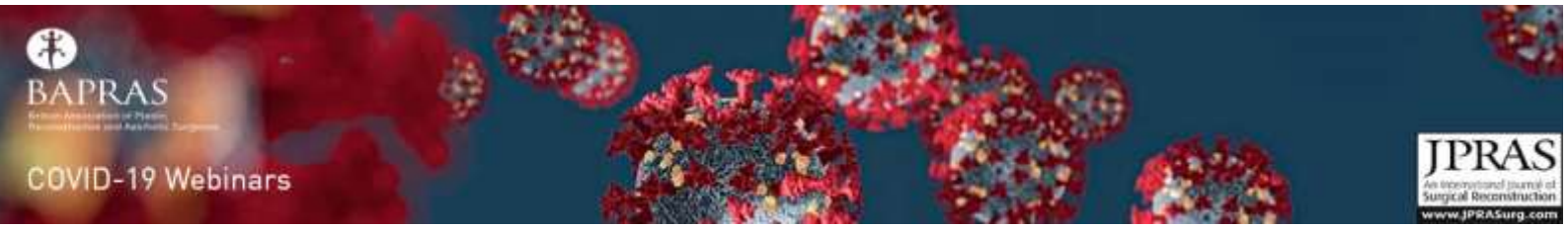


Free Flap Breast Reconstruction
11 June 2020

Faculty

- Professor Andy Hart, Editor JPRAS, Consultant Plastic Surgeon, Glasgow
- Mr Mark Henley, BAPRAS President, Consultant Plastic Surgeon, Nottingham
- Mr Nigel Mercer, FSSA President, Senior Consultant Plastic Surgeon at North Bristol NHS Trust.
- Miss Ruth Waters, BAPRAS Deputy President, Consultant Plastic Surgeon, University Hospital Birmingham NHS Trust
- Mr Adam Gilmour, Consultant Plastic Surgeon, Canniesburn Unit & Breast SIG Member
- Mr Venkat Ramakrishnan, Consultant Plastic Surgeon, St Andrew's Centre for Plastic Surgery, Chelmsford
- Miss Anita Hazari, Consultant Plastic Surgeon, Queen Victoria Hospital, East Grinstead
- Mr Richard Haywood, Consultant Plastic Surgeon, Norwich and Norfolk University Hospital
- Miss Rieka Taghizadeh, Consultant Plastic Surgeon, St Helens and Knowsley Teaching Hospitals NHS Trust
- Mr Sherif Wilson, Chair BAPRAS Breast SIG, Lead clinician in Breast Reconstruction, North Bristol NHS Trust
- Miss Julie Doughty, ABS President, Consultant Breast Surgeon, Gartnavel General Hospital, Glasgow
- Mr D Boyce, Chair, BAPRAS Education Committee, Consultant Plastic Surgeon, Swansea

Resources

BAPRAS/ABS guidance on recommencing breast reconstruction services

Points from each speaker

Background

(A Hart) link to video

- Breast reconstruction one of the largest subspecialties within plastic surgery
- Hope to develop consent and safety guidelines via collaboration
- Decline in incidents of Covid-19 has produced a call to restart standard services
- Breast reconstruction is a priority 4 in current listing, which with in areas with limited resources equals no priority at all.
- ABS guidelines in contrast are advocating Breast reconstruction and immediate breast reconstruction.

FSSA guidance and issues pertaining to consent

(N Mercer) (recorded presentation)

link to video Or stand alone presentation

- Not just about availability of PPE. Also about how well is it managed and used
- Patients are reluctant to undertake treatment because of fear of catching Covid. 45% of patients on London hospital waiting lists have declined treatment at this stage
- Being Covid positive is notifiable to the HSE, but also notifiable to corona in the event of a death via occupation.
- Numerous guidelines produced. No overarching document. FSSA have tried to produce helpful guidelines. All need to be considered when setting up provision going forward.

- Have to consider post-operative care, inc 14 days shielding to manage risk of Covid. Who will deliver the care required for the outcome expected.
- Be aware of any changes to anaesthetics used.
- Consider new risks to patient pathway
- Look at legal issues that might arise
- Right to all other breast reconstruction is the same as for an immediate breast reconstruction so prioritising the waiting list needs to take this into account
- The post-operative recovery stage is very important to patient outcomes.

