

Breast Augmentation Information Sheet

This information sheet is a general guide for patients undergoing breast augmentation (enlargement) under the care of Paul Harris. It should help clarify some questions that you may have. Many factors may influence your individual operation, your recovery and the long-term result. They include your overall health, your chest size and body shape, previous breast surgery, any bleeding tendencies that you have and your healing capabilities, some of which will be affected by smoking, alcohol and medications. Issues specific to you need to be discussed with Mr Harris and are not covered here. Please feel free to ask him any further questions before you sign the consent form for the operation.

What type of implant will I have?

Breast implants come in different shapes and sizes and whilst almost all consist of an outer casing of silicone, different materials or fluids are used to fill them. The various implants can also have different surfaces and many different implant manufactures are available in the UK. As Mr Harris specialises in plastic surgery of the breast, he will recommend a particular implant to you based on your initial consultation and any subsequent discussions. Each patient is treated as an individual and a single type of implant is not appropriate for all patients.

Nevertheless, for most breast augmentation operations, Mr Harris will recommend a round silicone gel filled prosthesis. This is because they have a natural feel, produce a fuller, more desirable look to the breast, do not suffer the problem of distortion from implant rotation and have very good long term durability. The silicone filling is usually a cohesive gel (often known as 'gummy bear' implants in the USA) rather than a liquid.

Most implants that are described as 'round' actually only have a round outline from front view. They routinely have a flat back to fit against the chest wall and can have various amounts of projection forward. Hence there are a number of possible implants to fit a particular chest wall dimension. The internal gels can be very soft like a liquid or much firmer to maintain their shape. Some implants are shaped like a tear-drop and these are more frequently used in thinner patients or for breast reconstruction. Implants can also be filled with saline rather than silicone and for breast reconstruction, 'tissue-expanders' which are a combination of part silicone filling and part saline are also used. The saline can be added to at a later date using a needle to a pre-positioned port under the skin, usually below the breast or in the axilla (arm pit).

How is the size of my implant chosen?

Mr Harris will discuss with you the type of 'look' that you would like to achieve. Some patients want as a natural a look as possible and others want a 'breast augmented look' with a fuller upper breast. This will help determine implant shape and size. Cup sizes are discussed but these can be inaccurate as they vary between bra manufacturers and most patients have never been formally measured. Cup size is however used as a guide to how much change is desired, although no guarantee can be given to achieve this exact amount, again because cups sizes are so variable.

Routinely, chest measurements are taken by Mr Harris to decide on the width and height of the implant needed. Three-dimension photography scans can also be undertaken at the time of the consultation with immediate analysis of the result. These are an excellent way of visualising your pre-operative chest wall and breast shape, together with a simulated result following breast enlargement with various implant sizes. It is important to recognise that these simulations are not necessarily

reproducible at the time of surgery, but the three-dimension scans are an excellent communication tool between you and Mr Harris to clarify what is desired and what is achievable. You will usually have confidential access to these scans and simulation following the consultation via a personalised email 'log-in' invitation.

From these discussions, measurements and scans, Mr Harris will recommend a range of implant sizes. This is routinely decided on at the time of the second outpatient meeting. You may try these implants in a bra, which will help narrow down the range. It is then usual for Mr Harris to order several sizes of implants for the operation, one either side of the recommended size. This allows the final decision to be made during the operation, thus producing the best possible result. The unused implants are returned to the manufacturer without incurring a charge.

What will the surface of my implant be like?

Most British Plastic Surgeons use rough-walled 'textured' silicone implants, which are thought to reduce the incidence of encapsulation requiring re-operation (see discussion below regarding encapsulation). The evidence for this assumption has come from our early experience with foam (polyurethane) covered implants and a major UK-based study. However, this study has been criticised by many and in the United States, smooth silicone implants are routinely used.

As a recognised expert in this area of surgery, Mr Harris believes that the surface characteristics of silicone implants does not necessarily affect encapsulation but may impact on the overall aesthetic result. He therefore uses both smooth and textured implants depending upon the desired result. He will inform you of his recommendation for you and why he has made that recommendation.

