

Service: **Breast Reconstruction**

Breast reconstruction options



What is a breast reconstruction?

A breast reconstruction is a surgical procedure carried out to create a new shape breast, using one or both of the following:

1. Using your own tissues (Autologous). This procedure may involve taking muscle, fat and skin from one of the following areas:

- Abdomen
- Inner thigh
- Back
- Buttock

This tissue forms the new breast mound which is transferred up to the removed breast area. Here arteries and veins, together with the tissue, are sutured into the chest wall.

Terminology

- **Flap** - A block of any tissue which is taken from one part of the body and put into another which survives there because it has its own blood supply.
- **Pedicled Flap** - A flap which is never detached from the body but is transported to the breast while still connected to its blood supply.
- **Free Flap** - A flap which is detached from its blood supply (artery and vein) at one site and then reattached to an artery and vein in the region to be reconstructed using micro surgery.
- **The Pedicle** - The name given to the vessels supplying either a free or pedicle flap.
- **Donor Site** - The area of the body from which the flap is taken.

2. Breast implants

- **Silicone implants** are filled with a silicone gel which is held within an elastomer silicone (rubber) outer shell.
- **Saline implants** are filled with a sterile saline solution which is held within an elastomer silicone shell.
- **Tissue expanders** are used to stretch the skin over a 12 week period when there is not enough skin for an implant to be inserted. The outer shell is made of elastomer silicone and is similar to a deflated balloon when not inflated. This will be gradually inflated with saline over 12 weeks. The expander can be left in or exchanged for an implant.

Both tissue expanders and implants are surgically implanted either under your breast tissue or under your chest muscle. It is important to know that implants do not last a lifetime and will require replacing due to aging of the implant.

It is important to note that both Tissue expanders and Silicone implants may be contraindicate if you need radiotherapy.

Therefore you to will need to discuss this option with your plastic surgeon.

3. A combination of using your own tissue with an implant. see fig 1.

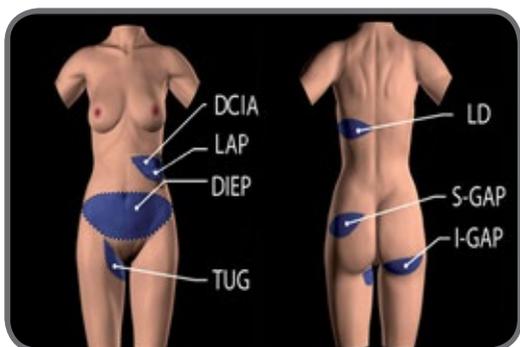


Fig 1.

www.uhb.nhs.uk/breast-reconstruction-dvd-preview.htm

Reasons for choosing breast reconstruction

Women choose breast reconstruction for both physical and psychological reasons. For example :

- Make your breasts look balanced when you are wearing a bra so you feel comfortable about how you look in most types of clothing.
- Permanently reform a breast shape.
- Help you to feel more feminine and address psychological and psycho-sexual wellbeing.

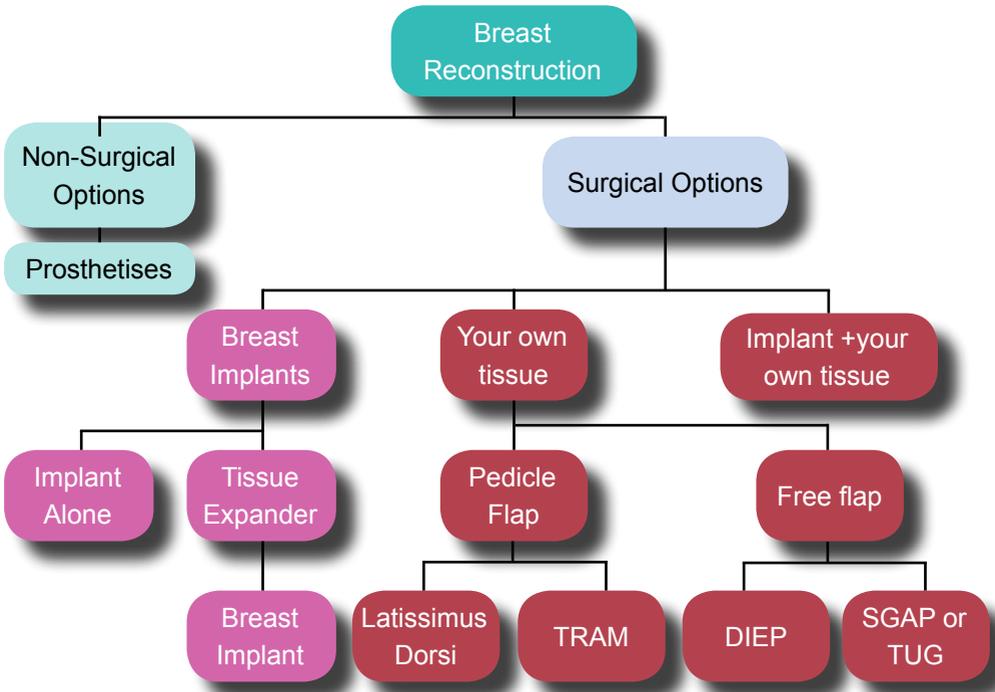
When can a breast reconstruction be performed?

