Company Registration No. 07999059

TITUS ADAMS

PLASTIC SURGEON

Patient Guide for:

Abdominal–based Breast Reconstruction

(DIEP or msTRAM flap)

Contact information for the breast reconstructive nurses:

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Contents

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Introduction

Abdominal-based breast reconstruction

An abdominal- based breast reconstruction involves an operation to remove the skin and fat of your tummy (abdomen) below the umbilicus (belly button), along with its blood supply from the pelvis. This tissue is then transferred onto your chest to reconstruct your breast. It is transferred along with its blood supply which comes from the pelvis. The blood supply is then reattached to other blood vessels in your armpit or chest. Because the blood vessels are small, the surgeon will use very fine instruments and will be working with the help of a microscope (microsurgery).

You may have this operation at the same time as your mastectomy (immediate reconstruction) or after your mastectomy in a separate operation (delayed reconstruction).

TRAM flap – Transverse Rectus Abdominus Myocutaneous flap.

This refers to an abdominal –based breast reconstruction in which some of the "six pack" muscle is removed along with the skin and fat of the tummy.

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PLASTIC SURGEON

DIEP flap – Deep Inferior Epigastric Perforator flap.

This type of reconstruction does not involve removal of any of the muscle from your abdomen.

It is not possible for your surgeon to guarantee which of these two operations you will have. A scan known as a CT angiogram may be organised for you as an outpatient before your surgery in order to help plan your operation.

What is the Enhanced Recovery Programme?

The Enhanced Recovery Programme is about improving patient outcomes and speeding up a patient's recovery after surgery. It results in benefits to both patients and staff. The programme focuses on making sure that patients play an active part in their own recovery process. It also aims to ensure that patients always receive the correct care at the right time.

This patient guide forms part of the Enhanced Recovery Programme by providing you with essential information so that you can become an active participant in your choices for surgery, anaesthesia and your recovery.

What other information is available?

If you have received this patient guide, you will have had a discussion with your Plastic and Reconstructive Surgeon regarding your choices for breast reconstruction, including the process involved and the benefits and risks of surgery.

Photographs

In the outpatient department we have access to photographs of breast reconstructions which have been performed here and would be happy to talk through suitable examples with you.

Oxford Breast Reconstruction Awareness (BRA) Group

This is nurse-led patient group, which is held 8 times a year. It involves meeting some of the experienced nurses who will talk you through the process of your operation. It is an opportunity to learn more about the process of breast reconstruction. You will be able

TITUS ADAMS
PLASTIC SURGEON

to meet patients who have had their breast reconstruction and see the results of their surgery.

The date and time of the next meeting can be given to you in clinic or through your surgeon's secretary.

Video Diary

A DVD showing one of our patient's journey through their reconstruction is to become available soon.

Websites

A list of useful websites for further information is available at the back of this guide.

Pre-operative assessment

Once you have been given a date for your operation, you will have an appointment at the pre-operative assessment clinic to make sure you are fit for an anaesthetic and surgery. Please bring with you a list of any medications you are using.

You will be asked to complete a health screening questionnaire.

Who will I see at pre-assessment?

The clinics are run by our experienced pre-assessment nurses. They will ask you questions about your medical history, any medical conditions you have, previous operations, medications that you take, allergies and your home circumstances.

Blood tests, a urine sample and other tests e.g. a tracing of the heart (ECG) will need to be done.

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PLASTIC SURGEON

Coming into hospital/preparation for surgery

Pre-operative carbohydrate drinks

You will be provided with two clear, high carbohydrate drinks in the pre-operative assessment clinic. These are fruit flavoured. One should be taken the night before your operation and the second to be finished by 6am on the morning of surgery.

These have been shown to be beneficial when given to patients before a major operation as they provide extra calories needed for the healing process.

Heparin injection

You will also be provided with a single heparin injection to be given at 6pm the day before your operation, this helps to prevent blood clots in your legs and lungs during the operation. You can do this yourself or arrangements can be made for it to be given by your practice nurse.