Polyurethane coated devices have been re-introduced into the European market for the last decade and these implants appear to convey a significant advantage in cases of revision surgery for encapsulation or in cases of breast reconstruction following radiotherapy. There are however some disadvantages in their use for routine breast augmentation and hence Mr Harris does not usually use them in this setting.

Which implant company does Mr Harris normally recommend and will the implants have a guarantee?

Mr Harris uses several different manufactures for different situations and will discuss these with you. Currently there are two main companies that he uses: Mentor – an American company who manufacture their implants in Europe, and Nagor – a British company that offers a lifetime guarantee to their implants.

Mentor have had their implants approved by the Food and Drug Administration (FDA), which has stronger regulation than the European authorities. Their implants have been rigorously studied by independent researchers and have the best ten-year follow up results available. Nevertheless the British company (Nagor) does provide very high quality implants, at a lower price. In some cases of exchange surgery Mr Harris also uses polyurethane coated implants, which are thought to have a reduced capsular contracture rate. He will be able to discuss these issues with you further when deciding which implant to use.

Most implant manufactures offer a guarantee to their implants, which may be time-limited or in some cases lifelong. It is important to note that these guarantees often have limitations and do not usually cover the cost of the surgeon, anaesthetist or hospital in the event of there being a need for replacement surgery.

It is also important to note that although Mr Harris makes the recommendation, the implants are actually supplied by the hospital where the surgery will take place and not by Mr Harris directly. Although Mr Harris never used PIP implants, clearly similar problems with implant manufactures could happen again. Mr Harris continually reviews the available literature to recommend the most appropriate implant at the time of surgery, but these recommendations do change as new data and implants become available.

Where will the implant be placed?

Conventionally breast implants are placed either in a subglandular position (between the breast tissue and the muscle on the chest wall) or in a submuscular position (beneath the muscle on the chest wall). The site chosen depends on the amount of breast tissue present and the breast skin laxity. A more natural result is usually achieved under the muscle because the edges of the implant will have thicker tissue coverage. However, this does not always completely fill out the breast skin because the muscle can restrict the expansion of the breast.

A more recent approach has been to place the implant beneath the muscle, whilst freeing off the breast from the superficial surface of the muscle. This is known as a 'dual plane technique'. Although this technique was initially described in the United States, Mr Harris has pioneered this technique in the UK, lecturing regularly to established and trainee plastic surgeons.

After the initial consultation, Mr Harris will advise you where he would like to place your implants and why.

Where will the incisions be?

The most common incision used is about 5cm long and close to the infra-mammary fold (crease of skin beneath the breast). This allows good access to correctly position the implant whilst placing the scar in an area that usually heals well and is not obviously seen. Incisions can alternatively be placed in the axilla (arm pit) or around the nipple. Each incision has advantages and disadvantages,

All incisions produce scars, which usually settle down over several months. However some scars can be troublesome. Hypertrophic scars are red, raised and itchy for several months following the operation. These can be treated but often result in a wide stretched scar. Keloid scars are larger and more difficult to treat but these are extremely rare following breast augmentation.

What will happen before the operation?

If you are unwell before the operation, please call M Harris' secretary (tel: 0207 927 6520) as the date of surgery may need to be postponed. No aspirin or medication containing aspirin should be taken for ten days before surgery. If you smoke you should cut down for three weeks before surgery and stop smoking completely three days before surgery to reduce the likelihood of post-operative complications.

The operation is performed under general anaesthetic with a one night stay in hospital afterwards. Please bring with you a nightdress, dressing gown, slippers and toiletries. Do not bring cosmetics or jewellery. You should have a shower at home before you go to hospital, or on the ward the morning of the operation.

When you arrive in hospital, you will be seen by a nurse who will talk to you about your general health and examine you to make sure that you are fit for surgery. They may also arrange for you to have some blood tests, a heart trace (ECG) and a chest X-ray. An anaesthetist will visit you to discuss the anaesthetic. Mr Harris will also come and discuss your surgery in detail with you. He will often take some pre-operative photographs and draw some markings to guide the surgery. It is important that you do not wash these lines off.

