Breast reconstruction

breast cancer care

This booklet is for women considering breast reconstruction after surgery to treat breast cancer.

This information is by Breast Cancer Care.

We are the only specialist UK-wide charity that supports people affected by breast cancer. We've been supporting them, their family and friends and campaigning on their behalf since 1973.

Today, we continue to offer reliable information and personal support, over the phone and online, from nurses and people who've been there. We also offer local support across the UK.

From the moment you notice something isn't right, through to treatment and beyond, we're here to help you feel more in control.

For breast cancer care, support and information, call us free on **0808 800 6000** or visit **breastcancercare.org.uk**

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Contents

Introduction

This booklet is for women considering breast reconstruction after surgery to treat breast cancer.

It may also be useful for women who are considering breast reconstruction for other reasons such as uneven breast development, or after a bilateral mastectomy (removal of both breasts) to reduce the risk of breast cancer due to a significant family history.

Reconstruction is not commonly offered to men who have a mastectomy for breast cancer, but it's possible to improve the appearance and evenness of the chest with surgery.

Combining breast cancer surgery with plastic surgery to provide the best cancer treatment and cosmetic outcome is known as oncoplastic surgery.

A range of techniques can be used to reconstruct the breast and these change as current methods are improved. The right one for you depends on the assessment by your breast surgeon, your preferences, expectations and personal circumstances. Each operation is adapted to your individual needs and suitability for a particular technique. The outcome of surgery and the final shape will differ from person to person.

You may want to compare different types of reconstruction by referring to the chart on page 28.

We hope this booklet will give you an understanding of breast reconstruction and the options available.

What is breast reconstruction?

Breast reconstruction is the creation of a new breast shape, or mound, using surgery. It may be done after removal of a whole breast (mastectomy) or part of the breast (breast-conserving surgery).

You can have reconstruction at the same time as breast cancer surgery, known as immediate reconstruction; or months or years later, known as delayed reconstruction. Breast reconstruction often involves several operations to give you the best outcome possible.

The new breast shape can be created using an implant and/or your own tissue from another part of the body, usually the back or lower abdomen (belly). Reconstructed breasts don't usually have a nipple but one can be created with surgery and tattooing. Prosthetic stick-on nipples can also be used (see page 31 for more information).

The aim of breast reconstruction is to create a breast shape that looks as natural as possible and to try to match the breast on the other side in size, shape and position. However, even with the best outcome, there will be differences between the remaining breast and the reconstructed one, and sometimes surgery on the other side can help. This can be done at the same time as the reconstruction, but waiting for the reconstruction to heal and settle into position may be better. Your specialist team will give you an idea of how long this is likely to be.

Where both breasts are being reconstructed, the aim is to recreate breasts that match and are in proportion to the body shape.

There are usually different options available for breast reconstruction and your breast surgeon and breast care nurse will explain which one is likely to suit you best. It's helpful if you can take some time to consider these options without feeling under pressure to make a decision. You may need a couple of discussions with your specialist team before you feel confident deciding what to do.

Having a breast reconstruction will not increase the chances of the breast cancer coming back.

Who can have a reconstruction?

Most women who have had a mastectomy, and some who have had breast-conserving surgery, can have either immediate or delayed breast reconstruction.

National guidance says the choice of immediate breast reconstruction should be discussed with anyone having a mastectomy. However, a delayed reconstruction may be a better option for some people. All suitable breast reconstruction options should be offered and discussed, even if they are not available locally.

Some people are advised not to have a breast reconstruction because of other existing medical conditions that might increase the risk of complications following surgery.

If it's likely you'll need radiotherapy this may affect the options for and timing of breast reconstruction. Radiotherapy can increase the risk of hard scar tissue forming around an implant. This is known as capsular contracture (see page 37). Capsular contracture can also affect a reconstruction that uses your own tissue, making the breast feel firmer, reducing its size and possibly altering its shape. Because of this, if radiotherapy is a likely treatment you may be advised to delay reconstruction for up to 12 months.

If you're advised against reconstruction your surgeon should explain why. You can ask for a second opinion if this would be helpful.

Making your decision about reconstruction

Choosing whether or not to have breast reconstruction is a very personal decision. Some women feel reconstruction is necessary to restore their confidence; others prefer to wear an external breast form (prosthesis); and some women choose not to have reconstruction and not to wear a prosthesis.

If you want more information about wearing a prosthesis, see our booklet **Breast prostheses, bras and clothes after surgery**.

You may choose to delay your reconstruction (see page 13), which can be a good option if you don't want to decide straight away. If you decide not to go ahead, this doesn't mean you won't be able to have one later.

There's no right or wrong choice and it's important to do what's best for you. It can be helpful to talk to other women who have had breast reconstruction before making your decision. Your breast care nurse may be able to arrange this. Breast Cancer Care can also put you in touch with someone who has had the type of breast reconstruction you are considering, through our Someone Like Me service. Call our Helpline **0808 800 6000** or visit **breastcancercare.org.uk** for more information. You might also find the organisations listed on page 41 useful.

Discussing reconstruction with your surgeon

Discussing reconstruction with your surgeon before making a decision is important. They will want to make sure you fully understand the reconstruction process and have realistic expectations of how your reconstructed breast will look and feel.

The surgeon you meet when you've been diagnosed is likely to be a general breast surgeon or an oncoplastic breast surgeon (a breast surgeon trained in plastic surgery techniques and breast reconstruction). They and their team can explain the types of reconstruction, what procedure may suit you best and what techniques are available in your local hospital or linked hospitals. Alternatively they may refer you to another surgeon or breast unit for this advice and guidance.

Every breast unit should have a breast reconstruction pathway (a set of processes to follow). This is to make sure you can get the most up-to-date information about reconstruction and access to the technique that's best for you, even if it's not at your local hospital.

If you choose to go ahead, your breast reconstruction may be carried out by an oncoplastic breast surgeon or a plastic surgeon trained in breast reconstruction.

Some reconstruction operations need plastic surgeons who are trained in microvascular surgery (operating on tiny blood vessels), and you may have to be referred to a specialist centre in a different hospital.

You might find it helpful to discuss breast reconstruction with more than one specialist in order to choose the right option for you. If so, your GP, surgeon or breast care nurse may be able to recommend someone else in your area.

Questions you may want to ask your surgeon

Make sure you've got all the facts you need and have received answers to all your questions before making an informed decision. You may find it helpful to write down any questions you want to ask and to take notes during consultations. Taking someone with you can help you to remember what has been discussed and give you extra support.

Here are some questions you may want to ask your surgeon.

Can I have an immediate breast reconstruction?

Which reconstruction would be best for me and why?

What are the benefits, limitations and risks of this type of surgery?

When would I be able to have my surgery done?

How long would I have to stay in hospital?

What is the recovery time for this operation?

When would I be able to move about, walk and drive?

How much pain is there likely to be?

Can you show me where the scars would be and how big/long?

Would I have scars elsewhere on my body?

Would I be able to keep my nipple?

Can reconstruction surgery delay my other cancer treatments, like chemotherapy and radiotherapy?

When would I be able to exercise again?

Can you show me any photographs or images of your previous breast reconstructions?

Can I speak to someone who has had the same type of reconstruction?

Would I need to wear a special bra after the operation?

Finding a surgeon

You can find some information online about which surgeons perform breast reconstruction surgery in which hospitals, although the information is not always complete or up to date. The British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) has a list of surgeons and hospitals with plastic surgery units. See the 'Useful organisations' section on page 41 for details.

Your GP, surgeon or breast care nurse may be able to recommend a hospital or particular surgeon for you. You can also contact the Breast Cancer Care Helpline for more information on **0808 800 6000**.

