

**Important Information for Reconstruction Patients
About Mentor MemoryGel™ Silicone Gel-Filled
Breast Implants**
November 2006

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GLOSSARY

Areola	The pigmented or darker colored area of skin surrounding the nipple of the breast.
Asymmetry	Lack of proportion of shape, size, and/or position between the two breasts.
Autoimmune disease	A disease in which the body mounts an “attack” response to its own tissues or cell types. Normally, the body’s immune mechanism is able to distinguish clearly between what is a normal substance and what is foreign. In autoimmune diseases, this system becomes defective and mounts an attack against normal parts of the body, causing tissue injury. Certain diseases such as rheumatoid arthritis, lupus, and scleroderma are considered to be autoimmune diseases.
Axillary	Pertaining to the armpit area.
Biocompatible	The condition of being compatible with living tissues or systems without being toxic.
Biopsy	The removal and examination of tissues, cells, or fluid from the body.
Body Esteem Scale (BES)	A questionnaire which asks about a person’s body image.
Breast augmentation	A surgical procedure to increase breast size. For this document, it refers to placement of a breast implant. The first time a breast implant is placed to increase breast size, it is called primary augmentation. All subsequent times the implant is replaced, it is called revision-augmentation.
Breast implant	An internal artificial device or implant intended to replace the breast.
Breast mass	A lump or body in the breast.
Breast reconstruction	A surgical procedure to replace breast tissue that has been removed due to cancer or trauma or that has failed to develop properly due to a severe breast abnormality.
Calcification	Process of hardening by calcium salts.

Capsule	Scar tissue that forms around the breast implant. Sometimes this capsule squeezes the implant, resulting in capsular contracture (below).
Capsular contracture	<p>A tightening of the tissue capsule surrounding an implant, resulting in firmness or hardening of the breast and in squeezing of the implant if severe. Capsular contracture is classified by Baker Grades. Grades III or IV are the most severe. Grade III often results in the need for additional surgery (reoperation) because of pain and possibly abnormal appearance. Grade IV usually results in the need for additional surgery (reoperation) because of pain and unacceptable appearance. Capsular contracture II may also result in the need for additional surgery. Capsular contracture is a known risk for implant rupture. Below is a description of each Baker Grade.</p> <ul style="list-style-type: none"> • Baker Grade I – Normally soft and natural appearance • Baker Grade II – A little firm, but breast looks normal • Baker Grade III – More firm than normal, and looks abnormal (change in shape) • Baker Grade IV – Hard, obvious distortion, and tenderness with pain
Capsulectomy	Surgical removal of the scar tissue capsule around the implant.
Capsulorrhaphy	Surgical stitching of a tear in the scar tissue capsule around the implant.
Capsulotomy (closed)	An attempt to break the scar tissue capsule around the implant by pressing or pushing on the outside of the breast. This method does not require surgery but is a known risk for rupture of the implant and is contraindicated.
Capsulotomy (open)	Surgical incision into the scar tissue capsule around the implant.
Congenital anomaly	An abnormal development in part of the body.
Connective tissue disease/disorder (CTD)	A disease, group of diseases, or conditions affecting connective tissue, such as muscles, ligaments, skin, etc. and/or the immune system. Connective tissue diseases (“CTDs”) that involve the immune system include autoimmune diseases such as rheumatoid arthritis, lupus, and scleroderma.

Contraindication	A use that is improper and should not be followed. Failure to follow contraindications identified in the labeling could cause serious harm.
Contralateral	Opposite side.
Core Study	The primary clinical study of augmentation, reconstruction, and revision (revision-augmentation and revision-reconstruction) patients that supported the approval of the premarket approval (PMA) application. Safety and effectiveness data are collected yearly through 10 years, with the follow-up from years 4 through 10 being performed as part of a postapproval Core Study.
Delayed reconstruction	Breast reconstruction that takes place weeks, months, or years after a mastectomy.
Delayed wound healing	Delayed progress in the healing of an opened wound.
Displacement	Movement of the implant from the usual or proper place.
Epidemiological	Relating to the science of explaining the relationships of factors that determine disease frequency and distribution.
Extracapsular rupture	A type of rupture in which the silicone gel is outside of the scar tissue capsule surrounding the implant.
Extrusion	Skin breakdown with the pressing out of the implant through the surgical wound or skin.
Fibromyalgia	A disorder characterized by chronic pain in the muscles and soft tissues surrounding joints, with tenderness at specific sites in the body. It is often accompanied by fatigue.
Fibrous tissues	Connective tissues composed mostly of fibers.
Flap	A portion of tissue (which may include muscle, fat, and skin) moved from one part of the body to another. The tissue flap may or may not have its blood supply attached.
Follicular cyst	Any closed sac, usually containing liquid, resulting from the blocking of a duct or small gland.
Functional Living Index-Cancer (FLIC)	The Functional Living Index-Cancer (FLIC) is a questionnaire used to evaluate day-to-day functioning in patients who have cancer.

Granuloma	A lump or mass made of inflammatory cells surrounding a foreign substance due to longstanding inflammation.
Hematoma	A collection of blood within a space.
Hypertrophic scarring	An enlarged scar remaining after the healing of a wound.
Immune response	A bodily response to the presence of a foreign substance.
Infection	Invasion with microorganisms (for example, bacteria, viruses). An infection usually results in fever, swelling, redness, and/or pain.
Inflammation	The response of the body to infection or injury that is characterized by redness, swelling, warmth, pain, and/or loss of function.
Inframammary	Below the breast.
Inframammary fold	The crease at the base of the breast and the chest wall.
Inframammary incision	An incision made in the fold below the breast.
Inpatient surgery	A surgical procedure in which the patient is required to stay overnight in the hospital.
Intracapsular rupture	A type of rupture in which the silicone gel remains inside the scar tissue capsule surrounding the implant.
Lactation	The production and secretion of milk by the breast glands.
Latissimus dorsi	Two triangular muscles running from the spinal column to the shoulder.
Low molecular weight silicones	Components of silicone of smaller molecular weight that may bleed out of silicone gel.
Lumpectomy	Removal of a small amount of breast tissue.
Lymphadenopathy	Enlargement of the lymph node(s).
Malposition	Implant malposition or displacement is when the implant is not in the correct spot in the breast. This could have been due to incorrect placement of the implant during the surgery or due to shifting of the implant position over time.
MRI	Magnetic resonance imaging. A radiographic examination that currently has the best ability to detect

rupture of silicone gel-filled breast implants.

Mammary

Pertaining to the breast.

Mammography

A type of X-ray examination of the breasts used for detection of cancer.

Mammoplasty

Plastic surgery of the breast.

Mastectomy

The removal of breast tissue due to the presence of a cancerous or precancerous growth.

Subcutaneous mastectomy: surgical removal of the breast tissues, but sparing the skin, nipple, and areola.

Total mastectomy: surgical removal of the breast including the nipple, areola, and most of the overlying skin.

Modified radical mastectomy: surgical removal of the entire breast including the nipple, areola, and overlying skin, as well as the lymphatic-bearing tissue in the axilla.

Radical mastectomy: surgical removal of the entire breast including the nipple, areola, and overlying skin, as well as the pectoral muscles, lymphatic bearing tissue in the axilla, and various other neighboring tissue.

Mastopexy

Plastic surgery to move sagging breasts into a more elevated position.

Metastatic Disease

Spreading of cancer cells from the original site to other parts of the body.

Migration

Movement of silicone materials outside the breast implant.

Necrosis

Death of cells or tissues.

Oncologist

A doctor who studies, identifies, and treats cancer.

Outpatient surgery

A surgical procedure in which the patient is not required to stay in the hospital overnight.

Palpate

To feel with the hand.

Palpability

The ability to feel the implant.

Pectoralis

Major muscle of the chest.

Periareolar	Around the darkened or pigmented area surrounding the nipple of the breast.
Plastic surgery	Surgery intended for the improvement of appearance of the body.
Postoperatively	After surgery.
Primary breast reconstruction	The first time a breast implant is placed for the purpose of breast reconstruction.
Ptosis	Breast sagging that is usually the result of normal aging, pregnancy, or weight loss.
Rectus abdominus	A long flat muscle extending the whole length of the front of the abdomen (stomach).
Reoperation	An additional surgery after your first breast implantation.
Revision-Reconstruction	Refers to the correction or improvement of a primary reconstruction. In the context of this document, it refers to surgical removal and replacement of breast implants that were placed originally for primary breast reconstruction.
Rheumatological Disease/Disorder	A variety of diseases involving connective tissue structures of the body, especially the joints and fibrous tissue. These diseases are often associated with pain, inflammation, stiffness, and/or limitation of motion of the affected parts. Can include autoimmune diseases. Fibromyalgia is a rheumatological disorder.
Rosenberg Self Esteem Scale	A questionnaire that measures self esteem.
Rupture	A tear or hole in the implant shell. Silicone implant ruptures may be silent or symptomatic. Ruptures can be intracapsular or extracapsular.
Saline	A solution that is made up of water and a small amount of salt.
Scar revision	A surgical procedure to improve the appearance of a scar.
Seroma	A build-up of the watery portion of the blood in a tissue location.

SF-36 Scale	A questionnaire intended to measure health-related quality of life. It includes questions that measure physical, mental, and social health.
Silicone elastomer	A type of silicone that has elastic properties similar to rubber.
Silent rupture	A breast implant rupture without symptoms and which is not apparent except through appropriate imaging techniques such as MRI. Most silicone breast implant ruptures are silent. (see symptomatic rupture below)
Subglandular placement	Placement of a breast implant underneath and within the breast glands but on top of the chest muscle.
Submuscular placement	Placement of a breast implant wholly or partially underneath the chest muscle.
Surgical incision	A cut made to body tissue during surgery.
Symmastia	Joining together of implants in the middle of the chest resulting in loss of cleavage.
Symptom	Any perceptible change in the body or its functions that indicates disease or a phase of a disease.
Symptomatic	Any evidence or sign of disease or disorder reported by the patient.
Symptomatic rupture	A breast implant rupture that is associated with symptoms (such as lumps, persistent pain, swelling, hardening, or change in implant shape). Some silicone breast implant ruptures are symptomatic, but most are silent.
Systemic	Pertaining to or affecting the body as a whole.
Tennessee Self Concept Scale	A questionnaire that evaluates how the patient sees herself and what she does, likes, and feels.
Tissue expander	An adjustable implant that can be inflated with saline to stretch the tissue at the mastectomy site to create a new tissue flap for implantation of the breast implant.

Important Information for Reconstruction Patients about Mentor MemoryGel™ Silicone Gel-Filled Implants

1. Considerations for Silicone Gel-Filled Breast Implant Reconstruction

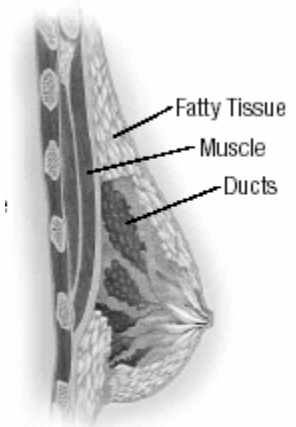
The purpose of this brochure is to help you in making an informed decision about having breast implants for reconstruction (restoration) or breast revision-reconstruction (replacement) surgery. This brochure is not intended to replace consultation with your surgeon. This educational brochure is set up to provide you information about risks and benefits of Mentor silicone gel-filled (MemoryGel™) breast implants.

