Scientific Research Publishing

Case Reports in Clinical Medicine, 2026, 15(4), 159-167
https://www.scirp.org/journal/crcm
ISSN Online: 2325-7083
ISSN Print: 2325-7075

Self-Explantation of a Prosthetic Breast Implant by Patient

Anna H. Maki[1], Jane Sohn[2*], Heather Anderson[3], Sommer R. Gunia[3]

[1]SMIL Research Institute, Southwest Medical Imaging, Ltd., Scottsdale, AZ, USA
[2]Department of Breast Imaging, Southwest Medical Imaging, Ltd., Scottsdale, AZ, USA
[3]Arizona Center for Cancer Care (AZCCC), Phoenix, AZ, USA
Email: *jsohn@esmil.com

How to cite this paper: Maki, A.H., Sohn, J., Anderson, H. and Gunia, S.R. (2026) Self-Explantation of a Prosthetic Breast Implant by Patient. *Case Reports in Clinical Medicine*, **15**, 159-167.
https://doi.org/10.4236/crcm.2026.154021

Received: March 12, 2026
Accepted: April 10, 2026
Published: April 13, 2026

Abstract

Removal of breast prostheses is a common surgical procedure, most often performed by plastic surgeons, occasionally by oncologic or general surgeons. In this report, we describe an unusual case in which a 72-year-old woman with a pre-existing silicone breast prosthesis underwent breast conservation therapy for primary invasive carcinoma. Two years later, she experienced pain and inflammation in the region of the lumpectomy bed and was found to have developed a complex fluid collection overlying the implant, for which percutaneous aspiration was performed. Despite aspiration and antimicrobial therapy for the isolated *Staphylococcus aureus* organism, a nonhealing wound persisted, through which the patient eventually performed nonsterile self-explantation of her own silicone implant. Following this unusual event, her wound healed, and she returned to her normal asymptomatic clinical baseline.

Keywords

Breast Imaging, Breast Implants, Explantation, Infection

1. Introduction

Breast augmentation via placement of breast prostheses, or breast implants (BI), is the most common cosmetic surgery performed worldwide, with almost 2 million augmentations performed in 2018 alone [1]. In most augmentations, exceeding 75% in the United States [1], silicone-based prostheses are utilized. Such BI may be placed deep to the pectoral muscle, or so-called subpectoral implants, or they may be placed ventral to the pectoralis, often referred to as prepectoral or subglandular BI.

Complications of silicone BI are not uncommon, most commonly capsular con-

tractions or implant rupture, both of which most frequently occur many years, often a decade or more, following implantation [2]. Infections occur in under 2.5% of BI procedures, about two-thirds of which occur in the acute postoperative period, but a minority of which may develop many months or even years following surgery [3].

In addition, in recent years, some patients have elected to undergo surgical explantation of BI due to concerns of potential BI-related chronic illness [4] or risk of anaplastic large cell lymphoma [5].

