

BREAST AUGMENTATION CONSENT FORM

This consent form was created to make my patients educated consumers regarding breast augmentation. Breast augmentation involves inserting a safe, saline filled implant under the breasts to enhance appearance by enlarging and elevating them. Breast augmentation is also done to enhance self-esteem, reduce anxiety in certain social situations and to permit a woman to obtain a better fit in clothes and swimsuits. Women who seek this operation either had small breasts from puberty or developed small breasts after pregnancy and/or breast feeding.

You should first and foremost be aware that it is impossible to create the “*perfect breast*” but I strive for a result that is natural in appearance, cosmetically pleasing and symmetrically in balance with the rest of the body’s anatomic features. At first, the enlarged breasts are swollen and stiff but within a few weeks, the swelling resolves and the breast soften and feel more natural. Breast augmentation has received much media attention and therefore many myths surrounding this operation have arisen. Hopefully, this information sheet will dispel many of these myths by presenting the facts about this procedure and this form will also describe what my personal approach is to this procedure and how I perform it safely.

1. Breast implants do **NOT** cause breast cancer. This has been proven by several long term studies. They may, however, interfere with mammograms and your radiologist must be informed about their presence before mammograms are taken.
2. I always strive to obtain symmetry between the breasts by a process called differential augmentation. If, however, the breasts are uneven before the operation, they may remain so after the surgery. Furthermore, malpositioning of the implants, although rare, can occur and may need a second surgery for correction. I never leave the operating room unless the implants are positioned as evenly as possible.
3. Capsular contracture is the most common problem after breast enlargement. This occurs when the body makes excess scar tissue around the implant, causing the breast to feel hard and the implant to appear displaced or malpositioned. The incidence of capsular contracture has dropped to about 1 in 100. There are four grades of capsular contracture (I-IV). The more severe the capsular contracture, the higher grade. Grade I is normal softness; grade II indicates firmness but the breast appears normal in shape; grade III indicates firmness but the implant is displaced and the breast looks abnormal; grade IV is when the breast is hard, painful and looks abnormal in shape.

The exact cause of capsular contracture is unknown, however, there is a relative good body of evidence that connects the development of capsular contracture with a subclinical infection within the breast postoperatively. This means an infection that is not detected but later manifests itself as a capsular contracture. To combat this, we irrigate each breast pocket with a solution containing three different antibiotics. There is hard science to show that this will reduce the capsular contracture rate and it has been my experience that this does in fact reduce the incidence of capsular contracture but it does not completely eliminate this risk.

If a capsular contracture, it may not need to be treated. Sometimes a 3-6 month supply of Singulair will eliminate or reduce it. If the capsular contracture progress to a grade III or IV and the patient is symptomatic or dislikes the appearance of the breast, then consideration for surgical intervention will be entertained. Surgical intervention generally entails removal of the capsular contracture and implant replacement. This usually eliminates the problem but capsular contracture may recur even after a successful surgical intervention for treatment. In my experience, however, it is rare for the capsular contracture to recur once the original implant is replaced and the capsule is removed. Fortunately, capsular contracture necessitating surgical intervention is a **rare** occurrence after primary augmentation mammoplasty.

4. The lifespan of breast implants is *not known*. Although it is *not* recommended that they be replaced at any given time in the future after insertion, no guarantees can be given that they will last for the lifetime of the patient. Long term studies are needed before this information is obtained. Basically, if there are no problems with the implants, they can be maintained as is.
5. I use breast implants from Inamed and there is a ten year warranty on their implants. This means that if the implant fails due to a rupture or some other form of mechanical complication, the company will replace the implant free of charge and pay \$1200.00 toward the surgery needed to replace it.
6. I use a very small (one half inch) incision in the armpit (axilla) **OR** a 1.5 inch incision along the inframammary fold to place implant. The silicone prosthesis is generally too large to insert through an axillary incision so an incision along the inframammary fold is used for silicone implants and an axillary incision is used for saline implants.
7. Although uncommon, the sensation in the enlarged breast and nipple areola complex may be temporarily or permanently altered after this procedure. The incidence of this complication is minimized by performing the procedure through the armpit incision.
8. I most always place the implants *above* the pectoralis major muscle. I believe that in this position, the implants are more natural in appearance and, more importantly, they do *not* become deformed while doing aerobics or any type of upper body exercise that involves muscular contraction. There is also significantly less pain/recovery time than implants placed under the muscle. Finally, implants placed under the muscle tend, over time, to be pushed by the muscle into a more inferior and lateral direction. I will place implants under the muscle if the patient desires so and if the patient is so thin that there is virtually no skin and subcutaneous fat in the anterior chest region so that I need more tissue coverage. In these cases, I will place the implant under the muscle.
9. Although uncommon, there is a risk of bleeding and/or infection after this surgery. To help prevent these complications, antibiotics are usually administered intravenously during surgery and a course of oral antibiotics is prescribed after the surgery as well. In addition, special medications (such as Vitamin K) may be taken for 4 days prior to

