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Breast reconstruction after mastectomy. A case report

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Case Report

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ABSTRACT:
Introduction: Breast cancer is defined as an accelerated and uncontrolled proliferation of glandular cells. In Mexico it is the second most common type of cancer and is the leading cause of cancer death in women between 50-59 years old. Ductal carcinoma in situ corresponds to approximately 90% of localized breast cancers. Current surgical techniques allow a correct comprehensive treatment of cancer, without the loss of the anatomy that affects the quality of life of the patient.
Objective: We aim to compare the results of the international bibliography on the skin flap technique, with those obtained with the case presented below.
Case report: A 50-year-old female with no relevant medical history, was diagnosed with carcinoma in situ grade III of the left breast. She is scheduled for total left mastectomy with lymphatic mapping, sentinel node biopsy and breast reconstruction with prosthesis and flap.
Conclusion: The skin flap technique is a technique that offers excellent results, with a very low probability of necrosis, which is why it turns out to be a safe course of action.

KEYWORDS: Mastectomy, reconstruction, skin flap.

Introduction

Breast cancer is defined as an accelerated and uncontrolled proliferation of glandular cells which can spread by lymphatic and/or hematogenous routes and invade other organs. In Mexico, it is the second most common type of cancer among its population and is the leading cause of cancer death in women between 50-59 years old. Ductal carcinoma in situ corresponds to approximately 90% of localized breast cancers and is considered an anatomical precursor with the potential to transform into invasive carcinoma in up to 30% during the 10-20 years after initial diagnosis. Current surgical techniques allow a correct comprehensive treatment of cancer, without the loss of the anatomy that affects the quality of life of the patient. We aim to compare the results of the international bibliography on the skin flap technique, with those obtained with the case presented below.

Case report

A 50-year-old female with a denied family history and non-chronic degenerative diseases, a surgical history of 2 cesarean sections and unspecified shoulder surgeries. OB/Gyn history: Menarche at 15 years, G2 P0 A0 C2 with regular 28x4 cycles, abundant flow, history of breastfeeding for 8 months during the last pregnancy. She began her condition 2 years ago when she noticed the presence of an indurated nodule in the left areola at the 12 o'clock position, with no accompanying symptoms. Her first mammography was performed on 11/07/2020 reporting BIRADS 4b (Fig.1)

Directed physical examination reveals a palpable nodule in R12 periareolar of the left breast with no nipple discharge, ipsilateral axilla with a palpable node of 1 cm approximately, well-defined borders, mobile and not painful on palpation.
USG of the breast 11/10/20: in R12, 2 adjacent periareolar nodules, both dependent on ducts, are located. The first of 1.6 x 0.7cm and the other of 3.1 x 1.2cm, both of irregular shape, lobed, with images inside that could correspond to calcifications. Axilla with ganglion with cortical 0.4cm

Cutting needle biopsy 12/19/20: Carcinoma in situ grade III of the left breast.

She is scheduled for total left mastectomy with lymphatic mapping, sentinel node biopsy and breast reconstruction with prosthesis and flap, which is performed on 01/21/21, with previous markings for symmetrization and skin island flap (Fig. 2). We proceeded to perform a total left mastectomy with

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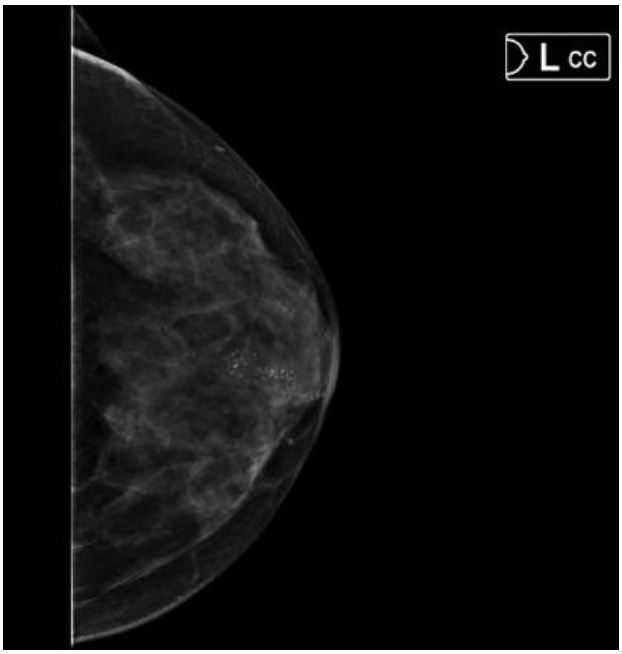

Figure 1. Left breast mammogram in craniocaudal projection showing 2 periareolar nodules and microcalcifications

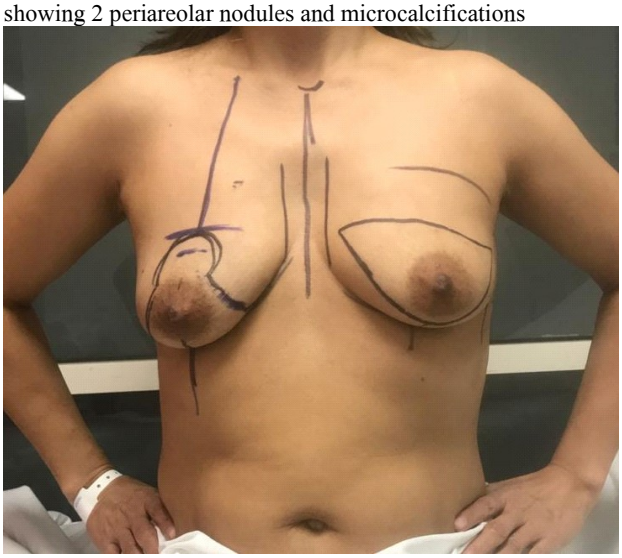

Figure 2. Pre-operative markings in front view

Figure 3. Post-operative posterior view showing proper wound healing

Figure 4. Post-operative front view with proper wound healing and breast symmetrization

reconstruction with a latissimus dorsi flap using the elevation technique, an implant was placed and a right mastopexy was performed. It is scheduled for a secondary reconstruction of the areola-nipple complex.

The histopathological result of mastectomy + sentinel lymph node 01/21/21 reports extensive ductal carcinoma in situ nuclear grade III luminal A with comedo-type necrosis, tumor size 6.5 cm with free surgical margins, without lymphovascular or perineural invasion.

In the immediate postoperative period, breast symmetry and adequate coloration of the flap are observed, the patient is discharged with tamoxifen 20 mg every 24 hours; Postoperative control shows adequate wound healing on the back and breast symmetrization (Fig. 3 and 4).

Discussion

Breast reconstruction is, nowadays, a common procedure among oncological patients, seeking to aminorate the physical and psychological trauma that comes with the diagnosis. The procedure can be approached using different surgical techniques depending on the needs of each patient. The latissimus dorsi flap offers well-vascularized muscle and fat, although it is almost always necessary to add a prosthesis to achieve an appropriate breast volume. Latissimus dorsi flap is a safe technique with consistent outcomes. In this case, our patient had a wide resection, so the skin flap allowed us to cover the defect while giving support for the implant. In the post-operative period, a good aesthetic and an adequate wound healing are shown after the surgical intervention.

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Conclusions

The skin flap technique is a technique that offers excellent results, with a very low probability of necrosis, which is why it turns out to be a safe course of action. In addition, its aesthetic sequelae are minimal, which has a very positive impact on the self-esteem of cancer patients.

Conflicts of interests

The authors declare no conflict of interest.

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