

Re construct ing After the Big C

Doctor communication
is essential for the
benefit of the patient

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For Jodi Withers, breast reconstruction meant she could continue her life and feel normal.

sis, Withers decided to have an immediate breast reconstruction—a procedure where a plastic surgeon reconstructs a breast using an implant or the patient's body tissue directly after a general surgeon has performed a mastectomy.

Knowing that she would have a “little bit of something there” after the surgery made the sense of loss that often accompanies mastectomies bearable for Withers.

“I didn't want to see the scar underneath,” Withers says. “Instead I woke up and was already on my way to having a breast again.”

For Withers, like many other patients who undergo a mastectomy, breast reconstruction meant she could continue her life and feel normal again.

“Knowing that I could have my body back, well that was just huge,” Withers says.

Withers is one of 79,000 women who had a breast reconstruction in 2008, a 39 percent increase from the year before, according to the American Society of Plastic Surgeons (ASPS). Yet, a study conducted the same year by Amy K. Alderman, M.D., MPH, and a team of researchers out of the University of Michigan Medical Center concluded that only 33 percent of breast cancer patients “had a general surgeon discuss breast reconstruction with them during the surgical decision-making process for their cancer.”

In an effort to educate both patients and medical providers about the different options for breast reconstruction, the ASPS has since launched a “Choices in Breast Reconstruction” campaign.

Roberta Gartside, M.D., a Reston plastic surgeon who is part of the campaign, says while not every patient needs breast reconstruction, every patient needs to know their options for the procedure. She says this lack of communication between general and plastic surgeons can lead to misinformed patients.

To encourage more communica-



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ody Withers wasn't afraid when doctors told her she had cancer in her left breast last January. She didn't flinch when she found out she would need a mastectomy. The 50-year-old Bristow resident simply treated her cancer treatment like a checklist. For Withers, this was familiar territory, and knowing she was going to have a

second mastectomy—her first was in 2004—meant she could finally stop living in fear, wondering if her breast cancer would return.

“I was so scared during my first diagnosis,” Withers says. “But the second time, I went into the doctor's office, they explained the steps, and I said, ‘I know the drill.’ I was just ready to get it over with.”

As she did with her first diagno-

tion, the campaign sends informational materials to hospitals, breast cancer centers and individuals.

“Breast reconstruction is a team approach,” Gartside says. “We need to work together to provide more coordinating care.”

Plastic surgeon Alex N. Mesbahi, M.D., says while he finds it hard to believe that only 33 percent of women are told about breast reconstruction, he thinks it is likely that many women aren’t told about all the different types of breast reconstruction, especially from plastic surgeons who don’t offer all the reconstruction options.

Mesbahi, a surgeon with the National Center for Plastic Surgery in McLean, says women need to talk to numerous doctors so they know the different options, which include using implants with or without an expander, or using tissue, skin or muscle from various parts of a patient’s body. Women also have to choose whether they want immediate or delayed reconstruction.

A team approach is especially necessary when a woman opts for an immediate reconstruction, as Jody Withers did. As opposed to a delayed reconstruction, where women have reconstructive surgery months after their mastectomy, an immediate reconstruction is performed at the same time as the mastectomy. Once a general surgeon removes the breast or lump, the plastic surgeon immediately starts to rebuild the breast.

This means that surgeons have to coordinate their schedules, which Gartside says isn’t always an easy task.

“I hear issues of plastic surgeons being called on a Tuesday morning and being asked to come in for a surgery that afternoon,” Gartside says. “And when a plastic surgeon has to decline, they may get a rep-

utation of not being available. We need to all work together so surgeries aren’t just last minute.”

Hernan I. Vargas, M.D., F.A.C.S., agrees that breast reconstruction calls for a full team approach, but says the level of communication between a general and plastic surgeon varies greatly.

“If a patient goes to a general surgeon who has experience and interest in breast cancer care, there’s a strong likelihood that a working relationship with a plastic surgeon will be there,” Vargas, a general surgeon with Virginia Surgery Associates, says. “It’s the nature of the business. If you go to a general surgeon who takes care of two breast cancer patients a year, it’s just less likely they’ll have that relationship with a plastic surgeon.”

Vargas, who does about 150 breast cancer surgical procedures a

year, is shocked at the number of women who immediately decide to remove the whole breast or even both breasts when they are told they have breast cancer.

“Patients are so scared when they’re first told they have cancer,” Vargas says. “They can’t see further than what’s coming at them quickly, and that’s understandable.”

But for Vargas, whose motto is “we’re not just taking care of cancer, we’re taking care of the whole person,” it’s vital to show patients that surgeons can’t only save their lives by getting rid of cancer, but can also restore them to a “natural life” through reconstruction.