You will then be asked to sign a consent form. Make sure that you fully understand the consequences of the surgery prior to signing this. Signing this form does not take any of your normal

rights away, it merely states that Mr Harris has explained the operation to you and that you have discussed the anaesthesia with an anaesthetist.

Do I need to buy a special bra?

It is important that the implants are held in place firmly for the first few weeks after the surgery and a well-fitted surgical (or sports) bra often helps with this. Mr Harris can provide these bras or you can purchase your own. Further advice on bra selection can be gained from discussion with Mr Harris' nurse (nurse@paulharrisplasticsurgeon.co.uk, tel: 074 9622 8878). Please bring one of the bras to theatre with you so that it can be put on at the end of the operation whilst you are still asleep.

These bras need to be worn for six weeks following the surgery, both during the night for sleeping and during the day. You should then be fitted for your new regular underwear.

How will I feel when I wake up after the operation?

The operation usually takes one to two hours. You will then wake up in the recovery area before transfer back to the ward. It is usual to feel groggy and a little disorientated for a short period. If you have pain or feel sick, you should tell the nursing staff so that they can give you the appropriate medication. The breasts will feel sore after surgery particularly when the arms are moved, but this rapidly improves over the first few days.

Will there be drains and when do they come out?

Drains are rarely used in routine breast augmentation under the care of Mr Harris. However, in some cases of revision surgery or when additional surgery (such as a breast uplift or mastopexy) has been carried out, they may be used. They will usually exit through a separate tiny incision on the outside part of the chest. If drains are used, they will normally come out the day after the operation. If a large amount of fluid is drained however, then the drains may stay for several days until this amount has reduced to an acceptable level.

When can I go home?

You will normally go home the day after surgery with some painkilling tablets. It is usually best to have someone drive you home rather than taking a taxi or public transport.

What post-operative care do I need and when can I go back to work or exercise?

On the day of discharge, you will be given an information sheet and be asked to attend a dressing clinic appointment approximately one week after the operation. At that appointment, the dressings will be removed by a nurse and the wounds checked. You will only see a doctor if there is a problem. You can shower or bath the day after surgery but it is inadvisable to soak in the bath with the wounds submerged for at least three weeks. The stitches are usually dissolvable. An appointment will also be made for you to see Mr Harris between two and four weeks following the surgery.

After ten days to two weeks you may go back to non-physical employment and resume driving a car, but check this with your insurance company as some do vary. Three weeks after your operation you may resume gentle exercise, but violent movements and physical employment are inadvisable for six weeks. You can sleep on your back or side but not on your stomach for at least four weeks. You should be back to complete normality by six weeks following the operation.

What effect does silicone have on my body?

Silicone is used in the body in a variety of ways from lubricating syringes to wrapping around cardiac pacemakers. Despite this, there has been a lot of media attention surrounding the use of silicone in breast implants, particularly after the PIP implant scandal. Minute quantities of silicone can diffuse, or 'bleed', through the silicone casing of the implant and it has been suggested that this silicone causes breast cancer, abnormalities in babies and a range of diseases related to arthritis.

Large studies in the United States and Europe have now shown that there is no increased risk of these diseases in women with breast implants. Therefore, at present there is no evidence to suggest that silicone from breast implants causes disease, however, the lifetime biological effects of silicone continue to be studied.

Do breast implants affect the development or detection of breast cancer?

Several large studies have now conclusively shown that breast implants do not increase the chances of getting breast cancer. Furthermore, women with breast implants who develop breast cancer have the same prognosis (overall outcome from the cancer) as women without implants. However, the implant can potentially interfere with routine mammography by 'hiding' areas of breast tissue, making it difficult to interpret the results. If you tell the radiographer that you have a breast implant when you are having routine mammography, different views can be taken to overcome this problem. If you are over thirty years old and have a strong family history of breast cancer or you already have screening mammograms, it may be beneficial to have a mammogram prior to the surgery and six months following the surgery as a 'baseline' in case of future changes to the breast. This should be discussed with Mr Harris prior to arranging the operation.

