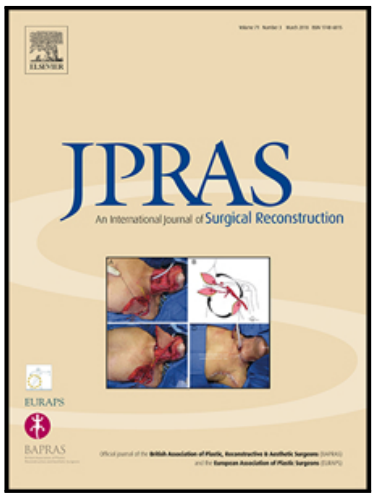

Breast Reconstruction and the Covid-19 Pandemic: Adapting Practice

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TITLE PAGE

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We thank Dr Cavalcante and colleagues for their constructive comments in response to our viewpoint on breast reconstruction during the COVID-19 pandemic.[1] We welcome discussion of this time-sensitive issue within the context of a different healthcare system which they base on an electronic survey of Brazilian surgeons over a two-month period.

A common concern is the backlog of patients, who will eventually require reconstruction, and the psychological impact of delayed reconstructive procedures – whether for partial or whole breast restitution. Restrictions imposed at the start of the pandemic are being gradually eased but re-introduction of breast reconstruction is a challenge for healthcare providers at the present time, especially with fears of a second wave of infection and other-site cancers still awaiting curative surgery.

Furthermore, resumption of 'normal' practice is arguably more difficult in those units where rates of immediate breast reconstruction (IBR) pre-COVID-19 were high; it is noteworthy that overall rates of breast reconstruction in Brazil were 29% before the pandemic, a figure that is higher than recorded in the UK National Mastectomy and Breast Reconstruction Audit (21%).[2] Issuance of COVID-19 specific guidelines by the Association of Breast Surgery[3] in the UK had a dramatic effect on IBR with only 30% of units reporting continuation of this practice during the pandemic (ABS National Audit – preliminary data).

The questionnaire sent out to 1462 Brazilian surgeons about reconstructive practice during the pandemic had a response rate of just over one-third; it is unclear whether this questionnaire addressed intentional or actual reconstructive practice during the pandemic with two-thirds (64%) of surgeons supporting IBR using predominantly implant-based techniques (permanent or temporary tissue expanders). It is reassuring that only 3% of surgeons would advocate complex flap-based reconstructive procedures during the active phase of the pandemic and this concurs with our viewpoint.

Of interest, just over half of Brazilian surgeons were opposed to therapeutic mammoplasty; this procedure can avoid complete mastectomy in some patients with larger breasts and hence negate any requirement for IBR. Furthermore, the contralateral side could be done at a later date – perhaps after breast irradiation as this can disrupt initial symmetry from a simultaneous balancing procedure. We agree

with our Brazilian colleagues that reconstructive procedures should be undertaken on a discretionary basis related to individual patient needs/preferences, local circumstances and critically operative capacity together with the phase of the pandemic.

We are now witnessing a resurgence of infection in some parts of the world and this will affect reconstructive practice if operative capacity becomes restricted once again. We would argue that implant-based reconstruction should largely be dependent on operative capacity rather than concerns about potential complications, prolonged hospital stays and re-admission. Reconstruction with tissue flaps (myocutaneous or otherwise) might be acceptable during the recovery phase if resources are adequate in terms of staff and facilities. Standard operating procedures should be adopted to streamline patient care and pre-emptively document management plans for any complications.

Remarkably there is no indication of pandemic stage at the time of this electronic survey; South America has lagged behind Europe by approximately 1 – 2 months for phase of disease. Moreover, the response rate might have been higher with use of the Total Design Method permitting a more representative cross-sectional sample.[4] Nonetheless, more than 500 surgeons belonging to the Brazilian Society of Mastology submitted responses and presumably these were a mixture of plastic and breast oncological surgeons.

We agree with Cavalcante and colleagues that carefully designed strategies are required as we move into the next phase of the COVID-19 pandemic. These must minimise the strain on healthcare systems, maximise patient safety and provide optimum cancer care. Surgical practice must be dynamic and adapt to changing circumstances with close co-operation between breast and plastic surgeons working synergistically within a multidisciplinary team. Resumption of reconstructive practice should closely mirror national guidelines and exercise due caution to minimise risks of complications whilst addressing clinical need and patient expectations. The latter must be realistic with appropriate selection of patients and adherence to a fully informed consent process that reflects the additional risks associated with COVID-19.

Conflict of interest

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