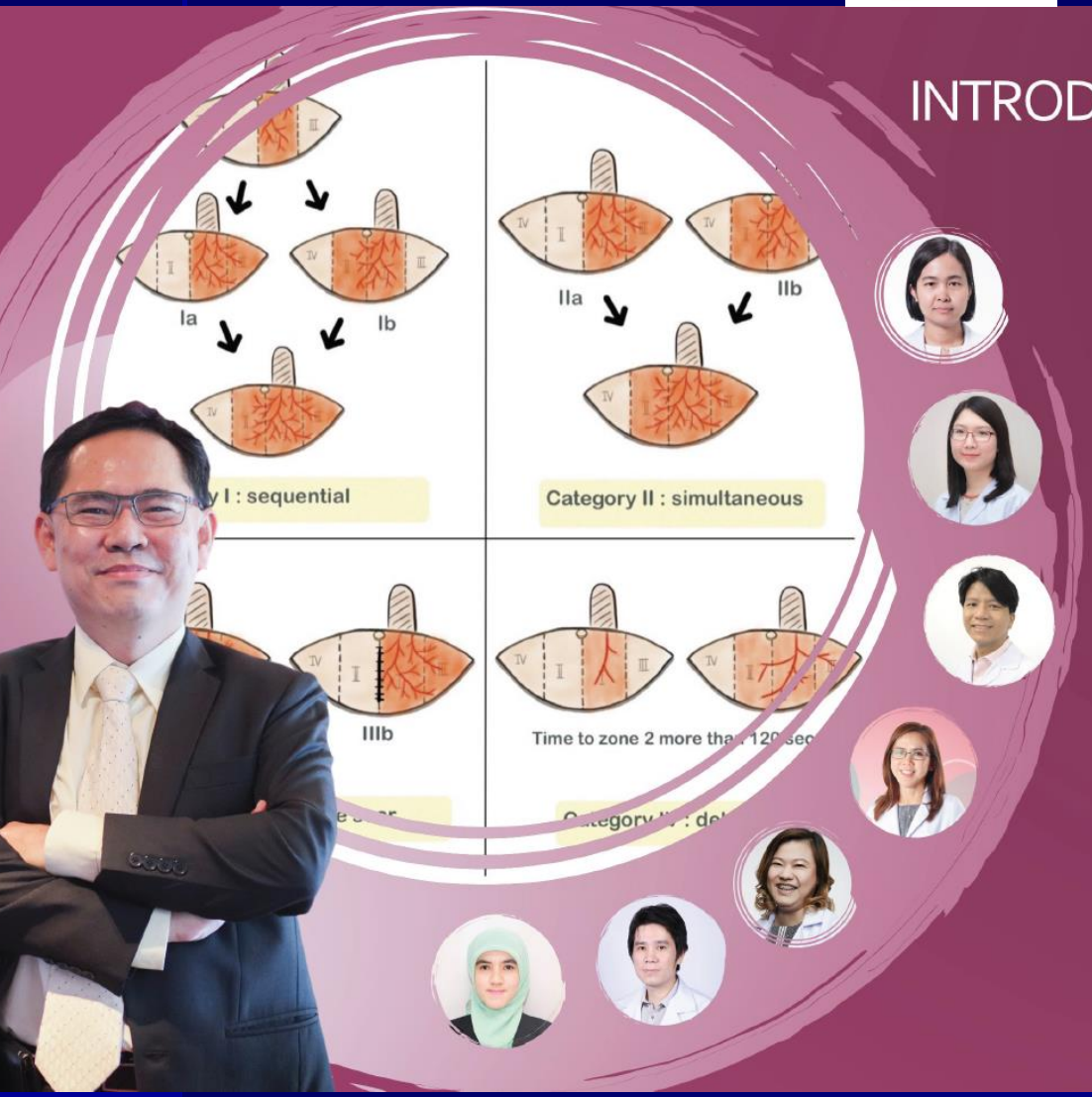

INTRODUCTION TO SURGICAL RESEARCH

ยาขมของศัลยแพทย์ : จากการวิจัยสู่ NEW KNOWLEDGE OF YAYA'S CLASSIFICATION

โดย รศ.นพ. ประกาศิต จิรัปปภา

Breast and Endocrine Surgery Unit, Department of Surgery,
Faculty of Medicine, Ramathibodi Hospital, Mahidol University

Acknowledgement: We wish to acknowledge Ms. Suraida Aeesoa for stat ist ical analysis of the text and Dr. Panya Thaweepworadej, Dr. Chayanoot Rattadilok, Dr. Chuleekorn Lawonggerd to encourage these operations.

ผศ.พญ. เยาวนุช คงด่าน และนพ. ประกาศิต จิรัปปภา ภาควิชาศัลยศาสตร์ ได้เดินทางไปนำเสนอผลงานในงานประชุม “Breast cancer: oncologic and reconstructive surgery. Interactive course with live surgery.” เมื่อวันที่ 18-20 มิถุนายน 2550 ณ กรุงมิลาน ประเทศอิตาลี ประเภท Oral presentation จำนวน 2 เรื่อง คือ “Sentinel lymph node biopsy performed under local anesthesia is applicable and accurate.” ซึ่งเป็นการผ่าตัดหาต่อมน้ำเหลืองเซนติเนลด้วยเทคนิคการใช้ยาชาเฉพาะที่เป็นแห่งแรกในประเทศไทย และเรื่อง “One-year follow-up of mastectomy with immediate LD flap reconstruction by the extended LD flap technique.” ซึ่งเป็นการผ่าตัดเสริมสร้างเต้านมใหม่ในผู้ป่วยมะเร็งเต้านมโดยใช้กล้ามเนื้อหลัง ซึ่งทำมากที่สุดในประเทศไทยในขณะนี้ และยังได้นำเสนอผลงานประเภท Poster presentation เรื่อง “Epidermiologic study 4546 breast cancer patients in Thailand.” ในงานประชุม “9th Milan Breast Cancer Conference” เมื่อวันที่ 21-22 มิถุนายน 2550 พร้อมนำทีมอาจารย์ในคลินิกโรคเต้านม หน่วยศัลยศาสตร์ทั่วไป สายบี อีก 4 ท่าน ไปศึกษาดูงานเพื่อกลับมาพัฒนาการรักษาผู้ป่วยโรคเต้านมในรามาธิบดีเพื่อให้เป็นผู้นำในระดับภูมิภาค ตามวิสัยทัศน์ของคณะฯ ต่อไป

สนใจข้อมูลเพิ่มเติม : http://www.cancerthai.org/slide/index.asp

J Med Assoc Thai. 2011 Jan;94(1):65-70.

Predictive factors of axillary lymph node metastasis in breast cancer.

Wasuthit Y[1], Kongdan Y, Suvikapakornkul R, Lertsithichai P, Chirappapha P.

Author information

Abstract

OBJECTIVE: To identify clinical, radiologic and pathologic factors significantly related to axillary lymph node (ALN) metastasis in women with operable breast cancer.

MATERIAL AND METHOD: Records of women with operable invasive breast cancer treated between July 2002 and May 2006 were reviewed Data on the number of axillary nodes, number of positive nodes, preoperative clinical, mammographic, and pathologic characteristics of each breast cancer were retrieved. Multiple logistic regression analyses were used to identify significant predictors of ALN metastasis.

RESULTS: Records of 590 patients were reviewed Positive ALNs were found in 302 patients (51%). Independent and significant predictors of ALN metastasis included younger age, larger tumor size, presence of lymphovascular invasion, category 5 mammograms and low mammographic breast density. The combination of age less than 60 years, low mammographic breast density, category 5 mammogram, tumor larger 1 cm., and presence of lymphovascular invasion, had a specificity for predicting ALN metastasis of over 95%.

CONCLUSION: A combination of clinical, radiologic, and pathologic characteristics highly specific for predicting ALN metastasis was found This prediction rule might be useful for selecting breast cancer patients for full ALN dissection without a preliminary SLNB.

J Med Assoc Thai. 2012 Jul;95(7):903-8.

Breast cancer cells in the afferent lymphatic tracts of sentinel lymph nodes.

Chirappapha P[1], Ratchaworapong K, Wongwaisayawan S, Lertsithichai P, Suvikapakornkul R, Wasuthit Y, Kongdan Y.

Author information

1 Department of Surgery, Faculty of Medicine, Ramathibodi Hospital, Mahidol University, Bangkok, Thailand.

Abstract

BACKGROUND: To identify breast cancer cells in the afferent lymphatic tracts of axillary sentinel lymph nodes (SLNs).

MATERIAL AND METHOD: The authors performed a prospective study of 1 00 breast cancer patients who underwent SLN biopsy between June 2009 and January 2010. The afferent lymphatic tracts of SLNs were identified by isosulfan blue or radiocolloid or both and were examined histologically.

RESULTS: One hundred three SLNs and afferent lymphatic tracts were examined. The mean age of the patients was 53.2 years (range, 24 to

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The Breast 17 (2008) 528–531
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Original article

Effectiveness and reliability of sentinel lymph node biopsy under local anesthesia for breast cancer

Youwanush Kongdan*, Prakasit Chirappapha, Panuwat Lertsithichai

Department of Surgery, Faculty of Medicine, Ramathibodi Hospital, Mahidol University, Bangkok 10400, Thailand

R ril 2008

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- **Brain barriers:** **Solutions: 3M**
- - Failure to *See* □ Midset
- - Failure to *Move* □ Management
- - Failure to *Finish* □ Materials

" Success is Science……
If someone can ….we can !!!" *

Mindset (เตรียมใจ)

- ให้คุณค่า (Value)
- ไม่ว่ากัน (Agree)
- ฝันให้ไกล (Ambition)
- ไปให้ถึง (Drive)

Management (เตรียมตัว)

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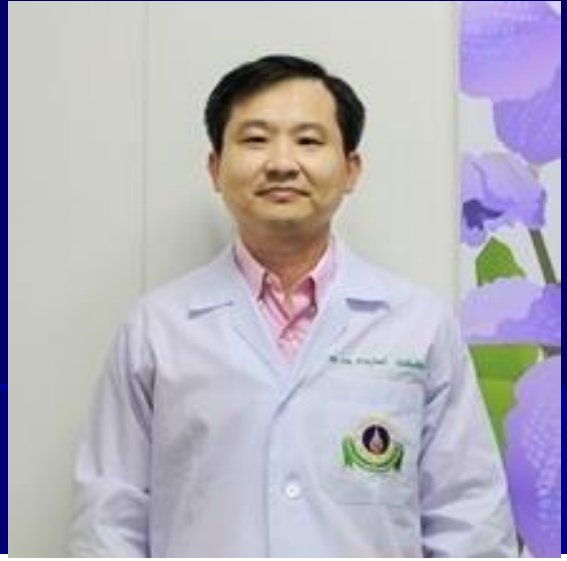

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Panuwat Lertsithichai <panuwat.ler@mahidol.ac.th> 13/09/2012

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อจอาจจองตั๋วเครื่องบิน วางแผนกลับเยี่ยมบ้านแต่เนิ่นๆ จะได้มีกำลังใจทำงานไปก่อนได้
สำหรับงานวิจัยของอจประกาศิต ไม่ต้องกังวล เรามีทีมงานช่วยวิเคราะห์ข้อมูลและช่วยร่าง manuscript หากจำเป็น
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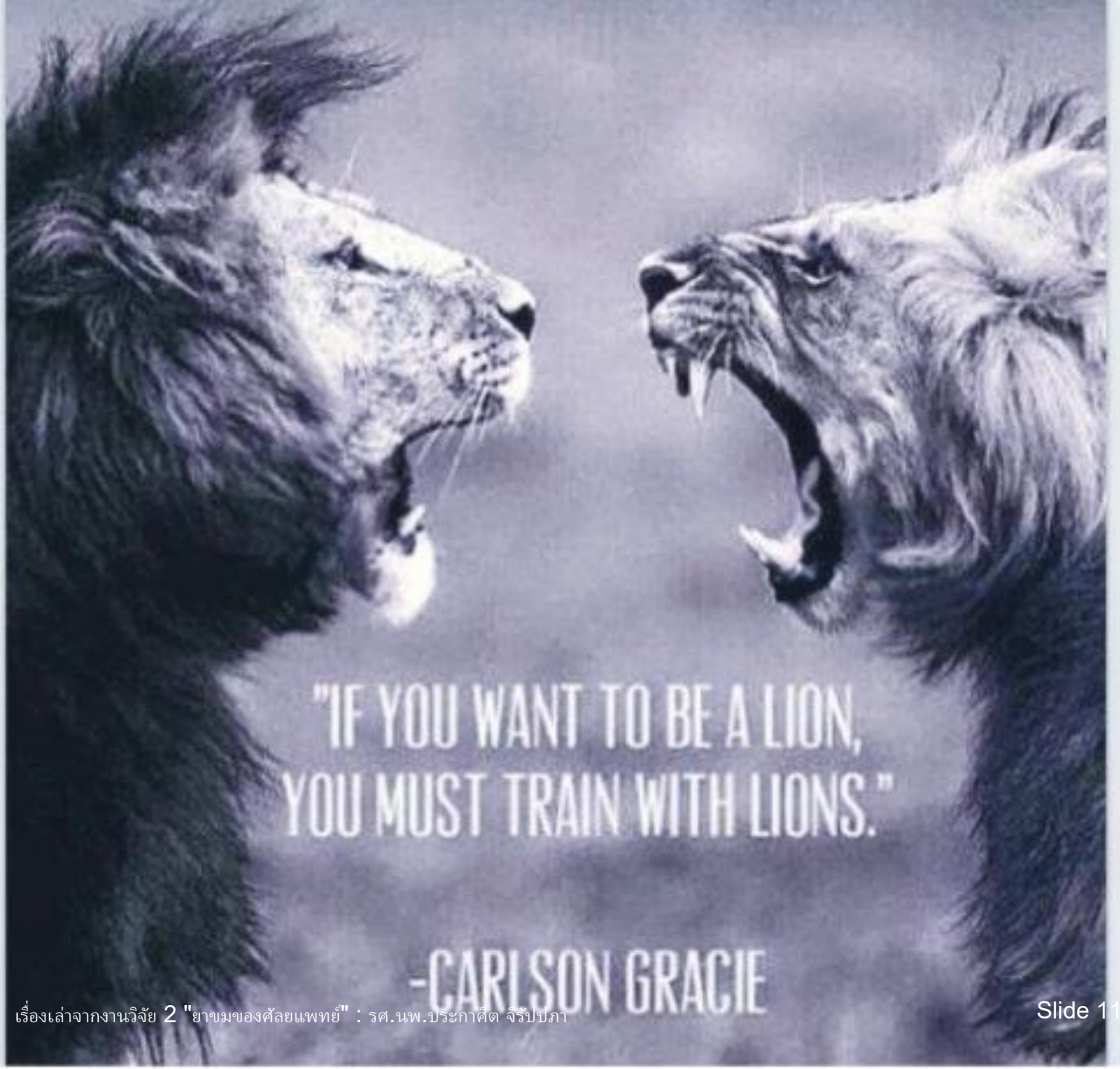
"IF YOU WANT TO BE A LION,
YOU MUST TRAIN WITH LIONS."
-CARLSON GRACIE

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10


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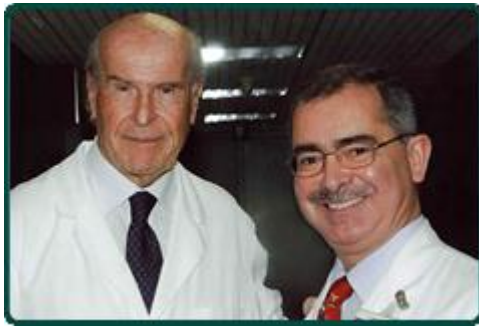
1

Review Article

Sentinel lymph node biopsy under local anesthesia with breast cancer



Prakasit Chirappapha[1,2], Visnu Lohsiriwat[1,3], Youwanush Kongdan[2], Panuwat Lertsithichai[2], Thongchai Sukarayothin[2], Chairat Supsamutchai[2], Nina Talakhadze[4], Stefano Zurrida[4]

[1]Department of Plastic and Reconstructive Surgery, European Institute of Oncology, Milan, Italy; [2]Department of Surgery, Faculty of Medicine Ramathibodi Hospital, Mahidol University Bangkok, Thailand; [3]Department of Surgery, Faculty of Medicine Siriraj Hospital, Mahidol University Bangkok, Thailand; [4]Division of Senology, European Institute of Oncology, Milan, Italy

Review Article

Oncoplastic technique in breast conservative surgery for locally advanced breast cancer

Prakasit Chirappapha[1,2], Youwanush Kongdan[2], Wichai Vassanasiri[3], Kampol Ratchaworapong[4], Thongchai Sukarayothin[2], Chairat Supsamutchai[2], Phatarachate Klaiklern[5], Monchai Leesombatpaiboon[2], Alaa Hamza[1], Stefano Zurrida[6]

[1]Department of Plastic and Reconstructive Surgery, European Institute of Oncology, Milan, Italy; [2]Department of Surgery, Faculty of Medicine, Ramathibodi Hospital, Mahidol University, Bangkok, Thailand; [3]Department of Surgery, Faculty of Medicine, Phramongkutklao Hospital, Bangkok, Thailand; [4]Department of Surgery, Charoenkrung-Pracharak Hospital, Bangkok, Thailand; [5]Breast Clinic, Bangkok Hospital, Rayong, Thailand; [6]Division of Senology, European Institute of Oncology, Milan, Italy

Corresponding to: Dr. Prakasit Chirappapha. Division of Plastic Surgery, European Institute of Oncology, Via Ripamonti, 435, 20141 Milan, Italy.

