

BREAST IMPLANT EXCHANGE

INTRODUCTION

The need to change breast implants has become a fairly common problem in the last few years for 2 main reasons:-

- 1) The distorting effect of encapsulation (scar formation around the implants).
- 2) The rupture of implants or fear of rupture of implants.

Unfortunately, changing implants is not as simple as people would like it to be. Many women think of it as simply changing a spare part like changing the wheel on your car “take out the old ones and put in the new ones,” but unfortunately it isn’t as simple as this.

In many ways it is a far more difficult and complicated procedure than the original operation of breast augmentation. Many private hospitals now charge considerably more for an exchange operation than they do for straight forward breast enlargement. This information sheet helps to try and explain the good and the bad points about this procedure. The background to it all of course comes from the fact that implants don’t last forever and they do cause a significant reaction inside the human body which usually takes the form of increasing scar formation around the implant. This is known as the capsule. There is nothing unsafe about the development of a strong capsular scar around an implant, but it will alter the feel of the breast and in many cases make it feel very hard and it becomes uncomfortable for the patient. The other problem is that it will change the shape of the breast regardless of whether the implant is behind or in front of the pectoral muscle. It is quite possible for an implant to disintegrate and rupture inside a capsule and for there to be no difference in the appearance or the feel of the breast other than the feel/look that one would get with straightforward encapsulation. Therefore if a person has very obvious encapsulation you can’t tell by feeling it whether or not the implant has ruptured inside it. If the capsule is relatively thin, it is possible for a ruptured implant to remain soft but for some of the silicone to migrate through the capsule into the surrounding breast and in a few cases continue to migrate on through the lymphatics to the lymph glands in the arm pit (axilla).

It may prove to be very much more difficult to achieve a normal natural looking and natural feeling pair of breasts after an implant exchange than after the very first operation.

This can give rise to disappointment and the belief by the patient that the Surgeon has done a poor job and isn’t to be trusted. There are a very large number of things which one needs to understand to appreciate why this operation can be difficult and why Surgeons can’t guarantee a good result.

1) The Need to Remove the Capsule Around the Implant

If one leaves the capsule in place and simply puts a new implant in place of the old one then the distorting effect of the capsule will be just the same and the breast will remain hard and distorted. If the capsule is very thin, Surgeons are sometimes tempted to simply divide the capsule in one or two places in order to allow it to stretch a bit this is called capsulotomy, but the problem about this is that cutting of the old capsule often provokes a stronger newer capsule to develop where one has made the cut and so in nearly all cases it is important to do a capsulectomy which means removal of the capsule. Removal of the capsule is technically quite difficult sometimes. It can't be done simply with finger separation between the layers but it usually involves very gentle slow delicate division of all the links between the capsule and the breast which means dividing lots of tiny blood vessels and so there's quite a high risk of bleeding after the operation and in fact it's a greater problem than after the primary augmentation. Removal of the capsule or capsulectomy takes much longer to do than making the space to put the implant in the first instance and so this means more operating time and whereas the standard breast augmentation usually takes between an hour and an hour and a quarter a capsulectomy operation for an exchange of implants make take two hours or sometimes up to three hours. This is why it is often more expensive than the primary operation.

2) Distortion of the Breast from the Capsulation

Encapsulation may well have stretched the skin in one part of the breast and left it slack in another and so the skin and breast tissue and fat has thinned out in one part but remained thicker in another and this tendency may persist after an exchange of implants. It may be quite difficult to get the two breasts to look absolutely the same because of this uneven stretching of the skin.

3) Loss of Feeling

When one removes the capsule one has to divide lots of tiny nerves which are too small to see which run inside the breast tissue over the surface of the capsule. Thus some patients (not all) experience loss of feeling in the skin or of the nipple and areola as a result of having to have an exchange of implants. This can be very upsetting for those women who enjoy sexual stimulation of their breasts.

4) Change of Size of Breasts

A large number of women who elect to have implant exchange want their breast to be made either bigger or smaller. In general, it is easier to put in larger implants than were there before and this can compensate to some degree for looseness of the skin which has occurred over the years, ie it can compensate for some of the sagging that may have occurred, but if the person wants to be made smaller then this is likely to prove cosmetically difficult unless the person is willing to have the skin tightened by cutting out some of the surface skin leaving the breast with visible scarring in a circular manner around the areola and as a vertical line from the areola down to the fold underneath the breast. There may also need to be a transverse scar along the fold under the breast.

This obviously complicates the operation and adds extra time to the operating and carries its own extra risks with the slightly increased potential for infection and wound breakdown. Although these problems are relatively low risk, in terms of their frequency, they can be absolutely devastating if they occur and the patient ends up regretting asking for the operation. The incidence of infection after this type of breast surgery is around 1%, ie one in a hundred, and in about half of these cases it can be brought under control by antibiotics but in the remainder it may end up with a patient having to have the implants removed because until they are removed the infection won't be controlled. The risk of the patient having a significant bleed and having to return to the operating theatre to remove the haematoma is also around 1% to 2%. This is seldom a disaster, but certainly it is a nuisance because the patient may well have to stay in hospital for an extra day and they may end up with quite a lot of bruising and swelling which takes much longer to settle down.

