



Desire to Inspire: My Breast Reconstruction Patients

I was asked to contribute an article to the candidate corner for *ASN* wherein I describe my most inspirational patient. As not one individual patient stood out as being more inspirational than another, I of course Googled “inspiration” which has many meanings: “to heighten, to prompt, to revolutionize, and to breathe.” I was then able to reflect on my diverse practice and identify a patient, however, with much thought; I deemed it more meaningful to present my most inspirational patient group instead: my breast reconstruction patients.

Breast cancer treatment has been a large part of both my general surgery and plastic surgery training. It is a unique and diverse patient population, which in general are young, healthy, well-informed and stoic women. I feel fortunate to have experience from both the oncologic and reconstructive aspects of the treatment, and have incorporated a significant amount of my formal aesthetic training into their management. This aesthetic application has pushed my reconstructive end-points and inspired me to think outside the box in the process.

My reconstructive patients do not want just a breast mound; they want a natural appearing and feeling breast. They do not want one reconstructive option, they want five. They do not want me to harvest their rectus muscle, they want DIEPs. They don't want a silicone gel implant, they want a cohesive gel implant. They don't want an insensate flap, they want it neurotized. They do not want a small, flaccid nipple, they want one with projection. These requests have inspired me to expand my reconstruction armamentarium and elevate the bar for reconstructive results.

The immediate breast reconstruction patient on the first consultation presents with the impossible task of deciding on a reconstructive modality while still dealing

with the thought of an active oncologic process and the time crunch of making decisions in a very stressful time. I am constantly challenged in the communication of the reconstructive goals and walking the patient through their individual options. The majority are more demanding than my aesthetic consultations with multiple questions gathered through extensive Internet searches and the desire to see multiple photographic reconstructive examples. The delayed reconstructive patient presents already battle weary and scarred from their treatment and presents an even more difficult reconstructive/aesthetic challenge with the effects of previous surgery and radiation. All of these patients have heightened my response to individualize their treatment and offer the best reconstructive modality for their breast defects.

One subset of patients that have been extraordinarily challenging and inspirational is the post-bariatric patient with breast cancer. These patients have significant amount of excess skin which can be utilized for autologous reconstruction. The experience of body contouring after massive weight loss combined with our ever expanding knowledge of perforator blood supply to these excisional areas has enabled us to individualize each patient's autologous options based on their body habitus and utilize the tissue best served for breast reconstruction: abdomen, inner or outer thigh, and buttock.

This has been the most interesting process in applying the advanced aesthetic techniques from our excisional experience and combining it with the formal anatomic mapping of arterial perfusion studies to help optimize flap design and pedicle dissection. This process combined with a close attention to the inseting and molding of the flap, as well as the aesthetic based donor

site closure has led to the delivery of a nearly one stage reconstruction.

At this point the bravery of these patients is truly amazing as you get them through any adjunctive treatments they may need. During the time after their first stage, their main concern is the timing of their implant exchange or flap revision, and not the ill-effects of chemotherapy or radiation. I have found that these patients do well with skin care and massage therapy during the adjunctive treatment phase, as well as Latisse™ for eyelash growth and Botox™ injections. Having these available improves the patient's self esteem and your relationship with your patient.

Once through with their adjunctive treatments, the safe delivery of reconstructive procedures is important, including addressing hormone therapy and cardiotoxic chemotherapy. My patients push me for excellence in their reconstructive process; I have applied adjunctive modalities such as fat grafting, dermal fat grafts and laser therapy.

Through this long journey I feel that these patients are transformed and often more friends than patients. Post-surgical follow-ups are more for catching up on our families rather than discussing scar care. My breast reconstruction patients are my patients for life, and their family members are now my patients. I would say that these patients have inspired me to not only be a better surgeon, but a better physician. I hope I have given my breast reconstruction patients a chance to breathe new life after their journey through their treatment of breast cancer; I know that they have given me the gift of inspiration.

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