Although not specifically breast cancer, there have been some reports of a rare type of lymphoma associated with breast implants. This is known as Anaplastic Large Cell Lymphoma (ALCL), which is a type cancer involving cells of the immune system. ALCL has generally been found adjacent to the implant in the fibrous scar (or capsule). It is thought to occur at a rate of 3 in 100 million cases of breast augmentation per year, and hence is exceptionally rare. It is also thought to be treatable with surgery alone in the majority of cases. The most recent clinical studies state that it is not possible to confirm with any certainty whether breast implants have any relation to an increased likelihood of developing ALCL, and particularly whether one type of implant can create a higher or lower risk than another of developing the disease.

Can I breast feed after having had implants?

The insertion of a breast implant does not routinely interrupt the ducts that connect the breast tissue to the nipple and breast feeding should therefore be unaffected. The present state of knowledge also shows that silicone does not affect breast milk and that it is quite safe to breast feed. If the nerve supply to the breast and nipple has been damaged (see below) then this may affect the ability of the milk to be produced although this is extremely rare.

What is breast implant encapsulation and are there any techniques that can be used to reduce the chances of this happening?

Wherever a cut is made, the body heals by making a scar. You will therefore make a scar that will completely surround the prosthesis. If you make a thin scar, the prosthesis will feel soft and you will not be able to differentiate it from the normal breast. Sometimes, for reasons not fully understood, the scar can thicken and squeeze the implant, making it feel harder and rounder. This process is called 'encapsulation' and the thick scar is sometimes referred to as a 'capsular contraction'. If this is very severe it can cause visible distortion of the breast or significant pain. The chances of experiencing a capsular contracture are approximately 10% in the first five years. It can however

happen at any stage, even 20 years after the initial operation. Capsular contracture can usually be treated by further surgery to release the scar and exchange the implant.

The current understanding of encapsulation is that it is your body's reaction to a problem with the implant. In most cases we feel this is a low-grade infection. This can happen at the time of the implant insertion or at a later date from a blood-borne source. The causative infection can live on the surface of the implant in an indolent (idle or non-active) state. This is known as a 'biofilm'. Therefore current concepts to reduce encapsulation are focused on reducing the chances of the implant becoming infected. Hence, Mr Harris will cover the nipples at the time of surgery with 'nipple shields' (a sterile clear plastic dressing) to reduce contamination from the normal flora that exist in the nipple ducts. He will also use a delivery device (Keller Funnel®) for the implant to reduce contact with the skin, and coat the implant with an antiseptic solution.

Placing the implant under the muscle, rather than under the breast tissue alone, appears to reduce the chances of encapsulation. Although this is more likely to be due to the increased soft tissue coverage making a mild encapsulation less obvious rather than an actual reduction in capsular contracture rate. Polyurethane texturing also reduces the ability of the tissue to tighten around the implant. There is no evidence that either the saline or silicone filled implants have a lower rate of this complication.

What other complications may arise from my surgery?

Any invasive surgical procedure has risks such as infection, haematoma (blood clot), dysaesthesia (changes in sensation), post-operative pain, and delayed wound healing. However, the overall complication rate for routine breast augmentation is less than 10% and most of these are minor problems. The most common complications are outlined below:

A haematoma is a collection of blood inside the body. In this operation it would be around the implant and result in pain, swelling and bruising. Very small haematomas are absorbed by the body and do not require any specific treatment. Large haematomas usually occur soon after surgery and a further operation is required to drain the haematoma and stop the bleeding point. If post-operatively you feel one breast getting larger than the other, especially if it is associated with pain or flu-like symptoms, then you should tell a member of the nursing or medical team as soon as possible.

Infection is very rare. Antibiotics are given at the time of the surgery to reduce the chances of infection occurring. Most infections resulting from surgery appear within a few days of the operation. Infections around implants are harder to treat than infections in normal body tissues. Some infections do not respond to antibiotics and the implants have to be removed. After the infection is treated and the scar has softened, a new implant can usually be re-inserted about 3 - 6 months later.