MRSA

We routinely perform swabs for all patients coming into hospital to see whether they carry methicillin-resistant staphylococcus aureus (MRSA).

We provide an antiseptic cleanser which should be used for a thorough wash (including hair) the night before and the morning of surgery. This will be given to you at pre-assessment. In addition, we may contact you after clinic and ask you to use a nasal cream.

The purpose of this process is to prevent patients being infected by their own MRSA when undergoing surgical treatment and to reduce the risk of spread of MRSA to other vulnerable patients.

On the day of your operation

You will be asked to come into hospital on the morning of your operation. Please follow the instructions on your admissions letter. Usually, you will be asked to attend the Lichfield Day Surgery ward at 7:30 a.m.

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PLASTIC SURGEON

We ask that patients only bring in the minimum of personal belongings as space is limited. Your belongings will be transferred to your allocated ward after your operation.

What to bring with you:

When packing for a stay in hospital we suggest you bring the following:

Medicines

If you are taking any medication, please bring these with you in their original containers if possible. If you use insulin please bring a sufficient supply, as well as your usual Insulin pen / syringes and needles, to last for the duration of your hospital stay.

Clothing

We suggest you bring the following items:

- Nightwear – a front fastening nightie is often found to be the most comfortable
- Dressing gown
- Lightweight loose day clothes (including a cardigan or jumper)
- Underwear
- Suitable footwear (shoes and slippers with backs)

Toiletries

- Toothpaste and toothbrush
- Flannel and soap
- Face wipes
- Hairbrush and / or comb
- Vaseline™ or lipbalm (as your lips may become dry)

Entertainment

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PLASTIC SURGEON

- Consider bringing in something to pass the time e.g. books or a magazine

- Laptops, kindles, ipads etc. may be used in the hospital. There is a television in your room. It is free to listen to the radio but payment is required for tv channels and the telephone service

Money

- Please do not bring large amounts of money or valuable items with you

If you wear glasses and / or have a hearing aid please bring the cases to protect them.

If you have any other specific requirements the nurse in pre-assessment will discuss these with you.

What happens next?

You will be seen by a member of the day surgery nursing staff who will ask you a series of pre-operative questions, check your blood pressure and provide you with a gown and stockings.

Your surgeon will go through the consent form in detail with you if this was not completed at pre-assessment. They will need to examine you and perform various measurements and markings on your chest and abdomen. These are essential for planning your surgery.
You will also be seen by the anaesthetist who will discuss the type of anaesthetic and pain relief you will be having.

You will usually go to the anaesthetic room between 8 and 8:30 a.m.

The Operating Department (Theatres)

The anaesthetic will be given in the anaesthetic room before you go into the operating theatre.

The anaesthetist / nurse will attach machines which measure your heart rate, blood pressure and oxygen levels.

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When the anaesthetic has been given, you will go through to the operating theatre for your operation.

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PLASTIC SURGEON

Immediately after the operation

You will wake up in the recovery room and will be transferred to the Specialist Surgery Inpatients ward (SSIP) when you are stable.

What will I notice when I wake up?

Your position

When you wake up from surgery, your bed will be bent in the middle and you will have several pillows under your knees. This is to reduce the tension in your tummy where the tissue for your reconstruction has been taken. Over the next few days, you will gradually straighten up and stretch your tummy as you begin to get out of bed and walk around.

Warming blanket

You will have a warming blanket covering you for the first 48 hours. It is essential to keep you warm as a drop in your temperature may cause serious problems to the blood supply to your breast reconstruction. Many patients find this level of heat uncomfortable, but it is very important that they are kept on for the initial 48 hours. Please tell the nursing staff if you find the heat uncomfortable. Occasionally it is possible to turn the heat level down but not off.

Drains

You will have several drains. The drains are to remove any blood and fluid collections from the operation sites. The drains are removed when not much has drained in a 24 hour period.

