Management of severe skin flap necrosis after mastectomy: Case report

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- The described protocol proved to be an effective method in managing severe skin flap necrosis complication caused by mastectomy with one operative management, shorter time, better aesthetic outcome and improved the patients' quality of life.

Introduktion
Mastectomy skin flap necrosis occurs more frequently than perceived, reported an overall incidence of 5%-30% of cases in the literature. The optimal management of severe mastectomy skin flap necrosis continues to remain a challenge. Skin grafting is the primary treatment for coverage of the skin defects. However, severe skin flap necrosis has a poor response to grafting, which is dependent on the condition of the recipient site. The large skin defects cannot be closed directly. Even if the defect were closed directly using overlap, the blood circulation to the edge of the skin would be disturbed and prevent wound healing.

Case report
We report a case of unexpected severe necrosis after mastectomy in a patient with ductal invasive carcinoma classified as pT2, N0 M0. A 77-year-old woman had been referred to surgery as a case of left breast invasive duct carcinoma. She was a smoker and known to have hypertension and polymyalgia rheumatica on medications. Her BMI is 18 kg/m2. After discussion in the Breast Meeting, the patient was booked for left breast mastectomy, sentinel lymph node biopsy. On the 7th postoperative day, the patient developed an extensive full-thickness skin flap necrosis on the breast.

Method
Patient photographs and wound measurement was used to estimate area of necrosis as about 50% for massive skin flap loss. The patient was managed initially with local wound care followed by delayed modified rhomboid flap (Limberg) flap operative management to close the skin defects. Postoperative PICO negative pressure wound therapy.

Results
Patient photographs and wound measurement was used to estimate area of necrosis as about 50% for massive skin flap loss (Figure 2. A). The protocol of surgical debridement, treated with modified rhomboid flap (approximately 4 X 8 centimeters) and direct wound closure (Figure 2. B) and PICO negative pressure wound therapy were started with successful complete wound closure in almost 6 weeks without any further reconstructive procedures (Figure 3).

Conclusion
The described protocol proved to be an effective method in managing severe skin flap necrosis complication caused by mastectomy with one operative management, shorter time, better aesthetic outcome and improved the patients' quality of life.