

Guideline for the Management of Patients Suitable for Immediate Breast Reconstruction

Version History

Version	Summary of change	Date Issued
2.0	Endorsed by the Governance Committee	20.02.08
2.1	Circulated at Network Site Specific Group (NSSG)	21.09.10
2.2	Reviewed and updated by Hamish Brown Circulated to the Breast NSSG	23.06.11
2.3	With comments from consultation	08.07.11
2.4	Final approval by Hamish Brown	18.07.11
3.0	Reviewed and Endorsed by Guidelines Sub Group	03.08.11

Date Approved by Network Governance	August 2011
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Date for Review	August 2014
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Changes made during review in 2011

- Clearer definitions as to the involvement of non-surgical oncologists.
- The role of chemotherapy prior to surgery.
- The referring team should ensure all relevant diagnostic information is sent with the referral.
- The role and timing of sentinel node biopsy.

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1. Scope

This guidance has been produced to support the management of patients requiring mastectomy who may be suitable for, or who request, immediate breast reconstruction.

2. Guideline Background

- 2.1 Mastectomy with immediate breast reconstruction has been shown to be an oncologically safe procedure. The most satisfactory cosmetic results of breast reconstruction are seen where autologous tissue reconstruction is performed at the same time as the mastectomy.

Guideline Statements

3 Diagnosis, patient selection and referral

- 3.1 In all patients where the optimum surgical treatment of breast cancer is mastectomy, consideration should be given to the possibility of combining this surgery with an immediate breast reconstruction. Such cases would include tumours where conservative surgery would lead to unacceptable cosmetic deformity, multi-focal breast cancer, and widespread DCIS. This information may only become available after initial attempts at conservative surgery.
- 3.2 The decision to offer mastectomy with immediate breast reconstruction should be reached after multidisciplinary team discussion. This should include non-surgical oncologists where the patient has invasive disease and there is a possibility of adjuvant or neoadjuvant treatments. It should be recorded in the multi disciplinary team minutes if there is dissent. Plastic surgeons undertaking reconstruction should be members of the local breast multidisciplinary team (MDT).
- 3.3 Where initial pathology gives a clear indication that the patient will benefit from adjuvant chemotherapy without radiotherapy, due consideration should be given to potential adverse effects of delaying chemotherapy by performing surgery first. The MDT meeting should consider chemotherapy before reconstructive surgery in these cases.
- 3.4 Where mastectomy with immediate reconstruction is not performed locally, or is unavailable, patients should be referred to the multi-disciplinary team in a centre carrying out this procedure. Referral should be to the breast surgeons rather than the plastic surgeon and should be made urgently by fax, to allow early attention and adherence to waiting time targets. Local measures should be instituted to allow quick and easy access to reconstructive plastic surgeons, ideally in a joint clinic.

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- 3.5 Where tertiary referrals for immediate breast reconstruction are received, the individual referral must first be discussed by the reconstructing multi-disciplinary team, with full reference to, and review of, the patient's imaging and pathology, before any discussion of reconstruction with the patient. The referring team should ensure all relevant diagnostic information is sent with the referral.
- 3.6 In all cases, where mastectomy and immediate breast reconstruction is carried out, the aim should be to deliver treatment within the national waiting time targets. If mastectomy and immediate reconstruction cannot be offered within the target waiting time and a patient rejects an offer of surgery without reconstruction (that can be given within the target waiting time) in favour of mastectomy and immediate reconstruction outside the target waiting time, this will still classify as a breach.