It is possible that one drain will need to stay in after you go home. Detailed instructions will be given to you in order for you to go home with the drain and the nursing staff will teach you to measure how much is coming out of the drain every day. They will provide you with a telephone number to ring every day and report the drain output. Once the output falls below a set amount, the staff will arrange for you to return to the hospital and have the drain removed or for a district nurse to remove the drain for you.

Drips

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PLASTIC SURGEON

At least one drip will be in your arm. This can be used to give you fluid, medications and blood products during and after the operation. The drip is removed once you are eating and drinking adequately and do not require further medications through the drip.

Sometimes, a drip will be inserted into your neck. This is known as a central line. A central line is useful if it challenging for the doctors to put drips in your arms or take blood, e.g after previous chemotherapy. This can be used to give fluid, blood and drugs as well as monitoring your level of hydration and allowing the doctors to take blood samples.

Pain Relief

This can be given in several different ways and your anaesthetist will discuss the options with you before your operation.

TAP Block

This stands for Transversus Abdominis Plane block. It is an injection of local anaesthetic into your tummy muscles to reduce pain during and after surgery. The procedure is usually performed just after you have been put to sleep so you will not be aware of it happening. It is an alternative to an epidural and, as it is a single injection, avoids the need for an extra tube in your back. The TAP block provides pain relief while at the same time allowing you to start to move around at an early stage after the surgery.

Epidural

An epidural is a narrow plastic catheter (small flexible tube) inserted and left in the "epidural space" near to the nerves in your back. This means that the anaesthetist can give repeated doses of local anaesthetics and painkillers without further injections. This will provide pain relief for your tummy. It numbs the area where the flap for the reconstruction has been taken from.

Intrapleural blocks

An intrapleural block is a small plastic tube inserted into the space between the two linings of your lungs (intrapleural space) through which local anaesthetic is given. It numbs the chest area where the reconstruction has been performed.

TITUS ADAMS
PLASTIC SURGEON

Patient controlled analgesia (PCA)

This is where you, the patient, are in control of a set amount of painkilling medicine to help control pain. You will be given a hand-held button which is connected to a computerised pump. The pump has a syringe containing the medicine and this is connected to a vein in your arm. You can press the button when you feel the pain coming on; the pump will then give you a dose of the pain killing medicine.

Pain killer tablets

Once you are eating and drinking, you will be offered regular pain killer tablets by the nursing staff. It is important that both your chest and tummy areas are as pain free as possible. Please ask the nursing staff if your pain is not adequately managed.

Urinary catheter

A urinary catheter will be placed into your bladder just after you have been put to sleep to monitor how much urine you are passing and for your comfort. Once you are able to get to the bathroom by yourself, this will be removed.

Monitoring

Observations including blood pressure, breathing rate, oxygen levels, pulse and temperature will be recorded on a regular basis, every half an hour initially, even through the night. This may disrupt your sleep and can be tiring. However, the frequency of this is essential for the success of your breast reconstruction.

Venous Doppler machine

You may have a machine called a Venous Doppler attached to your breast reconstruction flap with a wire. This enables the nursing staff to listen to the blood flow in your breast reconstruction.

Scars and dressings

The scars on your chest will vary according to the type of reconstruction you have and whether you have had an operation on one or both breasts. Your surgeon will discuss the scars before the surgery and give you the opportunity to see photographs of reconstructions.

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PLASTIC SURGEON

You may have an additional scar in your armpit where the microsurgery has been performed.

You will have a scar running right across your lower abdomen, approximately along the bikini line from one hip to the other. Your umbilicus (belly button) will not be removed but the tissue above it is moved downwards and a new hole created to bring the umbilicus (belly button) through, creating a circular or heart shaped scar.

Your wounds will be covered with flesh coloured tape known as *micropore* which is waterproof. You can wash as normal.

Drains will be secured in place with a white dressing known as *mefix*.

