CHAPTER 2 WOMEN'S MOTIVES TO OPT FOR EITHER IMPLANT OR DIEP FLAP BREAST RECONSTRUCTION

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Abstract

Objective Understanding women's motives concerning breast reconstructive surgery will contribute to a better counseling and care for the increasing number of women choosing post mastectomy breast reconstruction (BR).

Methods We interviewed 31 women who opted for implant or DIEP flap BR after therapeutic or prophylactic mastectomy. Motives for BR in general and for the selected type of BR were investigated following a phenomenological qualitative research approach.

Results Women opting for implant BR were concerned with surgery related issues such as recovery time, number of scars and impact of surgery. They wanted to return to their daily life and restore their body image as soon as possible. Patients choosing DIEP flap BR were more focused on regaining a natural breast and wanted to benefit from the advantages of autologous tissue. Women scheduled for prophylactic mastectomy saw BR as an integral part of their treatment. Patients choosing for BR after therapeutic mastectomy wanted to regain a complete body image with BR.

Conclusions Patients' motives for implant BR were primarily related to surgical issues, whereas women who chose DIEP flap BR especially focused on regaining a breast that resembles their own lost breast as good as possible. Clinical variables (such as therapeutic or prophylactic mastectomy, breast irradiation, and waiting lists) need to be taken into account when considering a certain type of BR, as these can be of great importance in the decision making process.

Introduction

Body image is an integral component of the self-concept which for women includes a sense of femininity and attractiveness [1;2]. Mastectomy may have a negative effect on body image and may induce sexual problems and loss of womanhood [3]. Fortunately, breast reconstruction (BR) after mastectomy has shown to improve quality of life [4-8]. At present, an increasing number of women opt for BR, although the majority still rejects any form of BR, despite information about the possibility by their physician [9-12].

Several clinical factors contribute to decision making regarding BR, such as treatment (therapeutic or prophylactic mastectomy, history of breast irradiation, timing of BR) and physical characteristics (radiation of breast skin, amount of tissue loss), but also patient preferences play an increasingly important role [13-17].

Women who choose BR tend to be younger, are more likely to be well-educated, Caucasian, wealthy, and married or have a relationship [18]. Most reported reasons for choosing BR are to get rid of the external breast prosthesis, to be able to wear a greater variety of clothes, and to restore feelings of completeness and body integrity. Women who decided to have mastectomy only, considered BR as not essential for their physical and/or emotional wellbeing, were uncertain about the procedure, did not want to undergo more surgery or have any unnatural substance in their body [16;19;20].

BR with foreign material (e.g., silicone implant), autologous tissue (e.g., DIEP flap [21]), or with a combination of both (e.g., latissimus dorsi flap and implant) are presently available. Previous studies on patient satisfaction after BR have shown that in general satisfaction scores after autologous reconstruction were higher compared to following implant reconstruction [22-25].

Physician-patient communication is not always efficient and consequent in the decision making process regarding BR [12;26-28]. For example, discrepancies have been found between patients' preferences and physicians' perspectives,[29] which may result in low satisfaction rates or patients' regret after BR [26;30;31].

In this qualitative study we describe patients' motives to choose either implant or DIEP flap BR. It is important that physicians understand women's motives and integrate women's preferences before giving recommendations, to prevent regret and improve satisfaction after BR. Patients will then receive accurate and personalized information to establish more realistic expectations, which eventually may lead to improved satisfaction.

Methods

Participants

Women who participated in a multi-center prospective follow-up questionnaire study on the psychological effects of different types of BR and who also consented to be interviewed were included. They had previously undergone mastectomy or were about to have therapeutic mastectomy for breast cancer (BC) or prophylactic mastectomy (PM) for a high-risk for developing BC. Exclusion criteria were previous BR and poor command of the Dutch language.

We used the method of purposive sampling, the most commonly used form of nonprobabilistic sampling. Sample size relies on the concept of "saturation" or the point at which no new information or themes are observed in the data, which is usually reached within twelve interviews [32].

Patients were approached between December 2007 and January 2009 at six different Dutch hospitals.[1] Ethics approval was obtained from all participating hospitals.

Implant BR group

Twenty-three women who chose immediate or delayed implant BR (usually preceded by tissue expansion) after (prophylactic) mastectomy, were asked to take part in the interview study. Eighteen women consented to participate (78%) and fifteen were interviewed. Due to logistic problems three women were not interviewed.