Please read this entire brochure carefully, and if you have any questions or there are things you do not understand, please discuss them with your surgeon before making any decisions. As part of your decision, both you and your surgeon will be required to sign the last page of this brochure to confirm your understanding of what you have read.

You should wait at least 1-2 weeks after reviewing and considering this information before deciding whether to have primary breast reconstruction or replacement (revision-reconstruction) surgery, unless an earlier surgery is deemed medically necessary by your surgeon.

1.1. What Gives the Breast Its Shape?

The breast consists of milk ducts and glands, surrounded by fatty tissue that provides its shape and feel. The chest muscle (pectoralis major muscle) is located beneath the breast. Factors such as pregnancy (when milk glands are temporarily enlarged), rapid weight loss, and the effects of gravity as you age, combine to stretch the skin, which may cause the breast to droop or sag.



Breast cancer surgery can significantly change the shape of the breast, to a greater or lesser degree, depending on how much breast tissue is removed in a partial or complete mastectomy; how much skin is removed at the time of surgery; and how much tissue reaction or scarring there is in the remaining breast and skin in response to chemotherapy or radiation therapy.

1.2. What Is a Silicone Gel-Filled Breast Implant?

A breast implant is a sac (implant shell) of silicone elastomer (rubber) filled with silicone gel, which is surgically implanted under your breast tissue or under your chest muscle.



Are You Eligible for Silicone Gel-Filled Breast Implants?

Mentor MemoryGel Silicone Gel-Filled Breast Implants are indicated for females for the following uses (procedures):

- **Breast augmentation for women at least 22 years old.** Breast augmentation includes primary breast augmentation to increase the breast size, as well as revision surgery to correct or improve the result of a primary breast augmentation surgery. (A separate patient brochure is available and should be read for breast augmentation.)
- **Breast reconstruction.** Breast reconstruction includes primary reconstruction to replace breast tissue that has been removed due to cancer or trauma or that has failed to develop properly due to a severe breast abnormality. Breast reconstruction also includes revision surgery to correct or improve the result of a primary breast reconstruction surgery.

Contraindications

Breast implant surgery should not be performed in:

- Women with existing cancer or pre-cancer of their breast who have not received adequate treatment for those conditions
- Women with active infection anywhere in their body
- Women who are currently pregnant or nursing.

Precautions

Safety and effectiveness have not been established in patients with the following:

- Autoimmune diseases (for example, lupus and scleroderma).
- A weakened immune system (for example, currently taking drugs that weaken the body's natural resistance to disease).
- Conditions that interfere with wound healing and blood clotting.
- Reduced blood supply to breast tissue.
- Clinical diagnosis of depression or other mental health disorders, including body dysmorphic disorder and eating disorders. Please discuss any history of mental health disorders with your surgeon prior to surgery. Patients with a diagnosis of depression, or other mental health disorders, should wait until resolution or stabilization of these conditions prior to undergoing breast implantation surgery.

1.3. Important Factors You Should Consider When Choosing Silicone Gel-Filled Implants.

- You should be aware that there are many factors that will affect the outcome and timing of your reconstruction with breast implants, such as the stage of your disease, the type and extent of cancer removal surgery you have had, the amount of skin and soft tissue available for the reconstruction, and additional treatments such as chemotherapy and radiation, which you may require.

- Breast implants are not lifetime devices, and breast implantation is likely not a one-time surgery. You will likely need additional unplanned surgeries on your reconstructed and/or contralateral augmented breasts because of complications or unacceptable cosmetic outcomes. These additional surgeries can include implant removal with or without replacement, or they can include other surgical procedures. When you have your implants replaced (revision-reconstruction), your risk of future complications increases compared to first time (primary) reconstruction surgery, so you should review the complication rates for revision-reconstruction patients to see what future risks you may experience.
- Many of the changes to your breast and chest wall following preparation and implantation are irreversible (cannot be undone). If you later choose to have your implant(s) removed and not replaced, you may experience unacceptable dimpling, puckering, wrinkling, or other cosmetic changes of the breast.
- If you undergo a mastectomy, removal of the breast tissue eliminates the ability to breast feed with the removed breast. In addition, contralateral breast augmentation may affect your ability to breast feed, either by reducing or eliminating milk production.
- Rupture of a silicone gel-filled breast implant is most often silent. This means that neither you nor your surgeon will know that your implants have a rupture most of the time. In fact, the ability of a physical examination by a plastic surgeon who is familiar with breast implants to detect silicone breast implant rupture is 30%¹ compared to 89% for MRI.² You will need to have regular screening MRI examinations over your lifetime in order to determine if silent rupture is present. You should have your first MRI at 3 years after your initial implant surgery and then every 2 years, thereafter. The cost of MRI screening may exceed the cost of your initial surgery over your lifetime. This cost, which may not be covered by your insurance, should be considered in making your decision.
- If implant rupture is noted on by MRI, you should have the implant removed, with or without replacement.
- With breast implants, routine screening mammography for breast cancer will be more difficult. You should continue to undergo routine mammography screening as recommended by your primary care physician. The implant may interfere with finding breast cancer during mammography. Because the breast and implant are squeezed during mammography, an implant may rupture during the procedure. More x-ray views are necessary for women with breast implants; therefore, you will receive more exposure to radiation. However, the benefit of having the mammogram to find cancer outweighs the risk of the additional x-rays. Be sure to inform the mammography technologist that you have implants.
- You should perform an examination of your breasts every month for cancer screening; however, this may be more difficult with implants. You should ask your surgeon to help you distinguish the implant from your breast tissue.

- You should perform an examination of your breasts for the presence of lumps, persistent pain, swelling, hardening, or change in implant shape, which may be signs of symptomatic rupture of the implant. These should be reported to your surgeon and possibly evaluated with an MRI to screen for rupture.
- The timing for any revision following reconstruction surgery should be discussed with your surgeon so that all issues such as the potential effects of radiation, chemotherapy, and additional cancer surgery or treatments can be fully discussed.
- After undergoing cancer treatment and/or reconstructive breast surgery (either primary or revision), your health insurance premiums may increase, your insurance coverage may be dropped, and/or future coverage may be denied. Treatment of complications may not be covered as well. You should discuss the complete extent of your insurance coverage with your insurance company before undergoing reconstructive surgery with breast implants.
- You should inform any other doctor who treats you of the presence of your implants to minimize the risk of damage to the implants.
- Mentor will continue its ongoing Core Study through 10 years to further evaluate the long-term safety and effectiveness of these products. In addition, Mentor has initiated a separate, 10-year postapproval study to address specific issues for which the Mentor Core Study was not designed to fully answer, as well as to provide a real-world assessment of some endpoints. The endpoints in the large postapproval study include long-term local complications, connective tissue disease (CTD), CTD signs and symptoms, neurological disease, neurological signs and symptoms, offspring issues, reproductive issues, lactation issues, cancer, suicide, mammography issues, and MRI compliance and results. Mentor will update its labeling as appropriate with the results of these two studies. You should also ask your surgeon if he/she has any available updated clinical information.
- It is important that you read this entire brochure because you need to understand the risks and benefits and to have realistic expectations of the outcome of your surgery.

2. Potential Breast Implant Complications

Undergoing any type of surgical procedure involves risks (some serious) such as the effects of anesthesia, infection, swelling, redness, bleeding, pain, and even death, which need to be balanced against the benefits of the breast reconstruction surgery. There are potential complications specific to breast implant surgery and breast implants, as described below. It should also be noted that the cited references include data from augmentation and/or reconstruction patients, as well as from a variety of manufacturers and implant models.

- **Rupture**

Breast implants are not lifetime devices. Breast implants rupture when the shell develops a tear or hole. Rupture can occur at any time after implantation, but they are more likely to occur the longer the implant is implanted. The following things may cause your implant to rupture: damage by surgical instruments; stressing the implant during implantation and weakening it; folding or wrinkling of the implant shell; excessive force to the chest (for example, during closed capsulotomy, which is contraindicated); trauma; compression during mammographic imaging; and severe capsular contracture. Breast implants may also simply wear out over time. Laboratory studies have identified some of the types of rupture for Mentor's product; however, it is not known whether these tests have identified all causes of rupture. These laboratory studies will continue postapproval.

Silicone gel-filled implant ruptures are most often silent. (MRI examination is currently the best method to screen for silent rupture.) This means that most of the time neither you nor your plastic surgeon will know if the implant has a tear or hole in the shell. This is why MRI is recommended at 3 years and then every 2 years, thereafter, to screen for rupture. However, sometimes there are symptoms associated with gel implant rupture. These symptoms include hard knots or lumps surrounding the implant or in the armpit, change or loss of size or shape of the breast or implant, pain, tingling, swelling, numbness, burning, or hardening of the breast.

When MRI findings of rupture are found, or if your surgeon determines you have signs or symptoms of rupture, you should have the implant and any gel removed, with or without replacement of the implant. It also may be necessary to remove the tissue capsule as well as the implant, which will involve additional surgery, with associated costs. If you have symptoms such as breast hardness, a change in breast shape or size, and/or breast pain, you should have an MRI to determine whether rupture is present.^{3,4}

There are also consequences of rupture. If rupture occurs, silicone gel may either remain within the scar tissue capsule surrounding the implant (intracapsular rupture), move outside the capsule (extracapsular rupture), or gel may move beyond the breast (migrated gel). There is also a possibility that rupture may progress from intracapsular to extracapsular and beyond. There have also been health consequences reported in the literature. See below for details.

Rupture Information on Mentor Implants

In Mentor's Core Study, rupture was assessed for patients who had scheduled MRIs to screen for rupture (i.e., part of the MRI cohort) and those who were not assessed for rupture by MRI (i.e., part of the non-MRI cohort). For primary reconstruction patients in the MRI cohort, the rupture rate was approximately 1% through 3 years. This means that through 3 years, 1 of every 100 primary reconstruction women had at least one ruptured breast implant. There was one primary reconstruction patient in the Mentor Core Study with a suspected implant rupture that was silent and only detected with MRI. Rupture has not been confirmed with examination of the implant following removal. For revision-reconstruction patients in the MRI cohort, the rupture rate was 0% through 3 years. There were no ruptures reported in the non-MRI cohorts for either the primary reconstruction or revision-reconstruction patients through 3 years. Across all patients in the Mentor Core Study, of the 8 implants

reported as ruptured, 4 showed intracapsular gel and 4 showed extracapsular gel on MRI (3 implants with extracapsular gel were in 2 revision-augmentation patients and 1 was in a primary reconstruction patients). For one of these implants with extracapsular gel, this was a confirmed case in which the device was explanted and the intracapsular gel rupture progressed into an extracapsular gel rupture as shown by MRIs at approximately 10 months and approximately 2 years. There were no cases of migrated gel.