The New York Times

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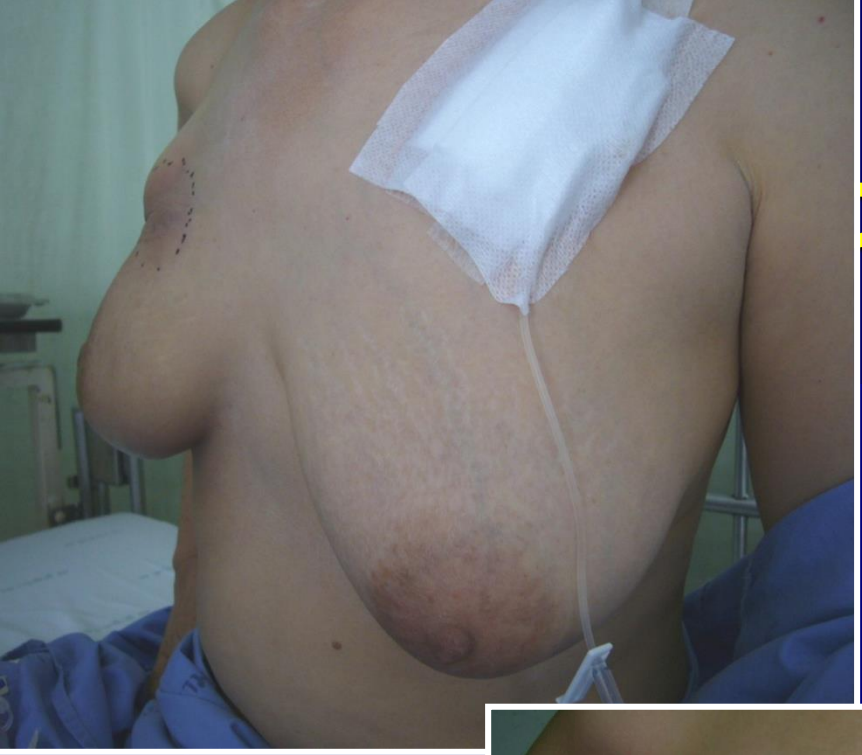
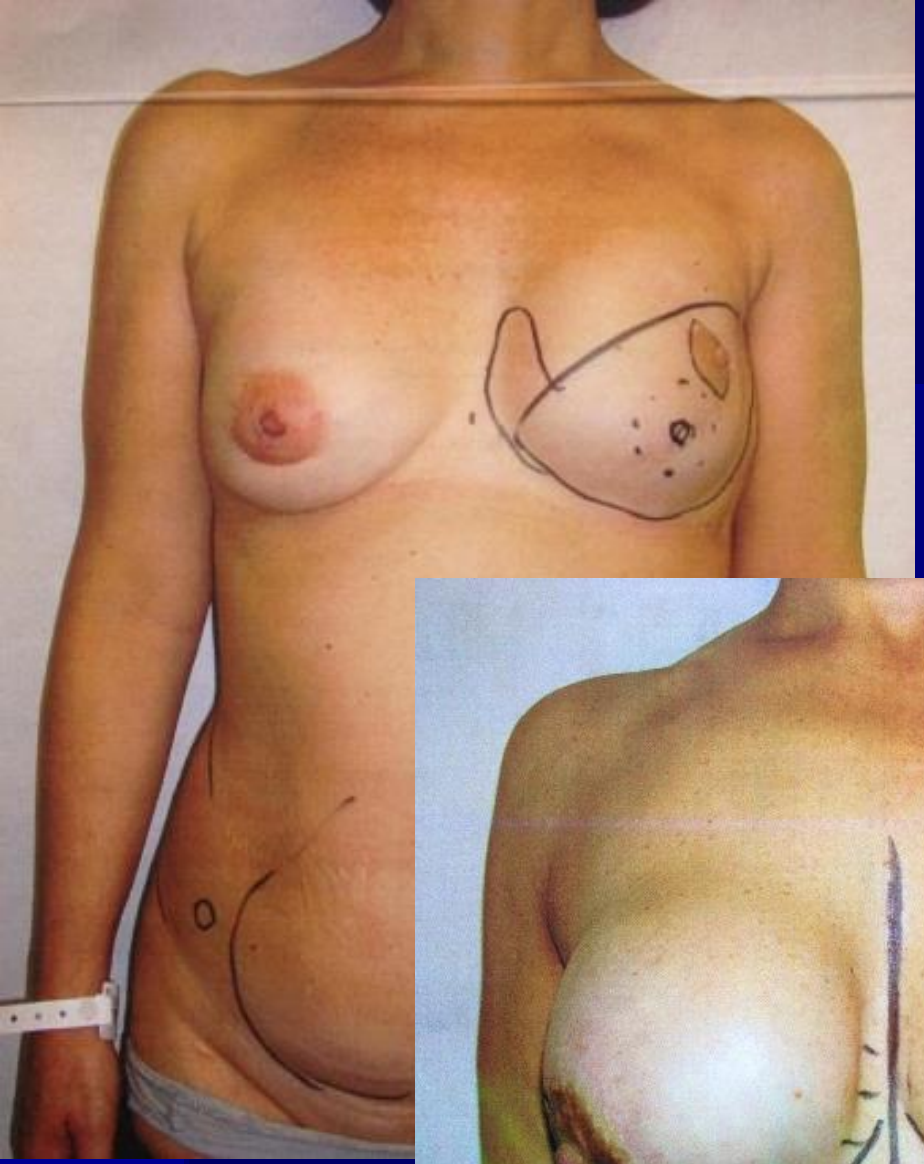
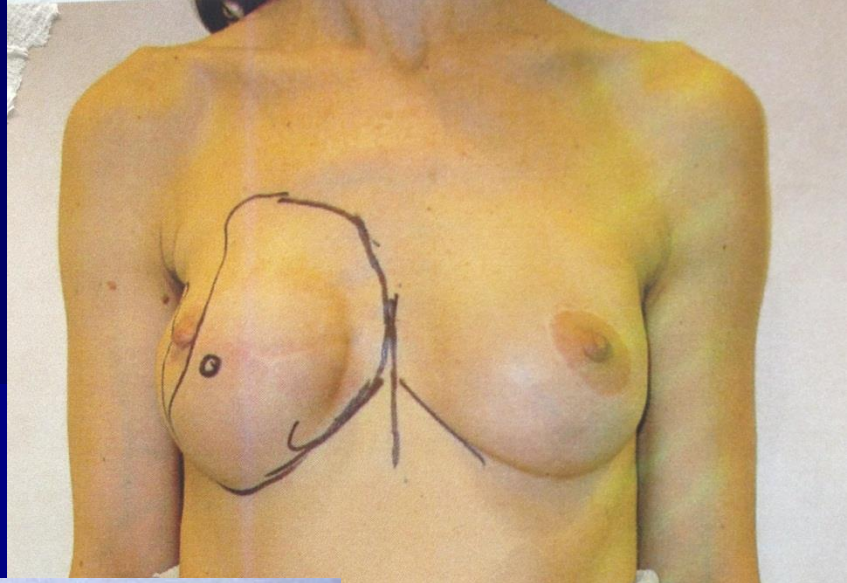
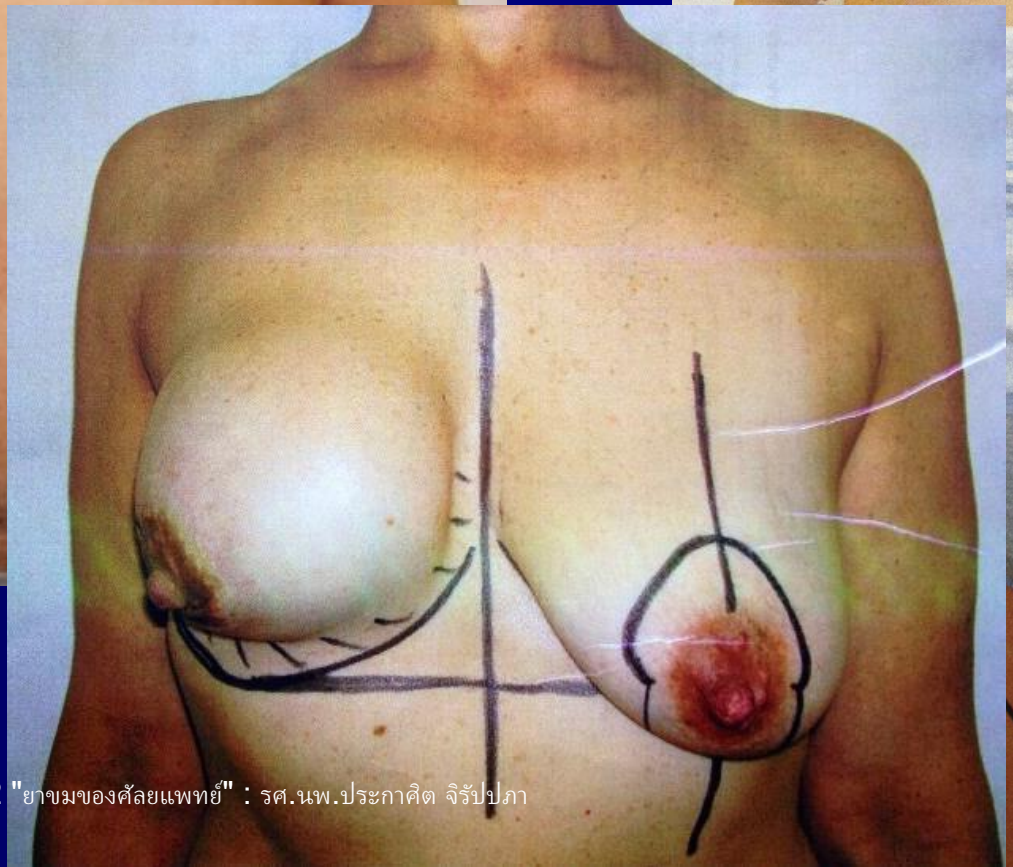
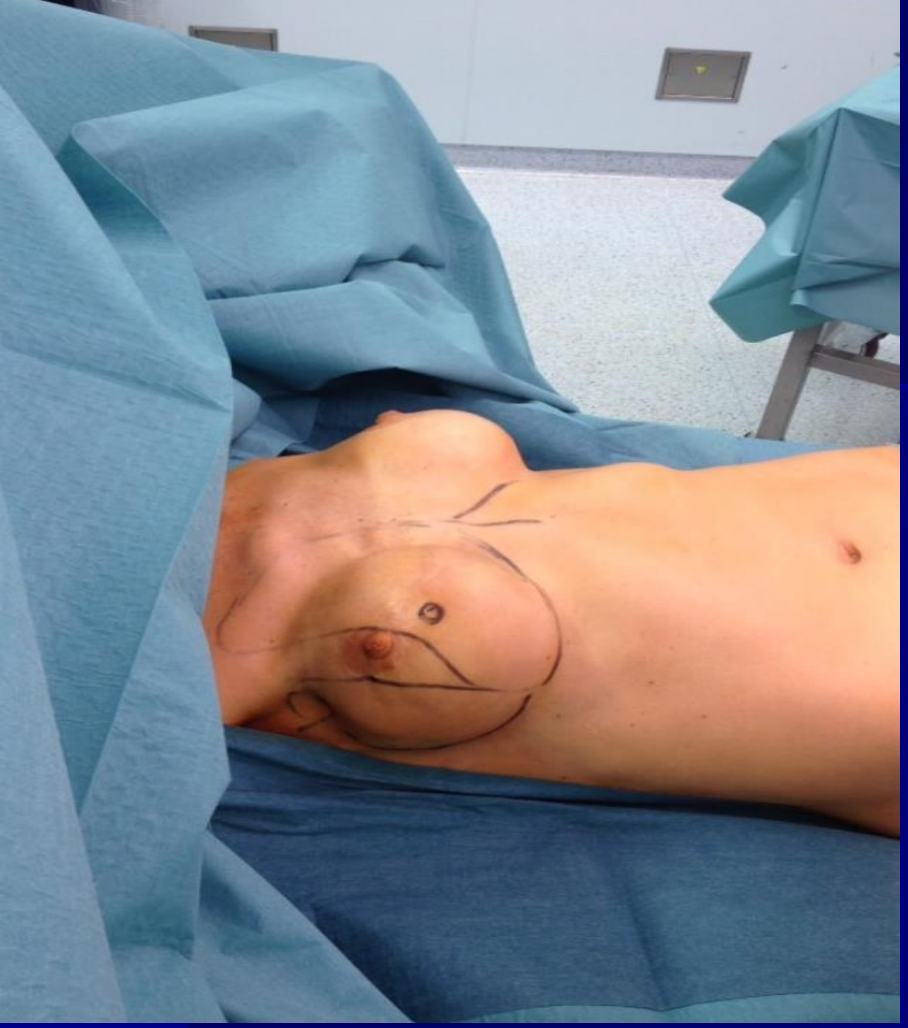
Alaa Hamza

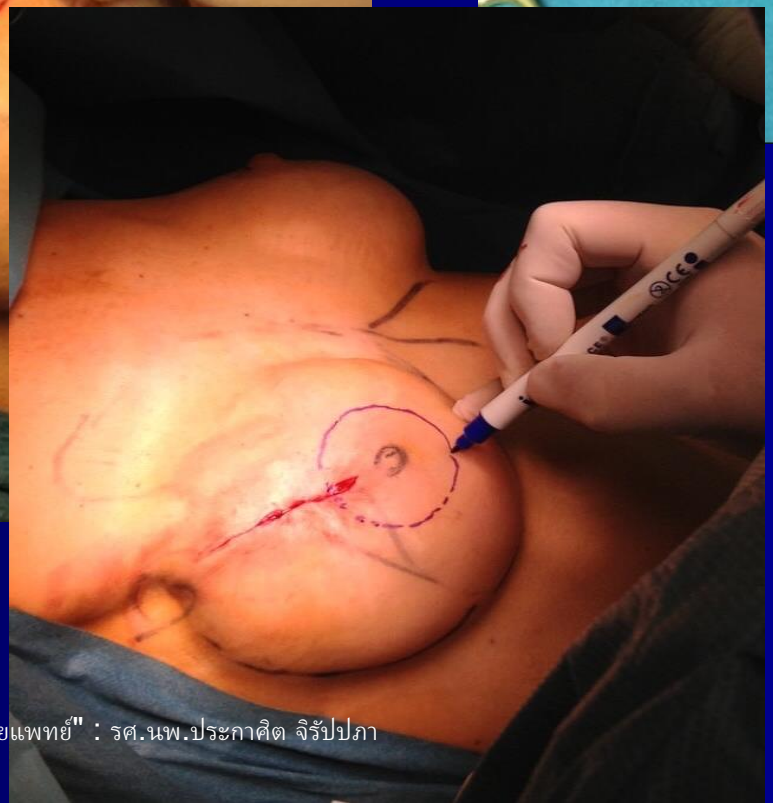












Author	Year	No. Cases	Preoperative Diagnosis	Operative Technique	Complication
Ali et al[15]	1997	1	Malposition of reconstructed NAC after NSM with a pedicled LD flap	Rotating the figure 8 shaped NAC graft	None
Spear and Hoffman[10]	1998	2	Displaced NAC after NSM with implant, augmentation with infection	Reciprocal full-thickness skin grafts	None
Mohmand and Naasan[1]	2002	1	Distortion NAC after burn	Double U-Plasty	None
Colwell et al[4]	2007	3	High position of nipples after reduction, augmentation/mastopexy	Infraclavicular subcutaneous tissue expansion	None
Frenkiel et al[11]	2010	1	High-riding nipple after NSM with implant and WBR	Z-plasty transposition	None
Takayanagi[19]	2010	2	Malpositioned nipple after NSM	Two subcutaneous pedicles and the purse-string suture	None
Taneda and Sakai[18]	2011	1	Malpositioned nipple after NSM	Rotation flap and an advancement flap	None
Staley and Serra[16]	2012	1	Malpositioned nipple after wide local excision	Transposition flap and skin graft	None
Spear et al[17]	2013	4	High-riding nipple after NSM with implant and WBR, mastopexy	Reciprocal transposition flap	Transient flap ischemia 1 case

LD, latissimus dorsi; WBR, whole breast radiation.

Preoperative Evaluation and Surgical Planning

All patients underwent a physical examination preoperatively and postoperatively. The midsternal and midclavicular lines were marked before surgery and the inframammary folds with the patient in the standing position. These anatomical landmarks help the surgeon to define the ideal NAC position. The area of parenchymal defect to be corrected with fat grafting and the new NAC location were marked on the breast. The new position of NAC was planned between 21 and 23 cm from the sternal notch, being approximately at the same level of the contralateral NAC with the patient standing with abducted arms (Fig. 1).

Operative Technique

With the patient standing, the new NAC area was marked corresponding to the size of the existing NAC. The NAC was harvested as a full-thickness graft with a scalpel at the level of the subdermis, preserving

Fig. 2. The NAC graft is removed and saved.

Free Nipple Graft Technique to Correct Nipple and Areola Malposition after Breast Procedures

Mario Rietjens, MD*
Francesca De Lorenzi, MD, PhD*
Manconi Andrea, MD*
Prakasit Chirappapha, MD*†
Stefano Martella, MD*
Benedetta Barbieri, MD*
Alessandra Gottardi, MD*
Lomeo Giuseppe, MD*
Alaa Hamza, MD*
Jean-Yves Petit, MD*
Visnu Lohsiriwat, MD*

Summary: Secondary correction of nipple areola complex (NAC) malposition represents a major concern after breast reconstructive procedures. It is frequently requested by patients complaining about asymmetric areolas impairing the whole reconstructive procedure and asking for improved cosmetic outcomes. Several methods have been described to achieve a good symmetry between the 2 areolas, either natural or reconstructed. We describe our correction technique with free NAC graft. A total of 16 patients were treated with free NAC grafts between April 2010 and April 2013 at the European Institute of Oncology, Milan, Italy. This series focused on the surgical technique and its postoperative outcomes. Three cases of partial graft loss (18%) were observed in the postoperative period. No total NAC necrosis occurred. No infection was observed. All the complications were managed with a conservative treatment, not requiring any further surgery. NAC malposition following breast reconstructive procedures can be corrected using the technique of free NAC graft with reliable and satisfactory results. *(Plast Reconstr Surg Glob Open 2013;1:e69; doi: 10.1097/*

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Egr. Sig.
Dott. Prakasit CHIRAPPAPHA
Via Avancinio Avancini, 4
20142 MILANO MI

Milano, 20 agosto 2012
Hr/12/1111/am

Egregio Dottor Chirappapha,

abbiamo il piacere di confermarle che è stata accettata la sua richiesta di poter frequentare, in qualità di "**frequentatore volontario**", la Divisione di Chirurgia Ricostruttiva del nostro Istituto.

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La informiamo che al suo arrivo in IEO dovrà contattare il Servizio Amministrazione del Personale-DRUO per il completamento della pratica amministrativa.

Nel rivolgerle il benvenuto e con l'augurio che il suo impegno futuro possa rappresentare un utile apporto per la sua formazione professionale, la preghiamo di ritornare controfirmata per ricezione e accettazione l'allegata copia della presente.

Con i migliori saluti.

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dott. Daniele Piacentini

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Programma della Formazione Residenziale

Titolo: CORSO DI STATISTICA BIOMEDICA PER LA RICERCA CLINICA

Data inizio: 30/10/2012

Data fine: 18/12/2012

Durata corso totale ore: 16

Responsabile Scientifico: Santoro Luigi

FASCIA ORARIA	CONTENUTI	SPEAKER
8.00-10.00	*I test di ipotesi e le principali misure di associazione nella ricerca clinica*	*Luigi Santoro*
8.00-10.00	*La dimensione campionaria degli studi clinici*	*Davide Radice*
8.00-10.00	*Problematiche degli studi clinici di fase II*	*Sara Gandini*
8.00-10.00	*La metanalisi*	*Elena Pasquali*
8.00-10.00	*L'analisi della sopravvivenza*	*Edoardo Botteri*
8.00-10.00	*Sviluppo e valutazione dei modelli prognostici in ambito*	

2) ได้ฝึกช่วยเขียนงานวิจัยให้แพทย์ในทีม 4 ท่าน ดังนี้

2.1 เขียน case report เรื่อง The large pseudoangiomatous stromal hyperplasia located beneath nipple areolar complex for performing mastopexy with unavoidable thin nipple areolar complex flap : A case report ให้ *Dr. Lomeo Giuseppe* (เอกสารแนบ 1)

2.2 แก้ไขเพิ่มเติมงานวิจัยให้ *Dr. Cristina Garusi* (เอกสารแนบ 2)

2.3 เขียน case report เรื่อง Paget's disease arising at mastectomy skin flap after performing nipple-sparing mastectomy with immediate breast implant reconstruction: A case report ให้ *Dr. Stefano Martella* (เอกสารแนบ 3)

2.4 แก้ไขเพิ่มเติมงานวิจัยให้ *Dr. Thais Helena Antoniete Fernandes* (เอกสารแนบ 4)

3) ได้ร่วมวิเคราะห์ข้อมูลผลงานวิจัยเกี่ยวกับ lipofilling 'WAT cell profile' ของ *Prof. Jean-Yves Petit* (เอกสารแนบ 5)

4) เข้าร่วม Activity Grand Round ของสถาบันทุกเช้าวันพุธ (เอกสารแนบ 6)

5) ได้รับอนุญาตให้เขียน paper ดังนี้

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to Giuseppe.Lomeo

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I send the PASH file for you.

Prakasit Chirappapha

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Dr Giuseppe Lomeo

NAC Sparing Mastectomy

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Petit Jean Yves <jean.petit@ieo.it> 17/04/2013
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You can give a look to the first part of my correction

Prof. Jean Yves Petit
Divisione di Chirurgia Ricostruttiva
Division of Plastic Surgery
Via Ripamonti, 435 - 20141 Milano
T 0257489723 F 0294379203
E jean.petit@ieo.it W http://www.ieo.it/


paper NAC necro...