DIEP flap BR group

Twenty-four women who were scheduled for an immediate or delayed DIEP flap BR after (prophylactic) mastectomy were asked to take part in the interview study. Eighteen women consented to participate (75%) and sixteen women were interviewed; the other interviews could not be scheduled due to logistic problems.

Procedure

A semi-structured interview was developed concerning motivational aspects of the decision making process, containing contextual factors (personal, social and clinical situation), personal views and expectations regarding BR. Examples of open-ended interview questions are: "Which options regarding reconstruction did you consider?"; "Did a specific inducement effect your choice for this type of breast reconstruction and could you describe this?"; "How do you think reconstruction will affect your social functioning?". Examples of structured questions are: "Do you expect changes in your relationship due to the reconstruction?" and "Do you expect reconstruction to influence your self-esteem?". The interview was pilot tested among five women planned for another type of BR or who had previously undergone BR. Refinements to improve clarity were made after feedback of interviewees and interviewers. In addition, patients were asked about their awareness of BR methods using implant or autologous material.

[1] The Leiden University Medical Center, Erasmus MC-University Medical Center in Rotterdam, Erasmus MC-Daniel den Hoed Cancer Center in Rotterdam, Haga Hospital in The Hague, Rijnland Hospital in Leiderdorp and the Lange Land Hospital in Zoetermeer.

An invitation to participate, informed consent, and prepaid envelope were sent before BR. Two weeks later non-respondents were sent a reminder. All consenting patients received the questionnaire (concerning the follow-up study, not incorporated in this study) with a prepaid envelope and were phoned to plan the interview.

All interviews were conducted by a psychologist (JG) and were planned either in a consulting-room at the hospital or at the patients' home, in case they were not able to visit the hospital due to practical reasons.

Table 1. Patient characteristics

	Implant BR N = 15	**DIEP flap BR N = 16**
Mean age at time of interview in years (sd)	44.2 (9.3)	48.5 (8.4)
Partner	14	13
Children	14	15
Children at home	12	8
Education:		
Low	3	2
Intermediate	7	7
High	5	7
Inherited predisposition for BC [a]	10	6
Mastectomy for BC:		
unilateral	4	12
bilateral	0	1
with contralateral PM	5	0
Bilateral PM	6	3
Timing of breast reconstruction:		
Immediate	12	3
Delayed	3	13
Mean BMI (sd)	25.7 (4.6)	27.0 (3.2)
Mean time since BC diagnosis in months (sd)*	35.6 (74.6)	46.6 (30.6)

BR: breast reconstruction; BC: breast cancer; [a]: brca1/brca2/familial risk; PM: prophylactic mastectomy; BMI: body mass index; DIEP: Deep Inferior Epigastric artery Perforator;
n* = only patients with a history of breast cancer: 9 women with implant BR,
13 women with DIEP flap BR

Data preparation and analysis

All 31 interviews were recorded and transcribed verbatim. Interviews were analyzed using the phenomenological hermeneutical research approach [33]. By repeatedly listening to the interviews and iterative reading of the transcripts (JG, MH), personal and motivational

context concerning the decision-making process of BR were identified. Reported values, norms and expectations were categorized until no new key themes were detected. Saturation was reached after fourteen interviews in the implant group and after eight interviews in the DIEP flap group [32]. Afterwards, all interviews were reviewed to look for any additional significant statements, which were not found. Thematic analysis was performed by three authors who reached consensus (JG, MH, AT). This whole procedure was independently conducted for the interview analysis of both patient groups.

Results

The interviews were planned on average 16.8 days (range 2 to 65 days) preoperatively and mean interview duration was 54 minutes (range 28 to 111 minutes).

Breast reconstruction

Patient characteristics are shown in Table 1. The majority of patients were aware of BR options with implant and autologous material.

In general, similar key themes regarding personal and motivational context of BR were identified: most women reported they wanted to have BR because they found themselves too young to live without breasts. They wanted to avoid wearing an external prosthesis, or wanted to get rid of it. In particular, BR was expected to result in feeling more free and self-confident.

"You're actually like a do-it-yourself kit: wearing contacts, my dentures, my breast – every morning…"

Femininity was also a very important motive to choose BR. Patients stated they would not feel feminine without their breasts. Above all, they felt the need to be 'normal'. The majority of all participants believed that a woman needs to have breasts to feel normal or to have a normal body. Most participants also stated they needed to have their breasts reconstructed because they wanted to be or stay representative in clothing.