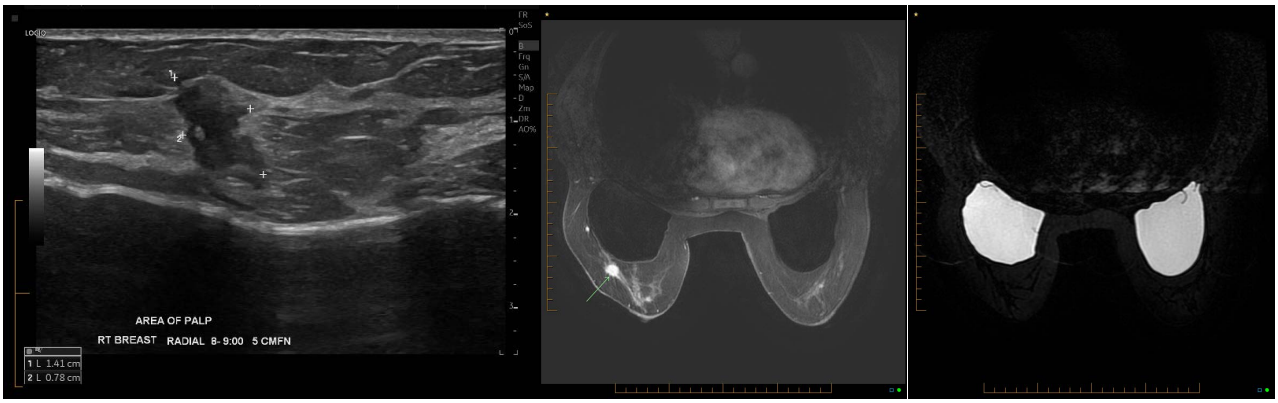
2. Case Presentation

A 72-year-old female presented with a complaint of a clinically palpable mass in the right breast. Sonography revealed a solid 1.4 cm angular mass in the right breast along the 8:00 axis, suspicious for malignancy (**Figure 1(a)**). She proceeded to percutaneous ultrasound-guided biopsy of the mass, revealing invasive ductal carcinoma, and was referred to a breast surgeon for treatment planning.

The patient had undergone bilateral breast augmentation 35 years previously, with placement of a single lumen non-textured BI into the subglandular space, anterior to the pectoralis. The BI, at the time of cancer diagnosis, demonstrated thick calcified fibrous encapsulation but appeared intact.

Preoperative gadolinium-enhanced breast MRI revealed a 1.4 cm homogenously avidly enhancing mass in the lateral right breast, located less than 1 cm from the implant capsule, but without evidence of invasion or adherence to the implant (**Figure 1(b)**). Silicone-sensitive water saturation sequences showed the underlying BI to be intact (**Figure 1(c)**).

There was no clinical or imaging evidence of multicentric or contralateral

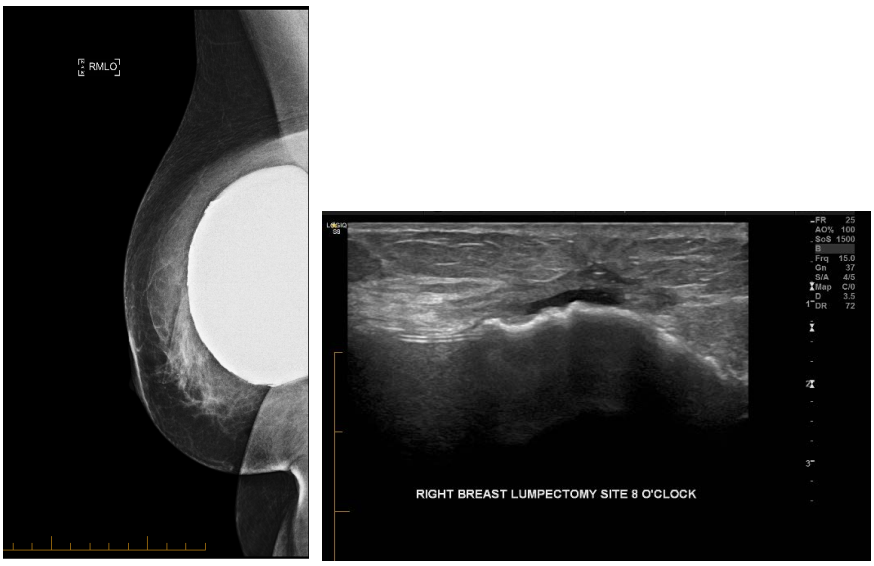


(a) (b) (c)

Figure 1. (a) Sonography of the right breast demonstrates a 1.4 cm angular lobulated solid mass at the 8:00 position, suspicious for carcinoma. The mass appears in close proximity to the underlying intact silicone implant, but no evidence of capsular invasion is seen. (b) Gadolinium-enhanced non-subtracted axial VIBRANT image shows a 1.4 cm avidly enhancing mass (arrow) in the 8:00 position representing a known carcinoma. Although the mass is located within 5 mm of the implant capsule, no capsular invasion is seen. (c) Axial silicone-sensitive (inversion recovery water saturated) sequences, performed pre-operatively for implant evaluation, confirm both prepectoral, single lumen implants to be intact. There are smooth contours, a symmetric shape, and normal radial folds. No intracapsular rupture or extracapsular free silicone is seen.