Nipple sparing mastectomy: Can we predict the breast morphological factors predisposing to necrotic complications?

ABSTRACT

Background: Nipple sparing mastectomy (NSM) can be performed for the treatment breast cancer and prophylactic mastectomy with oncologic safety. The risk ~~of necrotic complications are~~ the main limiting factor of NSM procedure and it is usually related to surgical technique. However, the patients' breast morphological factors should be also investigated.

Method: We prospectively performed an analysis of 124 NSM from September 2012 to January 2013 at the European Institute of Oncology (EIO), Milan, Italy, focusing on necrotic complications. We analyzed the association between the risks of necrotic complications and the breast morphological factors of the patients.

Results: Among 124 breasts in 113 patients, NSM procedures were associated with necrotic complications in 22 mastectomies (17.7%). Partial necrosis of NAC was observed in 15 of 124 NSM cases (12.1%), total necrosis was observed in 4 cases (3.2%).The NAC was removed in 5 cases (4%). The significant risk factor is volume of breast removed and significantly more patients with NAC necrosis had associated mastectomy skin flap necrosis.

Conclusions: In our study, breast morphological factors have a significant impact on necrotic

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Comment [JP8]: was the only significant factor increasing the risk of skin necrosis

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Comment [JP12]: other publications

Comment [JP13]: confirmed the safety of the nipple sparing mastectomy in

significant for NAC necrosis in our study which is different from other studies showing a significant impact on necrotic complications.[13,17,19,31,38] The reason for no association with NAC necrosis is the bias of our patient selections. Some ~~plastic surgeons preferred to put tissue expanders with minimal intraoperative expander inflation in patients that have high risk of NAC necrosis (large or pendulous breast, pale color NAC intraoperative) to prevent skin flap tension.~~

Surprisingly, skin incision types are not related to necrotic complications in our study. Several studies have shown that incision types are an important risk factor of NAC necrosis.[13,17,30,31] As we know, the periareolar incision provides the best cosmetic outcomes but limits view of operative field and this incision can compromise blood supply to the NAC.[33,34] Regolo et al. reported of 60% NAC loss with periareolar incision.[32] Lateral or inframammary incisions give a better view in the operative field and provide the good blood supply to the NAC.[35] Other authors also agree to use radial or lateral incisions. [13,15] On the contrary, Paepke et al. reported only a 1% of NAC loss with periareolar incision.[36] In our study, we had 25% of NAC necrosis in superior circumareolar and periareolar incisions that ~~is more than~~ 13% ~~from~~ other incisions but it was not statistically significant. This finding may related to the individual surgeon's technique. ~~The surgeon must carefully make the dissection of the gland more precisely and the preservation of the subdermal vessel network to the cutaneous flaps. To reduce severity of necrotic complications, the reconstruction should be performed with autologous flap (LD flap, TRAM flap) with the use of an additional implant.~~ When ~~mastectomy skin flap or NAC necrosis occurred, we sometimes performed only skin flap debridement with or without NAC and we did not remove implant because the flap could protect and cover it. In summary, surgeons should be familiar with the studies and complete removal of~~

Comment [JP63]: What the results in relation of the technique in these studies?

Comment [JP64]: The lack of difference in our study is probably due to a bias of patient's selection.

Comment [JP65]: The choice of technique for us and others is related to the quality of the skin blood supply at the end of the mastectomy. We prefer to place an expander moderately inflated or eventually to choose an autologous flap reconstruction in case of poor blood supply of the skin envelope

Comment [JP66]: 26%

Comment [JP67]:

Comment [JP68]: As compared with

Comment [JP69]: 14%

Comment [JP70]: in

Comment [JP71]: partial or total necrosis was treated by conservative dressing or debridement in 17 casesnwithout sremoving the prosthesis and skin or Nac removal in 5 cases usually with implant removal

necrosis after performing NSM. The study by Nahabedian et al. reported the risk of flap related complication due to inadequate vascular perfusion in patient with breast volume > 1,000 cc.[42] We recorded the volume of breast removed by measurement length, width and thickness of specimen after finishing NSM procedure and reported as cubic centimeter (cm^3). Interestingly, significant association could be seen between NAC necrosis and volume of breast removed (P= 0.042) which it was only one of the breast morphological factors that cause necrotic complications in our study ~~and significantly more patients with NAC necrosis had associated mastectomy skin flap necrosis (P<0.001) too. Despite the fact that most of our NAC patients had BMI less than 25 kg/m^{2}and had medium to large size breasts, both groups had a similar breast specimen weight. They may depend on the fact that majority of the breasts removed were relatively large and therefore there was difference in tension and stretching on the NAC and skin flap during operation.~~ This finding may be due to the individual surgeon's technique. Although this finding should be investigated by further ~~study and~~ larger studies, we recommend that the patients with volume of breast removed ≥ 750 cm^3 increase risk for NAC necrosis and flap-related morbidity.

Conclusion

Despite a relatively high necrotic complication rate (17.7%) after therapeutic NSM, NSM remains an option for appropriately selected patients. ~~In our study breast morphological factors have significant impact on necrotic complications in performing NSM procedure. High volume of breast removed indicates a risk of necrosis and the surgeon should perform NSM precisely and more caution in patients with this factor.~~

Comment [JP73]: to be placed in surgical technique

Comment [JP74]: we observed an increasing risk of necrosis related to the volume of the breast removed (p=0.042)

Comment [JP75]: Our study underlines the risk of skin and NAC necrosis in case of large glandular specimen and suggests to modify the choice of the technique in such cases and to prioritize the expander with slow expansion or autologous musculo cutaneous flap

OPEN

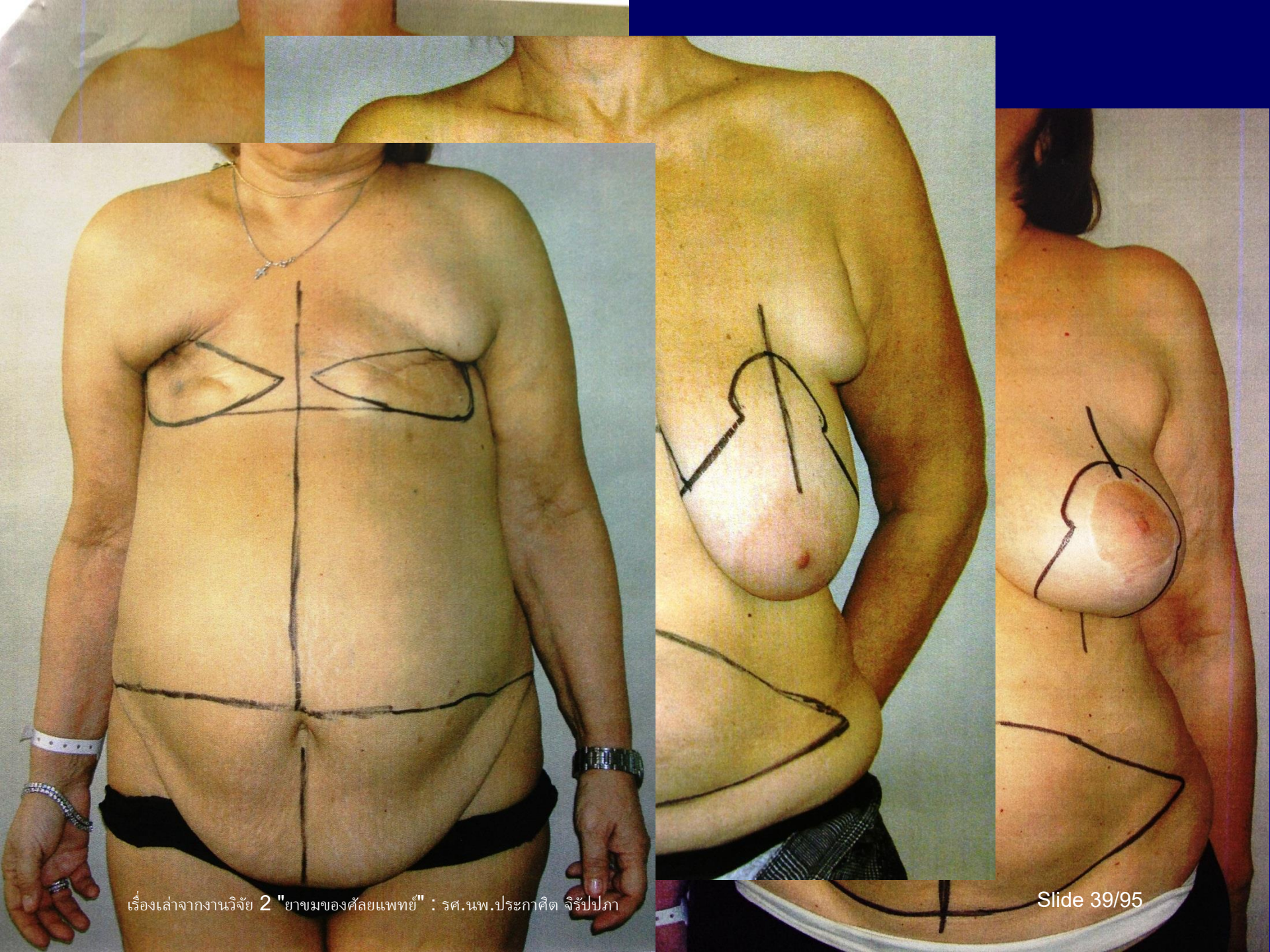
ORIGINAL ARTICLE

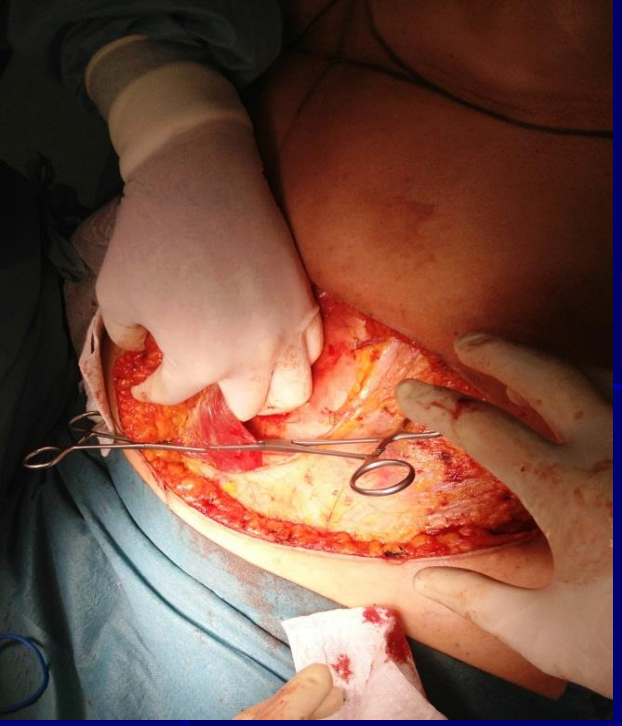
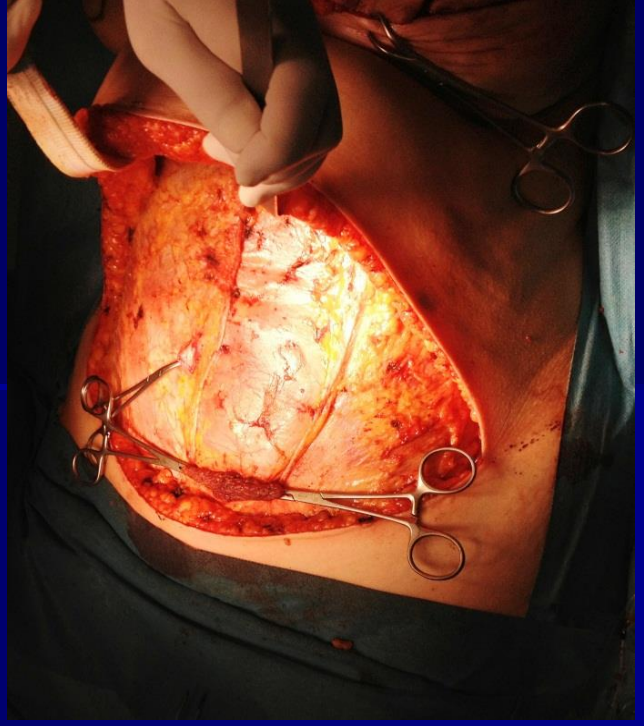
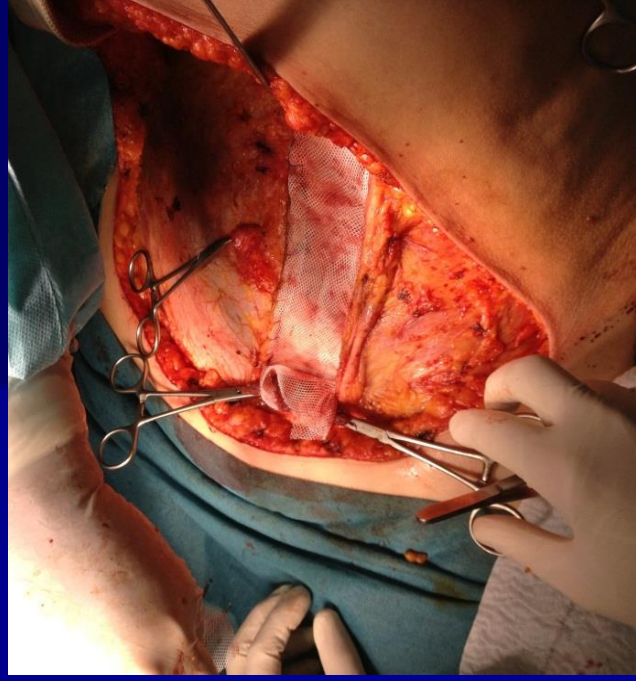
Breast

Nipple Sparing Mastectomy: Does Breast Morphological Factor Related to Necrotic Complications?

Prakasit Chirappapha, MD*†
Jean-Yves Petit, MD*
Mario Rietjens, MD*
Francesca De Lorenzi, MD, PhD*
Cristina Garusi, MD*
Stefano Martella, MD*
Benedetta Barbieri, MD*
Alessandra Gottardi, MD*
Manconi Andrea, MD*
Lomeo Giuseppe, MD*
Alaa Hamza, MD*
Visnu Lohsiriwat, MD*

Background: Nipple sparing mastectomy (NSM) can be performed for prophylactic mastectomy and the treatment of selected breast cancer with oncologic safety. The risk of skin and nipple necrosis is a frequent complication of NSM procedure, and it is usually related to surgical technique. However, the role of the breast morphology should be also investigated.
Method: We prospectively performed an analysis of 124 NSM from September 2012 to January 2013 at the European Institute of Oncology, Milan, Italy, focusing on necrotic complications. We analyzed the association between the risks of skin necrosis and the breast morphology of the patients.
Results: Among 124 NSM in 113 patients, NSM procedures were associated with necrosis in 22 mastectomies (17.7%) among which included partial necrosis of nipple-areolar complex (NAC) in 15 of 124 NSM (12.1%) and total necrosis in 4 cases (3.5%). The NAC was removed in 5 NSM cases (4%). The volume of breast removed was the only significant factor increasing the risk of skin necrosis. The degree of ptosis was not significantly related to the necrosis risk.
Conclusions: Large glandular specimen increases the risk of NAC necrosis. The degree of ptosis and the distance between the sternal notch and the NAC have no significant impact on necrotic complications in NSM. To reduce the necrotic complications in large breast after NSM, reconstruction should better be performed with autologous flap or slow skin expansion using the expander technique. *(Plast Reconstr Surg Glob Open 2014;2:e99;*




OPEN

ORIGINAL ARTICLE

Breast

Technique for Minimizing Donor-site Morbidity after Pedicled TRAM-Flap Breast Reconstruction: Outcomes by a Single Surgeon's Experience

Mario Rietjens, MD*
Francesca De Lorenzi, MD, PhD*
Manconi Andrea, MD*
Jean-Yves Petit, MD*
Prakasit Chirappapha, MD*†
Alaa Hamza, MD*
Stefano Martella, MD*
Benedetta Barbieri, MD*
Alessandra Gottardi, MD*
Lomeo Giuseppe, MD*

Background: Breast reconstruction with pedicled transverse rectus abdominis myocutaneous (TRAM) flap can result in significant abdominal wall donor-site morbidity. We present our technique of transversely dividing the anterior fascia and rectus abdominis combined with reinforcement above the arcuate line for closure of the anterior abdominal wall defect to prevent contour deformities performed by a single senior surgeon and compare these results with those of our prior series.

Methods: We described our new technique of closure of the abdominal wall defect and retrospectively performed the comparison between the results of pedicled TRAM flaps using the new closure technique and those of 420 pedicled TRAM flaps from our 2003 publication in terms of abdominal bulging and hernia.

Lipofilling

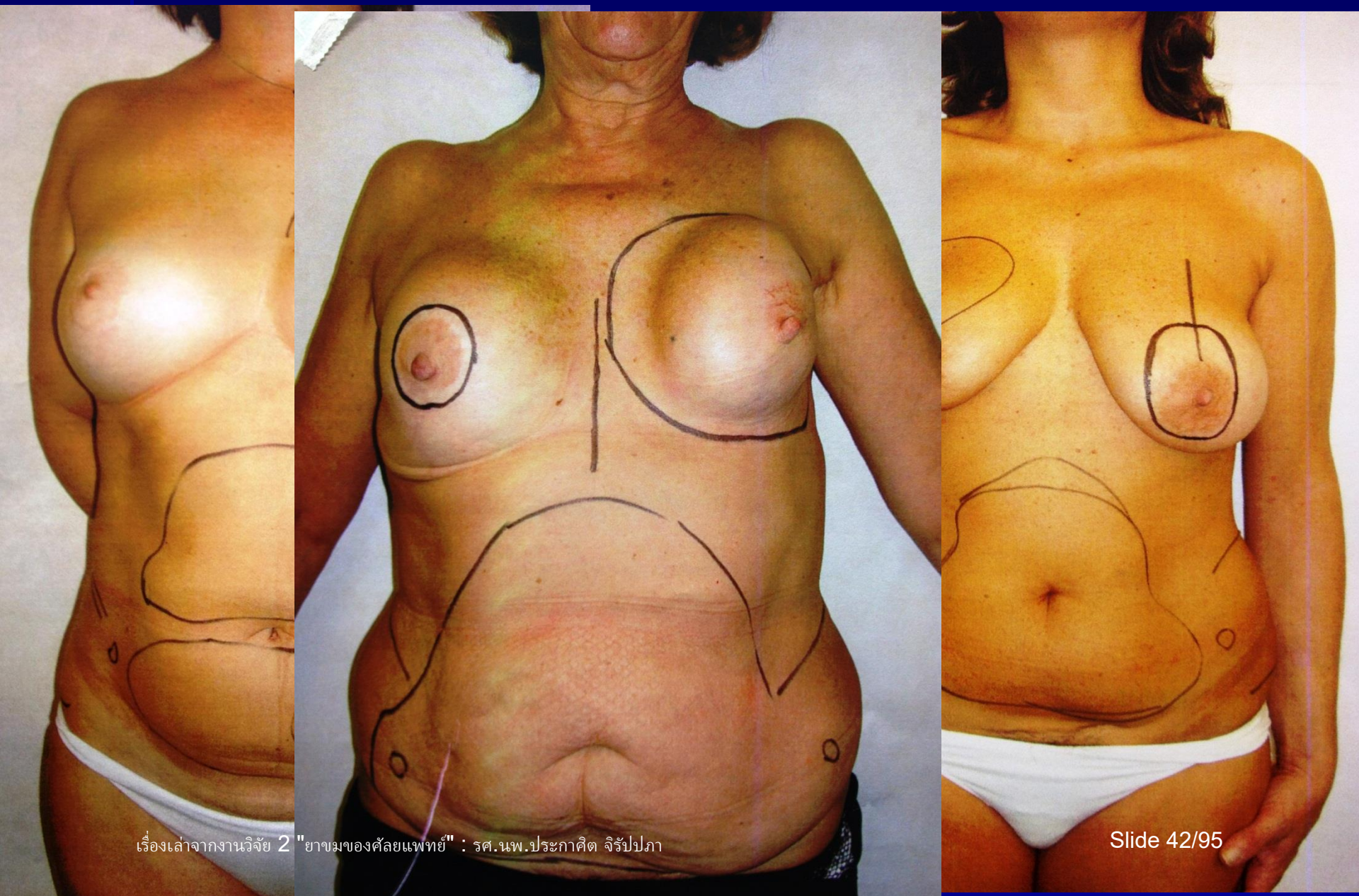


Table 1. Summary of Patients' Characteristics

Patient Characteristics	Summary, N = 137
Age (y), mean (SD)	64.8 (4.2)
Age 60–69 y, n (%)	118 (86)
Age 70–78 y, n (%)	19 (14)
Comorbidity (DM, HT, dyslipidemia), n (%)	41 (30)
Smoker, n (%)	7 (5)
RT before lipofilling, n (%)	78 (57)

