Understanding the benefits and risks of breast augmentation

Can be an emotive subject. It is particularly important to remember that breasts are a subject frequently in the media for a variety of reasons and patients may be ill-informed. Perhaps the subtle external pressure on girls and women to have a perfect figure has increased, so the reasons for wanting the surgery need to be gently explored. Some women say that pressure from husbands or partners is the reason that they need surgery or that they hope the surgery will relieve sexual inhibition (McGrath and Burkhardt, 1984).

Nurses may be asked for advice about breast augmentation surgery. It is, of course, sensible to advise all patients to be referred by their GP or go on recommendation and check out the surgeon rather than simply respond to an advertisement in a magazine. Some women find it helpful to seek more than one opinion.

Nurses can advise patients that the National Care Standards Commission monitors independent health care providers. Patients should be advised to check that the surgeon concerned is on the General Medical Council register for plastic surgery and a member of a relevant association, such as the British Association of Plastic Surgeons or the British Association of Surgical Oncology.

The role of the clinical nurse specialist

Clinical nurse specialists in breast care should be involved in discussing the concerns of patients considering breast surgery. Specialist nurses should be aware of the evidence in relation to cosmetic breast augmentation (Sarwer et al, 2000). These nurses are able to show the women the implants and let them try the external prostheses (which are silicone breast form shapes similar to enhancers worn in a bra). The patients can take external prostheses away for a period of weeks, to give them the opportunity to try different sizes and carry out their daily activities with larger breasts to see which size they wish to be. Some patients may change their minds about their desired size while others may decide on the external prosthesis as being the permanent solution for them, rather than having the surgery.

Patients can only make an informed choice by being fully aware of the surgical options and the benefits and risks. Some women may need to be seen several times over a period of time. All patients should be offered written information and the opportunity to see photographs of surgical results, both good and bad. Good care necessitates that the women receive the information based on evidence (Coulter, 1998).

Some hospitals have a psychologist in the surgical team who can assess the patient’s psychological state. In some patients, the desire for surgery could be due to low self-esteem, an insecurity or underlying depression. It is therefore good practice to assess the psychological state of all patients and to check that they do not have any underlying mental health problems.

All patients considering this type of surgery should have access to full information, the time to consider the options and the chance to discuss concerns (Muir Gray, 1999). It is not clear to what extent this occurs in private practice and the available evidence suggests that women are not always informed of the risks (Napoli, 2000).

What are implants?

The implants, sometimes referred to as ‘internal prostheses’, are basically firm silicone rubber cases filled with either silicone or saline. The silicone gel comes in different consistencies, and both types have been used for several years. The implants come in a variety of shapes and sizes. They may have a smooth or a textured surface.

There has been ongoing research, by the Medical Devices Agency (MDA) – now known as the Medicines and Healthcare products Regulatory Agency (MHRA) – to determine the best material, but there are no restrictions on the sale or use of silicone-filled breast implants or CE-marked saline-filled breast implants in this country. Silicone is, however, a common material and is used in food, drinks, medicines such as insulin and cosmetics, and is generally thought to be safe (Gerszten, 1999).

Research carried out by the Department of Health has found no connection between implants and systemic complications such as autoimmune and connective tissue problems (Independent Review Group, 1998).

The implant will not look and feel exactly like a natural breast and may not have the natural sag that breasts have, but most women seem to appreciate this and see it as an advantage. Some women feel that implants can make the appearance worse, particularly for those with larger, droopy breasts, so a ‘mastopexy’ may be needed – surgery that tightens the skin and lifts the breast.

Because breast implant surgery is a relatively new procedure, the long-term effects are largely unknown. There has also been considerable litigation in the US, where the advisory body on drugs, the Food and Drug Administration (FDA), has banned the use of silicone and continues to debate its use (Sims and Lundberg, 2002).

How is implant surgery done?

The surgeon and the patient decide on the exact position, size and type of implant. An incision is made (most commonly in the crease below the breast but sometimes around the areola or under the axilla) and an envelope

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Independent Review Group (1998)."
The nurse’s role

For some patients, the first time they have to consider breast surgery will be following a diagnosis of breast cancer or in relation to prophylactic mastectomy if they are at high genetic risk of the disease. Nurses may also have some awareness of the emotional trauma these women go through and some knowledge of the risks of this type of surgery (Resnick and Belcher, 2002).

Nurses may occasionally encounter patients who have considered surgery because they have a congenital deformity of one or both breasts, or an asymmetry (uneven breasts). Increasing numbers of women are also considering breast surgery because they feel their breast size and shape has been adversely affected by pregnancy, weight loss, growing older or because they feel their breasts are ‘too small’.

Given the link between self-esteem and breast size for some women, it is apparent that the option of surgery for such ‘cosmetic’ reasons is literally a lifeline. For these patients, their smaller breasts can adversely affect their lifestyle and relationships to such a degree that they are relieved at the possibility of a surgical solution. This type of breast augmentation surgery is becoming more popular in the UK, despite the controversy surrounding it and the potential risks involved (Bren, 2000).

It is likely that nurses will come across patients who are either considering this type of surgery or have already had it done. Given the rise in referrals, it seems increasingly possible that nurses will be asked about cosmetic augmentation surgery at some point, making it important for them to understand the issues behind the decision, so they can care for these patients with compassion (Allen and Oberle, 1996).

