NHS
Queen Victoria Hospital
NHS Foundation Trust

Undergoing breast surgery at Queen Victoria Hospital (QVH)

(MS TRAM/DIEP flap, TUG/DUG/LUG flap and LD flap)

Welcome to Queen Victoria Hospital NHS Foundation Trust

You have been referred to this hospital to be considered for breast reconstruction surgery. This booklet will explain the various treatment options and what to expect. Please do not hesitate to ask if you have further questions.
Breast reconstruction can be performed at the same time as a mastectomy (removal of the breast) as an 'immediate' reconstruction for breast Cancer or risk-reduction, or after a mastectomy as a 'delayed' procedure for breast cancer.
Breast reconstruction surgery usually involves several operations over an extended period. The first procedure is to create a breast mound. The second procedure may involve symmetrising surgery (if necessary) to balance and sculpt the reconstruction. The last procedure is nipple reconstruction (if required) finishing with micropigmentation (tattooing). This information booklet concentrates on the first procedure, which is creating the initial breast mound using your own tissue (autologous / free flap).
In this hospital, it can be performed using tissue from your abdomen (MS TRAM flap, DIEP flap or SIEA flap), inner thigh (TUG / DUG / LUG flap) or back (LD flap). There are other methods such as buttock (SGAP / IGAP) flaps available, but this is not offered here at QVH.

Reasons for choosing breast reconstruction

You may choose breast reconstruction for both physical and psychological reasons. The goals of reconstruction are to:

- help make your breasts look balanced when you are wearing a bra so you feel comfortable about how you look in most types of clothing
- permanently regain a breast contour
- provide a permanent breast mound so that an external prosthesis is not required
- help you to feel more feminine and address psychological and psychosexual wellbeing.

Important factors to consider when deciding if and when to proceed with breast reconstruction

It is important to make your decision about having breast reconstruction only when you feel fully informed about the procedure. There are often many options to think about as you and your surgeon explore what is best for you. It is important to consider the following factors:

- Breast reconstruction does not affect your ability to have other breast Cancer treatments, such as chemotherapy or radiotherapy. However, having radiotherapy may affect or delay the reconstruction options offered to you for up to a year. Oncological follow up after treatment is the same as if you had only a mastectomy.

- The reconstruction process usually requires more than one operation.
- Breast reconstruction surgery takes longer than a mastectomy and free flap surgery is a major operation. This means your overall hospital stay may be longer than for a mastectomy alone.
- Not all types of reconstruction are suitable for each patient and this is determined by many factors. The surgeon will discuss which options are most appropriate for you during your consultation.
- The difference between a reconstructed breast and an unaffected breast can be seen when you are naked. A breast reconstruction will not be an exact match.
- A reconstructed breast will not experience the sensations of a natural breast.
- Your body image and self-esteem may improve after your reconstruction surgery as, naturally, some types of reconstruction may improve areas of your body e.g. uplifted breasts or improved abdominal contour, but this is not always the case. Breast reconstruction will not change anything you may have been unhappy about before your surgery.
- You may be disappointed with how your breast looks after surgery. You, and those close to you, must be realistic about what to expect from reconstruction.

You should discuss the benefits and risks of reconstruction with your doctors and breast reconstruction nurses before the date of surgery to give yourself plenty of time to make the best decision for you.

Questions you may wish to ask

It is very important that you ask as many questions of your surgeon as you need to before having breast reconstruction. It is always useful to write down any questions as you think of them. It is usually advisable to bring a friend or family member with you to your outpatient appointments to help you remember what is discussed. Please visit the hospital website to confirm the latest visitor advice at the time of your appointment.

Here is a list of questions you may wish to ask. The answers to these may help you make your decisions.

- What type of reconstruction is best for me? Why?
- What results are realistic for me?
- Will the size of the reconstructed breast match my remaining breast?
- Will I have any feeling in my reconstructed breast?
- What are the risks and possible complications I should know about?
- How much discomfort or pain will I feel?
- How long is the recovery time?
- What do I do if I get swelling in my arm (lymphoedema)?
- How can I meet with other women who have had the same surgery to discuss their experiences?
- Will reconstruction interfere with chemotherapy?
- Will reconstruction interfere with radiotherapy?
- How long will an implant last?
- What kinds of changes to the breast can I expect over time?
- How will ageing affect the reconstructed breast?
- What happens if I gain or lose weight?
- Are there any new reconstruction options that I should know about?