Further rupture rate information on Mentor implants in augmentation patients is provided from an unpublished European study known as the U.K. Sharpe and Collis Study. Silent rupture was assessed by a single MRI on 101 augmentation patients implanted with textured Mentor implants by one surgeon. The average age of the implants was approximately 9 years. Silent rupture was found in approximately 10% of these augmentation patients, which includes one patient for which the device was not explanted to confirm rupture. There were no cases of extracapsular rupture or migrated gel.

Additional information on rupture will be collected through Mentor's postapproval Core Study and large postapproval study.

Additional Information on Consequences of Rupture from Literature

Studies of Danish women evaluated with MRI involving a variety of manufacturers and implant models showed that about three-fourths of implant ruptures are intracapsular and the remaining one-fourth are extracapsular.⁵ Additional studies of Danish women indicate that over a 2-year period, about 10% of the implants with intracapsular rupture progressed to extracapsular rupture as detected by MRI.⁶ This means that for women with silicone gel rupture within the scar tissue capsule detected via MRI after 2 years, 1 in 10 of these women had progression of the gel outside the scar tissue capsule. Approximately half of the women whose ruptures had progressed from intracapsular to extracapsular reported that they experienced trauma to the affected breast during this time period or had undergone mammography. In the other half, no cause was given. In the women with extracapsular rupture, after 2 years, the amount of silicone seepage outside the scar tissue capsule increased for about 14% of the women. This means that for 100 women with silicone gel rupture outside the scar tissue capsule, the amount of gel outside the scar tissue capsule increased for 14 women 2 years later. This type of information pertains to a variety of silicone implants from a variety of manufacturers and implant models, and it is not specific to Mentor's implants.

Below is a summary of information related to the health consequences of implant rupture, which have not been fully established. These reports were in women who had implants from a variety of manufacturers and implant models.

- Local breast complications reported in the published literature that were associated with rupture include breast hardness, a change in breast shape or size, and breast pain.⁷ These symptoms are not specific to rupture, as they also are experienced by women who have capsular contracture.
- There have been rare reports of gel movement to nearby tissues such as the chest wall, armpit, or upper abdominal wall, and to more distant locations down the arm

or into the groin. This has led to nerve damage, granuloma formation (see glossary), and/or breakdown of tissues in direct contact with the gel in a few cases. There have been reports of silicone presence in the liver of patients with silicone breast implants. Movement of silicone gel materials to lymph nodes in the axilla also has been reported, even in women without evidence of rupture, leading to lymphadenopathy.⁸

- Concerns have been raised over whether ruptured implants are associated with the development of connective tissue or rheumatic diseases and/or symptoms such as fatigue and fibromyalgia.^{9,10,11,12} A number of epidemiology studies have evaluated large populations of women with breast implants from a variety of manufacturers and implant models. These studies do not, taken together, support an association of breast implants with a typical, diagnosed rheumatic disease. Other than one small study,¹³ these studies do not distinguish whether the women had ruptured or intact implants.

- **Capsular Contracture**

The scar tissue (capsule) that normally forms around the implant may tighten over time and compress the implant, making it feel firm and leading to what is called capsular contracture. Capsular contracture may be more common following infection, hematoma, and seroma, and the chance of it happening may increase over time. Capsular contracture occurs more commonly in revision-reconstruction than in primary reconstruction. Because you may have your initial implants replaced, you should be aware that your risk of capsular contracture increases with revision-reconstruction. Capsular contracture is a risk factor for implant rupture, and it is the most common reason for reoperation in primary reconstruction patients.

Symptoms of capsular contracture range from mild firmness and mild discomfort to severe pain, distorted shape of the implant, and palpability (ability to feel the implant). Capsular contracture is graded into 4 levels depending on its severity. Grades III or IV are considered severe and often additional surgery is needed to correct these grades:

Grade I:	the breast is normally soft and looks natural
Grade II:	the breast is a little firm but looks normal
Grade III:	the breast is firm and looks abnormal
Grade IV:	the breast is hard, painful, and looks abnormal

In Mentor's Core Study, for women receiving reconstruction implants for the first time, the risk of severe capsular contracture was 8% through 3 years. This means 8 out of every 100 women who received Mentor implants for primary breast reconstruction had severe capsular contracture at least once during the first 3 years after receiving the implants.

For women receiving revision-reconstruction implants, the risk of severe capsular contracture was 16% through 3 years. This means 16 out of every 100 women who received Mentor implants for breast revision-reconstruction had severe capsular contracture at least once during the first 3 years after receiving the implants.

Additional surgery may be needed in cases where pain and/or firmness are severe. This surgery ranges from removal of the implant capsule tissue, to removal and

possible replacement of the implant itself. This surgery may result in loss of your breast tissue. Capsular contracture may happen again after these additional surgeries. Capsular contracture may increase the risk of rupture.¹⁴

- **Additional Surgeries (Reoperations)**

You should assume that you will need to have additional surgeries (reoperations). In the Mentor Core Study, the reoperation rate was 27% for primary reconstruction patients, which means that 27 out of every 100 women who received Mentor implants for primary reconstruction had a reoperation during the first 3 years after receiving the implants. The reoperation rate was 29% for revision-reconstruction patients, which means that 29 out of every 100 women who received Mentor implants for revision-reconstruction had a reoperation during the first 3 years after receiving the implants.

Patients may decide to change the size or type of their implants, requiring additional surgery. Problems such as rupture, capsular contracture, hypertrophic scarring (irregular, raised scar), asymmetry, infection, and shifting can require additional surgery. Summary tables are provided in Section 3.5 that describe the reasons for performing additional surgeries experienced in the Mentor Core Study. For women receiving primary reconstruction implants, the three most common reasons for reoperation were asymmetry, patient request for style/size change and implant malposition. For women receiving revision-reconstruction implants, the three most common reasons for additional surgery were biopsy, severe capsular contracture, and implant malposition.

- **Implant Removal**

Because these are not lifetime devices, the longer you have your implants, the more likely it will be for you to have them removed for any reason, either because of dissatisfaction, an unacceptable cosmetic result, or a complication such as severe capsular contracture. Having your implants removed and replaced increases your chances of getting future complications.

For women receiving primary reconstruction implants in Mentor's Core Study, 12% had their implants removed at least once through 3 years. Patient choice and asymmetry were the most common reasons for implant removal. For women receiving revision-reconstruction implants in Mentor's Core Study, 14% had their implants removed at least once through 3 years. The most common reason was severe capsular contracture.

Most women who have their implants removed, have them replaced with new implants, but some women do not. If you choose not to replace your implants, you may have cosmetically unacceptable dimpling, puckering, wrinkling, and/or other potentially permanent cosmetic changes of the breast following removal of the implant. Even if you have your implants replaced, implant removal may result in loss of your breast tissue. Also, implant replacement increases your risks of future complications. For example, the risks of severe capsular contracture increase for patients with implant replacement compared to first time replacement. You should consider the possibility of having your implants replaced and its consequences when making your decision to have implants.

- **Unsatisfactory Results**

Unsatisfactory results such as wrinkling, asymmetry, implant displacement (shifting), incorrect size, unanticipated shape, implant palpability, scar deformity, and/or hypertrophic scarring, may occur. Some of these results may cause discomfort. Pre-existing asymmetry may not be entirely correctable by implant surgery. Revision surgery may be recommended to maintain patient satisfaction, but carries additional considerations and risks. Selecting an experienced plastic surgeon may minimize, but not necessarily prevent, unsatisfactory results.

- **Pain**

Pain of varying intensity and length of time may occur and persist following breast implant surgery. In addition, improper size, placement, surgical technique, or capsular contracture may result in pain. You should tell your surgeon about significant pain or if your pain persists.

- **Changes in Nipple and Breast Sensation**

Feeling in the nipple and breast are typically lost after complete mastectomy where the nipple itself is removed, and can be severely lessened by partial mastectomy. Radiation therapy also can significantly reduce sensation in the remaining portions of the breast or chest wall. The placement of breast implants for reconstruction may further lessen the sensation in the remaining skin or breast tissue. While some of these changes can be temporary, they can also be permanent, and may affect your sexual response or your ability to nurse a baby with the remaining breast.

- **Infection**

Infection can occur with any surgery or implant. Most infections resulting from surgery appear within a few days to weeks after the operation. However, infection is possible at any time after surgery. In addition, breast and nipple piercing procedures may increase the possibility of infection. Infections in tissue with an implant present are harder to treat than infections in tissue without an implant. If an infection does not respond to antibiotics, the implant may have to be removed, and another implant may be placed after the infection is resolved (cleared up). As with many other surgical procedures, in rare instances, toxic shock syndrome has been noted in women after breast implant surgery, and it is a life-threatening condition. Symptoms include sudden fever, vomiting, diarrhea, fainting, dizziness, and/or sunburn-like rash. You should contact your doctor immediately for diagnosis and treatment if you have these symptoms.

- **Hematoma/Seroma**

Hematoma is a collection of blood within the space around the implant, and a seroma is a build-up of fluid around the implant. Having a hematoma and/or seroma following surgery may result in infection and/or capsular contracture later on. Symptoms from a hematoma or seroma may include swelling, pain, and bruising. If a hematoma or seroma occurs, it will usually be soon after surgery. However, this can also occur at any time after injury to the breast. While the body absorbs small hematomas and seromas, some will require surgery, typically involving draining and potentially placing a surgical drain in the wound temporarily for proper healing. A small scar can result from surgical draining. Implant rupture also can occur from surgical draining if there is damage to the implant during the draining procedure.

- **Breast Feeding**

Breast feeding difficulties have been reported following breast surgery, including breast reduction and breast augmentation. If your surgeon uses a periareolar surgical approach (an incision around the colored portion surrounding the nipple), it may further increase the chance of breast feeding difficulties in the remaining breast.

- **Calcium Deposits in the Tissue Around the Implant**

Calcium deposits can form in the tissue capsule surrounding the implant. Symptoms may include pain and firmness. Deposits of calcium can be seen on mammograms and can be mistaken for possible cancer, resulting in additional surgery for biopsy and/or removal of the implant to distinguish calcium deposits from cancer. If additional surgery is necessary to examine and/or remove calcifications, this may cause damage to the implants. Calcium deposits also occur in women who undergo breast reduction procedures, in patients who have had hematoma formation, and even in the breasts of women who have not undergone any breast surgery. The occurrence of calcium deposits increases significantly with age.

- **Extrusion**

Extrusion is when the breast implant comes through your skin. This may occur, for example, when your wound has not closed or when breast tissue covering your implants weakens. Radiation therapy has been reported to increase the likelihood of extrusion. Extrusion requires additional surgery and possible removal of the implant, which may result in additional scarring and/or loss of your breast tissue.

- **Necrosis**

Necrosis is the death of cells or tissues. This may prevent or delay wound healing and require surgical correction, which may result in additional scarring and/or loss of your breast tissue. Implant removal may also be necessary. Factors associated with increased necrosis include infection, use of steroids, smoking, chemotherapy, radiation, and excessive heat or cold therapy.

- **Delayed Wound Healing**

Some patients may experience a prolonged wound healing time. Delayed wound healing may increase the risk of infection, extrusion, and necrosis. Depending on the type of surgery or the incision, wound healing times may vary. Smoking may interfere with the healing process. You should contact your surgeon immediately if your wound does not heal within the period of time he/she has discussed with you.

