How Breast Implants Compromise Your Health and Make You Sick – Rob Whitfield, M.D. – #1043

Dave Asprey:

You're listening to The Human Upgrade with Dave Asprey. Today's interview is an in-person interview in Austin, Texas. Today, we're going to talk about something that I think you need to know about because either you may have breast implants or people in your life do, and it's not really clear to understand why you're having some strange symptom and how it could possibly be connected to your breasts. What I thought I'd do is I'd find a top expert in the country on breast implants and that we'd have a real serious conversation about it. Dr. Rob Whitfield is here on the show, and he's done a lot of breast implants. You've put them in.

Robert Whitfield, M.D.:

Yes.

Dave:

And you've taken probably more out than you've put in?

Rob:

By far, yes.

Dave:

All right. Most people who put breast implants into women will tell you on penalty of death, breast implants are harmless. But at some point, you must have had a wake-up call to figure out that this wasn't working. What was your wake-up call? You must have had a wake-up call to figure out that this wasn't working. What was your wake-up call?

Rob:

Right. My background is mostly in oncology reconstruction. My intent through training both in surgery, plastic surgery and microsurgery, was to provide patients with procedures that would salvage and protect them through a cancer journey. Predominantly, breast cancer's a very prevalent cancer, so we were involved with cancer reconstruction. One of the tools you utilize in cancer reconstruction is a breast implant. If you're doing a sarcoma reconstruction and they remove part of your tibia, you use a tibial implant. Whether it's a knee, a hip, a breast, a dental implant, a neural spinal implant, a defibrillator, I've helped every single provider take care of their implant problems.

There's not an implant that's devoid of a problem because it's a foreign body. When you put it into somebody, your body immediately reacts to that and creates a capsule around, a scar because it doesn't want that in your body. Everybody has an immunologic response to it. I get asked a lot like, how many breast implants did I put in, which is something you're alluding to. For oncologic reconstruction, the dominant method of reconstruction in the United States is a breast implant. It's a small number of women who actually get reconstruction. The reason it's so prevalent is in any community, if the plastic surgeons in those communities are basically trained, they can provide that service for the client.

My specific niche was microsurgery. I would do nerve and muscle-sparing procedures to take skin and fat from the abdomen, inner thigh, even upper buttock tissue, and transport that to the chest and hook that up via microsurgery using the blood vessels that the cardiac surgeons used to revascularize the heart.

Dave:

A little bit different than sticking some [inaudible 00:03:39]

Rob:

Right. For me, I didn't put in a large number of implants. I took a large number out. When I look back at my experience, I was taking care of folks with this problem without knowing I was taking care of folks with this problem. Somebody would show up with a red chest, a tight band feeling across their chest, a capsular contracture, very firm implant. I knew, I'm like, well, if I just take that out and I take all the scar out and I put their own tissue there, then it's autologous. It'll heal.

Dave:

It'll work. All right.

Rob:

Moving forward, in 2016, I had a breast cancer patient who relocated from Georgia to retire here in Austin on the lake. She came to me and said, "I want my reconstruction taken down, Dr. Whitfield." I said, okay. There was no specific reason. She just wanted to be flat. She was tired of having a reconstruction. She had had one forever, 20 some years. She had no real physical findings on examination. Her history was otherwise consistent with a breast cancer survivor. Her laboratory analysis, which we'll talk about later, just revealed basically nothing.

Dave:

She was healthy?

Rob:

Yeah. One complaint, bad fatigue.

Dave:

Oh, okay, so she wasn't healthy. People who are tired aren't healthy unless it's because they didn't sleep or they ate crap.

Rob:

But the predominant thinking, Dave, is if you had cancer and you were treated with poison to cure your cancer and you had bone marrow suppression, that explains your fatigue. I was in that lane. That's what I saw.

Dave:

That's what you believed.

Rob:

I took her to the operating room. There's one caveat. She asked me to do something I'd never been asked before by a patient. She said, "Can you take out my implants en bloc?" For the audience, en bloc is a term used in pathology. It’s tumor extirpation or removal is done en bloc. Say for a sarcoma or any cancer, you want to be around it, not in it.

Dave:

She wanted you to take the tissue around the capsule?

Rob:

The scar capsule and the implant together. When I talk about it, I say it's like taking things out in an undisturbed manner, like not breaking the Easter egg.

Dave:

The Easter egg, just for listeners, you have the silicone or whatever, the bag of fluid is made out of, the implant, and then you have a scar capsule around it that your body made. You could take out just the implant and leave the scar.

Rob:

Correct.

Dave:

Okay, good deals. En bloc meant removing the scar tissue and the balloon.

Rob:

En bloc versus total versus partial capsulectomies. I mean, I had done cancer surgeries with my colleagues and on our own and reconstructed. This was not a big thing for me to do, and so I did it that way.

Dave:

But how dare you do what your patient wanted? I mean, aren't you the doctor?

Rob:

Well, I think it was just one of those things where I was like... I've always been intellectually curious, and I didn't make a big deal about her asking me that. I said, "Well, I take them out that way basically anyway. Yeah, it's fine. There's some nuances to it, but yeah, of course."

Dave:

Why did she want that?

Rob:

She didn't allude to that at the time. She did not tell me anything. I was like, okay. I took her to the operating room. She had to be monitored overnight for a separate medical condition. Her case was done in the hospital, which predominantly I don't use hospitals. I use surgery centers. I took her to the operating room. Each oncology take down for reconstruction proceeds for me the same way. Of course, I'm trying to do everything and take it out intact. Because if they're going to have a cancer recurrence, it's usually at the scar in a breast cancer case or the tissue associated with the scar underneath it.

You excise the scar. You take it out altogether. When it comes out and the pathologist looks at it, they can actually make sure that everything is in order. And also, you take cultures of the area when you remove it, because as we all know, implants are foreign and they can become infected, frankly infected

or contaminated with biofilm. I take everything out. On her one week follow-up, I see her and she's doing very well. We're going through the pathology. There's no evidence of recurrent cancer, which is obviously great. And then I look at her microbiology report, and she has an E. coli infection. Not a smattering of E. coli, a true infection.

