

Transcript Details

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Full Spectrum of Breast Reconstruction Surgeries: From Cosmetic to Breast Cancer Diagnosis

Narrator:

You're listening to Medical Breakthroughs from Penn Medicine, advancing medicine through precision diagnostics and novel therapies. The following program was recorded at Penn Medicine's live event, Hot Topics for the Primary Care Provider. Your host is Dr. Matt Birnholz. Dr. Birnholz welcomes Dr. Paris D. Butler, plastic surgeon at Pennsylvania Hospital. Dr. Butler's clinical focus is in breast augmentation, breast lifts, breast reconstruction, abdominoplasty, liposuction, buttock augmentation, body contouring, and facial aesthetics. Now, here is your host, Dr. Matt Birnholz.

Dr. Birnholz:

Good to have you Dr. Butler.

Dr. Butler:

Nice to be here.

Dr. Birnholz:

What I am so looking forward to with our particular discussion is that in a way we get to blend some of the prior discussions. We get to move in on a little bit of back pain as an issue that you deal with from your vantage point in plastic and reconstructive surgery, and also talk about breast healthcare innovations, and so why don't we turn to that first and consider a female patient who comes in with chronic back and shoulder pain and considering the approach for these patients for which breast reconstruction actually becomes a viable option to assist with that. What are the benefits of taking this particular direction, from your experience as a plastic and reconstructive surgeon?

Dr. Butler:

So, you are a friend of breast reduction?

Dr. Birnholz:

Exactly

Dr. Butler:

Yeah, so on the reconstruction side, we usually kinda refer to that as it pertains to breast cancer care. It's very, very common to have a woman who suffers from macromastia. Frequently, it's somebody who is a little on the portly side who has been suffering

from shoulder notching from bra straps, neck pain, back pain – some of the catch phrases that we use in order to hopefully get their insurance companies to pay for their procedure, are those kinds of things – neck pain, back pain, recurrent rashes, skin irritation under the breast – and we have a dialogue about what I think we can do in order to remove some of the breast tissue in order to make that weight somewhat relieved. So, I can say from a cosmetic end, they are my happiest patients by far and away. They tend to have been suffering from this for a significant period of time. It's been hard for them to find a plastic surgeon that's willing to take it on, because not all plastic surgeons take insurance, so they tend to be very excited about having surgery. They tend to do very well with surgery, and more times than not, I always tell them, "It's not a guarantee that it's going to relieve or resolve all of your neck and back pain, but it will at least help."

Dr. Birnholz:

Do you find it's a pretty immediate turnaround for these patients?

Dr. Butler:

I mean, once we get them through the, what we say, "perioperative period," I would say that they notice a significant difference and motivates many of them to get back on the treadmill to get back to running and jogging, because some of this really, basically prevents them from exercising the way that they could otherwise.

Dr. Birnholz:

Why don't we then turn from reduction to reconstruction? I mixed the terms because the other side of it is talking about breast reconstruction specialty and the timing of that after a diagnosis of cancer and treatment for cancer. In that context, though we know that the procedure can play a big, big role in healing for these women when they look at reconstruction, what are the pros and cons of taking an immediate versus a delayed reconstruction approach after their surgery for the cancer?

Dr. Butler:

Yeah, so I'll back up just a little bit just to get a little bit of context. So, we now know in the country that about 55% of women who end up having a mastectomy undergo some form of reconstruction, whether it's in the immediate period or in a delayed fashion. Of those that end up having reconstruction of that 55%, the vast majority are having implant-based reconstruction. It kind of comes in two flavors – implant-based reconstruction or autologous reconstruction where we use their own tissue, primarily the abdominal tissue, because most of the folks in our country are a little more on the rotund side and they have that to donate. I think understanding that part over the course of the last 25 or 30 years, we've really been pushing for this to take place in an immediate fashion. There was some really antiquated literature out there that said that, you know, you needed to have a woman understand what it's like to not have a breast so she could really appreciate it. Clearly antiquated, clearly not the right thing to do, in my opinion and most people's opinion, so we're now really encouraging women, that once they have been diagnosed, that they come and see a plastic surgeon to have that dialogue, so, you know, we have folks like Ari and Dahlia Sataloff and Stacy Ugras at Pennsylvania Hospital who are very good at making sure that everyone that comes in with a diagnosis that they have a cancer that's going to require a mastectomy, at least have a dialogue with a plastic surgeon. Whether or not they opt for it, is obviously a personal dialogue that they have with that plastic surgeon and that personal decision that they make, but at least they are having a conversation with a plastic surgeon, and we really try to do it in an immediate setting.

