# Preparing for Breast Surgery at TriHealth

We are pleased that you will be having your surgery with us at the TriHealth Breast Center and are confident that you will have the very best experience possible. This handout is to provide you with information about the most common breast surgeries performed at TriHealth by our fellowship trained breast surgeons. Please contact your nurse navigator with any questions.

## Surgery Appointment Information

**Surgery Date:** _____ **Arrival Time:** _____

**Ensure your pre-op physical, any required specialist clearance and any tests are completed.**

- You must complete this testing between the following dates: _____ and _____.
- Failure to complete pre-operative physical will result in your surgery being rescheduled.

**Localization procedure required:**

- ☐ Yes – please review information in the Localization Procedure box below
- ☐ No – ignore Localization procedure information box below

**Location of Surgery:**

- ☐ **Bethesda Butler Hospital Surgery Center**
  - 3125 Hamilton Mason Road Hamilton, Ohio 45011
  - Check in at Registration desk.

- ☐ **Bethesda North Hospital**
  - 10500 Montgomery Road Cincinnati, Ohio 45242
  - Check in at the Main Hospital Entrance Registration Desk.

- ☐ **Bethesda North Minimally Invasive Surgical Center**
  - 10506 Montgomery Road Cincinnati, Ohio 45242

- ☐ **Good Samaritan Hospital**
  - 375 Dixmyth Ave Cincinnati, Ohio 45220
  - Check in at the registration desk in the Dixmyth Lobby.

## Localization Procedure Information

**Localization Date:** _____ **Arrival Time:** _____

**Location of Localization Procedure:**

- ☐ **Bethesda Butler Hospital**
  - You will receive a phone call within 7 days of the surgery date with your appointment information for the localization procedure.

- ☐ **Bethesda North Hospital Breast Center**
  - 10506A Montgomery Road Cincinnati, Ohio 45242

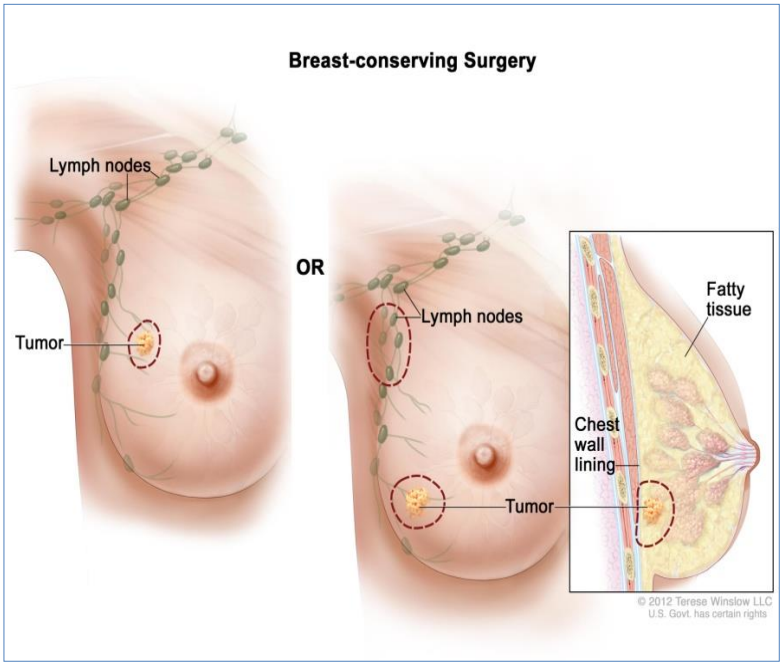
- ☐ **Good Samaritan Hospital Breast Center**
  - 375 Dixmyth Ave 5th Floor Cincinnati, Ohio 45220

If your localization procedure is done the **day before** surgery, you may have food and drink before your appointment.

## Lumpectomy or Breast Conserving Surgery

A lumpectomy is the removal of the breast tumor (the "lump") and some of the normal tissue that surrounds it.

Lumpectomy is a form of “breast-conserving” or "breast preservation" surgery. There are several names used for breast-conserving surgery: biopsy, lumpectomy, partial mastectomy, re-excision, quadrantectomy, or wedge resection. Technically, a lumpectomy is a partial mastectomy, because part of the breast tissue is removed. But the amount of tissue removed can vary greatly. Quadrantectomy, for example, means that roughly a quarter of your breast will be removed.