Dave:

A medical crap load.

Rob:

Just so the audience knows for a hospital to identify that, there is greater than 10 to the fifth or 100,000 bacteria in that sample. I was pretty taken aback by that. I had missed a breast implant infection. I hadn't missed a small amount of contamination. I had missed an entire occult infection. That really bothered me. I went back through all the notes and I talked to my team. I was like, what is going on here? Because it was done in a hospital, as you know, they'll create an antibiotic sensitivity profile for it. As tradition, I followed that profile. I put her on antibiotics. And what do you know? Magically her fatigue was all better in a month.

Dave:

You mean chronic infections anywhere in the body make people feel tired and have all sorts of unpredicted things when bacteria make bacterial toxins and circulate them around in your body?

Rob:

Yeah, it was pretty shocking. I think we're all basically collections of experiences, and this one shaped how I practiced moving forward.

Dave:

What made her want to get it taken out this way? She had to have some secret knowledge, or she was psychic.

Rob:

Well, she didn't really ever allude to this, but shortly thereafter, my office started getting calls from patients requiring explants. They're like, "You have all these people wanting this now." She put me on some Facebook group.

Dave:

She was probably an early advocate for breast implant illness.

Rob:

She didn't call it that, because this was 2016. People who do well don't wander back to see you. She just went about her way. And all of a sudden, I just had people coming, calling. Not tons of initially, but because I would do it this way and what's becoming the vernacular on bloc, which is it's not a term that's frequently going to be used, but that's what's posted on these message boards and they identified surgeons. And then I started having people come. I left my group practice, went into solo practice, this became more and more the theme. I still did oncologic reconstruction.

I would take care of breast implant problems, meaning that if you had a capsular contracture, if you had a poorly positioned breast reconstruction or a cosmetic one that had been revised multiple times, because of all my experience using techniques for cancer patients, I would correct those. Just so that everybody listening understands, those all will ultimately fail. It doesn't really matter how good I am. You can spend all day pat yourself on the back, because eventually that device over its lifetime, there will be a problem with it. My wife came and asked me for breast implants and I was like no.

Well, first of all, it's not my aesthetic. I don't think big boobs are the thing. But second of all, if you can't avoid foreign bodies of any nature, then I don't feel like that's a bad thing for your biome. I think as much as we can take care of ourselves through improvements whether it's our diet, supplements, sleep, many of the things you ascribe to, implants don't really fall into those as categories. We just kept rolling along doing these cases. In Q4 of '18, I had an ICU nurse travel from Louisiana. Her sister lived in Austin. She wanted me to do her explant, and I did her explant. It was the nastiest set of implants I had ever taken out.

I take everything out. Hers went according to plan. No disruption in the capsule at all. Took it all out, put it on the back table, got everything. At that point, I used to use drains, and we'll explain why I don't anymore, but got her closed, wrapped up. I opened these things on the back table, and I think many providers confuse gel bleed for biofilm.

Dave:

They're saying that the gel is coming out of the thing, but it's not. It's actually growing on it?

Rob:

You know what biofilm is. It's basically a polysaccharide and it's gooey. When people feel it, and I see them on YouTube or IG going, "This is gel bleed," I'm like, no, that's biofilm.

Dave:

It's basically a bacterial slime, kind of snotty, right?

Rob:

Yes. You know, and your audience should know, when you do the traditional culture swab technique on biofilm, you will not find out what is there. The bacteria has purposefully created that biofilm to avoid detection by your body and by the techniques we use.

Dave:

You know what, it's like some people have thought about the lining of the gut. If you think about it, you have the gut and you have a layer of mucus. The mucus is put there by your body so that you don't digest your own gut, basically. You need to have that slimy layer that's there and the bacteria's behind that layer.

Rob:

This is the second thing that changed how I practice. One, I never assumed anybody with an implant didn't have an occult infection.

Dave:

Everyone has that.

Rob:

When I got that symptom pattern, which as we talked about earlier, doctors, they're trained to recognize patterns. One of the problems with breast implant illness is it does not fit a pattern of recognition for the doctor.

Dave:

It's a lot like toxic mold because the symptoms, there's so many, and you might have eight out of 50 possible symptoms. Those are the things that seems like modern medicine is designed to fail at.

Rob:

And because they commonly happen at the same time in the same patient, it's even more confusing.

Dave:

Well, that means it's hypochondria, because if you have eight symptoms all at the same time. They teach you that in medical school, do they not?

Rob:

This gal, this is an ICU nurse. When I used to get a medical provider coming to me, this lady worked in the ICU for years, I'm like, God knows what kind of biofilm she has. She's colonized with everything. Everything. Every antibiotic resistant bacteria you can think of, this person would have. Had I used what tech I use now, I would've really had some insight. But back then, I was using CLIA based lab testing, which is taking a swab, like a Q-tip, wiping it in the pocket, sending it to the lab in a container. They incubate it, which has been done for 100 years basically, hasn't changed. You'll get a report kick back if in fact there's something to kick back.

Dave:

If there's something that will grow on the media that they're using it with. What that means for testing, imagine that if you lived on steak and they wanted to see if you existed and they gave you Impossible Burgers, you wouldn't exist because you couldn't eat Impossible Burgers because they're not food. It's one of those things. You have to have the right food for the right bacteria. One of the things, even if you swab something that's unusual, it may not grow in the lab test. You're just saying that universally you're seeing bacteria, but what about yeast and fungus? Are those major players too growing on implants?

Rob:

Oh, we're going to get to that, because that's an internet sensation thing. I go out to the husband, I say, "Look, she's going to do better." I go out to the husband, I say, "Look, she's going to do better. These are clearly infected, and I just need to wait for the results to come back." I'm going back to my 2016 experience. I'm going to find some god awful bacteria from the ICU, multi-drug resistant, da, da, da, da, da, da. Comes back normal. Now I'm just pissed.

