



**BAPRAS**

British Association of Plastic  
Reconstructive and Aesthetic Surgeons

# Restarting Breast Reconstruction Services - Delayed Reconstruction

## **BAPRAS Breast Reconstruction Working Group**

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### **Background**

In response to the COVID-19 pandemic NHS hospitals were told to suspend all non-urgent elective surgery for 3 months from 15 April. In a letter to NHS staff on 17 March, NHS England's chief executive, Simon Stevens said that these measures were needed to free up general and acute capacity.<sup>1</sup> He advised that emergency admissions, cancer treatment and other clinically urgent care should continue unaffected. Extra capacity was bought at private hospitals to enable this.

The NHS has managed COVID-19 patients well and capacity has not been exceeded to the extent that the new facilities in the Nightingale Hospitals have largely not been needed. Simon Stevens issued a further statement on 29 April allowing planning for the resumption of elective surgical activity.<sup>2</sup> The relaxation of lockdown alongside this means that the services must remain flexible and able to respond to any potential new surges in COVID-19.

In restoring services we need to consider how to deal with pre-existing waiting lists alongside patients who have had their treatment plans altered or surgery denied because of the crisis. Consideration needs to be given to the resources available in terms of staff, facilities, equipment and the systems needed for infection control.

Breast reconstruction encompasses a range of surgical techniques to reconstruct and help rehabilitate patients who are undergoing or who have had treatment(s) for this very common condition.<sup>3</sup> The benefits of breast reconstruction are well known in terms of improvements in patients social, sexual, psychological and aesthetic well-being.<sup>4,5</sup> Understandably breast reconstruction stopped as part of the pandemic arrangements although breast cancer surgery has not.

The purpose of this document is to identify a way forward for the restoration of breast reconstruction in the risk reduction populations and also delayed breast reconstruction. Our intention is to enable breast services to not only give women full access to the options for reconstruction as outlined in NICE guidance NG101<sup>6</sup> but to improve access, efficiency and standards in a manner consistent with the GIRFT process.<sup>7</sup>

Risk Reduction Surgery / Reconstruction is offered to patients with identified genetic profiles that put them at greatly increased risk of developing Breast Cancer in comparison to the general population risk. The commonest genes associated with developing Breast

Cancer are mutations of BRCA 1 and 2 gene which occur in about 1:400 people.<sup>8</sup> Patients with these gene mutations are about 55-65% (BRCA1) / 45% (BRCA2) likely to develop invasive breast cancer by the age of 70.<sup>8</sup> Many of these BRCA1/2 patients are identified either at a young age when they develop their first cancer or through genetic screening after identification of one of their close relatives as a gene carrier. Surgical prophylaxis with mastectomy provides the greatest reduction in risk of breast cancer development (>90%) and also has proven gains in life expectancy over increased radiological surveillance alone.<sup>9</sup> Capacity needs to be made to address not only the immediate breast reconstruction in breast cancer patients but also those high risk patients requiring prophylactic mastectomy and breast reconstruction. These patients do not register on cancer tracking pathways and so have been categorised as 4 and can wait as the current plans to allow surgery exist. There is the potential that delaying mastectomy and reconstruction in these patients could lead to them developing Cancer whilst awaiting surgery.

**Delayed Reconstruction** takes place in patients who have already had their cancer treatment and are therefore missing breast volume /skin, have pre-existing chest wall scars and may have had radiotherapy and or chemotherapy. The different reconstructive choices are covered well in the BAPRAS booklet on breast reconstruction which easily accessible as a pdf or hard copy.<sup>3</sup>

Post Covid we feel it is sensible to revisit the availability and strategies that we consider with our patients wishing to undergo breast reconstruction.