## Localization Procedure

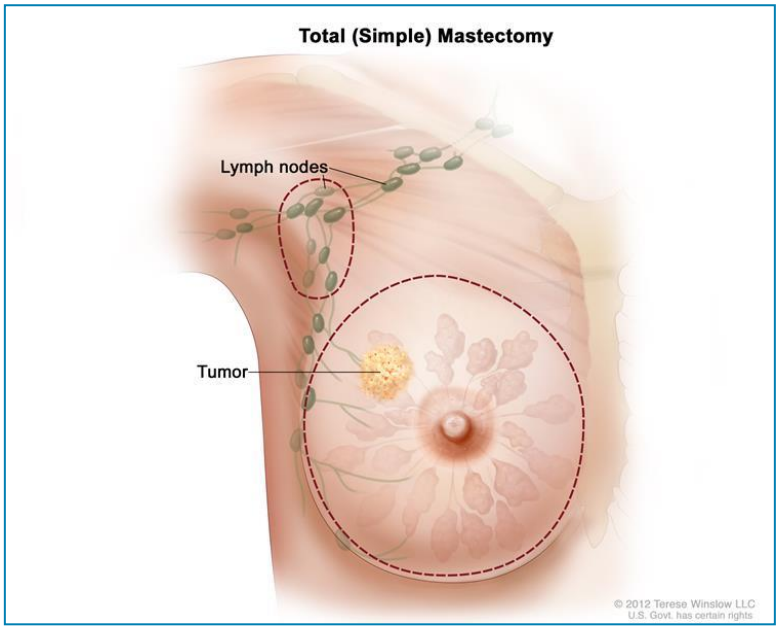
If you have a breast mass or lump that is not able to be felt by your surgeon, you will be scheduled for what is called a localization procedure. During this procedure a seed (marker) or wire will be placed under ultrasound, mammogram or MRI guidance. This allows the surgeon to identify the precise location of abnormal breast tissue during surgery. A seed or marker localization is usually performed the day prior to surgery. A wire localization procedure is typically done the day of your surgery. **This is not the same as the clip or marker placed at the time of biopsy.**

The seed (marker) or wire will be removed at the time of surgery. The clip that was placed at the time of biopsy will be removed during surgery as well.

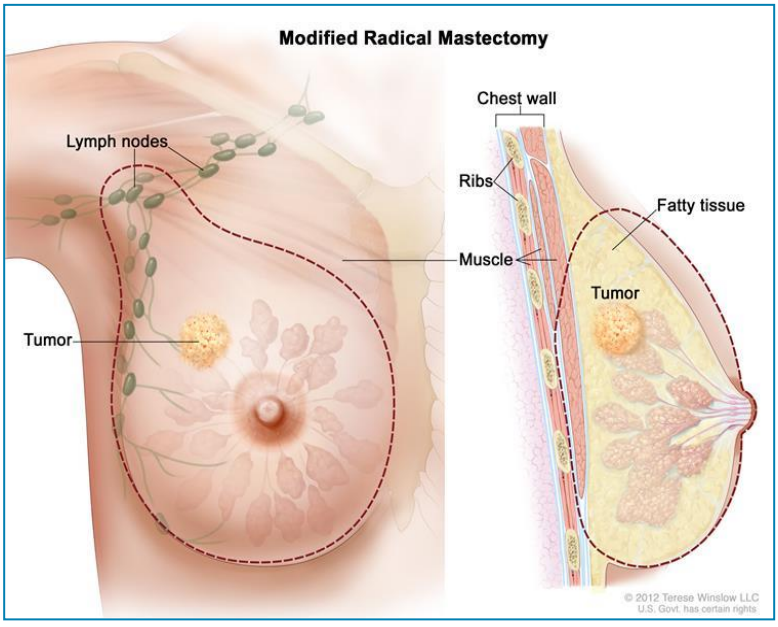
# Mastectomy

There are multiple methods of mastectomy surgery. We have explained three of the more common methods used below. Please ensure you have a clear understanding of the approach your breast surgeon is using.