Dave:

She was really sick?

Rob:

Yeah. If someone's infected, just so the audience understands this, back when I used to drain people, which I don't do now, the drain tube in this patient was putting out over 200 ccs of pure fluid a day per side.

Dave:

That's a lot of fluid going through this.

Rob:

Which means it's an infection. I didn't do anything back then other than use antibiotic solution to cleanse a pocket and put a drain tube in, because that was my teaching, my learning from oncology reconstruction. Concordantly with this, I was in the leadership position in the Aesthetic Society's Research Education Foundation, and ALCL had come to fore, which is anaplastic large cell lymphoma. It's closely associated with textured breast implants. I had never used textured breast implants in cosmetics at all. I had used them in reconstruction, because the intent for them in a reconstructive case was to prevent malposition and rotation.

Dissent up or down, medial lateral or by degrees of change because you're using shaped implants typically in a reconstructive case. This happened. The reports came out. I discontinued use right away. As an early adopter of that practice, not knowing what was actually going on with textured implants and breast implant associated large cell lymphoma. There were reports with that early on about a particular bacteria, rickettsia, and I knew the company that had done those with quantitative PCR. I got in touch with that company who happens to be in Lubbock, Texas, MicroGenDX. I said, "I want to negotiate a rate to send all of my samples to you."

Dave:

You found a new way of doing testing.

Rob:

They do quantitative PCR. For everybody listening, quantitative PCR is a research tool that's now become commercially available to take a DNA fragment and amplify it. If there's one copy...

Dave:

It's cool, because with PCR testing, if you just amplify it enough times, you can find anything you want, right?

Rob:

No. It has to be there. It has to be there. They run it, the table they run for me specifically is 150 bacteria, fungus, and a mycobacteria.

Dave:

Oh, and mycobacteria. Can you say what a mycobacteria is for listeners? It's something that a lot of people don't know about. You can say, "Dave, I don't care." Trust me, you care.

Rob:

Mycobacterium in plastic surgery is a very bad actor.

Dave:

And in dental health, right?

Rob:

Yeah. We'll talk about how I do fat transfers later, but every year somewhere where sterilization techniques are not meeting standards, there's a mycobacterium outbreak. It may happen in a few patients before it's caught, but it is definitely a bad actor in plastic surgery, in immunosuppressed patients. If everybody remembers from the AIDS crisis, mycobacterium avium was a big problem in patients with AIDS. But mycobacterium in a plastic surgery patient means to me they're significantly immunosuppressed or it's transplanted there through contamination.

Dave:

The immunosuppression can happen because of what's in the breast implant illness itself, the things that are in there, or toxic mold in your environment is immunosuppressant. I used to have a suppressed immunity. All sorts of stuff will grow during that, and then this stuff takes advantage of it.

Rob:

Yeah, it's an opportunistic infection. You have to have suppression in order to have this be a problem. I wanted to make sure that all of my samples, my client samples, were being looked at completely, both for cancer and through a microbiology lens, because you cannot have something that affects someone's long-term health by doing what I did in 2016, which miss an occult infection. I certainly don't ever want to miss a cancer. That is technically, I do the operation the same way all the time in terms of I'm trying to take it out like an undisturbed Easter egg.

We send this off to pathology. We send this off for quantitative PCR analysis. We know exactly what's going on with each of our clients. They have that peace of mind that I'm going to make sure and do it the right way every single time and get them this information. There is no question at a month, three months, three years, did I do this and is it gone? That spurned me doing this. From Valentine's Day 2019 to present, that's how everything is done when I treat a patient.

Dave:

Wow. You really test for all these things. The reason that I wanted to have you on the show today is when I sat down and talked with you a couple months ago, I was just impressed, number one, that you listen to your patients in a way that a lot of physicians don't. Many people, when I go to see the doctor, many doctors would say, "I don't believe you because you can't have all this stuff going on." Your ability to listen was really strong. But also, just over the last five or so years, it seems like you've unpacked the problem in a way that's really changed how a lot of people think about it.

I would consider you to be one of our top experts in the illness around what's happening in the breast implants, what's going on in the body. You do some things that are pretty unusual from what I've seen. For instance, you'll do an EEG, the same kind of stuff I do at 40 years in, like a brainwave test of people with breast implants. That is so abnormal for a surgeon that I would just call your doctor abnormal, but I'm pretty sure that's already been said, right?

Rob:

Yeah. I've been called a lot of things. That's not even that new, honestly.

Dave:

Right. EEG for breast implant illness, what do you find in the brains of women with breast implant illness?

Rob:

I was upset when I would hear people be critical of the patients by saying, "What the hell is brain fog?"

Dave:

It's so real.

Rob:

When someone from the client side said this to me for the first time, I said, okay, so I just need to understand exactly what that means to you. What is that? What are you describing to me? They said, "Well, I have trouble remembering my kid's name."

Dave:

God, I remember that.

Rob:

And then they said, "I can't find my keys sometimes." I'm like, "Well, okay, that's short-term memory loss." To me as a provider, if you say short-term memory loss, I understand that. I don't know what the hell brain fog is. I understand it from the client side now, but back then I was like, oh, so it's just short-term memory loss.

Dave:

Short-term memory loss plus a lack of energy. You have to summon the effort to think of something that should just come automatically is also part of it and short term memory loss. At least that's how I would've described it.

Rob:

It was actually you who convinced me to do EEGs.

Dave:

Was it really? Oh, that's amazing.

Rob:

I was listening to the show and you described WAVi Medical.

Dave:

Yeah, they've been on the show. Guys, if you're new to the show, a lot of doctors do listen to it. Thanks for being a listener. I didn't actually know this part. WAVi, we did an interview a while ago about brain speeds. If you read my new book, Smarter Not Harder, I talk about one of the measures that they take as proof that there's an operating system in your body. That's a little side note about WAVi. You learned about EEG on the show?