Immediate or delayed reconstruction

- Immediate reconstruction is reconstructive surgery that is done at the same time as the mastectomy when the entire breast is removed leaving the skin envelope. Immediate reconstruction can be offered when the chest tissues have not been damaged by radiotherapy. Immediate reconstruction may also result in one less operation.
- Delayed reconstruction is reconstructive surgery that is undertaken later and may be performed

several years after initial breast Cancer surgery. For some women, this may be advised if radiotherapy is to follow mastectomy. This is because radiotherapy following breast reconstruction can increase complications after surgery. Delayed reconstruction is not offered at QVH for a minimum of 12 months after completion of radiotherapy.

Decisions about reconstructive surgery will depend on many personal factors such as:

- your overall health
- your lifestyle
- the stage of your breast Cancer
- the size of your natural breast
- the amount of tissue available
- the quality of your skin
- your desire to match the appearance of the opposite breast
- your desire for bilateral reconstructive surgery
- the type of procedure
- the size of implant or reconstructed breast.

The decision about the most appropriate type of reconstruction for you is a joint one between you and your surgeon.

Reconstructive surgery using your abdomen

TRAM (Transverse Rectus Abdominis Muscle) flap
The TRAM flap procedure uses your own tissue (autologous) and muscle from the lower abdominal wall. The tissue from this area is often enough to create a comparable breast size and shape to your unaffected breast. The skin, fat, blood vessels (perforator) and all or some abdominal muscle are moved from the abdomen to the chest area. This procedure also results in a tightening of the lower abdomen similar to but not the same as a "tummy tuck".

There are several types of TRAM flaps:

- Free flap MS TRAM (Muscle Sparing Transverse Rectus Abdominis Muscle) means that the surgeon cuts the flap of skin, together with fat, blood vessels and a small cube of abdominal muscle, free from its original location and then attaches the flap to blood vessels in the chest area. This requires the use of a microscope (microsurgery) to connect the tiny vessels and takes longer to finish than a pedicled flap.
- Free TRAM flap – this procedure involves transferring the whole muscle and is very rarely undertaken.
- Pedicle flap (TRAM) involves leaving the flap attached to its original blood supply and tunneling it under the skin to the breast area. Due to advances in surgical techniques, we no longer perform this type of surgery at this hospital.

DIEP (Deep Inferior Epigastric Artery Perforator) flap
This is the most commonly used abdominal flap procedure. It is a more advanced type of abdominal flap, which uses fat and skin from the same area as in the MS TRAM flap, but no muscle. This procedure results in a tightening of the lower abdomen, similar to but not the same as a "tummy tuck". The procedure is carried out as a free-flap, meaning that the tissue is completely detached from the tummy and then moved to the chest area. This requires the use of a microscope (microsurgery) to connect the tiny vessels.

SIEA (Superficial Inferior Epigastric Artery) flap
Is very similar to a DIEP and MS TRAM flap, it involves using fat and skin and a blood vessel that runs above the muscle layer and just under the skin in the lower abdomen.

Both MS TRAM, DIEP and SIEA flap types may involve a small piece of third rib or cartilage being removed to enable access so the tissue can be reconnected, using the microscope, to a blood supply sitting on top of the lung. Sometimes these vessels are found in between the ribs.

The type of reconstruction undertaken is dependent on the position and availability of the blood vessels within the abdomen. A Computerised Tomography Angiogram (CTA) or a Magnetic Resonance Angiogram (MRA) will be carried out before your surgery to give the plastic surgeon a "map" of your blood vessels, enabling them to plan your surgery. This may also involve a blood test to measure your kidney function because a dye is injected into your vein during the CTA/MRA which is excreted by your kidneys. If you have had a Staging CT scan as part of your oncological follow-up, please let the surgeon know as sometimes the vessels can be seen on these scans – avoiding the need for you to have further scans.