A **total mastectomy** or **simple mastectomy** is surgery to remove the whole breast that has cancer. This procedure is also called a simple mastectomy. Some of the lymph nodes under the arm may be removed and checked for cancer. This may be done at the same time as the breast surgery or after. This is done through a separate incision. The dotted line shows the breast tissue that is removed. Some lymph nodes under the arm may also be removed. Your skin will be closed with sutures under the skin. Steri-strips will be applied over the incision.




A **Modified radical mastectomy** is a surgery to remove the whole breast that has cancer, many of the lymph nodes under the arm, the lining over the chest muscles, and sometimes, part of the chest wall muscles. The dotted line shows the tissue that will be removed and some lymph nodes may be involved. Your skin will be closed with sutures under the skin. Steri-strips will be applied over the incision.



**Skin-sparing mastectomy** is a technique that preserves as much of the breast skin as possible. Skin-sparing mastectomy can be performed as a "simple" or "total" mastectomy or as a modified radical mastectomy to provide the skin needed for immediate reconstruction.

During skin-sparing mastectomy, the surgeon removes only the skin of the nipple, areola, and the original biopsy scar. Then the surgeon removes the breast tissue through the small opening that is created. The remaining pouch of skin provides the best shape and form to accommodate an implant or a reconstruction using your own tissue. Many women choose this type of mastectomy in order to get the most realistic and pleasing results from immediate breast reconstruction.

Most women are eligible for skin-sparing mastectomies. However, there are some exceptions:

- **A skin-sparing mastectomy is not usually performed if you've decided that you will not have immediate breast reconstruction.** If you won't be having immediate breast reconstruction at the time of your mastectomy, your surgeon will most likely remove as much skin as is required to make your scar and the surface of your chest flat.
- **A skin-sparing mastectomy is not safe if there is a possibility that tumor cells are close to the skin.** If there's any question that the tumor may involve the skin, such as in inflammatory breast cancer, then skin-sparing mastectomy is not an option.

## Sentinel Lymph Node Biopsy

A sentinel lymph node is defined as the first lymph node to which cancer cells are most likely to spread from a primary tumor. Sometimes, there can be more than one sentinel lymph node. A sentinel lymph node biopsy (SLNB) is a procedure in which the sentinel lymph node is identified, removed, and examined to determine whether cancer cells are present.

A negative SLNB result suggests that cancer has not developed the ability to spread to nearby lymph nodes or other organs. A positive SLNB result indicates that cancer is present in the sentinel lymph node and may be present in other nearby lymph nodes (called regional lymph nodes) and, possibly, other organs. This information can help a doctor determine the stage of the cancer (extent of the disease within the body) and develop an appropriate treatment plan.

The sentinel lymph nodes are identified by injecting a blue dye and/or radio labeled technetium into the breast to locate the sentinel lymph node or nodes. Radio labeled technetium is a radioactive material that allows the tumor to be found using a Geiger counter. The injection of the radio labeled technetium is done prior to you undergoing anesthesia. You will be awake for this portion of the procedure.
The surgeon looks for lymph nodes that are stained with the blue dye or "hot" via the Geiger counter during surgery. Once the sentinel lymph node is located, the surgeon makes a small incision in the overlying skin and removes the node.

## Axillary Lymph Node Dissection

There are three levels of axillary lymph nodes (the nodes in the underarm or "axilla" area):

- Level I is the bottom level, below the lower edge of the pectoralis minor muscle.
- Level II is lying underneath the pectoralis minor muscle.
- Level III is above the pectoralis minor muscle.

A traditional axillary lymph node dissection usually removes nodes in levels I and II. For women with invasive breast cancer, this procedure accompanies a mastectomy. It may be done at the same time as, or after, a lumpectomy (through a separate incision). Based on the doctor's physical exam and other indicators about the likelihood that cancer has spread to your lymph nodes, the surgeon will generally remove between five and thirty nodes during a traditional axillary dissection. The total number of lymph nodes "involved" (showing evidence of cancer) is more important than the extent of cancer in any one node.

Your doctor will let you know if any lymph nodes were involved (and if so, how many), as well as the extent of tumor involvement in each node.

