BAPRAS

British Association of Plastic
Reconstructive and Aesthetic Surgeons

Breast Care Nurses Study Day

Monday 18th April 2016

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Day One- Monday 18th April 2016

08:45	**Registration and Coffee**	
09:25	**Welcome: Mr J O'Donoghue**	
	Session 1	**Chair: Mrs E Weiler- Mithoff**
09:30	The role of the specialist breast reconstruction nurse	Mrs R Harcourt
09:50	Keeping Abreast patient-led support	Mrs R Harcourt / Mrs K Kemp
10:00	Breast reconstruction – a patient's experience	Mrs M Howe
10:10	Providing a bra fitting service	Ms G Hurd
10:30	Pain management in breast surgery	Dr R Bajekal
10:50	Questions and panel discussion	
11:10	**Coffee and Trade Exhibitions**	
	Session 2	**Chair: Mr G Ross**
11:30	Update on surgical management of breast cancer	Mr G Gui
11:50	Update on oncological management of breast cancer	Dr M Kelleher
12:10	Reconstruction options following mastectomy	Mrs E Weiler-Mithoff
12:30	The use of ADMs and meshes with implants	Ms J Skillman
12:50	The iBRA study – An update	Ms S Potter
13:10	Questions and panel discussion	
13:30	**Lunch and Trade Exhibitions**	
	Session 3	**Chair: Mr H Cain**
14:20	Genetics and Managing the High Risk Patient	Mr D Macmillan
14:40	Reconstruction following risk reducing surgery	Mr G Ross
15:00	Preventing deformity following breast conservation	Mr S McCulley
15:20	Questions and panel discussion	
15:30	**Coffee and Trade Exhibitions**	
	Session 4	**Chair: Ms S Potter**
15:50	The use of fat grafting to improve outcomes	Mr F Fatah
16:10	Symmetrising surgery to improve outcomes	Ms F MacNeill
16:30	Nipple reconstruction	Mr J Scott
16:50	Micropigmentation of the nipple areolar complex	Ms D Forshaw
17:10	Questions and panel discussion	
17:30	**Close**	

CME points: Day 1 : 6 points

Faculty Biographies

Mr Rahul Bajekal



Consultant Anaesthetist at the Royal Victoria Infirmary, Newcastle upon Tyne since 2012.

Interests in neuro, upper GI and anaesthesia for plastic surgery. Other roles include clinical governance and enhanced recovery pathways.

Mr Henry Cain



Henry Cain qualified in 2001 from Leicester and returned to the North of England to complete his surgical training. Following the award of MD in breast cancer signalling pathways and higher surgical training he spent a year as the Oncoplastic Fellow at the Canniesburn Unit in Glasgow. He was appointed a Consultant Oncoplastic surgeon at the Royal Victoria Infirmary Newcastle upon Tyne in 2013. Henry Cain maintains numerous research activities along with a commitment in teaching advanced oncoplastic breast surgery. He is a member of the Faculty for the ABS advanced breast disease course and organises the ABS annual Trainees Meeting. He is a faculty member for the National Breast TIG fellow's course. Clinically he has been one of the lead surgeons in the introduction of Radioactive Seed Localisation of impalpable breast cancer to the UK.

Mr Fazel Fatah



Fazel Fatah is a consultant Plastic Surgeon, retired from the NHS and practices at The Westbourne Centre, Birmingham. He has a wide experience of fat graft in breast and facial rejuvenation surgery and, in the past, has advised the National Institute of Clinical Excellence on matters related to the subject of fat graft. He is co-author of the current national guidelines on lipomodelling with fat graft in breast reconstructive surgery.

Ms Dawn Forshaw



Dawn is the founder, co-owner and Managing Director of Finishing Touches which was formed in 1996. She set up Finishing Touches as a working clinic to offer first class cosmetic and medical tattoo procedures. Dawn then moved into training and was approached and became involved in working with HABIA writing the original NVQ for micropigmentation, which is still the benchmark set today for governmental authorities.