disease, and the patient thus underwent right breast conservation therapy, with surgical lumpectomy and sentinel node dissection. Pathology revealed grade II invasive ductal carcinoma, estrogen receptor 95%, progesterone receptor 60%, HER2 negative, and FISH negative. Maximal lesion diameter was 2.4 cm, with >5 mm clear margins, and sentinel nodes were negative for metastatic involvement. She underwent 10 treatments of external beam radiation therapy without significant side effects or complications. Recovery was uneventful, and the patient resumed normal daily activities.

Eighteen months following cancer treatment, routine surveillance mammography (**Figure 2(a)**) and sonography (**Figure 2(b)**) demonstrated no evidence of disease recurrence. The BI again showed thick fibrous calcified encapsulation, but no rupture or interval change.



(a) (b)

Figure 2. (a) Single MLO mammographic projection of the right breast, 18 months following lumpectomy, shows no evidence of cancer recurrence. There is thick capsular calcification of the implant periphery, as was seen pre-operatively. (b) Sonography performed 18 months post-lumpectomy shows a typical trace seroma in the lumpectomy bed, and thick capsular calcification, but no evidence of recurrence or implant rupture.

Two years after her original cancer diagnosis, the patient experienced right breast pain and swelling, which she noticed while traveling and lifting heavy suitcases repeatedly. The symptoms did not subside after several days, and the patient therefore presented to the emergency department. At presentation, she was afebrile and did not appear in acute distress. A malleable fluctuant 3cm lump was palpable along the lateral right breast, however, in the vicinity of her prior malignant lumpectomy. An approximately 5 cm area of dermal erythema was evident, overlying the palpable lump. Bloodwork was not performed. Enhanced CT chest performed in the emergency room showed a 3.5 cm complex fluid collection in the lateral right breast, interposed between the breast implant and overlying skin

(Figure 3). Hazy stranding of the surrounding fat, throughout the lateral and anterior breast, and thickening of the overlying skin, was also observed, consistent with either cellulitis or noninfected regional inflammation. The emergency physician felt the clinical picture could represent inflammation and hematoma due to trauma while traveling, or an evolving cellulitis developing into an abscess. She was therefore placed on oral doxycycline empirically and instructed to follow up with her surgeon in the outpatient clinic.