If you have an allergy to any dressings, please let your surgeon know and a patch test can be arranged before your operation.

Your reconstruction is monitored very closely by the staff to ensure that there is no abnormal swelling and that it is the correct colour and temperature.

Blood tests will be taken about 10pm on the night of your operation to check your blood count.

Your recovery

Everyone's recovery will be different and this summary is an example of what to expect. Some patients may reach their goals sooner and some later than others.

How long will I stay in hospital for?

As a rough guide, we expect you to stay in hospital for 7 days. Some patients may reach their discharge goals at day 5 and others need up to 10 days in hospital.

Before you can go home, you will be required to reach the following goals

- Mobilise safely without assistance
- Lie down flat in bed and walk upright
- Wash and dress independently
- Use the toilet safely

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PLASTIC SURGEON

- Your pain should be adequately controlled using tablets
- You must have opened your bowels
- Maximum of one wound drain to be left in
- Wounds should be healing satisfactorily
- Stitches around your umbilicus (belly button) need to be removed
- You need to have adequate support at home

Your discharge plan will be discussed in pre-assessment clinic. Should your circumstances and arrangements change, please speak to the doctors and nurses as soon as possible so that your discharge from hospital is not delayed.

Visitors

Visiting hours on SSIP ward are from 2-8pm

Visiting outside of these hours may be possible on prior arrangement with the nursing staff. It is unlikely that you will be ready for many visitors in the first 48 hours and it would be helpful for a delegated family member or friend to let others know when you are ready for visitors.

What will happen during my week in hospital?

The nurses usually change shifts 3 times in a 24 hour period. Your allocated nurse will introduce themselves at the beginning of each shift. They will perform routine observations, help with your nursing care and distribute any medications you require. They are supported by Health Care Assistants (HCAs)

You will be seen on the ward round each morning by the team involved in looking after you whilst you are in hospital; these include doctors, nurses and physiotherapists.

You will be seen separately by the physiotherapists on day 1 to discuss deep breathing exercises, improving your mobility and arm movement exercises. The nursing staff will contact the physiotherapists again should you require further input from them during your stay.

TITUS ADAMS
PLASTIC SURGEON

The pain team will visit you on the first 2-3 days during your recovery to address any problems you may have with pain or nausea and vomiting

Day 1

You will remain in bed for the majority of the day. The bed will remain bent in the middle and the warming blanket will stay switched on.

It is unlikely that any tubes will be removed in the first 24 hours.

You will be encouraged to

- Eat and drink
- Perform deep breathing exercises
- Report any problems with pain, nausea and vomiting

In the afternoon, the nursing or therapy staff will gently help you to sit on the edge of the bed. We advise you to drink plenty before this is attempted as dizziness is common. It is also important to ensure that your pain is adequately controlled. You may need to press your PCA button before attempting this for the first time.

Day 2

Most tubes and drains will remain in. Observations will continue regularly. Your intravenous fluids will be stopped if you are drinking enough. You will be encouraged to sit in a chair for a short period of time, moving with the assistance of the nursing or therapy staff.

Days 3-7

You will be given daily goals on the ward round so that you can be actively involved in your recovery.

You will gradually become more mobile, walking with assistance or aids initially and gradually straightening up and becoming more independent.

TITUS ADAMS
PLASTIC SURGEON

Epidural , intrapleural and PCA lines are removed on day 2-3 and you will be given pain killer tablets instead.

The drain outputs will be measured every day before the ward rounds. Your surgeon will give the nursing staff specific instructions on when to remove them. This is usually when they have drained less than 30mls in a 24 hour period. To remove a drain, the nursing staff will remove the dressing and cut the stitch keeping the drain in place. The drain is then simply pulled. This procedure can give a strange sensation but is not usually painful.

Once you can reach the toilet independently, your urinary catheter will be removed. We usually suggest this is done after your bowels have been opened.

If you have a Venous Doppler wire and / or central line, these are usually removed when you are nearly ready for discharge.