Breast reconstruction can be performed at the same time as a mastectomy which is called an immediate reconstruction, or at a later date after the mastectomy, referred to as a delayed procedure. At your appointment these options will be discussed by your plastic surgeon to enable you to choose the right breast reconstruction procedure for you.

If I need chemotherapy or radiotherapy will this affect me having breast reconstruction?

You can still have breast reconstruction if you need chemotherapy and radiotherapy. However, radiotherapy will change the size and shape of a reconstructed breast as well as increasing the risk of complications. For these reasons many surgeons prefer to do a delayed reconstruction to avoid using skin and tissue which has been altered by radiotherapy. You will need to discuss this with your surgeon.

Breast reconstruction options



Non-surgical option

Bra inserts

Bra gel or foam inserts are a good way to give you an even shape when wearing clothes. Your local hospital will have a breast prosthetic bra fitting service which you can be referred to. Here you will be advised on the different produces which you can use, as there are many different types and styles to choose from. The breast foam/gel inserts can be built into a special bra or custom made to fit into your regular bra. You may also consider this option if you are having a delayed surgery or choosing not to have a breast reconstruction.

Psychological Support

The Outlook and Clinical Health Psychology team (which is part of the Plastic & Reconstructive Surgery service) provide specialist psychological support for:

- People with appearance-related concerns.
- People needing emotional support as part of coping with an illness and preparing for, or recovering from, surgery.

The sessions will give you the opportunity to talk through any concerns, learn strategies to cope with difficult thoughts and feelings, find ways to feel more confident to cope (e.g. with changes to your body, coping with surgical procedures), and practical support to help you move forwards in line with your personal goals.

Surgical options

Implants

Implants are the simplest option for breast reconstruction. They have the benefit of leaving no donor site scarring and carry none of the risks associated with using your own tissue. The implant can be placed directly under the skin and muscle of the chest through the original incision left

by the mastectomy. However, If there is not sufficient skin to allow the insertion of the implant then a tissue expander will be used. A tissue expander is a silicone balloon which is placed under the skin where the breast mound will be. Once your mastectomy site has healed the expander can be slowly inflated by injecting salt water through the skin via a port connected to the expander. This happens every 2-6 weeks until the desired size is reached. Some expanders are designed to be left in as an implant but many prefer to have them replaced with a silicone implant of the equivalent size. (Fig 2 and 3). The implant is placed just under one of the chest muscles in a prepared pocket. This is done to try and hide the edge of the implant and reduces the chance of the implant coming out through the skin.

Fig 2. tissue expander unfilled **Fig 3. inflated tissue expander**

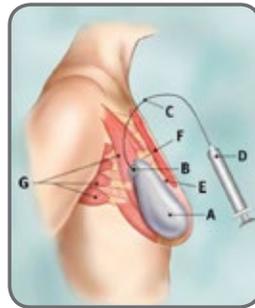
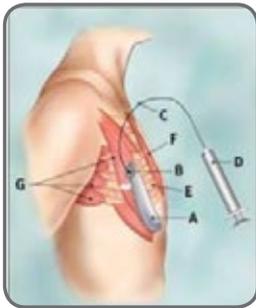


Fig 2: A Tissue expander
Unfilled/

Filled B Port C Catheter D Syringe E Ribs F Pectoralis Major Muscle G
Other chest wall muscles

Fig 3: an inflated tissue expander

Anaplastic Large Cell Lymphoma (BIA-ALCL)

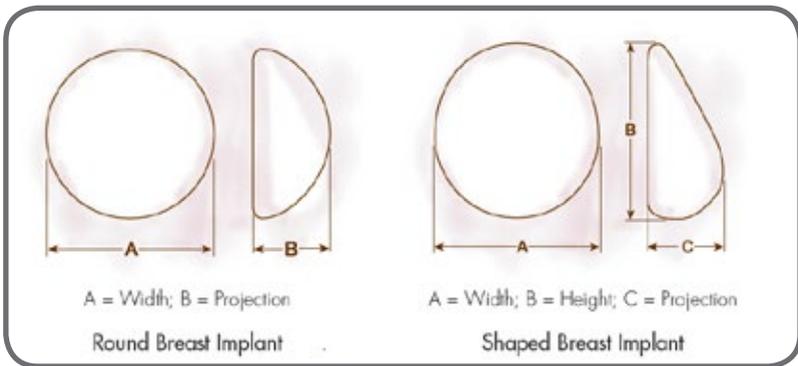
What is breast implant associated Anaplastic Large Cell Lymphoma (BIA-ALCL)?