Dawn wanted to push boundaries so decided to create her own range of equipment and went on to design the Precision Plus Medical machine (which to-date this is the only tattoo system in Europe to attain a Class 2a certificate) and after that came an overhaul of all of the products used. Dawn also went on to create a unique range of safe and stable pigments, to offer patients realistic natural results with the aim of being able to realistically "put colour back into people's lives".

Her co-director and Dawn head a unique team of specialist trainers. Their companies solid reputation is synonymous with a professionalism and commitment to improving procedures through education – a service that many other companies promise but very few deliver. They have raised the standards in medical tattooing, by teaching surgeons, nurses and medical professionals how to create realistic results for their patients, as we are aware that it is not only physical scars but also emotional scars that medical tattooing can treat post-surgery or trauma.

Dawn also work extensively in R&D pioneering new and innovative ways to perfect and improve treatments and outcomes.
She has lectured and has held workshops at leading conferences such as BAAPS, BAPS, ORBS and BASO and at The Royal College of Surgeons, as well lecture overseas at conferences in both Europe and worldwide.

Mr Gerald Gui



Mr Gerald Gui qualified from University College and Middlesex Hospital Medical School, London in 1986. His postgraduate training in surgical oncology was based at St Bartholomew's Hospital and St George's Hospital, London. Mr Gui is a fellow of both the Royal College of Surgeons of England and Edinburgh, and was awarded the Surgeon-in-training medal of the Royal College of Surgeons of Edinburgh in 1994. He was travelling fellow of the Royal College of Surgeons in New York in breast reconstructive surgery at Emory University, Atlanta, USA. He has awarded the Master of Surgery degree from the University of London. Mr Gui is a teacher and examiner for the University of London and is visiting examiner for several other British universities. Mr Gui was appointed Consultant Surgeon to the Royal Marsden in 1996 as a specialist breast surgeon and is Honorary Senior Lecturer in the Institute of Cancer Research, London.

Mrs Ruth Harcourt



Ruth has been a nurse for a little over 37 years now and found out early that Plastic Surgery was somewhere she wanted to spend her nursing career. In the late 1990s breast reconstruction was evolving and in Norwich and Elaine Sassoon joined the team of Plastic Surgeons. When the new Norfolk & Norwich University Hospital opened on the outskirts in 2001, breast reconstruction began to be offered more widely and the need for a specialist nurse was found. In 2003 Ruth became the first and still is the only breast reconstruction nurse specialist in norwich.

Mrs Margaret Howe



Margaret Howe – age 55 retired health care assistant, Norfolk & Norwich University Hospital. Breast cancer diagnosed in November 2004 and again in November 2006. Reconstruction initially with DIEP flap and then LD & Implant. Active member of Keeping Abreast.

Ms Geraldine Hurd



Geraldine Hurd, a former head of lingerie design (18 years) for many high street brands and Macmillan volunteer, set up 'Betty and Belle' lingerie shop in 2007. It was started with a desire to create the best shopping experience possible for ladies who had undergone any type of breast surgery. Geraldine, an expert bra fitter, now works closely with many hospitals and support groups across the UK. Over the past nine years 'Betty and Belle' has proven to be a great success, having won numerous business excellence awards, including Best lingerie shop in the UK / Best female retail entrepreneur in the UK.

Dr Muireann Kelleher



Dr Muireann Kelleher is a consultant medical oncologist specialising in the treatment of patients with breast cancer. Dr Kelleher assesses the need for chemotherapy hormone therapy and targeted treatment in early breast cancer and plans with each woman which treatments are required. She also provides lifelong treatment to patients with metastatic breast cancer. Dr Kelleher graduated from National University of Ireland in 1998 with an honours degree in Medicine. Her specialist oncology training was completed at The Royal Marsden and Guy's and St Thomas' Hospitals. She was awarded her PhD from Kings College London in 2009 for research developing novel methods of imaging protein-protein interactions to better predict which breast cancers might metastasize and improve targeted more personalised therapies.

