World Academy of Science, Engineering and Technology
International Journal of Biomedical and Biological Engineering
Vol:10, No:02, 2016

Grisotti Flap as Treatment for Central Tumors of the Breast

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Abstract : Introduction : Within oncoplastic breast techniques there is increased interest in immediate partial breast reconstruction. The volume resected is greater than that of conventional conservative techniques. Central tumours of the breast have classically been treated with a mastectomy with regard to oncological safety and cosmetic secondary effects after wide central resection of the nipple and breast tissue beneath. Oncological results for central quadrantectomy have a recurrence level, disease- free period and survival identical to mastectomy. Grissoti flap is an oncoplastic surgical technique that allows the surgeon to perform a safe central quadrantectomy with excellent cosmetic results. Material and methods: The Grissoti flap is a glandular cutaneous advancement rotation flap that can fill the defect in the central portion of the excised breast. If the inferior border is affected by tumour and further surgery is decided upon at the Multidisciplinary Team Meeting, it will be necessary to perform a mastectomy. All patients with a Grisotti flap undergoing surgery since 2009 were reviewed obtaining the following data: age, hystopathological diagnosis, size, operating time, volume of tissue resected, postoperative admission time, re-excisions due to positive margins affected by tumour, wound dehiscence, complications and recurrence. Analysis and results of sentinel node biopsy were also obtained. Results: 12 patients underwent surgery between 2009-2015. The mean age was 54 years (34-67) . All had a preoperative diagnosis of ductal infiltrative carcinoma of less than 2 cm,. Diagnosis was made with Ultrasound, Mamography or both . Magnetic resonance was used in 5 cases. No patients had preoperative positive axilla after ultrasound exploration. Mean operating time was 104 minutes (84-130). Postoperative stay was 24 hours. Mean volume resected was 159 cc (70-286). In one patient the surgical border was affected by tumour and a further procedure with resection of the affected border was performed as ambulatory surgery. The sentinel node biopsy was positive for micrometastasis in only two cases. In one case lymphadenectomy was performed in 2009. In the other, treated in 2015, no lymphadenectomy was performed as the patient had a favourable histopathological prognosis and the multidisciplinary team meeting agreed that lymphadenectomy was not required. No recurrence has been diagnosed in any of the patients who underwent surgery and they are all disease free at present. Conclusions: Conservative surgery for retroareolar central tumours of the breast results in good local control of the disease with free surgical borders, including resection of the nipple areola complex and pectoral major muscle fascia. Reconstructive surgery with the inferior Grissoti flap adequately fills the defect after central quadrantectomy with creation of a new cutaneous disc where a new nipple areola complex is reconstructed with a local flap or micropigmentation. This avoids the need for contralateral symmetrization. Sentinel Node biopsy can be performed without added morbidity. When feasible, the Grissoti flap will avoid skin-sparing mastectomy for central breast tumours that will require the use of an expander, prosthesis or myocutaneous flap, with all the complications of a more complex operation.

Keywords : Grisotti flap, oncoplastic surgery, central tumours, breast
Conference Title : ICBC 2016 : International Conference on Breast Cancer
Conference Location : London, United Kingdom
Conference Dates : February 25-26, 2016