Breast implant-associated anaplastic large cell lymphoma (BIA-ALCL), is not a form of breast cancer, but rather a rare type of non-Hodgkin’s lymphoma that is associated with the

insertion of textured breast implants.

Please visit the following website for further information on implants: British Association Of Aesthetic Plastic Surgeons (Baaps) Medicines & Healthcare products Regulatory Agency (MHR) www.gov.uk/guidance/breast-implants-and-anaplastic-large-cell-lymphoma-alcl

Implants consist of a silicone envelope filled with various liquids or gels to mimic the consistency of the normal breast. There have been some concerns in the past as to the safety of silicone as an implanted substance. These concerns led to the withdrawal of its use in the USA although this has never been the case in the UK. There is however no evidence of harm being caused by implanted silicone and these implants are now back in use in USA. The silicone contained in the implant would only come into contact with the body if the lining of the implant was breached. For this reason some implants are filled with saline. This produces an implant which is very soft and safe but fails to give the shape required for a good breast reconstruction. The silicone implants are divided into soft silicone and cohesive gel implants. The soft silicone has a more realistic feel but if the lining is breached it can leak into the breast. Cohesive silicone gel implants have a similar consistency to “Turkish Delight”, hence this texture makes the feel of the breast slightly firmer than a normal breast but because they are cohesive cannot leak if the lining is breached.

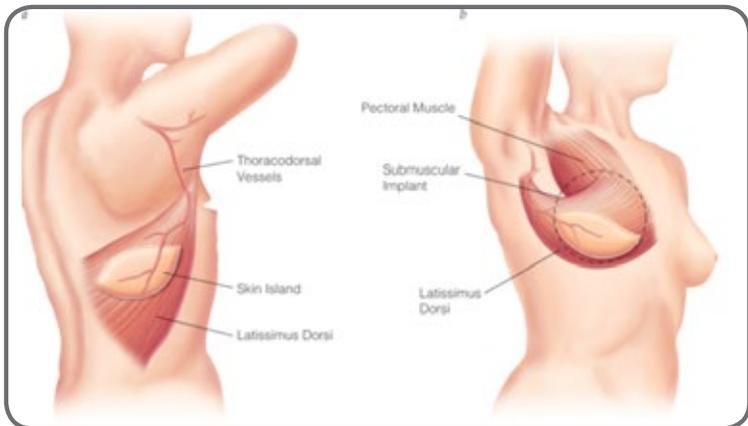


The cohesive gel implants can be round or tear drop shaped whereas saline and soft gel implants can only be round shaped. The Shaped Implant which is tear drop shape has the maximum projection further down the implant creating a more natural breast shape. However, an issue to consider when choosing a Shaped Implant is the possibility that the implant may rotate within the pocket of the chest wall. If this occurs surgery may be required to return it the implant back into the correct position again. The Round Shaped Implants do not have this issue due to their shape.

See fig 4

Latissimus Dorsi Flap (Lat Dorsi)

The Latissimus Dorsi is a large powerful muscle of the back which is important in pulling down the arm in actions such as climbing. Therefore if you do sporting actives such as swimming rowing tennis which involves powerful arm movement you need to be aware that you will experience



http://206.47.151.137/bcdecker/figures/acs/part03_ch05_fig16.gif

weakness in the back, shoulder and arm were the latissimus dorsi muscle has been taken to form your new breast. If sport plays a big role in your life you need to discuss this with the plastic surgeon before undertaking this form of surgery.

The lat dorsi flap reconstruction involves taking skin, fat and the muscle with its blood vessels from the back. The blood supply to this muscle comes from an artery and vein in the arm pit near to where the muscle joins to the upper arm. The muscle also gives a blood supply to the overlying skin so the muscle can be raised with some skin from the back. Once the flap has been raised it can be swung under the armpit without being detached from its blood supply and be used to reconstruct the breast (fig. 4).

Fig 5. the location of the scar following lar dorsi breast reconstruction surgery



www.breastreconstructionprocess.com/myImages/back/back01_scars.jpg

This is called a pedicled flap. The muscle may be detached from its nerve supply and its attachment to the upper arm. If it is not detached the muscle will still contract on movement of the arm. For a small breast the muscle alone creates enough volume to produce breast symmetry. If a bigger breast is required a tissue expander or implant can be used under the muscle. This adds to the volume of the breast but without the problems of being able to feel the edge which may occur with an implant alone. The transferred muscle from the back to form the breast may cause functional problems when climbing

ladders, pulling down or doing exercise. The removal of the muscle will leave a large wound under the skin of the back (fig. 5). This scar can often be hidden in the bra line, however due to movement this scar can become stretched.

Following surgery a drain is placed into the back to prevent the collection of fluid. Once the drain is removed fluid can collect in this space left in the back. This is called a seroma. If this becomes large or painful it can be drained with a needle and syringe in the outpatient department. This might need to be done on two or three occasions but they normally settle down with time. As with all skin flaps there is always the possibility that a small part of the skin flap might not survive. If this should occur the dead skin may be removed during another small operation and the wounds closed again, or your plastic surgeon may decide to allow the wound to heal by using dressing.

