Surgeon talks of advances in breast reconstruction

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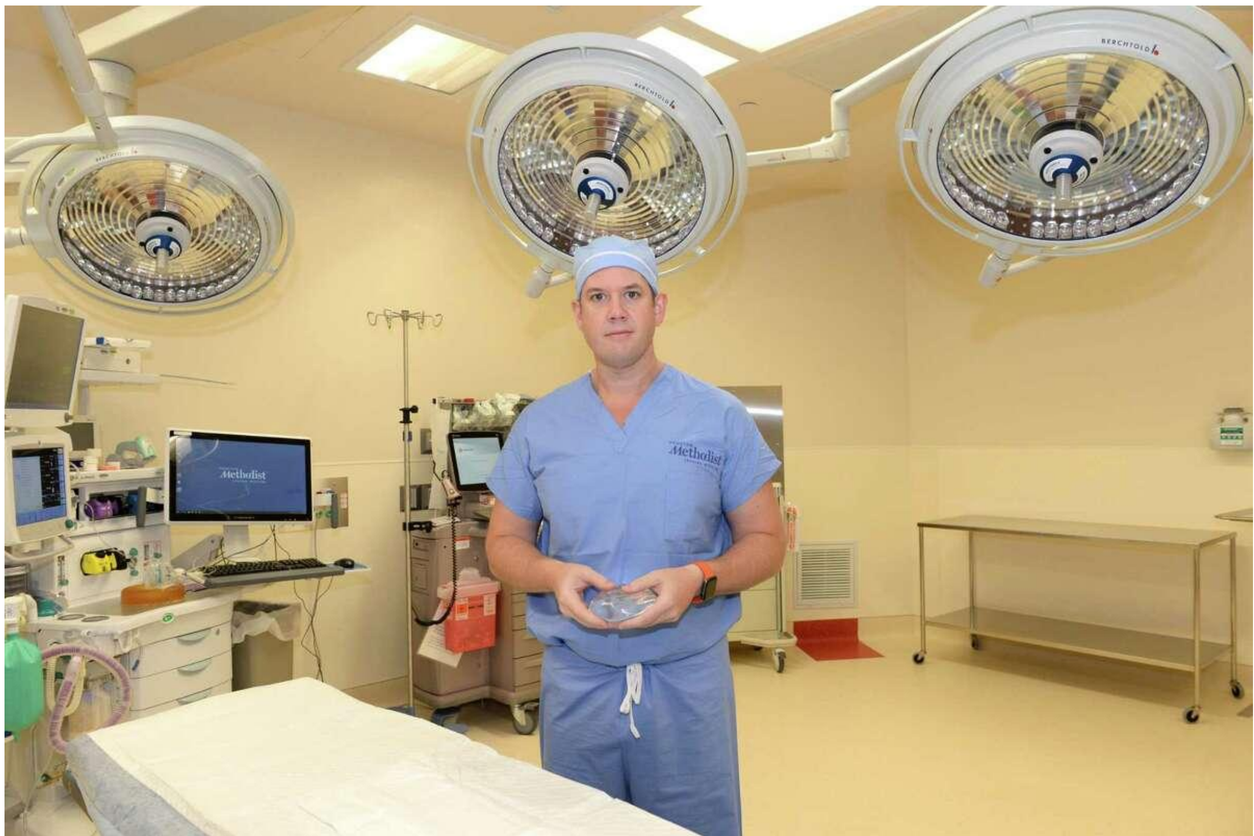

Dr. Warren Ellsworth holds a breast implant in an operating room at Houston Methodist West Hospital in Katy on Friday, Sept. 13.

Craig Moseley, Houston Chronicle / Staff photographer

The majority of women who have breast cancer are candidates for some type of reconstruction, said Dr. Warren Ellsworth, a plastic surgeon, who practices at Houston Methodist West Hospital.

“Some women with advanced cancer or many medical problems do better when they have reconstruction at a later date after their cancer surgery,” he said. “That being said, over the last 30 years, doctors have been able to incorporate breast reconstruction at the same time as the cancer surgery.” He talks of a better cosmetic outcome when the surgeries are done at the same time, but added that not everyone is a candidate for that.

Ellsworth said much has changed in the field of reconstruction since he graduated from Baylor College of Medicine in 2004. He talks of a revolution, in part, because of changes in microvascular reconstruction surgery, which transfers body tissue from one part of the body to another. “It’s more efficient and faster,” he said. “Practices only offered in major medical centers now are down the street from a patient’s home in a community,” he added.

Oncoplastic reconstruction is performed on patients who have had a lumpectomy which allows for reducing or enlarging the breast size as well as reshaping the breast. Commonly, it doesn’t need follow-up surgery which is attractive to some women. The down side is that most women who have a lumpectomy need radiation, he said. In general, radiation after a lumpectomy shrinks the remaining breast tissue, he explained.