Timing of breast reconstruction

More than half of the women who were about to undergo delayed BR, reported they first wanted to recover from their BC treatment, physically as well as emotionally. Most women planned for immediate BR were not particularly concerned with timing of BR, although few said they preferred immediate BR to move on with their life as soon as possible. For women who were about to undergo PM, timing of BR was not an issue as BR was an integral part of PM.

Therapeutic or prophylactic mastectomy

Almost all patients who had undergone unilateral therapeutic mastectomy in the past were concerned with the asymmetry of their body. They were very aware of their daily

confrontation with mastectomy and felt asymmetry was unacceptable. They expected that BR would make them feel more complete.

Most women who were about to undergo bilateral PM regarded BR as an integral part of the entire treatment. Some of them associated BR itself with the risk reduction for BC and anxiety reduction. Some patients even stated that, if BR would not be possible, they would reconsider undergoing PM.

Women opting for implant breast reconstruction

Women who opted for implant BR (n=15) were on average 44 years old (28-61 years). Most women were moderately educated and had children at home. Their mean BMI was 25.7 (sd = 4.6). Nine women had a history of BC and six women were about to undergo PM with direct BR. Twelve women in this group were about to undergo immediate BR, while three women were planned for delayed BR (see Table 1).

Surgical considerations (n=9)

Women opting for implant BR predominantly had a pragmatic approach towards BR and predominantly focused on surgical aspects. They preferred to have a short recovery period and a smaller impact of surgery, since they wanted to regain their daily life as soon as possible.

"To undergo breast reconstruction with bodily material is more complex than implant reconstruction, the recovery period is longer and more intense, and given my social circumstances with three little children… Being out of daily routine for weeks already is inefficient, not to mention a recovery period of months!"

Some women preferred a short anesthesia period and, therefore, decided to have implant BR. In addition, some women were told that they had insufficient bodily tissue to undergo autologous BR, so implant BR was the most appropriate option.

Aesthetics (n=8)

Some women believed they would obtain the best aesthetic result by opting for implant BR. They were concerned about the number of scars on their body and definitely did not want to get donor site scars, which resulted in their preference for implant BR.

Women opting for DIEP flap breast reconstruction

Women who choose DIEP flap BR (n=16) were on average 48 years old (32-59 years) and most were moderately to well educated. Their mean BMI was 27.0 (sd = 3.2). Half of the group had children at home. Thirteen women had a history of BC and were planned for delayed reconstruction. Three women were planned for prophylactic surgery followed by immediate reconstruction (see Table 1).

Surgical considerations (n=14)
Participants felt the complication risk after DIEP flap BR was the lowest compared to other BR types. They often rated the complication risk of implant BR to be much higher than DIEP flap BR. Moreover, they felt DIEP flap surgery would offer long-term benefits compared to the use of implants, because the latter would require future revision operations for capsular contracture or implant malpositioning. Some women felt DIEP flap BR would offer an additional advantage: they would benefit from an abdominoplasty during the same operation. Finally, a few women stated implant BR was contraindicated due to previous radiation therapy.

"I'm a bit frightened when I think about implants. Imagine you'll have bad luck... You sometimes hear about leaking silicones or capsular contracture. Then, after a year, the breast has to be opened again, or maybe already after some months. So I think, well… a DIEP flap feels safer to me."

Aesthetics (n=14)
The majority expected a DIEP flap BR to give the best result. In particular, they preferred a new breast reconstructed with their own tissue that would feel soft and look natural. In addition, patients anticipated that such a reconstructed breast would sag just like their own contralateral breast, in contrast to a breast reconstructed with an implant. One woman illustrated this as follows:

"With silicones, at the age of 80 - if I get to make it (…) - then I'd probably end up with one pretty breast, while the other would be hanging down like a teabag. That would be no good!"

Sexuality (n=4)
Some women who had BC hoped DIEP flap BR would improve the sexual relationship with their partner. Since mastectomy they had experienced serious problems in their intimate relationship and felt BR would help and make them feel more confident in their sexual contacts. In addition, some of them indicated that their partners had problems with mastectomy and, consequently, their sexual activity had reduced significantly.

"Our sexual activity declined… It's just… it's just not happening! If we have had sex three times in one year, it's a lot!"