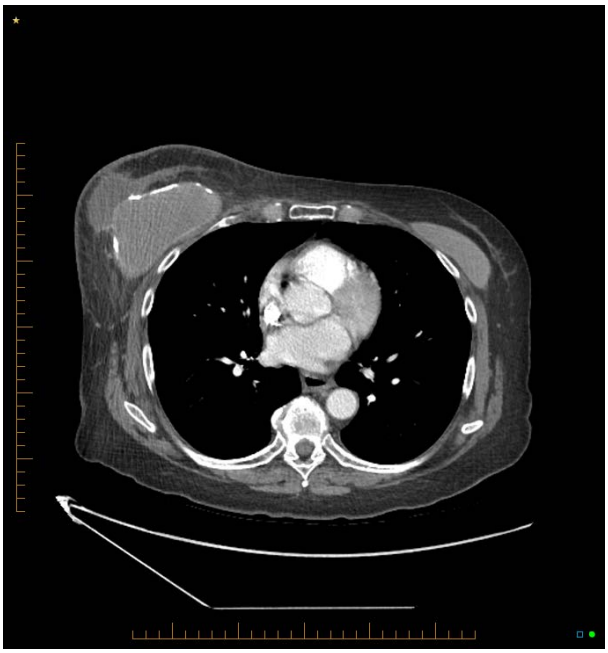


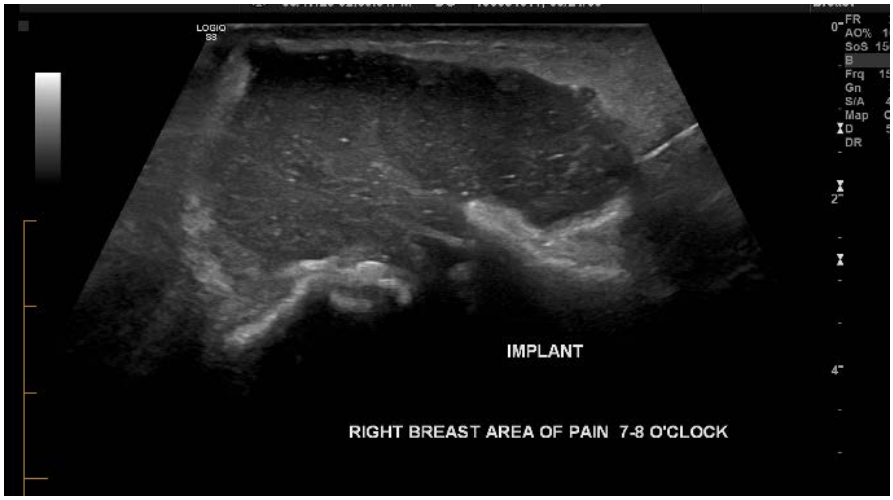
Figure 3. Axial contrast-enhanced CT image demonstrates a 3.5 cm fluid collection in the right breast, overlying and contiguous with the underlying implant. Haziness of the surrounding fat and thickening of the overlying skin are also observed, consistent with regional inflammation.

The patient was evaluated the following week in the surgery clinic and reported no improvement on five days of doxycycline. Her antimicrobial was therefore changed empirically to amoxicillin/clavulanate, and an ultrasound was ordered.

Sonography of the right breast, performed 10 days following her symptomatic presentation, revealed a complex 3.5 cm fluid collection contiguous with the implant capsule, and extending to the overlying thickened skin (Figure 4), corresponding to findings on CT. Swirling internal echoes were evident in the collection, and the patient was experiencing pain, skin changes, and findings suspicious for infection; aspiration of the collection was therefore recommended. Differential diagnosis was felt to include infection/abscess, implant rupture, or anaplastic large cell lymphoma (ALCL).

Ultrasound-guided needle aspiration of the collection yielded cloudy yellowish fluid, without frank blood, and without syrupy silicone-type consistency. The fluid was sent to pathology for cytologic analysis, revealing no malignant or atypical cells, but the presence of many polymorphonuclear leukocytes, and heavy

growth of Staphylococcus Aureus, susceptible to both amoxicillin and doxycycline. Cytology showed no evidence of ALCL or recurrent breast carcinoma.



,

Figure 4. Sonography of the right breast demonstrates a 3.5 cm complex fluid collection interposed between the underlying implant and the skin. There are swirling internal echoes within the collection, in keeping with debris, but no snowstorm-type shadowing is seen to specifically suggest free silicone.

The patient was followed for an additional 4 weeks in the surgery clinic. During this time, she completed an additional 10-day course of amoxicillin-clavulanate, and her symptoms gradually improved. She continued to complain of flaking and residual erythema at the skin, and stated a small opening at the skin, at the site of aspiration was failing to heal completely, despite six full weeks of treatment following her initial symptomatic presentation.

She also described a small, angular palpable structure emanating from within the wound, which slowly seemed to migrate closer to the skin surface, week by week, by her description. Surgical exploration was considered, but because she was otherwise doing well, conservative follow-up was instead elected.

Eleven weeks following initial presentation, the patient gripped the edge of this firm, angular structure within the wound, utilizing a clothespin-shaped device (a "chip-clip", by the patient's own words), while sitting at her own kitchen table, and pulled firmly. With one strong tug, a rush of syrupy sticky silicone-like fluid was ejected, and the entirety of the implant shell was removed in one piece. She photographed the shell for documentation and contacted her plastic surgeon for follow-up. She was seen immediately by her plastic surgeon, who determined the implant shell had been removed entirely, did not require further exploration or debridement, and felt the small remaining wound should be left to heal with secondary intention. A complete capsulectomy was felt unnecessary, and no further procedures were performed. The patient was referred to an outpatient wound clinic.