Mr Douglas Macmillan



Douglas Macmillan qualified at the University of Glasgow in 1988 and trained in Glasgow, Edinburgh and Nottingham. He was appointed as consultant oncoplastic breast surgeon at the Nottingham Breast Institute in 2001 where he is also the clinical lead for breast surgery and breast cancer. He leads a research group in oncoplastic breast surgery, collaborates with the Nottingham University Breast Cancer Research Unit and has published extensively (over 130 original articles and over 20 book chapters). He has given over 150 invited presentations at international meetings and performed many live surgery demonstrations. In oncoplastic surgery he has a particular interest in the techniques of therapeutic mammaplasty, chest wall perforator flaps and implant reconstruction. He is co-director of the International Oncoplastic and Reconstructive Breast Surgery Congress and manages the associated on-line resource for oncoplastic and reconstructive breast surgery.

Miss Fiona MacNeill



Fiona has been a specialist breast and oncoplastic surgery trainer, educator and mentor for over 20 years. She qualified from St Bartholomew's Hospital, London and was awarded an MD thesis investigating first generation aromatase inhibitors.
As Breast Tutor at the Royal College of Surgeons of England she established the first educational courses in oncoplastic breast surgery and was key to rolling out the UK sentinel lymph node training programme NEW START. Awarded the Silver Scalpel Trainer of the Year in 2006.

She has lectured on oncoplastic breast surgery education and training worldwide and was awarded the inaugural Querci Della Rovere Prize for 'Excellence in Cancer Surgery' ESSO/BASO 2014. As President of ABS she is working with the joint colleges, SAC and GMC to develop a breast specialty training framework.

Mr Stephen McCulley



Stephen McCulley FCS(SA)Plast, FRCS(Plast)
Consultant Plastic and Reconstructive Surgeon, Nottingham, UK.

Stephen McCulley graduated in the UK in 1989 and has specialist training in both the UK and South Africa, being registered as a specialist Plastic Surgeon in both countries. He returned to the UK in 2000 and has been a consultant Plastic Surgeon in Nottingham since 2002.

He specialises in all aspects of cosmetic, oncoplastic and microvascular breast surgery. He has been a leading figure in the development of breast-conserving oncoplastic techniques in the UK over the last 10 years, particularly in mammaplasty techniques and perforator flaps. He has also trained in breast oncology surgery and performs both the oncological excision and reconstruction.

As part of the Nottingham team he has helped develop and refine the use of MRA pre-operative assessment for DIEP flaps and continues to develop processes to improve the efficiency and outcomes in DIEP flap reconstruction and other microvascular breast reconstruction techniques. He is co-founder of the ORBS (Oncoplastic Breast Reconstructive Surgery) International meeting in Nottingham.

Mr Joe O'Donoghue



Joe O'Donoghue is a consultant plastic, reconstructive and oncoplastic breast surgeon based at the Newcastle Upon Tyne NHS Trust, UK. He is the lead clinician for the oncoplastic breast service in Newcastle where more than 600 cancers per year are managed. He was previously a member of BAPRAS Council, Chair of the Education and Research Committee, member of the SAC, ISCP Editor, member of the breast TIG and Honorary Secretary of BAPRAS. He is currently Chairman of the BAPRAS Breast SIG , Deputy Editor of JPRAS Open and non-executive director of the Plastic Surgery indemnity scheme PRASIS.

Miss Shelly Potter



Shelley Potter is an academic clinical lecturer in general surgery at the Bristol Centre for Surgical Research at the University of Bristol and Honorary Speciality Registrar in general surgery in the Severn Deanery. Her research interest is improving outcomes for women undergoing breast reconstruction and she is lead investigator for the NIHR Research for Patient Benefit funded iBRA Study. She is Chair of the Mammary Fold Academic and Research Collaborative and trainee representative on the NCRI Breast Clinical Studies Group. She has recently been appointed as a TIG oncoplastic fellow for 2016/17.

Mr Gary Ross



Mr Gary is a consultant plastic reconstructive and aesthetic surgeon based in Manchester and an honorary senior lecturer at the University of Manchester. He has a special interest in breast surgery and has published and presented extensively.

