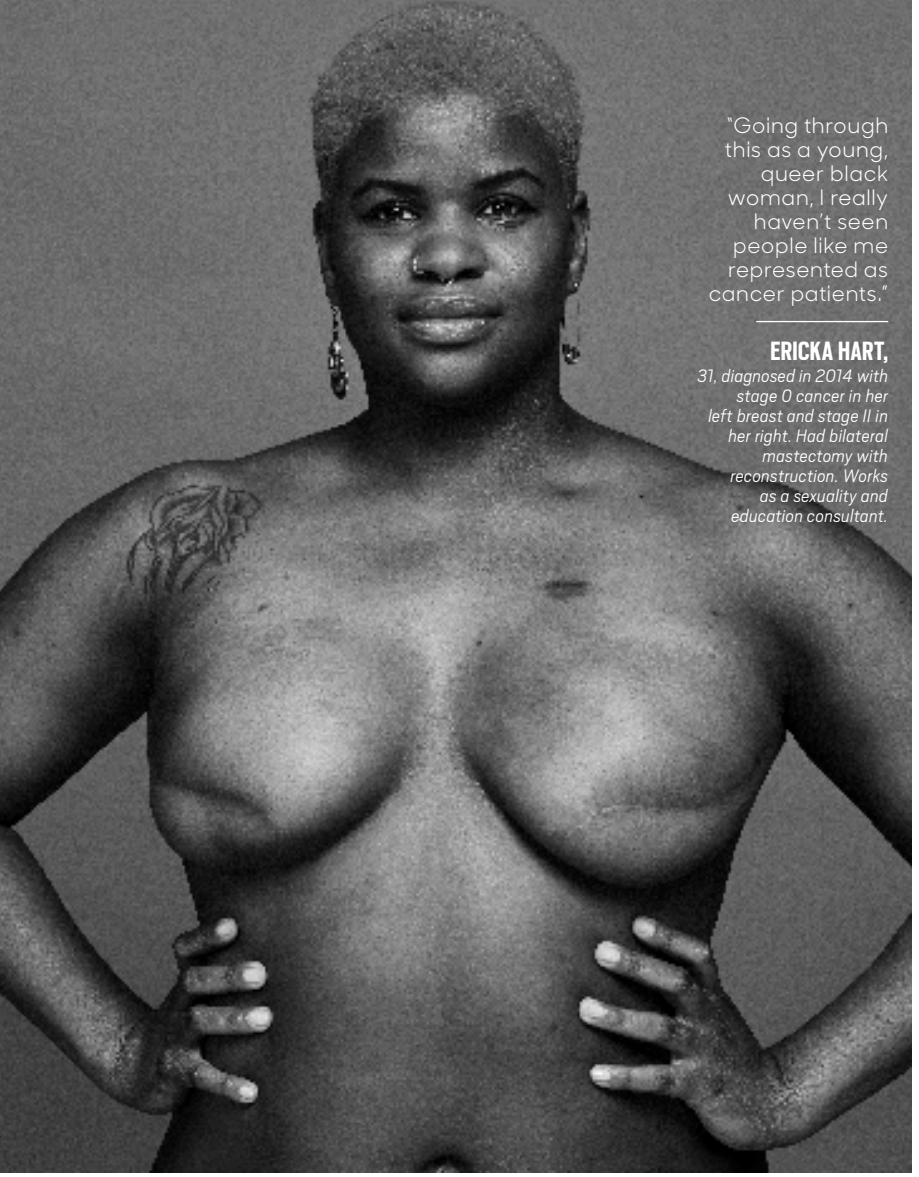


"Going through this as a young, queer black woman, I really haven't seen people like me represented as cancer patients."

ERICKA HART,
31, diagnosed in 2014 with stage 0 cancer in her left breast and stage II in her right. Had bilateral mastectomy with reconstruction. Works as a sexuality and education consultant.

IMPLANTS FYI

Breasts 2.0: What women need to know.

Getting implants, either immediately after removal of the breast or at a later date, can add up to two hours in the OR. When it comes to choosing the kind of implant, most surgeons have a brand preference but will still ask the patient for her input so they can select the style that makes the most sense for her goals and needs. Even women who defer to their surgeon should understand what kind of implant they're getting, says Angela Cheng, MD, a plastic surgeon at Emory University School of Medicine and Atlanta's Grady Memorial Hospital, one of the Avon Breast Cancer Crusade's Centers of Excellence.