Rob:

I sent an inquiry to WAVi and Austin, who lives in Austin, he recognized my address because his family used to live right there. He called me on Sunday in the office and we talked. I explained to him what I was interested in by acquiring WAVi to look at my patients who have brain fog.

Dave:

WAVi is an EEG system designed to basically do a basic brain health setup or checkup.

Rob:

WAVi has a wonderful program. They have an IRB, an Institutional Review Board, approved study. My clients who are willing to participate sign the study consent form, and we're able to include them. We try to do an EEG pre-op, a week post-op, a month, and three months. Their scientists are looking at the data and they have identified changes in latency. I think for us, I want to provide as much data and science that we can apply to this problem. It's not viewed as it's in someone's head. It's not viewed as hypochondriac or anything of that nature. I feel like whatever we can do to help the women who have this issue, I feel like that's... I don't charge anybody to do this. I have this as part of my program.

Dave:

Do they have brain fog? What do you see?

Rob:

We're doing it across the board, and there are changes in, as you would imagine, voltage. There's a little decrease. We don't have enough accrued yet to make strong claims, but the scientist is comfortable with what we're giving them and their reviewing.

Dave:

Okay, got it. The results aren't in. Guys, brain voltage, what? Your brain has electricity in it. That's what EEG is based on. It's one of the things that when you do the 40 Years of Zen training in Seattle on the last couple days, we actually train you to increase voltage in your brain, but you can only do that if you have the right minerals, you have the right building blocks, and you have enough energy production in the brain. If all of the things are lined up to allow you to do it, then you need the brain to want to do it.

When you set all that up, you can actually improve your own voltage if that's a tuning of your brain that's the right one for your performance. Most people when you say brain voltage, it's like, "What? You mean I could have a battery pack in my Tesla or something?" Kind of, yeah. You can have a faster, hotter spark in the brain. You're finding that people with breast implant illness have just lower...

Rob:

They have changes. Yeah, they have changes. As you would imagine, as you've alluded to on your show many, many times, having toxic mold exposures, when you deal with the folks who have mold and breast implant illness, they have a lot of neural inflammation. When you look at their genetics or their food sensitivities or their hormones or their GI-MAP or their toxicity report, which we'll get to shortly, it paints a really good picture of why they have so much chronic inflammation and why the doctors who are trying to care for them have zero understanding of what is going on.

One, because the actual tools, and you've mentioned on the show, the CRP and SED rate, are these traditional tools used to look at inflammation. In my patients, because I've looked at lp-PA2, IL6, CRP, SED rates, they do not show that.

Dave:

We're going to pause for a second there. He's looked at all the inflammatory markers that you would expect, and they didn't work. Sorry, keep going.

Rob:

Exactly. These are the traditional markers that have been mentioned both by Dave on his show and we've looked at, and they do not track with this patient population.

Dave:

What that means is that when you have breast implant illness, the markers don't change to show inflammation?

Rob:

No.

Dave:

So then people say, "Well, on a lab test, you don't have inflammation. Therefore, you're making it up. Therefore, you're crazy."

Rob:

Last year, a company was brought to me at a meeting at the Mindshare Collaborative, who has a novel biomarker for inflammation.

Dave:

This is JJ Virgin's group. JJ's been on the show. She's a close friend. See how this works? There's almost a community of biohackers working all over the world to make things better. All right, keep going.

Rob:

Well, had I not went to that a couple years ago, I wouldn't be where I'm now, because the collaboration of that group is strong. When people know what I do, they find other people to help me do a better job. They brought this company to me, which I had no idea existed. Basically they had been treating their clients that had COVID with this... Not treating the client, checking inflammation on patients with COVID, because they were trying to find a way to follow the inflammation that exists after COVID, which as you've explained on your show many times, a big cytokine release. Poor genetics will give you a lot of problems with COVID.

Basically it's a urine study that looks at metabolism on thromboxane A2. I was like, okay, sure, send it to us. We started doing it. I have the tiniest gal in my practice whose wonderful, eats a great diet, takes best supplements, has out of control blood pressure, breast implants, all the symptoms. I had to put her on blood pressure medicine, because her doctors couldn't get her blood pressure down. Traditional medicines and diuretics or ACE inhibitors, sometimes newer doesn't mean better. I put her on something old, centrally acting clonidine, and lowered her blood pressure and did her surgery.

Her brain fog has lifted. She feels kind of like herself again. She still has problems with hypertension, but she had the highest chronic inflammatory tests before surgery I've ever had. It's called the chronic inflammatory test.

Dave:

Nice.

Rob:

I mean, I've got a lot of companies who they're wonderful, but names are...

Dave:

Got it. There's all kinds of...

Rob:

Right. This test now we use routinely to follow, and I know it works. Because if you put someone on my program before surgery, it drops before surgery.

Dave:

Wow.

Rob:

We always talk about leveling up in business, but you can decrease your inflammation and level up prior to surgery.

Dave:

Got it. When you say put them on your program, what is the program?

Rob:

As everybody listening, this is six years of work of figuring out what mistakes I've made, what have I missed, what can I do to help this group?

Announcer:

You're listening to The Human Upgrade with Dave Asprey.

Rob:

This is six years of work of figuring out what mistakes I've made, what have I missed, what can I do to help this group of women? On your show, you've elaborated on gut health. I don't know how many episodes you've done just about the gut.

Dave:

I always think I'm done, and then they find something new. Like damn, another show on gut health, but okay.

Rob:

We linked your food sensitivity testing to your GI-MAP. We take what is going to cause you more inflammation from your diet and leak it to basically I think of it as what you're absorbing, what you're not getting. And then do you have leaky gut? Is your secretory IgA super high on your GI-MAP? As you know, if you can't absorb nutrients at all or you're limited, then your ability to recover is minimized. You're going to stay swollen longer. You're going to have fatigue longer. All things that nobody who's coming to my office wants.

