

Mr Michael Cadier

**BA MA (Oxon) MBBS (London) MS (Soton), FRCSEd, FRCS (Plast) President of BAAPS 2014-2016
Consultant in Plastic, Reconstructive & Aesthetic Surgery**

Secondary Procedures after Breast Augmentation.

Breast augmentation is one of the most popular cosmetic surgical procedures. It is associated with extremely high rates of patient satisfaction. Although in many patients the implants will last for many years some patients require or request additional surgery either to remove or replace the implants or perform additional procedures such as fat transfer or uplift surgery. This information sheet provides some guidance about these procedures and supplements the information sheet on breast augmentation.

What are the reasons for further surgery?

- Patient preference – usually a change in size or request for removal.
- Implant visibility (rippling and knuckling).
- Implant rupture or significant leakage.
- Capsular contracture.
- Recurrent seroma.
- The breast mound drooping off the implant mound (waterfall effect).
- Implant moving into undesirable position.
- Delayed infection.
- Implant recall.
- ALCL.

Patient preference for further surgery.

Patient preference is by far the commonest reason for changing implants, usually to go larger. It is important therefore to get the initial sizing correct. Patients need to be aware that the larger the implant the less natural it will look and the more risk of implant visibility and palpability. Additionally, larger implants may cause the breast to droop. All surgery comes with risks and care needs to be taken to avoid the risks outweighing any potential benefits.

Some patients seek removal because of concerns regarding having foreign material in their bodies or following a scare or simply because they wish to go smaller. In other cases, it is because of a clinical problem such as leakage or rupture or capsular contracture. Removing implants in uncomplicated cases is relatively straightforward and can be undertaken either under local or general anaesthetic as a day case procedure. The procedure takes 30-45 minutes and recovery is very rapid. Obviously, the breast will be significantly smaller and may appear deflated. A firm sports bra should be worn for 2 weeks. In most cases the breast actually settles down extremely well and few patients seek any further surgery.

In more complicated cases when there is a hard capsule or a rupture the removal procedure is best undertaken under general anaesthetic and may require drains and a night's stay in hospital.

Implant visibility and palpability.

In most cases patients can feel the edge of the implants by the crease under the breast. This is normal and requires no treatment. Implant visibility may occur over the years as the patients breasts natural tissues shrink or following weight loss. It is more common when the implants are situated in pockets created in front of the muscle. If weight gain is not an option then potential options for treatment include the following:

- Change of implant plane – usually placing behind the muscle.
- Change of implant type – to a firmer implant.

- Fat transfer to increase the tissue coverage.

Which of these, either alone or in combination, is most appropriate will be discussed at the consultation. The timings, recovery, aims and limitations and risks will also be discussed.

Implant rupture or significant leakage

All breast implants leak tiny quantities of silicone into the surrounding tissue. This microscopic leakage has been known about for many years and initially it was thought that it might be associated with skin and joint conditions. This is now not believed to be the case, though there are on-going studies and patients may wish to keep informed by looking at the web sites of key associations such as BAAPS, BAPRAS, ISAPS and ASAPS – these are all associations of plastic surgeons whose web sites will provide up to date information on silicone breast implants. It should be noted that modern implants incorporate special shells and the filler gel is cohesive, these both being designed to minimize any silicone leakage.

The breast implants used by Mr Cadier are all state of the art being made by highly reputable companies and are extremely well designed and subjected to rigorous tests. Breast implants will not rupture when going in airplanes, contrary to some popular belief. It is recognized that with some implants over the course of many years the shell of the implant may develop cracks and silicone gel can be found between the capsule and the implant shell (termed intra-capsular rupture). Usually this is not associated with any symptoms and may be picked up when a patient is having a scan or mammogram for some other reason. In these cases, patients are advised that it is probably appropriate for the implants to be changed as it is possible that over the course of several more years that free silicone gel may be found outside of the capsule in the breast tissue (termed extra-capsular contracture). This free silicone gel can form lumps in the breast (granulomas) which in themselves are not dangerous but can be potentially confused with breast cancers. It should be stressed that even with the implants used 15-20 years ago (which neither had cohesive gel nor extra barriers as found in the modern implants) that the incidence of granuloma development, even after 20 years, is very small. The surgery to remove and replace breast implants that have leaked or ruptured takes

about an hour to perform and is usually undertaken under general anaesthetic. The recovery, expectations, aims and limitations and risks will need to be gone over on a case by case basis.

Capsular contracture

When a breast implant is inserted the body will automatically put a layer of scar tissue (a capsule) around the implant. In most cases this is of no consequence. However, in some patients, for reasons not fully understood, the scar tissue thickens and squeezes the implant. This is termed capsular contracture. This may occur at any stage following augmentation, though it is unusual in the first year. It can come on slowly or rapidly and affect one or both breasts. In many cases it is manifest by firmness of the implant, but in severe cases the implant becomes hard and painful and the breast shape is distorted. Capsular contracture is detected in about 1:10 to 1:20 patients at 10 years following augmentation, though only about 1:25 to 1:50 require treatment. The surgical options include:

- Release of the scar tissue envelope – capsulotomy.
- Partial removal of the scar tissue envelope – partial capsulectomy.
- Full removal (often en bloc) of the scar tissue envelope – full capsulectomy.
- Change of implant.
- Change of implant plane (usually repositioning from in front to behind the muscle).
- Fat transfer to increase tissue coverage.
- Removal without replacement in recurrent cases.

All of these options require a general anaesthetic and which is most appropriate, as well as expectations, recovery times, aims, limitations and risks will all be discussed at the consultation.

Recurrent seroma.

