WPRS
Warrnambool Plastic & Reconstructive Surgery

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this issue

Let us answer some questions you may have

- **What are the benefits vs dangers of curetting skin lesions?**
- **What are the benefits of tissue expanders post mastectomy?**

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Tissue expanders post mastectomy: what are the benefits?

Insertion of a tissue expander post mastectomy is now common practice in women considering breast reconstruction. The expander is inserted at the time of a subcutaneous mastectomy and is placed in a sub-pectoral pocket. The expander is then inflated in the rooms via a percutaneous puncture. This process can often take 4 weeks to complete.

The benefit of a tissue expander is that it maintains and expands the breast skin post mastectomy. As a result when it comes to definitive reconstruction the expander can be removed and replaced with a formal implant or DIEP/TRAM flap. This results in a better cosmetic reconstruction.

The reason a formal reconstruction is not undertaken immediately following a subcutaneous mastectomy for breast cancer, is that adjuvant therapy especially radiotherapy will affect the long term cosmetic outcome. However, with an expander the adjuvant therapy can be undertaken with no effect on oncological management and the formal reconstruction undertaken once the patient has recovered from treatment.

Tissue expanders can result in increased rates of infection and seroma. They can often also result in patients staying in hospital for an extra 2-3 days until the drain tubes are removed. However, they have not been shown to delay oncological management.

It is important that women who are considering reconstruction post mastectomy see a plastic surgeon early, so that all their options can be discussed with them.

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Curetting skin lesions: benefits vs. dangers

Curetting of skin lesions has become relatively common practice. The principle behind curetting, is to remove the epidermis and superficial layer of the dermis with the lesion and allow the wound to heal by secondary intention. The perceived benefits are that it heals without scarring; it's quick to perform and does not require removal of sutures.

However, before you take out the curette, here are some of the dangers:

1. Hypopigmentation: if the curette is too deep then the area will heal by scarring rather than regeneration which will lead to an area of hypopigmentation. This is worse than a scar from an excision and more difficult to hide.
2. Increased recurrence of lesion: as some lesions extend into deeper dermal layers e.g. intra-dermal naevus, the rate of recurrence is higher than excision.
3. Poor histology specimen: pathologists dislike curetted specimens. There is often no histological architecture with a curetted specimen, meaning the pathologist often needs to make the diagnosis on the basis of cytology. This can lead to a malignant lesion being labelled benign.
4. No histological clearance margins: means that if the curette specimen is reported as malignant, formal re-excision is required to ensure clear margins.
5. Upgrading of treatment: if a pigmented lesion is curetted and is reported as a melanoma, then definitive treatment is affected. Formal excision margins for melanoma are based on Breslow's depth. As there is no depth able to be measured with a curetted specimen, the melanoma needs to be treated as deep and a 2cm margin excised with sentinel node biopsy performed.

Personally, the only time I use the curette is for removal of seborrhoeic keratosis or for intra-dermal naevus in cosmetically sensitive areas, where excision would lead to a significant deformity. I however, do warn patients of increased recurrence rates.