4. Surgery

- 4.1 The primary objective of treatment is the timely and appropriate treatment of the patient's breast cancer. During the decision making process, and in discussion with the patient, due consideration should be given to the likelihood of other adjuvant treatments and their likely importance in the treatment of that patient's cancer. Adverse effects from potential delays in treatment and potential longer term effects of adjuvant treatment on the reconstruction should be clearly explained to the patient. Where there is sufficient pathological evidence available for the MDT to decide that the patient's adjuvant treatment should include chemotherapy, it is appropriate to plan mastectomy and immediate reconstruction after neoadjuvant chemotherapy in the majority of cases. This will avoid delays in instituting systemic cytotoxic treatment and the consequent negative impact on overall survival.
- 4.2 For all patients considered suitable for mastectomy with immediate reconstruction, including those with apparent DCIS only, and who have not yet undergone axillary lymph node biopsy, it is recommended that the nodal status is determined prior to the definitive operation, by sentinel lymph node biopsy carried out as a separate procedure. The result of the sentinel node biopsy should be discussed at the MDT prior to carrying out the mastectomy and reconstruction and if appropriate, the treatment plan altered. The patient should be informed of the possibility that the treatment plan may be altered as a consequence of the result of sentinel node biopsy prior to the definitive operation.
- 4.3 Sentinel node biopsy should not be carried out simultaneously with mastectomy and reconstruction if it is felt that radiotherapy might compromise the cosmetic outcome.
- 4.4 Where invasive cancer is found in a patient previously thought to have in-situ disease only, who has not had a preceding sentinel node biopsy, the usual lymph node surgery should be performed as a second operation, although the timing of this may depend on other adjuvant treatment. It should be recognised that the accuracy of sentinel node biopsy after mastectomy and reconstruction is unknown, and more invasive surgery might be unavoidable to stage the axilla in these cases.

- 4.5 Due consideration of the patient's general health and psychological status should be taken when discussing reconstructive surgery, with particular reference to diabetes, obesity and smoking history.
- 4.6 The surgery for breast cancer should be carried out by a surgeon with appropriate training in surgery for breast cancer.
- 4.7 The reconstructive surgery should be carried out by a surgeon with appropriate training and experience in plastic and breast reconstructive surgery. Team working between plastic surgeons and breast surgeons is the norm for the Network.

5 MDT discussion and adjuvant therapies

- 5.1 The mastectomy specimen should be examined by a pathologist who is a member of the local breast multi-disciplinary team. The specimen should be reported according to national guidelines, with particular record of the anterior margin of excision, especially in cases of skin sparing mastectomy.
- 5.2 The pathology of the specimen should be discussed by the multi-disciplinary team and appropriate adjuvant treatment offered.
- 5.3 The breast surgeon, rather than the plastic surgeon, will usually discuss the pathology report with the patient after MDT discussion.
- 5.4 Where the MDT decides that the patient operated on as a tertiary referral should be offered adjuvant chemotherapy, the patient should have the option of returning to the referring breast team for treatment. It is the responsibility of the breast surgeon to make the referral back in a timely manner, to allow further discussion at the referring hospital's MDT if appropriate.
- 5.5 Where complications of reconstructive surgery lead to delays in adjuvant treatment, it is the responsibility of the plastic surgeon to keep the MDT informed of the patient's progress, to allow other adjuvant therapies to be instituted at the earliest safe opportunity.

6. Patient information and counselling

- 6.1 All patients, and with their consent, their partners will be given access to appropriate written information during their investigation and treatment, and on diagnosis will be given the opportunity to discuss their management with a clinical nurse specialist who is a member of the relevant MDT. The patient should have a method of access to the breast team at all times.

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6.2 Access to psychological support will be available if required. All patients should undergo an holistic needs assessment and onward referral as required.

7. Follow up

7.1 Follow up of the breast cancer patient should be according to Network guidelines (<http://www.birminghamcancer.nhs.uk/staff/clinical-guidelines/breast-cancer>).

7.2 If a patient reports symptoms or signs which may indicate local or regional recurrence at plastic surgery follow up, urgent referral should be made to the breast team.

8. Clinical trials

8.1 Wherever possible, patients who are eligible should be offered the opportunity to participate in National Institute for Health Research portfolio clinical trials and other well designed studies.

8.2 Where a study is only open at one Trust in the Network, patients should be referred for trial entry. A list of studies available at each Trust is available from Pan Birmingham Cancer Research Network.
Email: PBCRN@westmidlands.nhs.uk.

8.3 Patients who have been recruited into a clinical trial will be followed up as defined in the protocol.

Monitoring of the Guideline

Implementation of the guidance will be considered as a topic for audit by the NSSG in 2013.

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