

Bye-bye Bitty Boobies, Hello Honkin' Hooters

Cancer sufferer throws a party for her breasts before double mastectomy

BY JODIE SINNEMA, THE EDMONTON JOURNAL FEBRUARY 14, 2009



Lianne Hanson enjoys her booby party -- a party to celebrate her life and breasts and friends because in less than one month, she is having a double mastectomy due to genetic breast cancer.

Photograph by: John Ulan, Edmonton Journal

A diagnosis of hereditary breast cancer last October turned Lianne Hanson's life into a struggle for survival, an ordeal she has shared with The Journal's Jodie Sinnema and Candace Elliott. Here is her story.

- FRIDAY: Finding breast cancer

- TODAY: Prevention through mastectomy

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"Welcome to my Bye-bye Bitty Boobies, Hello Honkin' Hooters Party," reads a sign leading down to Lianne Hanson's basement.

The walls are decked with pairs of pink balloons ranging in sizes from Double A to Triple E.

Hanson points to a deflated pair, hanging wrinkly and sad on the wall. These, she jokes, best represent

her A-minus breasts.

When she was in Grade 6, she plumped them up with sports socks stolen from her friend's brother.

When she was 14 or so, they sent her into such a panic that she phoned her aunt and asked if sleeping on her belly was keeping her chest flat.

Now, Hanson uses black humour to help cope with breast cancer, a looming double mastectomy and breast reconstruction: Lianne Hanson today, Dolly Parton or Pamela Anderson tomorrow.

In a poem posted on the wall, she writes:

I like my boobs, could not be fonder,

Small as they are, eyes still wander.

Now they're sick and it's a drag.

They'd hardly even begun to sag!

But what the heck, no big deal.

So my boobies won't be real!

My new boobs will be big and plump.

(too bad they can't take 'em from my rump!)

No worries, though, good times are comin'.

Maybe Jay'll finally get some lovin'!?!)

Beneath the poem lies the shadowy truth: Hanson, 31, was diagnosed with hereditary breast cancer on Oct. 21, 2008. Because a gene mutation put her risk for breast cancer at 57 per cent -- and increases her chances of getting another breast cancer as well as ovarian cancer -- she will say goodbye to the perfect, albeit small, breasts that fed her baby daughter.

It's Nov. 8 and she has only a few short weeks to decide how to proceed.

"Thanks for making this a celebration instead of a sad time," Hanson says early in the fete, her baby daughter sitting in her arms, with a pink luau hanging around her neck.

"I'm going to be OK and I promise I'm not going anywhere and this little baby I'm holding is why."

Dr. Kelly Dabbs, an Edmonton surgeon who devotes 80 per cent of her practice to patients with breast cancer, says she was drawn to this area of expertise because patients with breast cancer typically have more individual choice for treatment than other cancer patients. People with colon cancer, for

instance, must have their colons removed.

Women with breast cancer, on the other hand, can choose lumpectomies, mastectomies and a range of breast reconstruction possibilities, depending on the size of their tumours, lifestyle preferences and body shapes. For women with sporadic breast cancer, which accounts for 90 to 95 per cent of breast cancer cases and has no familial link, a lumpectomy is often the way to proceed if the tumour is small and the cancer hasn't had the chance to spread, Dabbs says.

"For an ordinary woman, there is no benefit of having a mastectomy over a lumpectomy. Zero benefit," Dabbs says. "Survival is exactly the same."

Women with the BRCA1 genetic mutation also have the same survival rate if they have a lumpectomy for the exact same cancer, Dabbs explains. But if they keep their breasts, they have a 40- to 50-per-cent risk of breast cancer reoccurring, thus needing more surgery and chemotherapy. That's a risk five times higher than the average woman. Those are scary odds to live with.

"You can't prevent breast cancer," Dabbs says.

In order to make sure she lives through this cancer scare, Hanson chooses to not only have her right breast removed, but also her left, healthy breast in what is called a prophylactic mastectomy.

"The only way you can prevent cancer is by doing what she's doing, which is having a prophylactic mastectomy," Dabbs says. "And we would recommend that for very few women, only women in her situation. And even the women who have bad genes, it's not the right answer for all of them."

It also can't offer the full reassurance women crave, that the drastic operation will guarantee no return of cancer.

"Do you know how we'll know if you have (beaten) cancer? When you're 90 (years old)," Dabbs says to Hanson. "We worry about little cancer cells that are out and about. That's why no one will ever tell you the cancer is cured."

Women remain breast cancer thrivers or survivors throughout their lives, she says.

Less than two weeks after her cancer diagnosis, Hanson sits with her mother in the office of Dr. Blair Mehling, the plastic surgeon who will spend more than 14 hours in the operating room reconstructing Hanson's breasts -- after Dabbs has cut away her nipples and emptied out her breast pockets, leaving an envelope of skin. This skin-sparing mastectomy is possible because the cancer is a disease of the breast tissue, not the skin.

