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Explant consult questions

This is a set of questions that Dr Sandercoe sees on a regular basis when consulting with explant patients. He felt it was a better use of everyone's time that the questions were answered and posted online for patients.

1. **ARE YOU A BOARD CERTIFIED PLASTIC SURGEON?**

This initial question indicates that this list was generated in the USA. In Australia, the equivalent question is "Are you a Specialist Plastic Surgeon?" Dr Gavin Sandercoe is a fully qualified Specialist Plastic Surgeon. He holds a Fellowship from the Royal Australasian College of Surgeons (FRACS) in Plastic & Reconstructive Surgery. At the time of writing this page, he is the current Head of Department of Plastic Surgery at Norwest Hospital & the past Head of Department at Liverpool Hospital. He is the main Plastic Surgeon providing Breast Reconstruction to the Breast Cancer Unit at Liverpool Hospital.

2. **DO YOU HAVE HOSPITAL PRIVILEGES?**

Dr Gavin Sandercoe has current hospital privileges at Norwest Private Hospital and Liverpool Public Hospital. He has had held accreditation at Castle Hill Day Surgery, Hunters Hill Private and the Sydney Adventist Hospital Wahroonga. Patient demand for procedures at these other hospitals was so low that Dr Sandercoe relinquished his accreditation at these hospitals so that other surgeons could utilise the available operating time.

3. **IS THE SURGICAL FACILITY ACCREDITED?**

Dr Gavin Sandercoe currently performs all of his private operating at Norwest Hospital. This hospital is fully accredited by the Australian Council of Health Care Standards. He does not perform, and never has performed, any operating at unaccredited day surgery facilities. Dr Sandercoe does perform procedures that can be safely managed under local anaesthetic in his rooms, as per NSW Dept Health Guidelines. If using any sedation for very stimulating procedures (such as laser resurfacing or croton oil peels), he always has a specialist anaesthetist managing the sedation. Patient safety is always his primary concern.

4. **DOES YOUR SURGEON PERFORM EN-BLOC CAPSULECTOMIES?**

Dr Gavin Sandercoe performs many en-bloc capsulectomies every year. Not every patient wishes for an en-bloc capsulectomy, as it requires a longer scar than is used to put the implants in. Abnormal capsules, or those that have capsular contracture, are often the easiest to remove en–bloc. Normal capsules (thin & filmy) are more difficult to remove en-bloc, and the limitations of this procedure are discussed **here**.

The procedure can take anywhere between 2-4 hours depending on the thickness of the capsule (thicker, contracted capsules are faster), plane of the implant (in front of the muscle is faster), any existing silicone leak that requires removal, muscles that require repair.

5. **WILL YOUR TISSUE BE TESTED FOR BIA-ALCL?**

All capsules are sent to the pathologist for testing. If you have top-level private health fund coverage, this pathology is often covered by the health fund. If you are not insured, you can ask our staff for the contact details of the pathology lab that we use for a quote on their services for histopathology +/- immunohistochemistry. The pathologist that Dr Sandercoe uses is widely used by Specialist Plastic Surgeons in Sydney and has an interest in BIA-ALCL.

If there are visible lymphocytes (white blood cells) in the histology stain, the capsule will automatically be tested for CD-30 as well as the other immunohistochemistry stains that are positive in BIA-ALCL. If there are no lymphocytes visible, it is at the discretion of the pathologist to perform CD30 testing (even if Dr Sandercoe requests it). Performing a CD30 test on a sample that has no visible lymphocytes cannot return a positive result – it is like looking for a shark in the desert.

All implants have a small amount (5-10cc) of fluid around them. Pathology testing requires a minimum of 10cc for a definite positive test, and 20cc is better. It is very rare to see BIA-ALCL with any less than 50cc of fluid.