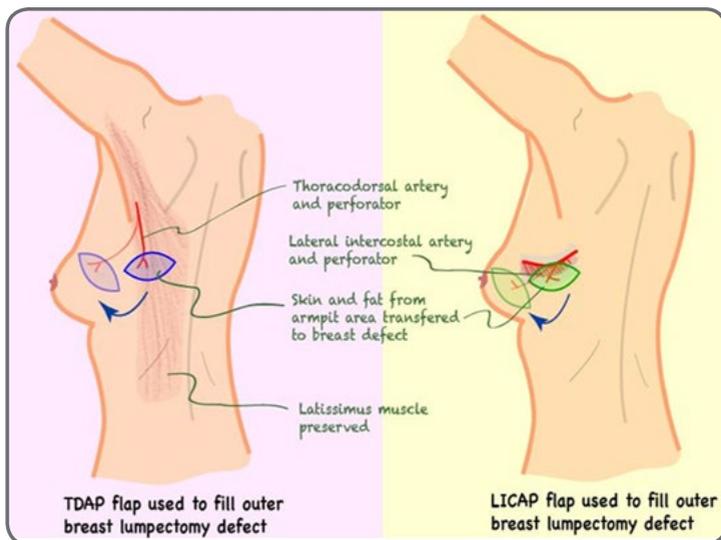
Important factors for you to think about when deciding on a Lat dorsi breast reconstruction:

- Some women experience weakness in their back, shoulders and arm.
- When the muscle is moved from the back to the front you may experience muscle twitching over the implant if an implant is used with your lat dorsi flap reconstruction.
- Your implants are unlikely to last a lifetime, so you are likely to need additional operations to replace the implant.
- You may experience local complications with breast implants such as rupture, pain, capsular contracture (scar tissue around the implant), infection.

You will be given an additional leaflet about implants if this is necessary.

Thoracodorsal Artery Perforator (TDAP) flap

The Thoracodorsal Artery Perforator flap, known as a TDAP or TAP flap, is a perforator flap that can be rotated from the upper back in to a position on the chest wall for use in breast reconstruction. TDAP flaps are composed of skin and fat along with the blood vessels that keep the flap alive. These flaps are obtained from the same region of the back as the latissimus dorsi flap, however, no muscle is sacrificed with



a TDAP flap. The flap is rotated into place without having to divide and reattach blood vessels. This procedure does not require microsurgery and therefore requires a shorter stay in hospital. The scar that results from TDAP flaps can generally be placed horizontally along the bra line so that it can be covered up by a bra.

Why would you use a T DAP

T DAP flap is used for partial breast reconstruction or if the abdominal tissue has been used in the past, thus unable to undergo a DIEP flap.

Deep Inferior Epigastric Perforator (DIEP) Flap

A DIEP flap is the name of the blood vessel that supplies the lower part of the rectus muscle at the front of the tummy. This procedure uses the fat and skin taken from the tummy leaving the muscle intact. To do this the blood vessels supplying the skin between the rectus muscle and the skin, called the perforators, are identified and followed back to the deep inferior epigastric vessel.

This is a more involved dissection and in some people there are not sufficient perforating vessels to supply the skin. If this is found to be the case, during surgery the flap would be raised as a free TRAM flap as previously stated. A CT scan will be undertaken before breast reconstruction surgery to confirm the position and presence of these perforating blood vessels making the conversion to a TRAM flap less likely

The DIEP is a free flap which means the blood vessels are disconnected in the groin and reconnected to other vessels in the breast area using microsurgery. At the same time as the flap is raised in the tummy another surgeon prepares the site of the breast reconstruction by preparing a pocket for the flap. Once this is done the vessels beside the chest bone (sternum) and behind the ribs are identified and prepared for microsurgery. This will involve removing a small segment of rib. If you have previously had heart bypass surgery we will not be able to use this blood vessel.

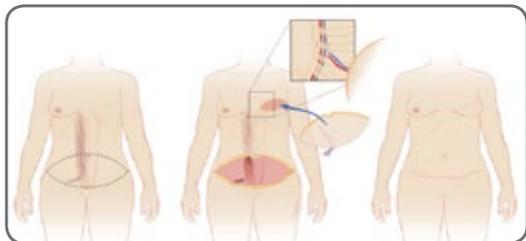


Fig 6. <http://intermountainhealthcare.org/services/medicalgroup/clinics/physicianclinics/plasticsurgery/services/breastreconstruct/Pages/DIEP.aspx>

In these cases an alternative vessel in the arm pit can be used. The donor site is closed in the same way as for the

TRAM flap. After your surgery you will be in hospital for about a week. It is very important after microsurgery to monitor you very closely to maximise the chance of success. We need to keep the flap warm so a heated blanket which has hot air blown through it is placed over the breast. It is very important to be comfortable and pain free afterwards. This is as much for survival of the flap as for your safety and comfort.