Wounds will be inspected daily.

The stitches around your umbilicus (belly button) will be removed on day 5-7. All other stitches are usually dissolvable and do not need to be removed. Occasionally, a dissolvable stitch will poke through the wound and feel sharp. This can be trimmed in the dressings clinic.

Discharge planning

When preparing for your operation, it is essential to include plans for discharge (when you are sent home). These include:

- a person to collect you from the hospital and take you home
- someone to stay with you or provide support for you at home once you have been discharged for at least 2 weeks
- arrangements for your dependents e.g. childcare, pets

After your operation, you will be discharged from hospital once you have met the following goals

TITUS ADAMS
PLASTIC SURGEON

- your pain is well controlled with tablets
- you have a maximum of 1 drain left
- you can eat and drink normally
- you have opened your bowels
- you can get in/out of bed and to the toilet and back without assistance
- you can walk around upright and without using assistance
- you can manage the stairs without help (if you have stairs at home)

You will be assessed by the doctors, nurses and therapy staff before discharge to make sure you are ready to go home. They will also check you have appropriate plans in place for transport and home support. Please speak to a member of the nursing staff if you have any concerns about going home after you operation.

In most circumstances, it is essential that you arrange your own transport to take you home on discharge.

Risks and complications of surgery

The majority of patients will recover well from their surgery without significant problems. As with all operations, there are some risks that might occur and these include:

Wound problems and wound infection

This type of operation involves long wounds and multiple stitches, most of which will dissolve.

At first, the wounds may appear lumpy. This is normal and will settle down over a period of weeks or months. Wound problems can be minor, for example, slight redness or a protruding stitch which can be trimmed in the dressing clinic or at your GP surgery. Occasionally, a more troublesome problem may occur, such as wound infection or breakdown.

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PLASTIC SURGEON

Surgery is carried out under strict sterile conditions in an operating theatre. Antibiotics are administered intravenously (by tube into a vein) at the time of your surgery (allergies to any known antibiotics should be brought to the attention of your surgeon or anaesthetist).

Despite these measures, there is still a chance of developing a wound infection.

A minor infection may require a course of antibiotics.

A more severe infection may require admission to hospital, antibiotics and occasionally, return to theatre where the wound can be cleaned under anaesthetic. A regular change of your dressings at the dressings clinic or with your practice nurse will be needed if wound problems occur.

Seroma

A seroma is a collection of tissue fluid at the operation site. This is sometimes seen in the tummy and, less frequently in the chest. You may notice swelling and a feeling of fluid moving around where we have operated. If a lot of fluid collects, it may become uncomfortable and need to be drained. This can be done very simply, using a needle and syringe, in the dressings clinic. This maybe slightly uncomfortable but not painful and a local anaesthetic is not required. Sometimes, a seroma may need more than one drainage and your surgeon will give you instructions about coming back to clinic should the seroma return.

Excessive bleeding

Inevitably some blood is lost at the time of surgery. Sometimes people lose larger volumes of blood and a transfusion may be required. If this becomes necessary, donated blood that has been carefully matched to your blood group will be given through a drip to replace the blood that has been lost. Bleeding is more likely to occur with patients taking aspirin or other anti-inflammatory drugs. They should usually stop taking these types of medication at least one week prior to surgery. If you take any of these types of medication, please discuss this with your surgeon or pre-assessment nurses to confirm if or when you need to stop taking them.

There is a risk of developing a collection of blood (haematoma) at the operation site. If this happens it is usually within the first 48 hours after surgery. The ward staff will check you very regularly and if a haematoma is suspected and is large, you may have to

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PLASTIC SURGEON

return to the operating theatre to clear the blood clot away and stop any on-going bleeding.

Flap loss

This occurs when the tissue transferred from your tummy to your chest (the flap) loses its blood supply. This may happen to part of the flap or, very rarely, all of the flap.