## A Word about Reconstruction

If a patient is going to have a mastectomy, breast reconstruction (surgery to rebuild a breast's shape after a mastectomy) may be considered. Breast reconstruction may be done at the time of the mastectomy or at some time after. The reconstructed breast may be made with the patient's own (non breast) tissue or by using implants filled with saline or silicone gel.

**We encourage all patients considering mastectomy to have a consultation with one of our recommended plastic surgeons to discuss the best reconstruction options available to your unique case.**

## A Word about Drains

Attached at the end of the packet is information regarding the Jackson Pratt drains that are utilized with a mastectomy. The drains are typically left in place for 7 – 10 days following surgery. The actual length of time depends on the amount of drainage that you produce. You will be educated on the care of the drains by the inpatient nurse prior to your discharge from the hospital.

# Timeline to Surgery

## 30 days to 1 week prior to your Surgery

1. **Schedule a pre-op physical with your primary care provider within 30 days of surgery. Please make sure this is completed at least one week prior to your surgery date.**
    - *NOTE: Tell the surgery scheduler when they call you if you do not have a primary care provider.*
    - *If you see a heart doctor (cardiologist) or a lung doctor (pulmonologist), please discuss with your primary care physician or the surgeon if you need surgery clearance from the specialist.*

2.  **Smoking People who smoke can have breathing problems when they have surgery.** Stopping even a few days before surgery can help. If you smoke, please make an appointment with your primary care provider to discuss ways to stop. Smoking also slows the healing process.

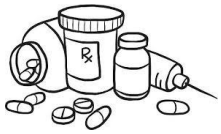
3. **Nutrition is important way to help you prepare for surgery and heal from surgery.** Eating a well-balanced diet and increasing your fluid intake will help with your healing process. Increasing your daily fiber and fluids will help to maintain regular bowel movements. You may take over the counter laxatives or stool softeners if needed to stay regular before and after surgery. Drink 6 – 8 full glasses of water each day for 3 days prior to surgery. This will allow you to be well hydrated for surgery and help flush out the anesthesia medications. Limit your caffeine intake one week prior to surgery, since caffeine is a natural diuretic (water pill). Alcohol consumption should be decreased

4. **Have someone to take care of you after surgery.** This person will need to be at the hospital after your surgery for the discharge instructions. If you will be admitted to the hospital after your surgery, your person does not need to stay for the entire surgery.

5. **Have someone to drive you home after surgery.** You must have someone 18 years or older to take you home after surgery. Taxi transportation is allowed if you have family or a friend to ride with you.

6. **Special Considerations**
    - Tell your surgeon if you have any medical conditions that require pre-procedure antibiotic prophylaxis.
    - Tell the surgeons' office if you are taking any blood thinning medications such as fish oil, glucosamine chondroitin, vitamin E, Coumadin, Warfarin, Plavix, Lovenox, Heparin or Fragmin.

7. **One week before your surgery, please stop taking the following medications:**
   - Ibuprofen, Advil, Motrin, Aleve, Naproxen, etc. – these medications can increase the chances of bleeding during and after surgery. It is okay to use Tylenol (acetaminophen).
   - Aspirin or aspirin containing medications
   - Cold medications that contain aspirin, ibuprofen or naproxen.



8. **Disability and FMLA paperwork.** Forward this paperwork to our offices. Please allow 10 business days for paperwork to be completed. You may bring the paperwork to the Breast Center or fax it.
   - Bethesda North patients, please fax your paperwork to (513) 865-5923.
   - Bethesda Butler and Good Samaritan patients, please fax your paperwork to (513) 862-5164.

9. You will receive a phone call from the Pre-Admission Testing department the week prior to surgery to review your medical history and medications.

10. **For any questions concerning your surgery appointment and/or localization procedure information, contact Dr. Wexelman's and Dr. Kuritzky's Surgery Schedulery at 513 865 5942. You may reach Dr. Raque's scheduler at 513 865 5110.**

## The night prior to your surgery

1. **Shower with antibacterial soap such as Dial**. Do not apply lotions, powders or deodorant. This can be done the morning of surgery as well.
2. **Go to bed early and get a full night of rest.**
3. **Do not eat or drink after midnight before your surgery** unless your doctor or anesthesiologist tells you otherwise. This includes foods, liquids, water, coffee, candy, gum and breathe mints.

