WPRS
Warrnambool Plastic & Reconstructive Surgery

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this issue

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Breast Reconstruction: Autologous reconstruction

Breast reconstruction using your own tissue is often considered the gold standard in reconstruction. Most commonly used autologous reconstructions are the TRAM or DIEP flap.

TRAM (Transverse Rectus abdominal myocutaneous flap) and DIEP (Deep Inferior Epigastric Perforator flap) flaps both use the lower abdominal tissue to reconstruct a breast. They are disconnected from their blood supply on the abdominal wall and are microvascularly reconnected to vessels on the chest with tissue shaped to match a breast.

TRAM and DIEP flaps are very similar. The only difference being that the DIEP flap spares the rectus abdominus muscle whilst the TRAM takes the muscle. The pros and cons of each of these flaps is debated in plastic surgery, however, in reality there is very little difference between the result for patients. My preference is to perform a DIEP flap unless the vessels are unfavorable in which case I will do a TRAM.

The benefits of autologous breast reconstruction are that it uses the patient's own tissue, the reconstructed breast feels soft and like a breast, and it provide a long lasting result. The downsides are however, it is not available to everyone (need enough tissue to reconstruct a breast), long surgery time, and the 1% risk of microvascular failure meaning patients would lose the reconstruction.

Another form of autologous breast reconstruction is the latissimus dorsi flap. This involves rotating the muscle and skin from the back to reconstruct a breast. This is often combined with an implant to provide enough volume for reconstruction. It is a good option for people who do not have enough abdominal tissue for reconstruction and have had radiotherapy so an implant only reconstruction cannot be considered. Risks of implant reconstructions following radiation is significantly decreased if covered with muscle. The down side of this reconstruction is an unsightly scar and functional loss of latissimius dorsi muscle.

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Rosacea

Treatment for Rosacea consists primarily of oral and topical antibiotics, steroids and retinoid, with a focus on skin eruptions including papules and pustules rather than the lasting vascular and fibrotic sequel. For many patients whose common concerns include facial flushing and redness, symptom relief has been limited to avoidance of associated symptoms (eg hot and cold temperatures, spicy foods and alcohol).

As collagen decreases with age and elastosis worsens due to continuing UV exposure, the supporting structure of cutaneous vessels breaks down, which may support the notion of rosacea showing up in the third decade, continuing to worsen without treatment. Using laser and light based therapies we are able to provide patients with management options for erythema and the vascular component of their condition.

Intense Pulsed light has been shown to aid in the resolution of fine telangiectasia and general erythema. Utilised as a combination approach along with non-ablative 1064Nd: YAG laser, management of vascular symptoms and fibrosis have shown longer lasting results than treatment from oral and topical treatments alone. Our laser treatments are performed without the use of anaesthesia or numbing gels therefore candidates must be able to tolerate some associated discomfort to be appropriate for treatment.

The WPRS laser clinic runs from Tuesday-Friday and patients are welcome to book with or without a referral. Please note there is no Medicare Rebate available for laser treatments at WPRS.

Annual Leave Notification

Please note that Mr Robert Toma will be on Annual Leave from -

Saturday 18th October until Sunday 26th October inclusive.

WPRS will remain open as usual from 8.00am to 5.30pm
with the exception of Public Holidays.