- **Breast Tissue Atrophy/Chest Wall Deformity**

The pressure of the breast implant may cause breast tissue thinning (with increased implant visibility and palpability) and chest wall deformity. This can occur while implants are still in place or following implant removal without replacement. Either of these conditions may result in additional surgeries and/or unacceptable dimpling/puckering of the breast.

- **Lymphadenopathy**

Lymphadenopathy is a chronic enlargement of the lymph nodes. A lymph node is a round mass of tissue which makes cells as part of your immune system. The lymph nodes in the armpit (axilla) drain the breast area of fluid. Sometimes the enlarged

lymph nodes are painful. If they become too large or painful, the lymph node(s) may need to be surgically removed. Painful and/or enlarged lymph nodes should be reported to your doctor.

Literature reports associate lymphadenopathy with both intact and ruptured silicone breast implants. One study reported that armpit lymph nodes from women with both intact and ruptured silicone gel implants had abnormal tissue reactions, granulomas, and the presence of silicone.¹⁵ These reports were in women who had implants from a variety of manufacturers and implant models.

Other Reported Conditions

There have been reports in the literature of other conditions in women with silicone gel-filled breast implants. Many of these conditions have been studied to evaluate their potential association with breast implants. Although no cause and effect relationship has been established between breast implants and the conditions listed below, you should be aware of these reports. Furthermore, there is the possibility of risks, yet unknown, which in the future could be determined to be associated with breast implants.

- **Connective Tissue Disease (CTD)**

Connective tissue diseases include diseases such as lupus, scleroderma, and rheumatoid arthritis. Fibromyalgia is a disorder characterized by chronic pain in the muscles and soft tissues surrounding joints, with tenderness at specific sites in the body. It is often accompanied by fatigue. There have been a number of published epidemiological studies which have looked at whether having a breast implant is associated with having a typical or defined connective tissue disease. The study size needed to conclusively rule out a smaller risk of connective tissue disease among women with silicone gel-filled breast implants would need to be very large.^{16,17,18,19,20,21,22,23,24,25} The published studies taken together show that breast implants are not significantly associated with a risk of developing a typical or defined connective tissue disease.^{26,27,28,29} These studies do not distinguish between women with intact and ruptured implants. Only one study evaluated specific connective tissue disease diagnoses and symptoms in women with silent ruptured versus intact implants, but it was too small to rule out a small risk.³⁰

- **CTD Signs and Symptoms**

Literature reports have also been made associating silicone breast implants with various rheumatological signs and symptoms such as fatigue, exhaustion, joint pain and swelling, muscle pain and cramping, tingling, numbness, weakness, and skin rashes. Scientific expert panels and literature reports have found no evidence of a consistent pattern of signs and symptoms in women with silicone breast implants.^{31,32,33,34,35} Having these rheumatological signs and symptoms does not necessarily mean you have a connective tissue disease; however, you should be aware that you may experience these signs and symptoms after undergoing breast implantation. If you notice an increase in these signs or symptoms, you should consider seeing a rheumatologist to determine whether these signs or symptoms are due to a connective tissue disorder or autoimmune disease.

- **Cancer**

Breast Cancer – Reports in the medical literature indicate that patients with breast implants are not at a greater risk than those without breast implants for developing breast cancer.^{36,37,38,39,40} Some reports have suggested that breast implants may interfere with or delay breast cancer detection by mammography and/or biopsy; however, other reports in the published medical literature indicate that breast implants neither significantly delay breast cancer detection nor adversely affect cancer survival of women with breast implants.^{41,42,43,44,45} You should discuss this with your surgeon if you are thinking about placing a breast implant in the remaining breast to balance it with the reconstructed breast.

Brain cancer – One recent study has reported an increased incidence of brain cancer in women with breast implants as compared to the general population.⁴⁶ The incidence of brain cancer, however, was not significantly increased in women with breast implants when compared to women who had other plastic surgeries. Another recently published review of four large studies in women with cosmetic implants concluded that the evidence does not support an association between brain cancer and breast implants.⁴⁷

Respiratory/lung cancer – One study has reported an increased incidence of respiratory/lung cancer in women with breast implants.⁴⁸ Other studies of women in Sweden and Denmark have found that women who get breast implants are more likely to be current smokers than women who get breast reduction surgery or other types of cosmetic surgery.^{49,50,51}

Cervical/vulvar cancer – One study has reported an increased incidence of cervical/vulvar cancer in women with breast implants.⁵² The cause of this increase is unknown.

Other cancers – One study has reported an increased incidence of stomach cancer and leukemia in women with breast implants compared to the general population.⁵³ This increase was not significant when compared to women who had other types of plastic surgeries.

- **Neurological Disease, Signs, and Symptoms**

Some women with breast implants have complained of neurological symptoms (such as difficulties with vision, sensation, muscle strength, walking, balance, thinking or remembering things) or diseases (such as multiple sclerosis), which they believe are related to their implants. A scientific expert panel report found that the evidence for a neurological disease or syndrome caused by or associated with breast implants is insufficient or flawed.⁵⁴

- **Suicide**

In several studies, a higher incidence of suicide was observed in women with breast implants.^{55,56,57,58} The reason for this increase is unknown, but it was found that women with breast implants had higher rates of hospital admission due to psychiatric causes prior to surgery, as compared with women who had breast reduction or in the general population of Danish women.⁵⁹

- **Effects on Children**

At this time, it is not known if a small amount of silicone may pass through from the breast implant silicone shell into breast milk. Although there are no current established methods for accurately detecting silicone levels in breast milk, a study measuring silicon (one component in silicone) levels did not indicate higher levels in breast milk from women with silicone gel-filled implants when compared to women without implants.⁶⁰

In addition, concerns have been raised regarding potential damaging effects on children born to mothers with implants. Two studies in humans have found that the risk of birth defects overall is not increased in children born after breast implant surgery.^{61,62} Although low birth weight was reported in a third study, other factors (for example, lower pre-pregnancy weight) may explain this finding.⁶³ This author recommended further research on infant health.

- **Potential Health Consequences of Gel Bleed**

Small quantities of low molecular weight (LMW) silicone compounds, as well as platinum (in zero oxidation state), have been found to diffuse (“bleed”) through an intact implant shell.^{64,65} The evidence is mixed as to whether there are any clinical consequences associated with gel bleed. For instance, studies on implants implanted for a long duration have suggested that such bleed may be a contributing factor in the development of capsular contracture⁶⁶ and lymphadenopathy.⁶⁷ However, evidence against gel bleed being a significant contributing factor to capsular contracture and other local complications, is provided by the fact that there are similar or lower complication rates for silicone gel-filled breast implants than for saline-filled breast implants. Saline-filled breast implants do not contain silicone gel and, therefore, gel bleed is not an issue for those products. Furthermore, toxicology testing has indicated that the silicone material used in the Mentor implants does not cause toxic reactions when large amounts are administered to test animals. It also should be noted that studies reported in the literature have demonstrated that the low concentration of platinum contained in breast implants is in the zero oxidation (most biocompatible) state.⁶⁸ In addition, two separate studies sponsored by Mentor have demonstrated that the low concentration of platinum contained in its breast implants is in the zero oxidation (most biocompatible) state.

Mentor performed a laboratory test to analyze the silicones and platinum (used in the manufacturing process), which may bleed out of intact implants into the body. Over 99% of the LMW silicones and platinum stayed in the implant. The overall body of available evidence supports that the extremely low level of gel bleed is of no clinical consequence.

3. Mentor Core Study Results for Reconstruction and Revision-Reconstruction

This section of this brochure summarizes the results of the Mentor Core Study conducted on Mentor’s silicone breast implants for primary reconstruction and revision-reconstruction. The Mentor Core Study is the primary clinical study for this product. The results of the Mentor Core Study give you useful information on the experience of other women with Mentor silicone gel-filled implants. While the results

cannot be used to predict your individual outcome, they can be used as a rough guide of what you may expect. Your own complications and benefits depend on many individual factors.

As a note, supplemental safety information was also obtained from the Mentor Adjunct Study, the U.K. Sharpe/Collis Study, and the literature to help assess long-term rupture rate and the consequences of rupture for this product. The literature, which had the most available information on the consequences of rupture, was also used to assess other potential complications associated with silicone gel-filled breast implants. The key literature information is referenced throughout the Breast Implant Complications section above.

3.1. Overview of Mentor Core Study

The Mentor Core Study is a 10-year study to assess safety and effectiveness in augmentation, reconstruction, and revision (revision-augmentation and revision-reconstruction) patients. Patient follow-up is at 6 months, 12 months, 24 months, and annually through 10 years. Safety is assessed by complications, such as implant rupture, capsular contracture, and reoperation. Benefit (effectiveness) is assessed by patient satisfaction and measures of quality of life (QoL).

The Mentor Core Study consists of 1,007 patients, including 551 primary augmentation patients, 146 revision-augmentation patients, 251 primary reconstruction patients, and 59 revision-reconstruction patients. Of these patients, 202 primary augmentation patients, 57 revision-augmentation patients, 134 primary reconstruction patients, and 27 revision-reconstruction patients are in the MRI cohort, which means that they are assessed for silent rupture by MRI at years 1, 2, 4, 6, 8, and 10. The study is currently ongoing, with the results through 3 years reported in this brochure. Mentor will periodically update this brochure as more information becomes available. You should also ask your surgeon if he/she has any available updated clinical information.

Mentor's Core Study results indicate that the risk of at least one occurrence of any complication (including reoperation) at some point through 3 years after implant surgery is 49% for primary reconstruction patients and 48% for revision-reconstruction patients. The information below provides more details about the complications and benefits you may experience.

Described below are benefits and complications reported in the Mentor Core Study for reconstruction patients. The findings are described separately for primary reconstruction and revision-reconstruction patients.

3.2. What Was the 3-Year Follow-Up Rate in Reconstruction Patients?

At the 3-year follow-up visit, data are reported for 82% of the eligible primary reconstruction patients, and 86% of the eligible revision-reconstruction patients.

3.3. What Were the Benefits for Reconstruction Patients?

The Mentor Core Study measured a variety of outcomes that assessed the benefits of the implants. For reconstruction, these outcomes included circumferential chest size, satisfaction, and quality of life (QoL) measures. These outcomes were assessed before implantation and at 1, 2, and 3 years after surgery for those patients who still had their original implants and came back for follow-up visits.

Primary Reconstruction Patients: For primary reconstruction patients, 183 (73%) out of the original 251 patients were included in the analysis of circumferential chest size at 3 years. Of these 183 patients, the average increase in circumferential chest size was 1.3 inches.

Mentor's satisfaction assessment was based on a single question of "Would the patient have this breast surgery again?" At 3 years, 189 (75%) out of 251 primary reconstruction patients enrolled answered that question. Of these 189 patients, 185 (98%) stated to their surgeon that they would have the breast implant surgery again.