In working with breast cancer patients, Vargas’ main goal is to dissect his patients’ fears and educate them on their options—whether they want plastic surgery or not.

“There are a lot of psychological benefits with reconstruction, but we don’t push reconstruction on anyone,” Vargas says. “We know

2010 Top Plastic Surgeons

How they made it to the list:

Choosing the tops in any medical category is no easy task, so we took the challenge to those who know the field best, Northern Virginia plastic surgeons. We surveyed over 150 surgeons, and asked them: “Aside from yourself, who are the two board certified plastic surgeons you would recommend most highly to a friend or family member who wishes to undergo plastic surgery?” Surgeons were able to nominate peers in the following categories: breast augmentation, liposuction, rhinoplasty (nose reshaping), blepharoplasty (eyelid surgery), abdominoplasty (tummy tuck), hair transplantation, breast reduction, rhytidectomy (facelift), Botox and soft tissue fillers, and chemical peels.

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Different types of Breast Reconstruction

Implant procedures: Saline- or silicone gel-filled implants are used to reshape the breast. If the skin and chest walls are tight and flat, an expander is used, which requires a second surgery. In addition, the implants may have to be replaced later on in life.

Tissue Flap Procedures: The breast is rebuilt using tissue from the abdomen, back, thighs or buttocks, so these procedures require two surgical sites. There are numerous types of tissue flap procedures:

» **TRAM (transverse rectus abdominis muscle) flap:** Tissue and muscle are taken from the abdomen.

» **Latissimus dorsi flap:** Muscle and skin are taken from the upper back.

» **DIEP (deep inferior epigastric artery perforator) flap:** This is similar to the TRAM flap, but doesn't use any muscle.

» **Gluteal free flap:** This is a newer form of surgery that uses tissue from the buttocks.

source: cancer.org

plastic surgery isn't for everyone, depending on patients' values or how their bodies are built."

Even if his patients aren't interested in plastic surgery, Vargas advises them to at least speak to a plastic surgeon to get all the right information. Education, he says, is the best weapon a breast cancer patient can have, since that is the only way that patients can arrive at the best option for them.

Fairfax plastic surgeon Christopher Hess, M.D., F.A.C.S., thinks Alderman's study has limitations when applied to invasive breast cancer; reconstructive options aren't always applicable to early cancer patients needing a lumpectomy.

"With that said, I do believe that conversations about breast reconstruction between patients and their general surgeon are still greatly lacking," Hess says.

While Hess agrees a team approach is necessary, he doesn't think general surgeons should be discussing reconstruction surgery beyond informing the patient that it is an option. According to Hess, once the general surgeon explains reconstruction surgery as a possible choice, the patient should be referred to a plastic surgeon "for an in-depth discussion."

Fellow plastic surgeon, George Bitar of the Bitar Cosmetic Surgery Institute, agrees with Hess, believing these involved conversations about reconstructive options should be left up to the plastic surgeon.

"The details of which [surgery] to select should be the job of the plastic surgeon who will be performing the surgery, since ultimately, they will be responsible for the patient's surgical outcome," Bitar explains.

Bitar and Hess also emphasize the importance of monthly self breast exams in the fight against breast cancer. Since women are more familiar with their bodies than any doctor, women are their own first line of defense.

And while speaking to numerous doctors and surgeons is an obvious first step, breast cancer survivor Wendy Goldfein says her biggest educator during her diagnosis was a book. "Dr. Susan Love's Breast Book," a comprehensive and candid book written by a breast specialist, was a lot easier for Goldfein to understand than her doctors were.

"I would go talk to my doctors and sometimes feel like I was in a "Peanuts" cartoon where all they were saying was 'Womp, womp, womp,'" Goldfein says. "I'd walk out thinking, well, I have no idea what that meant."

So Goldfein used Love's book, commonly referred to as the bible of breast cancer, as a textbook and looked up terminology and procedures whenever needed.

And to make sure she got the most out of her doctor appointments, Goldfein always brought her husband or a close friend along to take notes.

"It's so hard to process all the information the doctors throw at you, and sometimes your brain freezes," Goldfein explains. "If you bring along someone else, and tell them the questions you want to ask before, they can ask them if you go into la-la land."

With the help of family, friends and the book, Goldfein was able to make the decision that was best for her: to have a reconstruction. For an elementary school teacher with fall around the corner, Goldfein's main goal was to get the procedure done and move on with her life, and an immediate reconstruction provided her with that.

"When you hear you have breast cancer, you go through shock, anger and denial," Goldfein says. "What's most positive about a reconstruction is that you can look at yourself in the mirror and look normal, instead of looking like a cancer patient. It allows you to close that chapter in your life and get on with the rest of your life." 🐾