Overview of risk benefit
(R Waters) link to video

- In contrast to publication in the lancet stating 23% mortality rate in personal experience over 30 operations **no** mortality, or complications and all good outcomes.
- Risk areas of operating: Resources, Morbidity and Mortality
- Risks of not operating: Waiting lists are worsened, patient choice is limited, "temporary" implants are offered with no follow up plan, Trusts never reinstate free flap breast reconstructions, the postcode lottery is worsens, deskilling of the workforce, especially in microsurgery. It is known that lack of use of skills results in loss of ability.
- There could be a loss of skills in the whole MDT.
- Need to continue operating to maintain necessary skill levels.

The case for restarting immediate free flap breast reconstruction
(A Gilmour) link to video

- Breast reconstruction is not just one thing as labelled in present prioritisation list
- Question if in all cases it should be a priority 4.
- In the light of GIRFT then delay can result in unnecessary resource allocation
- It is an outdated concept that breast reconstruction is a risky procedure with more recent evidence should 1% failure rate at most.
- Immediate breast reconstruction is a better option for most patients. If implants are used, then there is requirement for follow up procedures at a later date.
- The best option for the patient is the one that should be chosen
- The patient whatever procedure is chosen will have to undergo a general anaesthetic, so best to have only one operation and cut the risk.

Thoughts on free flap breast reconstruction in the COVID era, and relevant preliminary findings from the National Flap Audit
(V Ramakrishnan) link to video

- Mitigate – limiting resource use
- How they are screening patients and staff
- Glad to have an expert nursing team
- Carrying out an audit of free flaps, pedicles and replants. Over an 8 week period they had 455 cases which produced a good dataset. There were 3 deaths resulting from operating on high risk cases
- Found that some people choose a different flap due to considerations around Covid
- Continuing study so that can produce objective data for patients.

Process of re-establishing microsurgical breast reconstruction services in a low-COVID site
(A Hazari) link to video

- EG has been designated as a regional Covid free hub. But have to bear in mind there is no such thing as a Covid free unit.

- Work has been undertaken into providing a consent form that covers risks from Covid 19. This can be shared, but with the proviso that due diligence is carried out by units and medico legal team has to pass it before it can be used elsewhere.
- All patients are being discussed via the MDT inc Anaesthetists so that priority patients can be matched with resources available.
- Problem is ability to test staff to minimise staff to staff and staff to patient transmission.
- Using virtual attendance for follow up and hoping to move to 1 to 1 face to face one stop shop.

Resources from QVH
NOTE- These resources have been provided as a guide and should not be used without approval at local Trust level

- Breast reconstruction in the recovery and restoration phase of COVID 19 click to access
- QVH ERAS pathway click to access
- COVID co-consent form click to access

Norfolk & Norwich experience of having restarted immediate free flap breast reconstruction
(R Haywood) link to video, link to slides

- Been able to continue practice due to good co-operation and support with colleagues from all disciplines, including outpatients and service director. This has also been at a regional level
- Dedication of ward staff looking after patients has helped and have adopted early discharge more often
- Have adapted their existing consent form to take note of Covid – Happy to share
- Advises to ensure good planning and timing that a lead surgeon is allocated to each case
- Make sure when you are operating that you have the correct mask and that your loupes are not going to steam up. You will be operating in an unfamiliar theatre so make sure you check microscope etc before you start.
- 2 can operate at once. One can close while another concentrates on microsurgery elements – therefore there is no rush with the microsurgery or shaping the breast. Have managed to reduce operation time to 4 hours this way
- Upsides to Covid – enjoy operating with colleagues, standardisation of equipment, management understanding what surgeons do
- Downside – lack of training opportunities for upcoming consultants.

Merseyside experience of having restarted immediate free flap breast reconstruction
(R Taghizadeh) link to video

- All work cessed at end of March, team was redeployed to other areas of the hospital
- Patient plans needed to be revisited which was done via teleclinics
- Have continues to communicate with all including the rest of the region
- With discussion via a MDT discussion have been able to go ahead with 3 very active cases.
- Took 3 weeks to redeploy staff back into the team
- Now have 3 on standby for any one operation in case of sickness etc
- Now have ICU empty of Covid 19 patients and 7 in the hospital
- Now planning to be allocated lists for June and July
- In the future need to base discussion with an emphasis on outcomes
- Greater collaboration is the key to the future working

Commentary
(S Wilson) link to video

- Shared experience.

- BAPRAS has set up small group for this.
- Communication statement will be issued soon.
- Lot to discuss as reflected in this evening's webinar.
- Survey has been sent out and results shared.