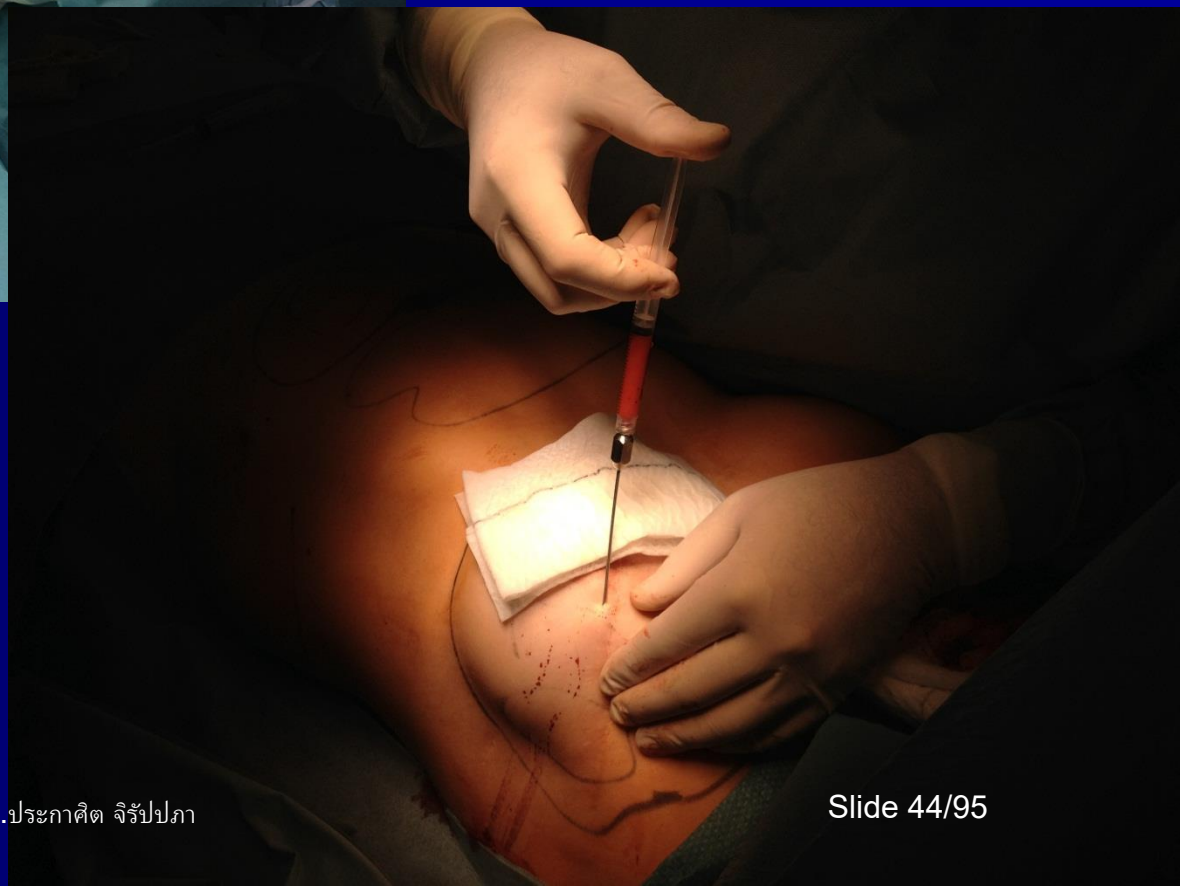
DM, diabetes mellitus; HT, hypertension; RT, radiation therapy.

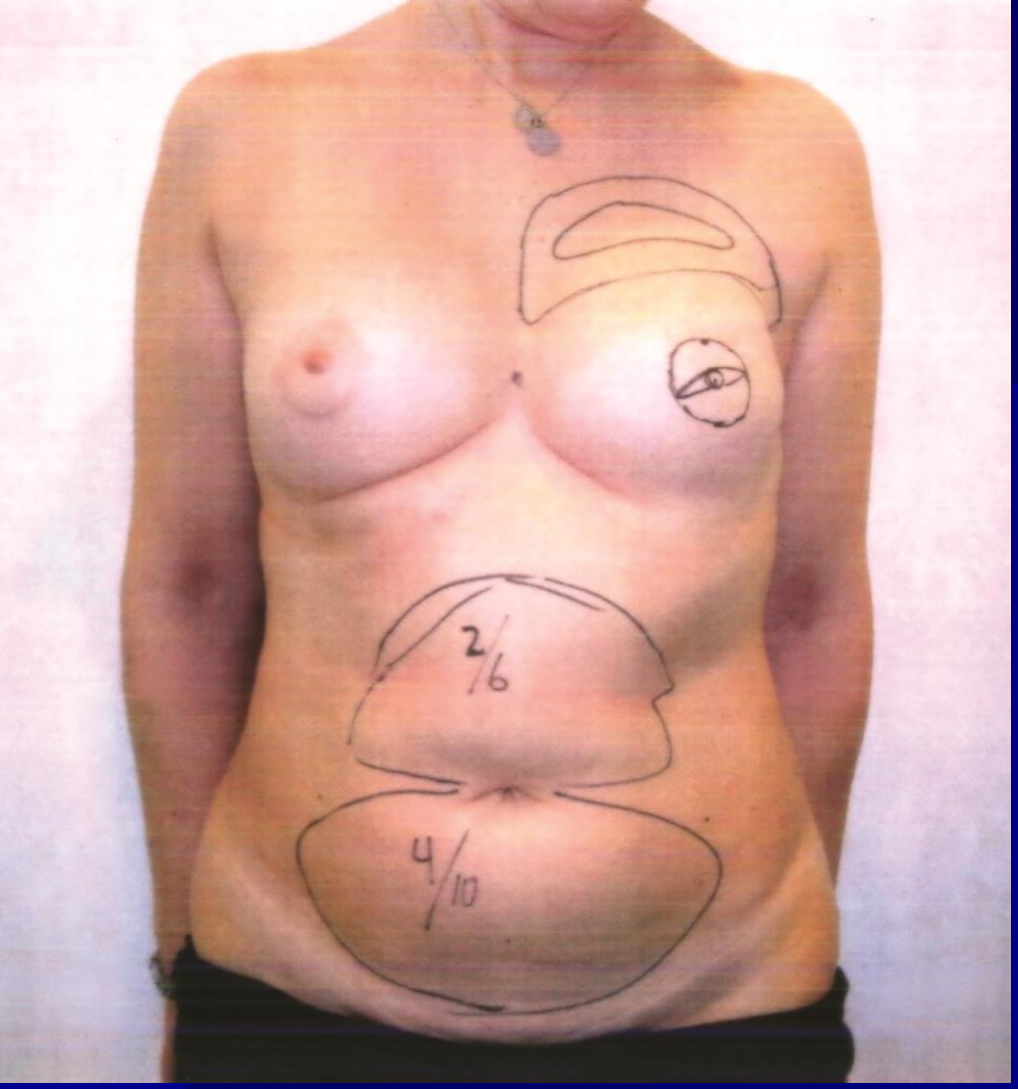
Table 2. Surgical Characteristics

Surgical Characteristics	Summary
Duration of initial lipofilling (min), median (range); n = 137	60 (20–157)
Previous surgery, n (%); n = 153 breasts	
Quadrantectomy alone	49 (32)
Quadrantectomy plus parenchymal transfer	6 (4)
Quadrantectomy plus prosthesis	3 (2)
Mastectomy plus prosthesis	79 (52)

Table 3. Estimated Breast Defect Volume and Lipofilling Volume

Volume (mL)	Summary, median (range)
Estimated breast defect volume, all available data; n = 75	60 (5–495)
Estimated breast defect volume, quadrantectomy only; n = 45	84 (5–495)
Estimated breast defect volume, mastectomy only; n = 30	54 (12.6–105)
Total volume injected; n = 153	81 (6–460)
Volume of injection (per session)	
Volume of 1st injection; n = 153	60 (6–220)
Volume of 2nd injection; n = 50	47 (17–170)
Volume of 3rd injection; n = 16	49 (18–138)
Volume of 4th injection; n = 4	106 (27–120)
Volume of 5th injection; n = 1	35
Lipofilling to breast defect volume ratio, all available data; n = 75	1.50 (0.11–34.3)
Lipofilling to breast defect volume ratio, quadrantectomy; n = 45	0.97 (0.11–34.3)
Lipofilling to breast defect volume ratio, mastectomy; n = 30	2.11 (0.57–11.1)

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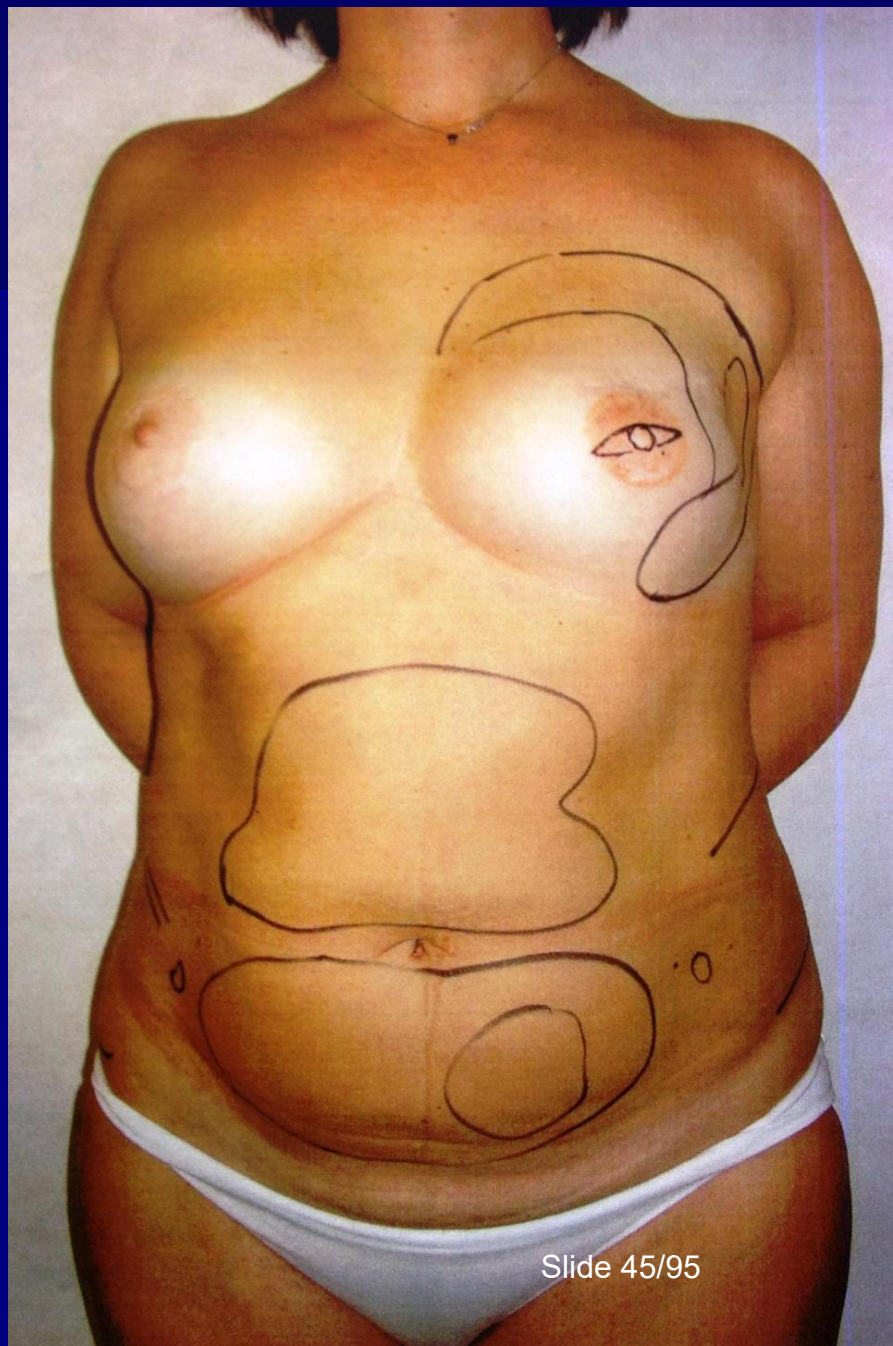
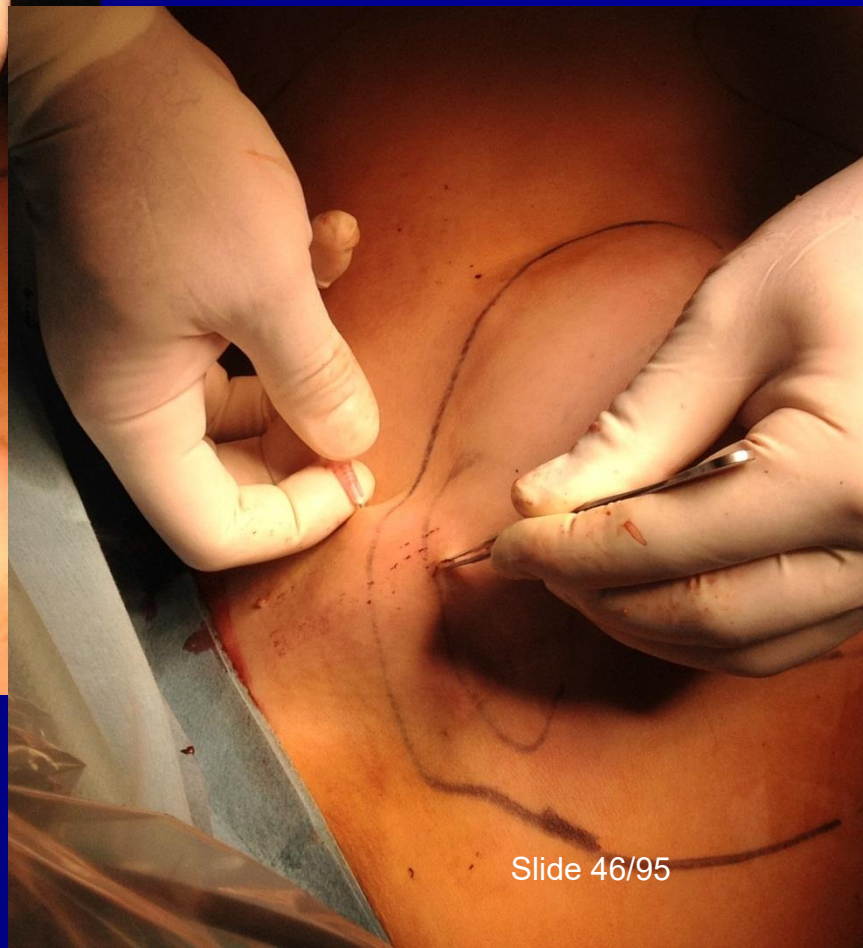
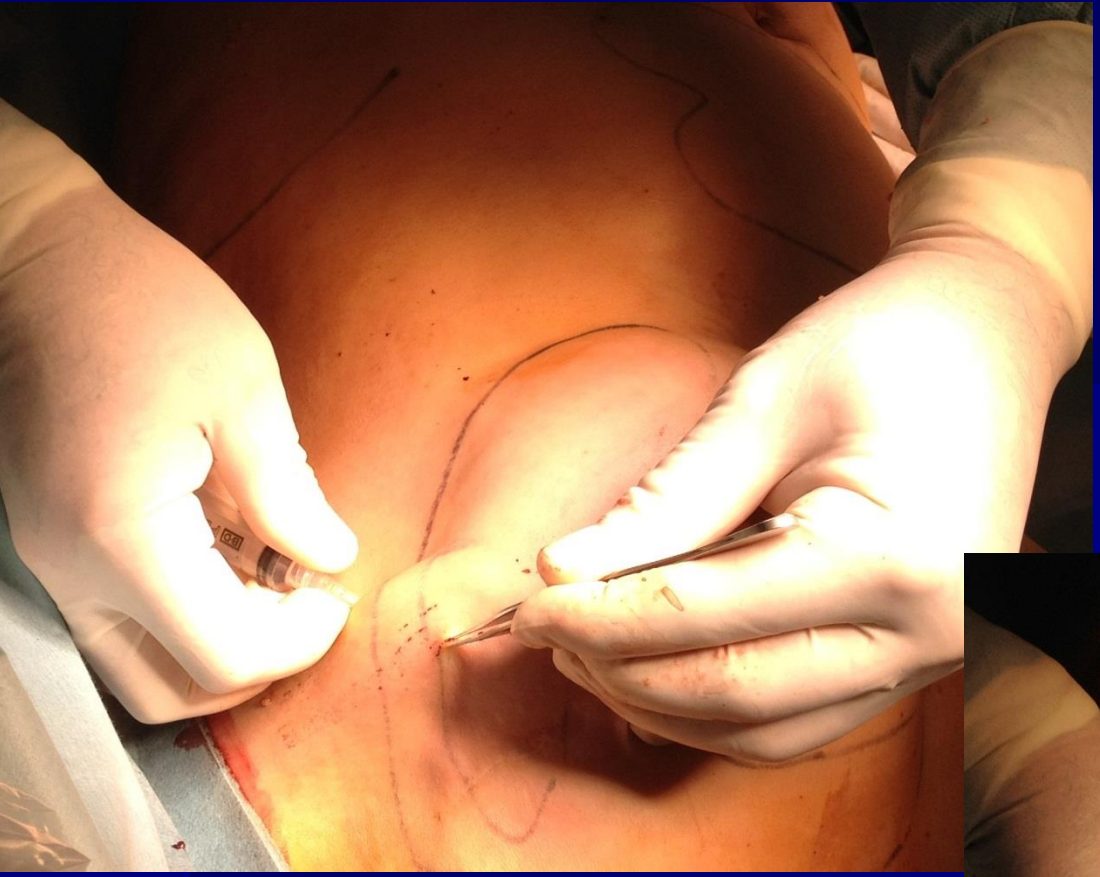


We broke the fibrotic scar with a sharp cannula to create the space for grafting





Prepared cellular component was then injected into the defect area through a blunt Coleman's cannula

Picture from IEO

เรื่องเล่าจากงานวิจัย 2 "ยาขมของศัลยแพทย์" : รศ.นพ.ประกาศิต จิรัปปภา

OPEN

ORIGINAL ARTICLE

Breast

Evaluation of Lipofilling Safety in Elderly Patients with Breast Cancer

Prakasit Chirappapha, MD*†
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Francesca De Lorenzi, MD, PhD*
Manconi Andrea, MD*
Alaa Hamza, MD*
Jean-Yves Petit, MD*
Cristina Garusi, MD*
Stefano Martella, MD*
Benedetta Barbieri, MD*
Alessandra Gottardi, MD*

Background: Lipofilling is widely used in breast reconstruction after mastectomy with reconstruction or breast conserving surgery in patients with breast cancer. The aim of this study is focused on complications associated with lipofilling in elderly breast cancer patients with breast defects after breast conserving surgery or reconstruction.
Methods: A total of 137 patients older than 60 years who underwent 153 lipofilling procedures were included. All patients had undergone breast lipofilling using Coleman's technique. Estimated breast defect volume, lipofilling volume, and complications after lipofilling were obtained for analysis.
Results: Most patients (67%) had only 1 lipofilling procedure. The median lipofilling volume to breast defect volume ratio was 1.5. No severe complications were found after treatment. Liponecrosis was detected in 10 of 153 breasts (7%) or 9 of 137 patients within 2 weeks after lipofilling and required surgical drainage in 2. No local recurrences were noted.
Conclusions: The incidence of liponecrosis after lipofilling in elderly patients was relatively high, requiring surgical drainage in some cases. As a rough guide, the lipofilling volume should not exceed 1.5 times the defect volume, and close postoperative follow-up within the first 2 weeks is suggested for these patients. *(Plast Reconstr Surg Glob Open 2015;3:e441; doi:*

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Chirappapha, Prakasit; Rietjens, Mario; De Lorenzi, Francesca; More

Plastic and Reconstructive Surgery - Global Open. 3(7):e441, July 2015.