If you are considering this operation your Plastic surgeon will need to book you in for a Computed Tomography Angiography (CTA) based at Southmead Hospital. This is the only hospital in your area which can undertake diagnostic reporting.

What is a Computed Tomography Angiography (CTA)?

CTA is used to locate Perforator found in your abdomen. These are the blood vessels (artery and vein) which are needed to plumb in a blood supply into your chest area to keep your breast reconstruction alive. The CTA results will enable the Plastic surgeon to plan your reconstruction based upon the position of these vessels. With this information your plastic surgeon will discuss your options.

Reconstructive surgery using your inner thigh

Transverse Upper Gracilis (TUG Flap)

The TUG flap uses part of the Transverse Upper Gracilis muscle which is taken from your inner thigh area together with the blood vessels perforator, fat and skin to create the new breast. See fig 7. The inner thigh is directly closed back together and once healed the scar cannot be seen in the groin area as it is covered by your underwear. The TUG flap and blood vessel are then plumbed into the chest wall by removing a small piece of the third rib or cartilage to enable the new breast to be connected up to the chest blood vessels using micro-surgery.

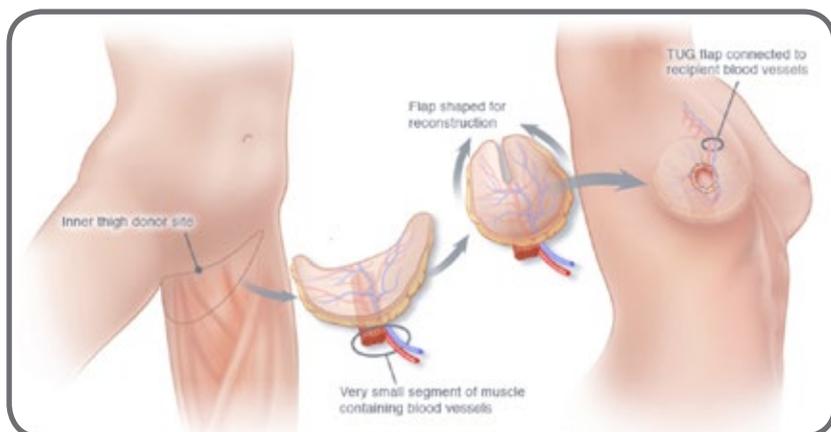


Fig 7.

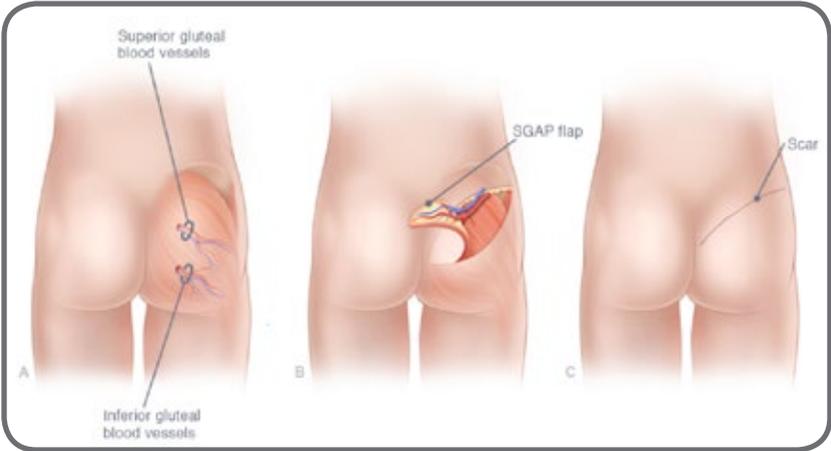
www.davidgreenspunmd.com/images/popups/popup-TUG_Flap_Ig.jpg

Reconstructive surgery using your buttock

Gluteal Artery Perforator (GAP flap)

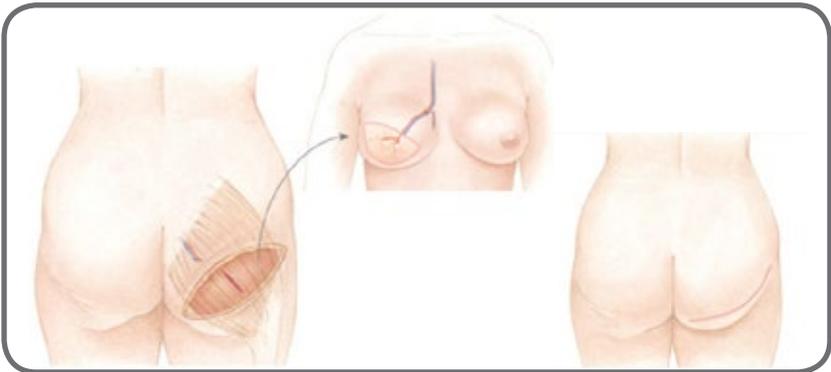
The **gluteal artery perforator** is a blood vessel that runs through your buttocks. There are two gluteal artery perforators, **Superior** and **Inferior**. Both these gluteal artery perforators may be used when the abdomen tissue cannot be used due to the abdomen tissue being too thin or has been damaged by other previous major surgeries or a tummy tuck.

