Tips For Success

Contour Profile® Becker Surgical Technique Guide

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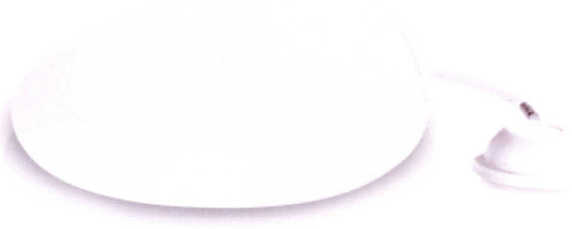
The Contour Profile® Becker implant is a welcome addition to the breast reconstruction armamentarium. It is a unique anatomical gel implant having an inner lumen in the lower pole that can be adjusted via a remote detachable injection dome. The Contour Profile® Becker implant has several advantages.

Preoperative Planning

Consideration should be given to the following measurements during preoperative planning: After the general surgeon has completed the mastectomy, the tissue volume is measured to confirm the implant size. Measurements are also made of the nipple and inframmary fold, breast base width, breast envelope assessment (elasticity of patient's skin) and superior pole thickness.

Implant Selection: Selecting an implant with the correct base diameter, correct volume and correct projection would require an inordinate number of implants, especially with unilateral reconstruction, because there is usually a discrepancy in those ratios. For example, a patient with a 200 cc opposite breast may have a 13.5 cm base diameter. A 13.5 cm base diameter may only be available in a 400 cc volume. However, a 13.5 cm base diameter Contour Profile® Becker implant has a volume ratio of 130 cc gel and 270 cc saline, and the saline volume can vary from 240 cc to 270 cc.



Incision Planning: The skin incision is planned with the general surgeon. The more skin that is saved, the more natural the final result will be.

Pocket Dissection

Dissection is started at the lateral border of the pectoralis major muscle.

Muscle Release: The muscle is elevated and detached inferiorly and partially infero-medially. The serratus anterior and pectoralis minor are elevated laterally. The muscle is released inferiorly at the level of the pectoralis major. The two muscles are then sutured together with 3/0 vicril or monocril sutures.

Technique

An intraoperative temporary sizer is placed in the pocket. The inferior edge of the muscle is sutured to the subdermal tissue at the level of the inframammary fold. By not fully approximating the muscles, a portion of the inferior pole is devoid of muscle, thus creating laxity of the inferior pole relative to the upper pole, i.e., an anatomical pocket is created to accommodate the anatomical implant. Alternatively dermis is sutured to the inferior side of the muscle and then sutured to the inframammary fold.

Although rotation is discouraged by both the textured surface and ballast effect of the saline in the lower pole, it is important that an anatomical

implant pocket be created, i.e., the muscle in the lower pole should be released to allow for greater lower pole expansion relative to the upper pole.

The implant is filled to the required volume. Gloves (powder-free) are changed, and the implant is placed in the pocket. The muscle or dermis is adjusted to accommodate the implant.

In cases where there is tension on the wound or circulation to the skin flaps is compromised, the saline can be removed from the implant. When the circulation has improved, healing is progressing.

Domes

A large or small injection dome can be attached to the fill tube. The fill tube can be adjusted to the desired length, thus enabling optimum placement of the injection dome.

The injection dome is attached using the metal connector and 3/0 silk ties. The injection dome is placed laterally, but should be tunneled from the medial to lateral in order to avoid rotation of the implant during dome and tube removal.

Postoperative Management

A Jackson-Pratt® drain is positioned through a long subcutaneous tunnel to avoid retrograde infection.

Postoperatively, a Velcro® strap or elastic bandage is placed securely on the upper pole to keep compression on the superior edge of the implant.

Injection Dome Removal

The injection dome can be removed up to six months later by means of a minor procedure under local anesthesia. It is usually removed three to six months after surgery. If the dome is placed near the mastectomy incision, the same incision site may be used. Alternatively, a small incision is made directly over the dome. The dome is grasped proximal to the connection, and moderate traction is applied until the fill tube is removed. The incision is closed with two or three sutures.