



DR GAVIN SANDERCOE
plastic & cosmetic surgeon

AHPRA Registration MED0001182300, Specialist: Surgery, Plastic Surgery
Norwest Plastic & Cosmetic Surgery ABN 14 132 351 387
Suite 108, Level 1, 10 Norbrik Drive Bella Vista NSW 2153 | PO Box 8210, Baulkham Hills BC NSW 2153
p. 1300 112 358 | f. 02 8824 3877 | e. info@drgavinsandercoe.com.au | w. www.drgavinsandercoe.com.au



Breast Augmentation Consent Form

GENERAL RISKS	2
POST OPERATIVE PNEUMONIA AND AREAS OF LUNG COLLAPSE	2
DEEP VENOUS THROMBOSIS AND PULMONARY EMBOLISM	2
STROKE, HEART ATTACK	2
ALLERGIES	2
AWARENESS	2
DEATH	3
SPECIFIC RISKS – INTRAOPERATIVE	3
BLEEDING	3
DAMAGE TO DEEPER STRUCTURES.....	3
SPECIFIC RISKS – SHORT TERM	3
BLEEDING	3
INFECTION.....	3
SENSATION CHANGE.....	3
HAEMATOMA AND SEROMA	3
FIRMNESS	4
DELAYED HEALING & TISSUE DEATH	4
EXPOSED SUTURES	4
DRESSINGS.....	4
SPECIFIC RISKS – LONG TERM	4
ASYMMETRY.....	4
SCARS	4
BREAST CANCER RISK.....	4
BREAST FEEDING	5
CHANGES IN SIZE AND SHAPE.....	5
UNSATISFACTORY RESULT	5
RISKS RELATED TO IMPLANTS	5
IMPLANT FAILURE	5
IMPLANT INFECTIONS.....	5
IMPLANT DISPLACEMENT AND TISSUE DISPLACEMENT	6
CAPSULAR CONTRACTURE	6
CALCIFICATION.....	6
IMPLANT EXTRUSION	6
SKIN WRINKLING AND RIPPLING	6
SILICONE GEL BLEED	7
CHEST WALL IRREGULARITIES	7
DOW-CORNING SILICONE CONTROVERSY	7
BIA-ALCL.....	7

General Risks

All operations have some inherent risk due to the administration of drugs and the induction of sedation or anaesthesia.

Risks that are involved in having an operation include (but are not limited to):-

Post operative pneumonia and areas of lung collapse

When you are asleep, or anaesthetised, you breathe more shallowly than normal. This can allow some areas of your lungs to partially collapse. If these areas are not inflated again soon after you wake up, this can lead to a pneumonia or lung infection. Smokers are at a higher risk than non smokers as the waste products from cigarette smoke clog the airways and damage the airway lining cells, which prevents them from cleaning out the usual mucous secretions. Our anaesthetists carefully monitor how deeply you are breathing during the operation to prevent this from occurring. This is one of the reasons that we insist that all smokers abstain from smoking for 6 weeks prior to an elective operation.

Deep venous thrombosis and pulmonary embolism

This gained notoriety as “Economy Class Syndrome” but the medical profession has been aware of this for decades. Your legs rely on gentle constant muscle activity to propel blood back towards the heart. If the blood stays stagnant it can clot in the leg veins, and then later dislodge and end up in your lungs. Whilst you are asleep, you generally move around enough to keep the blood moving, but whilst you are anaesthetised, your legs do not move at all. So we put compression stockings on most patients (to collapse the veins) and all patients have Sequential Compression Devices put on their legs (to massage the blood back to the heart, and the intermittent compression on the veins releases a natural anti-clotting agent). Once you go home from hospital, you should go to the emergency department if you experience irregular heartbeat, shortness of breath or chest pain.

Stroke, Heart Attack

These are very rare complications of general anaesthesia in otherwise fit & healthy patients. Elderly patients, whom are at a greater chance of having these events happening daily, are at a greater risk. If we believe that you are at increased risk of such a complication, we will arrange for you to see our anaesthetists prior to the operation and may arrange additional tests to ensure your safety in the operating room.