The Inside

An implant can be filled with **saline** or **silicone.** Saline implants are inserted empty and filled with sterile salt water once they're in place. If they rupture, they'll deflate within days. Silicone implants are prefilled with silicone gel, meant to mimic the feel of breast tissue, and can hold their form. Silicone is more popular: 94 percent of women getting implant reconstruction in 2016 chose it, according to the American Society of Plastic Surgeons. It's harder to diagnose rupture in silicone implants; an MRI or ultrasound may be needed to be sure.

The Outside

There are two main shapes: **round** and **teardrop.** Round implants can be filled with either saline or silicone. Teardrops are typically filled with a more cohesive silicone gel and have a textured, or pebbly, surface that creates friction in the body and helps the implants stay in position (because nobody wants an upside-down teardrop on her chest).

The Issues

If a woman with implants notices swelling or redness in the area, she should have it checked out by her surgeon for a possible infection or other type of complication (she can also ask for an ultrasound to look for fluid that could signal a rare form of lymphoma called ALCL). After reconstruction, patients will receive a medical device card noting information about their implant, says Cheng. She recommends keeping this in a safe, accessible place in case a doctor ever needs to see it.

WHEN LESS IS MORE

Not all patients need to sacrifice their breasts for their safety. BY *Leslie Goldman*

AFTER SERVING AS a Susan G. Komen volunteer for 23 years, Peggy Johnson of Wichita, Kansas, was herself diagnosed with breast cancer in 2012. The lesion was small—no bigger than the tip of her finger—but her type of cancer, triple negative, was aggressive and tricky to treat. Johnson, then 63, was offered two options: mastectomy plus chemo or lumpectomy plus radiation plus chemo. Her decision to go with the latter, she says, was nearly instantaneous.

"The damage to my body would be so much less significant with a lumpectomy," Johnson says. "I'd miss fewer days of work, and I knew I could still get a good cosmetic result." But the most important factor in her choice was the knowledge that lumpectomy would not jeopardize her chances of survival: "I review research for Komen, and science tells us that the likelihood of surviving breast cancer is *not* better after removing the whole breast versus having lumpectomy with radiation to kill any lingering microscopic cancer cells." Indeed, says Laura Dominici, MD, division chief of breast surgery at Brigham and Women's Faulkner Hospital in Massachusetts, recent research suggests that lumpectomy plus radiation has a very low local recurrence rate, similar to mastectomy.

Lumpectomy's other name, breast-conserving surgery, goes right to the point of the outpatient procedure: The surgeon takes out tissue where cancer is present, but leaves the rest of the breast intact. Then a pathologist in a lab examines the excised tissue to determine whether any cancer cells are near the edge of the tissue, a.k.a. the margin. "We want a negative margin—meaning all the cancerous tissue was removed, along with a small border of healthy tissue," explains Monica Morrow, MD, head of breast surgery at Memorial Sloan Kettering Cancer Center in New York City. Once a negative margin is confirmed, the patient is given at least four weeks to heal before starting radiation to reduce the risk of the cancer returning in the breast. If the margin is not clear, more surgery, including possibly a mastectomy, may be required.

That's harsh news for women trying to avoid mastectomy. However, the probability of having such additional treatment is declining, thanks to a change in protocol. In 2014, an expert consensus panel tweaked the guidelines to declare that a very small negative margin is just as safe as a wider one, and rates of postlumpectomy surgery dropped 16 percent from

2013 to 2015, according to a *JAMA Oncology* study. "We're shifting away from more aggressive, potentially unnecessary surgeries while still minimizing the risk of the cancer recurring," says Morrow, who led the study.

For Johnson, the only physical reminders of her cancer are a paper clip–size scar on her right breast and a bit of pulling of her skin when she raises her arm, a result of radiation damage. "I had my lumpectomy on a Thursday and was back to work on Monday," she says. "Five years later, I'm still pleased with my decision."

Lumpectomy Lowdown

PATIENT PROFILE

Generally, the cancer must be stage I or II (85 percent of such patients are eligible, Morrow says) and can't be scattered throughout the breast. Individuals are not good candidates if they have previously received breast radiation or have lupus, scleroderma, a genetic risk of developing another breast cancer, or a tumor that is very large relative to the size of the breast.

SURGICAL PROCESS

Incisions can be closed with dissolvable stitches or glue; the process usually takes about an hour, and patients often go home the same day.