If you choose private healthcare for your breast cancer treatment, most health insurance plans cover the full cost of breast reconstruction. Contact your health insurance company for further details to check what is covered on your policy.

Reasons for having reconstruction

Some women choose reconstruction for practical reasons such as not having to wear a prosthesis.

Surgery for breast cancer is likely to affect how you look and feel in some way. Some women find it harder than others to come to terms with losing one or both of their breasts. After breast surgery, you might

be concerned about the shape of your body and how your breast area will look.

Like many women, you may choose breast reconstruction because your breasts are an important part of your body image, self-esteem and sexuality.

Some women choose to have a reconstruction as they think it will make a difference to their partner, or that it may help them feel more confident during intimacy and sex. However, any decision you make about having a reconstruction should be based on whether it's right for you.

If you're not in a relationship at the time of your breast cancer surgery, you may be worried about meeting someone new in future. Breast reconstruction may help you feel more at ease in new relationships, and help you to talk about your breast cancer and feel more confident about showing your body to your partner.

Limitations of breast reconstruction

A lot of women who have reconstruction are satisfied with the result. However, not everyone's experience is positive and some women feel unsure about their new shape or self-conscious about their new breast.

- Reconstructed breasts will not feel, look or move exactly the same as before. They tend to be less sensitive and sometimes very numb.
- If you lose or gain weight, this will affect the natural breast but not the reconstructed breast, causing a difference in shape and size.
- Several visits to the hospital for appointments and further operations are often needed to get the best cosmetic result.
- Recovery after breast reconstruction will take longer than if you have a mastectomy without reconstruction.
- You may have scars on other parts of your body depending on the type of reconstruction.
- Compared with a mastectomy without reconstruction, there is a higher risk of complications, and this may delay further treatment.
- If you need radiotherapy after your reconstruction, this can affect the appearance of your reconstructed breast.
- Reconstructed breasts don't usually have a nipple, but one can be created with surgery, or a nipple tattoo, often at a later date (your specialist team will discuss timings with you).

A reconstructed breast will not look the same as the breast you have lost – it will often be a slightly different size and shape. Any differences should not be noticeable when you are clothed, even in a bra or in swimwear. But when you are undressed, the differences are more obvious. You'll be able to see some scarring, although this should fade over time.

You won't get the same feeling as before from a reconstructed breast and you may have no sensation at all. A natural breast will change over time and droop as you get older. Reconstructed breasts (especially those using implants) will not change in the same way. Over time the differences between a natural and reconstructed breast may become more obvious, and you may need further surgery to restore symmetry.

Where a muscle has been used to cover an implant or is part of the reconstruction you may see movement of the reconstructed breast as that muscle contracts.

Despite these limitations, most women say the results after reconstruction surgery are acceptable and that they feel confident about the way they look.

When to have reconstruction

Some women choose to have reconstruction at the same time as their mastectomy, while others need or choose to have it later.

Immediate reconstruction (reconstruction at the same time as mastectomy)

One of the benefits of immediate reconstruction is that the skin of the breast can sometimes be preserved. Your breast surgeon may discuss a skin-sparing mastectomy. This is removal of the breast and nipple area without removing much of the overlying skin of the breast.

Most women who have a mastectomy have their nipple removed as part of the operation. However, for some women, keeping the nipple (a nipple-sparing mastectomy) may be possible.

Your surgeon will discuss which type of operation is appropriate to best treat your breast cancer.

Delayed reconstruction (mastectomy first, reconstruction later)

You can have a reconstruction months or even years after your breast surgery, so you have plenty of time to make a decision if you opt for a delayed operation. During this time you may adapt to your mastectomy and feel that you no longer want to go through further surgery; it's fine to change your mind.

Women who want reconstruction at a later date after completing treatment for breast cancer can still have their operation on the NHS. However, in some areas there may be a long wait.

Types of reconstruction

There are three main types of breast reconstruction:

- reconstruction using only a breast implant
- reconstruction using your own tissue (a tissue flap), which can be taken from a number of places in the body (the most common being the back or the lower part of the abdomen)
- reconstruction using a combination of tissue and an implant

A number of options may be available to you. However, one type of operation may be the most suitable depending on your shape and build, general health, your expectations and whether you're having or have had radiotherapy treatment to the breast.

You can see animations of some reconstruction techniques at **breastcancercare.org.uk/reconstruction-animations**

We have also included a chart on page 28 which compares different types of reconstruction at a glance.

There's information on reconstruction after breast-conserving surgery on page 30.

Reconstruction using an implant

Implant breast reconstruction involves restoring the shape and volume of the breast using a breast implant. Breasts reconstructed in this way tend to be close to a natural breast shape, but are firmer and move less

naturally than those using your own tissue. This can mean it's more difficult to get a natural shape when one breast, rather than both, is being reconstructed.

The reconstructed breast will not droop with age and may look higher than the other breast, particularly as you get older. If you lose or gain weight, this will affect the natural breast but not the reconstructed breast, causing a difference in shape and size. At some point you may need more surgery to the reconstructed breast, or to the other breast, for a better match.

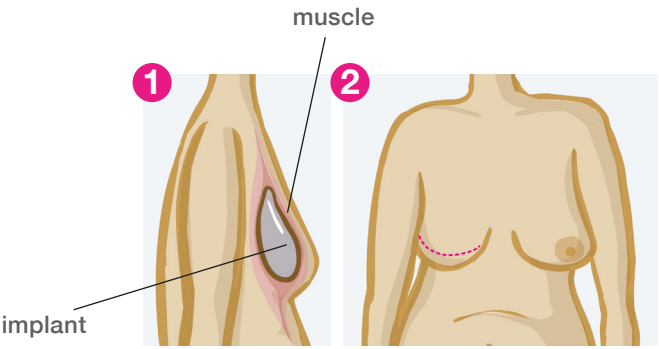
Implant reconstruction is often recommended for women with small and firm breasts, as it avoids the need for more extensive surgery using tissue from another part of the body.

With any type of reconstruction there is a risk of infection or other problems. If this happens with implant reconstruction, the implant may need to be removed.

Silicone breast implants are expected to last at least 10 to 15 years, and are unlikely to need replacing.

There are different types of implant reconstruction (see below). Your surgeon will be able to advise you on the best option for you.

Immediate reconstruction using an implant



If the breast cancer can be removed without taking away too much skin (skin-sparing mastectomy) and the remaining breast is not too large and doesn't have a significant droop, an implant may be inserted under or

in front of the chest muscle (see image 1). Inserting the implant under the chest muscle helps to keep the implant in the right place and hide its outline. A mesh or an acellular dermal matrix (ADM) can also be used to cover the implant (see page 16). Talk to your surgeon about the best options for you.

For women with larger breasts, implant reconstruction may be possible using a dermal sling (see page 16).

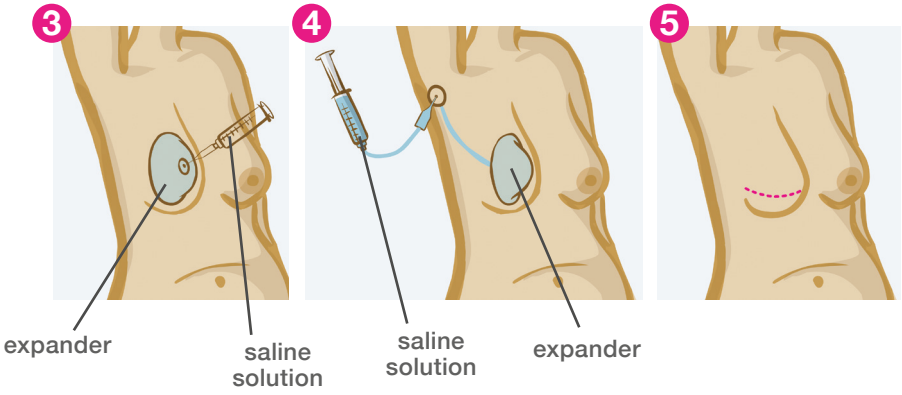
Using a breast implant alone is the simplest type of reconstruction operation and the recovery time is usually quicker than for other types of reconstruction. It's most often done at the same time as the mastectomy (immediate).