Personal view on restarting breast reconstruction
(J Doughty) link to video

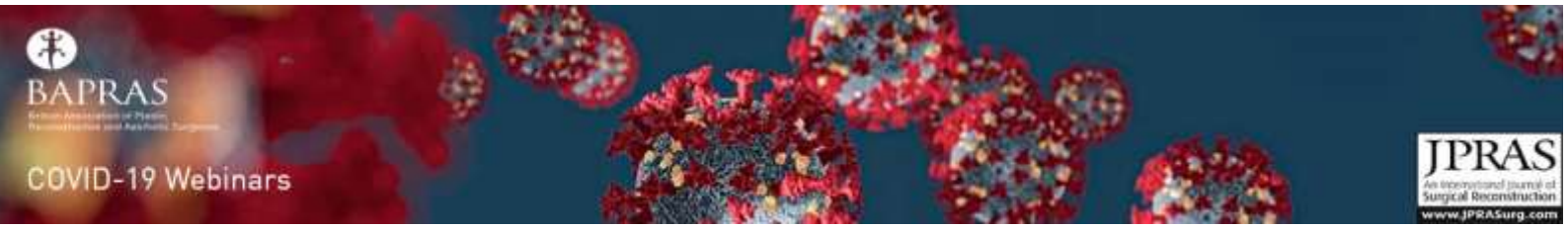
- Clinics and operations have been running throughout lockdown period
- Much business as usual, many areas where business has been halted and others free that are not able to be utilised.
- Older patient still need to be considered. With careful auditing they have not encountered Covid complications with these patients.
- Organising pathways for breast cancer patient treatment so they do not run into complications
- Starting to think about reconstruction now. Selection has proved difficult

Concluding remarks
(M Henley) link to video

- Patient safety is paramount
- A good case was made by the panellists for immediate breast reconstruction and for modifying the prioritization document in favour of breast surgery.
- Good to come together to improve the quality of the service proved to patients to go forward a consistent and even-handed manner.
- The Covid crisis is an opportunity to change practice to improve things for patients and surgeons.

Questions and discussion (link to discussion)

- Ethical committees will play a great part in adjudicating due to limited through put for the foreseeable future. Needs a level head going forward.
- Anita emphasised that though happy to share consent form – it must go through management and legal at each hospital.
- Patient reactions and requests. Anxiety over contracting Covid in hospitals turning to requests to go ahead with surgery.
- Patients very understanding when immediate reconstruction not available – this is likely to change. Therefore, there is the need for robust recommendations on prioritisation.
- The ABS have always prioritized via biology of the cancer involved and continue to do so.
- Review of priorities in about 3 weeks' time. Specialities can ask for a change in priority for categories of patients feel justify this and lobby for change to listing.
- East Grinstead using a 2/4 classification which finding useful.
- Overall agreement that cancer patients/breast reconstruction should be in category 2 (there will be a worse outcome for the patient if operation is delayed) rather than present category 4.
- Make sure that pathways are followed for patient outcomes to gather data to justify role out of further.
- NM: Should be looking at immediate and delay reconstruction equally, not the case in the past. RH able to do operations in 4 hours proving to hospital better use of resources. Proved point with immediate reconstruction makes a stronger case for delayed reconstruction to go ahead.
- Space will continue to be a problem going forward along with post code lottery of resources available to patients.



- Problem of waiting list for delayed reconstruction predates Covid
- Candidates for delayed reconstruction as of various categories
- If going to change prioritization it will be in consideration of cancer treatment and not other issues at present. Using cancer operation helps sway managerial decision making
- EG has looked at all patients on their wating list and non-cancer requiring reconstruction have been classified as 3, so that when that opens up they can be dealt with
- Restart with the immediate to at least keep the waiting lists from getting any worse than already are.
- Need to increase capacity and need to start with a group and evidence is there to safety and positive outcomes for cancer patients
- Post op complications – reduced by careful patient selection. Can reduce return to theatre to 1-2% via patient selection.

- **Overall seen as a very positive discussion with positive ideas for the way forward**

Resources

- Bruno Di Pace,a,b,c John R. Benson,c,d and Charles M. Malatab,c,d,, Breast reconstruction and the COVID-19 pandemic: A viewpoint, J Plast Reconstr Aesthet Surg. 2020 May 22. doi: 10.1016/j.bjps.2020.05.033 [Epub ahead of print] PMCID: PMC7243749, PMID: 32487361
- https://associationofbreastsurgery.org.uk/for-members/covid-19-resources/ Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study, https://doi.org/10.1016/S0140-6736(20)31182-X
- https://fssa.org.uk/_userfiles/pages/files/covid19/developing_safe_surgical_services_dsss_for_the_covid19_era_may2020updated.pdf
- UK National Flap Registry
  https://rs2.e-dendrite.com/csp/bapras/frontpages/index.html