“If patients come to me and we know they need a mastectomy because of cancer status and lymph nodes need radiation after a mastectomy, we can make a different surgical plan. We can do a DIEP (deep inferior epigastric perforator) flap after radiation is completed.”

Considered one of the newest advancements in free flap breast reconstruction, DIEP flap surgery involves making an incision along the bikini line, removing a portion of skin, fat and blood vessels from the lower half of the belly and moving them up to the chest where they’re formed into a breast shape. No removal of muscle is involved.

DIEP flap is a longer surgery that requires more recovery time, he said. “However, once it works, it works for the patient’s entire life. That’s an attractive option for many women. In addition, an important difference is using a woman’s own tissue offers the most natural and appealing reconstruction we can do.”

He prefers DIEP flap to a TRAM (transverse rectus abdominis, a muscle) flap. During TRAM flap surgery, an incision also is made along the bikini line that takes the same tissue as well as rectus muscle from the lower half of the belly and moves it to the chest. “That flap with muscle can lead to bulges in the belly because it weakens the abdominal wall,” explained Ellsworth.

Breasts can also be reconstructed using tissue from the buttocks and thighs but Ellsworth prefers the lower abdominal tissue because the scar can be well hidden and it offers the potential cosmetic benefit of flattening the abdomen as well which pleases many women.

According to Ellsworth, most implants and radiation don’t mix well long term. There’s a 50 percent to 70 percent complication rate long term when radiation is used with implants, he said.

“Some women have had radiated implants that do OK,” Ellsworth said. “The majority of women have problems in the form of hardening of the breast, asymmetry or pain.

“I like to tell patients the implant option is attractive because it’s a quicker recovery,” explained Ellsworth. “The down side is they don’t last forever. They’re man-made,” he added comparing them as similar to what’s used in knee surgery.

“A 35-year-old woman chooses implants knowing some time in the future she’ll need more surgery to upkeep those implants,” he added.

Microvascular reconstruction surgery also is entering a newer field — breast resensitization techniques after a mastectomy.

During a mastectomy, all nerves to breast skin are removed, explained Ellsworth. “The patient is left with numb breast skin.”

Ellsworth is part of a trial study in which removal of abdominal tissue includes dissecting nerves and creating a nerve graft to connect them to nerves in the chest. That opens the possibility of nerve growth from the chest to the flap and restoring sensation to the patient. He cautioned that this is a trial.

“My partners and I offer this technique to patients who choose the DIEP flap,” he said, and the procedure has been done about a year. The study requires evaluation over a two-year period, he said.

“Nerves grow very slowly,” said Ellsworth. “They’re the slowest body part to regrow. We’re very encouraged by the data that we’ve seen so far.”

Patients usually are referred by a breast surgeon or by word of mouth. He emphasizes that he’s part of a team of doctors who work with a patient.

“As your readers consider their options, they need to make sure they have the right team, including a board-certified plastic surgeon. It took years of training to offer all these options and I think every woman deserves that,” he said.

What follows a patient referral is research and study. Ellsworth said he collects the background documents about the tumor size, tests done and biopsy

results so that “I have a thoughtful picture of their cancer history when they arrive.”

The initial consultation is lengthy because Ellsworth said there’s a lot to talk about: medical history/health issues, home life/children and work. They talk about options, which includes before and after photos of his breast cancer patients who have agreed to share them with newly diagnosed patients and families. Unlike most cancer patients, breast cancer patients have options, he added.

“Some patients come diagnosed with lymphedema (swelling) or the higher risk of lymphedema,” he said. “We can do procedures and incorporate unique procedures that treat that or help prevent that. Each patient is her own story because there are so many unique differences.”

Ellsworth encourages patients to bring family and significant others with them to the consultations. “It’s important to have a support network. If they bring a loved one, partner or spouse, it’s another set of ears,” he said, especially considering that the newly diagnosed patient is receiving a lot of information.

Reconstruction doesn’t present an obstacle for a patient as she has follow-up visits to check to make sure her cancer hasn’t returned. “We’ve done a lot of studies over many, many years,” said Ellsworth. “Reconstruction does not

increase the chance of a patient’s cancer returning nor does it make it harder to diagnose a cancer that did come back.”

Ellsworth said that he hopes reconstruction not only positively impacts the patient’s psychological health but also their physical health.

“Reconstruction has a significant impact on the daily life of women — not only the psychological benefits of making a patient whole again — but it gives them a confidence these women deserve as they return to the work place, home to a partner and spouse so that they do not have a constant reminder of the battle they survived.”

His mother is an example. She had breast cancer but did not have reconstruction right away. “Seeing her change with her reconstruction and realizing the impact it had on her and our family was a big motivator,” said Ellsworth in talking about his career choice.

“I don’t cure cancer,” said Ellsworth. “I do believe reconstruction has a critical and important impact on a survivor’s life as well as the well-being of her family.”