The SGAP Superior Gluteal Artery Perforator blood vessels together with the fat and skin are taken from the upper part of your buttock. The blood vessel are then plumbed into the chest wall by removing a small piece of the third rib or cartilage to enable the new breast to be connected up to the chest blood vessels using micro-surgery. The buttock is then directly closed back together. This will leave a scar near the top of your buttocks. However this can be covered by your underwear. See fig 8.



Inferior Gluteal Artery Perforator (IGAP flap)

The Inferior Gluteal Artery Perforator IGAP flap, uses these blood vessels together with the fat and skin from the bottom part of your buttocks, near the buttock crease. Hence this is less noticeable when healed. See fig 9. The IGAP flap is then connected up to the chest wall in the same way as the SGAP.



Lumbar Artery Perforator flap (LAP)

The LAP flap is a flap from the dorsal lumbar area extending to the lateral edge of the rectus abdominis muscle which consists of fat, skin and one paravertebral perforator from the

lumbar vessels. The lumbar vessels travel through the erector spinae muscles or between the erector spinae muscle and quadratus lumborum muscle. Preoperatively, the perforators are located using a hand held doppler. The vessels are cut at the beginning of the vasa lumbales.

Advantage

Large flap.

Disadvantages

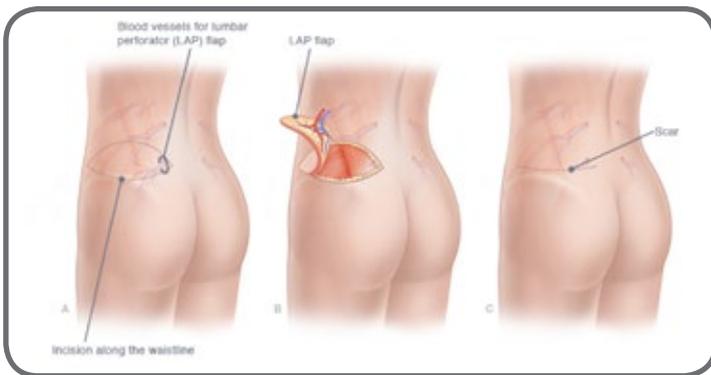
Flap harvest in prone position necessitating turning of the patient during the operation. Not in all cases a suitable perforator is available.

Indication

In case other free flaps are not possible.

Contraindications

Insufficient or unsuitable perforator. Insufficient skin and fat redundancy at donor site.



Deep Circumflex Iliac Artery Free flap (DCIA) or “Rubens flap”

The Rubens flap consists of the peri-iliac fat pad which is based on the deep circumflex iliac artery and vein. The flap pedicle is 5–6 cm. long and the blood vessels are approximately 2.5 mm. in diameter.

Advantages

The length and calibre of the vascular pedicle of the flap are usually sufficient. Bilateral reconstruction is possible. Flap dissection is possible with the patient in prone position. The donor-site defect appears to be more acceptable than with the LTF flap and in selected cases it can even be less conspicuous than the donor site of an abdominal based flap.

Disadvantages

The Deep Circumflex Iliac Artery Free flap is technically more difficult than the TRAM flap, and shaping the new breast seems more challenging than with the TRAM or gluteal flap, which may leave an asymmetrical donor site after unilateral breast reconstruction. Asymmetrical donor site after unilateral breast reconstruction. The blood supply to the flap is less robust and sometimes the deep circumflex iliac vein is small, making venous anastomosis required to transfer the flap more difficult. Part of the donor site scar may be visible in swimsuit. Improper reinsertion of donor site muscles on the iliac crest can cause postoperative complications, like a hernia. Also, nerve paresthesias are possible.

Indication

The Rubens flap is indicated if a TRAM flap is not possible because of a previous abdominal surgery or if the patient does not accept an abdominal scar.

Contraindication

Insufficient skin and fat redundancy at donor site.

What are the risks and complications following breast surgery?

All surgery and anaesthesia carry some uncertainty and risks. The following list gives you information on the most common or most significant problems that can occur following this type of surgery.

Blood transfusion - It is rare to require a blood transfusion after this surgery, however, this may occasionally be required. If you have strong views or religious beliefs about this, please discuss any issues with your plastic surgeon before surgery.

Anaemia - If you are found to have a low blood count (anaemia) after your operation, a course of iron tablets may be prescribed. After you are discharged from hospital, your GP may repeat the blood test.

Haematoma - This is a collection of blood underneath the skin, which may occur after surgery. The breast may become painful and swollen. A second operation may be necessary to remove the haematoma.