Allergies

During your medical history, you will be asked if you are aware of having any drug allergies. This question will be repeated by your anaesthetist prior to the operation. During the administration of any drug there is a small risk of allergy. Reactions can be from mild itchiness to severe anaphylaxis requiring adrenaline. Some allergies can be predicted, but most are random events that are only discovered once they occur. Should an allergy occur during the operation it will be treated immediately, and you will be notified at the end of the operation.

Awareness

This is a favourite topic of TV shows but is exceptionally rare. Increased blood pressure or heart rate will alert anaesthetists that the patient is feeling pain. Nowadays brain wave monitoring will alert anaesthetists that a patient is not completely asleep enough earlier than heart rate and blood pressure will rise.

Death

The risk of death under anaesthesia in Australia is around 1 in 3 million cases for elective procedures in healthy patients. Your level of health before the operation will impact on your personal risk. In general terms, you are more likely to have an accident travelling to and from the hospital than your risk of dying in the hospital.

Specific Risks – Intraoperative

Bleeding

There is always some bleeding with breast augmentation surgery. We aim to minimise this by infiltrating local anaesthetic with adrenaline into the operating site before the operation. It is exceptionally rare for the bleeding to be significant enough to require a blood transfusion (with its attendant risks). However, it is prudent to ensure that your haemoglobin levels are well stocked before the operation by ensuring that you have a diet high in iron and vitamins for about a month prior to the operation. Doing this will mean you are less likely to feel washed out after the operation.

Damage to deeper structures

During any operation there is always a risk of damage to surrounding structures such as nerves, arteries, muscles. Breast augmentation surgery is performed mostly between planes of tissues, like layers in an onion, so the risk of going a layer too deep is quite small. There is a small risk of puncturing the chest wall (pneumothorax) that may require a tube in the chest for a day or two.

Specific Risks – Short Term

Bleeding

There will be a small amount of bleeding or red discharge from your wounds in the first few days after your operation. Large amounts of bleeding should be treated by keeping calm (to lower your heart rate and blood pressure), using ice packs (to shrink the blood vessels), and applying constant gentle pressure to the area. If the bleeding does not stop within 20-30 minutes, you should call the rooms or go to the hospital. Very rarely, bleeding after breast surgery requires a visit back to the operating room to drain the collected blood and control any bleeding vessels.

Infection

Infection is uncommon after elective breast surgery. You will be given antibiotics through the drip during the operation and you will be sent home with tablet antibiotics for a week after the operation. Should an infection develop, it would usually begin at about the 5th to 7th post operative day (around about the time that you are due to see us for removal of sutures and dressings). If you notice increasing pain, swelling and redness of the area that was operated on, please call the office or the hospital.

Sensation change

Changes in sensation to the nipple and breast are impossible to predict. Most women have a temporary decrease in sensation that returns to normal within a few weeks. It is uncommon to have long term numbness, although pre-existing decreased nipple sensation may be an indicator this may happen. Implants that are placed in front of the muscle have a higher rate of permanent breast numbness.

Haematoma and Seroma

Any operation in which there is a large surface area that is operated on runs the risk of having blood or fluid collect in the space left behind as it heals. We place surgical drains to prevent these collections of fluid, but they will occasionally arise after the drains have been removed or collect in an area that does not flow to the surgical drain. Should this occur it can be removed either with a needle aspiration in the rooms, or occasionally another drain can be placed under ultrasound guidance.

Firmness

After any operation, as tissues heal there is some swelling and firmness. The majority of this will resolve within 6 weeks, but the last small amounts can take up to a year or so to completely resolve. By the end of a month after your operation, some gentle tissue massage will help speed the recovery of the tissues. You will be advised how and when to perform this massage at your second post-operative follow up appointment. Occasionally there will be patches of fat that has not survived the operation (fat necrosis) that become hard and may need to be removed.

Delayed Healing & Tissue death

The expected time frame of healing is that skin should heal over within a week, and soft tissues around about 6 weeks. Diabetics, smokers and people with some other diseases will have the risk that their tissues will take longer to heal and may have some tissue death before healing. Most of these problems can be managed with appropriate dressings, but you may need additional surgery

Exposed sutures

Many sutures (both permanent and dissolving) that are used to reshape the breast are buried within the soft tissues. Occasionally, these sutures will show themselves through the skin. If they become problematic, they may need to be removed. This is usually something that can be done in the office under local anaesthetic.