Serendipitously, after removal of the implant, her wound rapidly healed fully,

and within one month the patient became asymptomatic, back to her clinical baseline.

Six months following presentation, the patient returned for asymptomatic surveillance mammography (Figure 5) and sonography, showing a portion of retained calcified capsule within the breast, but no evidence of disease recurrence or recurrent fluid collection.

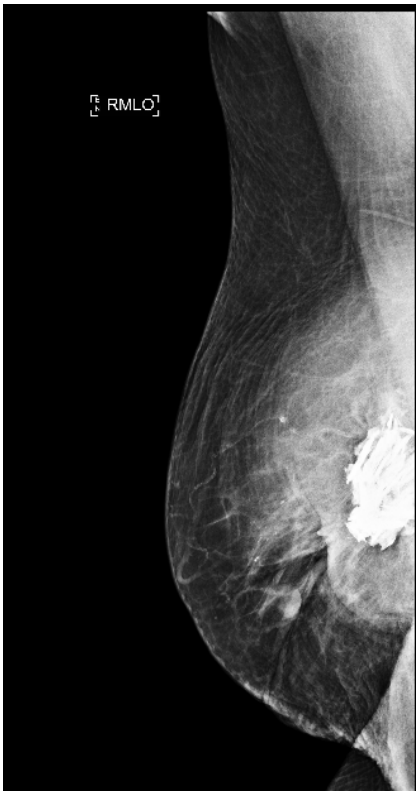


Figure 5. Single MLO mammographic projection of the right breast, performed 3 years following lumpectomy, and 9 months following self-explantation, shows coarse calcification in the central breast consistent with the retained portion of the calcified implant capsule. No findings were seen by mammography or sonography to suggest cancer recurrence.

3. Discussion

Explantation of BI is a common surgical procedure, most often performed by plastic surgeons, and most often precipitated by clinically symptomatic encapsulation or rupture of the prostheses [2]. Elective removal of intact BI has also become more common recently, due to lay media coverage and increasing recognition of breast implant-related illness as a clinical entity. This illness, previously a controversial diagnosis, encompasses a complex constellation of neuromuscular, cognitive, immunologic, and generalized systemic complaints, which are felt potentially mediated by immunologic response to the implant shell, silicone, heavy metals, or biofilms on the implant [4]. Finally, some patients have been more recently electing explantation of longstanding BI due to risk of a rare malignancy—anaplastic large cell lymphoma—which can arise within the fibrous capsule of longstanding

implants, particularly textured implants [5]. In any of these cases, however, explantation is performed in a surgical facility, by trained specialists, utilizing sterile instruments. Under these conditions, patients invariably do well, and the procedure is typically uneventful, with rapid recovery.

Spontaneous extrusion of BI is considered a rare event, occurring more than 1 year post augmentation. Indeed, a case report of this phenomenon in 2008 described only two prior cases in the medical literature [6].

In this case, our patient developed a complex fluid collection and signs of potential infection following equivocal trauma to the chest. Aspiration confirmed both bacteria and inflammatory cells, but a wound developed, indicative of ongoing inflammation, which did not clear with conservative treatment. Admittedly, the patient did not undergo an MRI at this stage to evaluate implant integrity, and it is therefore difficult to exclude that potentially trauma led to implant rupture, which led to localized inflammation, and subsequent superinfection. However, sonography did not show classic snowstorm-type features, indicating extracapsular free silicone, and the aspirate did not appear grossly sticky or silicone-like, and no silicone was reported in the cytology report.

Given the extreme age of the patient's implants, exceeding 35 years, and their chronically encapsulated nature at the time of breast conservation therapy, she was likely at risk for implant rupture prior to lumpectomy. Nonetheless, she tolerated surgery and radiation without mammographic or sonographic evidence of rupture at her 18-month post-lumpectomy follow-up. It seems quite plausible, however, that the combination of advanced implant age, chronic fibrous encapsulation, and superimposed surgery and radiation eventually contributed to soft tissue breakdown, capsular weakness, and ultimately implant extrusion.