Seroma - Sometimes serous fluid may collect behind the breast, abdomen, back, or thigh wound after the drains are removed. Usually this is a small amount only and the body will gradually re-absorb the fluid over a period of a few weeks. Occasionally, a larger amount of fluid collects. This can be drained in the outpatient department and may need to be done on several occasions.

Infection - A wound infection can occur after any surgical procedure. If this happens it may be treated with antibiotics and, if necessary, further dressings. In severe cases, a return to theatre is required to wash out the infected wound. After an infection the scars may not be quite as neat. Any major operation with a general anaesthetic carries a small risk of a chest infection, particularly among people who smoke.

Deep vein thrombosis - This is a blood clot in the legs and is a potential complication following surgery and bed rest. People who are taking the oral contraceptive pill or hormone replacement therapy and those who smoke are at the greatest risk.

Occasionally clots can break off and pass to the lungs, known as a pulmonary embolus (PE). All patients are given compression socks to try to prevent this problem. Pre-operative assessment will also result in the need for blood thinning injections to reduce this risk. During the first 24 hours following surgery you will also wear 'flotron' boots that massage your calves while you are less mobile. You will be encouraged to mobilise the first day following surgery. Taking Tamoxifen may increase the risk of DVT, if you have been prescribed Tamoxifen you will be asked to stop taking it two weeks before surgery until two weeks after surgery. This will not affect your cancer treatment.

Wound breakdown - Wound healing may sometimes be delayed. This may be because of tension on the wound, poor blood supply to the area, poor nutritional status and/or infection. Occasionally the wound may break down, resulting in; a longer hospital stay, increased hospital visits to have the wound/s assessed and, possibly, further surgery. Smoking increases the risk of this as smoking can have an adverse effect on the healing of all surgical wounds. Eating a healthy diet promotes good wound healing.

Scars - Any operation will leave a permanent scar. Infection can cause a wound to re-open; this may lead to problems with scar formation such as stretching or thickening. At first, even without any healing problem, the scar will look red, slightly lumpy and raised.

Regular massage of the scar using a light non-perfumed moisturising cream and using sensible sun protection measures, such as a factor 30 sun block, should help it to in time and fade over some months. This may take up to two

years. Some people may be prone to the development of keloid or hypertrophic scars which are raised, itchy, and red. If you have a tendency to produce scars like these, please discuss this with the plastic surgeon. In the majority of cases, scars settle to become less noticeable. Occasionally revision surgery may be performed to improve the appearance of scars.

Symmetry - Although every effort will be made to make your breasts equal in size and shape, you may find that there is a difference between the two breasts. This is quite normal, but if you have any concerns or questions please talk to your plastic surgeon. If necessary, revision surgery may be performed to improve the look of your breasts. A degree of asymmetry in all women is normal.

Flap failure - There is a small chance that the flap or part of the flap may die. If its blood supply is insufficient, there is an approximate risk of 1.5% failure rate. This is rare, and is most likely to happen within the first 24-48 hours post operatively. If this does occur you will need another operation to remove the affected area. Your plastic surgeon will also discuss with you other reconstruction options that are available.

Occasionally it is possible to save the flap, if the problem with the blood supply can be rectified, but this usually involves a return to the operating theatre.

Fat necrosis - This is an uncommon, benign condition where fat cells within the breast may become damaged/die and delay wound healing. It is usually painless and the body repairs the tissue over a period of weeks/months. Occasionally the fatty tissue swells and may become painful. The fat cells may die and their contents form a collection of greasy fluid which will drain to the skin surface. The remaining tissue may become hard. In severe cases the skin may die. It is uncommon to require further surgery.

Other important factors to consider

Body image - The majority of patients are pleased with the results of their surgery. However, not all surgery is completely successful and you may not be pleased with your cosmetic result. Occasionally, women feel very anxious about their treatment or have difficulty coming to terms with their new look because their breasts are not as they had imagined they would be or as a result of a complication. If you feel very anxious, worried about your treatment or depressed please speak to the breast reconstruction nurses for more information about the psychological therapy service available.

Intimacy - Initially, your breasts and abdomen, inner thigh or back will feel tender and you may not feel up to intimate physical contact. However, you may resume your sex-life as soon as you feel comfortable. Patients having the TUG flap may be unable to externally rotate their legs comfortably until 4 to 6 weeks after the operation.

Breast reconstruction restores the shape of the breasts but cannot restore your normal breast sensation. With time, the skin on the reconstructed breast can become more sensitive, but it will not give you the same kind of pleasure as before a mastectomy.

Some women are concerned that her partner hesitates to touch her and this makes the woman feel less attractive. The most likely reason for this is that her partner is afraid of hurting her. Couples need to talk about their fears and feelings.

Sport - Some sport can be resumed within 6 to 8 weeks, but we suggest that you check with your plastic surgeon or breast reconstruction nurse first. If the sport involves strenuous upper body movements for example aerobics, golf, swimming and any racquet sports then it is probably advisable to return gradually to these activities and ensure you have a supportive sports bra on during the activity.