Discussion

The main goal of the current study was to explore motives for choosing specific types of BR after therapeutic as well as PM. Motives for choosing BR in general were consistent with previous findings [16;19;20]. The most mentioned reasons to choose BR were feeling too young to live without breasts, wanting to avoid an external prosthesis, and wishing to feel feminine and self-confident. Regarding the decision making process of the specific type of BR, it remains difficult to distinguish between clinical and motivational aspects and to

discriminate their influence. Although this suggests heterogeneity of our patient groups, we feel this is representative for the Dutch patient population, as we recruited patients from different hospitals in the Netherlands.

Women who opted for DIEP flap BR focused on *aesthetic outcome*, such as gaining a natural breast that would resemble their own breast most. Women in the implant group reported more *surgery related* considerations, such as a shorter recovery period. However, total recovery time for two-stage implant procedures might actually be longer than after one-stage autologous BR, without patients realizing this.

Contrary to patients from the DIEP flap group, no women from the implant group expressed the specific desire to improve sexuality or their relationship. This can be explained by the fact that the majority of them were planned for immediate BR, and had not experienced the consequences of mastectomy on their sexual functioning.

The majority of the delayed BR patients opted for a DIEP flap reconstruction. They possibly chose a more sophisticated BR type with a better chance for a more natural result, because they had lived some time with an asymmetrical thorax. They had experienced the daily confrontation with mastectomy and its effect on their sexual relationships as well as on clothing limitations. Also, they had had more time to obtain information and consider all their reconstructive options. Another motive could have been the beneficial abdominoplasty effect of a DIEP flap procedure after closure of the donor site, as on average these women were older and slightly heavier than women from the implant group. However, as additional donor site scarring was seen as a disadvantage for some women opting for implant BR, abdominoplasty might as well be a contra-motive in the decision for the type of BR.

Decision making and information needs vary distinctly between women with BC diagnosis and those opting for PM. Women who are about to undergo therapeutic mastectomy followed by immediate BR often are in an “emotional roller coaster” at the time of decision making. They primarily need to undergo cancer treatment, and additionally have to consider BR, which may be secondary. Therefore, these women may be more concerned with surgery related considerations such as quick recovery and returning to daily routine.

Patients with prophylactic mastectomy generally choose for BR, in contrast to a considerably lower number of breast cancer patients [9-12;34]. Feelings of isolation may emerge as women can experience counterproductive reactions after telling others they opted for PM [35]. Most PM patients saw BR as an inclusive part of the prophylactic treatment which is most likely related to the information they preoperatively receive. All our patients are offered BR as an integral part of PM. Our PM patients predominantly chose implant BR, which is generally the reconstruction type performed after immediate bilateral PM [36]. Furthermore, women opting for prophylaxis are younger and often have young children at home. Therefore, it is sensible that they focus on practical aspects of surgery, such as short recovery time.

In hospitals where certain techniques are unavailable, patient information is likely to focus on available methods, like implant BR which is an attainable, relatively simple, and cheap method. DIEP flap BR was performed in only two of the participating hospitals at the time of patient inclusion, therefore not all patients may have had the information and

the possibility to undergo DIEP flap BR. In particular, immediate DIEP flap BR is complicated due to logistic factors, such as long waiting lists. However, ideally pre-operative patient information should be similar for all patients, regardless of mastectomy indication or timing of BR.

Other clinical factors may contribute to the decision making for BR type, such as previous radiation therapy precluding implants as this leads to more capsular contraction, or (un)availability of donor tissue for autologous BR.

From a psychological perspective, cognitive dissonance may have played a role in patients' attitude towards their selected BR type [37]. Patients could have tended to justify their decision as surgery was already planned and there was nearly a point of no return. However, due to the interviews explorative character it is improbable this was of significance.

Finally, future quantitative studies including larger patient groups, matched for clinical characteristics are recommended to validate this qualitative study. Questionnaires could be developed based on the topics discussed, including the role of clinical characteristics in the decision-making process, which should not be underestimated.

In conclusion, some BR patients are more concerned with surgery related aspects, while others have specific desires concerning aesthetic outcome. Mastectomy indication and timing of BR seem to be predominant factors in deciding for a specific type of BR. Delaying BR gives women more time to consider their reconstructive options. However, the optimal timing of BR also depends on clinical factors, such as complication risk [38].