In rare cases, the implant may push through the covering tissue and become exposed. This is most likely to occur if the overlying tissue is already damaged, or becomes damaged from pressure ischaemia (lack of blood circulation) associated with an excessively large or displaced implant. Smoking also significantly increases your risk of implant extrusion by delaying the wound healing process. If the implant does become exposed then it needs to be completely removed and a new implant inserted at a later date.

All patients will experience a temporary reduction in nipple sensation, and subsequently a small number may not fully recover. These changes may also affect sexual response and the ability to nurse a baby. Very rarely some patients may experience an increased sensitivity to the nipple that can be temporary or permanent.

Most women's breasts are asymmetrical (not perfectly equal in either size or shape) and Mr Harris should mention this pre-operatively. If the same size implants are used on both sides then the small degree of asymmetry between the breasts will remain following the operation. Breast implants can be used to correct large differences between each breast either by increasing the size of one side alone or by increasing the size of both sides by differing amounts. Large differences are almost

impossible to totally correct by surgery and in particular differences in the nipple height and size will remain.

An implant may become visible with time as the overlying breast tissue becomes thinner with age and often the breast prostheses can be felt at the edges where there is less tissue coverage. With advancing age, the breast also tends to ptose or droop. This is usually corrected by a mastopexy (breast uplift) operation and not breast implants.

Modern breast implants have a laminated silicone shell, which is extremely tough to minimise leakage of the contents. However, the shell can be damaged by injury or vigorous contact. This is usually obvious as it results in a change in the shape of the breast with the patient often reporting a burning sensation and a change in size. Rupture releases the silicone gel filling which may remain around the implant or may migrate into the breast, axillary (arm pit) lymph nodes and other places in the body. Rupture requires surgical removal of the implant and gel mass, although removal of all of the gel may not be possible. Deflation or rupture of saline implants is commoner. The released salt water, naturally present in the body, is absorbed as a harmless fluid. The implant does however have to be replaced.

The implant surface may wrinkle. This may be noticeable on the surface of the skin, depending on the position of the implant and the thickness of the overlying breast tissue. Large wrinkles, or folds, occur uncommonly and may irritate or damage the surrounding tissue.

Do implants last a lifetime or will I need additional surgery?

You should not consider your implants to be lifetime devices, because although they can last twenty years or more, revision surgery, removal or replacement may be indicated at any time. The management of any of the complications described above may also involve removal. This may have a financial implication for you if revision surgery is required.

Where can I find additional information about breast augmentation?

The Department of Health give advice on protecting patients who are considering cosmetic surgery: www.gov.uk/government/news/recommendations-to-protect-people-who-choose-cosmetic-surgery

Specific advice regarding breast augmentation and implants can be obtained from:

The British Association of Aesthetic Plastic Surgeons (BAAPS)
www.baaps.org.uk

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

The Association of Breast Surgery (ABS)
www.associationofbreastsurgery.org.uk

The Practice

Mr Harris practices from 5 Devonshire Place in Central London, where he also performs minor outpatient procedures. Assisted by his regular anaesthetist, he operates at The London Clinic (<http://www.thelondonclinic.com>) and at The Royal Marsden Hospital, Fulham (<http://www.royalmarsden.nhs.uk>). He also consults and operates at Parkside Hospital, Wimbledon (<http://www.parkside-hospital.co.uk>). All provide a full range of medical support services.

Main correspondence, appointments and administration

Many patients are referred by their General Practitioner. You may, however, arrange your own appointment with Mr Harris, without referral.

Please refer all correspondence to:
5 Devonshire Place
London
W1G 6HL

For appointments please contact:
appointments@paulharrisplasticsurgeon.co.uk, tel: 020 7927 6520

For information and payments:
admin@paulharrisplasticsurgeon.co.uk, tel: 020 7927 6521

For nursing support please contact:
nurse@paulharrisplasticsurgeon.co.uk, tel: 074 9622 8878