Wound healing - Your plastic Surgeons may suggest you delay having the operation for one reason or another. This may happen if you smoke or have other health conditions. Many surgeons require you to stop smoking prior to reconstructive surgery to allow for better healing.

There is written evidence to show that wound healing is impaired dramatically the higher your body mass index (BMI). Our plastic surgeons will ask that your BMI falls between a healthy range and does not exceed 30, this is in order to reduce the chance of a complication arising. Your plastic surgeon may ask you to lose weight before agreeing to operate to achieve the best long-term results.

The plastic surgeon may recommend surgery to re-shape the remaining breast to match the reconstructed breast. This could include reducing or enlarging the size of the breast or lifting the breast at a later stage.

Common side effects following breast reconstruction surgery

Following breast reconstruction surgery you may experience one or some of these common side effects:

All types of reconstruction:

- Areas of specific discomfort where new breast mound is sutured to chest wall
- Dissolving sutures spitting out
- Feeling of heaviness/fullness to the reconstructed breast
- Numbness or lack of sensation to reconstructed breast
- Feeling of bulkiness under armpit to your reconstructed side
- Red lumpy scars during healing process
- Difficulty in getting bras to fit for duration of reconstruction journey

DIEP/ TRAM & TUG flap reconstructions only

- Some discomfort to the ribs above the reconstructed breast.
- As the newly connected blood vessels are healing it is possible that you may experience tingling, electric shock or warm sensations in your chest, although this is less common.

What arrangements do I need to make?

The hospital stay is usually between three and five days. You will be discharged as soon as you are clinically fit to go home. You will need to arrange help with shopping, housework and care of small children, as you will not be able to manage these on your own for at least two to three weeks after surgery. It may be necessary to organise between 8 to 12 weeks off work and you may need to consider a phased return to work if you have a physical job.

You will not be able to drive immediately after your operation for approximately four to six weeks. However, you should only consider driving when sufficient healing has taken place to allow you to wear a seatbelt without pain and you are able to perform an emergency stop (practice in a car park first). Before you drive, following surgery, we suggest that you check with your insurance company to ensure that you have the appropriate cover. Make sure you take note of the date and the name of the person you spoke to. Some companies ban driving for a specific period following surgery. Failure to comply with that condition would mean that you were driving without insurance, which the law regards as a serious offence.

If you are taking the oral contraceptive pill or hormone replacement therapies, you will be required to stop taking these medication six weeks prior to your surgery. Your plastic surgeon/ breast reconstruction nurse will advise you. Therefore you may need to seek Family Planning advice for birth control.

Always seek medical advice

You will need to bring a list of any medicines (prescribed, over-the-counter or herbal remedies) that you are currently taking to the Outpatient Department appointments, Pre-assessment Clinic and with you on admission to the hospital along with the prescribed medication (if possible complete in its box).

If you are prescribed Tamoxifen you will be asked to stop taking this two weeks before surgery and can re-commence two weeks after your surgery. This will not affect your cancer treatment in any way.

Contact information

If you have any further questions or need advice regarding the information in this leaflet please contact one of the Breast Reconstruction Nurse Specialists

Psychological Therapy Team - Outlook

Tel: 0117 414 4888

Email: Outlook.dsu@nbt.nhs.uk

'Keeping Abreast' – South West

Breast reconstruction 'Show & Tell' group, run by the breast reconstruction nurses. Past patients of Southmead Hospital share experiences and show results of breast reconstruction 'in the flesh'. Meetings held at Southmead Hospital every six weeks.

www.keepingabreast.org.uk

Further information and support

If you would like any further information you may find these contacts useful:

Breast Cancer Care

Free and confidential service, run by specially trained nurses

Web: www.breastcancercare.org.uk

Helpline: 0808 800 6000

Text phone: 0808 800 6001

Macmillan Cancer Support

Provides practical, medical, emotional and financial support

Web: www.macmillan.org.uk

Freephone: 0808 800 0000

Text phone: 0808 808 0121

**PATIENT
APPROVED** 

How to contact us:

Andrea Thompson waiting list coordinator



Email: Andrea.Thompson@nbt.nhs.uk



Phone number: 0117 414 7626

Plastic surgery Breast reconstruction team



Plasticsurgerybreastreconstructionteam@nbt.nhs.uk

Southmead Charitable Fund for breast reconstruction

Code 1009 for donations: Naila Hussain ext: 43679

Breast Reconstruction Nurse Practitioner: Caroline Oates



Email: caroline.oates@nbt.nhs.uk



Breast Reconstruction Nurse: Caroline Lewis

Tel: 0117 414 8700 or 0117 950 5050 bleep:1698



Email: caroline.lewis@nbt.nhs.uk



Secretary: Wendy Rodman

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www.nbt.nhs.uk

If you or the individual you are caring for need support reading this leaflet please ask a member of staff for advice.

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