Reconstructive surgery using your inner thigh

TUG (Transverse Upper Gracilis) or DUG (Diagonal Upper Gracilis) or LUG (L-shaped Upper Gracilis) flap

The TUG/DUG/LUG flap procedure uses your own tissue (autologous) and muscle (Gracilis) from the inner thigh area. The position of the scar on your thigh is dependent on where you carry the tissue. TUG will leave a scar in the groin crease, LUG will result in an L-shaped scar starting in your groin and extending down the inside of your leg toward your knee, and DUG will result in a diagonal shaped scar from the groin round the inside of your thigh to the back. The skin, fat, blood vessels (perforator) and muscle are completely freed from their original location and attached to blood vessels in the chest area using microsurgery. This procedure results in a tightening of the inner thigh area with scars. Similar to but not the same as a "thigh lift". Scars from this surgery may be visible when wearing underwear / swimwear / shorts / skirts.

This procedure may involve a small piece of third rib or cartilage being removed to enable access to your blood vessels so the tissue can be reconnected, using the microscope, to a blood supply sitting on top of the lung. Sometimes, these vessels are found in between the ribs.

Reconstruction surgery using your back with or without implant

LD (Latissimus Dorsi) flap

The LD flap procedure involves moving tissue from your upper back. The flap is made up of skin, fat, muscle and blood vessels. It is tunneled, with its blood supply attached, under the skin below the armpit to the front of the chest. This can provide added protection for an implant and additional skin following mastectomy. Sometimes, if the breast volume required is small, the muscle and fat alone can create a breast mound without the need for an implant (extended LD).

There are some important factors for you to think about when deciding on LD reconstruction with a breast implant:

- The implants are unlikely to last a lifetime, and you are likely to need additional operations.
- You may experience local complications with breast implants such as rupture, pain, capsular contracture (scar tissue around the implant), infection and a poor cosmetic result. This means that implants may change shape over time and become less attractive.
- Some women experience weakness in their back, shoulders and arm.
- When the muscle is moved from the back to the front, you may experience muscle twitching over the implant.

You will be given an additional leaflet about implants if this is appropriate.

What are the risks and complications of surgery?

All surgery and anaesthesia carry some uncertainty and risks. The following list gives you information on the most common or most significant problems that can occur following these types of surgery.

Anaemia - If you are found to have a low blood count (anaemia) after your operation, a course of iron tablets may be prescribed. After you are discharged from hospital, your GP may repeat the blood test.

Asymmetry - Although every effort will be made to make your breasts equal in size and shape, you may find that there is a difference between the two breasts. This is quite normal, but if you have any concerns or questions please talk to the surgeon. If necessary, revision surgery may be performed to improve the look of your breasts. A degree of asymmetry in all women is normal.

Blood transfusion - It is uncommon to require a blood transfusion after this operation, however, this may occasionally be required. If you have strong views or religious beliefs about this please discuss them with your surgeon before surgery.

Deep vein thrombosis (DVT) – This is a blood clot in the legs and is a potential complication following surgery and bed rest. People who are taking the oral contraceptive pill or hormone replacement therapy (HRT) and those who smoke are at the greatest risk.

Occasionally, a clot can break off and pass to the lungs, known as a pulmonary embolus (PE). All patients are given compression socks to wear to try to prevent this problem. Pre-operative assessment will also result in the need for blood thinning injections to reduce this risk. During the first 24 hours following surgery you will also wear "flotron" boots that massage your calves while you are less mobile.

You will be encouraged to mobilise the first day after surgery.

Taking Tamoxifen may increase the risk of DVT/PE. If you have been prescribed Tamoxifen and are having an MS TRAM, DIEP or TUG/DUG/LUG flap you will be asked to stop taking it two weeks before surgery and start taking it again no sooner than two weeks after surgery. This will not affect your oncological (cancer) treatment.

Patients having MS TRAM, DIEP and TUG/DUG/LUG (but not LD) will go home with blood thinning injections to self-administer into your thigh or abdomen for 7 days post-discharge. You will be taught how to give yourself the injections whilst you are an inpatient on the ward. We will also ask you to wear your compression stockings for three weeks after the operation.

