NHS
Royal Cornwall Hospitals
NHS Trust

Skin reducing mastectomy with immediate breast reconstruction using dermocutaneous flap (Goldilocks reconstruction)

affix patient label

What is an immediate breast reconstruction?

Reconstruction of the breast mound carried out at the same time as your mastectomy. The aim of breast reconstruction is to produce a small replacement breast with a satisfactory appearance both in and out of clothes, but that may need support with an external prosthesis. It helps re-create a more natural cleavage which would be lost by a simple mastectomy.

This approach is often suggested when it is not possible or desirable to produce a replica breast using more complex reconstructive surgery. It has become known as the 'Goldilocks reconstruction' because it is not a standard implant reconstruction operation, it is not a complex and high risk tissue flap reconstruction, but is an in-between these other operations (in complexity and recovery time) and has been recommended as being 'just right' for you!

This type of reconstruction creates a significantly smaller, flatter breast as it does not involve an implant. If you are only having one breast treated then you are likely to have some asymmetry and may need cosmetic surgery to the other (contralateral) breast in the future if you wish to improve your breast symmetry.

What are the benefits?

This method of reconstruction allows a quicker recovery and less scarring than a reconstruction which involves transferring tissue from elsewhere in the body (flap-based reconstruction) and avoids the use of implants. This is usually the most suitable form of breast reconstruction when there is significant breast ptosis (breast droop) and at least a moderate volume breast. If you have additional risks associated with surgery for example from diabetes or a smoking background, the more complex reconstruction techniques may not be recommended by your surgeon, leaving this as a potential option. This reconstruction is thought to tolerate radiotherapy reasonably well and where it is anticipated that you would need radiotherapy treatment it is sometimes useful to avoid implant surgery, making this option more useful to you.

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Are there any alternatives?

When mastectomy is necessary, the option of breast reconstruction will be discussed with you. Some patients may not be suitable for an immediate breast reconstruction. This may be because of the type of cancer they have developed or because of other health conditions. Others may choose to complete their cancer treatment first and have a breast reconstruction at a later date – this is known as **delayed breast reconstruction**. If immediate breast reconstruction is not done, you will be offered a simple mastectomy or if appropriate, medical cancer treatment.

How do I prepare for it?

Most patients attend a pre-admission clinic where we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. Please ask us any questions about the procedure, and feel free to discuss any concerns you might have. You will also have the opportunity to discuss any concerns or queries with a member of the breast care nursing team.

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RCHT2138 V2
Reviewed 06/2025 Review due 06/2028

You must **not** eat anything for at least **6 hours** before your operation. This is to make sure your stomach is empty when you have your anaesthetic. Drinks containing fats (eg. tea or coffee with milk) and sweets all count as food.You **can** drink water or a drink without fats in it (eg. black coffee) until **2 hours** before your operation. You may also have small sips of water to take tablets. There is a hospital leaflet about having an anaesthetic. Ask the staff for a copy if you would like one.

You will be given a general anaesthetic during the operation, which will keep you asleep. The anaesthetist will come and see you before your operation to discuss this with you. You will be able to ask them questions about the anaesthetic.

A member of the surgical team will also see you on the ward. This is usually the surgeon that will perform your operation. Feel free to ask any questions you have about the operation or what will happen afterwards.

The surgeon will spend a short time with you measuring and planning the exact steps of the operation and will usually draw and make notes of important landmarks on your skin with a special marker pen. This is called the 'marking-up' process and may be done whilst you are sitting, standing and lying down. An arrow will also be drawn on the side to be operated on and a check made that this consent form has been completed and signed. Part of the 'marking up' process will involve taking photographs in a special private photography room after the markings have been completed. This is done as a record of your operation planning and forms an important part of the medical record of your treatment. You have the right to decline photographs being taken and they will only be taken after your written consent has been given and you are happy about where they will be stored and who will have access to viewing them.

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What does it involve?

The dermocutaneous flap is created from your own extra skin in the lower part of your breast. The outer layer of the skin is trimmed so that it may be used on the inside. The dermal sling is used to recreate a rudimentary breast shape so that as natural a shape as possible can be produced. Given that there is only limited tissue available from this flap, only a modest volume breast can be created this way.

Your surgeon may leave one or two soft plastic drainage tubes to drain away the tissue fluid that will be produced as a result of your surgery. When these drains are removed will be decided by your surgeon, but they may stay in for up to two weeks.

All the stitches used are dissolvable and paper stitches (steristrips) are used to cover the scar lines. A waterproof dressing is put over this. You should leave the dressing intact if possible until you see your surgeon in the outpatient clinic.

What happens afterwards?

You will usually only need to spend one night in hospital after this operation. If your personal situation means you need to spend longer in hospital we will encourage you to be up and about as much as possible.

You will be able to go home with the drains in and the district nurses will take over the management and removal of the drain. Before you go home, the nursing staff will want to be sure that you are well enough and that the conditions at home are such that you can manage safely. They will offer advice about dressings and painkillers. Taking regular simple painkillers is recommended for the first week. You will be prescribed stronger painkillers for the first couple of days if necessary.