## Morning of Surgery

1. **Do not eat or drink after midnight on the morning of surgery unless told otherwise.**

2. You may brush your teeth or rinse your mouth the morning of surgery however do not swallow anything. Our pre-admission testing department will discuss with you if you may take your morning medications with a sip of water.

3. If you take insulin or any other routine medication, your doctor or anesthesiologist will tell you how to take your medication the day of your procedure.

4. Do not wear any makeup, lotion, powder or deodorant.

5. Avoid wearing any jewelry or bringing valuables with you.

6. If you wear contact lenses, please wear your glasses instead.

7. Dress comfortably with loose fitting clothes that open in the front to make getting dressed for the trip home easier. Front closing tops are the easiest to wear immediately following surgery.

8. Bring a list of your medications, driver's license or state ID and your insurance card to the hospital.

9. You will meet with your breast surgeon before your operation and before you undergo anesthesia. The surgeon will mark your breast for surgery and review your consent form.

10. You will meet with your anesthesiologist. He or she will review your medical history, discuss the type of anesthesia that will be used and answer any questions that you may have.

## Hospital Stay

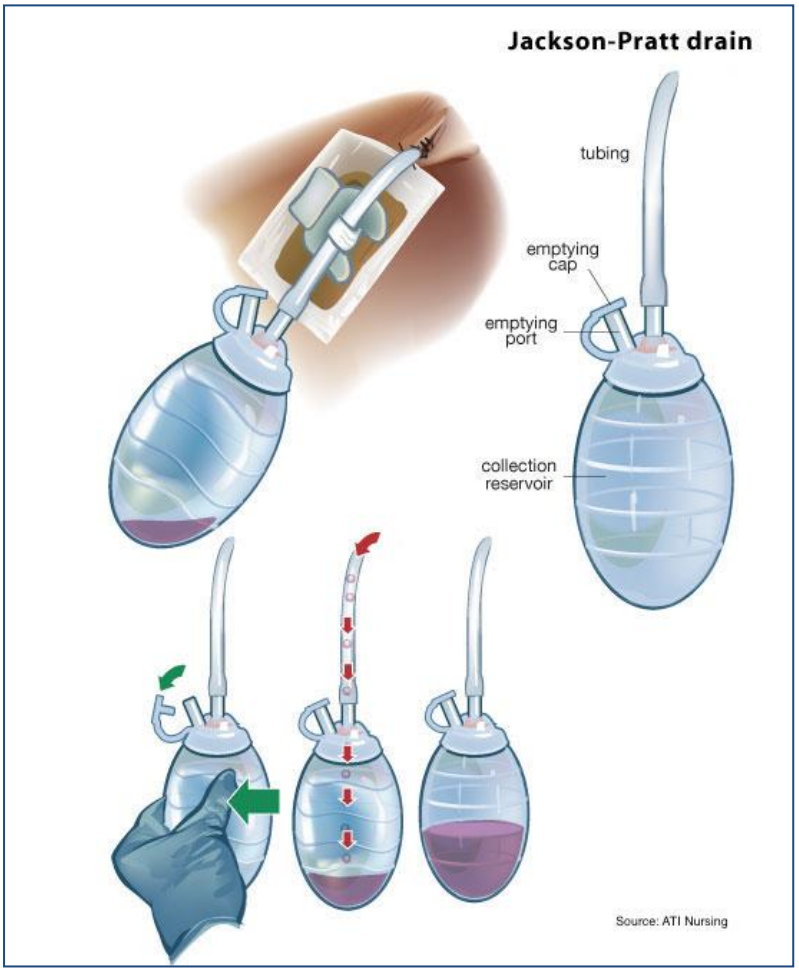
1. **Required for patients having a mastectomy and/ or having an axillary dissection.**
2. You will stay in the hospital for one at least one night after surgery.
3. We will make sure that your pain is controlled before you go home.
4. You will be sent home with drains in place. The nurses will teach you how to empty and record the drainage.
5. We will set up a home care nurse to come to your home after discharge if necessary.