For the first half of the 20th century, the only option for women was a radical mastectomy, pioneered by Dr. William Halsted. Since there were no screening methods, the operation often wasn't performed until the tumour was perceptibly large, sometimes oozing and incredibly painful. The radical mastectomy left women horribly disfigured, with concave chests, since a large part of the pectoral muscle was removed along with the breast and lymph nodes. Some lost use of their arms or experienced painful swelling from fluid retention.

The second half of the 20th century saw the development of mammograms to catch the cancer early, and mastectomies that left the chest muscles in tact. Breast reconstruction was pioneered in the late 1970s, '80s and '90s, although today's techniques are far more advanced.

Mehling explains the options to Hanson as he takes his Sharpie markers and draws lines and dots on her breasts and back. Hanson's body shape and breast size make her a rare, prime candidate for all three reconstructive surgeries. He can put in an expander followed by a breast implant made from safe, new generation silicone. The operation is shorter, but the end result doesn't feel or look natural.

He can take a large muscle from Hanson's back and use it to re-form and pad the breast over an implant.

Or he can use Hanson's tummy fat with a bit of muscle. Hanson hesitates over this one, in part because such an operation would compromise her desire to have a second child.

Cheryl Anne Guenther, who is BRCA1-positive like Hanson, chose to do none of the above and remains breastless at 55, largely because she is concerned that cancer could come back on her chest wall and would be hidden by implants. She remains content with her decision, even though surgeons such as Dabbs say that if cancer came back, it would develop on the skin surface or in the armpit and would be easily felt. Dabbs has never had a mastectomy patient who came back with breast cancer.

Guenther, who lives in Sylvan Lake, isn't bothered by what people might think when her blouses don't hang quite right.

"What do I care what they think?" asks Guenther, whose mother died of ovarian cancer at 41 and whose aunt died of breast cancer at 25. "If I had cancer in my left arm and had to cut below the elbow and didn't have it replaced by a prosthetic, would people look at me and think, 'Oh, she's not fashionable?' It doesn't matter to me at my age."

Mehling feels the weight of responsibility when women with the cancer gene come into his office, still healthy, and reconsider prophylactic mastectomy when they find out their breast reconstruction options are limited because of their breast size or body shape.

"If you're making a decision to potentially save your life ... it bothers me that the reconstruction can sometimes influence ... that much more important first decision about whether or not you're going to be around for your kids," he says.

Yet what he has to offer each woman is based on complex, highly individualized factors, including the patient's anatomy, health, cancer status and subsequent treatment, since radiation puts reconstruction at risk.

A woman with large breasts, for instance, typically has fewer options since implants don't come in large sizes. Even if they did, they would be too heavy for the skin envelope to contain and would float around like a ball in a stretched, distorted sock.

Giving such a woman smaller implants also isn't ideal, since it would be like putting a 1,000-square-foot

house onto a 2,000-square-foot base. Mehling says best results always come from creating breasts similar in size to the woman's original breasts.

Women who smoke also have limited options. Asking them to quit smoking at the moment they're losing their breasts is stressful, but smoking reduces blood flow, and could put the skin over the new breasts at risk of dying.

That's a concern for every patient since mastectomies remove breast tissue, which provides blood to the breasts, skin and nipples.

Mehling does encounter women who just want basic implants to fill their bras and aren't overly concerned about an unnatural feel or visible ripples, wrinkles and folds on the surface.

But many of Mehling's patients are young, and while they're intent on conquering the genetic mutation that sits in their bodies like a ticking time bomb, they want lifelong breasts that feel natural.

"What's unique about these patients is they're not sick yet," he says. "They're making a decision to take matters into their own hands and not sit around waiting to get sick. That is a unique scenario in surgery where you're taking healthy people into the operating room and subjecting them to surgery so as to keep them healthy and not have them get cancer down the road."

Bev Bruyere didn't allow the suspicious cyst on her ovary to develop. She followed her prophylactic oophorectomy with a prophylactic double mastectomy when she found out she inherited the BRCA1 gene mutation from her father. Between 29 and 35 people in her family have had breast, ovarian or prostate cancer, and most died from it, including one aunt who survived one breast cancer only to develop another that ate away her entire body.

"It was just like receiving news that you had leprosy or something," Bruyere said about receiving her genetic test results. "You had this thing that would be forever with you and will continue to cause you pain and fear and misunderstanding."

At first, Bruyere didn't want her husband to touch her new breasts because they felt strangely numb after getting implants. She says she still faces misunderstanding when people judge her for having perky breasts that are obviously fake for a 50-year-old mother.

"They're not real for the wrong reason," she says. "(But) in the scheme of things, it's a small price to pay for not becoming ill. I believe I will live a long, healthy life."

Six weeks after her cancer diagnosis, and two hours into her mastectomy surgery, Hanson lies on the operating room table with two red slits marking the spots where her breasts used to be. Her nipples are also gone, since they, too, are filled with breast tissue and are susceptible to breast cancer.