Dr. Birnholz:

You try to do it immediate as opposed to –

Dr. Butler:

Yes, we do.

Dr. Birnholz:

Because the decision often comes when people think that maybe they should delay, what are the factors that make you advocate for an immediate?

Dr. Butler:

So, I think it's a couple of things. From a supratentorial standpoint, psychologically not having to go without a breast mound I think is beneficial. I think from a technical standpoint, from my end, it's technically easier to do it in the immediate setting. They already have skin; we've improved our techniques as it pertains to mastectomy where we perform nipple-sparing mastectomy or skin-sparing mastectomy, and we don't want that skin to contract down over a delayed period of time, so when they perform the mastectomy, we immediately come in; we either do our free-flap breast reconstruction or autologous reconstruction, or implant-based reconstruction to take advantage of the skin that they natively have and is viable. So, that's why we really try to do it in the immediate setting if we can.

Dr. Birnholz:

I have to ask an off-shoot question that you opened up when you eluded to the rising obesity rates, because it goes back to a conversation I had with Dr. Debs earlier tonight.

Dr. Butler:

Sure.

Dr. Birnholz:

Have you found that in your own practice just from the beginning of your training to where you are now that the rising obesity rates and overweight rates have changed your approach in terms of, as you said, the availability of abdominal tissue – have you basically seen a changing way in which your surgical options come before you based on the population that you deal with, let's say, in the last 10 years even?

Dr. Butler:

Yeah, well I trained for 11 years, so in the beginning, I would say, particularly as it pertains to plastic surgery, there was much more of a focus on implant-based reconstruction. As the weights continued to kinda climb, what we were finding is that manufacturers just aren't making large enough implants, and that's what really pushed a lot of plastic surgeons to find some of these autologous options – the tram flap, as we describe, are the DIAP perforator flaps where we use abdominal tissue, it's a great source of tissue. They get a mini abdominoplasty out of it because we are taking away that tissue and then making new breast mounds with it. So, I would say the fact that our population has gotten larger has probably pushed us in the direction of finding additional means of creating a breast mound.

Dr. Birnholz:

Let me ask you then about the roles of people that would assist from other specialties in your work. We spoke with Dr. Brooks about the innovations from the surgical oncology side. When in this conversation with the patient about doing an immediate reconstructive procedure does a surgical oncologist get involved for you? When do you like to bring in the surgical oncologist?

Dr. Butler:

Well, I usually see them on the tail end; so historically they'll have their screening mammogram, something abnormal pops up, they will either be referred to their PCP or they'll be referred to their breast surgeon. At that point in time, they usually have the dialogue on the oncologic standpoint, oncologic side, and then they refer them to me, and we have a conversation about what reconstruction really means; what their options are; then we work in concert to determine when we can do a combination procedure. So usually, I'm on the tail end.

Dr. Birnholz:

Another question that often comes up with regard to reconstructive surgery after breast cancer is how does aging affect the follow-up here? Are follow-up surgeries required? Do you have to counsel patients about how aging of the reconstructed breast is going to affect their outcome?

Dr. Butler:

I would say aging of their reconstruction usually a tincture of time helps lots of things, particularly as it pertains to scars. I always tell my patients, "Don't judge your outcome until you're three months out; don't judge your scar until you're six months out." With the

process of wound healing, the remodeling process takes about six months in order for the scar to fully mature. I would say with breast reconstruction, as it pertains to autologous reconstruction where we do a flap, I think they tend to get a little bit better with time; with implant-based reconstruction, I think, initially, they can have a stellar result, but the implant doesn't necessarily grow with the body the same way that autologous tissue does, their native tissue, which, I guess, inherently kind of makes sense. So, I would say when we've kind of tracked these ladies over time, those that have had flaps I think they kinda maintain, where those that have had implant-based, usually require some kind of revision after "x" number of years, probably about a decade. The implant manufacturers all say that the shelf life for an implant is about 10 years, and that's whether it's a silicone implant or a saline implant. When we do breast reconstruction, it's silicone that we use, and in the cosmetic end, there are more options, saline vs. silicone.