Partial flap loss

Occasionally, some of the flap may not have an adequate blood supply when transferred up to the chest and this will result in part of the flap dying and becoming hard. Eventually, your body will absorb the tissue which is no longer alive and this may result in a change to the shape of your reconstruction. This can usually be improved with further day surgery in the future.

Complete flap loss

The flap is monitored very closely, particularly in the first 48 hours after the operation. If the doctors and nurses notice signs that the blood supply to the flap is failing, you will need to return to the operating theatre immediately where your surgeon will attempt to restore the blood supply. This is usually successful.

In 2 out of 100 patients, the surgeon is unable to keep the flap alive and the reconstruction is lost. In this situation, you will have a "tummy tuck" but no reconstruction. A further attempt at reconstruction using another technique is usually possible a few months later but the tummy tissue cannot be used more than once.

Abdominal bulges and hernias

We need to interfere with the tummy wall muscle during this operation and often remove a small part of muscle with the flap. This will result in weakness of the tummy wall. To strengthen the tummy wall, we use a plastic mesh to prevent bulges and hernias after the operation. In some patients, in spite of the mesh, bulges and hernias may develop. This complication usually occurs months to years after the surgery. For most patients, this is a minor problem but a few may experience a lot of discomfort or pain and require a further operation to repair the hernia

Nerve damage

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PLASTIC SURGEON

It is normal to be numb around the operating sites. The patch of skin transferred from the tummy to your chest will be numb. You may have some numbness along the underside of your arm and also on your tummy. This normally does not cause problems and feeling often returns with time. You should be careful not to rest a hot cup of tea or hot water bottle in these areas as you may not feel this burning you.

Occasionally there may be some damage to the nerves supplying the shoulder muscles, resulting in some weakness. Physiotherapy can help to strengthen the shoulder muscles.

Deep vein thrombosis and pulmonary embolus

All operations carry a risk of blood clots forming in the deep veins of the leg (deep vein thrombosis or DVT), and occasionally in the lungs (pulmonary embolus or PE). We take precautions during and after the operation to try to reduce the chance of this happening.

These precautions include

- Daily heparin injections to thin the blood which commence the evening before surgery.

- Compression stockings which will be given to you on admission and should remain on for the duration of your hospital stay. These are elastic stockings worn around the legs. They encourage blood flow back up to the heart and prevent blood pooling in the lower legs which increases the risk of DVT

- Calf pumps are used during your operation and for the first 24 hours when you are on the ward. These are like compression stockings but are attached to an electric pump which automatically squeezes the calves to keep blood moving and prevent it from clotting.

- Early mobilisation- you are encouraged to get up and about as soon as possible, although due to the type of surgery you are having this may not be until 2 or 3 days after your operation.

Please seek advice if you develop pain, redness or swelling in your calves, or chest pain, coughing up blood stained phlegm or breathlessness.

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PLASTIC SURGEON

General Risks

After any general anaesthetic there is always a risk of developing a chest infection. This risk can be minimised by not smoking before and after surgery, walking around as much as possible and doing deep breathing exercises. If you find that you are unable to perform these exercises due to pain, please inform the staff so that adjustments to your pain management can be made.

If you have any history of respiratory problems you should inform the staff at the hospital.

Any major operation also carries small risks of stroke or heart attack. These risks are small but very dependent on the patients' general health and lifestyle prior to the operation**.**

What can I do to minimise these risks?

This is a frequently asked question. Unfortunately we have little control over who will develop a complication. However, we know that obesity increases the risk of many of the complications listed. Your surgeon will advise you if any weight loss would be beneficial prior to your operation.

Smoking may also increase the risk of some complications. If you are a smoker, you will be advised to stop smoking for as long as possible prior to surgery.

For any help with weight loss, stopping smoking or management of other medical conditions, we advise you to firstly see your GP.

Follow-up

What follow-up arrangements will be made?

