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breast. However I feel lipofilling is very useful for small secondary adjustments to improve fullness of upper pole or to give a bit more volume to reconstructed breast after reconstruction with DIEP or TUG flaps.

Using fat grafting to resurface defects after wide local excision is not something that makes me feel at ease. There is ongoing broad research regarding safety of fat grafting. No strong evidence was provided against fat transfer to breast tissue with previous history of breast cancer, neither there is enough evidence to prove the contrary. Injecting stem cells to the irradiated breast tissue after wide local excision knowing that there is always risk of recurrence is very different from injecting it to the area of complete mastectomy where no breast tissue was left.

Issue 5. New Exciting Horizons - Joined Breast Reconstruction and Lymphoedema Treatment.

Following mastectomy and axillary lymph node clearance for breast cancer it is not uncommon for the woman to develop lymphoedema of her arm on the side of the cancer. The exciting news is that now it is possible to perform an operation combining the breast reconstruction using tissue taken from abdomen (DIEP flap) with the restoration of removed axillary lymph nodes using vascularized lymph node transfer (LNT) from the groin in order to simultaneously rebuild the breast and treat the lymphoedema. The lymph nodes are transferred to the area affected by lymphoedema to restore lymphatic outflow. The blood vessels of the lymph nodes are joined under the microscope to recipient vessels. This allows the preservation of blood flow to the lymph nodes ensuring their survival in the new location. The newly transferred lymph nodes stimulate growth of new lymphatic vessels thereby improving the lymphatic outflow circulation. If LNT is not enough additional lymphatico-

venular anastomosis (LVA) is performed small through 2-3 cm incisions, which are made on the skin of the patient's extremity. The surgeon then looks for viable lymphatic vessels, which are generally less than 1 mm in diameter. These tiny channels are then connected under a high magnification microscope to very small veins using sutures, which are smaller than the human hair. This procedure creates new pathways, which then allow lymphatic fluid that has accumulated in the obstructed lymphatic system to divert into the venous system bypassing the obstruction.



Fig 1.

Patient 1.

Patient had mastectomy and later on her breast was rebuilt with tissue from her abdomen (DIEP flap). No expander was inserted and the whole breast was reconstructed as a single unit using abdominal tissue with very satisfactory cosmetic outcome.

Patient 2.

Patient had an expander inserted after mastectomy, which became painful, displaced and encapsulated, causing distress and discomfort to the patient for a long time. As a consequence of insufficient expansion there was no possibility to expand the skin enough. Final result after reconstruction with DIEP flap is good, but the flap skin is inserted in the middle of the breast as opposed to the case 1.