You will be given a leaflet about arm and shoulder exercises depending on the type of axillary surgery you have had in conjunction with this breast operation.

You will be able to shower briefly but you need to be careful to keep your dressings dry. Your surgical and breast care nursing team will advise you of any special instructions about your post-operative care. You will need a full cup, well-fitting support bra to wear over your dressings night and day until you are seen again back in the clinic. Given the likely mismatch in breast volume, it is often difficult to find a well fitted bra.

Are there any risks or complications?

As with all procedures, there are risks from having this operation:

General risks

Risk from the anaesthetic: The risk to a healthy patient of problems arising from an anaesthetic is very small. However, each year in the UK a few healthy people will die or suffer serious heart lung or brain injury following an anaesthetic. For a woman who is otherwise in good health, the risk of a serious complication due to general anaesthesia is less than 1%.

Bleeding: This is usually minor and is stopped during the operation. Occasionally patients develop a collection of blood called a haematoma, which requires a second operation. For this procedure it is about 1-2 in every 100.

Infection: All surgery has a risk of infection. If the wound becomes red, hot or weeps, or you feel unwell you should consult your doctor. Treatment for this is likely to involve antibiotics and sometimes requires admission to the hospital for monitoring and intravenous antibiotics. Occasionally an operation is needed to drain infections, but more likely this can be achieved by draining infected fluid with a needle using ultrasound as an outpatient.

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Pain: A degree of pain is likely after any surgery. We aim to manage your pain with painkillers to an acceptable level post-operatively. There is evidence to suggest that if we get on top of your pain early following your operation, we can reduce the chance of it becoming a chronic problem. If the pain or numbness and tingling continues to be troublesome please let your surgeon or breast care nurse know and we can give you a medication to manage the pain.

DVT/PE: With all surgical procedures there is a risk of developing a clot in the deep veins of the leg, deep vein thrombosis (DVT). In a very small number of patients a bit of this clot breaks off and lodges in the lungs. This is a pulmonary embolus and in very extreme cases can be life-threatening. Your surgical team will prescribe you compression stockings and/or blood thinning medication after careful assessment of your individual risk.

Specific risks

Partial or full skin flap loss (necrosis): This is a rare but serious complication (up to 10 in every 100 women). The usual place for this is at the 'T' junction where the vertical and horizontal parts of your scar meet. If the circulation to the skin over the reconstruction is compromised, then some or all of the skin may not be healthy enough to survive. Although it may heal gradually with appropriate nursing care and dressings, in more serious cases the skin cannot be saved. In those cases the skin must be removed.

Seroma: This is a collection of fluid in the surgery site. If the seroma persists after the drains are removed it may need to be drained under ultrasound guidance in the Mermaid Centre. This is common, but usually fairly straightforward to manage and settles with time.

Numbness: The nerves that supply the sensation to the skin are disturbed by the surgery. This numbness usually lessens slowly over time, but may persist in some places long term. Most patients do become accustomed to the numbness over time.

Need for further surgery: There is a chance that you will need some further aesthetic (non-cancer surgery) at some point in the future. This may be a small adjustment to the reconstruction or you may need some volume supplementation with fat grafts, taken with liposuction from your abdomen, thighs or flanks. Your surgeon will discuss this with you once the reconstruction has settled and the final outcome from surgery can be judged (around 6-18 months depending on any further cancer-related treatment plans).

Asymmetry: No surgery can guarantee a complete match between your breasts. It is not possible to predict how the breast will change shape in the longer term. Shape, volume and nipple position of your healthy breast may alter due to the effects of aging of the tissues and changes in your body weight. This operation tends to produce quite marked asymmetry between the two breasts in terms of shape, volume and projection and in some cases, selective bra prosthetics can recreate acceptable symmetry.

Fat necrosis: This can occur when fatty tissue doesn't survive in its new position in the breast and becomes a firm new lumpy area called fat necrosis. It is not harmful or dangerous and may settle down and become less noticeable after a few months. Sometimes however the lumpy area may become firmer and permanent.

What should I look out for?

It is important to keep on top of your pain control following the advice above. If despite this routine, you have increasing pain, especially if it is associated with progressive breast swelling and bruising, you should seek medical advice. If in office hours Monday to Friday, you can contact the Mermaid centre using the details provided in your preoperative planning. Other sources of medical review can be via your GP or Emergency departments. Similar action should be followed if you become unexpectedly unwell, in particular with unexplained high temperatures and flu-like symptoms.

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If you develop any new lump after your surgery it needs to be fully assessed by your breast team and must never be assumed to be simply fat necrosis until a diagnosis has been properly made. This is likely to require further tests including imaging (ultrasound and /or mammography) and may involve a biopsy or rarely further surgery before reassurance can be given. This process of discovering and diagnosing fat necrosis may be anxiety provoking and stressful particularly since it occurs close to a place where you have previously had a cancer. It may also take several days and consultations to be able to be reassured.

If you would like this leaflet in large print, Braille, audio version or in another language, please contact the General Office on 01872 252690