surgery in an attempt to help prevent bruising and bleeding.

10. Should you become pregnant after this surgery, your breasts will enlarge and become engorged as normal due to the special hormonal influences of the pregnancy itself. This will not, however, interfere with the implants. Moreover, although breast augmentation typically does *not* impair your ability to breast feed, no guarantees can be given that this will be possible after surgery.
11. Occasionally, especially in woman with very little breast tissue, the edge of the implant can be felt, but not seen. This is called “rippling” and every attempt to avoid this is taken. All implants, once inside the body, tend to ripple to one degree or another. The presence of rippling is not caused by the type incision used, the suture used or whether the implant is placed above or below the muscle. Both silicone and saline implants can wrinkle but in general, the worst rippling is seen in tiny women with very little fat on their bodies and very small breasts. Saline implants also tend to ripple more commonly than silicone prostheses.
12. As with any breast surgery, there is a small but definite risk of infection, bleeding, hematoma, swelling, bruising, poor healing, keloid, postoperative nausea/vomiting and/or headache, altered breast lactation postoperatively, rejection of the implant, movement of the implant, visible rippling of the implant through the skin, functional impairment and permanent scarring and disfigurement.
13. I use both saline and silicone implants. Since the FDA approved the use of silicone implants in November, 2006, they have become more popular than saline implants. Silicone prostheses are generally preferred over saline because they are softer, more natural in shape and present less rippling over time. They are, however, more expensive than saline implants and can not be filled or deflated after the surgical intervention like saline implants can. Finally, saline implants in general must be placed in through an inframammary fold incision whereas saline implants can be placed via an axillary incision. In general, both implants have identical rates of capsular contracture.
14. Will the implants interfere with detection of breast cancer? The medical literature has addressed this issue and after several exhaustive studies, the answer is unequivocally no. With silicone prostheses, the FDA recommends that starting three years after the augmentation mammoplasty, the patient obtains an MRI examination of the breasts and then every two years thereafter, another MRI of the breasts should be performed. This is recommended not only to detect breast cancer but also to detect leakage, rupture, etc. The FDA does not have a similar recommendation for saline implants so routine mammography is acceptable. You must inform the radiology technician that you have implants so that proper precautions can be taken during the examination. An alternative to mammography is mammary ultrasound. Ultrasonography of the breast is becoming as sensitive as mammography in detecting mammary masses and it is vastly less physically painful and less offensive to the implants than mammography.

Photographs, which do not include the face, are a necessary part of this surgical procedure. The

preoperative photographs are taken in a standing position because the appearance of the breasts changes dramatically when the patient lies down on the operating room table. The preoperative photographs serve as important aids in planning and performing certain portions of the operation especially when one breast is significantly different in size and/or shape in comparison with the opposite breast. Photographs are also taken postoperatively not only to complete the medical record but also to serve as an educational and reference tool for both the surgeon and the patient. These photographs become a permanent part of your medical record but may be used for a variety of instructional and professional purposes within your surgeon's practice including, but not limited to, illustrations in scientific articles and for demonstration of the procedure to prospective patients with a similar breast condition.

I have read the above, it has been explained to me and I fully understand and accept the inherent risks, potential benefits, limitations, anticipated outcome, expected postoperative course, the likelihood of success, the estimated duration of care, the nature and purpose of the proposed procedure of breast enlargement, alternatives, options and all the known possible complications associated with this procedure. I hereby, therefore, consent to have this procedure performed.

PATIENT: _____ **WITNESS:** _____

DATE: _____