Mr John Scott



John R Scott MB ChB, FRCS, FRCS(Plast)

John Scott is a consultant plastic and reconstructive surgeon in Canniesburn Unit, Glasgow Royal Infirmary. He is a member of BAPRAS and was recently appointed an honorary member of the Association of Breast Surgeons. He is currently secretary of the Intercollegiate Specialty Board in Plastic Surgery and an Intercollegiate Specialty Examiner in Plastic Surgery. John is also the BAPRAS / Royal College of Physicians and Surgeons of Glasgow (RCPSG) Northern Tutor in Plastic Surgery. His professional interests include breast reconstruction and skin cancer surgery.

Miss Jo Skillman



Joanna Skillman studied medicine at Cambridge and Oxford Universities. She undertook broad and varied surgical training in Oxford, London, Durham, Sydney and Birmingham. She developed particular skills in breast reconstruction, microsurgery and cosmetic surgery. She completed an oncoplastic fellowship and a cosmetic fellowship in the West Midlands. In addition to clinical work, she is also a trainer on the oncoplastic skills course at the Royal College of Surgeons and for the MS in oncoplastic surgery. She was a co-author of the National Oncoplastic Guidelines, which sets quality standards in the UK. She is currently an NHS consultant in plastic and reconstructive surgery at a University Hospital Coventry and Warwickshire specialising in reconstruction for people with injuries and breast or skin cancer.

Mrs Eva Weiler-Mithoff



Eva Weiler-Mithoff FRCS Ed, FRCS Glasg, Plast is a consultant plastic surgeon with a specialist interest in breast reconstruction, microsurgery and fat transfer. She currently practices at Canniesburn Plastic Surgery Unit, part of the Glasgow Royal Infirmary, one of the leading units for breast reconstruction using the patient's own tissue. Canniesburn has embraced the concept of perforator flaps and was one of the first units to use this technique, which is where Eva's interest in microsurgery stems from. Eva likes the challenges of matching one breast to another to restore body balance and is currently doing research on use of cell assisted fat transfer and fat banking in breast reconstruction.

Abstracts

Day 1 Session 1 – 09:30 – 09:50

Mrs R Harcourt

The role of the specialist breast reconstruction nurse

This talk will be about Ruth's role, how it was conceived and how it has developed in the last 13 years. Ruth will discuss the pathway for referral to the Plastic Surgeons and how this is facilitated by the specialist nurse. She will also talk about patient involvement and support and how this can help with the many decisions that women undergoing breast reconstruction have to make.

Day 1 Session 1 – 09:50 – 10:00

Mrs R Harcourt/ Mrs K Kemp

Keeping Abreast patient-led support

An overview of Keeping Abreast and how they support patients.

Day 1 Session 1 – 10:00 – 10:10

Mrs M Howe

Breast reconstruction – a patient's experience

Margaret's experience as a patient undergoing breast cancer treatment and reconstruction and the support received throughout.

Day 1 Session 1 – 10:10 – 10:30

Ms G Hurd

Providing a bra fitting service

- Best immediate post-surgery bras
- Managing expectations after surgery
- Partial prostheses innovations: minimising any difference in breast shape
- Living with reconstructed breasts

Day 1 Session 1 – 10:30 – 10:50

Dr R Bajekal

Pain management in breast surgery

Breast surgery is associated with both acute and chronic pain. Traditional modes of analgesia have relied on parenteral opioids and local anaesthetic infiltration. With the evolution of surgery, anaesthetic techniques have changed as well. Recent advances in perioperative care have seen the role of novel local anaesthetic techniques and multimodal analgesia to improve the patient experience. Current practice and latest evidence will be reviewed.

Day 1 Session 2 – 11:30 – 11:50

Mr G Gui

Update on surgical management of breast cancer

Breast cancer is being detected at an earlier stage than ever with increasing awareness and screening. 75% of cancers diagnosed through surveillance are suitable for breast conservation surgery. Wide local excision with clear margins followed by radiotherapy provides similar outcomes to mastectomy in the management of stage I and II disease. The definition of clear margins has evolved with the benefits of modern adjuvant treatment with chemotherapy, biological agents such as Herceptin and advances in endocrine treatment. There is increasing acceptance of clear margins to mean no tumour identified at the microscopic inked margin. Re-excision requirements after breast conservation surgery vary between 5-10%.