RECOVERY

Acetaminophen is normally sufficient to manage pain. (On a scale of 1 to 10, Johnson rated hers a 1 or 2). Narcotics are usually needed only if lymph node surgery takes place.

FOLLOW-UP TREATMENT

Many women require three to seven weeks of radiation, Monday through Friday. In the short term, patients experience breast pain, peeling and inflamed skin, and fatigue; over time, they may notice breast firmness or shrinkage, tanning of the skin in the treatment area, or painful swelling in the arms or chest caused by lymphedema. In rare cases, radiation to the chest, especially the left breast, may cause heart disease. There could also be a need for additional surgery: In 2015, 18 percent of women with a lumpectomy had another lumpectomy or a mastectomy, according to Morrow's study.

SENSATION

One of lumpectomy's most significant benefits: Typically, some breast sensation can be retained.

RECONSTRUCTION

There will be scars. Depending on the tumor's location and size, its removal may distort the breast shape, so a woman may choose some reconstruction involving fat, tissue, or even an implant.

COST

In women younger than 65, lumpectomy plus radiation costs an average of $65,000, compared with $88,000 on average for mastectomy with reconstruction—and has almost half the risk of complications, according to 2016 research from the University of Texas MD Anderson Cancer Center.

WHAT THEY DON'T TELL YOU

"Some people are unaware that a woman who's had a single mastectomy can breastfeed. I was able to nurse my baby born 26 months after my left breast was removed and a lumpectomy was performed on the right one."
—Kelly Knee, 38, mother of five who was diagnosed in 2014 with stage IIB ductal and lobular carcinoma

"When the tissue expanders were placed beneath my pectoral muscles, the pain radiated from my chest around to my shoulder blades and even down my arms. I needed narcotics for about three days after every saline fill, and it took about 15 fills over five months to reach a C cup. Physical therapy helped, as did surrounding myself with pillows at night.'"
—Karen Malkin Lazarovitz, 43, who had a prophylactic double mastectomy in 2009 after testing positive for the BRCA2 gene mutation

"Women who have mastectomies expect to see scars on their breasts; they don't expect the scar on the upper chest from the port used to administer chemotherapy and other medication. But the port can be put in through an incision between the arm and the armpit—you won't see the scar unless you raise your arms."
—Dona Hobart, MD, medical director of the Center for Breast Health at Carroll Hospital in Maryland

I'M FLAT AND I'M PROUD

Who needs breasts? Not these women, who are **embracing a new kind of freedom.** BY *Catherine Guthrie*

IN 2014, WHEN Sarah Brown of Vancouver, Washington, learned she'd tested positive for the BRCA2 gene mutation, she had no qualms about getting a double mastectomy. The idea of reconstruction, however, gave the 37-year-old small-business owner pause. Brown was fond of her 38Cs, primarily because they were hers, not surgically re-created, mostly numb breasts.

Still, Brown met with a plastic surgeon, who recommended a DIEP flap reconstruction, which involves creating new breasts out of skin and fat from the patient's lower belly. She also talked to her therapist and joined a discussion board for women undergoing mastectomy and DIEP flap—and cringed at the grueling recovery stories. Then Brown discovered Flat & Fabulous, a Facebook page where women who'd had a mastectomy posted pictures of their unreconstructed chests along with stories about how, after just a few weeks of discomfort, they were back to jogging, biking, and playing with their kids. Brown noted that instead of comparing notes about pain control and follow-up surgeries, these women were sharing fashion tips and cheering one another on. She was sold.

Nearly 25 percent of women in the U.S. who undergo bilateral mastectomy choose not to reconstruct (as do approximately 50 percent of women who undergo unilateral mastectomy)—motivated, in many cases, by a desire to minimize their surgeries, complications, and recovery time: It's not unheard of for the reconstruction process, which often follows months of chemo and radiation, to involve up to seven surgeries. There's also the risk of infection at the incision site and, in the case of DIEP flap and similar procedures, of the transplanted skin and tissue's failure to survive. (Up to 30 percent of patients will have a major complication in the year after reconstruction surgery, according to the Mastectomy Reconstruction Outcomes Consortium Study; that's compared to a 5 percent surgical site infection rate after a mastectomy only.) Implants present additional concerns: Research suggests they may interfere with a doctor's ability to diagnose a heart attack; certain types of implants are associated with a rare form of lymphoma; and the FDA recommends that women with silicone implants get an MRI three years after receiving them and then every two years afterward to check for "silent

HEALING THROUGH ART: GIGI STOLL.

rupture." Even if all goes well, some women need surgery to replace their implants after ten years.

