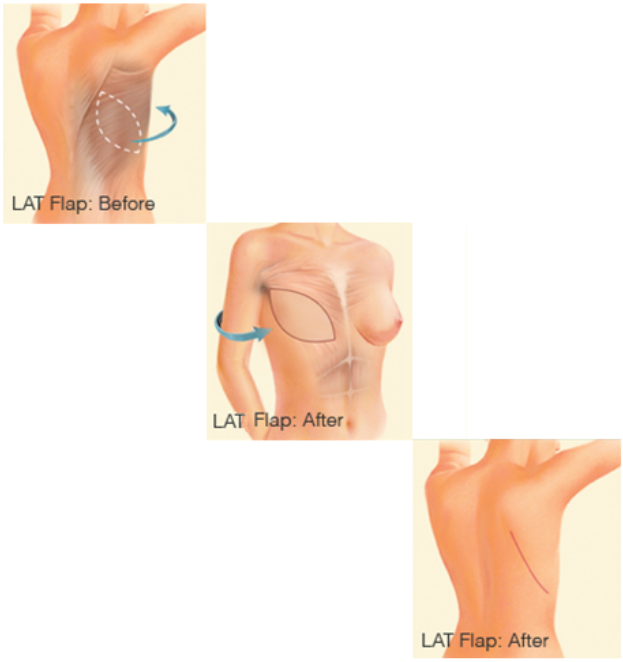
Latissimus Dorsi Flap

Breast reconstruction surgery is carried out to replace breast tissue and restore the shape of the breast that has been removed during a mastectomy.

A Latissimus Dorsi (LD) Flap may be combined with an implant to increase the volume and improve the shape of the breast. LD reconstruction may not be suitable for everyone and is best suited to women who have:

- Small breast volume
- Excess back tissue
- previous radiation and having an implant reconstruction
- are not suitable for a TRAM/DIEP flap
- need to correct a lumpectomy defect
- Desire a more natural appearance then implant alone



What does the operation involve?

The LD flap uses muscle and skin from your upper back to create a new breast mound after a mastectomy.

In this method the muscle remains connected to the original blood supply and an ellipse-shaped area of skin and your LD muscle will be elevated and moved from your upper back to your mastectomy area to create your reconstructed breast. This flap provides a source of soft tissue that can help create a more natural looking breast shape compared to an implant alone.

The LD flap is most commonly combined with an implant to give the surgeon additional options and more control over the aesthetic appearance of the reconstructed breast.

Post-operative Course

After your breast reconstruction surgery you will require a hospital stay of between around 4-7 days.

You may experience some discomfort, which will be controlled with pain relief. You will have a compression dressing over your breasts and back and will be encouraged to perform deep breathing and coughing exercises following your surgery.

Dressings will be in place over your surgery site and these will be managed by the hospital staff as per your surgeon's directions.

After surgery the nursing staff will be closely monitoring both your observations and that of the flap to ensure it has a good blood supply.

You will have two to three drains inserted during the surgery and these will be removed once fluid has adequately stopped draining. Occasionally it may be necessary to leave the drain tubes in place when you have been discharged. If this is the case the nurses at WPRS will follow you up and remove the drains

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Approximately one week following discharge from hospital you will attend WPRS for a wound check and scar management advice will be commenced.

Post surgery you will need to rest for a period of 2 weeks. It maybe up to 4 weeks before you can drive and 6 weeks before heavy lifting and exercise.

There will be some swelling and bruising post-operatively. This will continue to improve over time. It will take many months to achieve your final result.

Potential risks of surgery

Bleeding/haematoma: any bleeding after surgery is usually minor. However, rarely you may bleed enough to require a return to theatre to drain the blood and stop any bleeding.
Infection: uncommon, however if it occurs you may be required to commence antibiotics.
Wound separation/delayed healing: this is uncommon however small areas may break down and require dressing or revision surgery in the future.
Scar widening/hypertrophy: this can occur with any scar. Your wound will be carefully closed, however, some people may develop widened or elevated scars. At WPRS we will monitor closely for this and provide information to avoid this potential complication.
Seroma: is a collection of fluid at the operative site. If drains are removed to early the fluid may collect and need to be drained. This can often be drained in the rooms, however, occasionally requires further surgery.
Asymmetry: It is uncommon for both breasts to be exactly the same size and shape pre-operatively. Every attempt is made to obtain symmetry, however, minor revisions are occasionally required
Loss of the flap: Sometimes blood vessels supplying the flap can kink or get clots, causing bleeding and a loss of circulation. This may cause a partial or complete loss of the flap due to the tissue dying (necrosis).
Fat necrosis: when fat used to make the reconstructed breast does not have an adequate blood supply, fat may die (fat necrosis). These areas in the reconstructed breast can feel firm.. They can be left in place or surgically removed. Rates of fat necrosis are significantly increased in smokers.
Anaesthetic complications: sore throat, nausea/vomiting, other rare complications (i.e. allergic reaction to anaesthetic) can be discussed with your anaesthetist.
Deep venous thrombosis (DVT)/pulmonary embolism (PE): risk of a DVT is 1 in 100. Rarely these can be fatal if they become a PE. Special precautions are taken in hospital to avoid this. These include: calf compression devices, anticoagulant injections and early mobilisation.

We, at WPRS, pride ourselves in providing you with the best possible experience with your surgery. If there are any questions or concerns we encourage that you ring WPRS discuss these either with your Surgeon or the breast reconstruction nurse.

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