With regard to QoL measures at 3 years for primary reconstruction patients, a significant improvement in functioning was observed as measured by the Functional Living Index of Cancer. No change was observed on Rosenberg Self Esteem Scale. The Tennessee Self Concept Scale (TSCS) is a survey completed by the patient that evaluates how the patient sees herself and what she does, likes, and feels. There was no change in the overall score for the TSCS. There was no change on the overall score of the Body Esteem Scale. The Sexual Attractiveness Subscale of the Body Esteem Scale significantly improved. The SF-36 is a collection of scales assessing mental and physical health. There was no change in any of the 10 SF-36 scales.

Revision-Reconstruction Patients: For revision-reconstruction patients, 45 (76%) out of the original 59 patients were included in the analysis of circumferential chest size at 3 years. Of these patients, the average increase in circumferential chest size was 0.9 inches.

Mentor's patient satisfaction was based on a single question of "Would the patient have this breast surgery again?" At 3 years, 48 (81%) out of 59 revision-reconstruction patients enrolled answered that question. Of these 48 patients, 47 (98%) stated to their surgeon that they would have the breast implant surgery again.

With regard to QoL measures at 3 years for revision-reconstruction patients, no change was observed on the Rosenberg Self Esteem Scale nor on the Tennessee Self Concept Scale. For the Body Esteem Scale, 2 of 6 scales worsened over time, but, after adjusting for the aging effect, none of the changes were significant. The Sexual Attractiveness Subscale of the Body Esteem Scale significantly improved over time. The SF-36 is a collection of scales assessing mental and physical health. Although some of the SF-36 scales showed decreases over time, after adjusting for the aging effect, changes in 7 of 10 SF-36 scales were not statistically significant.

3.4. What Were the 3-Year Complication Rates in Reconstruction Patients?

The 3-year complication rates are shown from the most common to the least common in Table 1 (reconstruction) and Table 2 (revision-reconstruction) below. The rates reflect the percentage of reconstruction patients who experienced the listed complication at least once within the first 3 years after implantation. Some complications occurred more than once for some patients. The two most common complications experienced by primary reconstruction patients within the first 3 years of implantation were reoperation (27.0%) and capsular contracture III/IV (8.3%).

**Table 1 -- 3-Year Complication Rates for Primary Reconstruction Patients
N=251 Patients**

Key Complications	%
Reoperation	27.0
Capsular Contracture III/IV	8.3
Implant Removal with Replacement with Study Device	7.4
Implant Removal without Replacement	5.7
Infection	5.7
Rupture (MRI Cohort) ¹	0.9
Other Complications occurring in $\geq 1\%$ of the patients²	%
Ptosis (sagging) ⁴	6.9
Scarring/Hypertrophic Scarring ³	6.8
Asymmetry ³	6.7
Seroma	4.9
Breast Mass ³	3.6
Nipple Complications ³	3.3
Wrinkling ³	2.6
Breast Pain ³	2.2
Metastatic Disease	1.8
Implant Malposition ³	1.7
Recurrent Breast Cancer ⁴	1.7
Hematoma ³	1.3
Extrusion of Intact Implant	1.2
Breast Sensation Changes ³	1.0
Rash	1.0

1 - There was 1 patient with signs of rupture by MRI of one of her implants through the 3-year timepoint. This has not been confirmed with removal and visual inspection of the implant.

2 - The following complications were reported at a rate less than 1%: deep vein thrombosis, delayed wound healing, lymphadenopathy, miscarriage, muscle spasm, necrosis, new diagnosis of breast cancer, new diagnosis of rheumatic disease (1 patient with fibromyalgia), redness, stitch abscess, tight benilli suture, and trauma to breast due to car accident.

3 - Mild occurrences were excluded.

4 - The general recurrence rate for breast cancer reported in the medical literature ranges from 5 to 25%.^{69,70,71}

The two most common complications experienced by patients within the first 3 years of revision-reconstruction surgery were reoperation (29.1%) and capsular contracture

III/IV (16.3%). Notice that the rates for capsular contracture are higher than for primary reconstruction. (For primary reconstruction, reoperation was 27.0% and capsular contracture III/IV was 8.3%.)

**Table 2 -- 3-Year Complication Rates for Revision-Reconstruction Patients
N=59 Patients**

Key Complications	%
Reoperation	29.1
Capsular Contracture III/IV	16.3
Implant Removal with Replacement with Study Device	8.8
Implant Removal without Replacement	5.2
Infection	0
Rupture (MRI Cohort)	0
Other Complications occurring in $\geq 1\%$ of the patients¹	%
Asymmetry ²	8.9
Implant Malposition ²	8.5
Wrinkling ²	7.0
Breast Mass ²	7.0
Granuloma	5.1
Scarring/Hypertrophic Scarring ²	3.6
Breast Pain ²	3.5
Hematoma ²	3.5
New Diagnosis of Rheumatic Disease ³	3.5
Ptosis (sagging) ²	3.4
Breast Sensation Changes ²	1.9
Numbness in Both Hands at Night	1.8
Seroma	1.7
Nipple Complications ²	1.7
Inflammation	1.7
Recurrent Breast Cancer ⁴	1.7
New Diagnosis of Breast Cancer	1.7
Delayed Wound Healing	1.7
Trauma ⁵	1.7
Capsule Tear	1.7
Extrusion of Intact Implant	1.7

1 - No complications were reported at a rate of <1%.

2 - Mild occurrences were excluded.

3 -These rheumatic diagnoses were fibromyalgia (1 patient) and pyoderma gangrenosum (1 patient).

4 - The general recurrence rate for breast cancer reported in the medical literature ranges from 5 to 25%.^{72,73,74}

5 - Trauma to breast from fall.

3.5. What Were the Main Reasons for Reoperation in Reconstruction Patients?

There may be one or more reasons identified for having a reoperation (additional surgery after the primary or revision breast reconstruction). Furthermore, there may be multiple surgical procedures (for example, implant removal with or without

replacement, capsule procedures, incision and drainage, implant reposition, scar revision, etc.) performed during a reoperation. In Mentor’s Core Study, there were 143 additional surgical procedures performed in 79 reoperations involving 66 primary reconstruction patients.

Table 3 below provides the main reason for each reoperation in primary reconstruction patients following initial implantation that were performed through 3 years. The most common reason for reoperation through 3 years was because of asymmetry (16 of 79 reoperations).

Table 3 -- Main Reasons for Reoperation in Primary Reconstruction Patients through 3 Years

Reason for Reoperation	n
Asymmetry	16
Biopsy	11
Capsular Contracture II, III, IV	10
Implant Malposition	9
Patient Request for Style/Size Change	9
Infection	4
Scarring/Hypertrophic Scarring	3
Ptosis (sagging)	3
Hematoma/Seroma	3
Breast Cancer	3
Extrusion of Intact Implant	2
Nipple Complications (unplanned)	2
Delayed Wound Healing	1
Breast Pain	1
Implant Palpability/Visibility	1
Muscle Spasm	1
Total	79

In Mentor’s Core Study, there were 54 additional surgical procedures performed in 24 reoperations involving 17 revision-reconstruction patients. Table 4 below provides the main reason for each reoperation in revision-reconstruction patients following initial implantation that were performed through 3 years. The most common reason for reoperation through 3 years was because of biopsy (7 of 24 reoperations).

Table 4 -- Main Reasons for Reoperation in Revision-Reconstruction Patients through 3 Years

Reason for Reoperation	n
Biopsy	7
Capsular Contracture III/IV	3
Other ¹	3
Implant Malposition	2
Suspected Rupture ²	1
Asymmetry	1
Breast Cancer	1
Extrusion of Intact Implant	1
Hematoma/Seroma	1
Nipple Complications (unplanned)	1
Patient Request for Style/Size Change	1
Ptosis (sagging)	1
Wrinkling	1
Total	24

1 - Includes 1 follicular cyst palpable nodule, 1 palpable nodule, and 1 pocket tear.

2 - The device was removed and found to be intact (not ruptured).

3.6. What Were the Reasons for Implant Removal in Reconstruction Patients?

The main reasons for implant removal among primary reconstruction patients in the Mentor Core Study over the 3 years are shown in Table 5 below. There were 41 implants removed in 31 patients. Of these 41 implants, 23 were replaced. The most common reason for implant removal was patient request (15 of the 41 implants removed).

Table 5 – Main Reasons for Implant Removal in Primary Reconstruction Patients through 3 Years

Reasons for Removal	n
Patient Request for Style/Size Change	15
Asymmetry	10
Capsular Contracture II, III, IV	5
Implant Malposition	3
Extrusion of Intact Implant	2
Infection	2
Hematoma	1
Lack of Projection	1
Muscle Spasm	1
Recurrent Breast Cancer	1
Total	41

The main reasons for implant removal among revision-reconstruction patients in the Mentor Core Study over the 3 years are shown in Table 6 below. There were 11 implants removed in 8 patients. Of these 11 implants, 7 were replaced. The most common reason for implant removal was capsular contracture III/IV (3 of the 11 implants removed).

Table 6 – Main Reasons for Implant Removal for Revision-Reconstruction Patients through 3 Years

Reasons for Removal	n
Capsular Contracture III/IV	3
Asymmetry	2
Patient Request for Style/Size Change	2
Symmastia	2
Extrusion of Intact Implants	1
Pocket Tear	1
Total	11

3.7. What Were Other Clinical Data Findings in Reconstruction Patients?

Below is a summary of clinical findings from Mentor’s Core Study with regards to connective tissue disease (CTD); CTD signs and symptoms; cancer; lactation complications, reproduction complications; and suicide. These issues, along with others, are being further evaluated as part of a Mentor postapproval study involving patients followed through 10 years.

CTD Diagnoses

One primary reconstruction patient and two revision-reconstruction patients in the Mentor Core Study were reported to have a new diagnosis of CTD according to a rheumatologist. These diagnoses were two cases of fibromyalgia, both at 1 year, and pyoderma gangrenosum at 1 year. It cannot be concluded that these CTD diagnoses were caused by the implants because there was no comparison group of similar women without implants.

CTD Signs and Symptoms

In Mentor’s Core Study, data on over 100 self-reported signs and symptoms, including 50 self-reported rheumatological symptoms, were collected. Compared to before having the implants, a significant increase was found for joint pain in the primary reconstruction patients, and no significant increases were found for any individual signs and symptoms in the revision-reconstruction patients. The increase in joint pain seen in the primary reconstruction patients was not found to be related to simply getting older. The Mentor Core Study was not designed to evaluate cause and effect associations because there is no comparison group of women without implants, and because other contributing factors, such as medications and lifestyle/exercise, were not studied. Therefore, it cannot be determined whether this increase was due to the implants or not, based on the Mentor Core Study. However, you should be aware that you may experience an increase in these symptoms after receiving breast implants.

Cancer

For primary reconstruction patients, 1 (0.5%) patient had a new diagnosis of breast cancer and 4 (1.7%) patients had a reoccurrence of breast cancer. For revision-reconstruction, 1 (1.7%) patient had a new diagnosis of breast cancer and 1 (1.7%) patient had a recurrence of breast cancer. There were no reports of other cancers, such as brain, respiratory, or cervical/vulvar.

Lactation Complications

For primary reconstruction patients, of the 3 women who attempted to breastfeed, none experienced lactation difficulties. None of the revision-reconstruction patients attempted to breast feed.