Clinical implications include the need for plastic surgeons to explicitly ask patients who opt for immediate reconstruction whether they want their breasts reconstructed with implants or autologous tissue and inform them about all possibilities. If patients prefer autologous techniques, reconstruction might be delayed due to waiting lists. Also, if patients doubt their choice for BR or its timing, reconstructive surgeons might advise delayed BR or further clarify possible unrealistic expectations. In addition, since certain patients may need more information concerning psychosocial aspects of BR, breast-care nurses should be structurally involved in the decision making process as they can play an important role in information provision [39]. To gain ultimate satisfaction with BR, it is important to provide clear pre-operative information and to consider patient preferences and needs seriously [13;26;30;31].

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ADDENDUM CHAPTER 2

The decision not to undergo breast reconstruction

For reasons of comparison we invited 18 women who had undergone mastectomy without receiving breast reconstruction, to take part in the interview study to form the 'mastectomy only group'. Sixteen were treated for breast cancer in the LUMC in 2005 and 2006, and one woman had mastectomy at the EMCR. Fifteen women (83%) consented to participate. Fourteen interviews were used for the study as one interview was excluded from analyses as the quality of the audio-tape was insufficient for transcription.

Women in the mastectomy only group were on average older than women in the reconstruction groups. All had unilateral mastectomy and none of them underwent prophylactic surgery (Table 1).

Table 2 shows the motivations against breast reconstruction reported by the women in the mastectomy only group. Seven women said they felt too old to choose for reconstruction. One woman clearly stated: *"No, that would be foolish. (…). I cannot afford that, can I? At my age, I don't want to exhaust myself with things that are not really necessary, do I?!*".

Most women in this group accepted the loss of the breast and experienced no significant impairment of the mastectomy and therefore refrained from having reconstruction. Six women felt that their health and/or the emotional recovery from the breast cancer treatment were more important than the aesthetical loss. Four women stated they had other priorities than undergoing reconstruction, such as another chronic disease that required attention or the feeling that the expected end result would not outweigh the investment in reconstruction. Three women felt that they were not able to undergo reconstruction, because they had to take care of young children, a partner or a pet.

Several surgical specific aspects of reconstruction appeared to be important reasons not to opt for breast reconstruction. Ten women stated they did not want any more surgery. Eight women perceived the complication risk of reconstruction as too high. Other specific considerations were 'don't want the burden of the recovery', 'not being impressed by cosmetic end result' and 'don't want any (more) scars'.

One woman emphasized her opinion regarding the end result of reconstruction: *"I've never seen an impressive breast reconstruction. I find it hideous. I don't know what it is, but they are frayed, lumpy and not evenly formed. It is not something that belongs to a woman's body, to my opinion."*

The professional's advice was decisive for four women and two women stated they did not choose for reconstruction because their partner did not support this.

Three women explained they were not physically or mentally ready (yet) for reconstruction. They wanted to recover from their BC treatment first or stated they were just not ready yet to decide about reconstruction.

Discussion

The three patient groups differed significantly in 'age', 'mastectomy as treatment for BC or as prophylactic surgery' and 'laterality'. These demographic and medical variables can (partly) explain the choices that have been made.

Age appeared to be an important factor in the decision for reconstruction, which is consistent with earlier findings [1-3]. Some women found themselves too old to undergo reconstruction, whereas others found themselves too young to go through life without breasts. Undergoing prophylactic surgery is often related to age, as women with a high-risk for developing breast cancer, need to decide at a young age whether they want to undergo prophylactic surgery to protect themselves against the development of breast cancer. In addition, breast reconstruction is generally offered as an integral part of prophylactic mastectomy. The demographic and clinical differences might therefore also be related to the surgical options available at the hospitals (i.e., surgeon's expertise, operation time available, waiting lists) which determines or might limit reconstructive options.

Women who decided against reconstruction refer to a variety of considerations, for example: no more operations, accepted loss of breasts and loyalty to a partner. These women seem to take a broader perspective, in which they also refer to other values, relevant for the quality of their lives. In contrast, those who opt for reconstruction underline more specific considerations, directly related to their expectations of the reconstruction in cosmetic, psychological and practical respect, which is consistent with previous studies [2;3].

The large variation in medical demographic characteristics between the three patient groups, hinders an explicit comparison of the motivational aspects, although it is known that women who decide against reconstruction are older than women who opt in favor of it [4].

Another factor restricting a direct comparison was that women in the reconstruction groups were interviewed preoperatively, while women in the mastectomy only group were interviewed after the operation. Future designs should try to match their patient groups on these variables.