Regardless of whether her clinical process reflected infection alone or rather infection superimposed onto trauma-induced implant rupture, the eventual outcome was the same. The inflammation did not resolve despite conservative therapy and antibiotic treatment, and the underlying calcified implant capsule began to gradually protrude closer to the skin surface. Eventually, the capsule edge apparently became visible and symptomatic, and the patient elected to attempt removal of the structure herself. And whether a pre-existing rupture may or may not have been present, the patient's self-intervention effectively led to a decompression and evacuation of silicone from the intracapsular space. The implant shell was removed, and any potential reservoir for ongoing inflammation or infection was apparently flushed out. Her symptoms resolved, and her wound completely healed.

It is limiting, for the purposes of this report, that the plastic surgeon decided against performing a full capsulectomy, as pathological analysis of the retained capsule might have provided additional insights as to the definitive etiology for the phenomena. It is also unfortunate that no MRI was performed during her symptomatic course to definitively confirm or exclude implant rupture prior to the self-explantation.

The case is interesting from several perspectives. Firstly, it is remarkable to recognize that an explantation, performed at home under nonsterile conditions, could be inadvertently successful and not lead to compounding complications. In fact, in this case, the self-explantation is what finally led to the resolution of the patient's symptoms.

Secondly, it is interesting to speculate on what might have progressed had the patient not actively pulled out her implant. The sequence of events might suggest that the underlying implant, either due to infection, rupture, or a combination of both, may have been in the process of undergoing auto-explantation through the open wound. Had she not pulled on the capsule aggressively, it is certainly plausible that silicone may have eventually begun self-extruding through some rent or defect in the chronically fibrotic capsule.

In any event, it may be valuable for surgeons, radiologists, and primary providers to be aware of this potential implant-related phenomenon, following trauma or infection, in patients with longstanding implants. Specifically, recognition that acute inflammatory symptomatology, even occurring late following surgical intervention, could indicate infection, BI rupture, or a combination of both. A persistent nonhealing wound, particularly with a firm, angular structure abutting the skin, could reflect a harbinger of a migrating implant capsule or even imminent spontaneous implant extrusion.

Patient Consent

The patient provided oral and written consent for inclusion of her history and anonymized images for this publication.

Authors' Contributions

All authors have contributed to and approved the final version of this manuscript.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

References

[1] Jalalabadi, F., Doval, A.F., Neese, V., Andrews, E. and Spiegel, A.J. (2021) Breast Implant Utilization Trends in USA versus Europe and the Impact of BIA-ALCL Publications. *Plastic and Reconstructive Surgery—Global Open*, **9**, e3449. https://doi.org/10.1097/gox.0000000000003449

[2] Perrotta, R.E., Ronsivalle, V., Minervini, G. and Cicciù, M. (2025) Incidence of Long-Term Complications in Breast Implant "Prosthesis": A Systematic Review. *Prosthesis*, **7**, Article 38. https://doi.org/10.3390/prosthesis7020038

[3] Pittet, B., Montandon, D. and Pittet, D. (2005) Infection in Breast Implants. *Lancet*, **5**, 94-106.

[4] Ferreira, S., Barros, A.S. and Marques, M. (2025) Breast Implant Illness: Symptoms, Outcomes with Explantation and Potential Etiologies—A Systematic Review and Meta-Analysis. *Aesthetic Plastic Surgery*, **49**, 6600-6620.

https://doi.org/10.1007/s00266-025-05142-x

[5] Elameen, A.M., AlMarakby, M.A., Atta, T.I. and Dahy, A.A. (2024) The Risk of Breast Implant-Associated Anaplastic Large Cell Lymphoma; A Systematic Review and Meta-Analysis. *Aesthetic Plastic Surgery*, **48**, 5315-5328. https://doi.org/10.1007/s00266-024-03956-9

[6] Jabor, M.A. and Harley, D.H. (2008) Late Implant Extrusion after Transaxillary Breast Augmentation in a Healthy Patient. *Plastic and Reconstructive Surgery*, **121**, 345e-346e. https://doi.org/10.1097/prs.0b013e31816b11b8