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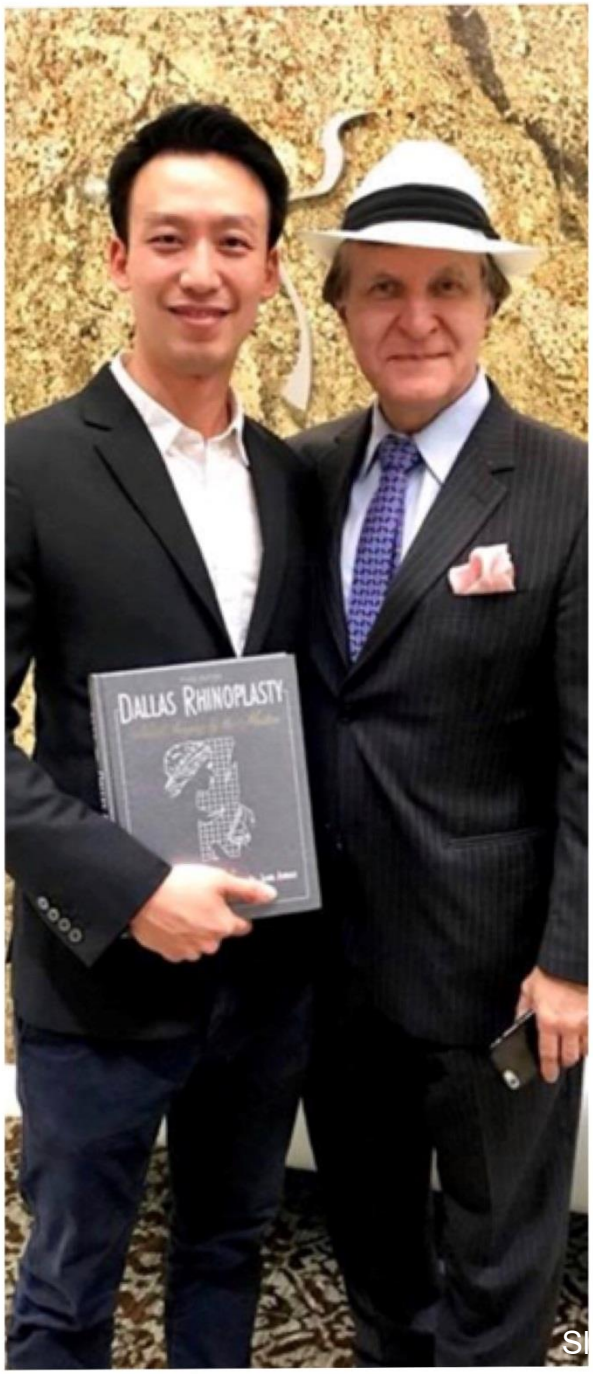
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Melvin Shiffman <shiffmanmdjd@gmail.com> 10 Mar 2016, 00:40

to me

Prakasit,

I would appreciate it if you would submit a chapter on **FREE NIPPLE GRAFT TECHNIQUE TO CORRECT NIPPLE AND AREOLA MALPOSITION AFTER BREAST PROCEDURES** for the book on **Nipple-Areola Complex Reconstruction** to be published by Springer Verlag. I am the Editor.

I would like the chapter by July 15, 2016.

Text in Word
Photos and Illustrations in JPG separate from the Text.

Please let me know if you will submit a chapter.

Kindest regards,

Mel

Melvin A. Shiffman, M.D., J.D.
17501 Chatham Drive
Tustin, CA 92780-2302
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E-mail: shiffmanmdjd@gmail.com

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Author(s) full name(s): Corresponding Author's name, address, affiliation and e-mail:
Author : Mario Rietjens[1]
Corresponding Author's name: Prakasit Chirappapha[1,2]
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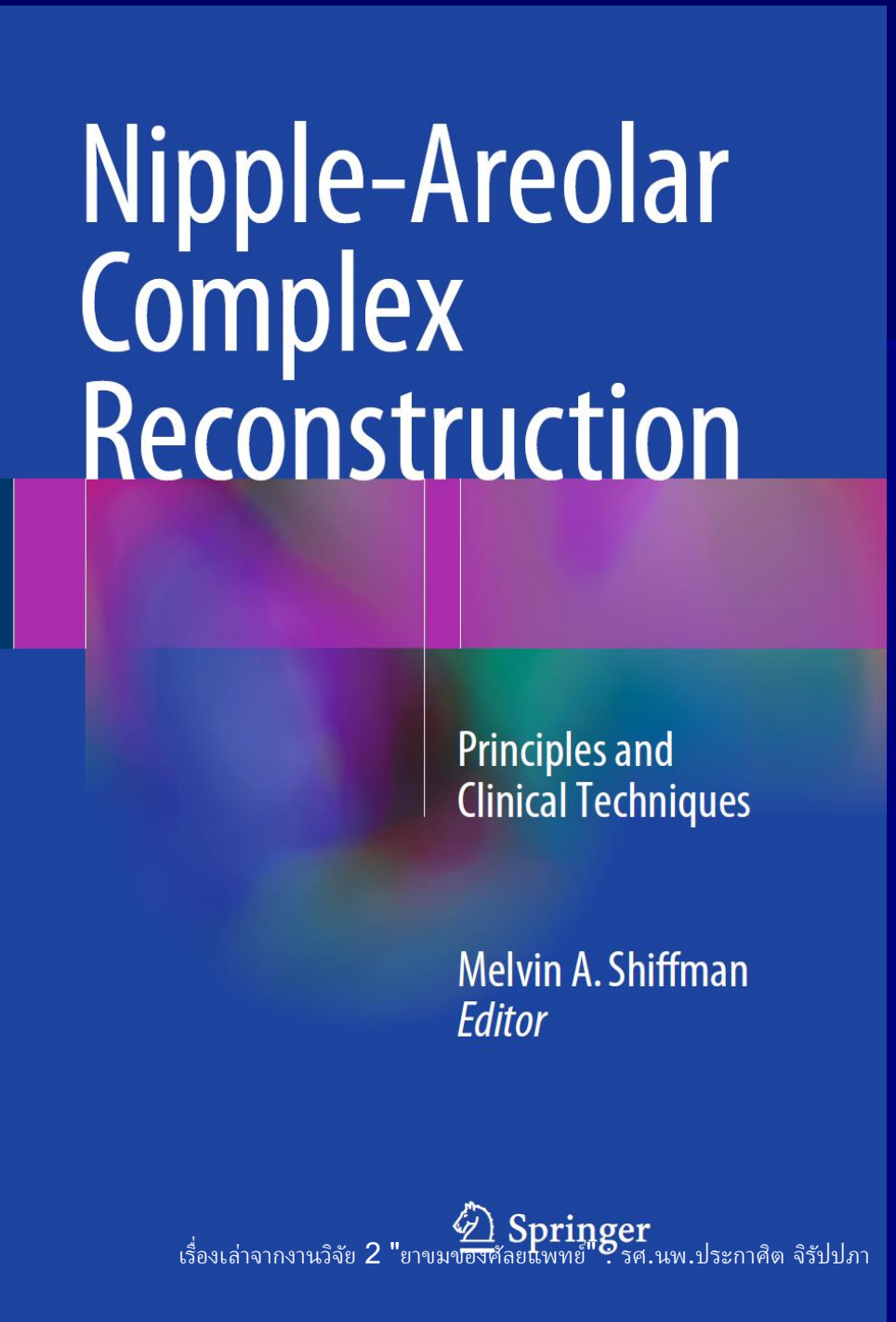

11 Free Nipple Graft Technique for Correcting a Malpositioned Nipple After Breast Procedures

Prakasit Chirappapha and Mario Rietjens

11.1 Introduction

The malpositioned nipple-areolar complex (NAC) can occur after several breast procedures. Dislocation of NAC after breast-conserving surgery (BCS) can occur in patients with large tumors in whom large volumes of breast tissue must be removed and are exacerbated by radiation. The NAC can also retract high above or laterally after nipple-sparing mastectomy (NSM) procedures. Management of the malpositioned NAC is a challenge in these patients. Several techniques have been described for treating malpositioned NAC including transposition of NAC on a pedicle [1, 2], lowering of NAC with implants [3, 4], expanding the skin superior to the NAC, and elevating the inframammary fold with breast parenchyma. Free nipple grafts have been reported for reduction mammoplasty [5–9]. Spear and Hoffman [10] corrected NAC displacement following NSM by using the reciprocal transposition flaps. Frenkiel et al. [11] reported a case of successful correction of a high-riding nipple using a Z-plasty technique. Thus, currently there are no generally accepted surgical techniques for managing NAC malposition. We present an alternative approach to relocate the NAC between both breasts by using free NAC grafts combined with lipofilling. By using lipofilling, symmetry between both NACs can be restored in terms of contour, size, and site.

11.2 Technique

Patients in our series had NAC that was superior to and/or lateral to the correct location. The malposition was quite obvious on both lateral and frontal views when compared with the normal side (Fig. 11.1).

11.2.1 Preoperative Evaluation and Surgical Planning

Physical examination was performed for all patients by oncologic or plastic surgeons both preoperatively and postoperatively. Midsternal and midclavicular lines were marked before surgery with the patient in the standing position. The area of parenchymal defect and the new NAC location were marked on the breast. The new

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M.A. Shiffman (ed.), *Nipple-Areolar Complex Reconstruction*,
https://doi.org/10.1007/978-3-319-60925-6_11

Fig. 11.2 (**a**) Preoperative marking of the new NAC area. (**b**) The NAC was excised with a scalpel at the level of the subdermis. (**c**) The NAC was excised as a full-thickness graft. (**d**) Intraoperative showing deepithelialized area after harvesting NAC. (**e**) The NAC graft is removed and saved in normal saline solution. (**f**) The new NAC area was deepithelialized after closing the harvesting NAC site. (**g**) Recipient site after deepithelialization. (**h**) The NAC was placed in the deepithelialized bed. (**i**) Four points were fixed with interrupted sutures. (**j**) Correction of parenchyma defect with lipofilling technique. (**k**) Using horizontal mattress suture technique, we fixed with interrupted subcuticular 4-0 Monocryl around the edge of NAC area. (**l**) The free nipple graft has been positioned and the bolus will be placed to ensure immobilization

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ORIGINAL ARTICLE

Breast

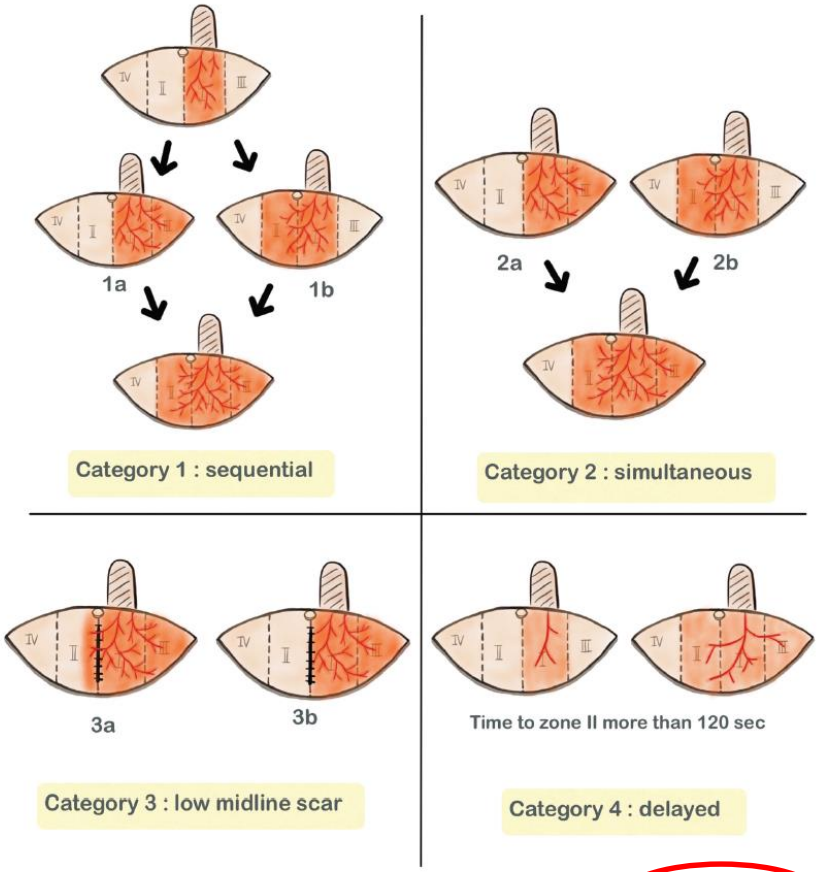
Is It Reasonable to Use Indocyanine Green Fluorescence Imaging to Determine the Border of Pedicled TRAM Flap Zone IV?

Prakasit Chirappapha, MD*
Tharintorn Chansoon, MD†
Siriporn Bureewong, MD*
Songpol Phosuwan, MD*
Panuwat Lertsithichai, MD*
Thongchai Sukarayothin, MD*
Monchai Leesombatpaiboon, MD*
Watoo Vassanasiri, MD*

Background: The contralateral lateral section (zone IV) of a pedicled transverse rectus abdominis musculocutaneous (TRAM) flap is generally removed intraoperatively. The border of zone IV is usually identified anatomically using the Hartrampf classification. In this study, we used the indocyanine green (ICG) fluorescence method to determine the border of zone IV and find the correlation with clinical flap outcome.
Methods: The study recruited breast cancer patients who underwent a pedicled TRAM flap reconstruction. The border of zone IV was identified using the intraoperative ICG fluorescence imaging. The medial border of the removed specimen

Table 3. ICG Fluorescence Enhancement Pattern Classified by YaYa's Classification in 29 Patients Who Underwent a Pedicled TRAM Flap Reconstruction

Category	Pattern	n (%)
Category 1: sequential	1a: Zone I and then zone III	6 (20.7)
	1b: Zone I and then zone II	5 (17.2)
Category 2: simultaneous	2a: Zone I and zone III	7 (24.1)
	2b: Zone I and zone II	5 (17.2)
Category 3: low midline scar	3a: Presence of ICG across midline	3 (10.3)
	3b: Faint (or loss of) ICG across midline	1 (3.5)
Category 4: delayed pattern	4: Delayed perfusion of ICG at zone II (>120 s)	2 (6.9)



Siriporn B.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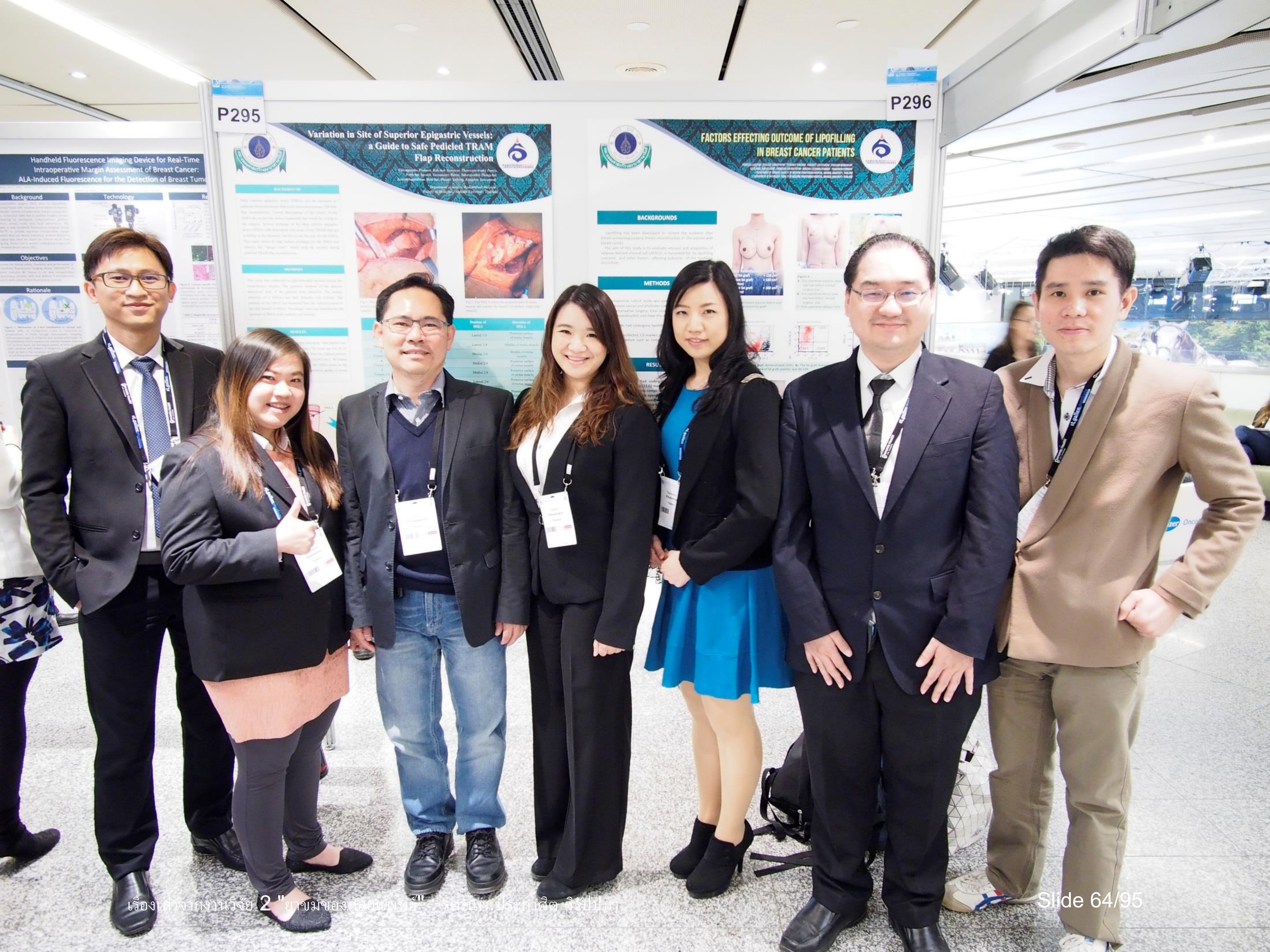
makeamem


P295
Variation in Site of Superior Epigastric Vessels: a Guide to Safe Pedicled TRAM Flap Reconstruction
P296
FACTORS EFFECTING OUTCOME OF LIPOFILLING IN BREAST CANCER PATIENTS
Handheld Fluorescence Imaging Device for Real-Time Intraoperative Margin Assessment of Breast Cancer:

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- สร้างเส้นทางของตนให้ชัด ไม่สะเปะสะปะ

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My Surgical Oncology & Breast Fellows

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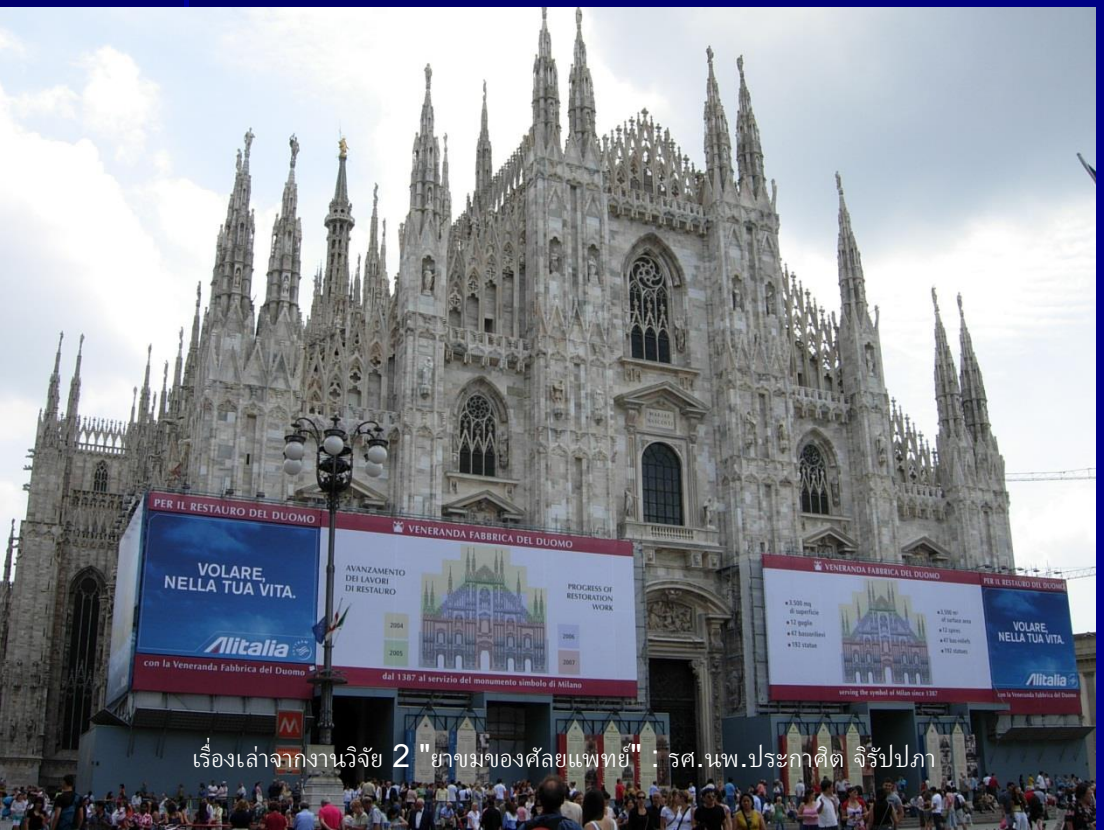

ประกาศิต จิรัปปภา

Free Nipple Graft Technique for Correcting a Malpositioned Nipple After Breast Procedures

11

Prakasit Chirappapha and Mario Rietjens

11.1 Introduction

The malpositioned nipple-areolar complex (NAC) can occur after several breast procedures. Dislocation of NAC after breast-conserving surgery (BCS) can occur in patients with large tumors in whom large volumes of breast tissue must be removed and are exacerbated by radiation. The NAC can also retract high above or laterally after nipple-sparing mastectomy (NSM) procedures. Management of the malpositioned NAC is a challenge in these patients. Several techniques have been described for treating malpositioned NAC including transposition of NAC on a pedicle [1, 2], lowering of NAC with implants [3, 4], expanding the skin superior to the NAC, and elevating the inframammary fold with breast parenchyma. Free nipple grafts have been reported for reduction mammoplasty [5–9]. Spear and Hoffman [10] corrected NAC displacement following NSM by using the reciprocal transposition flaps. Frenkiel et al. [11] reported a case of successful correction of a high-riding nipple using a Z-plasty technique. Thus, currently there are no generally accepted surgical techniques for managing NAC malposition. We present an alternative approach to relocate the NAC between both breasts by using free NAC grafts combined with lipofilling. By using lipofilling, symmetry between both NACs can be restored in terms of contour, size, and site.

11.2 Technique

Patients in our series had NAC that was superior to and/or lateral to the correct location. The malposition was quite obvious on both lateral and frontal views when compared with the normal side (Fig. 11.1).

11.2.1 Preoperative Evaluation and Surgical Planning

Physical examination was performed for all patients by oncologic or plastic surgeons both preoperatively and postoperatively. Midsternal and midclavicular lines were marked before surgery with the patient in the standing position. The area of parenchymal defect and the new NAC location were marked on the breast. The new

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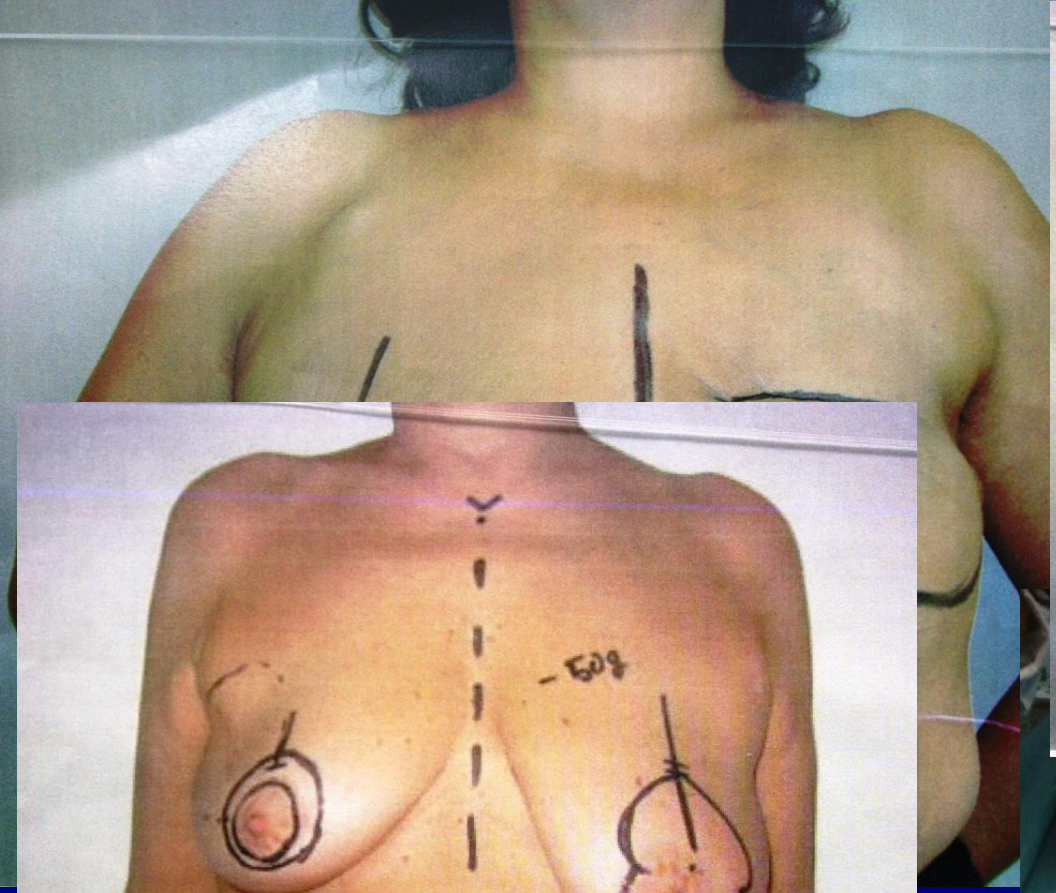
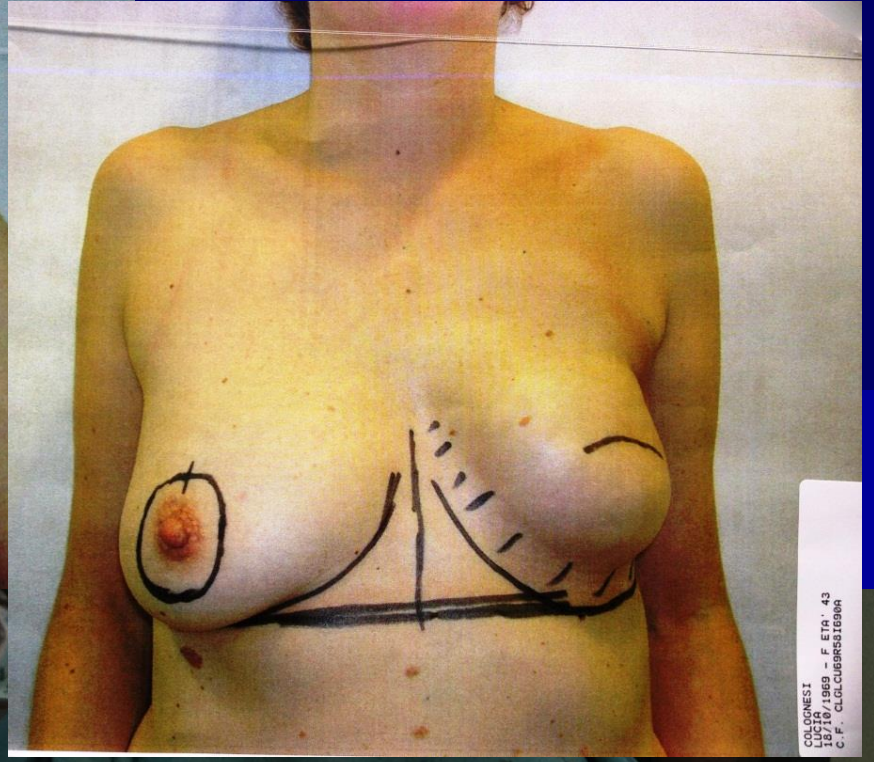
M.A. Shiffman (ed.), *Nipple-Areolar Complex Reconstruction*,
DOI 10.1007/978-3-319-60925-6_11

Fig. 11.2 (**a**) Preoperative marking of the new NAC area. (**b**) The NAC was excised with a scalpel at the level of the subdermis. (**c**) The NAC was excised as a full-thickness graft. (**d**) Intraoperative showing deepithelialized area after harvesting NAC. (**e**) The NAC graft is removed and saved in normal saline solution. (**f**) The new NAC area was deepithelialized after closing the harvesting NAC site. (**g**) Recipient site after deepithelialization. (**h**) The NAC was placed in the deepithelialized bed. (**i**) Four points were fixed with interrupted sutures. (**j**) Correction of parenchyma defect with lipofilling technique. (**k**) Using horizontal mattress suture technique, we fixed with interrupted subcuticular 4-0 Monocryl around the edge of NAC area. (**l**) The free nipple graft has been positioned and the bolus will be placed to ensure immobilization

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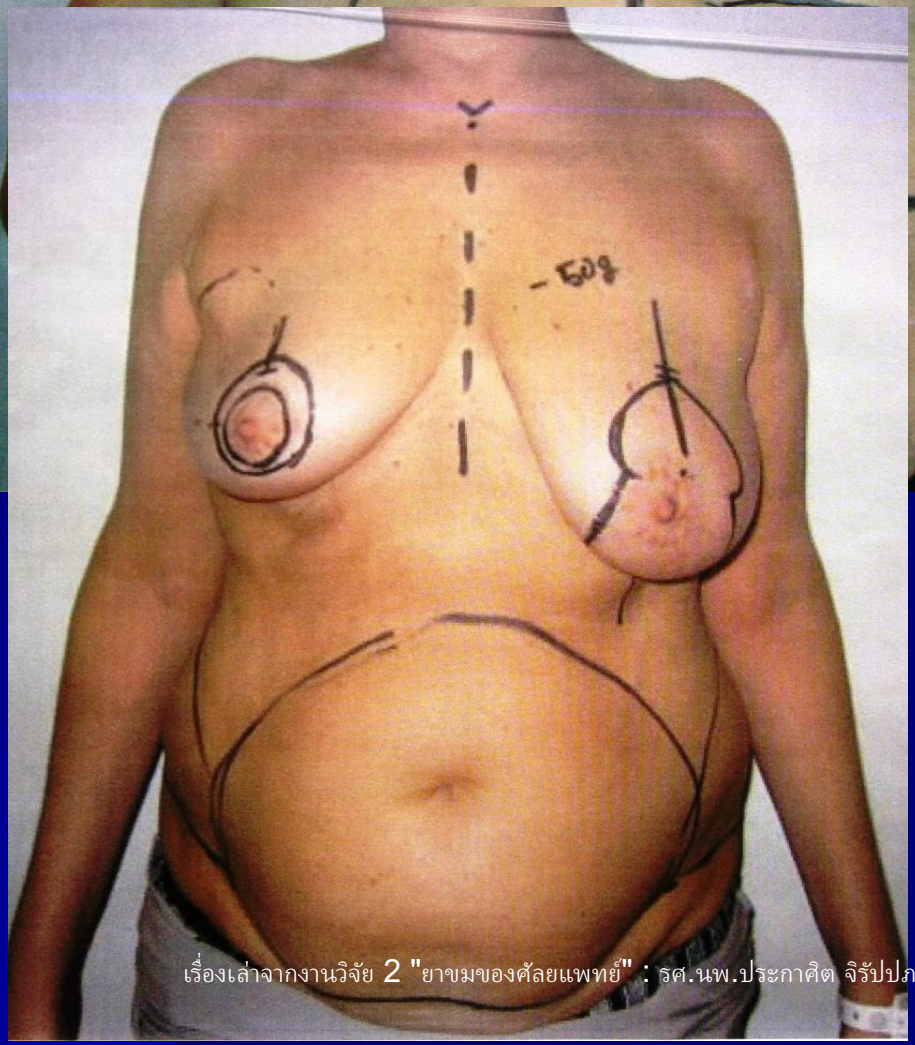

