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- **Breast reconstruction: Implant reconstruction.**

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Breast reconstruction: Implant reconstruction

As discussed in the previous newsletter, breast reconstruction can be divided into either Implant reconstruction or autologous reconstruction (DIEP/TRAM flaps). Worldwide, implant reconstruction makes up 70% of reconstructions undertaken. It is a very successful form of reconstruction providing patients with pleasing results, especially in ladies with smaller breasts or requiring bilateral reconstruction.

Reconstruction with implants is usually performed with an anatomical implant placed under the pectoralis major muscle to decrease complication rates. In order to be able to perform an implant reconstruction, there needs to be an adequate breast skin envelope for the implant. Hence, if the patient is considering reconstruction it is important that a tissue expander is inserted at the time of mastectomy.

As with autologous reconstruction, immediate implant reconstruction at the time of mastectomy can only be performed in the setting of benign disease or prophylactic mastectomy (i.e. BRACA patients). In breast cancer, a tissue expander is inserted and once the patient's oncological management is complete, the expander is changed for an implant. This two-stage reconstruction in cancer patients is required due to radiotherapy causing a very high rate of implant complications.

If part of the patient's oncological management requires radiotherapy, the use of implants for reconstruction becomes complicated. They will need a latissimus dorsi flap in addition to the Implant for reconstruction. In these cases, an autologous reconstruction if possible is often preferred.

The advantages of implant reconstruction are a shorter surgical time, quicker recovery and the lack of surgical scar elsewhere on the body. Disadvantage include, implant complication such as capsular contracture, probable need to replace implant in the future and the fact the implant never feels like breast tissue.

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Duypetren's disease: are the non- surgical treatments effective and safe?

Duypetren's disease is a disorder of the palmar fascia causing nodules, thickening and flexion contracture of the fingers. Estimates of prevalence in the community are between 1 to 7%. Often the disease is mild, however, at it's worst it can cause significant functional disability.

Surgery has been the mainstay of treatment, providing a reliable safe method for managing duypetrens disease. However, the recovery can often take weeks, hence the search for non-surgical options. Percutaneous fasciotomy has been a treatment performed with varying levels of success. This involves using a hypodermic needle and percutaneous dividing the disease. The finger is then serially splint to straighten. This can be effective when there is an isolated single band or in elderly wishing to avoid surgery. The downside is the fact there is a high recurrence rate and 4% chance of digital nerve injury. Hence, I have very limited indication for this technique.

A new therapy recently approved by the TGA in Australia is Xiaflex (collagenase). This is injected in the rooms into the band which breaks down the collagen allowing the finger to be straightened often with splinting. This may require up to 3 injections to be successful. It's use is however limited to single digit disease with a single band and minimal or no skin involvement. Reports are promising especially with regards to return to work post procedure.

However, many hand surgeons, including myself do not use Xiaflex at this stage. Reasons for this include:

1. Long term data regarding recurrence rates are not fully established at this stage.
2. Product is not PBS listed and hence cost is up to \$1500 per vial. If 3 treatments are required then cost of treatment adds up significantly
3. Risk of Tendon rupture. Some studies report rupture rates of 4%. A flexor tendon rupture results in very significant morbidity to the patient. This is not a risk associated with surgery
4. Risk of anaphylaxis: cases of anaphylaxis are having been reported and patients require close observation post procedure.

MELANOMA WORKSHOP: Up to date surgical and medical management

Mr Robert Toma, Plastic & Reconstructive Surgeon, together with Dr Oliver Klein, Specialist Oncologist, will present a Melanoma Workshop for their colleagues.

**Monday 8th September, 2014
6.00pm –including 2 course dinner
Deep Blue Hotel and Spa**

**RSVP—Monday 1st September 2014
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