I thank the lady concerned and also Mr D. J. Whitby for allowing me to report this case.


The impact of breast augmentation on the breast-screening programme

Sir,

Screening women with breast implants is more time consuming and labour intensive than screening other women. It also requires compression techniques to minimise the amount of breast tissue obscured by the implant.\(^1,2\) It is not known how many women with breast implants are in the screening programme or what impact this group has had on local resources. This was examined in Newcastle/Northumberland, and the number of screened breast cancers picked up in the implant group was reviewed.\(^3\)

The total number of women and the number of women with breast implants in the screening programme were identified over a 9 year period (1990–1999). Women with breast reconstructions using implants, those with missing films and those outside the screening age range of 50–64 years were excluded.

The number of episodes and the percentage of total screened episodes (in parentheses) involving implants has steadily increased from 61 (0.10%) in 1990–1993 to 97 (0.13%) in 1993–1996 and 135 (0.22%) in 1996–1999.

Despite this increasing workload, no additional staff or funds have been allocated to the Breast Unit to date. However, the number of younger women receiving breast implants continues to rise according to National Implant Registry figures,\(^4\) and when these women become eligible for the National Health breast-screening programme when they are 50 years old additional personnel and finance may well be needed.

A total of 1209 cancers (5.7 per 1000 women) were found in the screened population. There were no screen-detected or interval cancers in the implant group, but the numbers are not yet large enough to be statistically significant \(P=0.13\).

Yours faithfully,

R. James I. Colville MSc, FRCS, Specialist Registrar in Plastic Surgery
Neil R. McLean MD, FRCS, Consultant Head and Neck/ Plastic and Reconstructive Surgeon
Department of Plastic Surgery,
Carole A. Mallen, Manager
Lesley McLean FRCS, Head of Department
The Breast Screening Unit,
Royal Victoria Infirmary, Queen Victoria Road, Newcastle upon Tyne NE1 4LE, UK.

References


An intraoperative DIY breast sizer

Sir,

Intraoperative breast sizers serve as guides for determining implant size in breast augmentation, breast asymmetry and breast reconstruction.\(^1,2\) Inflatable sizers and gel sizers have both been used in the past, but neither is endorsed by the manufacturers for multiple use.

We have therefore designed an intraoperative DIY (do it yourself) breast sizer, which is readily made by the surgeon using commonly available sterile items in the operating theatre. It takes about 10 min to assemble and is sterile, inexpensive and disposable. The volume can be easily adjusted up to 350 ml without fear of rupture or leakage, and it contains a luer lock valve for ease of inflation and deflation. The use of a glove to make a breast sizer is certainly not new, and was described by Rigg in 1973,\(^3\) but the incorporation of a luer lock system into a glove sizer has not been described before to our knowledge.

The components used to make the sizer are a ‘dispensing pin’ (Braun Medical Inc, USA), a size 8 latex surgical glove (Biogel) and a 2/0 silk suture (Ethicon) (Fig. 1). All these components are commonly available in operating theatres. The dispensing pin is commonly used to withdraw fluid from sterile intravenous-fluid bags, but is ideal for incorporating into the breast sizer because it has a valve.

Figure 1—A maternity bra as a dressing after breast reduction.

Acknowledgments

I thank the lady concerned and also Mr D. J. Whitby for allowing me to report this case.

The base of each of the glove’s four fingers is manually knotted. The ends of the tied glove fingers are trimmed distal to the knots. The glove is inverted, knotted manually at the wrist and the free end trimmed with a pair of scissors (Fig. 2). A small cuff of the thumb tip of the glove is trimmed to allow insertion of the dispensing pin. The dispensing pin is telescoped into the glove thumb with the protective sheath in-situ to prevent any inadvertent perforation of the sizer. The end of the protective sheath is trimmed or perforated, as an adhesive paper seal covers the end. This converts it into a cannula, and allows fluid to pass through the pin with the sheath in-situ. The thumb of the glove is advanced over the dispensing pin just beyond its flange. A 2/0 silk ligature is tied around the thumb sleeve just over the grooved area under the flange (Fig. 2). This secures the thumb sleeve to the dispensing pin, which will serve as a valve and port for inflating the sizer. A 50 ml luer lock syringe is used to inflate or deflate the implant (Fig. 3). The shape of the saline-filled DIY sizer closely resembles the shape of a round silicone implant, in both height and diameter, once inserted into the breast-implant pocket.

The sizer was compared with the commercially available inflatable saline sizer that we had previously used on two occasions in cases of breast asymmetry. The DIY breast sizer was found to reproduce the results of the commercially available sizer in terms of overall shape and the calculated volume in both the test cases. We therefore no longer use proprietary sizers.

The total cost of the DIY sizer is very reasonable, at approximately £4, compared with £55–£90 for commercially available sizers.

Your faithfully,

Sunil Choudhary MS, FRCSEd
Locum Consultant Plastic Surgeon
Stoke Mandeville Hospital NHS Trust, Mandeville Road, Aylesbury HP21 8AL, UK.

Alain Curnier MSc, FRCSEd
Registrar in Plastic Surgery
Plastic Surgery Unit, Canniesburn Hospital, Switchback Road, Bearsden, Glasgow G61 1QL, UK.

Disclaimer
The authors have no financial interest or stake in the companies manufacturing the components used to make this breast sizer, i.e. Biogel, Braun Medical Inc and Ethicon. The use of the components was solely dictated by their availability and clinical merit.

References