How little can downtime be because they have a family and work. No scarring, painless. These are just a few things that are asked of me on a daily basis. Food sensitivity, GI-MAP. I really pay attention to hormones now. I think it's a really underserved area in this group, because women, perimenopausal, postmenopausal women, their hormones are changing. In particular, the hormone that we look at, specifically for me, is their testosterone. Estrogen will change and go down.

Progesterone changing, going down. But as those go down, testosterone just plummets. If your testosterone is super low, especially the bioavailable testosterone, your ability to recover and get from catabolism to anabolism and healing phase is severely limited. This has been shown in all sorts of studies over time. In surgery and as I cared for burn patients in training, this was hammered into us about the use of oxandrolone. We did a study on that in pediatric burn patients for wound healing.

I think I focus on that to make sure, once again, that we're enhancing the ability of the patient to recover. But as we talked about a little bit too, I have a large number of patients who fly from around the country to get fat transfers at the same time. Because when you take implants out, you're affecting the aesthetics and you may be able to do a lift, but revolumization provides less of a visual change and more of an enhancement to offset that change.

Dave:

Basically when you get the artificial stuff taken out, you can get fat from somewhere else in the body, put it in there, and you're still going to have breasts that look the way you want them to look.

Rob:

We're trying to make it as close as possible because it is a big psychological issue.

Dave:

It's okay to want to look the way you want to look.

Rob:

Absolutely.

Dave:

That's part of biohacking.

Rob:

You got breast implants for a reason. Obviously after doing oncology work for so long, I'm uniquely sensitive to what those problems are with image and trying to get the best possible results. I've done fat transfers since the '98 essentially. People will typically say that they can't execute them. They don't work as well. Just so for everybody in the audience, I'll explain what a fat transfer is, which a fat transfer has been done for over 100 years. You take fat from one location of the body, whether it's the love handle, the tummy, inner outer thigh, and you transfer it to another place.

Whether we're doing a breast enhancement or a buttock enhancement, fat goes where fat belongs, and that's in the subcutaneous layer of beneath the skin. It's not in the muscle in the butt transfers, and it's not in the breast in a transfer to the breast. If you put fat inside of a breast, you will get cyst formation, radiographic abnormalities. If you put it in the subcutaneous layer, which is underneath the skin, you will not have radiographic abnormalities, provided it all lives.

It will not confuse a radiologist trying to look for breast cancer and microcalcifications, which is often written about and is a misnomer. It's not going to be misconstrued for that. The cancer screening doesn't change. I've been doing it in cancer patients since 2002, for goodness's sake. Of course, we would never do anything that would affect the surveillance of a cancer patient.

Dave:

You're saying that if you inject fat in the skin around the breast, that you're not going to have problems with diagnosis later. But if you inject it directly into the tissues of the breast, I guess the glands?

Rob:

In the breast parenchyma, in the gland itself.

Dave:

Then you would have radiographic problems. That means that people...

Rob:

Which is common sense.

Dave:

It means you can't see if a person has breast cancer or not, because it's going to look like breast cancer, but it's just fat.

Rob:

Right. Fat transfers cannot cause breast cancer.

Dave:

But it just looks like it might be, so they freak out.

Rob:

Right. So everybody understands, they come from different cell lines. Breast cancer is an epithelial, the fat is muscleable. Fat can only transform into a sarcoma basically. A fluidity tumor as a breast tumor is super rare. Basically we're talking about things that don't happen.

Dave:

The fat transfer is safe because you're not going to get an immune reaction. You might get an infection, but not like a breast implant, just because if the procedure was done wrong, you'd get an infection. But once it's healed, you'd be fine.

Rob:

Correct. Super low complication rate. Super low.

Dave:

I've had fat taken out twice for stem cells, and I did not enjoy the liposuction. Both times I had it done with Dr. Harry Adelson. I mean, it's not suction to pull fat out like for cosmetics. It's about a coffee cup's worth of fat. They took it from my love handles. But it wasn't particularly comfortable to have it harvested. Probably the ease of slice a little bit, opening the breast, stuff a balloon in, and fill it up or whatever. I have no idea how it works.

Putting a breast implant in is much easier than pulling fat out via some mechanism from somewhere that hurts, and then putting the fat and purifying the fat and putting it back in. But that procedure, even though its more work, is safe. If someone wanted breast enhancement, that's what you'd recommend is a fat transfer.

Rob:

It's very safe and individualized to the patient. We'll have longevity, of course. We talk about maintenance of diet. We use higher protein diets, higher fat diets, in fact. Healthy fats, of course,

Dave:

Heaven forbid, healthier fat diet, how dare they?

Rob:

Right, especially me. I'm always causing a little trouble. But I think balancing that in conjunction with their hormones sets them up for success. If I were to do a breast dog on somebody in their 20s with that technique, a fat transfer, would it work? Well, yeah.

Dave:

Will it still work when they're 60?

Rob:

As they go through metabolic changes, they'll gain and lose according to their habits, their lifestyle, or their diet. But it's yours, right? It's autologous. It's not foreign, so you're not going to attack it.

Dave:

Assuming they don't go through rapid weight gain or weight loss. You have a healthy 24-year old that says, "I want bigger breasts," you do a fat transfer. And then if she maintains her within 10 or 20 pounds, her breasts are going to hold up over time.

Rob:

Yeah. Biologically it just makes sense. When I have the mom who had kids and skin's in good shape, not stretch marks, not a lot of sag, and she's like, "I just want more volume," well, that's what you do. Of course, it's going to have longevity, provided they're taking care of themselves.

Dave:

This seems like a safer alternative for women who want breast enhancement, but does it affect sensation? Because I know women with breast implants who've lost sensation or they lost sensation in their nipples after they had them taken out. If you do a fat transfer, are you going to have sensation problems?

Rob:

It should not create a sensation issue, because think of the nerve supply. There's nerves that terminate around the nipple complex and the superficial layer of the epidermis and dermis. The 12th nerve comes in from the side. When you place a device and rapidly expand and stretch it, you affect those nerves, particularly the 12th nerve. That is a common problem in patients who had large implants placed, very, very tight skin envelope, meaning maybe they haven't had kids, which is typical.

