Letter to the Editor

Reduction Mammaplasty and Mastopexy in Previously Irradiated Breasts: Notes on Safety and Pitfalls

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We read with great interest the article from Spear et al1; we commend the authors for their engaging and challenging study, which makes a breakthrough on such a relevant topic as reconstructive procedures after breast conservation therapy (BCT).

Advances in breast cancer treatment have made BCT an effective and widely adopted surgical strategy. However, morphological and aesthetic outcomes are often not optimal and require secondary breast remodeling that may be confounded by previous radiation therapy. Although based on a small patient cohort, given the paucity of literature on this topic, the study by Spear et al2 provided informative data that will support surgeons in adopting a safe, therapeutic algorithm for patient care. It is important to note that complication rates (28%) could be reduced—even 2 years or more after radiation therapy—by means of a careful patient selection and intuitive technical processes during surgery, all despite the presence of additional risk factors (eg, overweight to mild obesity, smoking habit, age).1 Even if we agree with the authors that “reduction mammaplasty and mastopexy should be approached with extra caution, but the surgeries may still be safely and successfully performed,”1 we believe that prudence should be more significantly emphasized for 2 main reasons.

First, this and previous case series collectively still report a conspicuous complication rate ranging from 28% to 60%; the most alarming cases include severe complications, such as partial or complete parenchyma necrosis, since most of the time resolving these issues requires major reconstructive procedures like placing microsurgical flaps.2 Given the increase in BCT, such reconstructive surgeries are not uncommon. For example, 1 of our patients (Figure 1), a 54-year-old woman with a body mass index of 32 and no other risk factors, underwent primary breast reconstruction via a bilateral reduction mammaplasty 6 years after a right inferior internal quadrantectomy combined with axillary node dissection and radiation therapy; this resulted in complete loss of the right inferior internal quadrant due to liponecrosis, distortion of the nipple-areola complex (NAC), and scar retraction. The only option for correcting such severe deformity was secondary reconstruction with a right deep inferior epigastric artery perforator (DIEP) microsurgical flap and a left secondary mastopexy. The secondary procedures ultimately yielded an excellent morphological and aesthetic outcome with no further complications at a 1-year follow-up.

Second, clinicians should encourage further discussion concerning whether, for selected post-BCT patients, a risky secondary remodeling would be more advisable instead of—as recently highlighted in the literature3,4—a primary reconstruction with a microsurgical flap following a skin-sparing/nipple-sparing mastectomy. For select postmastectomy patients, microsurgical flaps already represent the standard of care for irradiated breasts: despite being a more invasive procedure with donor site morbidity, these flaps are advantageous in that the patient undergoes immediate reconstruction with a safe, effective single-stage surgery. Elective microsurgical flaps in irradiated breasts show both a minimal complication rate and a minimal need for prolonged postoperative care, as well as optimal morphological and aesthetic outcomes from which most patients would benefit.5

We once again congratulate the authors for their interesting study, and we trust that their future work will...
contribute to further clarifying the optimal surgical management of this patient group.

Disclosures
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REFERENCES