Seromas are an unusual problem following breast augmentation and represent an accumulation of blister-like fluid around the implant on one or both sides. Patients notice a

sudden swelling of the breast. This can occur several years following surgery and may be precipitated by a violent bout of exercise. In most cases this is not a significant problem and treatment is usually non-surgical and includes wearing a compression bra, avoiding the precipitating exercise and taking anti-inflammatory medication. However, because of the very rare risk of BIA-ALCL (see below) patients should always seek medical advice, and ideally return to Mr Cadier for review. When recurrent seromas occur implant removal and capsulectomy with either immediate, or delayed replacement may be required.

Breast tissue dropping off implant mound (waterfall effect).

With the natural changes that occur with ageing, sometimes aggravated by breast feeding or weight change, the breast tissue can start drooping off the implant mound. This appears to be more common when the implant has been placed behind the muscle and when the patient's natural pre implant insertion breast was droopy or lax. The options for treatment if required include:

- Change of implant plane usually from behind to in front of the muscle
- Change of implant size.
- Breast uplift surgery.

Implants moving into undesirable positions.

Over the course of time the implants can move into undesirable positions. There are many potential reasons, including mild capsular contracture, excessive muscle contraction, lax tissues (sometimes following massive weight loss). Options for treatment are varied and bespoke.

Delayed infection.

This is a rare problem and usually occurs when there is a focus of infection in another part of the body that has spread to the implant through the blood. The treatment specific to the

implant is in most cases urgent removal and delayed reinsertion several months later.

Implant recall.

Over the years there have been several implants recalls most notably the Trilucent soya bean oil filled implants (the first publication of the problems of Trilucent implants was by Mr Cadier, directly resulting in a request for widespread removal by the MHRA regulatory body) and the fraudulently poorly manufactured PIP implants.

Although all attempts are made to try to use well established and reputable implants with good long-term safety data it is impossible to predict potential problems. In the past patients were often unaware what breast implants they had and there was limited data collected. However, since 2017 a nationally organized breast registry has been set up (Mr Cadier was on the committee) so that in the future if there is any concern regarding a breast implant type the patients with those implants can be identified and contacted and appropriate action taken in an expedient manner.

Breast Implant Associated - Anaplastic Large Cell Lymphoma.

Anaplastic large cell lymphoma (ALCL) is an extremely rare type of cancer that can occur in adults and children. Over the last two decades, there have been rare reports of ALCL occurring in the scar tissue surrounding breast implants. This has led the medical community to recognise a new and different type of ALCL, referred to as Breast Implant- Associated ALCL (or BIA-ALCL for short). BIA-ALCL does not appear to behave in the same way as ALCL and in most cases is less severe. It should be noted that this is a very rare condition: at the time of writing (October 2018) there have been 500 cases reported worldwide since 1997, with an estimated 10 million implants inserted during the same period. Although there have been 17 reported deaths to date, BIA-ALCL in most cases is readily treatable by removing the scar tissue surrounding the implant and replacing the implant. It usually presents in women 8-10 years following implant insertion with sudden swelling of the breast as a result of a fluid collection – a seroma. Should this occur patients should seek urgent medical advice.

Conclusion.

Breast augmentation is one of the commonest aesthetic surgical procedures and is associated with very high rates of patient satisfaction. However, there are a multitude of problems that can occur over the years which may necessitate further surgery, and certainly all patients undergoing breast augmentation should anticipate the need at some stage for further surgery.

About your Surgeon:



Michael Cadier was educated at the French Lycée in London, studied at Oxford University and undertook Medicine at St Thomas' Hospital, London. After training in London, Salisbury and Bristol he became an NHS Consultant in the Supra-regional Plastic Surgery Unit in Salisbury in 1996, becoming Head of this Service in 1999. In his NHS practice he developed a breast reconstruction service in Portsmouth, and in 2000 was appointed as cleft surgeon to the newly established Spires Cleft Centre, for which he also became the first Clinical Director in 2002. He undertook yearly cleft lip and palate Charity missions in rural Pakistan from 1996 to 2009.

He has a busy aesthetic surgery private practice along the South Coast, undertaking the full range of aesthetic surgery procedures. He has performed over a thousand facelifts, and over 1500 breast augmentations, with similar numbers for all of the more common aesthetic procedures.

He is widely published, and lectures and teaches on aesthetic surgery both nationally and internationally. In 2006 he was invited to become an examiner for the FRCS (Plast). He is the Program Director for the South Coast Reconstructive Cosmetic Surgery Fellowship, was part of the first UK delegation in the CEN in cosmetic surgery (European regulation) and chaired the CSIC Royal College committee on Clinical Quality and Outcomes in Cosmetic Surgery.

The British Association of Aesthetic Surgeons (BAAPS) is the leading organization for aesthetic surgery in the UK. He was elected to BAAPS Council in 2006 and was President of BAAPS from 2014 to 2016. One of his key objectives is to ensure that UK plastic surgeons of the future will practice aesthetic surgery to the highest possible and with that aim he has helped establish a comprehensive national training program in aesthetic surgery.

PA: **Nicola Haicalis**
Ph: **01725 511 550**
Fx: **01725 511 846**
Email: nicola.haicalis@michaelcadier.com

Website : www.michaelcadier.com

BMI Harbour Hospital, St Marys Road, Poole, Dorset, BH15 2BH
Ph : 01202 244 200

BMI Sarum Road Hospital, Sarum Road, Winchester, Hampshire, S022 5HA
Ph : 01962 844 555

Spire Southampton Hospital, Chalybeate Close, Southampton, Hampshire, S016 6UY

For all Spire enquiries, please contact Lyn Corlass on :
Ph : 02380 764 979
Email on lyn.corlass@spirehealthcare.com)