Although BIA-ALCL is being recognised more often, it is still a rare disease. Most countries do not require the breast implant manufacturers or wholesalers to report their sales figures. Through co-operation with the Federal Dept of Health, the Australian Society of Plastic Surgeons does have accurate sales data for the major brands of breast implants. The most aggressively textured implants have a risk of about 1/4000, micro textured implants are around 1/6000 to 1/8000. Patients that have only ever had smooth implants have never been reported to have BIA-ALCL (worldwide).

There is some geographical component to BIA-ALCL. There seems to be some geographic clusters within Australia & New Zealand that are out of proportion to implant sales. Recently the Canadian Health Department reported 5 cases of BIA-ALCL in the last decade, or 1 case per 77, 190 implants. Based on this data, BIA-ALCL is much rarer in Canada than Australia. Surgeons do not have a reason for this yet.

6. Is there a confidentiality agreement?

At this stage there is no confidentiality agreement.

All surgical quotations have been individually tailored based on the predicted operating time. A patient with Grade 3 capsular contracture in subglandular implants that is happy for a longer scar will take substantially less operating time than a patient with clinically normal (Baker Grade 1) capsules around a polyurethane submuscular implant with muscular problems that will require repair. We explain this to patients during their initial consultation. Sharing of quotes can lead to patients expecting a similar fee, despite having very different surgical circumstances.

As breast tissue takes around 3 months to settle after an explant, we also encourage patients to wait those 3 months before sharing their patient experience. Your first two follow up appointments will be mostly with Dr Gavin Sandercoe's nurse, and your 3 month appointment is with Dr Gavin Sandercoe. At this appointment, he will take post op photos and release all of your photos to you in a single batch.

Please consider the potential effects of sharing information that is incomplete or may not be applicable to the reader.

7. What kind of anaesthetic?

Dr Gavin Sandercoe performs all of his explants under general anaesthetic. General anaesthesia should only be administered by a fully qualified Specialist Anaesthetist. If you have any concerns about prior anaesthetics or any health concerns, you should discuss this with the anaesthetist directly – they will call you a few days before your operation for this reason. If there are reasons that the anaesthetist should call you with a greater lead time, Dr Gavin Sandercoe will facilitate this. Dr Gavin Sandercoe works primarily with two Specialist Anaesthetists – one works on Wednesdays, the other on Thursdays. Both

anaesthetists work with multiple plastic surgeons and have worked in CareFlight medical retrieval. Nitrous oxide is an uncommon gas to use for routine general anaesthesia in Australia.

8. Will you receive antibiotics? Anti-nausea drugs? Steroids?

Routine surgical care in Australia includes administration of a minimum of 1 intravenous dose of antibiotics on induction of anaesthetics. Dr Gavin Sandercoe prefers that patients stay on oral antibiotics whilst drains are still in to prevent drain site infections. Oral antibiotics during recovery and to protect drain sites is negotiable if patients have medical issues.

Patients are given anti-nausea drugs during their anaesthetic. If you have had issues with post operative nausea and vomiting, please discuss this with your anaesthetist as they may have some ideas for modifying which anti-nausea drugs you receive or changing your anaesthetic to minimise your risk.

Steroids are not routinely used by Dr Gavin Sandercoe or his team. Steroids have a role in reducing swelling, but also increase infection risk. They are not considered a routine medication for any breast surgery. Steroids can be used to treat nausea with good effect.

9. Will the surgeon use cautery? Are any foreign materials used in reconstruction?

Mono-polar cautery is the standard of care in Australian surgery, and is used for cutting as well as stopping bleeding. At the end of an explant procedure, Dr Gavin Sandercoe washes out the cavity with saline and double checks that the walls have stopped bleeding. He is currently trialling a natural product that helps prevent oozing after the procedure, which should minimise the time that the drains are in.

All of the sutures used in your reconstruction are dissolvable. The sutures closest to the skin should dissolve in about 90 days, and the deeper sutures (those used in muscle and breast gland/fascia repair) take about 6 months to completely dissolve. There are no permanent staples, meshes or silicone products used.