Flap failure – There is a small chance that the flap or part of the flap may die. If its blood supply is insufficient, there is an approximate risk of 1% failure rate. This is rare and is most likely to happen within the first 24-48 hours post-operatively. If this does occur, you will need

another operation to remove the affected area. Your surgeon will also discuss other available reconstruction options with you. Occasionally, it is possible to save the flap. If the problem with the blood supply can be rectified, you will usually need a further operation

Fat necrosis – This is an uncommon, benign condition where fat cells within the breast may become damaged/die and delay wound healing. It is usually painless and the body repairs the tissue over a period of weeks or months. Occasionally, the fatty tissue swells and may become painful. The fat cells may die and form a collection of greasy fluid, which drains to the skin surface. The remaining tissue may become hard. In severe cases the skin may die. It is uncommon to require further surgery.

Haematoma – This is a collection of blood underneath the skin that may occur after surgery. The breast may become painful and swollen. You may need a second operation to remove the haematoma.

Infection - A wound infection can occur after any surgical procedure. If this happens, it may be treated with antibiotics and, if necessary, further dressings. In severe cases, a further operation is required to wash out the infected wound. After an infection the scars may not be quite as neat. Any major operation with a general anaesthetic carries a small risk of a chest infection, particularly among people who smoke.

Seroma – Sometimes, serous fluid will collect behind the breast, abdomen, back or thigh wound after the drains are removed. Usually, this is only a small amount and the body gradually reabsorbs the fluid over a period of a few weeks. Occasionally, a larger amount of fluid collects. This can be drained in the outpatient department and may need to be done on several occasions.

Scars - Any operation will leave a permanent scar. Infection can cause a wound to re-open which can lead to problems with scar formation such as stretching or thickening. At first, even without any healing problem, the scar will look red, slightly lumpy and raised. Regular massage of the scar using a light non-perfumed moisturising cream and using sensible sun protection measures, such as a factor 30+ sunblock, should help it to settle and begin to fade. This may take up to two years. Some people may be prone to the development of keloid or hypertrophic scars that are raised, itchy and red. If you have a tendency to produce scars like these, please discuss this with the surgeon. In the majority of cases, scars settle to become less noticeable. Occasionally, revision surgery may be performed to improve the appearance of scars.

Wound breakdown – Wound healing may sometimes be delayed. This may be because of tension on the wound, poor blood supply to the area, poor nutritional status and/or infection. Occasionally, the wound may break down, resulting in a longer hospital stay, increased hospital visits to have the wound(s) assessed and, possibly, further surgery. Smoking increases the risk of this as it can have an adverse effect on the healing of all surgical wounds. Eating a healthy diet rich in protein and iron promotes good wound healing. If you have been trying to lose weight, you may wish to take a vitamin or mineral supplement in addition to following a healthy diet, but we advise you to take no more than your recommended daily amount.

Other important factors to consider

Body image - The majority of patients are pleased with the results of their surgery. Occasionally, women feel very anxious about their treatment or have difficulty coming to terms with their new look either because their breasts are not as they had imagined they would be or as a result of a complication. If you feel very anxious, worried about your treatment or depressed please speak to the breast reconstruction nurses for more information about the psychological therapy service available.

Intimacy - Initially, your breasts and abdomen, inner thigh or back will feel tender and you may not feel up to intimate physical contact. However, you may resume being intimate as soon as you feel comfortable. Patients having the TUG/DUG/LUG flap may be unable to externally rotate their legs comfortably until four to six weeks after the operation.

Breast reconstruction restores the shape of the breasts but cannot restore your normal breast sensation. With time, the skin on the reconstructed breast can become more sensitive but you may not feel the same kind of pleasure as before a mastectomy.

Some women are concerned that their partner hesitates to touch them and this makes them feel less attractive. The most likely reason for this is that their partner is afraid of hurting them. Couples are encouraged to talk about their fears and feelings.

Sport - Some sport can be resumed within six to eight weeks, but we suggest that you check with your surgeon or breast reconstruction nurse first. If the sport involves strenuous upper body movements, for example aerobics, golf, swimming and any racquet sports, then it is advisable to return gradually to these activities and ensure you wear a supportive sports bra during the activity.

Self-isolation - you may need to follow a strict self-isolation period before your operation at QVH. This will be explained to you in the lead up to your surgery.

