

Breast reconstruction using lipomodelling after breast cancer treatment

Interventional procedures guidance

Published: 23 January 2012

www.nice.org.uk/guidance/ipg417

1 Guidance

- 1.1 Current evidence on the efficacy of breast reconstruction using lipomodelling after breast cancer treatment is adequate and the evidence raises no major safety concerns. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit.
- 1.2 There is a theoretical concern about any possible influence of the procedure on recurrence of breast cancer in the long term, although there is no evidence of this in published reports. NICE therefore encourages long-term data collection on this procedure.
- 1.3 Patient selection should be carried out by a breast cancer multidisciplinary team.

- 1.4 Breast reconstruction using lipomodelling after breast cancer treatment should only be carried out by surgeons with specialist expertise and training in the procedure.

2 The procedure

2.1 Indications and current treatments

- 2.1.1 Breast reconstruction following surgery for breast cancer may be done during the same operation or at a later date, and may involve prosthetic material (implant) alone, or autologous tissue (tissue from elsewhere in the body, usually the abdomen, buttocks or back), or a combination of the two.

2.2 Outline of the procedure

- 2.2.1 Lipomodelling uses the patient's own fat cells to replace volume after breast reconstruction, or to fill defects in the breast following breast-conserving surgery. It can be used on its own or as an adjunct to other reconstruction techniques. The procedure aims to restore breast volume and contour without the morbidity of other reconstruction techniques. However, a degree of fat resorption is common in the first 6 months and there have been concerns that it may make future mammographic images more difficult to interpret.
- 2.2.2 With the patient under general or local anaesthesia, fat is harvested by aspiration with a syringe and cannula, commonly from the abdomen, outer thigh and/or flank. The fat is usually washed and centrifuged before being injected into the breast. Patients subsequently undergo repeat treatments (typically 2–4 sessions).
- 2.2.3 Commencement of lipomodelling treatment may be delayed for a variable period of time after treatment of breast cancer.

Sections 2.3 and 2.4 describe efficacy and safety outcomes from the published literature that the Committee considered as part of the evidence about this procedure. For more detailed information on the evidence, see the [overview](#).

2.3 Efficacy

- 2.3.1 In a case series of 734 procedures for breast reconstruction (880 procedures in total), the results of lipomodelling following conservative surgery were judged to be 'very good' in 50% of procedures, 'good' in 40% and 'moderately good' in 10% (based on clinical examination, photographs and patient opinion: absolute numbers not stated).
- 2.3.2 A case series of 820 patients, including 381 with asymmetry after mastectomy and breast reconstruction, reported that the majority of patients had a 'significant improvement in their breast size and/or shape postoperatively'. Long-term breast asymmetry was reported in 4% (34/820) of patients.
- 2.3.3 A case series of 69 patients (74 breasts) reported a 'good to very good' improvement in 87% (64/74) of breasts and a 'moderate' improvement in 14% (10/74) of breasts (assessment from photographs by 2 independent surgeons).
- 2.3.4 A non-randomised comparative study of 61 patients (62 breasts) treated by lipomodelling (n = 20) or standard treatment only (n = 42) (not described) reported improvement in mean aesthetic results from 2.7 at baseline to 4.3 and 3.1 points respectively at 3-month follow-up ($p \leq 0.032$) (evaluated using a 5-point scale: 5 = very good).
- 2.3.5 The Specialist Advisers listed key efficacy outcomes as volume change, aesthetic assessment of breast shape, quality of life and body image assessments.

2.4 Safety

- 2.4.1 The case series of 734 lipomodelling procedures for breast

reconstruction reported that 10 years of oncological follow-up did not reveal any increased risk of local recurrence after mastectomy or after conservative treatment. In a case series of 137 patients who had a modified radical mastectomy, 96% were free from recurrence and 98% were free from distant metastasis at 5-year follow-up (absolute figures not stated).

- 2.4.2 The case series of 880 procedures reported 1 intraoperative pneumothorax (probably caused by the transfer cannula piercing the pleura), which resolved with the insertion of a pleural drain.
- 2.4.3 The case series of 880 procedures reported local infection in less than 1% of procedures (6/880); all resolved with treatment and had no impact on the final result. There was also an infection at a harvesting site in 1 case, which resolved with antibiotics.
- 2.4.4 The case series of 880 procedures reported a 3% rate of fat necrosis (absolute figures not stated). Liponecrotic cysts were reported in 7% (5/74) of breasts at 3-month follow-up in the case series of 69 patients and in 5% (2/43) in a case series of 37 patients.
- 2.4.5 The Specialist Advisers listed adverse events known from reports or experience as oil cysts, haematoma, calcification, donor and breast site deformity, complete resorption of fat, and uncertain findings on clinical surveillance and mammography. They raised the theoretical possibility of an increased rate of breast cancer recurrence and fat embolism.

2.5 Other comments

- 2.5.1 The Committee noted that there have been concerns about possible interference as a result of the procedure with imaging of the breast for cancer surveillance. However, it was advised that this ought not to be an issue with current techniques for lipomodelling and with expert interpretation of subsequent images.
- 2.5.2 The Committee noted that the techniques used for lipomodelling continue to evolve.

- 2.5.3 The Committee noted that devices are being introduced which aim to concentrate adipose stem cells in the tissue that is being used for lipomodelling. Further information about the outcomes of this and other adaptations of the technique of lipomodelling is desirable for guiding their future use in clinical management.
- 2.5.4 The Committee noted that joint guidelines on lipomodelling are in development and these include a dataset for a proposed national audit.

3 Further information

- 3.1 For related NICE guidance see [the NICE website](#).

Information for patients

NICE has produced information on this procedure for patients and carers ('[Understanding NICE guidance](#)'). It explains the nature of the procedure and the guidance issued by NICE, and has been written with patient consent in mind.

About this guidance

NICE interventional procedure guidance makes recommendations on the safety and efficacy of the procedure. It does not cover whether or not the NHS should fund a procedure. Funding decisions are taken by local NHS bodies after considering the clinical effectiveness of the procedure and whether it represents value for money for the NHS. It is for healthcare professionals and people using the NHS in England, Wales, Scotland and Northern Ireland, and is endorsed by Healthcare Improvement Scotland for implementation by NHSScotland.

This guidance was developed using the NICE [interventional procedures guidance](#) process.

We have produced a [summary of this guidance for patients and carers](#). Tools to help you put the guidance into practice and information about the evidence it is based on are also [available](#).

Changes after publication

May 2012: minor maintenance

Your responsibility

This guidance represents the views of NICE and was arrived at after careful consideration of the available evidence. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. This guidance does not, however, override the individual responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

Copyright

© National Institute for Health and Clinical Excellence 2011. All rights reserved. NICE copyright material can be downloaded for private research and study, and may be reproduced for educational and not-for-profit purposes. No reproduction by or for commercial organisations, or for commercial purposes, is allowed without the written permission of NICE.

Contact NICE

National Institute for Health and Clinical Excellence
Level 1A, City Tower, Piccadilly Plaza, Manchester M1 4BT

www.nice.org.uk

nice@nice.org.uk

0845 033 7780

Endorsing organisation

This guidance has been endorsed by Healthcare Improvement Scotland.

Accreditation