Oncoplastic breast surgery utilises volume displacement and volume replacement techniques to close the space created at wide local excision. Simpler volume displacement methods mobilise adjacent breast tissue directly or in the form of a modified mastopexy. The round block repair is based on the principle of re-coning the central mound while peripheral defects can incorporate tissue harvested adjacent to the breast as a crescenteric flap. As the volume of resection increases, skin adjustment will become necessary and a range of therapeutic reduction mammoplasty approaches have been adapted to facilitate breast conservation. Larger resections often require contralateral symmetrisation surgery to achieve a good long-term match. Examples of volume replacement with tissue harvested away from the breast are the lateral intercostal artery perforator and mini-latissimus dorsi flaps.

Mastectomy is still required for multicentric disease or multifocal cancer involving a large segment of the breast where clear margins cannot be achieved. Immediate breast reconstruction has led to the recognition of skin-sparing mastectomy as an oncological procedure. With patient selection, mature studies have shown acceptable local recurrence rates and meta-analyses have not identified a worse outcome compared with standard mastectomy. The advantage of skin-sparing mastectomy is the preservation of skin overlying the reconstructed breast that might otherwise have had to be achieved by tissue expansion techniques or incorporation of autologous tissue at the time of delayed reconstruction.

With nipple-sparing mastectomy, a small amount of retro-areolar breast tissue is retained. Tumour size, proximity of the cancer to the nipple, and pathological features such as extensive DCIS with cancerisation of the lobules are relative contraindications to nipple preservation. Nipple-sparing mastectomy has rekindled an interest in inframammary and lateral breast fold incisions, thus avoiding scars on the visible breast mound. Methods of preserving the nipple on a skin-reduction pattern is a challenging

procedure but with careful surgery and patient selection can provide good results in women with large and ptotic breasts.

Continued progress in primary medical therapy facilitates downsizing of tumours to enable breast conservation in patients that might otherwise have required a mastectomy. Locally advanced disease may be down-staged for curative resection. Patients presenting with locally advanced disease often require post-mastectomy radiotherapy as part of the oncologic management and this in turn impacts on decision-making for oncoplastic and reconstructive techniques.

In parallel with conservative surgery to the breast, sentinel lymph node biopsy has enabled a conservative approach to the axilla; dissection may only be needed in patients who are node positive. There is widespread acceptance that micrometastases to lymph nodes does not require surgical clearance. Clinical trials have shown equivalence of outcome in treating the positive sentinel node with completion surgery or radiotherapy. Further randomised trials are required to ascertain the long-term oncologic safety of a conservative approach to the sentinel node positive axilla. Controversy remains as to the optimum management of the axilla in patients who present with node positive disease who achieve a complete response to primary chemotherapy.

Whilst breast cancer management has made tremendous progress, ideal surgical management remains focused on patient selection alongside appropriate application of surgical and patient choice.

Recommended reading: Early Breast Cancer: From Screening to Multidisciplinary Management, CRC Press, 2013. Editors: Benson J, Gui G, Tuttle T

Day 1 Session 2 – 11:50 – 12:10

Dr M Kelleher

Update on oncological management of breast cancer

Dr Kelleher will outline the role of the medical oncologist in the breast cancer MDT. She will review the rationale for chemotherapy in early breast cancer and discuss the sequence of treatment, particularly the choice of neo-adjuvant versus post-operative chemotherapy.

The talk will encompass drug choices and their impact on wound healing and include a discussion of the impact of chemotherapy and radiotherapy choices on reconstructive options.

There will be a review of new treatment options and the optimal timing of radiotherapy in the treatment algorithm.

The role of plastic and reconstructive surgery in metastatic disease will be discussed.

Day 1 Session 2 – 12:10 – 12:30

Mrs E Weiler-Mithoff

Reconstruction options following mastectomy

Technical advances in reconstructive surgery and the availability of information online have raised patient's expectations. Patients are no longer content with improved appearance in clothes, avoiding an external prosthesis, but expect their reconstructive surgeon to match the opposite breast in dimension, position and contour.

It is therefore important to select a range of techniques which are most cost effective, have low revision rates, a low rate of symmetry surgery and are able to withstand adjuvant radiotherapy.

