don't have insurance to pay for one or you haven't decided between prosthesis or reconstruction, you'll probably want the least expensive form available, at least temporarily. Catalogs and many stores offer forms for as low as $20 and mastectomy bras for around $15.

Prostheses are made in different sizes and for different operations. If you had a radical mastectomy, you can get a fuller prosthesis. If you had a wide excision that's left you noticeably asymmetrical, you can get a small "filler," or shell that fits comfortably in your bra. In the past, prostheses didn't have nipples, which caused problems for women whose remaining breast had a prominent nipple. (Betty Rollin, in her book *First, You Cry*, has a very funny description of her efforts to make her own "nipple" out of cloth buttons.) Fortunately any prosthesis you buy now has a nipple, and you can get a separate nipple to attach to it if your own nipple is more prominent than the one on the prosthesis.

Some situations may affect what makes a prosthesis right for you. Certain kinds of disabilities, for example, can make a particular form uncomfortable. Judith Rogers, an activist in Breast Health Access for Disabilities, has mild cerebral palsy, and she found that her first prosthesis

caused problems. “It was good in terms of matching the size of my remaining breast,” she says. “But it was bad for my shoulder: it was too heavy for me. It pulled down, harming my muscles and increasing the effects of lymphedema.” When she got a lighter one, she had less pain. You need to take time to consider all the factors involving your body and mind when you choose a prosthesis.

DOING NOTHING

Finally there is a third option, which a few women have embraced—not disguising the operation at all. If your lumpectomy doesn’t create a dramatic lopsided look, you may decide just to ignore it. Even with the more noticeable change that comes with a larger lumpectomy or a mastectomy, some prefer doing nothing cosmetically. One of my patients early in my career thought about her options, then concluded that “a prosthesis sounded too uncomfortable, and reconstruction hasn’t been around long enough to see what long-term effects it can have. And then I decided I was comfortable with the way I looked.” She went to work dressed normally, jogged in a loose T-shirt, and felt that it was other people’s problem if they were uncomfortable with it. Once in a while she felt a need to look more “normal”—especially when she had important meetings with new business associates. Her solution was to stuff shoulder pads from her dresses into her bra.

For other women, refusing to create the illusion of a breast is part of their feminist beliefs. Artist Matuschka created photographs of herself in a cutaway gown, showing not her remaining breast but her mastectomy scar. One photograph was on the cover of the August 15, 1993, *New York Times* magazine. The effect is of harshness and defiance, showing the world what breast cancer does to a woman’s body. Writer Deena Metzger, whose book *Tree* addresses her cancer, includes a photograph with a different approach: she softens the effect of the amputation by covering her scar with a beautiful, evocative tattoo of a tree, creating a new beauty where the beauty of her breast once was.[19]

Some people feel too conspicuous in public without a prosthesis, but they still don't like how the form feels. In that case there is another possible alternative: you can have both breasts removed. Although this destroys a healthy breast, it does make it possible to wear loose shirts without self-consciousness. I had only one patient take this route, and she had to fight with her insurance company to get them to pay for the removal of the healthy breast. She told them that because they paid for reconstruction for symmetry, they should pay for a contralateral mastectomy also for symmetry.

Having the self-confidence to feel comfortable without the appearance of a breast shows wonderful courage, but most of us are products of our culture and still need to feel cosmetically acceptable to the outside world. In some cases there are actual penalties for failing to appear "normal." If nonconformity will cost you your job, for example, you're likely to want to have reconstruction or wear a prosthesis at least part of the time.

A fashion designer, Hilary Boyajian, came up with an interesting line of tunic-style garments she calls "Chikara" for women with one breast or no breasts. It drapes loosely across the chest so that unusual shapes aren't visible. "I get so many e-mails from breast cancer survivors thanking me for doing this," she told the reporter who interviewed her.[20]

As more women live and even thrive after a breast cancer diagnosis, more attention has been paid to the results of surgery. As with everything, what road you want to take is your choice. The good news is that there are now lots of options, and you can make a choice at the time of your diagnosis or years later. In a disease with which you often feel out of control, this is one area where you can make the choice that works for you.