Breast augmentation

Surgery to increase the size of the breasts usually involves an implant. This form of cosmetic surgery is designed to make the breast fuller and larger, and has been available for a number of years. About 77% of breast implants are performed for cosmetic reasons and the remainder for breast reconstruction after surgery, mainly after cancer but also to address a congenital deformity or breast asymmetry (Box 1) (National Breast Implant Registry, 2001). It is now the most common cosmetic surgical procedure performed in the UK (Gerszten, 1999).

Many women’s magazines also carry adverts for private clinics and hospitals that will undertake this surgery, and most registered breast-implant operations are carried out privately in the UK (National Breast Implant Registry, 2001). In some areas this may be available on the NHS, depending on the woman’s circumstances. There is relatively little research on breast augmentation surgery in UK medical and nursing journals.

Guidance for women

Nurses should remember that this issue needs to be handled very sensitively because breast size and shape

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REFERENCES


of skin is created. The implants are inserted under the skin and are placed either under the pectoralis muscle or directly under the breast tissue, which leaves the breast tissues largely untouched.

An adjustable/expandable saline-filled implant is available, which is placed surgically in the same way. However, the doctor can adjust the size by injecting saline via a port under the skin, and sometimes a second excision will be needed to remove the injection port (Springer, 1999).

Postoperative care
Immediately after the surgery there will be some swelling, bruising and discomfort. Perioperatively, advice on wearing a bra, exercise, lifting, driving and so on varies and depends on the type of surgery and the surgeon’s preferences. There may be temporary and permanent changes in breast sensation and the surgery will leave a scar. Depending on the type of employment, patients may need to take time off work.

The surgeon should write to each patient’s GP with details of the surgery and implant. The nature of follow-up and any screening for rupture or leakage depends on the surgery and individual circumstances. Patients should be given information on what symptoms would require investigation in future, such as pain, inflammation or injury to the chest.

Counting the cost
There is no evidence to show how many patients opt for surgery, much of which is done in private clinics and hospitals. It is not known what the satisfaction rate is. The procedure is expensive, at about £2,000–£3,000, and is potentially painful and harmful. As with any invasive surgical procedure, and one that usually requires a general anaesthetic, there is an associated risk. Some patients are very pleased with the results and feel that their quality of life and self-confidence improves as a result, but for others the surgery will be unsuccessful.

The MHRA has recently reclassified breast implants as ‘high risk’ medical devices to improve the regulation of cosmetic surgery. There is evidence that localised complications are relatively high (Oberle and Allen, 1994).

Associated risks
The patient’s overall health, body shape and healing will affect the results of surgery. Smoking, alcohol intake, any previous breast surgery and any existing scarring or stretch marks may affect healing. Infection and bleeding, although rare, usually require the implant(s) to be removed. If rupture or leaks occur, surgery may be necessary to remove the implant.

Capsular contracture, where the body responds to the implant as a foreign body, forming a tough, fibrous tissue around it, is a common complication, affecting about one in 10 patients who have implants. There are other potential problems, including:

- Nipple sensation may be affected, either temporarily or permanently;
- Occasionally the position or size of the implant may be unsatisfactory;
- There may be skin creases or ripples, and the breast may not give the natural cleavage;
- Sometimes the breasts are different sizes after surgery, despite the same size implants being used;
- Some patients feel that the implants have affected their health, and worry about the long-term effects;
- Breast implants may cause problems with performing and readability of mammograms, although magnetic resonance imaging scans are an option (Oh, 2002).

The National Implant Registry
Patients are asked to consent to being added to the National Implant Registry. Following recommendation from the Department of Health, the registry identifies patients with implants and the data can be used for health protection, since patients can be notified of any manufacturer’s concerns.

All breast implant operations can be recorded on a form that is sent to the registry. It covers both private and NHS surgery, but it is voluntary and there is no legislative basis to ensure compliance. Informed consent also applies to the holding of information on this database. The registry complies with the Data Protection Act and patients have access to the information held on them.

Lifestyle after surgery
Breast implants do not last a lifetime and will need replacing in the future. This timespan will vary among patients. Some surgeons replace them after 10 years. Younger patients will need to have several operations through their lifetime.

It is unlikely that an implant will rupture during normal activities. However, severe chest injury could rupture it. Weight gain/loss will not affect the size of the implant significantly. Implants should not generally interfere with breastfeeding ability and will not affect the infants.

Some patients feel that breast augmentation surgery has significantly improved their psychological well-being in terms of self-confidence, femininity and sexuality. Others, although this is a smaller percentage, wish they had never undergone surgery and request the removal of the implants (Roberts et al, 1999).

There is no increased risk of developing breast cancer after having implants. The breast awareness message for women to be aware of the normal look and feel of their breasts and report any changes should continue.

Conclusion
Nurses should ensure that patients considering breast surgery understand the potential risks involved. Informed consent is a major issue. For some women the potential benefits of this surgery will outweigh the risks.

There needs to be more research not only into the complications and long-term effects of such surgery, but also into why women feel it necessary to have the procedure, as well as gaining information on their postoperative experiences.