Immediate breast reconstruction is most cost effective and leads to the best cosmetic results due to maximum preservation of breast skin but exposes the reconstructions to the effects of radiotherapy. Delayed reconstruction involves a separate episode of hospitalisation, requires replacement of a larger amount of skin and potentially poor mastectomy flaps.

Implant based breast reconstructions require limited surgery initially but have a high rate of symmetry and maintenance surgery. The long term outcome is directly related to the tolerance of breast implants and generally poor after radiotherapy. The aesthetic results of autologous reconstruction are superior due to their versatility, their more natural appearance, consistency and durability. Autologous tissue can better withstand radiotherapy but donor site morbidity has to be appreciated.

Day 1 Session 2 – 12:30 – 12:50

Ms J Skillman

The use of ADMs and meshes with implants

Implant-based breast reconstruction is the most commonly performed reconstructive procedure in the UK. The introduction of techniques to augment the subpectoral pocket with acellular dermal matrix and meshes has revolutionised the procedure. The product types, principles of surgical technique, advantages and disadvantages of these new techniques will be presented.

Day 1 Session 2 – 12:50 – 13:10

Ms S Potter

The iBRA study – An update

Implant-based breast reconstruction (IBBR) is the most commonly-performed reconstructive procedure in the UK. New techniques to augment the subpectoral pocket have revolutionalised the procedure, but there is a lack of high-quality outcome data to support the safety or efficacy of these techniques. Randomised trials provide the best evidence for the effectiveness of an intervention, but there is a lack of high-quality data to inform the feasibility, design or conduct of an RCT and premature progression to a trial may alienate potential participants. The iBRA (implant breast reconstruction evaluation) study therefore aims to use novel trainee collaborative methodology to:

- Define the current practice of IBBR in the UK
- Compare the outcomes of the new approaches to IBBR against standard practice and quality standards defined by the Oncoplastic Breast Reconstruction: Guidelines for Best Practice.
- Inform new guidelines
- Determine the feasibility of a pragmatic trial comparing different approaches to IBBR

iBRA started recruitment in May 2014 is now the largest prospective evaluation of implant-based breast reconstruction in the world with over 1,400 patients recruited from 65 centres.

It has demonstrated the feasibility of undertaking collaborative research in reconstructive surgery and will provide comprehensive data relating to the practice and outcomes of IBBR in the UK. It will allow the feasibility of a pragmatic RCT to be explored; variations in the quality of care to be identified and experiences of women undergoing the procedure in the future to be improved.

Day 1 Session 3 – 14:20 – 14:40

Mr D Macmillan

Genetics and Managing the High Risk Patient

High-risk gene mutations are rare, affecting approximately 1 in 800 women for BRCA1 mutations and 1 in 500 for BRCA2 mutations. They confer a 10- to 30-fold increase in the risk of breast cancer in carriers compared with non-carriers. They also confer a risk of ovarian cancer. The threshold for offering genetic testing is becoming lower.

Options for women with a BRCA gene mutation include doing nothing, intensive screening, chemoprevention, and risk-reducing surgery. As not many women currently choose chemoprevention / find the options acceptable, for most women the choice is between screening and risk-reducing surgery.

Intensive screening is associated with increased recall rates and more interventions compared with standard whole population screening. In addition, for those BRCA mutation carriers who are diagnosed with cancer, the treatment pathway is usually surgery and chemotherapy (in over 90%) with radiotherapy and/or hormone therapy in approximately 50%. In addition, for those who develop breast cancer in a screened group of BRCA mutation carriers, the risk of dying of breast cancer is approximately 10% over 10 years.

All women with BRCA gene mutations are recommended oophorectomy after the age 35 – 40 providing their family is complete, after which they are recommended HRT. This preventive measure also reduces risk of breast cancer if risk-reducing mastectomy has not been performed.

Risk reducing mastectomy is an option for all women with BRCA gene mutations. If choosing it, women need to accept the risks and possible additional operations associated with the surgery they have chosen and that the operation does not eliminate risk completely, sensation will be lost, and the best result will not match a normal breast. Most women choose simultaneous reconstruction and the two most common techniques would be implant reconstruction or DIEP flap reconstruction. All women have the option of nipple preservation and most will have the option of being bigger or smaller or different shape compared to the starting one.