Reproduction Complications

For primary reconstruction patients, 2 (0.9%) patients reported a miscarriage. None of the revision-reconstruction patients suffered a miscarriage.

Suicide

There were no reports of suicide in either the primary reconstruction or revision-reconstruction indications in Mentor's Core Study through 3 years.

4. Surgery Considerations for Receiving Breast Implants

This section provides a discussion of surgical considerations for primary breast reconstruction, followed by a discussion of general surgical considerations, and surgical considerations for revision-reconstruction.

4.1. Surgical Considerations for Primary Breast Reconstruction

Your decision to have breast reconstruction is an important personal choice involving both risks and benefits. There are other options for breast reconstruction that do not involve breast implants. Be sure to ask your surgeon for a detailed explanation of each alternative to help you decide which reconstruction option is most suitable for you and your lifestyle. This brochure is intended to provide general information about silicone breast implants and surgery, but is not a substitute for a thorough consultation with your surgeon. You are advised to carefully review and consider all the information you have received before deciding whether to have reconstruction surgery. Prepare a list of questions after reading this brochure, and discuss them with your surgeon.

4.1.1. Should You Have Primary Breast Reconstruction?

Whether you decide to have breast reconstruction depends on your own individual case, medical condition, general health, lifestyle, emotional state, and breast size, and shape. You should consult your surgeon to discuss your personal goals for breast reconstruction, and you may also consider consulting your family, friends, breast implant support groups, and breast cancer support groups to help you in making this decision.

If you are considering breast reconstruction and do not have a reconstructive surgeon, ask your general surgeon for a referral for the names of experienced, board-certified surgeons in your area. Your general surgeon, breast reconstruction surgeon, and oncologist should work together to plan your mastectomy and reconstruction procedure and to advise you based on your specific clinical needs and desired outcome.

4.1.2. What Are the Options in Primary Breast Reconstruction?

You may choose not to undergo breast reconstruction. In this case, you may or may not decide to wear an external breast form (prosthesis) inside your bra. Breast forms are available in a variety of shapes, sizes, and materials such as foam, cotton, and silicone. Custom prostheses are also available to match the size and shape of your breast.

4.1.3. What Are the Choices in Primary Reconstructive Procedures?

The type of breast reconstruction procedure available to you depends on your medical situation, breast shape and size, general health, lifestyle, and goals.

Breast reconstruction can be accomplished by the use of a prosthesis (a breast implant, either silicone gel or saline-filled), your own tissues (a tissue flap), or a combination of the two. A tissue flap is a combination of skin, fat, and/or muscle that is moved from your stomach, back, or other area of your body to the chest area, and shaped into a new breast. A tissue flap also may be used to provide skin or other tissue needed to make up for what was removed at the time of surgery, or changed following radiation therapy. Your surgeon can help you decide what method of breast reconstruction is most suitable for your particular situation.

Whether or not you have reconstruction with or without breast implants, you will probably undergo additional surgeries to improve symmetry and appearance. These additional surgeries may be part of a several stage reconstruction of the removed breast, or to shape the remaining breast to bring it into better balance with the reconstructed one. Most commonly, breast implants are placed after a space has been created for them using a temporary soft tissue expander that can be placed at the time of mastectomy or at a later time.

Portions of the reconstruction may be done in stages. For example, because the nipple and areola are usually removed with the breast tissue in mastectomy, the nipple is usually reconstructed by using a skin graft from another area of the body, or the opposite breast in addition to tattooing the area to obtain a better color match. Nipple reconstruction is usually done as a separate outpatient procedure after the initial reconstruction surgery is complete.

4.1.3.1. Breast Reconstruction with Breast Implants

Your surgeon will decide whether your health and medical condition make you an appropriate candidate for breast implant reconstruction. Your surgeon may recommend breast implantation of the opposite, uninvolved breast in order to make them more alike, or he/she may suggest breast reduction (reduction mammoplasty) or a breast lift (mastopexy) to improve symmetry. Mastopexy involves removing a strip of skin from under the breast or around the nipple to lift the nipple and breast location, and tighten the skin over the breast. Reduction mammoplasty involves removal of breast tissue and skin. If it is important to you not to alter the unaffected breast, you should discuss this with your surgeon, as it may affect the breast reconstruction methods considered for your case.

4.1.3.2.Reconstruction Incision Sites

In reconstructive surgery, the incision placement and length is decided by your surgeon, and largely influenced by the type of cancer surgery that is planned for you.

4.1.3.3.Surgical Settings and Anesthesia

Reconstruction surgery is usually performed on an inpatient basis in an operating room when it begins at the same time as the mastectomy. Some of the stages, such as nipple reconstruction, or placement of the implant after soft tissue expansion, can be done as an outpatient. General anesthesia is most often used.

4.1.4. The Timing of Your Primary Breast Implant Reconstruction

The following description applies to reconstruction following mastectomy, but similar considerations apply to reconstruction following breast trauma or reconstruction for congenital anomalies. The breast reconstruction process may begin at the time of your mastectomy (immediate reconstruction) or months to years afterwards (delayed reconstruction). This decision is made after consultation with the cancer treatment team based on your individual situation. Immediate reconstruction may involve placement of a breast implant, but typically involves placement of a tissue expander, which is used to recreate skin that was removed during the cancer surgery. The tissue expander will eventually be replaced with a breast implant. It is important to know that any type of surgical breast reconstruction may take several steps to complete.

A potential advantage to immediate reconstruction is that your breast reconstruction starts at the time of your mastectomy and that there may be cost savings and potentially fewer days in the hospital for you in combining the mastectomy procedure with the first stage of the reconstruction. However, there may be a higher risk of capsular contracture, implant extrusion, and other complications associated with immediate reconstruction as a result of postoperative radiation and chemotherapy treatments. Your initial operative time and recovery time may also be longer.

A potential advantage to delayed reconstruction is that you can delay your reconstruction decision and surgery until other treatments, such as radiation therapy and chemotherapy, are completed. Delayed reconstruction may be advisable if your surgeon anticipates healing problems with your mastectomy, or if you just need more time to consider your options.

There are medical, financial, and emotional considerations to choosing immediate versus delayed reconstruction. You should discuss with your general surgeon, reconstructive surgeon, and oncologist, the pros and cons of the options available in your individual case.

4.1.5. What Is the Primary Breast Implant Reconstruction Procedure?

- **One-Stage Immediate Breast Implant Reconstruction**

Immediate one-stage breast reconstruction may be done at the time of your mastectomy. After the general surgeon removes your breast tissue, the reconstructive

surgeon will then place a breast implant that completes the one-stage reconstruction. In reconstruction following mastectomy, a breast implant is most often placed submuscularly, underneath the muscle of the chest wall.

- Two-Stage (Immediate or Delayed) Breast Implant Reconstruction

Breast reconstruction usually occurs as a two-stage procedure, starting with the placement of a breast tissue expander, which is replaced several months later with a breast implant after enough new skin has been created to obtain the best result. The tissue expander placement may be done immediately, at the time of your mastectomy, or be delayed until months or years later.

Stage 1: Tissue Expansion



Mastectomy Scar



Tissue Expander with remote injection dome

During a mastectomy, the general surgeon removes skin as well as breast tissue, leaving the chest tissues flat and tight. To create a breast-shaped space for the breast implant, a tissue expander is placed under the remaining chest tissues.

The tissue expander is a balloon-like device made from elastic silicone rubber. It is inserted unfilled, and, over time, sterile saline fluid is added by inserting a small needle through the skin to the filling port of the device. As the tissue expander fills, the tissues over the expander begin to stretch, similar to the gradual expansion of a woman's abdomen during pregnancy. The tissue expander creates a new breast-shaped pocket for a breast implant.



Tissue expander with integral injection dome



Final result with implant

Tissue expander placement usually occurs under general anesthesia in an operating room. The procedure may require a brief hospital stay, or be done on an outpatient basis. Typically, you can resume normal daily activity after 2 to 3 weeks.

Because the chest skin is usually numb from the mastectomy surgery, it is possible that you may not experience much pain from the placement of the tissue expander or the needle sticks that follow to fill it with saline solution. However, you may experience feelings of pressure, tightness, and discomfort after each filling of the expander. These feelings stop after several days, once the tissue expands, but they may last for a week or more. The tissue expansion process typically lasts 4 to 6 months.

Stage 2: Placing the Breast Implant

After the tissue expander is removed, the breast implant is placed in the pocket. In reconstruction following mastectomy, a breast implant is most often placed submuscularly. The surgery to replace the tissue expander with a breast implant (implant exchange) is usually done under general anesthesia in an operating room. It may require a brief hospital stay or be done on an outpatient basis.

4.1.6. Primary Breast Reconstruction Without Implants: Tissue Flap Procedures

In some patients, the breast may be reconstructed by surgically moving an area of skin, fat, and muscle from one area of your body to another. The section of tissue may be taken from such areas as your abdomen, upper back, upper hip, or buttocks in order to provide enough tissue to match a large remaining breast, to replace tissue removed or damaged at the time of mastectomy, or following radiation therapy.

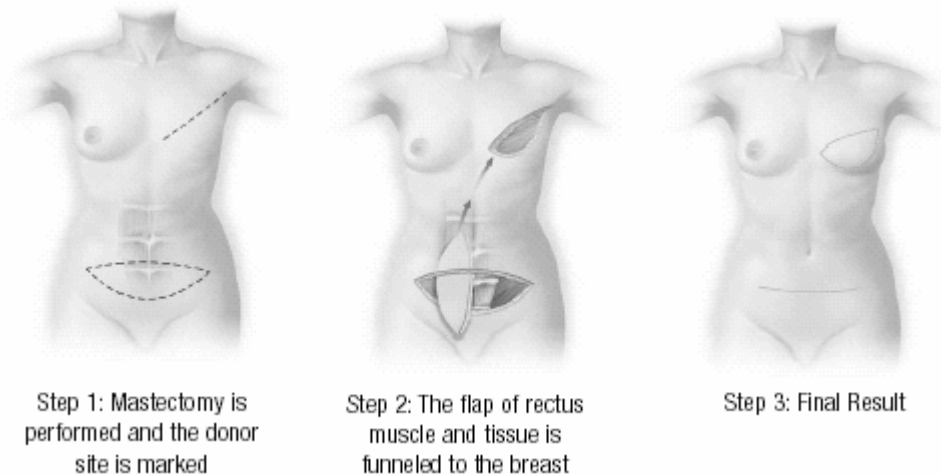
The tissue flap may be left attached to the blood supply and moved to the breast area through a tunnel under the skin (a pedicle flap), or it may be removed completely and reattached to the breast area by microsurgical techniques to reconnect the tiny blood vessels from the flap to vessels on the chest area (a free flap). Operating time is generally longer with free flaps because of the microsurgical requirements.

Flap surgery requires a hospital stay of several days and generally a longer recovery time than implant reconstruction. Flap surgery also creates scars at the site where the flap was taken and on the reconstructed breast. However, flap surgery has the advantage of being able to replace tissue in the chest area. This may be useful when the chest tissues have been damaged and are not suitable for tissue expansion. Another advantage of flap procedures over implantation is that alteration of the unaffected breast is generally not needed to improve symmetry.