The other option is to have an implant called a permanent tissue expander inserted at the same time as the mastectomy. This is an implant that is gradually expanded or 'inflated' over time. See 'Delayed reconstruction using an implant' (below) for details about this.

For some women a temporary tissue expander implant is used and then expanded over time. It is then replaced with a permanent silicone implant. This might be referred to as a two-stage procedure.

If you need radiotherapy, surgeons may be able to insert a tissue expander or implant immediately after a mastectomy to create and preserve a space. The expander will not be inflated until the radiotherapy has finished. This can help to reduce the extent of any hard scar tissue (capsular contracture, see page 37).

Delayed reconstruction using an implant



A permanent or temporary tissue expander is first placed behind the chest muscle, usually through the mastectomy scar. This helps keep the implant in the right place and hides its outline. Several weeks later, when the scars have healed, a surgeon or nurse gradually inflates the implant with saline (salt water) through a small port. The saline solution is injected into the port just under the skin. This is located either in the expander (see image 3) so that the solution can be injected directly or is connected to the expander by a short tube (see image 4).

This procedure is done during outpatient appointments, usually every one or two weeks, to slowly stretch the muscle and overlying skin. The number of appointments needed varies from person to person.

When expander implants are being filled, you'll feel a stretching sensation and tightness within the breast reconstruction. It can be uncomfortable for a day or two after each inflating, but it shouldn't be painful. The expander is generally inflated until the new breast is slightly larger than the other breast and then left for a few weeks so the skin stretches.

If a temporary expander is used, a further small operation will be needed to remove the expander and port, and replace it with a permanent implant, which will be your final breast shape.

If a permanent expander implant has been used, the port can be taken out under local anaesthetic, leaving the expander implant in place.

Implant reconstruction with tissue expansion can be particularly useful if you don't have enough skin left on your chest to comfortably cover and support an implant, especially if you're having delayed reconstruction.

Skin is very elastic and has a surprising ability to stretch but tissue expansion may not be suitable for women who have had radiotherapy treatment. This is because radiotherapy reduces the elasticity and quality of the skin.

Acellular dermal matrix (ADM) and dermal sling

These products are used to support breast implants. They are attached to the chest muscle to create a pocket that holds the implant in place, like an internal bra. They help to create a natural droop, shape and contour.

ADMs are made from animal tissue (usually pig or cow skin) and look and feel like very thin leather. They are processed and preserved so

they can safely be left in the body. Meshes are manmade (synthetic) supports.

If you don't want your surgeon to use products made from animal skin, talk to them about possible alternatives.

An ADM or mesh is most suitable for women with small or medium sized breasts. ADMs are not available in every hospital. You can ask your surgeon if it's suitable for you and talk to them about any possible risks or complications with this type of reconstruction.

For women with larger breasts, their own tissue (from the lower half of the breast) can be used to support the implant. This is known as a dermal sling.

It's not suitable for everyone and your surgeon can tell you if it is an option for you.

What scarring should I expect?

Scars will vary following reconstruction surgery using implants, but will often be horizontal across the newly formed breast (see images 2 and 5). With immediate reconstructions the implant may be placed through an incision around the areola (the darker area of skin around the nipple). You can ask your surgeon about the position and length of the scar before the surgery takes place.

What are implants made from?

Breast implants have an outer shell made from silicone elastomer (similar to rubber). The shell is filled with silicone gel or saline. The surface of implants is usually textured, although some are smooth.

Silicone gel

Most implants used for reconstruction surgery contain silicone gel and the result tends to look more natural than with saline implants. The gel can be firm and feel more jelly-like or may be softer and feel more fluid-like depending on the type of implant used. Implants shaped like a teardrop are commonly used because they mimic the natural shape of a breast.

Saline

Saline (salt water) is an alternative to silicone gel. The outer shell of the implant is still made of silicone. These implants contain a liquid rather than a gel so they are more likely to wrinkle under the skin and

can sometimes leak. Any leaks are absorbed by the body and are not harmful, but as the saline leaks out, the breast gradually gets smaller and in time the implant has to be replaced. Saline implants are also heavier, which may restrict the size that can be used. For these reasons this type of implant is not commonly used.

Expander implants

These use both silicone gel and saline. The outer shell is made of silicone with an inflatable inner chamber. Saline is injected in to the inner chamber to expand it. It's used in both immediate and delayed reconstructions.

Are silicone implants safe?

Experts regularly examine evidence for the safety of silicone gel implants. Implants used in Europe should adhere to specific safety standards and surgeons in the UK continue to recommend them to women considering breast reconstruction surgery.

Modern silicone gel implants are expected to last at least 10 to 15 years, and are unlikely to need replacing. The Medicines and Healthcare Regulatory Agency (MHRA) has a publication called Breast Implants: Information for women considering implants, which you may find useful. For details see page 43.

Once inserted, implants are very difficult to damage. You can continue with all your normal activities including travelling by plane and taking part in sports.

Breast implants and lymphoma

Some women with breast implants have been found to have a very rare type of cancer called breast implant associated anaplastic large cell lymphoma (BIA-ALCL). It has been diagnosed in women with and without breast cancer who have implants for breast reconstruction or breast enlargement.

It's not known if the implants are the cause, but there may be a link, particularly to implants with a textured surface.

The most common symptom for BIA-ALCL is a seroma (a collection of fluid) that forms between the breast implant and the capsule at least six months after the breast implant surgery. Most cases have happened years after surgery.

If you develop a seroma, a breast lump or a swelling around your implant more than six months after having the breast implant (regardless of how many years later), tell someone in your specialist team such as your surgeon or breast care nurse.

Breast and Cosmetic Implant Registry (BCIR)

Since October 2016, anyone who has had breast reconstruction using a tissue expander or breast implant in England will be asked for their permission to have this recorded on a national registry. This is so that details of patients can be easily found if implants ever need to be recalled or removed. Talk to your specialist if you would like to know more about this.

Reconstruction using your own tissue (tissue flap)

A commonly used reconstruction technique uses flaps of your own tissue (with or without an implant), including the skin, fat and sometimes a muscle. This can be taken from your back or lower abdomen, or from the inner thigh or buttock. This is then reshaped to form the new breast. Because the skin used is taken from another area of the body, it may be a slightly different shade or texture to the rest of the breast.

This method is particularly suitable for women with moderate- to large-sized breasts that have a natural droop.

Tissue flap reconstruction is commonly used in delayed reconstruction, particularly if radiotherapy has been given. Flaps without implants may also be used for immediate reconstruction.

You may need to have an ultrasound (a scan that uses high frequency sound waves to produce an image) or CT scan (a scan that uses x-rays to take detailed pictures across the body) before your flap reconstruction to look at the blood supply to the tissue which will be used to create your new breast.