Analysis from the lab down the hallway, where the breast tissue was dyed and sliced like bread, indicates Hanson's 1.3-centimetre tumour is a firm, well-defined white pebble surrounded by a good margin, which indicates it hasn't spread.

Back in the operating room, where the air is filled with the beats of Funky Town and other disco music, the medical team carefully flips Hanson onto her stomach and begins work to remove the large latissimus dorsi muscles that line both sides of her back. They remain connected by only an artery and vein to make sure they stay flush with blood when they are transplanted to her chest and wrapped around an implant to become Hanson's new breasts.

Hanson will barely notice the missing back muscles, since others will take over all the functions. Better this than lose some stomach strength. Baby thoughts are still strong for her, even knowing she faces a 40-per-cent chance of developing ovarian cancer because of her BRCA1 gene mutation. Most women's risk for ovarian cancer is less than two per cent.

"I'm getting a really strong feeling I'm not going to have a second child," says Hanson, in tears days before the surgery. "Talking about cancer and mastectomies doesn't make me cry. This makes me cry."

Hanson has done the math in her head: six weeks to recover from surgery. Three to nine months of chemotherapy to make sure the cancer hasn't spread. Nine months of pregnancy, if indeed her ovaries still work after chemotherapy.

That would be a minimum two-year delay, giving ovarian cancer a 24-month window to begin growing.

The decision hovers over her like a knife. "It hurts my heart," she says.

During Hanson's 14-hour surgery, Mehling works with a colleague to cut out her back muscles. He tucks them into her armpits before closing the two incisions on her back.

Turning Hanson face up again, the surgeons pull the muscles through tunnels in her armpits to Hanson's front, where they spill out the mastectomy holes, red and raw. Then begins the artistry of forming and shaping Hanson's new breasts.

With her bed tilted up, gravity pulls the tissue down, helping surgeons form even, round, natural-looking breasts. The surgeons line Hanson's breast skin with the muscle and tuck in a breast expander, pumping it up slightly with saline solution. Over the coming months, more saline will slowly expand Hanson's breasts as her latissimus dorsi muscles lose volume from lack of use.

As the breasts round out, Mehling uses his gold nipple areolar marker to mark the areas that will eventually be formed into nipples. To build them now would risk having them die from lack of blood. Instead, after approximately nine months, Mehling will mould new nipples from small pieces of skin he transferred from Hanson's back along with the large muscles.

For now, those pieces are round flat circles, intricately stitched to fill the nipple holes.

"The Pandora's box that is opened when there is a genetic risk involved is huge," Mehling says, who considers his work with genetic breast cancer patients his most challenging and rewarding. "These women live with the constant fear that they are going to meet the same fate of people they have lost. They place a lot of trust in the physicians in taking them through these big operations so that they can

eliminate that fear, that they can actually do something proactive, that they can minimize their cancer risk. And my role is hopefully to keep them intact physically, as well."

Hanson gives him her trust, thinking of her new daughter.

"If you need to take my breasts, go ahead," she tells the world. "If you need to take my hair, go ahead. All I need is my arms to hold her, my lips to kiss her and my eyes to see her beautiful face."

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- How many mastectomies were performed last fiscal year (2007-08) in Alberta Health Services, Edmonton area?

Single=one breast / Bilateral=two breasts

Inpatient Single 452 Bilateral 21 Total 473

Day Surgery Single 15 Bilateral 3 Total 18

- HOW MANY BREAST RECONSTRUCTIONS WERE PERFORMED?

TOTAL MASTECTOMIES WITH SIMULTANEOUS RECONSTRUCTION:

Inpatient Single 25 Bilateral 6 Total 31

Day Surgery Single 1 Bilateral 0 Total 1

BREAST RECONSTRUCTIONS POST-MASTECTOMY

Inpatient: Single 44 Bilateral 13 Total 57

Day Surgery: Single 99 Bilateral 30 Total 129

DEFINITIONS:

- Lumpectomy: Also called breast conservation therapy, lumpectomy involves surgically removing only the breast lump or tumour, along with a small amount of normal tissue surrounding it. - Mastectomy: Surgery removing the entire breast. There are several different kinds of mastectomies, including bilateral (both breasts), prophylactic (preventive before breast cancer arrives) or radical (a surgery used most often in the early 1900s that removed breast, lymph nodes and parts of the pectoral muscle). - TRAM flap: The transverse rectus abdominis myocutaneous flap procedure allows surgeons to reconstruct breasts using fat and muscle from the patient's belly. There are several different kinds of TRAM flaps, including ones that demand microsurgically attaching blood vessels. - Latissimus Dorsi flap:

Breast reconstruction surgery where surgeons use the patient's latissimus dorsi muscle from her back to wrap around a breast expander, then a breast implant, to build new breasts. Both flap procedures

create breasts that feel and look more natural than using breast implants alone.

IN SUNDAY READER:

- Part One -- Hope beyond the cancer gene;

- Part Two -- New nipples from tattoos

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