The most common types of tissue flaps are the TRAM (transverse rectus abdominus musculocutaneous flap) (which uses tissue from the abdomen) and the latissimus dorsi flap (which uses tissue from the upper back). In most patients the TRAM flap can provide enough tissue to completely rebuild the breast mound, but breast implants are frequently needed to complete the reconstruction for patients having latissimus flaps because there is rarely enough fatty tissue in the flap to completely rebuild the breast mound.

It is important for you to be aware that flap surgery, particularly the TRAM flap, is a major operation, and more extensive than your mastectomy operation. It requires good general health and strong emotional motivation. If you are very overweight, smoke cigarettes, have had previous surgery at the flap site, or have any circulatory

problems, you may not be a good candidate for a tissue flap procedure. In addition, if you are very thin, you may not have enough tissue in your abdomen or back to create a breast mound with this method. You should discuss with your surgeon whether you would be a candidate for either of these procedures. There potentially are complications associated with flap procedures that you also should discuss with your surgeon.



4.1.6.1.The TRAM Flap (Pedicle or Free)

During a TRAM flap procedure, the surgeon removes a section of tissue from your abdomen and moves it to your chest to reconstruct the breast. The TRAM flap is sometimes referred to as a “tummy tuck” reconstruction, because it may leave the stomach area flatter.

A pedicle TRAM flap procedure typically takes 3 to 6 hours of surgery under general anesthesia; a free TRAM flap procedure generally takes longer. The TRAM procedure may require a blood transfusion. Typically, the hospital stay is 2 to 5 days. You can resume normal daily activity after 6 to 8 weeks. Some women, however, report that it takes up to 1 year to resume a normal lifestyle. You may have temporary or permanent muscle weakness in the abdominal area. If you are considering pregnancy after your reconstruction, you should discuss this with your surgeon. You will have a large scar on your abdomen and may also have additional scars on your reconstructed breast.

4.1.6.2.The Latissimus Dorsi Flap With or Without Breast Implants

During a latissimus dorsi flap procedure, the surgeon moves a section of tissue from your back to your chest to reconstruct the breast. Because the latissimus dorsi flap is usually thinner and smaller than the TRAM flap, this procedure may be more appropriate for reconstructing a smaller breast. This flap is frequently used when there is not enough skin available to use a soft tissue expander alone, or when there is too much tightness after mastectomy, or when radiation therapy has been used. Latissimus flaps may be combined with soft tissue expanders in a variation of the two stage breast reconstruction technique.

The latissimus dorsi flap procedure typically takes 2 to 4 hours of surgery under general anesthesia. Typically, the hospital stay is 2 to 3 days. You can resume daily activity after 2 to 3 weeks. You may have some temporary or permanent muscle weakness and difficulty with movement in your back and shoulder. You will have a scar on your back, which can usually be hidden in the bra line. You may also have additional scars on your reconstructed breast.

4.2 General Surgical Considerations

4.2.1 Choosing a Surgeon

When choosing a surgeon who is experienced with breast reconstruction, you should know the answers to the following questions:

- How many breast reconstruction implantation procedures does he/she perform per year?
- How many years has he/she performed breast reconstruction procedures?
- Has he/she obtained training certification from Mentor to use its silicone gel-filled breast implants?
- Is he/she board certified, and if so, with which board?
- In which state(s) is he/she licensed to practice surgery? Note that some states provide information on disciplinary action and malpractice claims/settlements to prospective patients either by request or on the Internet.
- What is the most common complication he/she encounters with breast reconstruction?
- What is his/her reoperation rate with breast reconstruction, and what is the most common type of reoperation he/she performs?

4.2.2 Implant Shape and Size

Depending on the desired shape you wish to achieve, you and your surgeon have implants with three different round profiles, or styles, from which to choose. Generally, the larger you want your cup size, the larger the breast implant the surgeon will consider (measured in cubic centimeters, or cc's), not in cup sizes, because this depends on the size and shape of the individual woman's chest.

Your surgeon will also evaluate your existing breast and skin tissue to determine if you have enough to cover the breast implant you are considering, or, in some cases such as after pregnancy, too much extra skin. If you desire a breast implant size that is too large for your tissue, the surgeon may warn you that breast implant edges may be visible or palpable postoperatively. Also, excessively large breast implants may speed up the effects of gravity on the breast, and can result in droop or sag at an earlier age. A recent report indicates that larger sized implants (greater than 350cc) may be too large for many women, increasing the risk of developing complications such as implant extrusion, hematoma, infection, palpable implant folds, and visible skin wrinkling requiring surgical intervention to correct these complications.⁷⁵

4.2.3 Surface Texturing

Some studies suggest that surface texturing reduces the chance of severe capsular contracture⁷⁶ while other studies do not.^{77,78} Mentor's Core Study did not show a difference in the likelihood of developing capsular contracture with textured implants compared to smooth-surfaced implants.

4.2.4 Palpability

Implants may be more palpable or noticeable if there is an insufficient amount of skin/tissue available to cover the implant and/or when the implant is placed subglandularly.

4.2.5 Insurance

In general, private insurance that covers medically necessary mastectomies will also cover breast reconstructive surgery. Insurance coverage for reoperation procedures or additional surgeon's visits following reconstruction may not be covered, depending on the policy. For example, a reoperation may include temporary removal of the implant to facilitate the oncologist's ongoing surveillance for breast cancer recurrence. Because coverage policies vary and can change over time, no guidance can be given with respect to coverage under any particular health plan. It is, therefore, recommended that you contact your health plan to obtain specific information regarding its coverage policies before deciding to proceed with reconstructive surgery.

4.2.6 Postoperative Care

Depending on the type of surgery you have (i.e., immediate or delayed), the postoperative recovery period will vary. Possible complications that may occur have been described above. Ask your surgeon to advise you on specific postoperative care instructions.

Note: If you experience fever, or noticeable swelling and/or redness in your implanted breast(s), you should contact your surgeon immediately.

4.3 Surgical Considerations for Breast Revision-Reconstruction

You should re-read the section above titled "Surgical Considerations for Primary Breast Reconstruction," as they are applicable to you.

Additional surgery may be considered at any time following original breast reconstruction for correction of complications, such as capsular contracture, infection, hematoma (bleeding), or seroma, or to improve the aesthetic outcome such as implant size/style change or pocket modification. Any device that has been removed during revision surgery should not be reimplanted. Mentor breast implants are "for single use only."

Occasionally, for breast reconstruction patients, temporary removal of the implant may be suggested by the oncologist to facilitate ongoing surveillance for breast cancer recurrence or additional chemotherapeutic or radiation treatment regimens. Effective

and sometimes aggressive disease treatment modalities always are a first priority for the patient and their healthcare team. Once the suggested treatment regimen is completed, surgical revision-reconstruction, including implant replacement, can be considered.

4.3.1 What Are the Alternatives to Surgical Revision-Reconstruction?

- Conservative treatment may be tried to improve implant-related concerns such as implant massage to slow progressive capsular contracture or the use of special garments (bras, bandeaus etc.) to improve implant placement.
- Aesthetic outcomes can be accepted as is or improved with undergarment choices, including the use of supplementary padding to correct volume asymmetries.
- In some cases there is no recommended alternative to surgical revision. For example, complications may require timely surgical revision to prevent a localized complication such as infection from progressing to a systemic health concern. Similarly, an implant that is clinically suspected to be ruptured and is confirmed by MRI, should be removed.

5. Follow-up Examinations

5.1. Breast self-examinations

You should perform a breast self-examination monthly. This may be more difficult with an implant in place. In order to do this effectively, you should ask your surgeon to help you tell the difference between the implant and your breast tissue. Care should be taken not to squeeze the implant excessively. Any new lumps may be evaluated with a biopsy, as appropriate. If a biopsy is performed, care must be taken to avoid injuring the implant.

5.2. Screening for Silent Rupture

Because most ruptures of silicone breast implants are silent, in most cases, neither you nor your surgeon will be able to find evidence of rupture. Therefore, evaluation of your implants is needed to screen for implant rupture. The best method of screening is currently MRI at a center with a breast coil, with a magnet of at least 1.5 Tesla. The MRI should be read by a radiologist who is familiar with looking for implant rupture.

It is recommended that your first MRI evaluation take place starting at 3 years after implant surgery and then every 2 years, thereafter, even if you are experiencing no problems with your implant. If signs of rupture are seen on MRI, then you should have your implant removed, with or without replacement. More information on rupture is provided in Section 2 of this brochure. Your doctor should assist you in locating a radiology/screening center, as well as a radiologist who is familiar with the technique and equipment for proper MRI screening for silent rupture of your breast implant.

5.3. Symptomatic Rupture

Symptoms associated with rupture may include hard knots or lumps surrounding the implant or in the armpit, loss of size of the breast or implant, pain, tingling, swelling, numbness, burning, or hardening of the breast. If you notice any of these changes, see your plastic surgeon so that he or she can examine the implants and determine whether you need to have an MRI examination to find out if your symptoms are due to rupture of the implant. If rupture has occurred, you should have your implant removed. More information on rupture is provided in Section 2 of this brochure.

You should monitor your breast implants for signs of symptomatic rupture when you check your breasts for lumps monthly. Examine your breast tissue by feeling for lumps. Then feel the breast implants. Move the implants around while looking in the mirror. Look for changes in shape, size, and feel of the implants. Know, and pay attention to, how the breast implants feel.

5.4. Mammography

After a complete mastectomy, mammography generally is not required. In patients who have had partial mastectomies, the current recommendations for getting screening/preoperative mammograms are no different for women with breast implants than for those without implants. Mammography exams should be interpreted by radiologists experienced in the evaluation of women with breast implants. It is essential that you tell your mammography technologist that you have an implant before the procedure. You should request a diagnostic mammogram, rather than a screening mammogram, because more pictures are taken with diagnostic mammography. The technologist can use special techniques to reduce the possibility of rupture and to get the best possible views of the breast tissue. More information on mammography is provided in Section 1.4.

6. The Types of Silicone Gel Breast Implants Available from Mentor

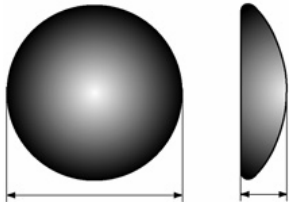
Mentor's silicone gel-filled breast implants, referred to as MemoryGel products, come in a variety of profiles and sizes. All currently available MemoryGel breast implants have either a textured shell or smooth surface shell.

Table 7 below shows the MemoryGel implant styles that were approved. Be sure to familiarize yourself with the different features of breast implants and to discuss the best type(s) of implants for you with your surgeon.