Reconstruction using your own tissue involves a longer operation and more recovery time than an implant-only reconstruction. But you will be less likely to need further surgery in the future than with reconstruction using implants alone. A reconstructed breast using tissue instead of an implant may also provide a better match with your other breast in

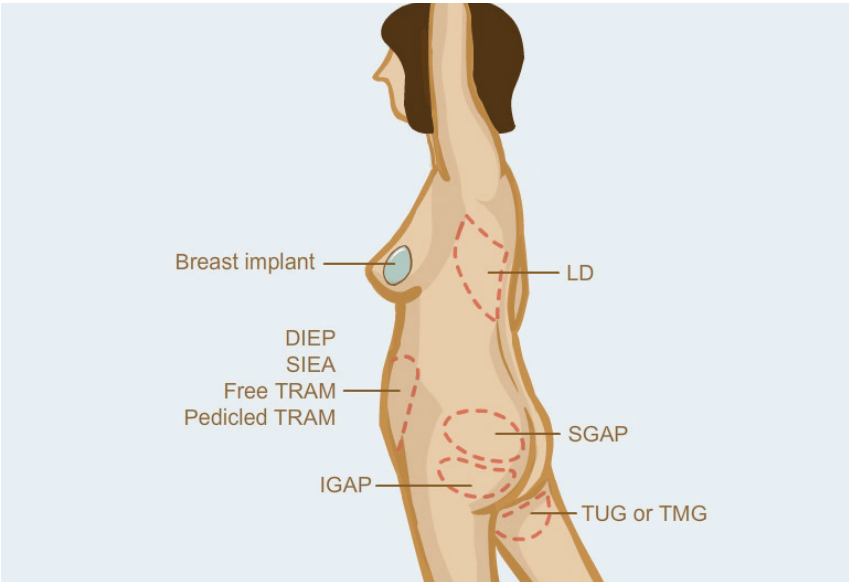
the long term. This is because tissue is affected by gravity, ageing and weight change more naturally.

There are two ways reconstruction with a tissue flap may be done:

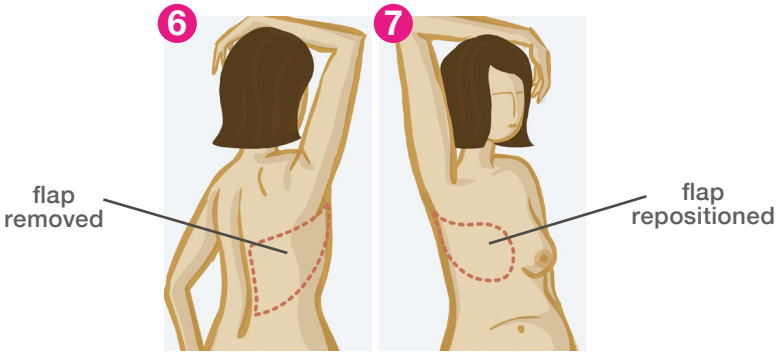
- **pedicled flap** – the flap remains attached at one end to its blood vessels which means the blood supply to the muscle doesn't need to be cut
- **free flap** – the flap is completely detached from the body along with its blood vessels and reattached by microsurgery in the position of the reconstructed breast

There are different types of tissue flap reconstruction (see below) and surgeons are developing new ways of improving the cosmetic result. Your surgeon will advise on the best option for you.

Different reconstruction options



LD (latissimus dorsi) flap – back flap



This procedure uses the latissimus dorsi muscle – a large muscle that lies in the back just below the shoulder blade. The skin, fat and muscle are removed from the back (see image 6) but the blood vessels of the flap remain attached to the body at the end nearest the armpit (known as a pedicled flap).

The flap is then turned and carefully tunnelled under the skin below the armpit and is brought round to the front of the body to lie on the chest wall and form the new breast (or part of the breast if being used in breast-conserving surgery) (see image 7). Some of the skin on the flap is used to form the new skin of the reconstructed breast while the muscle and the fat are used to form the volume of the breast. It's usually necessary to use an implant under the flap after a mastectomy to help create a breast that's a similar size to the other one.

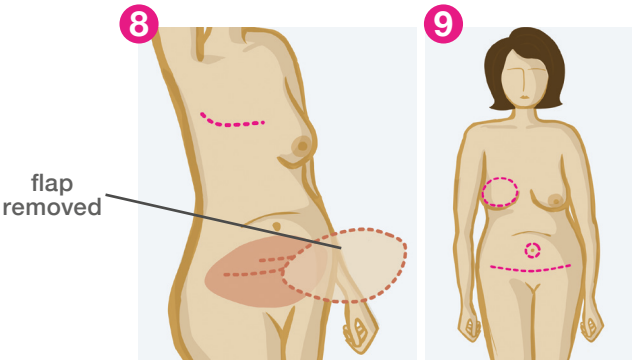
An expander implant is sometimes used, particularly in a delayed reconstruction, and the expansion process starts when the tissue flap has healed, usually two or three weeks after surgery. See page 18 for more information about expander implants.

The scar on the back is usually horizontal and hidden along the bra line, or it can be diagonal. The scar on the breast will vary depending on your shape, the size of your breast and whether you have the reconstruction done at the same time as your mastectomy or at a later date.

After fully recovering from an LD flap reconstruction, some women will notice weakness in the shoulder during everyday activities. Possible weakness will be an important consideration if you're very active, for example if you regularly swim, climb, row, play tennis or golf. So

consider this when deciding which method of reconstruction is best for you.

DIEP (deep inferior epigastric perforator) flap



A DIEP reconstruction uses a free flap of skin and fat, but no muscle, to form the new breast shape. The flap is taken from the lower abdomen and uses the skin and fat between the belly button (umbilicus) and the groin along with the artery and veins (see image 8). It is called DIEP because deep blood vessels called the deep inferior epigastric perforators are used.

The free flap is transferred to the chest and shaped into a breast while the artery and veins are connected to blood vessels in the armpit or chest wall using a specialised technique called microvascular surgery. Rarely, if the flap of tissue doesn't have a good blood supply it will die and the reconstruction will fail (see page 27).

The advantage of this type of reconstruction is that no muscle has to be removed so the strength of the abdomen is not affected. This means there is very little chance of developing a hernia (a bulge or protrusion where the wall of the abdomen has been weakened). If you do develop a hernia it can be repaired with an operation (see page 38).

The DIEP flap is major surgery involving a long and complex operation, and you will need to be in good overall health to go through it. Ideally you should be a non-smoker, have no existing scars on your abdomen and have enough fatty tissue in your lower abdominal area.

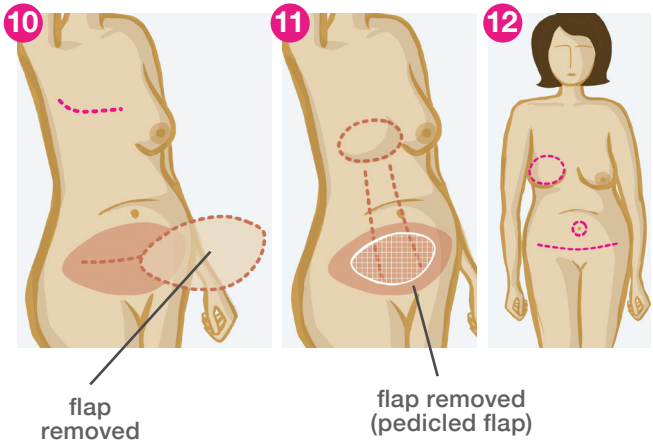
If you're very overweight you may be advised to lose weight before being offered this type of surgery. This is to reduce your risk of complications from the anaesthetic and the surgery.

Flap reconstruction is generally not suitable for people with diabetes.

There will be scarring on the breast, which is usually oval, and on the abdomen – usually below the bikini line stretching from hip to hip. The belly button (umbilicus) is repositioned during this type of surgery, leaving a circular scar around it (see image 9).

If you have a skin-sparing mastectomy, there may also be a circular scar around where your nipple was.

TRAM (transverse rectus abdominis muscle) flap



This technique uses the large muscle that runs from the lower ribs to the pelvic bone in the groin. It is called a TRAM flap because the rectus abdominis muscle (large tummy muscle) is used and because the skin is taken from across your tummy (transversely) (see image 10).

TRAM flaps can be free (see image 10) or pedicled (see image 11) (see page 20).