Dr. Birnholz:

Well, actually this is a good opening. Why don't we talk about the cosmetic end?

Dr. Butler:

Okay.

Dr. Birnholz:

It would be a massive understatement to say that cosmetic surgery has gained some traction and steam in the popular media. I think almost anybody here, any of their loved ones or their children can reference a reality show that they're following that focuses almost entirely on cosmetic surgery, so what can you tell me about some of the latest trends in cosmetic surgery?

Dr. Butler:

Yes, so my wife is a director of school counseling, and the periodical that she reads the most is not any of her counseling literature nor is it the *New England Journal of Medicine*, it's *People* magazine. So, I most frequently am asked about what Kim Kardashian had or Nicki Minaj, or what have you. I would say (1) there are many things. Once again, we could talk forever about it, but I would say the mommy makeover is a very popular request that I am getting. It usually involves a woman that has had any number of children who comes in, they've kinda gotten back down to their baseline weight, but they still have that central kinda redundancy, as they say, that central pooch that they just can't get rid of, frequently after having children with milk letdown, the breast don't sit necessarily in the same place that they used to, so it's a combination of doing a mastopexy or breast reduction; sometimes even a breast enhancement, so breast augmentation with a lift, augmentation mastopexy and then doing an abdominoplasty. Frequently, in order to accommodate a large uterus, the rectus muscles spread. Rectus diastasis is very common. We see that, so they don't necessarily present with a hernia, they present with a spreading of the rectus muscles that just don't retract appropriately. So, I say you can't fix the curtain without fixing the window underneath, so we tighten the muscle as a component of repairing the rectus diastasis and then remove the excess soft tissue as it pertains to skin and fat in order to complete the abdominoplasty. So, that kinda the full Monty; when they come in, they want the breast and the belly done at the same time, which we can accommodate them with.

Dr. Birnholz:

And do these patients that you see, do they often come right to you directly or do they come through primary care where they raise the issue up?

Dr. Butler:

I mean, I'm always advertising for them to come more through primary care. Word of mouth is really amazing. I think when it comes to breast reduction surgery, I have been trying to impart on my primary care physicians that there are many plastic surgeons out there that are willing to take insurance; they're willing to put the legwork in to work with their insurance companies to make sure that they can get that service. On the mommy makeover side, it's all out of pocket, so it's a little bit of a different referral pattern. A lot of that comes from the girlfriend of a girlfriend or a friend of a friend that had a good outcome and they liked me as a person and they'll come and see me as a proponent of that.

Dr. Birnholz:

Any other comments you want to add to a primary care audience, a number of the areas that we covered here from cosmetic to reconstructive to breast reductions?

Dr. Butler:

Yeah, I think I've got to put a little bit of pitch in on the breast reconstruction side, because I get a lot of questions about it. I do have a master's degree in public health; I have a lot of interest in healthcare disparities, and we do know that there are two groups that just aren't getting breast reconstruction at the same rate as others and those tend to be our ladies of color and our ladies that are more seasoned over 60 and I think it's multifactorial. Once again, I could talk ad nauseam about it, but I think some of it is patient education as it pertains to what they kinda qualify for. I know I've had numerous conversations, particularly with our ladies of color who say, "What are the economic ramifications of breast reconstruction?" and I articulate to them the fact that because of the Women's Health and Cancer Rights Act of 1998, if they have insurance that is covering their oncologic care, whether it's their surgery, their chemotherapy, their radiation, those insurance companies are mandated to cover their breast reconstruction for the duration of their life. That also includes a balancing procedure on the other side, so say that have a – they present with a right-sided breast cancer and they need breast reconstruction and they're a good candidate for an implant-based reconstruction, we perform that operation and then at the same time, or in a delayed fashion, we do a breast lift on the other side, and their insurance companies are mandated to cover that as well. So, I just think educating our patients that these options are out there, these are things they need to take advantage of. I think I would be remiss if I didn't mention that.

Dr. Birnholz:

Great parting comment. Thanks so much for your time.

Dr. Butler:

Thank you.

Dr. Birnholz:

Uh huh. It's good having you.

Dr. Butler:

It's nice to meet you also.

Narrator:

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