The rapid expansion creates too much stretch on those, and that causes, what you've described, an absence of sensation or loss of sensation. When I do their explant, I will find that nerve terminating into the capsule of the implant many times. They may have nerve pain. They may have absence sensation, as you've described. But I've seen all manner of nerves involved with the side of that implant as it runs from back through the armpit to the side.

I have people come in routinely and say, "Oh, I have all this nipple pain. I have all this electrical type activity here," and that's once the 12th nerve as it comes through that ear. I see it all the time. I try to take pictures of it too. Anytime I see it, I can show the client, "This is what was causing this." It's like a traumatic neuroma, basically.

Dave:

This is why I like talking with microsurgeons, because you know all that wiring stuff that I don't know, which is super cool. But the fat transfer, you're unlikely to have that because you can't. How many cup sizes can you go up with a fat transfer?

Rob:

Typically, it's one and a half cups. It varies. I always like anybody, I have examples in my mind where I feel like, yeah, this is a much better result than an augmented result, because an augmented result rarely looks natural because there's too much upper pole fullness typically. Over time it won't change with the breast because if you put it behind the muscle, the breast implant stays behind the muscle, the breast comes and ages and goes off of that.

You get like a change that's obviously not aesthetically attractive with time. You want something that will age with the patient. We have lots of clever ways to treat the skin now, so we can actually tighten the skin up over time in a non-scarring fashion, but we'll talk about that at another time.

Dave:

Guys, that was what in theater work we call foreshadowing, because there will be another episode because Rob's really a massive innovator in a couple different parts of this. The thing that most impressed me to have you on the show now is the fact that you're doing brain scans of people. Brain scans with breast implant illness, oh look, you are having changes. And then you're also doing the genetic testing. You're using the DNA company, which is also really, really cool.

Because guys, Dr. Mansoor [Mohammed] has been, I think four or five times, on the show because they're doing such cutting-edge DNA work.

To find that here we have a top expert in breast implant illness who's going to the DNA company. Yes, guys, I should disclose, I'm an investor and an advisor in the company, but you're doing that. I had no idea you were doing that until I sat down in your office. I'm like, "You're using who?" What are you finding on the DNA side with breast implants, because I think this is interesting?

Rob:

We talked a little bit about the urine marker and inflammation. That was a big puzzle piece. But the biggest puzzle piece has been functional genomics from Dr. Mansoor's group. I now have over 200 genetic reports on patients with breast implant illness.

Dave:

That makes me so happy.

Rob:

I explained to everyone, I can listen now. I didn't have this training obviously in medical school because we didn't have that information. But if you listen to and recognize the patterns of poor functioning genetic pathways coupled with environmental exposures, the story just writes it right in front of you. In my mind, I think of the four pathways described in their reports of immunity, the vitamin D pathway, the methylation pathway, glutathione essentially, and the antioxidant pathway.

Dave:

Geez, it's almost like if you've listened to any of the shows before, you've heard about these pathways, even if you don't have breast implant illness. Those one more time, glutathione.

Rob:

Glutathione, methylation, vitamin D, and antioxidant.

Dave:

Love it.

Rob:

Eventually I hope to write a paper where we just talk about the archetypes of what will lead to this. My first client who had that was not a breast implant illness client.

Dave:

No kidding.

Rob:

The first client I ever had, a male came to me. We do hair transplants and we use exosomes and all this stuff. He's like, "Dr. Whitfield, I want you to do my hair transplant." I was like, "Well, you have a lot of strange things in your health history and your review system." I don't understand why you have so much inflammation, and I don't operate on people with high amounts of inflammation until we can create a plan and get them on our heart protocol with supplements to just lower their inflammation.

Because you don't want to operate on somebody in a high inflammatory state because you're not going to cause that to be better, because Rob's the number one promoter of inflammation, right? I cause cortisol release. I give people problems.

Dave:

Well, that's what surgery is.

Rob:

That's what surgery does. Do no harm. I said, "You need to do this genetic test I have you. You'll get some insight from this." This guy, he was the first all four knockout I've ever had.

Dave:

All four knockout.

Rob:

He had a suboptimal vitamin D, methylation, glutathione, and antioxidant. I told this guy too, I was like, "Man, if you have breast implants, you would be so sick right now." He's like, "What are you talking about?" I was like, look, okay, when these things don't function, as you know, you're three out of four, I look at it with my clients and I was like, okay, if we have all four that don't function, they're acutely sensitive to this. They have difficulty with everything we try to implement. We implement it super slow. We take our immune support bundle.

We use only liposomal formulations so that we're bypassing the gut while that's trying to get healed, and really trying to bring their poor enzymatic function up so that they can actually have a reasonable level over maybe one or two months prior to surgery you're trying to get this built up. So when they have surgery, you're not then really setting them back, because what you don't know will really cause trouble for patients.

Dave:

I so appreciate that you're doing that. That's such a high standard of care for people. What differences do you see when people go through your prep protocols and how quickly they heal and what they do?

Rob:

Once we do the battery of tests that I feel helps you the most, and I would just say that I've spent the better part of six years curating this, the food test, the GI-MAP test, the hormone testing, our total toxicity testing, which identifies bisphenols, phthalates, herbicides, pesticides, heavy metals like arsenic and groundwater, which is chromium, and mycotoxins, which are what Dave refers to commonly about toxic mold exposures.

Combine that with our functional genomic testing, our inflammatory marker testing, and I can give you a very well-rounded picture of what I think from an individual standpoint you're facing and how we can help you. I'm kind of the air person, so I have air filters all over my office.

Dave:

You saw the ones around here too. I walked into your office, I'm like, "It doesn't smell like formaldehyde in here."

Rob:

No. We have the cleanest air in town in my office. But your water, so I gave you a hydrogen water bottle when you visited us. There's a lot of steps we can take just like you highlighted in your video. And then I use all of the programming prior to surgery to get you in the best possible position for surgery. At the time of surgery, it's very specific to how I run our... We call it a ERAS, enhanced recovery after surgery. I have a certain amount of medication that I use on a limited basis around the time of surgery.

