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DIEP flap for breast reconstruction: Retrospective evaluation of patient satisfaction on abdominal results

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Summary *Background:* Although some papers have analyzed patient satisfaction after traditional abdominoplasty, studies that have specifically assessed patient satisfaction on abdominal reconstruction after deep inferior epigastric perforator (DIEP) surgery are lacking.
Aim: The aim of this study was to assess satisfaction, specifically for abdominoplasty results, in patients who underwent breast reconstruction with a single DIEP flap.
Methods: This retrospective study included 53 consecutive patients who underwent unilateral breast reconstruction with a DIEP flap. The patients were all clinically evaluated during a specific consultation and answered a satisfaction survey based on a four-point scale (unsatisfied, satisfied, happy, and very happy).
Results: A total of 50 patients responded to the survey. The average age was 52.3 years. This study revealed that 52% of the patients were happy or very happy with the aesthetic result of their abdomen. A total of 34% of the patients confessed that they preferred their abdomen before surgery. A further analysis of the dissatisfied patients showed particular dissatisfaction with dog-ears (50%), residual abdominal overhang (18%), or the horizontal scar (12%). The average distance between the horizontal scar and vulvar anterior commissure was 10.6 cm. A total of 86% of the patients were happy or very happy with the preoperative counseling.
Conclusions: The authors note the necessity to give detailed preoperative information to explain the final abdominal aesthetic result, which can be quite different from the patient's expectations.
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Introduction

For 20 years, abdominal flaps have been considered a method of choice for mammary reconstruction.[1–3] The absence of implants and its autologous character make it one of the most popular techniques, especially for women with abdominal pendulum. The use of a deep inferior epigastric perforator (DIEP) flap helps the surgeon to preserve the rectus muscle fascia and reduces the risk of postoperative hernia.[4]

DIEP flap harvesting leads the surgeon to perform an abdominoplasty for abdominal closure. However, this abdominoplasty is not a classic one; indeed, several steps of the intervention are not usually done. For example, a liposuction of the abdomen could injure the flap vascularization, and a correction of the diastasis might increase thrombosis risk.[5] Above all, the final scar, which should be hidden by underwear, can be located in the middle of the abdomen. Do the benefits of this breast reconstruction method lead some surgeons to slightly over-propose it to patients without sufficient abdominal pendulum?

Plastic surgeons are trained to maximize the rate of aesthetic satisfaction of their patients, especially in breast reconstruction. Moreover, several studies have shown that patients who underwent DIEP flap surgery were very satisfied with their breast results.[6–9]

Conversely, standard abdominoplasty continues to be associated with a high incidence of patient dissatisfaction and litigation for surgeons.[10] Although some authors have analyzed patient satisfaction after traditional abdominoplasty, studies that have specifically assessed patient satisfaction on abdominal results after DIEP surgery are lacking.

The aim of this study was to assess patient satisfaction specifically regarding the abdominoplasty outcomes of patients who underwent breast reconstruction with a single DIEP flap.

Patients and methods

This retrospective study included all consecutive patients who underwent breast reconstruction with a single DIEP flap by the same operator in a plastic, reconstructive, and aesthetic surgery department between June 2010 and June 2013. Bilateral reconstructions and DIEP flaps for other injuries, such as limb traumas, were excluded for this study.

Skin markings

Only the abdominoplasty technique is described here. The skin marking was completed the day before intervention. Using computed tomography scan and Doppler results, we marked the emergence of the best cutaneous artery perforators. Then, a right suprapubic inferior incision of 14 cm was marked. If possible, this incision was placed 7 cm above the anterior vulvar commissure, as in standard abdominoplasty.[11–14]

Then, the two parts of this line met the two anterior superior iliac spine ASIS. The upper line was marked above the umbilicus and artery perforators in a gently curving fashion down to the lateral apex of the inferior line. Here, traction was used to verify that closure was possible (pinch test). If not, the lower incision was drawn a few centimeters higher.

Operative technique

Only the abdominoplasty is described here. We began with the incisions of the upper and lower lines and moved down to the muscle fascia. At the lower level, we tried to preserve the superficial inferior epigastric artery vessels. Then, the umbilicus was incised with a 15 blade perpendicular to the stalk of the umbilicus on each side. The flap side was then elevated up to the artery perforators. The undermining in this time was performed above Scarpa's fascia at the extremities to preserve the lateral cutaneous nerves.[11,12] Then, the DIEP perforators were individualized and followed through the rectus muscle until their origins.

After the flap was harvested, the undermining was continued at the level above the muscular fascia, up to the costal margins and xiphoid. Then, hemostasis was controlled, and the rectus sheath was repaired. That was achieved with many strong U stitches of Vicryl 1 and a running double-strand suture to secure this closure.

At the end of the intervention, the new skin site of the umbilicus was marked and incised in a V shape, and we performed a selective defatting to provide a natural periumbilical depression. The new umbilicus was then externalized. Two drains were placed beneath the abdominal flap, exiting the pubic region. The skin edges were approximated from lateral to medial to prevent the formation of dog-ears. Scarpa's fascia, skin, and umbilicus were sutured in that order.[15]

Design of the study

This study was designed as a questionnaire survey. Each patient was contacted by phone and was then seen in consultation by a senior surgeon (not the operator) for a semi-directive interview and a standardized questionnaire. The questionnaire was composed of questions on various aspects of the outcome. Four answers were set up using a four-point satisfaction scale (unsatisfied, satisfied, happy, and very happy), with the possibility of adding free text.[10] Patients answered the other questions with a yes or a no. The questionnaire is presented in Table 1.

Furthermore, during the follow-up, several lengths were measured, as follows: between the scar and the vulvar anterior commissure, between the scar and the umbilicus, and the eventual displacement of the umbilicus from the medial line. We took pictures of all patients before and after surgery.

All information and data from patients were collected, gathered, and computerized following the ethical recommendations of our clinical investigation unit.

Results

A total of 53 patients underwent single DIEP flap surgery for breast reconstruction during this period, and 50 patients answered the survey. Three patients were lost to follow-up.

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