Dressings clinic

An appointment will be made for you to see the nurses in the dressings clinic two weeks after your discharge. This appointment will usually coincide with your surgeon's

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PLASTIC SURGEON

outpatient clinic so that you can also be seen by him/her or a senior member of the team.

Consultant clinic

Once discharged from dressings clinic, an appointment will be made in your consultant's outpatient clinic approximately six weeks after your operation**.**

Breast Surgery Clinic

If you have had a reconstruction performed at the same time as a mastectomy for breast cancer, you should have an additional appointment to see the breast surgeon who diagnosed your breast cancer approximately 2- 3 weeks after your surgery. We send any tissue removed from your breast and/or armpit to be examined under the microscope. This gives us detailed information about the tissue, including any cancer that is present. This appointment is to discuss the results of the tissue removed (pathology) and arrange any treatment and follow-up which may be required.

Physiotherapy

If you have any problems with your mobility or exercises after leaving hospital, you can contact the therapy staff directly on 01865 231 181. You do not have to wait until your consultant review appointment.
Alternatively, you can ask to be referred to physiotherapy when you see your consultant for review.

Further Procedures

You may require further procedures to achieve an even, balanced look to your breasts and to create a new nipple for your breast reconstruction if desired. These will not be planned until the reconstruction has settled and all swelling has gone down. This is usually about 4-6 months after your initial operation. Any additional procedures are relatively minor and often performed as day surgery. Further appointments to discuss adjustments will be made in your six week appointment with your consultant.

After discharge from hospital

What happens when I go home?

Bathing and Showering

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PLASTIC SURGEON

The flesh coloured micropore dressings used by the plastic surgeons allow you to wash and shower as normal. You will find the tape gradually falls off after 2 weeks or so and should not need to be replaced. If alternative dressings have been used, the nursing staff will give additional instructions.

Driving

As a general rule, it is safe to start driving once you can perform an emergency stop without discomfort. This may be anything from 2-6 weeks after your operation.

Your insurance policy may not cover you unless you have been given medical permission to begin driving again, therefore, please check with your insurance company before returning to driving.

Patients often find it more comfortable to pad the seatbelt areas with a cushion for a few weeks after their surgery.

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PLASTIC SURGEON

Sleeping/Rest/Pain

You should remember that after an operation you may tire easily. It is quite common to feel frustrated on days when your progress seems slow. This is normal and you will gradually regain strength and stamina over the next few months.

Following your operation we aim to keep you as pain free as possible. When asked about your pain it is important that you give as accurate an answer as possible. This will help us to choose the most appropriate pain control for you.

When you go home you may find that you are still experiencing some discomfort. This is normal and should decrease over the next few weeks.

It is important to take the painkillers regularly for as long as you need them. Good pain control will help your overall recovery and make it easier for you to get up and about. Ensure you follow the pharmacist's advice on the container. You can obtain a repeat prescription from your GP.

As the pain decreases you will find that you need to take fewer painkillers until you can stop taking them altogether.

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PLASTIC SURGEON

Continuing your activities at home

When you get home you may feel tired and unable to do as much as you would like to. This can be unsettling but is quite common. You are likely to feel emotional and tearful at times. You will have good days and bad days. Do not demand too much of yourself. Allow others to help you. Begin by pottering around the house and by taking a short walk each day.

You should also allow some time each day for a rest. Over the next few weeks, gradually increase your activities until you get back to your normal lifestyle.

Domestic Activities

• You will need help around the house for at least the first two weeks after discharge.

• You may need to avoid heavy and strenuous housework, such as vacuuming or lifting for the first 4-6 weeks after surgery.

• Plan your activities carefully. You should do things little and often, rather than all in one go.

Going to the toilet

For the first two weeks after surgery it is very common for bowel movements to become irregular. This can be due to the effect of the pain killers combined with inactivity and a change of routine. This will resolve itself as you get back into your usual routine at home. Eating high fibre foods such as fruit, vegetables and wholemeal bread may help. If necessary try taking a mild laxative for a few days until you return to your normal routine.