Dressings

Dressings need to remain in place until your first post operative check at the office. You should expect that they could become warm and have a small amount of pressure. Occasionally dressings can cause some irritation, and rarely cause allergic reactions. Should the dressings become unbearable or cause increasing redness & swelling, please call the rooms to arrange for them to be changed.

Specific Risks – Long Term

Asymmetry

Small asymmetries should be expected. Under critical appraisal, most women's 'natural' breasts are asymmetric. The more obvious the original asymmetries, the harder it is to produce post operative symmetry. As the swelling subsides over the first 6-12 months, there will be different parts of your operation that you are more or less happy with. You should allow your operation at least 6 months to settle out minor asymmetries. Major asymmetries will be adjusted by your surgeon.

Scars

Depending on your needs, your surgeon will suggest an approach (or incision) that they believe will provide you with the results that you are after. This is not a hard and fast rule and there is some room for discussion as the importance that you place on length and position of scars, as opposed to breast/chest shape and the need for further touch up procedures. It is very rare for there to be problem scars in breast surgery. Please read your scar management sheet for more in-depth information on scars.

Breast Cancer Risk

Current information does not demonstrate an increased risk of breast cancer in women who undergo breast implant surgery for either cosmetic or reconstructive reasons. Some studies suggest an earlier detection of breast cancers in women with implants, which may be due to an increased awareness of breast shape and texture in women who undergo breast implant surgery.

Most cancers occur independently of surgery. Patients with a family history of breast cancer are at a higher risk than those with no family history. It is recommended that all women perform regular self examination and undergo imaging of their breasts.

Breast surgery that involves cutting through breast tissue may potentially interfere with diagnostic procedures to determine the lymph node drainage of breast tissue in cancer staging (sentinel lymph node biopsy).

Mammography is still the imaging method of choice; however special techniques are undertaken to ensure that the radiologists achieve the best view of the breast tissue. Most implant companies recommend screening with MRI every 2 years, as this will also detect problems with the implant that are not visualised on plain X-rays. Implants can be ruptured during mammography.

Breast Feeding

After breast augmentation surgery, your ability to breast feed is the same as the general population. 1 in 3 women will be able to breast feed normally, 1 in 3 will need some help (formula etc), and 1 in 3 will not be able to breast feed. Incisions and approaches that disrupt the nipple, areola or breast tissue may reduce the ability to breast feed.

It is not known if there are increased risks in nursing for a woman with breast implants. There is no increase in silicone levels in breast milk in women with breast implants when compared to women without implants, and in fact cow's milk contains higher levels of elemental silicone than human milk.

Changes in size and shape

As breast augmentation surgery enhances the overlying normal tissues, any weight gain or loss will be reflected in the size and shape of your breasts.

The presence of an implant will change the shape and volume of the overlying breast tissue over time. If the implants need to be removed, this may result in an unacceptable appearance of the breast.

Augmentation with implants that are larger than the suggested base dimensions and volume suggested by your surgeon may increase your chances of implant specific complications. In addition, this may also cause increased stretch on the overlying tissues and changes of breast shape.

Unsatisfactory Result

Your pre-operative consultations should help you realize the objectives and limitations of your operation. If you are unhappy with your result, you should wait for the swelling to settle before making a final judgment. Should the result still not be up to expectation by 6 months, you should discuss the need for further surgery with your surgeon.

Risks Related to Implants

Implant failure

Like most medical devices, implants can fail. This may be due to an injury, during mammography or from no apparent cause. Most of the time there is no warning signs from the body that the implant has ruptured (silent rupture).

Silicone gel filled implants may have a rupture of the outer layer that surrounds the silicone gel. Most of the time, the gel will be contained within the scar tissue surrounding the implant (intracapsular rupture), but it may rarely escape into surrounding tissues (extracapsular rupture), including the breast tissues. The body's reaction to the gel is unpredictable, and removal of all of the migrated gel may be impossible. This may cause delayed firmness in the breast.