These are all compelling reasons to say no to reconstruction. Yet most women who've gone flat have kept their choice under wraps (and baggy T-shirts), opting to create curves using prosthetics or even socks stuffed in a bra. Now, though, in the age of social media, radical transparency, and embracing difference, some women are not only refusing to hide the smooth plane of their chest but also showing it off. "When we started this group four and a half years ago, we said we'd be excited if we got 12 women to join. Today we're at 3,100," says Sara Bartosiewicz-Hamilton, founder of Flat & Fabulous. "There's enormous power in knowing you're not alone."

The group's members don't want to be weighed down by implants and the issues they bring. "My breasts and I had some good times," says 29-year-old Elspeth Lucas. "But I love being flat. I can fit into extra-small tank tops. And so few people even notice my lack of breasts." Another group member, Kelly Shiraki, notes: "My breasts were size 40G. Since going flat, it's been easier to drive, I can sleep on my stomach, and I can wear lace and flowy shirts that looked boxy on my old shape. The drawback: There's nowhere to tuck my phone or lip gloss."

Surgeons are noting an uptick in the number of patients who express interest in staying flat. "A small but growing number of breast cancer patients in my practice, including younger ones, are saying no to reconstruction," says Deanna Attai, MD, an assistant clinical professor of surgery at UCLA's David Geffen School of Medicine. Says Julie Margenthaler, MD, a breast surgeon and professor of surgery at Washington University School of Medicine in St. Louis: "I saw a young patient this morning whose main reason for opting out of reconstruction rings true for most patients: to minimize the number of procedures and risks during and after surgery."

And now pop culture is getting in on the act. On the Amazon show *Transparent*, a character played by Anjelica Huston reveals her flat, scarred chest in a bedroom scene. Comedian Tig Notaro jokes about life without breasts and has even removed her shirt onstage. An Equinox gym ad features a topless, flat model getting tattooed.

"That kind of visibility not only demystifies flatness, but also fuels a conversation about socially acceptable options for women with breast cancer," says Steven Katz, MD, director of the Cancer Surveillance and Outcomes Research Team at the University of Michigan. "Flatness is fresh. There's no doubt about it."

CATHERINE GUTHRIE *is author of the forthcoming book* Flat: A Memoir.

"I fought to have my breasts removed. Given that my cancer had already spread, my doctors said the surgery and recovery would diminish my quality of life, but it was one of the best decisions I ever made. I used to feel idealized for my breasts. I've never felt sexier than I do now."

BETH FAIRCHILD,
37, diagnosed in 2014 with stage IV lobular carcinoma with metastases to the bones, liver, ovaries, fallopian tubes, uterus, cervix, top portion of the vagina, and tissue around the stomach. A tattoo artist specializing in breast cancer patients, she owns Lucky Street Tattoo in North Carolina with her husband (also an artist) and is president of METAvivor, a nonprofit that raises awareness and funding for stage IV metastatic breast cancer.

HEALING BY DESIGN

Diane de Jesús (*above*) had never considered getting a tattoo. Then, at age 29, she was diagnosed with ductal carcinoma in situ and had a single mastectomy and reconstruction. "Even though I had a lovely result from my surgery," she says, "I still felt like something was missing." After reading about a cancer survivor getting inked near her scar, she wondered if that might resolve her sense of loss. By a stroke of luck, de Jesús was offered a free tattoo through Personal Ink (P.Ink), which connects breast cancer survivors with tattoo artists. P.Ink matched de Jesús with Roxx, a renowned artist in San Francisco. They began their appointment just by talking; de Jesús mentioned dreaming about doves, which made her think of her churchgoing grandmother, and peace and comfort. Roxx sketched on a notepad. "This is what I'm getting, listening to you," she said, revealing what she'd drawn. De Jesús was floored. "I *have* to have that!" she exclaimed. Roxx turned the drawing into a stencil that fit de Jesús's breast size and shape, and spent the next five hours applying the ink.

"After I got my tattoo, I realized I'd been avoiding looking at my chest," says de Jesús. "Now when I look, I don't see my scar—I see this beautiful art. My tattoo allowed me to get on with the rest of my life."