You said you don't do well with propofol, I heard you talk about before. I do the explant surgery under dental anesthesia. The night before, you take a medicine to reduce nausea, reduce inflammation, and prepare your nervous system because...

Dave:

What's the medicine?

Rob:

We use some Gabapentin and Zofran and Celebrex. That's a common ERAS protocol around the United States. It's been published. We use one dose of IV antibiotics 30 minutes prior to incision to reduce skin site infections. And that's the standard of care. I don't put anybody on antibiotics after surgery.

Dave:

You take it orally beforehand?

Rob:

They give it to you IB.

Dave:

Oh, iv.

Rob:

30 minutes prior to incision.

Dave:

If it's IV, it's less likely to affect your gut bacteria, right?

Rob:

Typically. The big misnomer is that if someone gives you oral antibiotics after surgery, they're somehow going to protect you from an infection. That's nonsense.

Dave:

Wow. Okay.

Rob:

We do our case. I have a very programmatic way to do the case every single time. Our goal is always taking everything out intact every single time, whether we execute other steps, like I said, a lift or a fat transfer. That's case dependent. Once we get the material out of the pocket, we use a lower pH solution

for the pocket. So your audience understands, I have so much data regarding what's in a pocket. I would never use an antibiotic rinse to try to control what's in a pocket.

Dave:

You're just using some that's more acidic. You mean vinegar?

Rob:

Well, any unicellular or multicellular organism, as you know, cannot tolerate pH change. As soon as you do that, what's in the pocket is done.

Dave:

You don't use anything like ozone or silver or other things like that that are really old.

Rob:

I have ozone in the office, as you know, but I don't have it in the OR. I don't use drains anymore. I drain it internally. Especially when I'm doing fat transfers, I interconnect the abdomen and breast pocket to drain it internally. People who have tubes are more likely to get infection. I know that's heresy, but in general, if you have something sticking out of you, bacteria travels in, not out. Once that part of the procedure's done, I go and I take a series of pictures of the implants and capsules and do a couple videos, because patients want to know in real time what I found.

I just do a brief video for them and we make longer ones. And then I open everything on the back table, examine it. You can't really see what I'm describing from results we get from quantitative PCR. It's hard, even if there was a small cancer, you send that to the experts to look at under a microscope. I take a small biopsy. I send it to the lab in Lubbock, MicroGenDX. They do all of my quantitative PCR sampling. And that comes back in a couple business weeks normally. And then the pathology is sent to a lab here in Austin.

That's usually three to five business days turned around. We'll wash off the implants, return it to the client, providing they're not ruptured. I wrap everybody up. I know this is another heresy thing, but I put ice packs on everybody before they wake up.

Dave:

Okay.

Rob:

Because it's the best anti-inflammatory. The cheapest one that's most effective is ice. The three medicines I described before, ice packs, just changing them 30 minutes on, 30 minutes off while you're awake, even more frequently if you want, will control your pain. Oh, I guess I didn't mention this. I do an intercostal nerve block with a medicine that lasts about five to seven days. It's a liposomal bupivacaine, and it's called Exparel.

Dave:

It's like lidocaine, but stronger.

Rob:

Yeah. It's diffusing into the tissue, so it just sits there.

Dave:

Oh, that's really smart. Any of the caines, as I understand it, even procaine, they reduce inflammation of nerves. Reducing nerve inflammation seems to make everything better.

Rob:

When I see that nerve, I told you, I directly inject by it. They'll never have that pain again.

Dave:

How common is it that doctors do that? I mean, are you just doing an unusual procedure?

Rob:

Oh, I've Exparel, that medicine. Surgeons use it quite frequently. I've been using it since 2004.

Dave:

Okay, so it's not new news.

Rob:

No.

Dave:

For a lot of people, this is maybe like, well, this is a surgical thing. But here's the deal, if you're going to go get a surgery, you might want to do a little bit of homework and just find out whether the person you're working with thinks like Rob or thinks like kind of a cookie cutter approach. Because if you aren't prepared for surgery, your outcomes are going to be worse. If you have this weird inflammatory stuff that doesn't make any sense, maybe it's your breast, maybe it's a root canal is another common source of this kind of a thing.

Rob:

Oh yeah. At one time, we found prevotella.

Dave:

Oh, wow, that's not very...

Rob:

It's in your mouth.

Dave:

If you look at some of the stuff that Naveen is talking about with Viome, guys, Naveen Jain, CEO of Viome, I'm also an investor and advisor there, he's finding more and more mouth bacteria relations to what's in the gut and what's going on throughout the body. I think our oral microbiome and our gut microbiome, there's a lot more science coming out about that. It's one of those things where I don't

think I'll be able to stop doing a gut bacteria episode at least once every two months for the rest of my life at this point.

Rob:

Well, I mean, since you mentioned that, I get asked all the time, when can I stop taking all these supplements in my diet and da da, da? I always ask, are you feeling better? If you're feeling better, what would Dave tell you to do? He'd try to make you feel even better.

Dave:

As soon as you feel a little bit better, you should definitely drink a six-pack of Bud and eat a box of Twinkies, because now you can. I mean, it's obvious.

Rob:

Well, I just stop there and I was like, well, I think I want you to feel even better.

Dave:

Oh, you mean you can keep upgrading over? Oh geez. I guess, okay, it's a big leap. I'm glad you thought of that. How many pills a day do you take?

Rob:

About 40.

Dave:

You take 40 supplements a day. Is it working?

Rob:

Absolutely.

Dave:

Do you feel pretty good?

Rob:

I do. I do. By full disclosure, there's not anything I give a patient that I haven't taken. It was one of your shows. You've made me think about toxic mold a lot.

Dave:

Thank God.

Rob:

With all the genetics from cautious company, I'm just like, I hear the story and I ask them, if you go into a place where there's a lot of smoke, or if you have a strong chemical smell, does it bother you? Do you know lived in a place that had mold? And that's the entire State of Texas.