A free flap is the most common type of flap used. The flap is completely detached and then reattached. A pedicled flap is where the flap remains attached at one end to the original anchoring point and the original blood supply.

In a free flap the muscle, fat and skin are removed completely from the abdomen and the surgeon shapes a breast from this tissue. The blood vessels that supply the flap are reconnected to blood vessels in the region of the reconstructed breast using microvascular surgery, either under the armpit or behind the breastbone.

In a pedicled flap, the rectus abdominis muscle, along with its overlying fat and skin and blood supply, is tunnelled under the skin of the abdomen and chest and brought out over the area where the new breast is to be made. Usually there's enough fat in the flap to make the new breast the same size as the other one without the need for an implant.

If the flap of tissue isn't getting a good blood supply following the procedure it will die and the reconstruction will fail. This is rare but if it does happen further surgery will be needed to remove the flap and, if possible, perform the reconstruction again at a later date (see page 27).

Both types of TRAM flap operation may weaken the abdominal wall, which you might notice afterwards when lifting or during sport. During the operation the surgeon will put a 'mesh' into the abdomen to help strengthen the muscles and to try to avoid a hernia (a bulge or protrusion where the wall of the abdomen has been weakened). If you do develop a hernia it can be repaired with a fairly simple operation (see page 38).

The free flap TRAM is sometimes a longer and more complex procedure, with a greater risk of complications than the pedicled flap, so a longer recovery time is usually needed.

You will need to be in good overall health to have either type of TRAM flap procedure. You'll need to be a non-smoker, have no existing scars on your abdomen (caesarean scars don't always mean you can't have this procedure) and have enough fat in the lower abdominal area.

If you're very overweight you may be advised to lose weight before being offered this type of surgery. This is to reduce your risk of complications from the anaesthetic and the surgery.

Flap reconstruction is generally not suitable for people with diabetes.

Both types of TRAM flap leave a scar across the width of the abdomen, from hip to hip, usually just below the bikini line. The scar on the reconstructed breast will be circular or oval and vary in size from person to person. The belly button (umbilicus) is repositioned during this type of surgery, leaving a circular scar around it (see image 12).

If you have a skin-sparing mastectomy, there may also be a circular scar around where your nipple was.

SIEA (super inferior epigastric artery flap)

This is similar to the DIEP flap as it uses only skin and fat from the lower abdomen and no muscle, but the vessels taken are superficial (nearer the surface) rather than the deep vessels used in the DIEP flap.

The blood supply might not always be sufficient to have this procedure. The operation, complications and recovery time are like those described on page 22 for the DIEP flap.

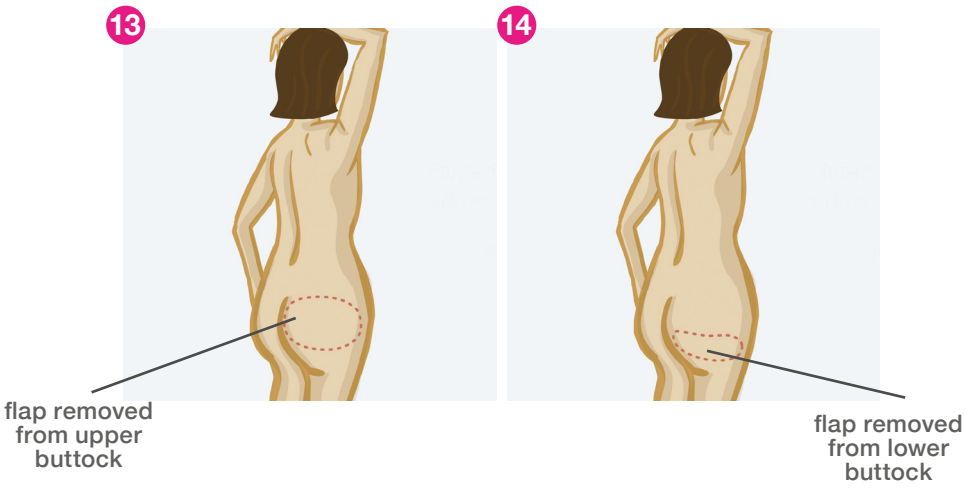
Other free flap reconstructions

There are some other reconstruction techniques using flaps from other areas of the body. The following types of free flap reconstruction use tissue from the buttocks or thighs.

These techniques are mainly used when other types of reconstruction aren't suitable. They may be appropriate for women who are too slim for tissue to be taken from their abdomen or who have scarring from previous surgery to their abdominal or back area. Only a few surgeons in the UK offer these techniques and you may need to travel to another centre if you need this type of surgery.

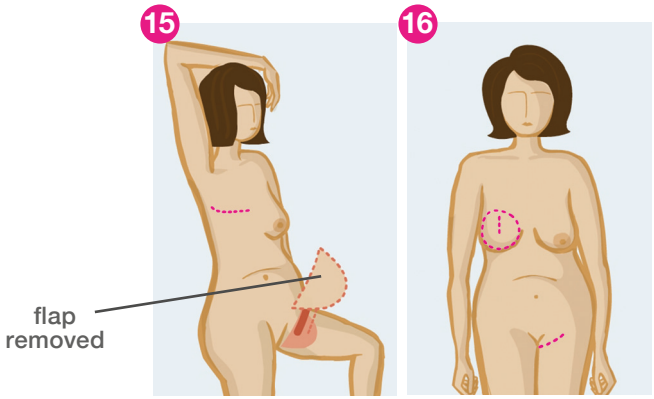
As with all types of flap reconstruction, these techniques are generally not suitable for women who have diabetes, are heavy smokers or are very overweight.

SGAP (super gluteal artery perforator) flap and IGAP (inferior gluteal artery perforator) flap



SGAP and IGAP use only fat and skin taken from the upper or lower buttock to create a new breast (see images 13 and 14). This involves microvascular surgery, which is the process of joining blood vessels together. Where tissue has been removed from the buttocks, there will be a scar and an indentation.

TMG (transverse myocutaneus gracilis) flap or TUG (transverse upper gracilis) flap



The tissue removed in this procedure is taken from the upper inner thigh and consists of skin, fat and a small strip of muscle (see image 15).

The procedure may be suitable for women with small- or medium-sized breasts. The inner thigh fat feels soft and is therefore similar in texture to the breast fat. Microvascular surgery is needed to join the blood vessels.

The scar is placed in the fold of the groin and runs to the fold of the buttock area – you will also have a scar on the breast where the flap is placed (see image 16). You can discuss with your surgeon how the scar will look. You may have to wear bandages or lycra shorts to reduce the risk of swelling, bruising and fluid collection for some weeks following surgery.

Tissue failure

With all flap methods of reconstruction, there's a risk that the flap, or part of the flap, will fail if it doesn't have a good enough blood supply. This is rare, but if it happens you may need another operation to remove the affected tissue. Your surgeon will then talk to you about your options for further reconstruction.

Comparing types of reconstruction

The table on the next page compares different forms of breast reconstruction.

