

Immediate Breast Reconstruction for All?

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Sir,

The rates of mastectomy and immediate breast reconstruction (IBR) are increasing.¹ Cosmetic outcomes are probably an important factor driving these trends, but the surgical procedure has also become less prone to morbidity with increased experience.² IBR fulfills the patients' desire for a reconstructed breast and the surgeons' wish to perform a successful single-stage procedure.² Nevertheless, these operations should be planned with the patient's cancer diagnosis in mind, and not all patients are suitable for IBR, skin-sparing mastectomy, and/or nipple-sparing mastectomy (NSM). **Figure 1** shows a magnetic resonance image of early postoperative recurrence after implant-based IBR. A 40-year-old patient presented with cT2 multicentric left invasive ductal carcinoma (7 tumor foci, between 7 and 32 mm, per magnetic resonance image), grade 3, triple negative disease, and cN1, including a tumor focus underneath the breast skin, without skin involvement (**Fig. 1A**). She was treated with preoperative chemotherapy, leading to only partial response per imaging. She underwent NSM and axillary dissection and IBR at a different institution. The final pathologic finding was positive for extensive multicentric

disease in the breast, ypT1 (7 foci, largest 10mm) with free margins, lymphovascular invasion, and tumor thrombi around the masses. Axillary residual disease included 2 out of the 8 positive lymph nodes. After surgery, the patient suffered from a wound infection and needed prolonged antibiotic treatment. She subsequently underwent additional surgery due to wound complications. Two months after the surgery, she was referred to our center to continue oncologic treatment, including postmastectomy irradiation. She suffered from painful palpable masses within the reconstructed breast and was referred for a biopsy, which confirmed loco-regional recurrence at multiple sites (**Fig. 1B**).

There are many issues to discuss in this specific case, but we would like to highlight the main concern that led to this letter. This patient had triple-negative disease and responded poorly to a full course of preoperative systemic therapy. Such patients have a higher rate of local recurrence and early systemic failure and tend to recur early within 2 years from primary surgery. Skin-sparing mastectomy and NSM are considered oncologically safe procedures based on retrospective studies, and both procedures tend to leave a larger amount of residual breast tissue (at least 5 mm of

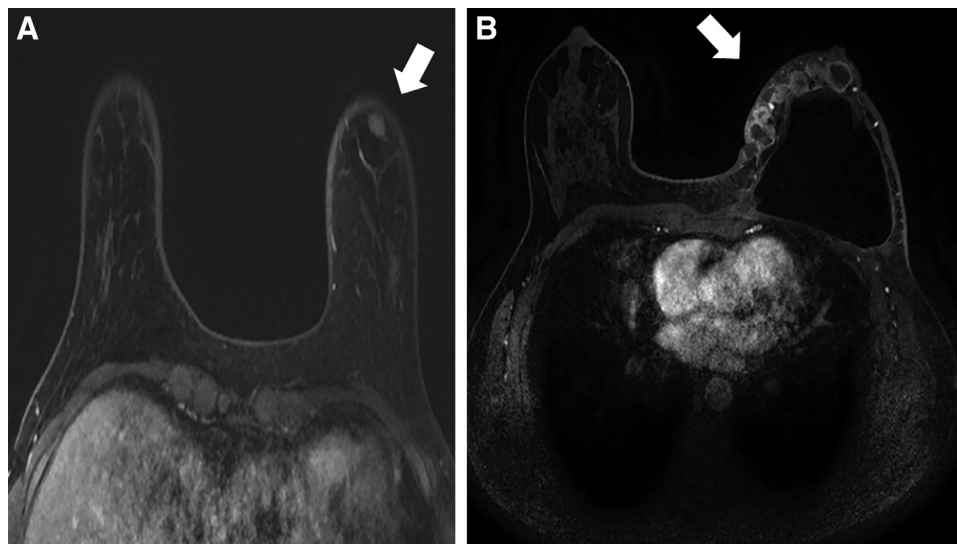


Fig. 1. Breast magnetic resonance image (MRI). A, Preoperative MRI showing a foci adjacent to the skin but not involving it. B, Local subcutaneous early recurrence after an implant-based reconstruction.

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subcutaneous tissue) after mastectomy to allow for IBR,³ and in this specific case, a possible unnoted residual tumor foci.⁴ Importantly, current evidence suggests that these patients may benefit from additional postoperative therapy (postmastectomy irradiation, systemic therapy), and IBR might interfere with postoperative treatment.⁵ Therefore, this patient should have been referred for modified total mastectomy without IBR to allow for complete glandular tissue removal and for immediate postoperative oncologic treatment. More studies are needed to identify the patients who are not suitable for IBR and skin-sparing with or without nipple-sparing procedures. In the meantime, the possibility of residual breast tissue after these procedures should be kept in mind and fully discussed with the patient.

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DISCLOSURE

The authors have no financial interest to declare in relation to the content of this article.

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