The best method of diagnosing implant rupture is with an MRI, although ultrasound can also be helpful.

Implant Infections

Subacute or chronic infections may be difficult to diagnose. Should an infection occur, treatment with antibiotics is begun. Infections in the presence of a breast implant are harder to treat than infections

in normal body tissues. If the infection does not respond to antibiotics, the implant may need to be removed. After the infection is treated, a new implant can usually be reinserted.

Infections in body areas remote to the implant can result in infections around the implant. It is very important that you do not have your breast implants placed during a time that you have remote infections such as ingrown toenails or urinary tract infections. Infections subsequent to your operation may still lead to bacterial seeding around your implant, and you should always have prophylactic antibiotics prior to any operative or dental procedure, and any infection should be treated promptly. Breast and nipple piercing procedures are at a high risk of causing an implant associated infection.

Implant Displacement and tissue displacement

Displacement, rotation or migration of a breast implant may occur after its initial placement, and can be accompanied by discomfort and/or distortion in breast shape. Unusual techniques of implant placement may increase the risk of the implant moving or rotating.

Capsular Contracture

All implants within the body have a thin layer of scar tissue around them (capsule). In breast implants, this capsule can tighten over time and make the breast firm, round and painful. The occurrence of this phenomenon is not predictable – it may occur in one side, both or none at all.

Implants that are placed between the breast and the chest wall muscles, and implants with a smooth surface, have a higher rate of capsular contracture than others. It is expected that the capsular contracture rate increases with the amount of time that an implant is in the body.

As there is an association of low-grade infection with capsular contracture, patients with implants should always make sure that they receive prophylactic antibiotics prior to any surgical or dental procedure, and that even minor infections are treated early.

Treatment of capsular contracture may require surgery, implant removal or replacement. There is a high rate of recurrence even after surgical treatment of this problem.

Mammography in patients with capsular contracture may be painful. The importance of regular breast screening outweighs the discomfort of the procedure and additional X-rays involved. Your radiologist may be able to perform screening via ultrasound or MRI if needed.

Calcification

Calcium deposits can form in the capsule around a breast implant. These may cause pain, firmness and may be visible on mammography. These deposits need to be identified as different from calcium deposits within breast cancer and may require additional surgery to remove and examine these calcifications.

Implant Extrusion

Lack of adequate tissue coverage, tissue necrosis or infection may result in exposure and extrusion of the implant through the skin. Tissue necrosis (death) has been reported with use of steroid drugs, chemotherapy/radiation to breast tissue, smoking or excessive cold or heat therapy. An implant that becomes exposed may need to be removed, and permanent scars & deformities may occur.

Skin Wrinkling and Rippling

Visible and palpable wrinkling of implants and breast skin can occur. A small amount of this is normal and to be expected, but this can be more pronounced in patients with thin overlying tissue or if textured surface implants are chosen. Rippling can be confused with a breast lump, and it should be investigated.

Silicone Gel Bleed

Over time, extremely small amounts of silicone gel and platinum can pass through the shell layer of the implant and coat the outside of the implant. This may contribute to capsular contracture, but the overall body of evidence supports that it is of no clinical consequence.

Chest Wall Irregularities

Chest wall irregularities have been reported secondary to the use of breast implants and tissue expanders. This may improve with time or can be surgically corrected.

Dow-Corning Silicone Controversy

The controversy surrounding silicone breast implants throughout the late 1980s & 1990s has been effectively debunked. After several large epidemiological studies, it has been concluded that there is no substantial link between silicone breast implants and immune or neurological disease.

BIA-ALCL

Breast Implant Associated Anaplastic Large Cell Lymphoma (BIA-ALCL) is a type of rare cancer that can develop in the scar capsule that forms around your breast implants. It is only associated with textured implants and occurs at a rate of about 1 in every 4,000 women (for the highest risk implant texturing). Compared with the risk of breast cancer (1 in every 8-10 Australian women develop breast cancer in their lifetime) and any other type of lymphoma (about 1 in 100 lifetime chance), the risk is relatively small. You will be provided with an information sheet from the Australian Society of Plastic Surgeons with additional information on this rare risk.