	Implant (page 14)	LD (latissimus dorsi) flap – back flap (page 21)
Implant or not?	Yes	Implant can be used behind the flap
Scars	Scar on breast only. Possible circular scar around pigmented/darker area of skin near nipple (areola), either side of nipple or an inverted T-shaped scar under breast	Scar on back near bra-strap line. If skin-sparing mastectomy, there may be a circular scar around where the nipple was
Effects on muscles	Not much change	Shoulder/back weakness
Sensation in breast after surgery	Little or none	Little or none
Approx length of surgery	1-3 hours	3-5 hours
Average hospital stay	1-3 days	2-7 days
Approx recovery time	6-8 weeks	6-12 weeks
Considerations	May not be suitable for large drooping breasts. Suitable if no excess tissue available for other types of reconstruction. May need further surgery in future to change implants	May not be suitable if you regularly swim, climb, row, play tennis or golf

TRAM (page 23)	DIEP or SIEA (page 22 and 25)	SGAP or IGAP (page 25)	TMG or TUG Page (26)
Implant not generally used	Implant not generally used	Implant not generally used	Implant not generally used
Bikini-line scar. If skin-sparing mastectomy, there may be a circular scar around where the nipple was	Bikini-line scar. If skin-sparing mastectomy, there may be a circular scar around where the nipple was	Scar on buttocks and on breast	Scar in fold of groin and runs to fold of buttock area. Scar on breast
Risk of abdominal muscle weakness	No muscle removed	No muscle removed	Small strip of muscle removed but normally with little muscle weakness
Little or none	Little or none	Little or none	Little or none
4-6 hours	4-8 hours	4-8 hours	4-8 hours
3-7 days	3-7 days	3-7 days	3-7 days
6-12 weeks	6-12 weeks	6-12 weeks	6-12 weeks
Need to be in good health. May not be suitable if you are very slim, have abdominal scars, are diabetic, overweight or smoke	Need to be in good health. May not be suitable if you are very slim, have abdominal scars, are diabetic, overweight or smoke	May be suitable if tissue can't be taken from tummy area. May not be suitable if you are diabetic, overweight or smoke	May be suitable if tissue can't be taken from tummy area. May not be suitable if you are diabetic, overweight or smoke

Reconstruction with breast-conserving surgery

Breast-conserving surgery is usually referred to as wide local excision or lumpectomy, and is the removal of the cancer with a margin (border) of normal breast tissue around it.

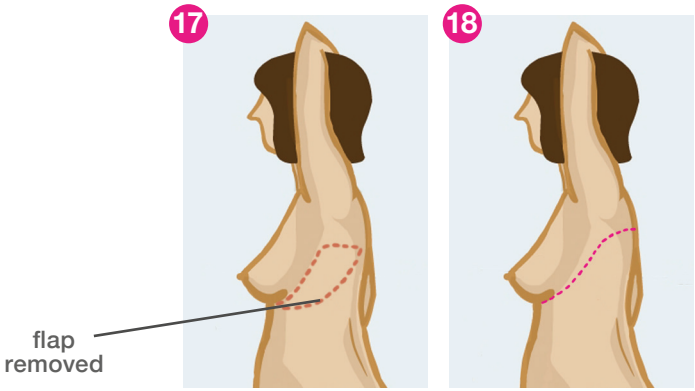
Oncoplastic surgery techniques can be used during or after breast-conserving surgery. The aim of this type of surgery is to remove the cancer and maintain the shape and symmetry of the breast if there's likely to be a noticeable indentation after surgery.

There are two ways of trying to maintain shape and replace the volume of the tissue lost from removing the cancer.

Volume can be replaced by moving some of the remaining breast tissue around to shape the breast and fill out the area where the cancer has been removed. This surgical procedure is sometimes called a therapeutic mammoplasty. This usually reduces the size of the affected breast so if this technique is used, you are likely to be offered surgery to your other breast to reduce its volume and restore symmetry.

Lost volume in the breast can also be replaced with tissue from elsewhere, usually from your back (called a latissimus dorsi flap). There's more information about latissimus dorsi flaps on page 21.

LICAP (lateral intercostal artery perforator) flap or TAP (thoracodorsal artery perforator) flap



A newer way of replacing lost volume is to use skin and fat from the side of the chest, under the arm (see image 17). This is called a LICAP or TAP flap. These types of reconstruction can be used when breast cancer has been removed from the outer part of the breast, and scarring will vary

(see image 18). Because it doesn't use muscle it does not affect the arm or chest movement.

If you are having radiotherapy after any of these procedures, your surgeon can advise you further.

Lipomodelling

This is a procedure used to improve the appearance of dents or a change in the outline of the breast that are sometimes noticeable after breast-conserving surgery. It may also be used after breast reconstruction, for example increasing the size of the breast, adjusting its shape or helping to hide visible implant ripples or wrinkles.

The technique uses fat taken by liposuction from one part of the body (usually the abdomen, hips or inner thigh), which is injected into the breast. It will be done under a general anaesthetic and may need to be repeated several times to achieve the correct shape. You will usually have some small scars where fat has been removed. Your surgeon and breast care nurse will explain what to expect after surgery, such as bruising and pain in the area where the fat is taken, and fat necrosis (where breast tissue has been damaged or has died, causing a hard lump).

Nipple reconstruction

Occasionally your own nipple can be preserved safely, but a mastectomy usually involves removing the whole breast including the nipple and areola. It's possible to have the nipple reconstructed and this may be done at the same time as the breast surgery. However, it's more commonly done a few months after the reconstruction to give the new breast time to settle into its permanent position and to make sure you're happy with the symmetry of your breasts. The nipple reconstruction can be done under a local anaesthetic if carried out after the breast reconstruction.

A reconstructed nipple can improve the appearance of your new breast, but it won't feel the same as a natural nipple. It has none of the nerves that allow it to become erect or flatten in response to touch or temperature, and it has no sensation.

There are several ways of reconstructing a nipple, so you may want to discuss different options with your surgeon. The skin of the new breast is usually used to make the nipple. This involves folding the skin to create a nipple shape. Sometimes part of the nipple from the other

breast can be used. However good the initial result, the reconstructed nipple may flatten over time.

For the nipple and areola area to look as realistic as possible, the skin needs to match the shade of the natural nipple and areola. A reasonable match can usually be achieved by colouring the skin using micropigmentation, which is similar to tattooing. This is usually done several weeks later once the surgery has had time to settle. The procedure takes about 30 minutes and may require local anaesthetic. Sometimes it needs to be repeated to give a better result. The colour will fade over time but should last for a few years.

Giving your new breast a nipple can be another stage in creating a breast that looks as natural as possible. On the other hand, you may choose not to have nipple reconstruction or you may decide to use stick-on nipples. These can be custom-made, sometimes by the hospital, to match your natural nipple and areola, or they can be bought ready-made.

Surgery to your other breast

Surgeons try to create a new breast that matches your natural breast as far as possible. If it is difficult to get the size, shape or position that matches your natural breast, you may want to discuss the option of having an operation on your other breast to improve symmetry. This may mean making the remaining breast a little smaller or larger, lifting it or moving the nipple. These procedures will all leave some permanent scarring, which will fade with time.

Any surgery to the natural breast may be done in a separate operation to give the reconstructed breast time to settle. If you have your reconstruction done privately it is worth checking that any surgery to your other breast is covered under your insurance plan; if it isn't you may have to pay extra.

Breast reduction

Sometimes it may be necessary to remove tissue and skin from the natural breast in order to make it smaller and more in balance with the reconstructed breast. The nipple and areola usually need moving to be more central on the breast. Breast reduction usually leaves some scarring around the nipple and areola, down the central part of the breast and along its underside. This isn't noticeable when wearing a bra,

and will usually fade over time. There may be less feeling and sensation in the breast and nipple, and you may not be able to breastfeed in the future.

Breast enlargement (augmentation)

Sometimes the reconstructed breast is larger than your natural breast, especially if you've had an implant. You can have an implant placed either under the breast tissue or behind the chest wall muscle of your natural breast to make both breasts more balanced. Scarring is usually in the fold beneath the breast or around the areola.

The feeling in the nipple and skin can change after breast enlargement and you may find the nipple is less or more sensitive for a few months after the operation.

When implants are used and there's also remaining breast tissue, mammograms (breast x-rays) can still be done (see page 40 for more information).

Breast enlargement does not usually prevent you from breastfeeding in the future.