Dave:

Well, it's the entire world. I mean, it's such a massive problem.

Rob:

This is my hack. I give them oral liposomal glutathione in my office. If it doesn't taste like it's supposed to, which you know how it's supposed to taste, they'll be like, "Hey, this tastes like sulfur," yeah, your liver doesn't work very well.

Dave:

If people take oral glutathione and it tastes really bad, they need it even more.

Rob:

Yeah, because you can't outrun your diet, you can't pick your parents, but we can level you up. If you just slowly start taking oral liposomal glutathione, you can bypass a problem with your gut until that's better, but you can build up your enzymatic activity so that you're... It's what you say, it's hacking, right? You're adapting to what your functional genetics are. There's your genotype and your phenotype. We have this genotype, and we're trying to use these supplements to give us a slightly different phenotypic expression of what's going on.

It is uniformly accurate in my office when these people do this. I know they have mold exposure or a phthalate exposure or something on their tox report because that's where all of that goes is to your liver. Everybody's needs to understand. As Dave's alluded to on his show many, many times, toxins that go to your liver have to be dealt with in the glutathione pathway. If you can't, your liver burden, it becomes super abnormal.

Dave:

I do. I want to make sure, if you're listening to this and someone in your life has breast implants, you are at breastimplantillnessexpert.com.

Rob:

Yeah. We've leveled this up too because people have asked, can I figure this out on the front end? We have a quiz you can take to identify sign, symptoms, many things we've discussed. We've put together a consumer's guide to explant surgery to highlight things that we've talked about, things like our recovery program, things that you would need to continue to heal after surgery. I think if you've been listening to this, you understand that I don't focus on just the surgery.

Surgery's one aspect of this problem. It's really your genomics, your diet, your absorptive capabilities, your hormone balance, your toxicity level that dictate much of this, and we can now follow it and assess it. And then in my office, we see you at a week, a month, three month intervals after that, because I have so many people who travel from into Austin out of state. I do things virtually, of course. I have an entire team. I have a detox specialist. I have a nutritionist. I have a patient advocate.

I have NPs and PAs that are very... Many of them have had explants, as I can add. They're uniquely aware of the problem. You're not going to call my office and get shined... No shade will be thrown at you for calling my office. Everybody understands the issue. We want this to really elevate the understanding of the issue.

Dave:

My read on this is that you are moving your field forward. There are a few people who've been really, really brave about talking about breast implants like Danica Patrick, who's a friend, who's been on the show. She's been very public about it and just saying, "Hey, I feel so much better. I'm rebuilding my health after this. I believe that the real value that you've provided in this episode is, look, if someone wants bigger breasts, that's okay. That's biohacking. You can have bigger or smaller breasts.

You can also have two arms or one arm. I mean, you can remove an arm if you want. It's your body. You get to do whatever you want with it. But you should know what happens when you do that. Your proposal is saying, look, if you want to do it, you can do a fat transfer, which is safe or at least safer than the other alternatives, but it's not as safe as having no procedures at all because all procedures carry a risk. But that's a path forward. If that's your thing, you can do it. Number one, that would solve a lot of problems.

And then number two, just acknowledging people who've had a procedure with implants, what does it look like? Thanks for doing that. Guys, that URL was breastimplantillnessexpert.com, and I want you to go there. There's all kinds of resources. I mean, there's Explant, the documentary. Is that something that you did, or is that something that you just use?

Rob:

No, it's something that's been sent to us. I mean, there's more and more in this movement. I think our biggest contributions will be publishing our EEG study, our biofilm study, our genetic study. I'm going to try to add as much scientific data as we can.

Dave:

This is something that I know is real. I have too many friends, including doctors, in fact, many of them, who've had their implants removed and just feel so much better. Some very close friends. This is a real thing, just like mold. No one believes it's real. It can take traditionally 20, 30 years for something like even mold to become more real. But when you have an industry manufacturing devices that make a lot of money, they're going to suppress that kind of information as much as they can, and they'll do it because of profit.

It's like there's an evil overlord saying, "We will do this." They just make little decisions to highlight how good their stuff is and to ignore all the data on the opposite. But it's guys like you who are saying, no, this is reality. I genuinely appreciate that because that's how we move our whole species forward. Thanks.

Rob:

At Dave's encouragement, we've started a program to help train practices, other-

Dave:

Thank God

Rob:

-medical providers to learn about this. And then I've started an explant surgeon program to help. I think this is not taught really in training in a manner that is how I would do it. Just being able to provide some resources and opportunities for observation of surgery and learning the ins and outs.

Dave:

You're teaching surgeons how to do it right because you don't get that in medical school. It takes a long time working with the surgeon, and you have to have someone who maybe knows how to do it, which is amazing. If you want to change the field, that's what you have to do. It's an enormous amount of work. I can see you did the work to do the discovery.

The journey you described of noticing one patient that's saying, "This doesn't make sense," and just having that unrelenting mindset like, I'm going to figure out what this is, and doing EEG and doing PCR and all. That has changed God knows how many women's lives, this quiet hopelessness that comes when your brain doesn't work and you're exhausted and you're trying to do your job and your family and all that.

Rob:

To the women, we want to support you. To your listeners, if you have a friend, a colleague, your spouse, a sibling, a daughter, if they have these types of issues, we can highlight basic things. If someone's suffering from anxiety and/or depression, shortness of breath, tightness in the chest, heart palpitations, really lots of problems with their digestive tract from constipation to the diarrhea, to bloating, swelling, muscle and joint pain, restless legs, and they have this accompanying having breast implants, it would be useful to send them to breastimplantillnessexpert.com. Have them take a quiz and see if they can learn something and help them.

Dave:

Do that and show this episode. The whole point of the show here is that if something's really useful, then you send it to someone who could use it. All the resources are linked on daveasprey.com on the page for the podcast. Thank you for listening. Rob, thanks for amazing work in the field.

Rob:

Thanks for having me.