## Typical Symptoms after Surgery

- **Tightness in the breast area, stiffness; tingling, burning or intermittent shooting pain**. These are normal experiences as the skin, muscles, tissue and nerves heal. *Consistent sharp pain or trouble breathing should be reported to our office immediately.*
- **Shiny skin or any itchy feeling.** Swelling can cause the breasts to appear shiny. As you heal, you may have mild to severe itchy feeling of the breast. An antihistamine like Benadryl can help to alleviate severe, constant itchiness. If the skin becomes red and hot to the touch, contact our office immediately.
- **Numbness along the incision line is normal.**
- **Seroma - the most common complication after breast surgery.** A seroma is a build-up of clear bodily fluids in a place on your body where tissue has been removed by surgery. Seromas can appear about 7 to 10 days after surgery, or after the drainage tubes have been removed. The breast area involved in the surgery may have a spot that's swollen and feels like there is liquid under the skin. **Tell your doctor if:**
    - the amount of fluid seems to be increasing or the seroma is putting pressure on the healing area or you notice signs of infection such as redness, warmth, or tenderness

# Drain Information

**What is a surgical drain?**




After a surgery, fluid may collect inside your body in the surgical area. This makes an infection or other problems more likely. A surgical drain allows the fluid to flow out and allows the skin of the breast to attach to the chest wall. The doctor will put a thin rubber tube into the area of your body where the fluid is likely to collect. The rubber tube will carry the fluid outside your body. The most common type of surgical drain carries the fluid into a collection bulb that you empty. This is called a Jackson-Pratt drain. The drain uses suction created by the bulb to pull the fluid from your body into the bulb.

The rubber tube will probably be held in place by one or two stitches in your skin. Most people attach the bulb with a safety pin to clothing or near the bandage so that it doesn't flip around or pull on the stitches. We will also provide you with a lanyard to wear around your neck to hold the drains. When you first get the drain, the fluid will be bloody. It will change color from red to pink to a light yellow or clear as the wound heals and the fluid starts to go away.

Your doctor may give you specific information on when you no longer need the drain and when it will be removed. In general, you will need the drain until you are collecting less than 2 tablespoons (30ml) of fluid in 24 hours for 2 consecutive days. Please be aware that all drains may not be removed at the same time if they are draining the same area. Follow-up care is a key part of your treatment and safety.

**How can you care for yourself at home?**

- Follow any instructions your doctor gives you.
- Empty the bulb at least 2 times daily and when it is half full.

**To empty the bulb:**

1. Wash your hands with soap and water.
2. Take the plug out of the bulb.
3. Empty the bulb into a measuring cup, and write down how much you collected including the date and time of collection.
4. Clean the plug and put it back into the bulb.
    a. Use alcohol to clean the plug.
    b. Squeeze the bulb until it is flat. This removes all the air from the bulb. You may need to put the bulb on a table or a counter to flatten it.
    c. Keep the bulb flat and put the plug in.
    d. The bulb should stay flat after you put the plug back in. This creates the suction that pulls the fluid into the bulb.
5. Empty the fluid into the toilet.
6. Wash your hands.
7. Document you drain output FOR EACH DRAIN on a log for your records. Please bring your log with you for the surgeon to review to ensure the drain is ready to be removed.

**Caring for the Insertion site**

You may have a bandage. Your doctor will tell you how often to change it.

1. Wash your hands with soap and water.
2. Take off the bandage from around the drain.
3. Clean the drain site and the skin around it with soap and water. Use gauze or a cotton swab.
4. Sometimes, the drain causes redness the size of a dime at your insertion site. This is normal.
5. Look for tenderness, swelling or pus from the insertion site. If you have any of these symptoms or a temperature of 100.5F or higher, you may have an infection. Please call your surgeon or nurse.

**Drain care**

Squeezing or "milking" the tube can help prevent clogs so that it drains correctly. You will do this at least 2 times per day or as often as needed when:

- You see a clot in the tube that is preventing fluid from draining. The clot may look like a dark, stringy lining.
- You see fluid leaking around the tube where it goes into the skin.
- You think there is no suction in the drain.

**To milk or strip the tube:**

- Use one hand to hold and pinch the tube where it leaves the skin.
- With the other hand, pinch the tube with your thumb and first finger just below where you're holding it.
- Slowly and firmly push your thumb and first finger down the tubing toward the bulb.
- Do this as many times as you need to. The clot should move down the tube and into the bulb.