Wound healing - Surgeons may suggest you delay having the operation for one reason or another. This may happen if you smoke or have other health conditions. Many surgeons require you to stop smoking and all nicotine replacement products before reconstructive surgery to allow for better healing.

There is evidence to show that an increase in body mass index (BMI) has a negative effect on wound healing. Surgeons will ask that your BMI falls between a healthy range and does not exceed 35. This is to reduce the chance of a complication arising. Your surgeon may ask you to lose weight before agreeing to operate in order to achieve the best long-term results.

Clinical research shows patients undertaking a delayed reconstruction are more emotionally accepting than those having immediate reconstruction. If you find it difficult to take a decision on immediate or delayed reconstruction, a tissue expander may be used during the mastectomy to preserve breast skin. The surgeon may recommend surgery to re-shape the remaining breast to match the reconstructed breast. This could include reducing or enlarging the size of the breast or lifting the breast at a later stage.

Common effects following breast reconstruction surgery

You may experience one or some of these common effects after breast reconstruction surgery:

All types of reconstruction
- Areas of specific discomfort where the new breast mound is sutured to chest wall
- Dissolving sutures working to the surface of the skin
- Feeling of heaviness/fullness to the reconstructed breast
- Numbness or lack of sensation to the reconstructed breast
- Feeling of bulkiness under the armpit to your reconstructed side
- Red lumpy scars during the healing process
- Difficulty in getting bras to fit for the duration of your reconstruction journey.

DIEP/MS TRAM/SIEA, TUG, LUG & DUG flap reconstructions
- Some discomfort to the ribs above the reconstructed breast
- Tingling, electric shock or warm sensations in your chest (less common) as the newly connected blood vessels are healing.

DIEP/MS TRAM/SIEA flap reconstructions only
- Numbness or a loss of sensation to the incision line and the area directly below the belly button
- Tightness/hardness to the abdomen
- Stepped appearance of abdomen scar.

TUG/DUG/LUG flap reconstruction only
- Wound healing issues to the inner thigh.

What if I'm a smoker?

Smoking can reduce the blood flow to surgical sites. Studies have shown that nicotine and other substances found in cigarettes can be harmful to your heart, lungs and skin. Smoking can affect the healing of all surgical wounds and cause infection. The same applies to the use of nicotine replacement therapy as, although this reduces the craving for a cigarette, the nicotine reduces the ability of the blood to carry enough oxygen to the tissues. For this reason, we request you to stop using any nicotine replacement therapies and smoking completely before any, surgery is considered.
If you are an active smoker, we will be happy to advise you on how to get help in stopping smoking. We have a Tobacco Dependency Advisor here at QVH and can refer you to their services if you wish. Surgery will not be considered if you smoke / use nicotine products.

You can get advice here:

- www.nhs.uk/smokefree
- Tel: 0300 123 1044 (free)
- www.qvh.nhs.uk/for-patients/help-to-stop-smoking

The hospital has a smoke-free site, which means that smoking is not permitted in any buildings or in the grounds.

Emotional response

An admission to hospital can be an anxiety-provoking experience. You are in a different environment away from family and friends. You are not in control of your daily routine, e.g. meal times and visiting times. After surgery, you may experience some pain and discomfort, anxiety about the result or "post-surgery blues". These are normal reactions. However, if you find they are causing you concern, please speak to the nursing staff. They can arrange for a member of the psychological therapies team to meet with you and discuss how best to manage your anxieties.

What arrangements do I need to make?

The hospital stay is usually between two and four days. You will be discharged as soon as you are clinically fit to go home. It may be necessary to organise between six to 12 weeks off work and you may need to consider a phased return to work if you have a physical job.

You should only consider driving when sufficient healing has taken place to allow you to wear a seatbelt without pain and you are able to perform an emergency stop (practice in a car park first). Before you begin to drive again after surgery, we suggest that you check with your insurance company to ensure that you have the appropriate cover. Make sure you take note of the date and the name of the person you speak to. Some companies ban driving for a specific period following surgery. Failure to comply with that condition would mean that you are driving without insurance, which the law regards as a serious offence.