It is important to note that not all women have reflected on all reconstruction options (the whole range). Some options may not have been available to them for medical reasons, may not have been offered to them by their centre or were not discussed with their doctor, whereas other women were only motivated to realize their preferred option, while neglecting other possibilities.

In conclusion, some patients focus more on practical, cosmetic aspects of the surgery, while others focus more on the psychosocial consequences of the reconstruction (type). This is an essential implication for the clinical practice: some patients might need more information concerning the psychosocial consequences of the breast reconstruction, in addition to the information provision about surgical aspects. Patients should be well informed about their reconstruction possibilities and about its consequences so they can make a well-informed decision.

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Table 1. Participants characteristics

		Breast Reconstruction			No Breast Reconstruction	
		Implant group	DIEP flap group	*p* Value*	Mastectomy only group	*p* Value*
		n = 15 (%)	n = 16 (%)		n = 14 (%)	
Age at time of interview (yr)	Mean (sd)	44.24 (9.33)	48.53 (8.42)	.189**	57.93 (9.44)	.001**
Partner	yes	14 (93.3)	13 (81.2)	.600	12 (85.7)	1.000
Children	yes	14 (93.3)	15 (93.8)	1.000	12 (85.7)	.578
Children at home	yes	12 (80.0)	8 (50.0)	.135	6 (42.9)	.206
Education	low	3 (20.0)	2 (12.5)		4 (28.6)	
	intermediate	7 (46.7)	7 (43.8)		4 (28.6)	
	high	5 (33.3)	7 (43.8)	.492β	6 (42.9)	.812β
Mastectomy for treatment for BC	yes	4 (26.7)	13 (81.2)	.004	14 (100.0)	.002
Mastectomy both as treatment for BC and as prophylactic surgery	yes	5 (33.3)	0 (0.0)	.018	0 (0.0)	.305
Mastectomy as prophylactic surgery	yes	6 (40.0)	3 (18.8)	.252	0 (0.0)	.040
Timing of breast reconstruction	immediate	12 (80.0)	3 (18.8)		-	
	delayed	3 (20.0)	13 (81.2)	.001	-	
Laterality	unilateral	4 (26.7)	12 (75.0)		14 (100.0)	
	bilateral	11 (73.3)	4 (25.0)	.012	0 (0.0)	.001
Weight	Mean (sd)	73.27 (15.85)	78.06 (11.45)	.340**	69.00 (8.07)	.116β
BMI	Mean (sd)	25.71 (4.59)	26.96 (3.18)	.386**	24.60 (3.52)	.158**
Time elapsed since diagnosis (months)***	Mean (sd)	35.57 (74.64)	46.56 (30.57)	.018β	35.57 (14.80)	.721β

Table 1. Participants characteristics *(continued)*

	Breast Reconstruction			No Breast Reconstruction	
	Implant group	**DIEP flap group**	***p* Value***	**Mastectomy only group**	***p* Value***
	n = 15 (%)	**n = 16 (%)**		**n = 14 (%)**	
Chemotherapy***	4 (40.0)	10 (76.9)	.102	9 (64.3)	1.000
Radio therapy***	4 (40.0)	6 (46.2)	1.000	4 (28.6)	.491
Hormonal therapy***	2 (20.0)	9 (69.2)	.036	7 (50.0)	1.000

BC: breast cancer; BMI: body mass index; DIEP: Deep Inferior Epigastric artery Perforator

* Fisher's exact test unless otherwise indicated; ** student t-test; β Mann-Whitney test, sig at .05.

*** N = only patients with a history of breast cancer: Implant group: 9; DIEP flap group: 13; Mastectomy only group: 14.

Table 2. Women's motivations to opt for mastectomy without breast reconstruction

	n = 14 (%)
Being too old	7 (50.0)
Situation or loss of breast is accepted	8 (57.1)
Aesthetics are subordinate to health and inner growth	6 (42.9)
Having other priorities than BR	4 (28.6)
Feeling limited by personal/social situation	3 (21.4)
Don't want more operations	10 (71.4)
Complication risk is too high	8 (57.1)
Don't want burden of recovery (period)	4 (28.6)
Not being impressed by BR	4 (28.6)
Don't want any (more) scars	2 (14.3)
No support professional	4 (28.6)
No encouragement partner	2 (14.3)
Not being physically or mentally ready (yet) for BR	3 (21.4)

BR: breast reconstruction