THE CROWNING TOUCH

Let's talk about nipples—and how there are more **postsurgical options** available for breast cancer patients than ever before. BY *Katherine Hobson*

IF YOU DO choose to have your breasts reconstructed after a mastectomy, they're likely to be completely smooth and round ("Barbie boobs," some call them). Yet for many women, a nipple is what makes the breast a breast, so the right cosmetic touch can provide a psychological boost and a connection to their precancer self. While it's not possible to restore nipple sensation or function once nerves are severed, there are now boldly artful ways to re-create (or save) one of nature's most exquisite anatomical flourishes.

Nipple-Sparing Mastectomy

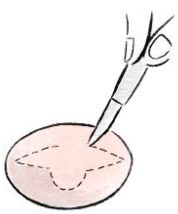
This technique, a variation of skin-sparing mastectomy, was first used in the 1960s only for benign tumors. While it's still not considered a standard breast cancer treatment by all experts, interest in it spiked after Angelina Jolie wrote about a version of this procedure for her prophylactic double mastectomy in 2013. Instead of removing the entire breast, surgeons take out all the breast *tissue* through a small incision. However, not everyone is eligible: Women who have tumors close to the nipple or extensive cancer in the milk ducts might be in danger of a recurrence if the nipple is preserved, says Elisa Port, MD, chief of breast surgery at Mount Sinai Hospital in New York City. (Also, the surgery tends to produce the most satisfactory aesthetic results in breasts that haven't yet succumbed to gravity's pull.)

Surgical Reconstruction

After the implant has settled into place, a surgeon can create a nipple with skin from the breast itself (*right*). A cosmetic filler or fat graft is sometimes used to give the new nipple more lift. For patients having a unilateral mastectomy, the surgeon can also remove a portion of the healthy breast's nipple and attach it to the reconstructed breast. (Sensation in the healthy nipple is often unaffected.)

HOW TO MAKE A NIPPLE

There are a few different techniques, but in each, sections of tissue containing skin and fat are lifted and wrapped around one another to fashion a natural-looking protrusion, says Debra Johnson, MD, president of the American Society of Plastic Surgeons. Here's a modified star-flap technique:



1. To form the areola, the surgeon tattoos a circle; then she makes incisions to create a sort of three-armed star shape.

2. Each of the three arms is lifted while the base remains attached to the breast.

3. The surgeon wraps the three arms around each other.

4. The wrapped arms are stitched together, and the nipple is secured at the base with sutures.

5. One flap is stitched at the top to close the nipple. Some surgeons elect to have the tattooing for areola color done after the nipple is healed, particularly in cases where a skin graft is required.

"I look like me. I don't like the way reconstruction feels—the numbness, the pain—but I'm happy for the most part with what I see in the mirror."

MELISSA McALLISTER,
41, diagnosed in 2013 with stage I invasive ductal carcinoma breast cancer. Had bilateral mastectomy with reconstruction and 3-D nipple tattoos by Amy Black in Richmond. Cofounded The Underbelly, an online magazine for women with breast cancer.

Tattoos

Like all tattoos, nipple tattoos are flat, but a skilled artist can make them look amazingly three-dimensional. Paying $600 to $800 for two nipples is common—and may be covered by insurance. Tattoos are usually added a few months after reconstruction, says Tara Dunsmore, a nurse and breast cancer survivor who owns Pink Ink Tattoo in Raleigh, North Carolina. Patients should ask to see examples of work, whether the person doing the ink is a nurse, a doctor, or a tattoo artist at a medical practice or an independent shop. Make sure an outside tattoo artist is licensed and familiar with the considerations of breast cancer survivors, including thinner breast tissue and the presence of implants, advises Vinnie Myers, who specializes in nipple and areola tattooing in Maryland. Not ready for the needle? Temporary tattoos like Rub-On Nipples come in nine shades, can stay on for a week or more, and are removed with rubbing alcohol, says company founder Elizabeth Vivenzio, who had a risk-reducing mastectomy in 2009.

Prosthetics

Realistic-looking silicone nipples can be attached to a reconstructed breast using a waterproof adhesive. Michelle Kolath-Arbel, owner of Pink Perfect, who herself lost a breast to cancer, will craft a custom nipple prosthetic (starting at $410 for six—insurance may cover it), or customers can choose from eight colors and three styles of ready-made nipples ($280 for two). The adhesive will stick for several days; the nipples themselves will stay perky for years.