Wound Care

You may find that the area around your wound feels numb, tingly, itchy or slightly hard and the wounds are initially slightly raised and lumpy. This is normal and should settle over the next few months. During this time you should protect it from sunlight as it will burn easily.

Avoid the temptation to scratch the area until it is fully healed. Once the wounds have started to settle, you will be encouraged to massage them firmly with moisturising cream which encourages blood flow to the area and helps to soften the scars.

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PLASTIC SURGEON

If you notice any redness, swelling or leakage from the wound, or if you experience increasing pain, you should contact the dressing clinic, SSIP Ward or your GP immediately.

Returning to work

The time to return to work depends on the extent of surgery, your level of mobility, the type of work you do and transport arrangements to get you to work. Your hospital team can advise you when you should be able to return to work. We usually expect you to have a minimum of 6 weeks off work but 2 – 3 months is often required. A phased return to work is often required to ease you back into work gradually. You should be provided with a certificate to cover the entire duration of time you require off work when you are discharged from hospital. This can be extended by your GP if necessary.

Sport and leisure activities

Your physiotherapist can advise you about exercises and choice of sports activities you are interested in pursuing.

Contact information in case of concerns or emergencies:

Email: breastreconstructionnurses@ouh.nhs.uk

Tel: 01865 234193

Out of hours

Please contact the Specialist Surgery Ward where the nursing staff will be happy to give advice regarding any problems.

Within office hours

For wound problems, please call the dressings clinic. The nursing staff will be happy to give advice and can arrange to see you if necessary.

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Physiotherapy

If you are having difficulty with mobility or exercises, please contact the therapy staff on 01865 231181

Your consultant's secretary

For non-urgent problems, your surgeon's secretary can be contacted to arrange a further appointment or speak to a member of the team for advice.

Telephone Numbers:

Specialist surgery ward

Dressings Clinic

Consultant's Secretary

Further Information

Organisations

Oxford Breast Reconstruction Awareness group (BRA) http://www.ouh.nhs.uk/services/departments/specialist-surgery/plastics/bra.aspx

British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) www.bapras.org.uk

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PLASTIC SURGEON

Association of Breast Surgery www.associationofbreastsurgery.co.uk

Irish Cancer Society
www.cancer.ie

Look Good….Feel Better
www.lookgoodfeelbetter.co.uk

Options for Breast Reconstruction
www.optionsforrbreastreconstruction.com

The Centre for Microsurgical Breast Reconstruction
www.diepflap.com

Publications

Breast Reconstruction: Your Choice
Rainsbury, D. & Straker, V. (2008), London, Class Publishing, ISBN: 978-1-85959-197-0

The Boudica Within: The extraordinary journey of women after breast cancer and reconstruction
by Elaine Sassoon published by The Erskine Press, 2007 ISBN 978-1-85297-097-0

Charities

Breakthrough Breast Cancer:
www.breakthrough.org.uk

Breast Cancer Care
www.breastcancercare.org.uk

Breast Cancer Support Board www.breastcancersupport.co.uk

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Macmillan Cancer Support – Breast Cancer
www.macmillan.org.uk/Cancerinformation/Cancertypes/Breast/Breastcancer.aspx

Macmillan Cancer Support – Coping with body changes after cancer
www.be.macmillan.org.uk

Cancer Research UK – Breast cancer
www.cancerhelp.org.uk/type/breastcancer/index.htm

Maggie's Cancer Caring Centres www.maggiescentres.org

Hereditary Breast Cancer Helpline
01629 813000 (24 hour helpline)
Email: canhelp@btopenworld.com

Other Websites

www.claireandthegenie.com
Real patient journey by a patient who has a hereditary breast cancer gene mutation (BRCA2)

Oxford University Hospitals NHS Trust
Useful information regarding your hospital stay and the Patient Advice and Liason Service can be found by clicking "Patient guide" on the hospital website at www.ouh.nhs.uk.