### **Issues to be addressed**

1. Delayed Breast Reconstruction, despite all functional and psychosocial benefits, is often classed as “low priority” as the patients Cancer treatment has already been completed. Some Health Boards/Foundation Trusts have stopped delayed breast reconstructions as the waiting lists were unsustainable (pre-covid) and resources were needed for immediate reconstructions. The number of and need for delayed breast reconstruction will have increased because of the cessation of all reconstruction in the last few months.
2. There is a danger of forgetting this delayed group as services restart with the effort concentrated around the provision of immediate breast reconstruction rather than risk reduction surgery / reconstruction and delayed reconstruction.
3. **Capacity for free flap breast reconstruction** (pre covid). Unpublished data (KA) has shown that out of 56 Plastic Surgery units in the UK, 52 out of 56 responded across 13 regions. 7 / 52 do not offer free tissue breast reconstruction. 161 Plastic Surgeons offer free tissue transfer and on average 22 free flaps per year each. 3209 free flap breast reconstructions were performed last year with a 54% / 46% split of immediate to delayed procedures. Clearly there is variation in the numbers and split of procedures

performed across the UK. This study suggested that there was a surgeon predicted requirement for an additional 78 Plastic Surgeons performing this type of surgery.

4. **Number of patients currently awaiting free flap breast reconstructions** There is great regional variation in the proportion of patients having immediate versus delayed reconstructions and some areas have more patients awaiting delayed reconstructions than others. SW unpublished survey of units suggests that there are 1500 waiting surgery.
5. Those units primarily offering Immediate autologous breast reconstruction (regardless of need for adjuvant radiotherapy) often have to prioritise immediate reconstructions over delayed thus already having extensive delayed waiting lists.
6. Units which follow the IDEAL breast reconstruction model<sup>10</sup> will have placed implants in patients requiring adjuvant radiotherapy with plans to switch to autologous tissue 1 year post mastectomy, this model may have worked well pre-covid for some units as it kept the free flap waiting list down.
7. Implant based breast reconstruction has downsides
  - a) Failure (9% at 3 months complete loss rate UK average)<sup>11</sup>
  - b) Either removal of implant and salvage with immediate autologous (not currently available)
  - c) Conversion to mastectomy and plan for delayed reconstruction with autologous tissue at later stage
  - d) Secondary to COVID-19 many salvage option may be currently unavailable leaving patients with increased implant related morbidity (i.e. painful capsular contracture)

## Strategy

1. We need to ensure capacity for risk reduction / reconstruction patients.
2. We need to highlight the importance of the delayed breast reconstruction group across all reconstruction choices and providing surgeons.
3. Delayed breast reconstruction has great benefits for patients psychologically and functionally.
4. NMBRA 2011 showed that patients who undergo delayed reconstruction are more satisfied and the cancer treatment is complete therefore no risk of delaying adjuvant treatments.
5. Work in conjunction with Position Paper 1 on restarting breast reconstruction in the immediate group.
6. Highlight to Royal Colleges and HM Government through all means available, the importance of this type of surgery for the risk reduction and delayed groups.

7. Having made the case for safe reintroduction of immediate reconstruction, introduce the same guidelines for the risk reduction and delayed reconstruction groups but with the following potential options: (review the access criteria every 2 months)
  - a) Use of Private sector for all types of NHS breast reconstruction. Currently only a minority of facilities do free flap reconstructions but with a change to 2 surgeon operating and some process change in units not offering this previously, this could be introduced and models exist to help this - Ruth and Anne, Anita etc..
  - b) Use of high volume / super centres with existing capacity for referral of backlog patients with a patient and or surgeon passport to go to those centres.
  - c) Make the case for increased numbers of Plastic / Reconstructive surgeons
  - d) Continue the provision of previous insured work - this may become unnecessary if we get better payment and provision for the NHS patients.
  - e) Re-introduce existing Plastic Surgery waiting lists as hospitals open. Look to change job plans to allow for weekend operating to take advantage of theatre capacity, ward capacity and also relaxation of the punitive annual allowance / pensions taxation rules for NHS consultant surgeons.

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