Risk reducing surgery is best performed in tertiary centres, where group counselling and education can be offered with experienced specialist input from nurses, genetics, psychology, gynaecology, and reconstructive surgeons is readily available.

Day 1 Session 3 – 14:40 – 15:00

Mr G Ross

Reconstruction following risk reducing surgery

Reconstruction following risk reduction surgery involves many different disciplines. A team approach is critical in educating and allowing patients to be empowered to make decisions. These decisions are focused on the risk and benefits of mastectomy and the various forms of reconstruction. Each patient should have individualised care and be allowed the opportunity to choose between the various forms of reconstruction. The choice of reconstruction will vary depending on the patient's wishes, the anatomical constraints, oncological decision making and the short, medium and long term goals of the patient.

Day 1 Session 3 – 15:00 – 15:20

Mr S McCulley

Preventing deformity following breast conservation

Chest wall perforator flaps have become an important option in volume replacement for Breast conserving surgery. The perforators available are abundant and although mostly lateral, supplying the Lateral Intercostal Perforator (LICAP) flap and the Lateral thoracic perforator (L-TAP) flap are also available inferior to the Infra-mammary fold supplying the Anterior intercostal perforator (AICAP) flap. The Thoracodorsal artery perforator (TAP) flap remains another important option but is less frequently used as it sacrifices the Thoracodorsal pedicle, is less often required and is a more complex procedure. The anatomical basis, flap selection and dissection and flap delivery methods are presented.

Day 1 Session 4 – 15:50 – 16:10

Mr F Fatah

The use of fat grafting to improve outcomes

The biggest challenge in breast reconstructive surgery is to produce symmetry of shape, size and profile between the two sides. It is almost impossible to achieve symmetry in implant based breast reconstruction and frequently autologous breast reconstruction, though superior to implant reconstruction requires significant tweaking to approach a near acceptable level of symmetry. Fat graft as an adjunct to other forms of breast reconstruction can play an important role in producing the maximum possible level of symmetry. It can address problems such as volume, shape and profile asymmetry, however, the procedure is highly technique dependent and a strict protocol is required to achieve improvements in outcome.

Day 1 Session 4 – 16:10 – 16:30

Ms F MacNeill

Symmetrising surgery to improve outcomes

Day 1 Session 4 – 16:30 – 16:50

Mr J Scott

Nipple reconstruction

The increasing demands on health care resources require the reconstructive surgical community to promote an evidence-based practice. The role of nipple-areolar complex reconstruction in terms of enhancing patient psychological well-being and performing reconstruction in the immediate or delayed setting are discussed.

Nipple-areolar complex (NAC) reconstruction facilitates the objective of achieving breast symmetry. Paradoxically, perfect breast symmetry is uncommon and strategies for the appropriate location of the NAC on the breast mound are presented.

Maintaining nipple construct projection continues to be a technical challenge. A variety of local flap and autologous graft techniques are presented and the outcome evidence is reviewed. The challenges of reconstruction in the presence pre-existing scars, previous breast mound radiotherapy and the role of micro-pigmentation are discussed. Finally, a novel technique for the correction of nipple inversion is presented.

Day 1 Session 4 – 16:50 – 17:10

Ms D Forshaw

Micropigmentation of the nipple areolar complex

Trade Exhibition

Exhibitors

Keeping Abreast

Contact: 01603667431 email: info@keepingabreast.org.uk

Website: http://www.keepingabreast.org.uk/

Keeping Abreast was established in September 2007 by patients Anna Beckingham and Beverley Birritteri and Breast Reconstruction nurse specialist Ruth Harcourt. They recognised a great need for women, both newly diagnosed with breast cancer and facing the possibility of mastectomy, and also women further down the line who are also considering reconstructive surgery, to be able to meet and talk to other women who have been through similar experiences. This allows women make an informed choice about whether or not to proceed with breast reconstruction.

Keeping Abreast
Breast Cancer Reconstruction Support