Breast uplift (mastopexy)

Breast uplift is an operation to raise, reshape and firm the breast, which reduces any natural drooping and improves the position of the nipple and areola. A strip of skin is taken from under the remaining breast or around the nipple to tighten and lift the skin over the breast. You may have similar scarring to that found after breast reduction, but this can vary. There may be less feeling and sensation in the breast and nipple. You should still be able to breastfeed.

Recovering from reconstruction

Your operation will be carried out under general anaesthetic. The length of surgery depends on the type of procedure you are having, and recovery time will vary too. Approximate timings can be found on the chart on page 28.

After the operation

When you wake up you'll have dressings on your newly reconstructed breast and, if you have had flap surgery, on the area where the flap has been removed.

You will be monitored closely to make sure the blood supply to the flap is good and there is no swelling. Initially it's very important to keep your new breast warm and you may have cotton padding and soft blankets to help with this.

You may have several drainage tubes coming out of the wounds to get rid of any excess blood or fluid, and these may be left in place when you leave hospital. You may also start a course of antibiotics to reduce the chance of infection.

You may have a urinary catheter (a tube into your bladder to drain urine) after your procedure if your surgery has been very long, or if your surgeon wants you to remain in bed. This will be removed as soon as you are able to get up and go to the toilet.

You'll be given pain relief to help with any pain you're having. There are many types of pain relief and different ways of giving them. If you're still in pain after having your medication, tell the staff looking after you.

Recovery time

Your recovery time will depend on the type of reconstruction you've had. After an implant operation you will probably be out of bed within a few hours and may be able to go home the next day. If you've had more extensive surgery it will take a little longer for you to be up and about, and you'll stay in hospital for several days.

You may be given advice and information from a physiotherapist on breathing correctly and how to go about everyday tasks – particularly if you've had abdominal surgery.

You will be given some exercises to keep your arms and shoulders mobile. You shouldn't feel pain when doing the exercises, but a stretching or pulling sensation is normal.

Your breast care nurse or surgeon will tell you what sort of bra or support garment is suitable and may give advice about massaging the area to keep the skin supple and in good condition. If you've had surgery to your abdomen (tummy), you may have to wear supportive knickers or lycra shorts to reduce the risk of swelling, bruising and fluid collection for several weeks following surgery.

You're likely to feel tired and not able to do as much as you are used to for several weeks. Again, how quickly you recover will depend on whether you had implant or flap surgery.

You'll be advised how best to look after your wounds and about stretching, bending, lifting and driving during the healing process.

Your new breast

The newly reconstructed breast takes a while to settle and resemble a natural breast. It's normal for it to be bruised and swollen for quite a while, and the wounds will take time to heal. If you are concerned about any part of your recovery talk to your specialist team.

Resuming normal activities

How long it takes to get back to your normal daily activities will depend on what type of surgery you have had. Gradually reintroducing them is generally the best way.

It's best not to drive or do anything strenuous while your wounds are healing. When you want to start driving again, think about whether you would be comfortable enough to wear a seatbelt and be able to do an emergency stop.

Listen to your body and stop if you feel you may be over-exerting yourself. Check with your surgeon or breast care nurse if you're not sure.

Returning to work

Whether and when to return to work is a personal decision that may take into account not only how you're feeling physically and emotionally but also your financial position. By law, an employer must make reasonable adjustments to help you at work if you have breast cancer.

You can find out more on our web pages about breast cancer and employment **breastcancercare.org.uk/employment**

Possible problems following reconstruction surgery

Immediate problems

Bleeding

Sometimes there can be bleeding within the reconstruction. If this happens, it will usually be within 24 hours after the operation. This may mean another operation is needed to stop the bleeding.

Infection

If you have a raised temperature or notice any redness, excess swelling or heat in the breast or where tissue has been removed, tell your specialist team or GP straight away as these might be signs of an infection. Treating an infection is easiest and most effective if caught early. Occasionally an infection develops around an implant that doesn't respond to treatment with antibiotics. In this case, the implant might have to be removed to allow the infection to settle completely.

Bruising

Bruising to the breast, and where any tissue has been removed, is common after your breast reconstruction and usually goes away after a few weeks.

Build-up of fluid or blood

Any drainage tubes put into your wounds during surgery are usually removed a few days after the operation.

However, a collection of fluid (seroma) or blood (haematoma) may continue to build up around the wound sites. These will normally be reabsorbed naturally over time, but larger amounts may need to be drawn off (aspirated) with a needle and syringe by your surgeon or breast care nurse. This is usually a painless procedure as the area is likely to be numb. Sometimes a seroma will refill so it may need to be drawn off several times over a few weeks before it goes away completely.

If you have an implant, the doctor or nurse may use ultrasound (high frequency sound waves that produce an image) to help guide them. This procedure can be done as an outpatient so you will not have to stay in hospital.

Pain and discomfort

You will have some pain or discomfort after surgery. After your operation you will be given pain relief to make you more comfortable.

There are different types and strengths of pain relief available and they can be given as tablets, suppositories (waxy pellets placed into your back passage) or injections. What you are given will vary according to your needs. Some people find changing position and using pillows to support the wound can help reduce pain or discomfort.

Sometimes pain relief may be given through a device called a PCA (patient controlled analgesia). This is a pump that gives pain relief straight into your vein when you press a button. It's usually removed a day or two after surgery.

You may continue to feel sore and stiff for several weeks after surgery. This should gradually improve over time and you can carry on taking pain relief. Your wound may also itch as it heals. This is natural but try not to scratch it.

Pain can occur in the scar, chest wall and upper arm, the area where the tissue was taken for a flap reconstruction, and your shoulder can feel uncomfortable. Some people also have phantom breast pain. This is pain that feels as though it's coming from the breast even though the breast tissue has been removed and reconstructed. These can all be the result of injury or irritation to the nerves, and may settle with time.

With an abdominal flap operation you will probably feel uncomfortable when you bend over or straighten up, cough or sneeze for a few weeks after surgery. Take things gently and support your wound with your hands and a small cushion or rolled up towel if you need to.

If you're experiencing pain around your scar areas that doesn't improve with time or pain relief, talk to your specialist team.

Longer-term problems

Capsular contracture

In the first year or so after an implant operation, tough fibrous tissue builds up around the implant to form a 'capsule'. This happens because the body sees the implant as a foreign object and wants to isolate it. In most cases this capsule stays soft and supple but sometimes it tightens around the implant, making the breast feel hard and sometimes painful. This is known as capsular contracture.

Radiotherapy can cause capsular contracture. For this reason, reconstruction using an implant alone may not be recommended for women having radiotherapy.

Capsular contracture is now less common than it used to be. This might be because many implants have a textured outer surface that reduces the amount of scar tissue that forms around the implant.

There are different degrees of capsular contracture and in mild cases no treatment is necessary. Occasionally the contracture is severe enough

to make the breast feel hard and look misshapen. In these cases the implant may need to be surgically removed, and may or may not be replaced.

Leakage and rupture

Silicone implants are expected to last at least 10 to 15 years, and even then are unlikely to need replacing. If they wear out, the silicone gel may leak into the fibrous capsule. Occasionally silicone gel may get into the breast, forming a lump. If this can be felt or a scan shows a ruptured implant, the implant may have to be removed and replaced. Modern casings are strong and the risk of leaks and rupture is small. If you notice any deflation of your reconstructed breast, or if it becomes misshapen, uncomfortable or swollen, tell your surgeon or breast care nurse.

Creasing and wrinkling

There can be noticeable skin creasing or wrinkling over the implant. It's most common in people who are slim and have saline implants. It's usually less obvious when you're wearing a bra. If it becomes very noticeable the implant may need to be replaced.