If you are taking the oral contraceptive pill or hormone replacement therapies, do not stop taking this medication without seeking medical advice. Talk to your GP or visit your local family planning clinic. You will need to bring a list of any medicines that you are currently taking (prescribed, over the counter, vitamin/mineral supplements or herbal remedies) to your outpatient appointments, pre-assessment appointment and on admission to the hospital. If you can, please bring the medication itself in its original box.

Pre-assessment clinic

All patients are seen in the pre-assessment clinic before surgery. You will receive a telephone call and/or a letter giving the date and time of your appointment or you may be sent directly from clinic after seeing the plastic surgeon.

The pre-assessment can include:

- Discussing your current medication, any allergies you may have and information on your planned treatment and about the hospital services.
- Assessing your general health and fitness before surgery by carrying out various tests and investigations, including blood tests and an ECG (electrocardiogram or heart tracing).
- Photographs may be taken to provide a record for your notes. Allow plenty of time as these procedures may take a few hours to complete. If you have any further questions, write them down and discuss them with the doctors and nurses.

- You will be advised to stop taking Tamoxifen 3-4 weeks before surgery. You will be able to restart this 2 weeks after surgery.

It is important that you are completely satisfied that you have been given all the information you need and that you fully understand the risks and benefits of your surgery before you sign your consent form. You can change your mind at any time before surgery.

Before the operation

Any valuables are brought into hospital at your own risk.

For your safety, it is important that you remove all make-up and finger and toenail varnish (including nail acrylics/false nails) before surgery. Mascara can cause corneal (eye) abrasions whilst you are under anaesthetic and foundation and nail polish/false nails can interfere with oxygen monitoring. All jewelry, including wedding rings and piercings should be removed before admission. Hair accessories, including clips, bands and extensions should also be removed before surgery. If in doubt, please discuss with your surgeon or nurse.

Please take care not to wash off any surgical markings until after your surgery. We advise you not to use any deodorant or lotions on the day of surgery.

For patients having the DIEP or TUG/DUG/LUG reconstruction it may be necessary during your procedure for hair close to your bikini line and lower abdomen to be shaved for hygiene purposes as it is close to the donor-site and wound drains may be placed here. You may want to consider your own hair removal prior to admission.

We may give you a foil blanket to wrap around you before you go to theatre. Our anaesthetists have requested this to ensure that your body temperature is maintained.
Please bring a dressing gown and slippers as you may be asked to walk to theatres before your operation.

After the operation

All the procedures described in this booklet usually mean you will be away from the ward for a considerable period (often for most of the day). Your surgeon or nurse can advise you on this as the timing will vary depending on the type of surgery performed. When you wake up after the surgery, you will be in the recovery area where you will stay until the nursing staff feel you are able to return to the ward.

The recovery team are very experienced and they will ensure that your recovery is as comfortable as possible. After review by the team you will return to the ward to the enhanced recovery area (ERA). This is a high-dependency unit attached to the ward where you will be monitored closely overnight to observe your newly reconstructed breast.

The nurses will look at and touch your flap (new breast) every half an hour for the first night to monitor the warmth, colour, sensation, tightness and blood flow. At first, it is important to keep your new breast warm. You may have a heated blanket over your body to keep you warm.

Wound drains are usually inserted into the breast and donor site at the time of surgery to allow any fluid collecting to drain away. The drainage tube is attached to a vacuum bottle where the fluid is measured. The nurses will remove them on the doctor's instruction, usually two to four days later, depending on the amount and colour of the fluid drained. Following removal, a small amount of leakage from the wound is not unusual and a light gauze pad can absorb this. A wound dressing will be in place and changed according to daily assessment by the doctors and nurses.

You will usually have an indwelling urinary catheter, which will be removed the day after surgery, or once you are more mobile.

You may have a PCA (patient-controlled analgesia) pump inserted into a vein that will allow you to self-administer painkilling medicine. You will not be able to overdose on this as it locks after each dose for a controlled period.

Your blood pressure and blood oxygen levels will be monitored regularly.

You will wear "flotron boots" that massage your calves overnight to help prevent DVT.

You may have intravenous (IV) fluids to hydrate you after your operation.