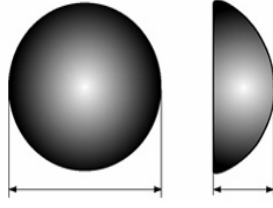
Table 7 -- Approved MemoryGel Implant Styles

Catalog Number	Breast Implant Description	Size Range
350-7100BC/7800BC	Smooth, Round, Moderate Profile	100-800 cc
354-1007/8007	Textured Round, Moderate Profile	100-800 cc
350-1001BC/8001BC	Smooth, Round, Moderate Plus Profile	100-800 cc
354-1001/8001	Textured, Round, Moderate Plus Profile	100-800 cc
350-1254BC/8004BC	Smooth, Round, High Profile	125-800 cc
354-4125/4800	Textured, Round, High Profile	125-800 cc

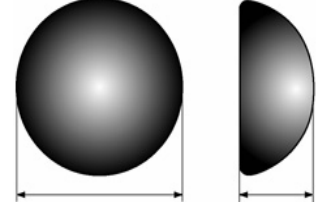
The following diagrams illustrate the high, moderate plus, and moderate profiles.



Moderate Profile



Moderate Plus Profile



High Profile

7. How to Report Problems with Your Implant

The Food and Drug Administration (FDA) requires that serious injuries (defined as those that need medical or surgical intervention to prevent permanent damage) be reported by hospitals if they are aware of the serious injuries. If you believe that you have experienced one or more serious problems related to your breast implants, you are encouraged to report the serious problem(s) through your health professional to the FDA. Although reporting by doctors or other health professionals is preferred, women may also report any serious problem directly through FDA's MedWatch voluntary reporting system. You can report by telephone to 1-800-FDA-1088; by FAX, use Form 3500 to 1-800-FDA-0178; electronically at <http://www.fda.gov/medwatch/index.html>; or by mail to MedWatch Food and Drug Administration, HF-2, 5600 Fishers Lane Rockville, MD 20857-9787. **Keep a copy of the MedWatch form completed by your doctor for your records.** The information reported to MedWatch is entered into databases to be used to follow safety trends (patterns) of a device and to determine whether further follow-up of any potential safety issues related to the device is needed.

8. Device Tracking

Silicone gel-filled breast implants are subject to Device Tracking by Federal regulation. This means that your physician will be required to report to Mentor the serial number of the device(s) you receive, the date of surgery, and information relating to the physician's practice. This information will be recorded on the Device Tracking Form supplied by Mentor with each silicone gel-filled breast implant.

Mentor strongly recommends that all patients receiving silicone gel-filled breast implants participate in Mentor's device tracking program. This will help ensure that Mentor has a record of each patient's contact information so that all patients, including you, can be contacted in the case of a recall or other problems with your implants that you should be made aware of. Please inform Mentor whenever your contact information changes.

9. Product Replacement Policy and Limited Warranties

The following is a description of the assistance available from Mentor Lifetime Product Replacement Policy, and the Mentor Advantage and Enhanced Advantage Limited Warranties.

Mentor's free Lifetime Product Replacement Policy involves the lifetime product replacement for its gel-filled and saline-filled breast implants, worldwide. When implant replacement is required and the Mentor Product Replacement Policy applies (see below), Mentor will provide, throughout a patient's lifetime, the same or similar Mentor breast implant at no cost. If a more expensive product is requested, Mentor will invoice the surgeon for the price difference.

The **Mentor Standard Advantage Limited Warranty** is free of charge to all patients who are implanted with Mentor gel-filled or saline-filled breast implants in the United States and Puerto Rico. When the limited warranty applies, Mentor provides the following:

- Financial assistance: For the first ten years following a breast implant procedure, Mentor will provide financial assistance up to \$1200 to help cover operating room, anesthesia, and surgical charges not covered by insurance. Financial assistance applies to covered events only (see below). Operating room and anesthesia charges will be given payment priority. In order to qualify for financial assistance, you will need to sign a Release Form.
- Free contralateral (opposite side) implant replacement upon surgeon request.
- Non-cancelable terms.

The **Mentor Enhanced Advantage Limited Warranty** is an optional limited warranty available for women who are implanted with Mentor gel-filled or saline-filled breast implants in the United States and Puerto Rico. To be eligible, the Mentor Enhanced Advantage Limited Warranty must be purchased for an enrollment fee of \$100 within 45 days from implantation. When the warranty applies, Mentor provides the following:

- Financial assistance: For the first ten years following a breast implant procedure, Mentor will provide financial assistance up to \$2400 to help cover operating room, anesthesia, and surgical charges not covered by insurance. Financial assistance applies to covered events only (see below). Operating room and anesthesia charges will be given payment priority. In order to qualify for financial assistance, you will need to sign a Release Form.
- Free contralateral implant replacement upon surgeon request.
- Non-cancelable terms.

With both the Mentor Standard Advantage and Mentor Enhanced Advantage Limited Warranties, it is important for you to also maintain your own records to ensure validation of your enrollment, as it is possible your surgeon may not retain your records for the entire duration of the limited warranty.

Products Covered

The Mentor Standard Advantage Limited Warranty coverage applies to all Mentor gel-filled and saline-filled breast implants that are implanted in the United States and Puerto Rico, provided they have been:

- Implanted in accordance with the Mentor package insert, current to the date of implantation, and other notifications or instructions published by Mentor; and
- Used by appropriately qualified, licensed surgeons, in accordance with accepted surgical procedures.

Events Covered

The Mentor Lifetime Product Replacement Policy, and the Standard Mentor Advantage and Enhanced Advantage Limited Warranties coverages apply to the following:

- Rupture due to localized stress, folding, manufacturing defect, patient trauma, or unknown cause.
- Other loss-of-shell integrity events, such as surgical damage may also be covered by these programs. Mentor reserves the right to determine if specific, additional events should be covered.

Events Not Covered

The Mentor Lifetime Product Replacement Policy and the Mentor Standard Advantage and Enhanced Advantage Limited Warranties coverages do not apply to the following:

- Removal of intact implants due to capsular contracture, or wrinkling.
- Loss of implant shell integrity resulting from reoperative procedures, open capsulotomy, or closed compression capsulotomy procedures.
- Removal of intact implants for size alteration.

Filing for Financial Assistance

- To file a Mentor Advantage claim for product replacement and/or financial assistance, the surgeon must contact the Mentor Product Evaluation Department at 1-866-250-5115 prompt #1 prior to replacement surgery.
- For financial assistance claims, a patient-specific Release form will be generated that you must sign and return.
- For either replacement or financial assistance claims, the surgeon must send the explanted, decontaminated Mentor breast implant(s) within six months of the date of implant removal to:

Mentor Product Evaluation
3041 Skyway Circle North
Irving, Texas 75038-3540

- Upon receipt, review and approval of the completed claim, including receipt of the explanted product and your completion of a full general release, financial assistance will be issued.

This is a summary of the coverage of the Mentor Advantage and Enhanced Advantage Limited Warranties. It is an overview only and not a complete statement of the program. A copy of the complete Mentor Advantage and Enhanced Advantage Limited

Warranties for saline-filled and silicone gel-filled breast implants may be obtained by writing or calling:

Consumer Affairs Department
Mentor Corporation
201 Mentor Drive
Santa Barbara, CA 93111
1-800-525-0245

A copy of the complete programs may also be obtained from your surgeon or by going to www.mentorcorp.com.

THESE ARE LIMITED WARRANTIES ONLY AND ARE SUBJECT TO THE TERMS AND CONDITIONS SET FORTH AND EXPLAINED IN THE APPLICABLE MENTOR LIMITED WARRANTIES. ALL OTHER WARRANTIES, WHETHER EXPRESS OR IMPLIED, BY OPERATION OF LAW OR OTHERWISE, INCLUDING BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS ARE EXCLUDED.

Mentor reserves the right to cancel, change, or modify the terms of the Mentor Advantage and Enhanced Advantage coverages. Any such cancellation, change, or modification will not affect the currently stated terms of the Mentor Advantage and Enhanced Advantage coverages for those already enrolled.

10. Other Sources of Additional Information

Upon request, you will be provided with a copy of the package insert (Directions for Use). You can request a copy from your surgeon or from Mentor. The package insert has many undefined medical and technical terms since it contains information directed only to the surgeon.

For more detailed information on the preclinical and clinical studies conducted by Mentor, please refer to the Summary of Safety and Effectiveness Data (SSED) for this product at <http://www.fda.gov/cdrh/breastimplants/>.

If you should decide to get breast implants, you will be given a device identification card with the style and serial number of your breast implant(s). This will be given to you right after your surgery. It is important that you keep a copy of this card because you may need to refer to that information at a later date.

For additional information or questions about Mentor breast implants, please call 1-800-MENTOR8.

Mentor Corporation

1-800-MENTOR8
www.mentorcorp.com

Institute of Medicine Report on the Safety of Silicone Implants

www.nap.edu/catalog/9618.html

Food and Drug Administration

1-888-INFO-FDA or 240-276-3103

<http://www.fda.gov/cdrh/breastimplants/>

You can find important information in the FDA breast implant consumer handbook, which is available through the phone number or website provided above.

American Society of Plastic Surgeons

http://www.plasticsurgery.org/public_education/Silicone-Breast-Implant-Surgery.cfm

Breast Reconstruction Resources

The following list of resources may help you to find more information and support for your breast reconstruction decision.

National Cancer Institute
1-800-4-CANCER
www.cancernet.nci.nih.gov

American Cancer Society
(Reach to Recovery)
1-800-ACS-2345
www.cancer.org

Y-ME National Organization for Breast Cancer Information and Support
1-800-221-2141
www.y-me.org



201 Mentor Drive
Santa Barbara
CA 93111 USA
(800) MENTOR-8
www.mentorcorp.com

ACKNOWLEDGMENT OF INFORMED DECISION

I understand that this patient brochure, "Important Information for Reconstruction Patients About Mentor MemoryGel™ Silicone Gel-Filled Breast Implants," is intended to provide the information regarding the risks and benefits of silicone gel-filled breast implants, both general and specific to Mentor's MemoryGel™ products. I understand that silicone breast implant surgery involves risks and benefits, as described in this brochure. I also understand that the long-term (i.e., 10-year) safety and effectiveness of silicone gel-filled breast implants continue to be studied. I understand that reading and fully understanding this brochure is required, but that there also must be consultation with my surgeon.

By circling the correct response and signing below, I acknowledge:

- Y/N** I have had adequate time to read and fully understand the Informed Decision brochure;
- Y/N** I have had an opportunity to ask my surgeon any questions I may have about this brochure or any other issues related to breast implants or breast implant surgery;
- Y/N** I have considered the alternatives to silicone breast implants and have decided to proceed with silicone breast implant surgery;
- Y/N** I have been advised to wait at least 1-2 weeks after reviewing and considering this information, before scheduling my silicone breast implant surgery, unless an earlier surgery was deemed medically necessary by my surgeon; and
- Y/N** I will retain this brochure, and I am aware that I may also ask my surgeon for a copy of this signed acknowledgment.

PATIENT (PRINT NAME)

DATED: _____

SIGNATURE OF PATIENT

IF PATIENT IS A MINOR:

DATED: _____

SIGNATURE OF GUARDIAN

By my signature below, I acknowledge that:

- My patient has been given an opportunity to ask any and all questions related to this brochure, or any other issues of concern;
- All questions outlined above have been answered "Yes" by my patient;
- My patient has been given a waiting period of at least 1-2 before making her final decision, unless an earlier surgery was deemed medically necessary; and
- Documentation of this Informed Decision will be retained in my patient's permanent record.

DATED: _____

SIGNATURE OF SURGEON

References

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