5) Change of Brand or Type of Implant

The process of encapsulation often results in distorted looking breasts with the implant remaining relatively high in the breast and a lot of the breast tissue descending down and flopping below the level of the mound created by the implant. Once one has removed the implant and the capsule around it, it may be sensible to change the shape of the implant to a new type which has its own shape rather than being a simple round flying saucer type shape. There are many different shapes of implant now; there are teardropped shapes which are still round but there are also teardrop with a lozenge shape so the vertical height of the implant is not as great as its width. This can be very helpful in cases where one wants to push the nipple and areola forward and upwards to give a much more natural slope to the upper breast and also to be able to narrow the cleavage which often ends up very wide after tight encapsulation. Thus, you may need to be guided by the Surgeon as to the best kind of implant to have. My own preference is, in nearly all cases, to recommend the use of an implant which has a polyurethane foam surface because although these are much firmer than the average implant for the first three months the long term results are very much better than with other kinds of implant because there is a much lower risk of the patient developing bad capsules again. It is difficult to be absolutely certain about the statistics for this because different statistics are quoted by different firms and different people, but there seems to be a consensus that if you have a standard gel filled textured surface implant there is a chance that you will get a significant and distorting capsule in 15% to 20% of cases within 10 years. The incidence is probably higher in those patients who have already experienced bad encapsulation after their first operation. The incidence of bad encapsulation with the polyurethane foam surface covered implants is much lower than this and is somewhere in the region of two to three percent at ten years. Put it another way you have one fifth of the risk of having recurrent serious encapsulation if you have the polyurethane implants as compared to the standard ones. In my own experience I have had to deal with very few patients for encapsulation problems after the use of polyurethane foam surface implants. In nearly all the cases of exchange of implants it has been because the implant was a standard silicone gel textured implant or it was because the patient had a PIP implant.

6) **PIP Implants**

There are now very few patients who are not aware of the risk of PIP implants. If you still have a PIP implant inside you then my firm recommendation is to have it removed while it is easy to do it. The PIP implants tend to rupture much sooner than other types of implants because of the chemical structure of the silicone contained in the implant. The PIP implant contained a much higher percentage of very low molecular weight silicone and this was capable of penetrating the shell of the implant and thus weaken the shell making it capable of splitting much sooner than would occur with standard implants. Thus, if you have a PIP implant which appears to be intact, it will be much easier for the Surgeon to remove it while it's intact than if it has ruptured. If it has ruptured the hope is that the capsule around it will still be intact and no silicone has penetrated through the capsule into the breast, but if silicone has migrated into the breast then the Surgeon may feel obliged to try and remove this breast tissue infiltrated by silicone which may well result in distortion of the breast, thinning of the breast tissue over the implant and thus irregularities of the contour (bumps and dips).

It is debatable whether one should remove lymph glands which have been shown to contain silicone. My own personal view is that very little harm will come from leaving such silicone infiltrated lymph glands alone in contrast to which the technical difficulties of removing the lymph glands may result in more problems than occurs from leaving them alone. In part it will depend upon how many lymph glands have been infiltrated by silicone and whether the patient has a known risk of breast cancer (in which case it can be a bit difficult to distinguish between a lymph gland made hard by silicone from a lymph gland made hard by breast cancer).

7) **Change of Plane**

If the implants were put in underneath the muscle originally and then become distorted through encapsulation, the Surgeon may recommend changing the plane of the implant so that it lies in front of the muscle rather than behind it. This saves all the effort of having to remove the capsule because once the implant has been removed from within the capsule the capsule goes flat and tends to soften and shrivel.

The reverse however is not likely to be true, ie if the implants were put in front of the muscle and have developed a bad capsule it isn't always such a good idea to try to put the implant in underneath the muscle unless one removes the capsule because the muscle will not stretch if the capsule is stuck to the muscle on the front side of the muscle. To give complete freedom of insertion underneath the muscle one may have to carry out a capsulotomy and if one is going to bother to do this then one might as well put the new implant back into the same space as it had been before. The only theoretical advantage of putting the implant in underneath the muscle in these cases would be if the skin and fat has become so thin in the upper part of the breast that one can see and feel the implant very easily through the skin.

8) **Wearing of Bra After the Operation**

When I carry out a primary breast augmentation I seldom think it is necessary for the patient to wear a bra immediately after the operation because the breast fits snugly around the implant and it is very unlikely to slide around inside the space and therefore holding the breast very firmly in its new shape and position by the use of a bra is not necessary. However the same does not apply after exchange of implants where one often finds that the skin has become very lax and the skin can slide around over the surface of the implant and so it may in these circumstances be helpful to wear a snug fitting bra like a good sports bra which is not underwired for the first few days after the operation. A bra may help to stop the skin from moving over the new implant.

9) **Further Surgery**

If a breast implant exchange results in an unsatisfactory result from dimples or obvious or visible hollowing of the upper breast, it may be possible to correct the problems by injecting fat to fill out the breast dimples or hollows. This may be done best at a second operation rather than at the first implant exchange operation.

10) **Drains**

After implant exchange it is common for the drainage from the breast to continue in a large quantity for several days post-operatively. This may mean having to go home from hospital with the drain still in place and measuring the drainage daily until it drops to low amounts.

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