10. Which pain-killers are provided and how will they affect you?

Dr Gavin Sandercoe and his anaesthetists use a wide variety of pain killers, and tailor the drugs and combinations to each patient. Explants for above the muscle implants are generally much less painful than under the muscle implants

For patients that are staying overnight, they might be given a PCA (patient controlled analgesia) or pain button for 24 hours.

Discharge medications are usually a combination of three types of drugs and possibly more if required! Each drug has it's own risks and side effects. When drugs are being used in combination, the risks are best to be discussed with your Specialist Anaesthetist.

The drug/s that most commonly have side effects are the opiates (heaviest pain killers) such as Endone. Common side effects are drowsiness, nausea, constipation and feeling 'trippy'.

11. Are microbiology swabs taken of the capsules?

Swabs of the capsule can be taken on request. With a complete or en-bloc capsulectomy, and organisms that might be grown on testing would be completely removed surgically. Costs need to be discussed directly with the lab if you are not insured.

12. What is used to clean out a contaminated pocket?

Dr Gavin Sandercoe uses aqueous chlorhexidine & betadine to clean contaminated pockets. Betadine is the most effective solution for killing micro-organisms, and chlorhexidine is very effective at dissolving any loose silicone gel.

13. What is the surgeon's the lymph node management?

Any palpable lymph nodes are imaged and are managed through consultation with a general surgeon that specialises in breast cancer treatment.

14. Are antifungals prescribed if the implants are colonised with fungi?

Fungal cultures often take about 2 weeks to be performed and reported by the lab, as fungi grow very slowly. A positive culture will require a consultation with an infectious diseases specialist so that patients get the best choice of antifungal. Antifungal drugs can have serious effects on your liver and kidney, and usually require the cessation of all supplements to ensure that you do not damage your vital organs.

15. Does the surgeon take photos of the procedure?

Photos are taken of the procedure and are released to the patient after the patient has signed a photo release form. Dr Gavin Sandercoe prefers that all photos are released in one single file at the 3 month post operative follow up appointment, so that a complete picture file is released to the patient, and anyone that they wish to share their photos with.

16. Does your surgeon release your files?

Our usual first follow up is at around 1 week, to look for early stages of infection. At this stage, pathology is not always ready. The final follow up is at 3 months post operatively, and Dr Gavin Sandercoe will discuss your pathology and physical results at that stage. You will be asked for permission to write back to your General Practitioner and asked to sign a photo release form. All requested files are released at this stage, but they can be released earlier with discussion.

17. Are your implants returned to you?

NSW law states that your breast implants are yours by rights of purchase, but that the surgeon and hospital need to return them to you "adequately decontaminated". This term leads to some variability between what different hospitals will allow. Liverpool Hospital does not allow the return of implants to patients. Its policy is that breast implants cannot be adequately decontaminated, as they are not designed to be resterilised. On Dr Gavin Sandercoe's request, Norwest Hospital clarified its policy in November 2017 – implants can be returned, but they need to be decontaminated with betadine before being returned.

18. Will you have drains?

All breast explant surgery requires a drain to minimise complications. Dr Gavin Sandercoe prefers to use Blakes drains as patients report that these are the most comfortable to manage, and to have removed. Drains are removed when they deliver less than 20ml/day for 2 consecutive days. This is usually around the 1 week post-operative mark. We use an antiseptic patch around the drain site and an occlusive dressing to minimise the risk of drain site infection. Your drains are usually removed by Dr Gavin Sandercoe's nurse.

19. What are the complications after a breast explant procedure?

Complications after explant surgery are uncommon. The most common complications are infection, seroma and haematoma.

A seroma is a collection of fluid in a cavity, and a haematoma is a collection of blood within a cavity. Dr Gavin Sandercoe uses surgical drains to prevent these complications. A late seroma will present with a new swelling of the breast, which can become painful over time and with enough volume. A haematoma presents a similar way, but with bruising as well as it is due to internal bleeding. Dizziness can be an accompanying symptom. Dr Gavin Sandercoe has had patients have haematomas as late as 1 month after breast surgery – sometimes from a bump, other times there was no inciting event that the patient noted.