The physiotherapists will visit you the day after surgery and give you an information sheet so that you will be able to follow some gentle exercises.

As you start to walk around more, you will be able to use the bathroom on the ward to have a shower. The nursing staff will be able to advise you depending on the type of dressing used and how you are feeling and give assistance where necessary.

What support garments will I need after surgery?

Support garments are required for patients undergoing all types of breast reconstruction surgery. You will need to buy a supportive, non-wired bra. A breastfeeding/nursing bra, sports-type bra or post-surgery bra is perfectly acceptable. It should be worn for six weeks for 23 hours a day (including night time) and should be taken off for showering/washing only. This is to help support the underlying tissue and suture (stitch) lines while healing and prevent build-up of seroma. It is important that the wound dressings are completely dried after showering and before dressing.

The ward nurses will help you into your bra and make sure it is comfortable for you. We suggest bringing in bra extenders that help loosen the bra to allow for post-operative swelling and drainage tubes.

After surgery there will be swelling, your reconstructed breast may seem high, and firm which may feel unnatural. However, after a while the swelling will reduce, you will become more comfortable and your breasts will begin to look more natural. After a settling in period, it is advisable to have your breasts measured to determine what new bra size you may need. The settling in period can vary from patient to patient.

If you have had the **MS TRAM/DIEP** procedure, you will need to buy medium support body-shaper knickers to support your abdomen. Make sure they extend up to just under your bra and do not cut across your umbilicus (tummy button). This is to prevent them rolling down and to provide compression to your abdomen to prevent fluid collecting.

If you have had a **TUG/DUG/LUG** procedure, you will need to buy medium support body-shaper or cycling short-style knickers or stretchy cycling shorts from a sports shop to support your inner thigh following surgery. The breast reconstruction clinical nurse specialists (CNS) can advise you where to purchase these.

Going home

Ward staff can provide you with a fit note (previously known as sick certificate). When the decision is made for you to be discharged, please notify the doctor or nurse during the ward round if you need one.

You should make sure you have a supply of paracetamol and ibuprofen at home (if you are able to take them and have not been told not to take them). You may also be given some stronger oral analgesia when you are discharged. It is important that you take pain relief on a regular basis for the first week after you have been discharged.

You will be given instructions regarding an appointment for review of your wounds to check the healing; this will be in plastic dressings clinic around a week after discharge. You will also receive a follow up appointment with the surgical team 6-8 weeks after your discharge, with either a surgeon or a breast reconstruction CNS. Please be aware that this may not necessarily be with your consultant and could be with another member of the team.

If we have performed the mastectomy at the time of reconstruction, you should have an appointment with your referring hospital approximately two to three weeks after your discharge. This is when you will be given the results of the mastectomy.

Make sure you set some time aside during the day for yourself; this will enable you to rest your mind as well as your body. If you are struggling emotionally after surgery, please contact your breast reconstruction nurse specialist for support.

You should continue to undergo regular mammograms (a type of x-ray of the breast) on the non-reconstructed breast. If you have had a tissue flap reconstruction, you do not need a mammogram of that reconstructed breast but should continue with screening of the other breast. You should also continue with routine oncology follow-up that would be arranged for you by your breast surgeon and oncologist.

What should I look out for?

Once you have gone home after surgery, it is important to check your wounds. If they become red, hot, swollen and painful or you notice a discharge, please contact either the Macmillan breast reconstruction nurse specialists or the ward.

You can upload photos of wounds if you have concerns and the breast reconstruction nurse specialists will triage them for you.

Questions or concerns

If you need any further information or you are concerned about any of the issues raised in this booklet, please talk to the surgeon at your outpatient appointment. Alternatively, you can contact the Macmillan Breast Reconstruction Clinical Nurse Specialists (CNS) who are available if you have any concerns before, during or after your stay.

Macmillan Breast Reconstruction Nurse Specialists
Tel: 01342 414302 (answer machine available)
Email: qvh.breastcare@nhs.net

Photo portal onlineservices.qvh.nhs.uk

Canadian Wing
Margaret Duncombe Ward Tel: 01342 414450
Ross Tilley Ward Tel: 01342 414451

If you'd like to find out how you can support QVH, please visit www.supportqvh.org