Abdominal hernia

There is a small risk after some flap reconstructions that a hernia can develop in the area where the tissue was taken from. A hernia happens when part of an internal organ (often a small piece of the intestine) bulges through a weak area in a muscle. Hernias can be painful and can cause a noticeable bulge in your abdomen. Usually an operation is needed to repair them.

Unevenness

It will take several months for your new breast to settle down and for scars to fade. Only then can you judge whether you are satisfied with the look and feel of your new breast and how well it matches your other breast. If you're unhappy with the size or shape of the breast or the positioning of the nipple there are things that can be done. You may want to consider further surgery to the reconstructed breast or to your other breast to give you a better match and symmetry. It's not unusual to need several separate surgical procedures before breast reconstruction is complete, including nipple/areola reconstruction and surgery to the other breast. Before you make any decision, discuss your options with your surgeon or breast care nurse.

Loss of sensitivity

For many women the loss of sensitivity of the reconstructed breast can be difficult to come to terms with. You may also experience loss of sensation in the area where the flap has been taken. Some women experience nerve pain and altered sensation while their reconstruction is healing. This may improve over time, but for some people the sensation won't return.

Fat necrosis

Sometimes a lump can form if an area of fatty tissue in the reconstructed breast is damaged or if the blood supply is poor. It can also happen in the area where the flap of tissue has been taken. The lump can feel firm, but is likely to soften over time. This is called fat necrosis (necrosis is a medical term used to describe damaged or dead tissue). You can read more in our leaflet **Fat necrosis.**

Being breast aware

It is important still to be breast aware after reconstruction surgery. Once your breast has settled down after surgery, get to know the way it looks and feels. If you have had an implant-based reconstruction, look out for hardness or tightness, which may indicate capsular contracture, or wrinkling of the implant.

After any type of breast reconstruction you should look out for changes in the breast. These include:

- a change in appearance or shape
- a lump or lumpy area in the breast or armpit
- a change in skin texture or swelling in the upper arm

If you notice any changes in either of your breasts, tell a member of your specialist team or your GP. If there's any concern that your cancer has come back your specialist will arrange further tests. Having a breast reconstruction should not affect the ability of you or your surgeon to detect a recurrence of your cancer.

Having a breast reconstruction will not increase the chances of your cancer coming back.

For more information about being breast aware, you may find our booklet **Know your breasts: a guide to breast awareness and screening** helpful.

Mammograms after breast reconstruction

You will still be offered regular mammograms on your natural remaining breast, and to check any remaining tissue in your reconstructed breast if only part of your breast tissue was removed.

If you've had an implant in your natural breast to match the reconstructed breast for size, tell the radiographer in advance so the Eklund technique can be used if appropriate. This takes an additional image of the breast during screening. It involves easing the breast tissue forward away from the implant so that it can be seen more clearly. The radiographer (someone trained to carry out x-rays and scans) should explain the technique and explain why they think it is suitable for you.

Bras after surgery

Sometimes you may be advised to wear a bra during both the day and night initially after your surgery.

Many women are concerned about finding comfortable and well-fitting bras following breast reconstruction. Initially after surgery your surgeon will advise what bra to wear depending on your type of reconstruction.

Our booklet **Breast prostheses, bras and clothes after surgery** provides practical information about bras and clothing for women who have had breast surgery.

Further reading

To order or download any of our publications mentioned in this booklet, go to **breastcancercare.org.uk/publications**

Useful organisations

Association of Breast Surgery (ABS)
Telephone: 020 7869 6853
Email: office@absgbi.org.uk
Website: associationofbreastsurgery.org.uk

Aims to ensure that breast surgery practice is based on common standards of competence and performance. It does this through education, training, service improvement and provision of information. There is also a patient information section on its website.

BRA Foundation
Email: info@brafoundation.org
Website: brafoundation.com

Provides support and information to women considering breast reconstruction following mastectomy.

British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS)
Telephone: 020 7831 5161
Email: secretariat@bapras.org.uk
Website: bapras.org.uk

A professional body for plastic and reconstructive surgeons in the UK. The website has information on breast reconstruction and gives access to a list of plastic surgery units.

The British Association of Aesthetic Plastic Surgeons (BAAPS)
Telephone: 020 7430 1840
Email: info@baaps.org.uk
Website: baaps.org.uk

A professional body for cosmetic and plastic surgeons in the UK. Their website has information about cosmetic surgery, such as breast enlargement, for patients.

Flat Friends
Email: support@flatfriends.org.uk
Website: flatfriends.org.uk

A charity for women who have chosen not to have breast reconstruction. Offers support, advice and friendship through their website and a closed Facebook group.

General Medical Council
Email: gmc@gmc-uk.org
Website: gmc-uk.org

Holds general and specialist registers of doctors practising in the UK. The registration department can also provide free information on specific named doctors.

Keeping Abreast
Email: info@keepingabreast.org.uk
Website: keepingabreast.org.uk

A charity providing information and support for women considering breast reconstruction, including regular group meetings and expert talks.

Macmillan Cancer Support
General enquiries: 020 7840 7840
Helpline: 0808 808 0000
Website: macmillan.org.uk

Provides practical, medical and financial support for people with cancer.

Medicines and Healthcare Products Regulatory Agency (MHRA)
Telephone: 020 3080 6000
Email: info@mhra.gsi.gov.uk
Website: mhra.gov.uk

Government agency responsible for ensuring that medicines and medical devices work and are safe.

National Institute for Health and Care Excellence (NICE)
Telephone: 0300 323 0140
Email: nice@nice.org.uk
Website: nice.org.uk

The independent organisation responsible for providing national guidance on good health and the prevention and treatment of illness. There is guidance on breast reconstruction using lipomodelling after breast cancer treatment.

NHS Choices
Website: nhs.uk

The UK's biggest health website and provides a comprehensive health information service. The website can help you make choices about your health, from decisions about your lifestyle, such as smoking, drinking and exercise, to finding and using NHS services in England.

Notes

4 ways to get support

We hope this information was helpful, but if you have questions, want to talk to someone who knows what it's like or want to read more about breast cancer, here's how you can.

Speak to trained experts, nurses or someone who's had breast cancer and been in your shoes. Call free on **0808 800 6000** (Monday to Friday 9am–5pm, Wednesdays til 7pm and Saturday 9am–1pm).

Chat to other women who understand what you're going through in our friendly community, for support day and night. Look around, share, ask a question or support others at **forum.breastcancercare.org.uk**

Find trusted information you might need to understand your situation and take control of your diagnosis or order information booklets at **breastcancercare.org.uk**

See what support we have in your local area. We'll give you the chance to find out more about treatments and side effects as well as meet other people like you.
Visit **breastcancercare.org.uk/in-your-area**

We're here for you: help us to be there for other people too

If you found this booklet helpful, please use this form to send us a donation. Our information resources and other services are only free because of support from people such as you.

We want to be there for every person facing the emotional and physical trauma of a breast cancer diagnosis. Donate today and together we can ensure that everyone affected by breast cancer has someone to turn to.

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We might occasionally want to send you more information about our services and activities

☐ Please tick if you're happy to receive email from us
☐ Please tick if you don't want to receive post from us

We won't pass on your details to any other organisation or third parties.

Please return this form to Breast Cancer Care, Freepost RRKZ-ARZY-YCKG, Chester House, 1–3 Brixton Road, London SW9 6DE

About this booklet

Breast reconstruction was written by Breast Cancer Care's clinical specialists, and reviewed by healthcare professionals and people affected by breast cancer.

For a full list of the sources we used to research it:

Phone 0345 092 0808
Email publications@breastcancercare.org.uk

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When you have breast cancer, everything changes. At Breast Cancer Care, we understand the emotions, challenges and decisions you face every day, and we know that everyone's experience is different.

For breast cancer care, support and information, call us free on **0808 800 6000** or visit **breastcancercare.org.uk**

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