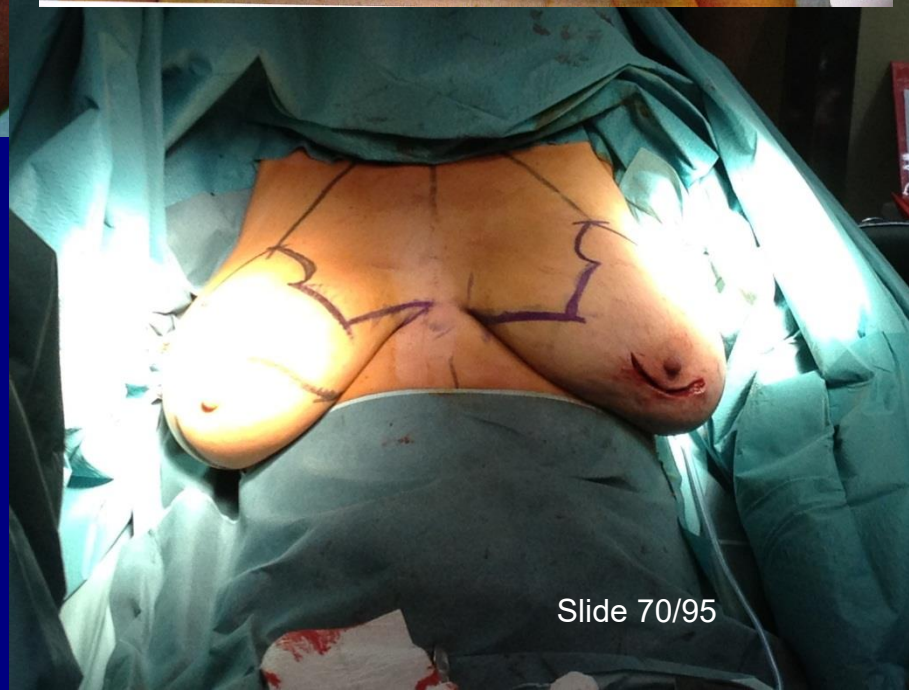

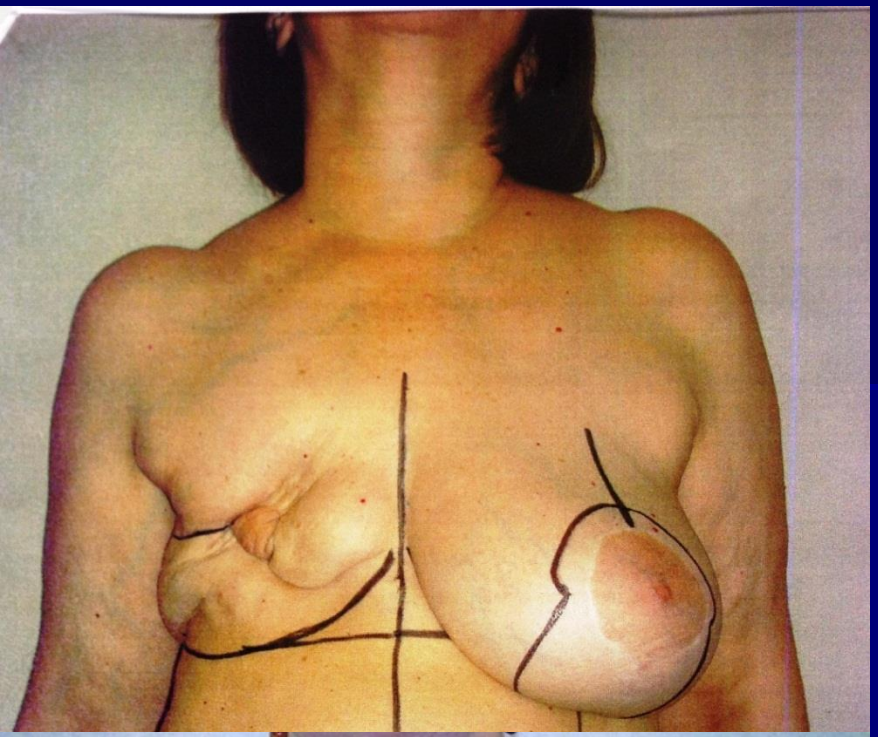

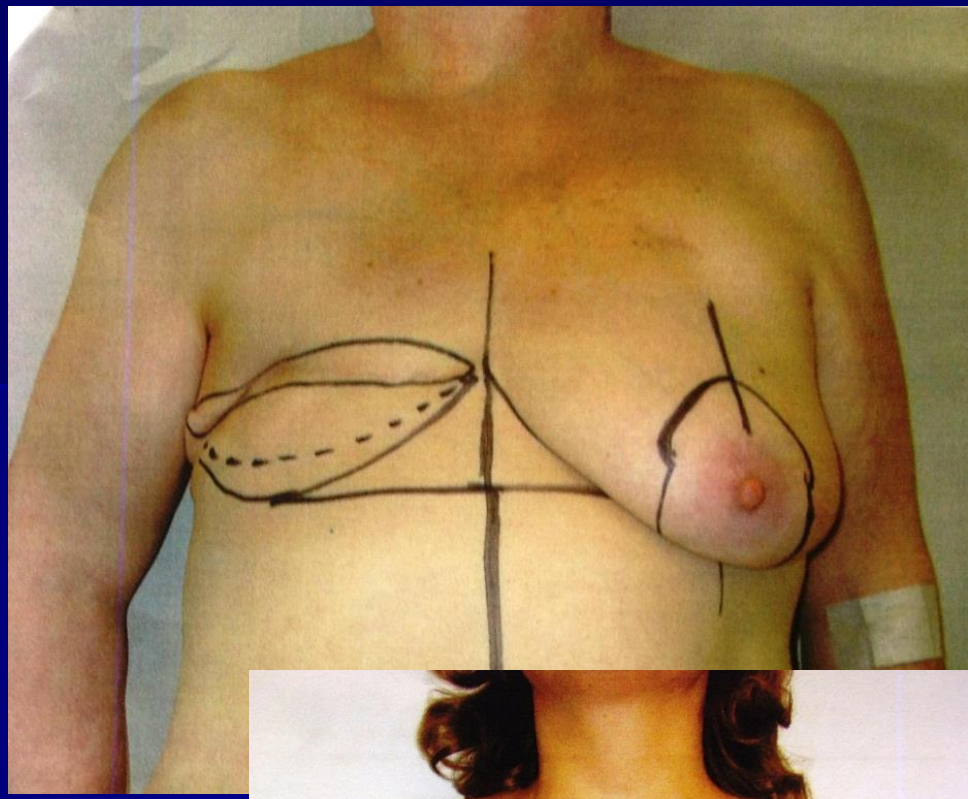

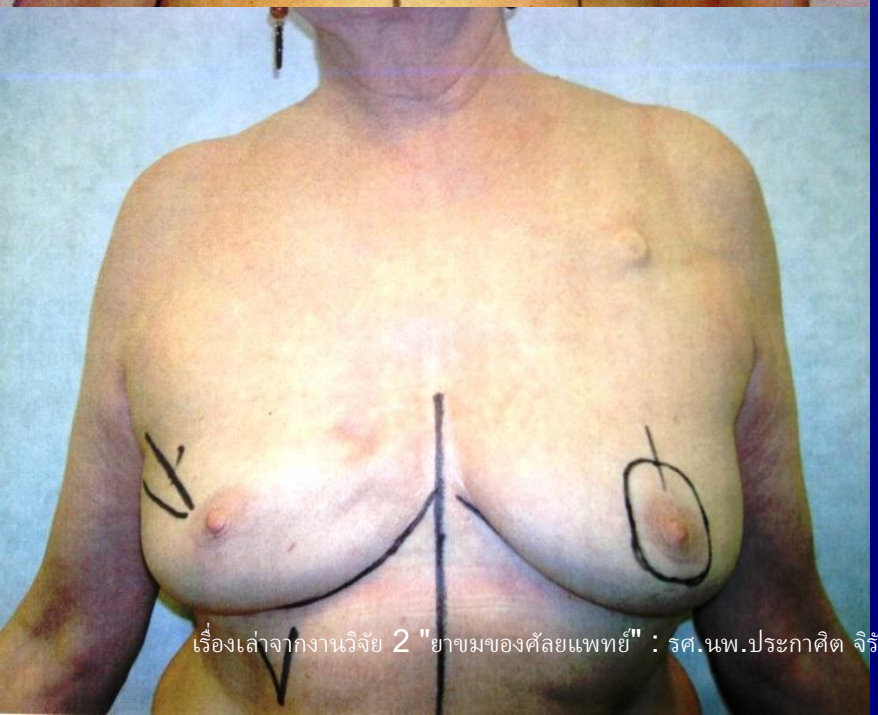

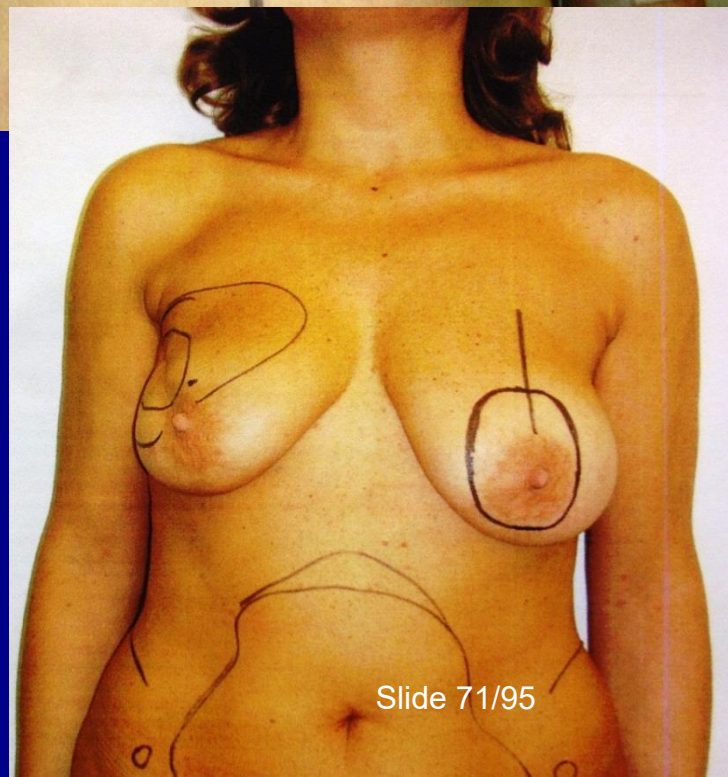

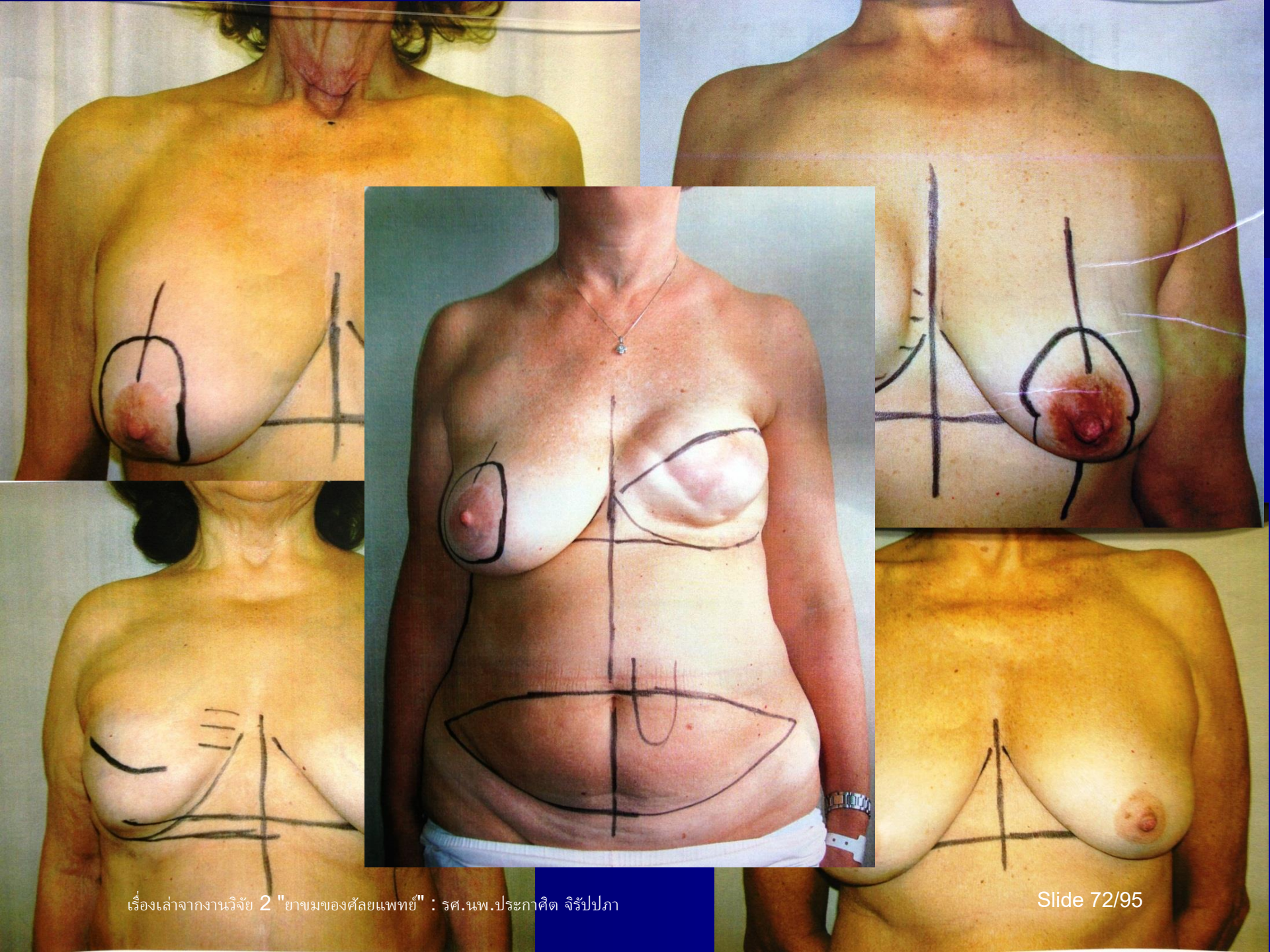

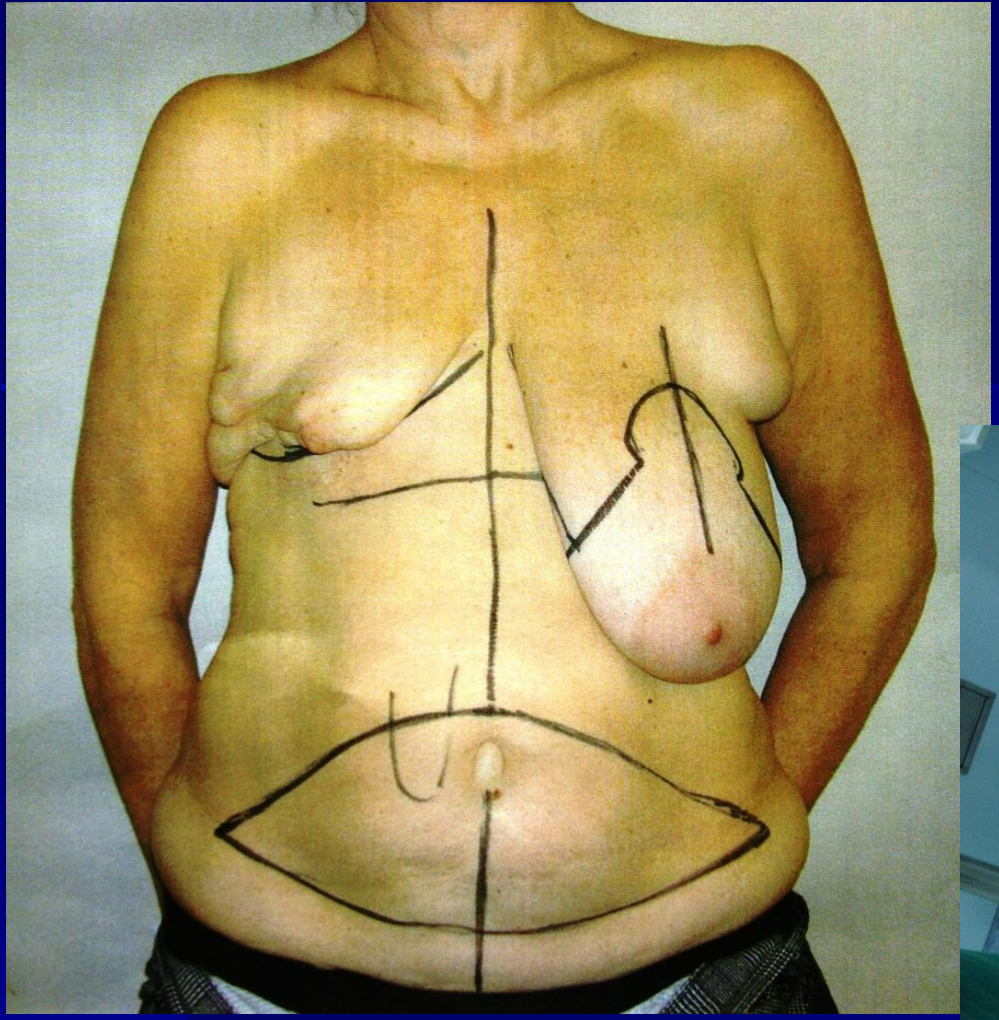

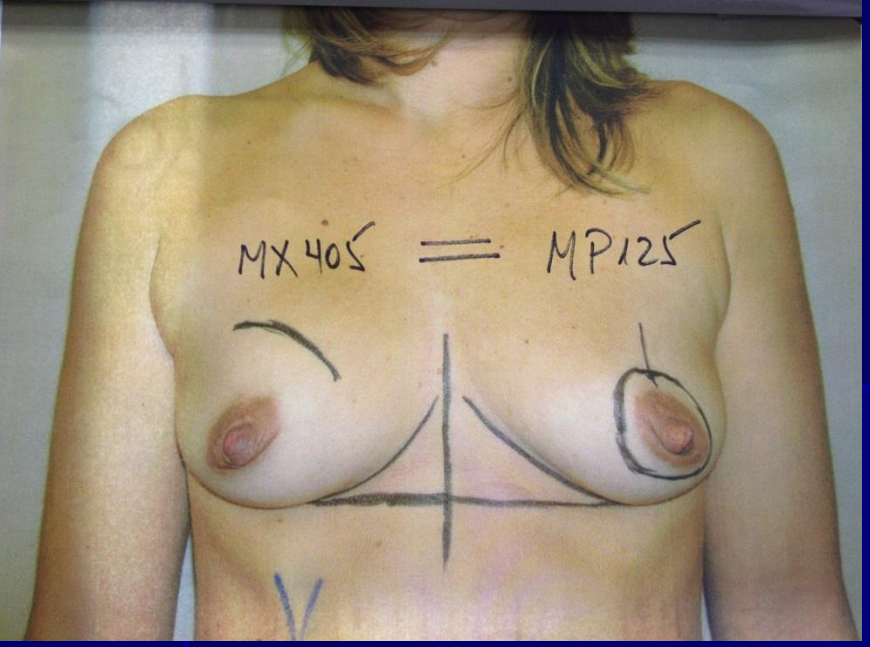
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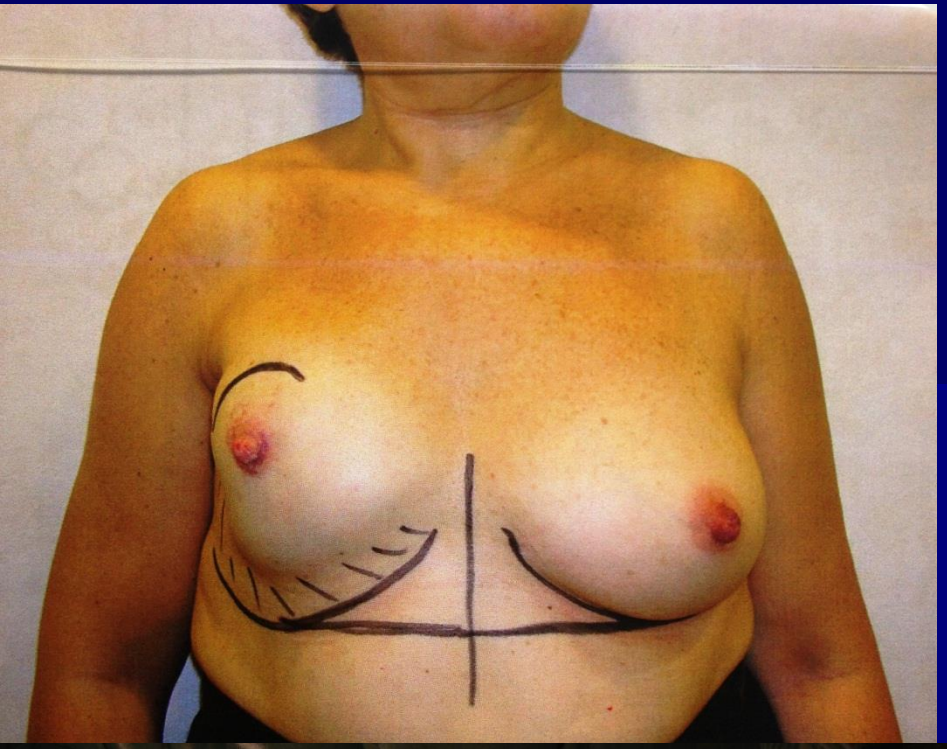

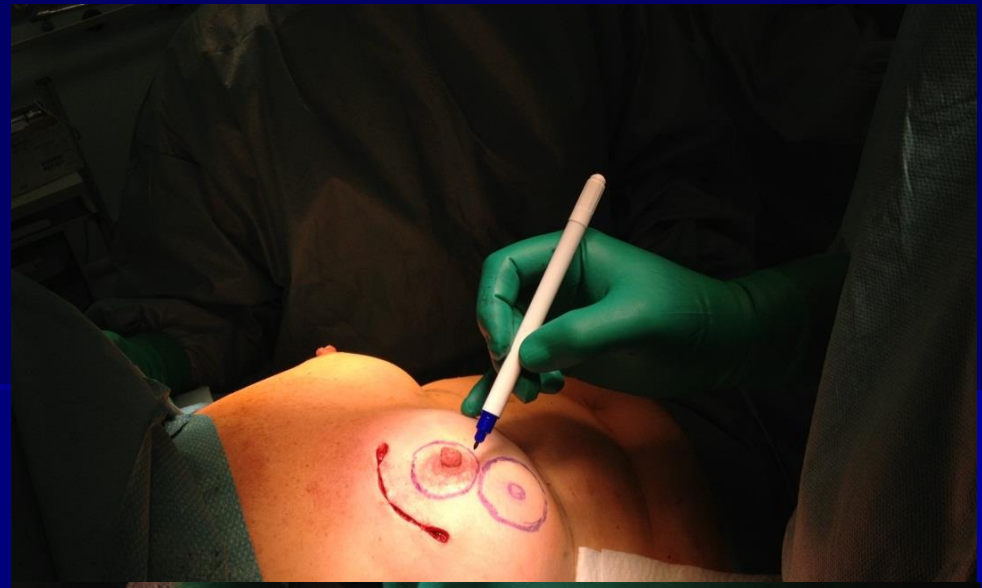

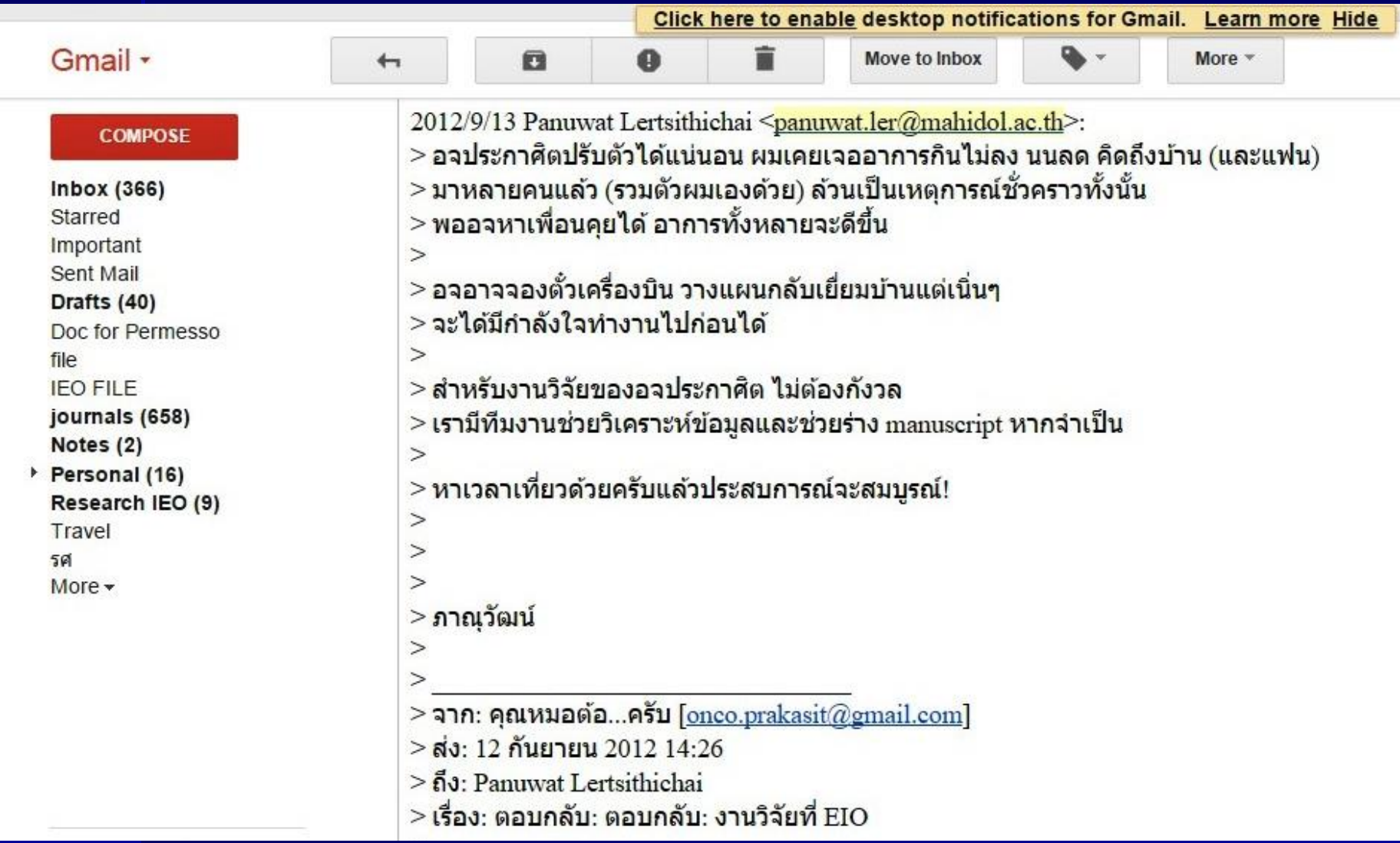
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Milano - Italia

NAC and parenchyma defects after BCS or NSM in breast cancer patients.