Infection normally presents within the first 7 days after an operation. This is the reason that patients receive intravenous antibiotics as they are put to sleep, and Dr Gavin Sandercoe encourages patients to take antibiotics whilst their drains are in. The signs are redness, swelling and tenderness. Very rarely, surgeons have patients that are on antibiotics that develop an infection that is resistant to the prophylactic antibiotics, and this needs a change of antibiotics.

20. Will your private health insurance cover your explant?

If your health insurance covers item number (Medicare code) 45551, your health fund will cover your theatre and any accommodation fees. There will be a gap in the surgeon's fees. In Australia, it is very rare to need letters to the insurance company to get coverage, but Dr Gavin Sandercoe and his team will happily provide any correspondence to the insurance companies as needed.

21. Is there a deposit required and what happens if you have to cancel or postpone?

From the beginning of 2018, our payment policy is as follows. Securing a date requires a 25% deposit. Full payment for the procedure is required 14 days prior to the operation to both the surgeon and anaesthetist. Postponing for medical reasons does not incur any penalties.

22. What are the directions for avoiding supplements & medications pre-operatively?

At least 2 weeks prior to your procedure, please cease all supplements that have not been prescribed by a specialist or general practitioner. Many herbs and compounds can have impacts on bleeding and surgical wound healing. It is ok to restart these supplements a week after the operation, once your sutures and drains have been removed.

Any medications that are prescribed by your GP or other specialist should be discussed with Dr Gavin Sandercoe and your anaesthetist. Most medications will be ok to continue up until the day of the procedure, but you will be informed if any should be ceased further ahead. For instance, the oral contraceptive pill increases your risk of blood clots in your legs (DVTs), and ideally should be ceased for a full menstrual cycle leading into the procedure.

23. What are the post operative directions?

Patients wake up with a binder compressing their breasts onto their chest wall and a drain in each side. The dressing is usually Prineo – a surgical tape that we glue onto the skin. It is semi-transparent and waterproof. Once the drains have been removed, patients can shower normally. Patients will heal fastest if they keep compression on their chest as much as possible for a month. There are plenty of good options for compression – a firm sports bra with a front zipper is also a good option (in 2017, patients were reporting that they were finding a good bra in Lorna Jane). You can sleep in any way that you feel comfortable – sleeping raised on pillows might help with swelling a small amount, but this will be offset by increasing your corticosteroid levels if you have poor sleep.

If you have problems post operatively, your initial point of contact should be calling the rooms during business hours. The staff can answer many of your questions, and will contact Dr Gavin Sandercoe for any questions that they cannot answer. Surgical emergencies after hours should go to your nearest

emergency department (whom will call Dr Gavin Sandercoe after a medical assessment) or to Norwest Hospital Emergency Department.

24. How long will it take for your breast to heal and feel normal?

The last of the swelling is usually gone at 3-4 weeks. If you have had a muscle repair, you will be asked to minimise the use of those muscles for about 8 weeks to ensure that the repair has had time to heal and become tough enough to cope with muscle use. The breast shape stabilises at about 3 months, which is why Dr Gavin Sandercoe encourages discussions about reconstruction (lift +/- fat transfer) until this time.

25. What is the follow up schedule?

Patients are usually reviewed at 1 week, 3-4 weeks and 3 months. Further follow up is determined based on patient wishes for reconstruction. The 1 week appointment is to review the wound for any signs of infection, check and possibly remove the drains, check on how the patient is going with pain control and compression. The 3-4 week appointment is to discuss scar management, massaging, weaning of compression, return to exercise. The 3 month appointment is to review the final shape and volume of the breast, and check if the patient wants to proceed with any reconstructive procedures.