

Quality of Life After Postmastectomy Breast Reconstruction

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Purpose/Objectives: To explore women's expectations about postmastectomy reconstruction and factors affecting their quality of life after reconstruction.

Design: Qualitative focus group study.

Setting: Integrated healthcare system in a midwestern suburban community.

Sample: 17 women who had undergone mastectomies with immediate reconstruction between 1.4 and 5 years previously and had participated in a study of women newly diagnosed with breast cancer.

Methods: An experienced focus group moderator conducted two focus group sessions. Comments from the sessions were audiotaped and transcribed verbatim. The sessions involved semistructured, open-ended questions about perceptions of preparation, experience, and satisfaction regarding postmastectomy reconstruction. Thematic content analysis began with open coding at the level of individual comments and proceeded through two levels of higher-order categorization.

Findings: Although women felt well informed about breast surgery, they wished they had been more informed about some issues. Ratings of satisfaction generally were high despite some concerns about cosmetic outcome and persistent anxiety about recurrence.

Conclusions: Reconstruction allows women to feel comfortable in clothing, but recovery can be difficult, and reconstruction does not neutralize the biggest emotional challenge of breast cancer: fear of recurrence.

Implications for Practice: Women appreciate thorough information to prepare them for reconstruction and recovery. For aspects of recovery in which substantial variation exists, the range of experiences should be provided.

The evolution of opinions about postmastectomy reconstruction has followed a course that seems to have been influenced as much by societal norms as by science. Until the late 1970s, a stigma was attached to reconstruction. Women who sought reconstruction often were considered a special and troubled subset of patients with breast cancer (Rowland, Holland, Chaglassian, & Kinne, 1993), and many male surgeons considered reconstruction merely vain (Goldwyn, 1987). After the dramatic changes in societal views of women's roles and sexuality during the 1960s and 1970s, opinions of reconstruction also began to change. In addition, more efforts were made to improve reconstructive techniques and document psychological benefits of reconstruction. The earlier question of why women would choose to have reconstruction was reversed, and people began to ask why women would choose not to have it (Handel, Silverstein,

Key Points . . .

- ▶ Women choose reconstruction for physical and emotional reasons.
- ▶ Women who had reconstruction felt well informed, but some aspects of recovery were more difficult than they had expected.
- ▶ Women believed that reconstruction helped them regain some sense of normalcy despite their concerns about breast symmetry and naturalness and their undiminished fear of recurrence.
- ▶ Current research indicates that reconstruction improves body image but not other aspects of quality of life.

Waisman, & Waisman, 1990; Schain, 1991). Some people believed that women who declined to have reconstruction at the time of mastectomy might have a martyr syndrome (Hart, 1996; Schain, Jacobs, & Wellisch, 1984) or be less assertive (Noone, Murphy, Spear, & Little, 1985).

As the number of women undergoing reconstructive surgery has increased, so have efforts to answer questions about who chooses it and what its psychosocial consequences might be. Women who seek reconstruction tend to be younger than women who do not, and some studies show that they are more likely to be white, well educated, affluent, and married or in a relationship (Rowland et al., 2000). The two groups, however, are difficult to distinguish psychologically before surgery (Rowland, Dioso, Holland, Chaglassian, & Kinne, 1995). According to several studies, body image and feelings of attractiveness generally are better with reconstruction (Dean, Chetty, & Forrest, 1983; Mock, 1993; Noone, Frazier, Hayward, & Skiles, 1982; Pusic et al., 1999; Stevens et al., 1984), but other aspects of quality of life (QOL) do not differ (Hart, Meyerowitz, Apolone, Mosconi, & Liberati, 1997; Mock; Reaby & Hort, 1995; Reaby, Hort, & Vandervord, 1994; Rowland et al., 2000; Wellisch et al., 1989).

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