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Patient risk factors

Table 3 Comparison of characteristics (Patient risk factors) and outcomes between patients

Patients Characteristics	No NAC necrosis N = 105	NAC necrosis N = 19	p-value
Age (years): mean (SD)	47.9 (9.3)	48.8 (9.8)	0.673
Weight (kg): mean (SD)	58.6 (9.3)	59.5 (7.0)	0.695
Height (m): mean (SD)	1.64 (0.07)	1.65 (0.05)	0.602
BMI (kg/m²): mean (SD)	21.7 (3.0)	21.7 (2.0)	0.919
Comorbidity (DM,HT,dyslipidemia): number (%)	14 (13)	4 (21)	0.379
Smoker: number (%)	31 (29)	3 (16)	0.217

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p=0.38 et non P=0.377 ...

Breast morphological factors

Table 4.1 Comparison of characteristics (Breast morphological factors) and outcomes between patients

Patients Characteristics	No NAC necrosis N = 105	NAC necrosis N = 19	p-value
Degree of ptosis: number (%)			
None	20 (19)	2 (11)	0.377
1	41 (39)	5 (26)	
2	31 (30)	9 (47)	
3	13 (12)	3(16)	
Specimen weight (g): median (range)	308 (102 to 856)	339 (200 to 550)	0.130
Volume of breast removed (cm³): median (range)	784 (60 to 4410)	920 (302.5 to 1870)	0.042
SNN distance (cm): mean (SD)	22.2 (2.2)	22.7 (1.7)	0.372
Breast density: number (%)			
Fatty breast	10 (10)	0	0.640
Scattered fibroglandular	47 (45)	10 (53)	
Heterogeneous	45 (43)	9 (47)	
Extremely dense	3(3)	0	
Flap necrosis: number (%)	3 (3)	7 (37)	< 0.001

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เรื่อง: เรียนปรึกษา 1st paper , NAC necrosis ครับ

กราบเรียน อ.ภาณุวัฒน์ ที่เคารพอย่างสูง

กราบเรียนปรึกษา อจ paper แรกครับ paper นี้ ผมเขียน full paper และ Prof. Petit ได้แก้ไขหลายครั้งมากครับ (7 ครั้ง, บ่นจนผมหูชาเลยครับ) ครั้งนี้น่าจะใกล้เสร็จแล้ว Prof. ให้แก้เพิ่มเติมดัง file ที่ผมแนบมาครับ รบกวน อจ ช่วยพิจารณาแก้ไขให้ผมด้วยครับ ผมไม่เข้าใจและทำไม่ได้เลยครับ โดยเฉพาะ jy3, jy5, jy6, jy7, jy8, jy9, jy12 ครับ อาจารย์ครับ

กราบรบกวนอาจารย์อีกแล้วครับ
ด้วยความเคารพอย่างสูง
ประกาศิต

ปล แก้แต่ละครั้ง depress และน้ำตาคลอทุกครั้งเลยครับ

Prosthesis volume (mL): median (range)	302 (100 to 600); n=60	338 (125 to 520); n=8	0.66[c]
Expander volume (mL): median (range)	200 (90 to 400); n=38	200 (100 to 350); n=9	0.91[c]
Recon (TRAM, LD): number (%)	6 (6)	1 (5)	0.99[a]
Hematoma/infection: number (%)	9 (9)	2 (11)	0.68[a]

a: p-value by Fisher's exact test; b: p-value by unpaired t-test; c: p-value by Wilcoxon ranksum test

Duration of operation, type of surgical incision, type of reconstruction were not statistically significant (Table 6). There seemed to be some tendency but not statistically significant for patients with NAC necrosis to have larger volume of breast expander (P= 0.91) and prosthesis (P= 0.66) placed. Similarly, we could not find the significant correlation between the total expander or prosthesis volume and the risk of necrotic complications.

Table .. Comparing degree of ptosis

	Ptosis grade 0	Ptosis grade 1	Ptosis grade 2	Ptosis grade 3	p-value		
NAC necrosis number (%)	2 (9%)	5 (11%)	9 (23%)	3 (19%)	0.377 Chi-square test	0.416 2-sided Fisher's exact test	0.128 Wilcoxon Ranksum test
No NAC necrosis number (%)	20 (91%)	41 (89%)	31 (77%)	13 (81%)			
Total: number(%)	22 (100%)	46 (100%)	40 (100%)	16 (100%)			

Comment [jy9]: No the volume are absolutely not different
Answer: Delete this sentence

Comment [jy10]: Present only the fisher test

Comment [jy11]: Could be added the Mantel-Haenszel to test the % of necrosis in relation to the degree of ptosis
Answer: Fisher's Exact test is sufficient to demonstrate lack of statistically significant difference

Comment [jy12]: This table shoes exactly the same data as the table 4.1
Answer: Delete table

Table 8. Comparing Type of Incisions

	Superior Circumareolar + Periareolar Incision	Others Incisions
NAC necrosis, *n* (%)	5 (25)	14 (13)
No NAC necrosis, *n* (%)	15 (75)	90 (87)
Total, *n* (%)	20 (100)	104 (100)

$P = 0.19$ by Fisher's exact test.

ed of 60% NAC loss with the periareolar incision. As we know, the periareolar incision provides the best cosmetic outcomes. This incision limits the view of operative field and may compromise blood supply to the NAC.[32,33] Lateral or inframammary incisions give a better view in the operative field and does not compromise blood supply to the NAC.[34] Other authors also favor the use of radial or lateral incisions.[13,15] In contrast, Paepke et al[35] reported only a 1% NAC loss with periareolar incision. Algaithy et al[19] recommended maintaining a 5 mm thickness of the areola and periareolar area to prevent from flap necrosis. In our study, the superior circumareolar and periareolar incisions were associated with a NAC necrosis rate of 25% as compared with a rate of 13% with

CONCLUSIONS

Despite a relatively high necrotic complication rate (17.7%) after therapeutic NSM, NSM remains an option for appropriately selected patients. Our study underlined the risk of skin and NAC necrosis in patients with larger breasts and suggests careful consideration of the choice of breast reconstruction in such cases, such as the use of tissue expanders with slow expansion or autologous musculocutaneous flap.

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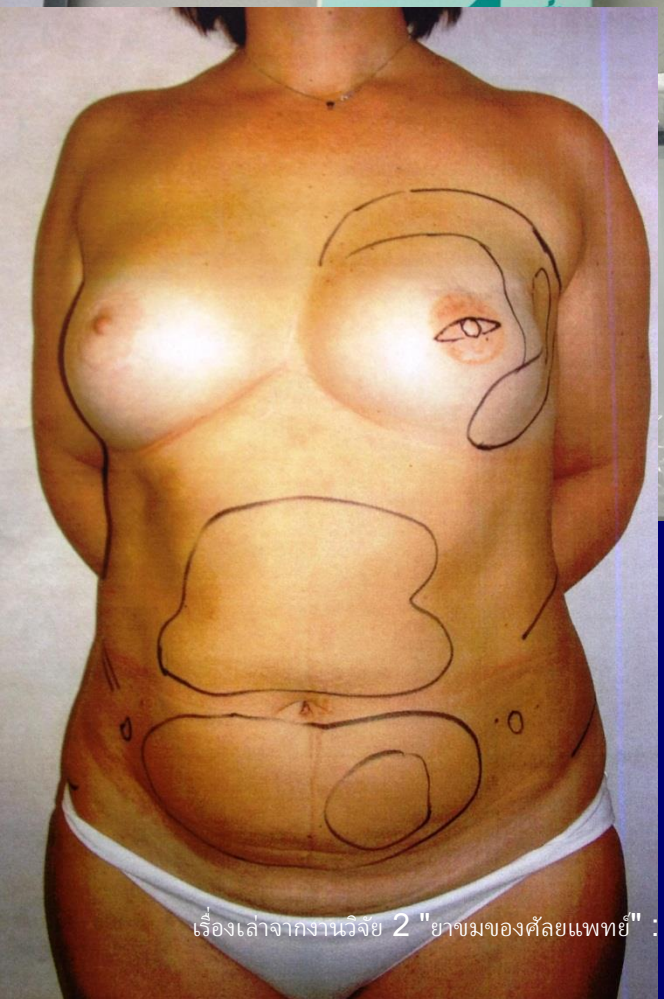
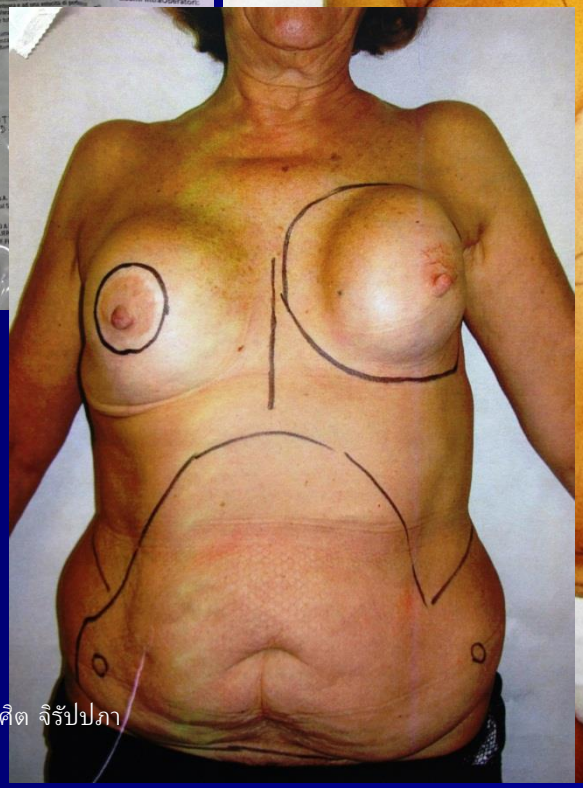
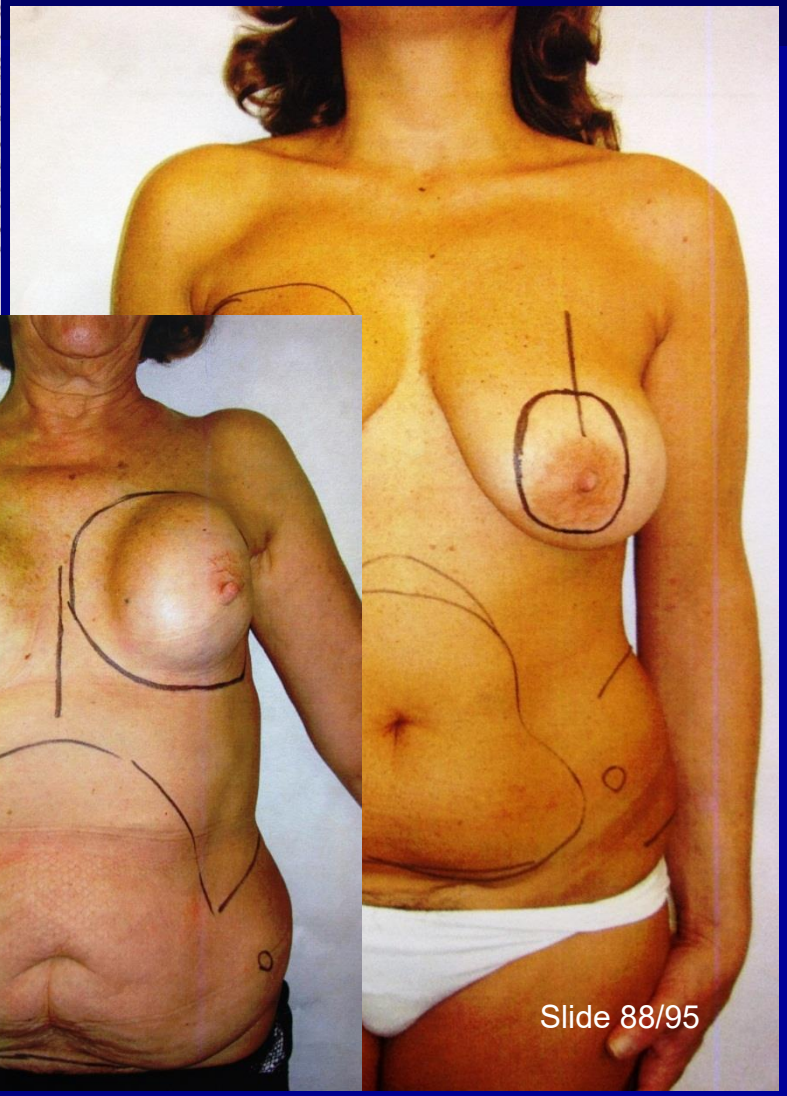
REFERENCES

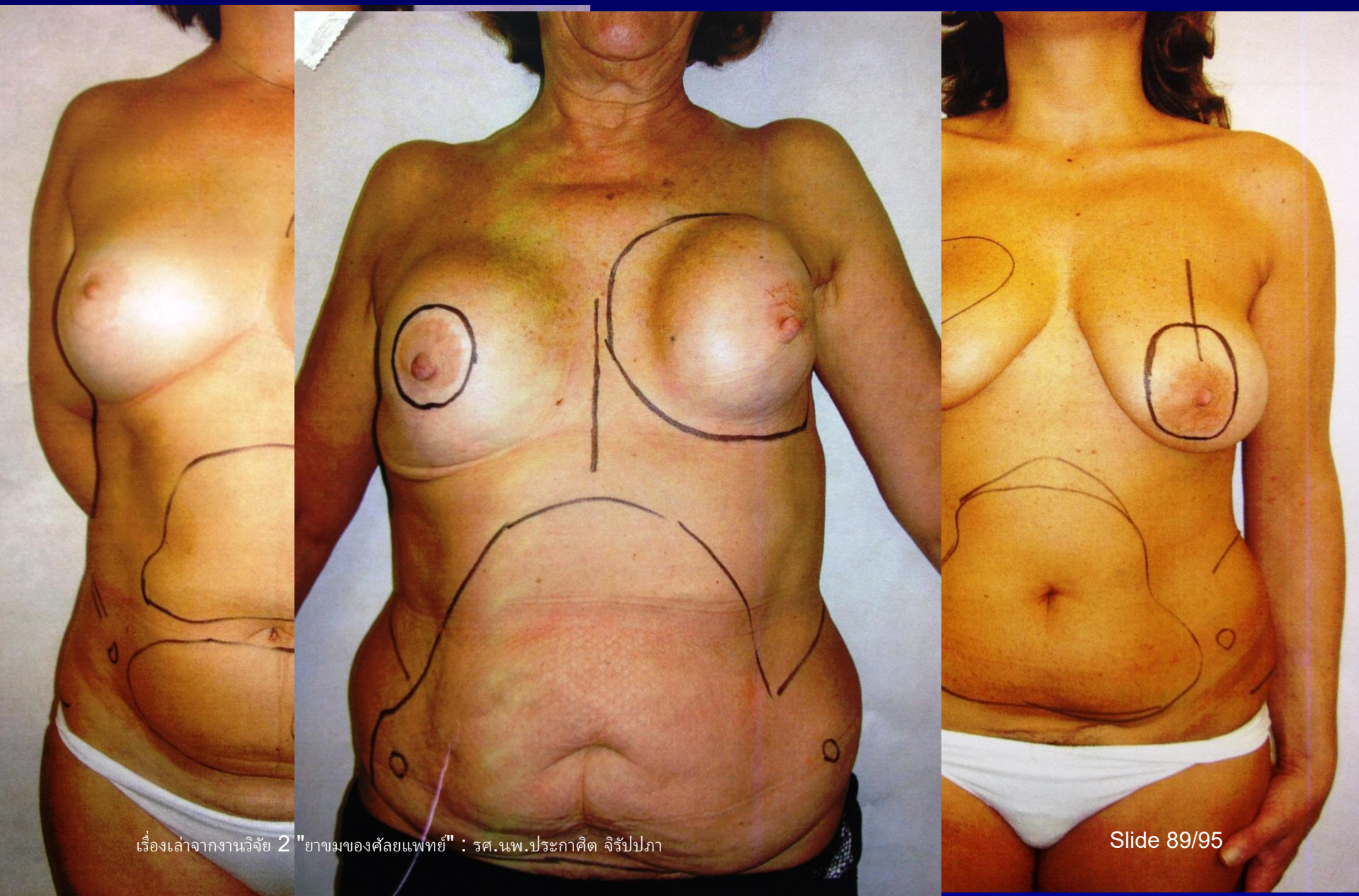
Lipofilling







Preoperative evaluation

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Research IEO (9)
Travel
รศ
More
Dr. Prakasit Chirappapha
Rietjens Mario <mario.rietjens@ieo.it>
13/08/2013
to me
Dear Prakasit
I agree with you to do a paper about lipofilling, but I think that Hamza cannot look for the data and do the job for you....
You can maybe do the data when you will finish your stay at IEO.
I'll do the last revision for your paper and send it to you.
thank you
Prof. Mario Rietjens
Direttore
Chirurgia Plastica Ricostruttiva
Istituto Europeo di Oncologia
Milano - Italia

Italian Center

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CONFERITO AL *SIG. PRAKASIT CHIRAPPAPHA*

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Introduction to Surgical Research

การอบรม "การแนะนำการวิจัยสำหรับแพทย์ประจำบ้าน และแพทย์ประจำบ้านต่อยอด"

8.00-9.00น. : "จาก Case Report ถึงงานเขียนใน Springer Nature"

ผศ.นพ. ประกาศิต จิรัปปภา

9.00-9.30น. : "งานวิจัยสู่งานนวัตกรรม"

ผศ.นท.นพ. สรยุทธ ชำนาญเวช

9.30-11.00น. : "Introduction to Surgical Research"

รศ.นพ.ภาณุวัฒน์ เลิศสิทธิชัย

วันอังคาร ที่ 16 ต.ค. 61 ณ ห้องประชุม 910C
ชั้น 9 อาคารเรียน และปฏิบัติการรวมฯ รพ.รามาธิบดี

DEPARTMENT OF SURGERY
FACULTY OF MEDICINE RAMATHIBODI HOSPITAL